EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 3rd June 2014, commencing at 10.00 am in the Oak Room, Hastings Centre

	AGENDA		**Lead:**
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 26th March 2014	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Chief Executive's report (verbal)		CEO
6.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

7.	Quality Account 2013-2014	Approval	C	DN
8.	Performance Reports: a) Quality – March 2014 (Month 12) b) Finance – April 2014 (Month 1) c) Serious Incident Annual Report 2013/14	Assurance	D	DN/ MDCG/ COO/ HRD/ DF
9.	Update on the response to the Royal College of Obstetricians and Gynaecologists and Royal College of Paediatricians and Child Health reports on maternity and paediatric services	Assurance	E	
10.	Staff Survey Summary 2013 Summary	Assurance	F	HRD
11.	Research and Development report	Assurance	G	MDCG

STRATEGY

12.	Response to the Better Beginnings Consultation	Ratification	H	DSA/ MDS

DELIVERY

13.	Annual Business Plan 2014/15	Approval	I	DSA
14.	Financial Plan and Annual Budget 2014/15	Approval	J	DF
15.	Shaping our Future Phase 1 – Emergency and High Risk Trauma and Orthopaedics Move	Approval	K	COO

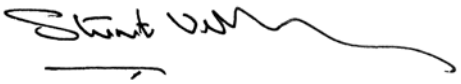
GOVERNANCE & ASSURANCE

16.	Fire Safety: a) Annual Report 2013 b) Fire Safety Policy	Assurance Approval	L	COO
17.	Trust Development Authority Monthly Self Certification	Assurance	M	CoSec
18.	Board sub-committees reports and Trust Board seminar notes: a) Finance and Investment Committee 30.04.14 b) Quality and Standards Committee 06.05.14 c) Trust Board seminar notes 12.02.14	Assurance	N	Comm Chairs
19.	Delegation of the approval of the Annual Report and Accounts for 2013/14	Approval		Chair
20.	Themes for Quality Walks	Assurance		Chair

ITEMS FOR INFORMATION

21.	Chairman's Briefing	Assurance	O	Chair
22.	Questions from members of the public (15 minutes maximum)			Chair
23.	Date of Next Meeting: Wednesday, 30th July 2014, commencing at 10.00 am in the Manor Barn, Bexhill			Chair

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



STUART WELLING
Chairman 28th May 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks March/April 2014
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

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

Introduction:

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

Themes for the walks are decided by the Board and the focus during March and April was as follows:

- General Surgery;
- Management of end of life care;
- Quality of Patient notes
- Maternity and Paediatric Services
- Aspects of Community Services feeling divorced from current issues;
- Impact of turnaround and financial recovery

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

22 services/departments were visited as part of the Quality Walk programme during March and April as detailed in the attached. In addition, the Medical Director and Chief Operating Officer visited all areas of the Rye Winchelsea and District Memorial Hospital. There were also a further two ad-hoc visits, one of which was carried out by the Trust Chairman and Director of Nursing who visited all wards at the Conquest Hospital out of hours (10pm – 2am). All of the other visits were arranged by the Assurance Manager or the Chief Executive's Office and the Ward or Unit Manager was notified in advance to expect the visit.

Feedback forms have been received to date relating to 19 of the arranged visits and both the ad-hoc visits. A copy has been passed on to the relevant department/service managers for information.

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

<u>General Surgery</u>

There were no areas of concern raised regarding General Surgery; very positive comments were noted relating to the implementation of Vitalpac.

Management of end of life care
This was not completed on the majority of feedback forms as it was not necessarily applicable to the area being visited, however one area stated that although they had looked after some distressing cases they had been managed well. End of life care was noted to be well embedded in culture and practice in the critical care setting.

Quality of Patient notes
There was little noted under this theme however one feedback form reported that the notes appeared excellent with no major risks or incidents identified. One Minor Injuries Unit reported issues regarding notes storage and copying facilities.

Maternity and Paediatric Services
It was noted that staff spoken to were positive about the moves of services that had taken place however concerns were raised about the future of the Midwifery Led Unit at Crowborough. Following the temporary change in the configuration of paediatric services it was noted that team working continues to improve and it is now far more united.

Aspects of Community Services feeling divorced from current issues;
Rye and Winchelsea District Memorial Hospital reported that out of hours medical cover had been withdrawn from 31st March 2014 as a result of a new out of hours contract, and they now had to call the out of hours service in Hastings if medical assistance was required, there was also no access to the mental health liaison service and psychiatric referrals had to be made through the GP service. They stated that they did feel however that being part of the Trust was beneficial, particularly with regard to accessing training, professional development and clinical support.

One of the Sexual Health Teams visited reported that they felt 'slightly more part of the Trust now.'

1 District Nursing team, 1 Health Visiting team and 1 School Nurse team were visited during this time period but they did not voice any concerns regarding not feeling part of the Trust, however the School Nurse team were concerned about the tender for services by East Sussex County Council.

The District Nursing Team visited noted that the number of contacts made by them was relatively stable but the acuity and complexity of patients was increasing significantly, they were positive about the implementation of SystmOne whereas the Joint Community Rehabilitation Service (JCRS) voiced concerns about it. The JCRS team however were very proud of their high standard of care delivery and were able to show high levels of positive patient experience feedback. It was noted that the team were very positive and forward thinking and the fact that they had no vacancies and minimal sickness out of a team of nearly 90 was a credit to them.

Impact of turnaround and financial recovery
The Speech and Language Therapy team (SaLT) visited voiced concern about delays in recruiting staff which had led to gaps in service impacting on the level of patient care, the numbers of patients seen and not being able to provide staff with adequate and varied training and experience, which in turn made posts less attractive.

At the Conquest Hospital ad-hoc visit to all wards there were no highlighted quality and safety issues identified, but some environmental issues were noticed and these had been escalated to the Chief Operating Officer.

Rye and Winchelsea District Memorial Hospital reported that payment of Health Care Assistants on bank shifts had started to be a problem with the turnaround changes to the rates of pay being less than their permanent post rate of pay. This had meant for the first time that they had used agency staff.

Other key issues
The Sexual Health service visited noted that the service is to be tendered in 2015 and raised concerns about the process and how it will be supported.

Patient feedback
The Sexual Health service visited reported very positive FFT results as did JCRS. There were no direct patient comments from patients recorded on the feedback forms.

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

Further visits are scheduled to take place in May and June as detailed on the attached.

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

- Health Visiting;
- Maternity and Paediatrics;
- Trauma and Orthopaedics;
- General Nurse Staffing Levels;
- Impact of new IM&T;

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

Proposals and/or Recommendations

The Board are asked to note the report.

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

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

Not applicable.

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

Name:	**Contact details:**
Hilary White, Assurance Manager (Compliance)	Hilary.White@esht.nhs.uk

Quality Walks March April 2014				
DATE	**TIME**	**SERVICE**	**SITE**	**Visit by**
March				
3.3.14	5pm	Sexual Health	Station Plaza	Vanessa Harris
6.3.14	11am	Cuckmere	EDGH	Darren Grayson
10.3.14	2pm	Benson	Conquest	Darren Grayson
10.3.14	3pm	Cookson Devas	Conquest	Darren Grayson
10.3.14	2.15pm	Paediatrics	Conquest	Stuart Welling
17.3.14	12 midday	Diabetes Team	EDGH	Jon Cohen
17.3.14	10.30am	Health Visitors	West Hastings Childrens Centre	Alice Webster
17.3.14	2pm	District Nurses	Station Plaza	Stuart Welling
19.3.14	2pm	School Nurses	Ore Clinic	Amanda Harrison
20.3.14	2pm	Radiology	Crowborough	James O'Sullivan
28.3.14	11am	Kipling	Conquest	Darren Grayson
28.3.14		ITU	Conquest	Darren Grayson
28.3.14		Theatres	Conquest	Darren Grayson
31.3.14	10.30am	SaLT	EDGH	Monica Green
April				
3.4.14	3pm	Maternity led Unit and in patients	Crowborough	Stuart Welling
7.4.14	9am	All wards and departments	Rye Hospital	David Hughes Richard Sunley
7.4.14	10am	MIU Radiology	LVH	Amanda Harrison
9.4.14	10am	District Nurses	Westfield	Stuart Welling
15.4.14	2.30pm	James Ward	Conquest	Darren Grayson
17.4.14	10pm - 2am	All areas	Conquest	Alice Webster Stuart Welling
23.4.14	3.30pm	JCRS	Firwood	Alice Webster
28.4.14	4pm	Jubilee Eye Suite	EDGH	Darren Grayson
30.4.14	10.30am	Hailsham 4	EDGH	Monica Green
Quality Walks Scheduled for May June 2014				
May				
4.5.14	10am	MaxFax OPD	Conquest	Darren Grayson
7.5.14	3pm	Irvine Unit	Bexhill	Stuart Welling
8.5.14	1.30pm	Seaford 3	EDGH	Stuart Welling
12.5.14	3pm	Dowling Unit	Bexhill	Amanda Harrison
13.5.14	2.30pm	Sexual Health	Station Plaza	Stuart Welling
23.5.14	2pm	SCBU	Conquest	Vanessa Harris
22.5.14	10pm	A&E	EDGH	Vanessa Harris
26.5.14	10am	Sovereign Ward	EDGH	Stephanie Kennett
28.5.14	3pm	Friston SSPAU	EDGH	Jon Cohen
29.5.14	10pm	East Dean	EDGH	Sue Bernhauser
30.05.14	11am	Electro Medical Engineering (EME)	Conquest	Monica Green
30.5.14	10am	HV's School Nurses Fellowship of St Nicholas St Leonards	Hastings	Alice Webster
June				
4.6.14	6.30am	Folkington	EDGH	Monica Green
6.6.14	9.30am	Sexual Health	Avenue House	Vanessa Harris
9.6.14	2pm	Community Paediatric Team	Conquest	Amanda Harrison
9.6.14	11am	Newington	Conquest	Monica Green
9.6.14	3pm	Sexual Health	Station Plaza	Stuart Welling
13.6.14	2pm	Child Protection Team	Conquest	Sue Bernhauser
16.6.14	2.30pm	Delivery Suite	Conquest	Vanessa Harris
18.6.14	12.30pm	Ward Out Patients	Crowborough	Alice Webster
19.6.14	3pm	CCU	EDGH	Stuart Welling
19.6.14	3pm	CCU	EDGH	Darren Grayson
26.6.13	9am	Audiology	Eastbourne Park Primary Care Centre	Amanda Harrison
27.6.14	11am	District Nurses	Marlborough House St Leonards	Stephanie Kennett

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday, 26th March 2014 at 10.00 am in the Ashdown Room, Uckfield Civic Centre

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

In attendance: Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chairman
Ms Dee Daly, Cancer Services Manager (for item 022/2014a)iii))
Mr Andy Horne, Programme Director – Market Testing (for item 023/2014)
Ms Paula Hunt, Nurse Consultant – Occupational Health (for item 023/2014)
Mr Christian Lippiatt, General Manager – Occupational Health (for item 023/2014)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

016/2014 **Welcome and Apologies for Absence** **Action**

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the meeting and in particular welcomed Jon Cohen to his first formal Board Meeting since his appointment as a Non-Executive Director.

Mr Welling announced that Mr O'Sullivan would be leaving the Trust at Easter to join Southend University Hospitals Foundation Trust as their full-time Director of Finance. He thanked Mr O'Sullivan for his excellent work as a Non-Executive Director and outstanding Audit Chair.

He also announced that Gary Barnes, who worked for Oracle Healthcare Systems, had taken up an unpaid role to provide assistance to the Trust in developing its Information Management and Technology services.

b) Apologies for Absence

Mr Welling reported that apologies for absence had been received from Stephanie Kennett and Barry Nealon, Non-Executive Directors.

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

c) Monthly Award Winners

Mr Welling announced that the monthly award winners for February were Beverley Attridge, Matron, and Sarah Canning, Principle Optometrist. The nomination by Sue Allen, Head of Nursing, read:

“They both worked tirelessly to ensure the relocation of the Age Related Macular Follow Up Service to Bexhill went very smoothly, after many months of planning.

This had required employing a new team and both Beverley and Sarah have been instrumental in hosting and supporting this new team with additional training and team building sessions. They both worked late into the evenings and on days off unpacking boxes and ensuring deadlines for the opening on 13th January would be met.

They also both met with the local Macular Societies to reassure patients about the relocation and answer patients’ queries and concerns. Sarah and Beverley organised the open day where several hundreds of patients and their relatives came to view the new unit.

There have been many difficulties to overcome but both had remained positive and driven in their belief that the relocation of this service would be delivered on time and to a high standard to the benefit of the patients and staff working in this new unit.”

The Board congratulated them on their efforts.

Mr Welling announced that the monthly award winner for March was Midwifery Matron Debbie Gowers from Crowborough Birthing Centre who had been nominated by a colleague as follows:

"Debbie is a very supportive band 7. If you ever have any worries or concerns she will make time for you to sit and chat with her (even though she is incredibly busy). She stays on late on a number of occasions sorting different bits out but never once complains about doing it. She goes above and beyond all the time."

d) Feedback from Quality Walks

Mr O’Sullivan reported on a day spent with one of the District Nurses and he gained an insight into the work the community teams undertake and they dealt with many frail, elderly and vulnerable patients.

He had received unsolicited tremendous feedback from both patients and carers about the work of the team although some feedback had been not so positive in relation to continuity of care.

Mrs Webster reported that she had gone out with the health visiting teams in east and west Hastings, and in Bexhill. The teams worked out of children centres as part of the multidisciplinary team around the child and the concept was to ensure that both health and social care supported the family in a joined up way. They were focused on looking at the person as a whole and supported the delivery of programmes relating to parenting, self esteem, stress and yoga, baby massage and many more.

She advised that staff had expressed an issue of concern in relation to the government led initiative to increase the numbers of health visitors on the ground – "Call for Action". Whilst they welcomed and were positive about the initiative, especially the positive impact on families, they were at present challenged to deliver the high numbers of supervised placements that were required.

Mr Welling noted that the report circulated with the agenda set out the walks undertaken since the last meeting and the key issues and discussion points.

The Board noted the reports on quality walks.

017/2014 **Declarations of Interest**

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

018/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 29th January 2014 were considered and approved as an accurate record.

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

b) Matters Arising

The matters arising log was noted and there were no further actions to report. It was noted that the Quality Governance Strategy had been removed from the agenda and would be presented at a future meeting.

019/2014 **Chief Executive's Report**

a) Quality and Safety

Mr Grayson reported that the Care Quality Commission (CQC) continued to visit different services and recent inspections had identified no significant areas of concern. A Chief Inspector of Hospitals inspection was expected later this year or early next and preparation for the visit had commenced.

He advised that performance remained good, particularly in A&E where the Trust continued to achieve the 95% 4 hour standard and, whilst it had been a good winter in terms of weather, it had not been an easy one. The Trust was focussed on reducing the number of people waiting over 18 weeks and there had been a significant increase in the number of elective patients being operated on – an average of three more inpatients per day over the last few weeks of the quarter plus a substantial increase in day patients.

Mr Grayson highlighted that the centralisation of the stroke service was continuing to pay dividends for patients with all the key quality indicators being delivered for the last three months. In addition, the Trust's Combined Unify Net Promotor Score (NPS) continued to be in the mid 60s and the latest patient satisfaction survey showed that 75% of patients had been satisfied with the service they received. A common issue of concern for patients and carers was food and the Trust had recently contracted with a new supplier and the feedback was that the food was better.

He reported that there had been one MRSA case reported which was very regrettable but was the first in a year. He advised that the number of Clostridium Difficile cases was running at approximately 12-15% lower year to date than for 2012/13.

b) Finance

Mr Grayson reported that good progress was being made on the turnaround plan in line with expectations whilst safety and quality were being maintained. The Trust was forecast to achieve 5% savings at the end of the financial year compared to the national requirement of 4% but he warned that the challenge would be even harder for 2014/15.

He reported that the East Sussex health economy had been designated a challenged health economy, one of 11 in England, and he welcomed that the work would focus on securing sustainability across the whole of the health economy.

He commented that the review would build on the unprecedented success the Trust had had in developing and implementing its clinical strategy and heralded a much needed radical change in approach. It would enable the local health economy to develop a fully aligned commissioning and delivery plan for the next five years.

Mr Grayson advised that the Board would be closely involved in the process as it unfolded and he would report on progress at future meetings.

c) Strategy

Mr Grayson reported that the Better Beginnings consultation on maternity and paediatric services was drawing to a close and noted that it had been a well run process and thanked the number of staff who had participated in the events. The Trust had attended the Health Overview and Scrutiny Committee evidence gathering session and had the opportunity to present and discuss the hard evidence of the safety and quality improvements that the temporary centralisation had achieved for patients and their families.

He noted that the Board would consider its response in April and the outcome of the consultation would be known by June/July.

The Board noted the report.

020/2014 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework and noted that it had been considered by the Audit and Quality Standards Committees at their meetings earlier in the month. She advised that updates and revisions had been made in red and there were no new gaps added but there were some amendments as assurance had increased against financial plans and cash holding, the need to develop clinical engagement and, following discussion at the Audit Committee, the level of assurance around recruitment risks had moved from red to amber.

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

021/2014 **Quality Improvement Priorities**

Mrs Wells reported that it was a statutory requirement for Trusts to produce a Quality Account each year and the majority of the information included was mandated. However, the Trust had control over the selection of its Quality Improvement Priorities (QIPs) and her report outlined the process that had been undertaken to achieve the shortlist of priorities including a patient engagement event.

She reported that the proposed QIPS fell into three domains:

Patient Safety

- Maximise our efforts to reduce healthcare acquired infections

Clinical Effectiveness

- Early recognition and action to support the care of the deteriorating patient – linking to Vitalpac

Patient Experience

- Continue to implement the Patient Experience Strategy
- Ensure that optimal care is provided for patients in the Trust's care who have mental health disorders

Mrs Wells reported that it had been planned to include a priority around the new community information system but this had been withdrawn as the benefits would not be realised until the following year once implementation was complete.

She advised that the Quality Account had to be published on 30th June 2014.

Professor Cohen asked how the priorities would be measured and fed back on and Mrs Webster advised that there would be detailed projects being undertaken and there would a quarterly report on progress.

In relation to patient experience, Mr Ellis congratulated Mrs Webster on the Dignity Day which she had organised recently. The day had been attended by clinical staff and members of the public and had discussed how dignity of care was being taken forward in the Trust. The feedback from members of the public had been that there had been a real improvement in the last two to three years, with people being listened to and learning from issues.

The Board noted the Quality Improvement Priorities and timetable for production of the Quality Account.

022/2014 **Performance Reports**

a) Quality Report including Performance, Activity and Workforce – January 2014 (Month 10)

i) Quality

Mrs Webster reported that the Trust had reported 43 cases of Clostridium Difficile (C Diff) year to date against the limit of 25 cases for the year and at the same period last year the Trust had reported 50 cases. Mr Grayson asked how many of the 43 cases this year were avoidable and Mrs Webster advised that six or seven were potentially avoidable due to outbreaks. He noted that approximately 38 to 39 of the cases were unavoidable and the avoidable cases often related to issues around ward environment. Mr Grayson advised that the C Diff objective agreed for 2014/15 was 44.

Mrs Webster reported that there had been one MRSA case since the last meeting and Mr Grayson queried the learning from the Root Cause Analysis (RCA).

Mrs Webster advised that the RCA had highlighted that testing needed to be more pro-active with appropriate screening processes undertaken, and increased rigour was needed in cleaning patient equipment, hand hygiene, the use of gloves and the disposal of equipment used.

She reported that there had been one mixed sex breach which had affected two patients and this was a reduction since the last meeting and demonstrated that the minor works undertaken in A&E at the Conquest were showing benefits.

Mrs Webster noted that there had been an improvement in the number of MUST assessments undertaken and this had been aided by the implementation of an electronic data capture system.

She reported that there had been a slight increase in patient safety incidents in January and there had been eight incidents of severe harm which were all subject to investigation and root cause analysis.

She advised that there had been an increase in the number of patients having a falls assessment to 91% and this had also been aided by the implementation of the electronic data capture system. Mrs Harris asked what was required to achieve the 95% standard and Mrs Webster advised that focus was on admissions through the assessment units and ensuring that assessments were undertaken in these areas.

Professor Cohen expressed concern that the trend line for severe harm incidents was rising and Mrs Webster advised that every incident was reviewed and there were occasions when the incidents were wrongly categorised and she would expect the number to reduce.

Discussion took place on complaint response times and Mrs Webster noted that there had been a significant improvement in the number of responses provided within timescales although the 95% threshold had not yet been achieved.

Dr Hughes reported that there continued to be good progress with medical revalidation and the system was now embedded in the organisation. There had been a satisfactory internal audit review of the process and plaudits had been received from the national team. He advised that the next step would be to show how revalidation links to the quality and safety benefits for each individual doctor over the next year.

ii) <u>Performance</u>

Mr Sunley reported that January had been a disappointing month as overall performance had dipped to below the ‘under review’ threshold in the National Performance Framework (NPF) for the first time in the year.

He reported that the key areas of non-performance in January had been the Referral to Treatment (RTT) waits, diagnostic waits and the all cancer 2 week waits and the 2 week wait symptomatic breast service.

He advised that the Trust had however continued its strong performance in A&E waiting times and sustained improvement in the stroke indicators.

He advised that In relation to A&E the Trust had performed well and had delivered green or amber for every month since April last year. He expected the quarter 4 and the year end target to be delivered by the end of March. This had been achieved through the winter plans laid down in late autumn which had enabled the Trust to cope in the midst of service reconfigurations, interim management structures and increased A&E attendances. The key to success had been the focus and team working of all staff involved, the extra winter funding of discharge facilities, discharge teams, private out of hours ambulance services, increased winter intermediate care capacity and close working with a responsive adult social care service had also contributed. He congratulated Pauline Butterworth, Dr David Hughes and the operational team for the on-going achievement.

Mr Sunley reported that the position for month 10 was failure on all the Referral to Treatment (RTT) targets and diagnostic 6 weeks targets and the Trust was in weekly discussions with the Trust Development Authority (TDA), Clinical Commissioning Groups (CCGs) and the national intensive support team was working with the Trust. The Trust had not achieved the targets through February and March as it continued to treat patients in order and reduced the use of expensive third party providers.

He advised that the backlog had reduced through improved activity, increased validation from the clinical unit teams, a re-organisation to increase management resources to focus on clinical engagement and clinical triage. The Trust was aiming to deliver the aggregate level by month 1 (April) in 2014/15 and at a speciality level for the first time ever by month 7 (October), with orthopaedics being the last to deliver.

In relation to diagnostic waits Mr Sunley reported that the Trust had been struggling to provide the required capacity following the cessation of ad hoc sessions in November. Capacity had been increased by pooling of lists, changes to training sessions and improved focus on efficiency, and he anticipated that the Trust would be performing in April, and a sustainable capacity level would be reached by September with the introduction of further nurse endoscopists.

He reported that there had been slippage on the 2 week wait all cancers and the 2 week wait symptomatic breast, the first being due to diagnostic waiting times and the second due to breast referrals up over 20% due to the national screening campaigns and high profile breast cancer cases.

He was pleased to report that mixed sex accommodation breaches had reduced to one in month 10 with the completion of some minor alterations in the A&E department in Hastings.

He advised that there had been zero breaches in month 11 but sustainability would only be achieved with the re-organisation of the emergency department area at the Conquest as part of the clinical strategy funding.

Mr Sunley reported that the stroke service had now achieved a sustainable level of performance since centralisation at Eastbourne DGH. For the second month running in January the Trust had achieved the direct admission to a stroke unit target and the indications for February were that this had continued for three months (rising to 96%). He congratulated the clinical unit, site team and supporting services on this achievement.

Professor Cohen queried the pinch points operationally and Mr Sunley advised that they related to radiology and endoscopy. The issue of MRI scanner access at Conquest and Eastbourne DGH had now been resolved and the numbers waiting had reduced considerably in the last few weeks. In relation to endoscopy some ad-hoc sessions had been reinstated, training sessions changed to service sessions, some under-utilised respiratory sessions changed to colo-rectal and two further nurse endoscopists were being trained up which would provide sufficient leeway for annual leave, etc.

iii) <u>Cancer Waiting Times Action Plan</u>

Ms Daly was welcomed to the meeting and reported that she had been asked by the Chief Executive to review how cancer waits were managed in the Trust following the issues that had arisen recently at Colchester Hospital University Foundation Trust. She was able to provide reassurance as the Trust now used the national Somerset Cancer Registry electronic database, and had previously an in-house electronic database, and not a manual system as had been used at Colchester. She had incorporated a number of the recommendations from the CQC report on Colchester into the Trust's cancer waiting times action plan.

Mr Grayson advised at Colchester there had been pressure put on individuals to maximise performance but as ESHT was part of the Somerset system there was not the ability to manipulate the data and Ms Daly confirmed this and advised that the pathways were regularly audited.

Mrs Harris queried whether there were sufficient resources to manage the system and Ms Daly confirmed that there were sufficient staff but they needed to be restructured in order to provide more emphasis on tracking patients and this was the first item on the action plan. She advised that this was being progressed.

Ms Daly reported that the Patient Target List (PTL) meeting was also being revised to enable staff to be able to drill down to the patient level detail and a root cause analysis (RCA) was undertaken of every single patient breach. She noted that some breaches were unavoidable due to the complexity of treatment.

Ms Daly reported that she was working closely with the GPs and primary care in general to encourage them to have the right conversations with their patients about not deferring appointments in relation to 2 week waits. The issue appeared to be more of a problem at the Eastbourne side of the patch and Dr Harrison advised that specific individual patient details were required in order to be able to escalate this with the Clinical Commissioning Groups.

Ms Daly highlighted the issues around 62 day bowel screening which was a complex pathway and currently patients could only be seen at either Conquest or Brighton as the unit at Eastbourne DGH was not yet accredited, and this reduced capacity. Mr Sunley reported that it was planned to apply for accreditation for the Eastbourne unit in April.

Ms Daly reported that breast screening was also a challenge as women attending local mammography screening units were called to Brighton if additional tests were required as it was the hub for screening. If there were any delays in the pathway at the beginning, the Trust had no control as it was not the screening hub and it only had control when the patients were referred back to our clinicians. She was working closely with Brighton to establish a process for the Trust to be notified in advance when its patients required surgical intervention and progress was being made. The other issue in terms of breaches was that they only involved small numbers and, if one patient was not treated within the timeframe, this could potentially cause a breach.

Mr Grayson asked if the increase in breast referrals over the last three months was a spike and Ms Daly reported that there were two principle causes – an early awareness campaign for women over 70 and a high profile story line in a soap opera - and both were having a significant effect but she did not think it was a permanent increase.

Mr Welling asked whether the Trust would be compliant with the targets at a sustainable level during 2014/15. Mr Sunley advised that there were a number of multi-faceted issues, some of which were within the Trust's control and some not, but the re-organisation of co-ordinators would help to deliver progress.

Mr Welling thanked Ms Daly for her presentation and in particular for the assurance provided from her review in relation to the Colchester issues.

iv) <u>Workforce</u>

Ms Green reported that in January less staff had been used to deliver the activity due to a reduction in permanent staff and overtime.

Ms Green advised that this had been offset by a small increase in bank and agency usage due to winter pressures and clinical issues. She reported that there had been an increase in medical agency in January but this had reduced again in February.

She advised that there had been a very slight reduction in sickness absence in January and the February figures were indicating that it had reduced even further. Detailed work was being undertaken reviewing the reasons for sickness including an Occupational Health survey on stress. Focus was also concentrating on long term sickness and how this could be reduced and measures being put in place were quite effective. She advised that most organisations were above the historical national target of 3% sickness absence and the Trust was not an outlier.

She reported that there had been a slight improvement in some areas of mandatory training and it was planned to introduce a Staff Passport in April for mandatory training in conjunction with other Trusts in the south east coast area. In addition, further e-learning training was being rolled out and the frequency of training sessions increased.

She highlighted that there were a number of areas where the levels of appraisal for non-medical staff were not acceptable but a new appraisal system for these staff was being introduced in April which tied in with the values and behaviours work and in a national initiative whereby only incremental progression would be allowed if staff had met their set objectives.

Mr Welling requested a greater emphasis on infection control and manual handling and Professor Cohen enquired about the provision of infection control training. Ms Green advised that the infection control nurses provided focused training to different groups of staff. She highlighted that staff found it difficult to attend mandatory training due to pressures on ward areas and it was planned to provide training to groups of staff in different ways, eg handover sessions, and increase e-learning.

Mrs Bernhauser shared the concerns around mandatory training, particularly manual handling, as this was a risk to both staff and the Trust and needed re-emphasising.

Mrs Harris asked whether there had been an improvement in Information Governance training in February and March as it had moved into red in January and Ms Green confirmed that it had improved.

The Board noted the quality report for January 2014.

b) Finance February 2014 (month 11)

Mrs Harris reported that the deficit had increased by £1 million in the month which compared against the original plan was favourable but not against the in year plan.

Mrs Harris reported that the deficit at the end of February amounted to £22.2 million and the forecast outturn for the year end was £23.1 million against the original plan of £19.4 million.

She reported that agreement had been reached with the Clinical Commissioning Groups (CCGs) on the amount of fines and penalties which had allowed the year end position to be calculated.

Mrs Harris advised that the difference between the planned £19.4 million and the forecast £23.1 million deficit was due to £2.5 million non delivery of the original cost improvement programme (CIP) plan and £1.2m of cost pressures. She explained that good progress had been made since the introduction of turnaround in October and re-emphasised that all turnaround schemes have been through a quality impact assessment.

She reported that the total costs amounted to £31.3 million which had been controlled better over the last six months of the year than in the first six months and this had been achieved through the minimisation of ad-hoc and premium costs, management of agency expenditure to a minimum and an improved recruitment process.

She advised that the risks to the year end position were now very few and related to pressure to incur premium costs, loss of control over agency usage and costs arising from stocktaking.

Mrs Harris reported that there was a significant impairment adjustment of £10 million following an assessment by the District Valuer during the year and this related most significantly to community assets of £6.8 million.

She confirmed that the Trust had received the allocation of permanent revenue Public Dividend Capital (PDC) in February which had allowed the temporary borrowings to be repaid and, following the agreement on fines and penalties and the likely outturn, the Trust had been able to repay a significant amount of over 30 day creditors in February and she anticipated that in March the Trust would achieve or be close the Better Payment Practice Code standard.

Mr Grayson reminded the Board that two years ago the Trust had agreed a two year plan with the commissioners which enabled the Trust to receive transitional funding whilst it restructured to improve efficiency and implement the Shaping our Future strategy. In year 1 the Trust received £16 million of additional support and in year 2 expected to receive £18 million but following the major restructuring of NHS the new commissioners were not in a position to honour the second year of the deal. The Trust had therefore set a deficit budget for 2013/14 which was 6% of its turnover and it had started the financial year with plans to achieve this but it became clear that towards the end of the second quarter it was not able to deliver the savings as quickly or at the level anticipated and the decision was taken to move into formal turnaround.

He reported that the Trust had now achieved £17.5 million of savings (5% of turnover) and maintained performance and safety at all levels. It had been recognised that the East Sussex health economy had one of the biggest financial challenges in England and this was why it had been included as one of the challenged health economies.

Professor Cohen queried why there had been an increase in elective excess bed days (XBDs) and non-elective excess bed days over the last year.

Mrs Harris advised that elective XBDs had increased by 14 compared to the previous year, mainly in trauma and orthopaedics, urology & respiratory, and the increase was not significant. Non- elective XBDs had increased by 2,275 compared to the previous year, mainly in trauma and orthopaedics, geriatrics and general surgery, which was the result of an increase in emergency in-patients and changes to trim points.

She explained that trim points were set at a standardised length of stay for each Health Resource Group (HRG) and lengths of stay beyond the trim point generated excess bed day income. Changes to trim points could arise for a number of reasons, notably arising from the latest reference cost collection or from changes in the methodology for standardising length of stay. Trim points were reviewed annually and could fluctuate significantly.

The Board noted the finance report for February 2014

d) Patient Experience Quarter 3 - October – December 2013

Mrs Webster presented the report and referred to the patient experience champions who had conducted a significant piece of work on dignity (as mentioned earlier in the meeting) which would be fed into the patient experience strategy.

She reported that there had been an increase in the number of complaints and the key themes remained issues around communication and care delivered. She advised that 100% of complaints had been acknowledged within 3 days but the number of overdue responses had risen slightly.

She noted that the report contained an example of how learning from complaints was shared and in the quarter advised that six complainants had referred their cases to the Health Service Ombudsman as they were not happy with the Trust's response. The Ombudsman had rejected two, accepted two and requested further information on the other two before making a decision.

She reported that the overall satisfaction score of all patients surveyed during the quarter was 86.8% and nutrition and quality of food had been the main concerns.

Mrs Webster outlined the steps taken by the catering team to address these concerns including the introduction of a new provider of meals, Steamplicity, in February 2014.

Mrs Webster reported that the Friends and Family Test (FFT) response rate was 25.9% for inpatients and the overlying score could be broken down to clinical unit level and issues discussed with the individuals concerned. She highlighted that work was being undertaken with the A&E teams and service users to improve data collection. The maternity services had commenced the FFT in October with patients being offered the opportunity to complete the FFT in relation to their ante-natal, delivery and post-natal care.

Mrs Webster outlined the top five PALS concerns and noted that standards of care and communications were the top two issues.

Mr Welling referred to the shared learning in practice example and Mrs Webster advised that staff sometimes made the assumption that patients would raise any issues and they needed to ensure that they asked patients if they had any issues.

Mr Sunley reported that as part of the efficiency work in theatres the pre-admission assessment system was being reviewed and streamlined and they would incorporate the quality issues raised in the report.

Mr Grayson queried whether the number of complaints referred to the Ombudsman pre-dated the Ombudsman's change in practice and Mrs Webster confirmed that this was the case and she expected more complaints could be considered in the future by the Ombudsman.

Mrs Webster outlined in more detail how the process for sharing learning from complaints worked. She said that following identification of issues at the clinical unit governance meetings actions and learning were shared upwards through the Patient Safety and Clinical Improvement Group where the issues were discussed and shared across the organisation. If there was a specific issue there would be a briefing to the Heads of Nursing and newsletters were produced by individual clinical units and shared with other areas. In addition, service users were invited to talk to groups of staff and a service user would be coming to the Quality and Standards Committee in April/May. She confirmed that any actions identified from complaints were monitored through the governance meetings.

Mrs Harris reported that there had been recent national interest in the number of times patients were moved from ward to ward at night and asked how this was managed internally and how it was measured. Mrs Webster advised that patients would only be moved if there was a clinical need and all such moves were discussed at bed meetings to ensure that they were clinically appropriate. Patient moves were recorded on the PAS system but, if the time of the move was not recorded, the system automatically defaulted to midnight.

Mrs Webster advised that a manual trawl of the records would therefore be required to identify the actual time of the move. She noted that a change in the system was being considered to ensure reporting of ward moves could be improved.

Mr Ellis reported that the Quality and Standards Committee were planning deep dives into complaints and pre admission assessment clinics.

The Board noted the Patient Experience Report for quarter 3 – October to December 2013.

023/2014 **Market Testing Programme**

Mr Horne presented his report and noted that it was supported by three commercial in confidence business cases for the occupational health, pharmacy manufacturing unit and staff crèche services.

Mr Horne explained that all three services had been benchmarked against national and local quality standards and financial costs and the three business cases had been reviewed by a number of committees in the Trust.

He reported that in relation to the occupational health services it had been difficult to drive through the efficiency requirements and all the committees recommended that this service should be market tested in order to ensure quality and value for money. The service specification was in the process of being finalised and there was also the opportunity to work with another local Trust in relation to this service.

Mr Lippiatt highlighted that the benchmarking data received showed that the cost for the service per employee was below average. Ms Hunt reported that there had been a lot of work undertaken to improve the service before the transformation plan had been put in place. This included work in relation to providing an improved service to support staff in the management of stress, delivering a Health & Wellbeing service, more telephone consultations and cutting waiting times from management referral to first contact. The service currently had a significant issue with sickness absence but was addressing this through the development of existing staff.

Mr Horne reported that a transformation plan had been produced for the pharmacy manufacturing unit which was a non-core service. If the net surplus dropped below 10% or £1.5 million the service would be referred back for a further review. He advised that the unit was not suitable for market testing as it only received small orders with a quick turnaround and a number of other such units would be very capable of taking up the extra capacity.

He highlighted that there was a high cost to ceasing the service including redundancies, loss of contribution and loss of any surplus.

Mr Horne reported that there was a possibility that the quality control department could be market tested and this was being discussed with the unit.

He proposed that the unit should be kept under review and, if the net surplus dropped below 10% or income level below £1.5 million, it would be referred back to the Finance and Investment Committee for review.

In relation to the staff crèche, Mr Horne reported that on the Conquest site the service resided in a building that would need to be replaced and, whilst this was not a core service, it was highly valued and the view was that the Trust would want to continue to provide the service. He advised that both services currently provided a small surplus which could be further increased through a transformational plan. However, because of the requirement for a significant capital investment at the Conquest site the proposal was the Trust should seek a partner to run either one or both crèches in partnership and discussions were taking place with potential providers.

Mr Lippiatt reported that the survey on the life expectancy of the Conquest crèche building was awaited but it was anticipated it would be 5-10 years.

Mr Welling asked how communications with staff were being handled and Mr Horne reported that there were two elements to the communications plan – newsletters and updates sent out via the normal process and then in-depth discussions with each of the groups going through the process. Mr Lippiatt advised that he met staff, gave feedback and answered questions face to face and/or via internal e-mails.

Mr Horne reported that Ms Humber or one of the members of the Joint Staff Committee had been invited to the market testing programme committee and regular updates were provided to the Joint Staff Committee for their meetings.

Ms Humber confirmed that she attended the programme meetings when she was able, received written monthly reports and market testing was a standing agenda item at every Joint Staff Committee meeting and she had no significant concerns about way the process had been handled.

Ms Green reported that she managed the occupational health and childcare services and, whilst they were not core services, they were very important services for staff and delivered very well. She highlighted the importance of maintaining the Staff Crèches as it was an attraction in the recruitment of staff and they provided after school clubs and emergency childcare, for example if schools unexpectedly shut or in cases of bad weather. She acknowledged that the life expectancy of the building on the Conquest site was an issue.

Dr Slater agreed that the staff crèches were highly valued by staff as historically it had been difficult to recruit to the Conquest and the ability to provide childcare that complimented working times should be taken into consideration.

Ms Green advised that the occupational health service enabled the Trust to fulfil its requirements to ensure that staff were fit and healthy to provide safe services and this included pre-employment checks, regular screening, absence handling and an extensive programme in Health & Wellbeing.

Mrs Bernhauser asked what the staff feedback was formally and informally and Mr Horne reported that in terms of general staff there was a level of anxiety about the market testing process as staff were not familiar with this approach and it was important to ensure that communication was maintained and explain what would happen if a service moved to a different provider and the impact of TUPE.

Mr Grayson stated that market testing was a normal process as many NHS organisations had undertaken the process a number of years ago but it was not known in East Sussex.

He recognised that, whilst it was not welcomed by staff, the Board had agreed that different options for the future delivery of some services needed to be considered.

Mr Welling queried the timescales to the end of process and Mr Horne advised that the service specifications would be developed relatively quickly but there would be a requirement for an OJEU process which would take five to twelve months and then the results would be brought back to the Board for a decision.

Mr Grayson reported that the confidential business cases had been through considerable scrutiny at the Finance and Investment Committee and other corporate committees.

The Board approved the transformation plans for the three services.

024/2014 **Nurse Staffing Levels**

Mrs Webster presented on an update on how the Trust had implemented the recommendations contained the National Quality Board report – “How to ensure the right people with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability”. .

She highlighted that there were differing views as to the benchmark that should be used for nurse staffing and guidance issued by the Royal College of Nursing and Safe Staffing Alliance recommended an average of one nurse to eight patients (1:8 ratio).

Mrs Webster advised that both organisations had highlighted the potential for a reduction in positive outcomes for patients if this ratio was not met. This ratio applied to general surgical and medical wards and it was recognised that the ratio would be different for areas such as A&E, assessment units and wards with a high acuity of patients.

She reported that the Trust had developed a process for reviewing staffing levels using the Hurst methodology and had also used a bottom up approach with the Heads of Nursing driving the process. The recommended levels for each ward had been through a series of challenge reviews and the final review was between the ward matron or their representative and the Director of Nursing.

Mrs Webster highlighted that there was no similar recognised methodology for establishing community staffing ratios. The Trust had developed a process which included a manual diary card exercise being undertaken by the family, school and district nurses supported by Hurst to determine their staffing levels.

She proposed that that there would be a 21% uplift to nursing budgets – 18% to manage annual leave, sick leave and study leave in the ward budget and 3% held centrally to cover maternity and long term sick leave. In addition, 50% of ward matrons time would be supervisory in order to provide support to more junior staff.

Mrs Webster drew the Board's attention to the progress made in relation to the recommendations in the National Quality Board report and advised that on-going work was taking place in relation to recommendations 7, 8 and 9 and these would be achieved in the not too distant future.

Dr Harrison commented that the Board's responsibility was to ensure that the agreed establishment numbers of nurses providing care were appropriate and therefore the Board would need to know whether the agreed establishment numbers were being met. Mrs Webster advised that she was discussing with Human Resources how this data could be provided in anticipation of the need to report nationally.

Dr Harrison queried whether the 18% uplift was to all budgets or was it applied differentially and Mrs Webster explained that the 18% uplift was applied on all agreed establishment levels in all inpatient areas.

Mr Grayson commented that the review had used a well known credible evidence based tool and professional judgement and adjustments had been made to establishments with an increase in trained nurses of 22.5 whole time equivalents (wte) and Healthcare Assistants by 4 wte and these were funded in next year's business plan. The Trust was demonstrating a clear commitment to increase nursing staff levels with the community staff still to be reviewed.

Mrs Bernhauser commended that there had been a rigorous approach in triangulation with professional judgement and especially supported the proposal that 50% of the ward matron time be supervisory.

Mr O'Sullivan asked Mrs Webster if in her professional judgement this gave the Board the appropriate assurance on safe levels of nurse staffing and Mrs Webster confirmed this was the case.

Mrs Harris thanked Mrs Webster for a helpful report and was assured by the robustness behind it and she asked how patients and carers would be helped to understand the figures being provided. Mrs Webster advised that this was one of the areas being developed with a notice board being provided on each ward to provide standard information. Discussions were taking place with service users on how best to provide understandable information and this had been discussed at the dignity conference. She would provide the Board with further information on how reporting would be undertaken.

The Board approved the recommendations as outlined in section 6 of the report.

025/2014 **2 Year 2014/16 Financial Planning Update**

Mrs Harris presented the provisional financial plan and underlying assumptions for 2014/15 in the context of a two year planning period. In June the Trust would be required to submit five year longer term planning assumptions to the Trust Development Authority (TDA) and this was part of the challenged health economy work.

Mrs Harris reminded the Board that the Trust had the Full Business Case in support of the capital investment funding required to support the clinical strategy awaiting approval from the TDA.

She reported that section 3 of the report outlined the broad clinical priorities, section 4 set out the quality improvement plan and main themes and how the Trust intended to meet quality, safety and operational performance standards.

She highlighted that section 8 provided more detail around the financial and investment strategy.

Mrs Harris advised that for 2014/15 the Trust was planning to budget for a £18.5 million deficit followed by £14 million in 2015/16 which was predicated on savings of £20.4 million in 2014/15 and £20 million in 2015/16.

She reported that agreement had not yet been reached on the final contract with commissioners although agreement had been reached on growth, pricing and re-admission fines and other penalties. Agreement still needed to be reached on QIPP and discussions were on-going.

She reported that all the expenditure budgets had been robustly examined as part of the budget setting process including zero based reviews and clinical units had signed up to their delivery including cost improvement plans (CIPs) in 2014/15. The CIPs had been signed off by the clinical unit management teams, been quality impact assessed and been through a review and challenge session with the Board where the clinical unit teams presented on their plans.

She advised that the savings plan represented 5.6% of the Trust's income and paragraph 9.1 outlined the income, pay and non pay costs and planned deficit.

Mr Welling confirmed that the Board had spent a whole day reviewing the detail of the clinical units' CIPs and they were more robust and grounded than they had ever been. A number of areas had been identified where there were risks and further work was required to mitigate these. The Board would therefore be making its decision today in that context.

Mr Grayson commented that this would be another hard year for the Trust and a 5.6% savings target was larger than the Trust had ever achieved before and, while the Board could take much assurance from the challenge and review session, a number of the plans relied on the help and support of neighbouring Trusts which gave an added level of complexity.

He advised that it was possible to set a deficit budget as the challenged health economy process would provide the opportunity to understand the scale of the financial challenge and provide solutions to address it.

Professor Cohen asked why it was better to set the budget on that premise rather than acknowledging and building in some of the risk management. Mr Grayson advised that this had been discussed by the executive team and it was based on a tactical judgement of what could be delivered and what would be expected of the Trust and the 5.6% CIP programme was around the average for Trusts in England.

Mrs Harris outlined the proposed capital programme and was expecting £17.4 million of the £30 million in the Full Business Case to be received in the 2014/15 financial year. She highlighted that the programme included the Pevensey ward upgrading and addressing backlog maintenance and infrastructure works to help with infection control. It was acknowledged that there was pressure around the backlog in estate infrastructure and also with medical equipment and the IM&T strategy.

The Board approved the overall plan, noted the outlook for 2014/15 based on current assumptions, noted and approved the provisional working budget and capital programme.

026/2014 **Risk Management Strategy**

Mrs Wells presented the report and noted that the amendments were identified in red in the strategy and summarised on the front page of the report.

The Board approved version 1.3 of the Risk Management Strategy.

027/2014 **Eliminating Mixed Sex Accommodation**

Mr Sunley reported that the Trust was required to provide an annual declaration on eliminating mixed sex accommodation and advised that the Trust would be fully compliant once minor works had been completed in A&E which were part of the Full Business Case funding for the clinical strategy.

The Board ratified the declaration which would be published on the Trust's website.

028/2014 **Bedside Monitoring (VitalPAC) Business Case**

Mr Welling reported that he had used Chairman's approval, following detailed review of the business cases at the Finance and Investment Committee on 22nd January 2014, to allow the business case to go forward to meet Trust Development Authority timescales.

Mr Sunley reported that the system had gone live on De Cham ward at the Conquest Hospital the previous day and would be rolled out across the Trust within six months.

The Board ratified the Chairman's approval of the business case.

029/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mr O'Sullivan reported that the summary of the meeting held on 5th March 2014 and the minutes of the previous meeting were self explanatory. He highlighted that a new provider of local counter-fraud services had been appointed as the existing contract had come to an end. He noted that there was significant media attention on fraud in the NHS and it was his view that the Trust had good governance processes supported by a robust counter-fraud service covering both detection and prevention.

b) Finance and Investment Committee

Mr Nealon advised that the majority of the issues in his report had been covered elsewhere on the agenda.

c) Quality and Standards Committee

Mr Ellis presented his report which was self explanatory but commended the Schwartz Rounds which would be of benefit to the Trust as a whole.

d) Remuneration Committee Annual Report

Mr Welling reported that the annual report was self-explanatory and this was received and noted by the Board.

e) Trust Board Seminar Notes

The notes of the Board Seminar held on 15th January 2014 were noted.

030/2014 **Themes for Quality Walks**

The following themes were agreed:

Health Visiting
Maternity and paediatrics
Trauma & Orthopaedics
General nurse staffing levels
Impact of Vitalpac

It was agreed that Professor Cohen and Mr Ellis would report on their walks at the next meeting. **JC/CE**

031/2014 **Chairman's Briefing**

Mr Welling advised that his briefing was self explanatory and included letters to the local MP and the use of the Trust Seal.

032/2014 **Questions from members of the public**

a) Finance

Mr Campbell noted that the 12 month cash flow forecast and year end balance sheet was not contained in the finance report and Mrs Harris advised that she was reviewing how these were reported.

Mr Campbell asked how the Trust expected to find more savings each year and Mr Grayson stated that this was a challenge for the NHS as a whole. There was a flat cash scenario whilst cost and demand for services were rising at 5% a year and the demand for 4% savings were at least 10 years old. A strategic and operational approach was therefore required in order to ensure patient safety was not compromised going forward.

b) Nurse Staffing Levels

Mr Campbell asked how nursing numbers were translated into the quality of care delivered.

Mrs Webster reported that she met with the individual clinical units and ward matrons and they reviewed the feedback from a multitude of performance indicators, observations of care and complaints. In addition, staff could raise concerns through the management structure or use the Trust's whistleblowing policy to raise any issues and staff unions were also there to support staff. Board members also undertook quality walks and she offered surgeries for staff to discuss issues.

033/2014 **Date of Next Meeting**

Tuesday, 3rd June 2014, at 10.00 am in the Oak Room, The Hastings Centre.

034/2014 **Closed Session Resolution**

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

Signed …….

Position ……..

Date …….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 26.03.14 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
030/2014 – Themes for Quality Walks	Professor Cohen and Mr Ellis would report on their quality walks at the next meeting.	Non-Executive Directors	03.06.14	On agenda

East Sussex Healthcare NHS Trust

Date of Meeting:	3 June 2014
Meeting:	Trust Board
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

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

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

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

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

- Risk that during the period of dissolution of the SHA/PCT to Local Area Teams and CCGs there is a loss of organisational memory and focus on the key issues affecting the Trust

  Replaced with:
  There is a risk that we will not be able to respond to the Challenged Health Economy work in a way which enables us to formulate a 5 year integrated business plan

- Development of FT membership strategy - on hold pending agreement of FT trajectory with TDA

- Increased pressure on Trust cash holding will impact ability to generate required surplus of cash to make payments.

- OPD review undertaken of planned activity against capacity. Whole system recovery plans being discussed with commissioners

  Replaced with:
  Risk to achievement of referral to treatment timescales, particularly the admitted pathway. Actions taken by the Trust to maintain performance and reduce adhocs resulted in an increasing backlog.

- Delay/failure of national IT programme means that the Trust cannot support the effective development of electronic records that support new models of clinical care.

- Lack of an appropriate estates strategy and backlog maintenance plan

  Replaced with:
  Trust requires significant investment in estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. However 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.

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

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

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

Review by other Committees/Groups (please state name and date):
CLT – 20th May 2014

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

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

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

BOARD ASSURANCE FRAMEWORK

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

Key:

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

↔ Status of risk unchanged

↓ Risk reduced

↑ Risk increased

Board Assurance Framework - May 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1	Risk management processes in place; reviewed locally and at Board sub committees. Robust CQC action plan in place, monitored at Board level. Feedback and implementation of action following "quality walks" and assurance visits. Provider Compliance Assessments (PCA) training and support Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg ADN, ward matrons, clinical leads. Implementation of quality governance framework and ongoing work to embed learning and review sources of assurance Health and Safety risk	Outcome of CQC inspections Internal reviews inc/board level 'Quality Walks' CQC intelligent monitoring Board and Committee minutes Patient and Staff Surveys Health and Safety Executive IG Toolkit HR processes External accreditation/peer reviews	CQC reports following inspections Provider Compliance Assessments completed at ward level and gaps reviewed. Internal audit report on CQC compliance Weekly audits and 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	Documented audit trail not always available eg declaration of serious incidents, discussions re DNAR.		Ward/department visits to continue involving assurance team and peer reviews. Focus on specific outcomes eg consent paperwork, medical devices checks. Incomplete DNARs being logged as incidents and escalated for action. Weekly DNAR spot checks by Resus team escalated to senior management. Trust wide audit Feb 13, compliance improving, agreed Resus policy and audit methodology to be reviewed. Aug-13 Resus policy reviewed and updated. Oct-13 Compliance with policies reviewed at Policy Group and paper drafted for CME (Nov-13) Feb-14 Board reviewing and agreeing revisions to performance and quality metrics reports *May-14 Annual review of Committee Structure to be undertaken by Board*	April 2012 ongoing audit throughout 2013/14 May-14 end Jun-14	↔	MD

Board Assurance Framework - May 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued - Risk 1.1: We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies									
1.1				Revision to CQC compliance and inspection regime to be reviewed and impact on organisational compliance considered		Oct-13 Trust reviewing changes in CQC compliance regime including new surveillance model Dec-13 Reviewing CQC inspections reports published for other Trusts recently inspected under new model Feb-14 Continued review and monitoring; developing process to ensure Trust is prepared for inspection and has continued evidence of regulatory compliance. *May-14 Trust Inspection date confirmed as Sept 14, developing programme for preparation.*	Mar-14 ongoing Sep-14	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
			May 14 - NRLS report indicates Trust in top 25% of incident reporters	Datixweb incidents are not 'finally approved' and a backlog has built up. This could impact export to NRLS and benchmarking reports against other similar organisations may not be a true reflection of the Trust incident profile.		Proposal for sustainable management of incidents and achievement of timely incident agreed with divisions. Dec-13 Quality checks and significant reduction in backlog achieved for Nov export to NRLS. Continued focus on incident management across Clinical Units. Feb-14 Datix working group established to review issues, development and support effectiveness of system. *May-14 Ongoing monitoring and review of incident review process. Need to strengthen central datix team.*	end Jan-14 end Apr-14 end Jul-14	↔	DSDA

Board Assurance Framework - May 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 1 – Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority									
Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.									
1.2	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with divisions Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) monitoring Regular audit of cleaning standards	Performance indicators Benchmarking and Dr Foster data Accreditation visits/Peer Reviews National Cleaning Standards Audit Group established HOSC Healthwatch External Audit Internal Audit Clinical Audit Clinical Commissioning Groups Regulatory bodies eg CQC, HSE Information Governance Toolkit	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review National benchmarking by WM Quality Observatory Dr Foster HSMR/SHMI data Low HCAI and SSA breaches Performance delivery plan in place	Demand and patient choice impacts ability to deliver cancer metrics.		Sep-12 Cancer network discussions re urology capacity/expectations. Mar 13 - Review of pathways/clock pause criteria. Co-ordinators working outside normal hours to facilitate patient contact. GP referral issues highlighted to CCGs. May-13 Developed patient info leaflet. Diagnostic urologist joins June; training chichester and brighton consultants in complexes cases. Sep-13 Somerset info system implemented. Reviewing DH benchmarks/engaging with regional centres. Dec-13 General surgery move expected to improve colorectal screening response, meeting screening service Jan to review pathway or transfer treatment option to BSUH Feb-14 Ongoing discussion with BSUH. *May-14 Action plan in place and reviewed Mar Board continuing work with commissioners and stakeholders to achieve compliance.*	end Apr-13 Sept-13	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2	Business Continuity and Major Incident Plans Training to develop service level BC plans Reviewing and responding to national reports such as Francis, Keogh and Berwick.		Cancer - all tumour groups implementing actions following peer review of IOG compliance. Major incident testing debrief indicated plan is effective. Trust Board reviewed analysis of Keogh, Berwick et al and actions will be agreed and monitored through Quality and Standards Committee.	Inability to meet national screening standards for diabetic retinopathy due to increasing demand and limited capacity.		Recovery Plan/prioritisation in place. Exploratory meetings with BSUH to discuss possible Sussex wide service. Escalated to specialist commissioners - advised no additional funding available, service provision being reviewed *May-14 Additional £89k recurrent funding has enabled the recruitment of 2 additional screeners, a failsafe officer and additional administrative support. New programme manager commences June. Working with programme commissioners to deliver improved screening interval of 12 months (a key KPI) by Apr-15 and to meet new common pathway in retinal screening, from Oct-14*	end Apr-15	↑	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
				Jan-13 Demand on emergency services, impacting patient assessment and treatment time and subsequent discharge to other specialist/bed areas		Action plan in place to enhance patient flow. Meet SECAMB monthly to review issues. May-13 Identified number of options to improve ambulance flows - being explored Sep-13 Ambulance flows improved. Focussed work to be undertaken on further improvement to minimise risk of handover fines. Oct-13 Discharge/ admission lounges on both sites,escalation plan in place for winter pressures Feb-14 Clinical site team in place to maintain and enhance patient flow. Escalation process to whole organisation to ensure clinical and professional standards of care and review are met.	end Nov-13	↔	COO

Board Assurance Framework - May 14 Update

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 1.2: We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.**									
1.2				June-13 Inability to achieve reduced Cdiff trajectory. Risk register identifies concerns with weekly multi-disciplinary reviews and failure to meet national cleaning standards		June-13 Gastroenterology Consultants have an agreed job plan that ensures senior representation at the weekly ward round. Monthly audits of National Cleaning Standards (NCS) are undertaken and any failures identified and actioned. Oct-13 26 Cdiff cases ytd, RCA of all cases to identify actions and share learning. TDA supporting and action plan developed. Dec-13 Review and monitoring ongoing as outlined above Feb-13 Only 1 case of CDiff in Jan 2014. Continued reduction in HCAIs will be QIP for 2014/15 *May-14 Y/ed position CDiff 43 cases, 16% reduction year on year. Focus on reduction continuing.*	Ongoing review and audit throughout 2013/14	↔	DN/MD

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

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic Objective 2 – Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences.									
Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.									
2.1	Develop effective relationships with CCGs Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners including ESCC and MPs	Evidence of participation in Clinical Leaders Group External reviews and reports	Membership of newly formed local Health Economy Boards – UCN, Elective, Integrated. Commissioners, GPs, Adult Social Care invited to be members of Strategy Board. Collaboration with neighbouring Trusts through networks Participant in emergency clinical senates	Transition in commissioning arrangements mean clinical networks and leaders groups under review. Relationship with HOSC now focused on implementation. Communications strategy and approach needs refocusing following consultation.		Building relationships with CCG and LAT teams.HOSC member on Shaping our Future Implementation Board. Communications strand part of implementation. Oct-13 Ensuring plans for delivery of service transformation are developed and aligned to Clinical Strategy. Meetings with CCGs re developing primary care strategy. Programme for strategic change 2020 vision instituted by EHS and HR CCG Feb-14 Fully engaged in consultation on the future configuration of Maternity, Gynaecology and Paediatric services. Participating in HOSC evidence gathering process. Trust participating in operational clinical networks across a range of areas including vascular	Mar-13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Continued: **Risk 2.1: We are unable to develop and maintain collaborative relationships based on shared aims and objectives with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.**									
2.1	Clinical Strategy engagement Communications Strategy and map of stakeholders Regular meetings with League of Friends		Trust participates in Sussex wide networks eg stroke, cardio, pathology. Monthly performance meetings with CC and TDA. Working with clinical commissioning exec via Sussex Together to identify priorities/strategic aims. Board to Board meetings with CCGs, SECAMB and other bodies.	Marketing strategy not yet developed, therefore assurance cannot be provided that the Trust is actively and effectively participating in the local market or developing and responding to market opportunities.	There is a risk that we will not be able to respond to the Challenged Health Economy work in a way which enables us to formulate a 5 year integrated business plan.	Mar 13: Stakeholder engagement strategy to be reviewed and further developed Aug 13 - Trust participating in CCG led 'large scale change' programme. Trust engaged in CCG process for public engagement, development of the case for change, model of care and options for delivering agreed service standards for Maternity, Paediatric and Gynaecology services Oct 13 - Trust fully engaged with CCGs on developing PCBC for Maternity and Paediatrics *May-14 - Trust actively engaging in work commissioned through NHSE and TDA to support strategic planning across local healthcare economy*	Commenced and ongoing through 2013/14 end Sep 13 end Jul-2014	↔	DSDA

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Develop and embed Patient and Public Involvement 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.	CQC patient and staff surveys and inspection reports SHA benchmarking PROMs Clinical quality & safety reports reviewed through Trust Committee structure Dr Foster/CHKS metrics	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.	Insufficient triangulation of clinical governance information and impact on patient outcomes.		Quality governance framework approved and quality dashboard implemented but to be fully embedded . May-13 Information Management Review finalised and structure changes being implemented. Sep-13 - BI restructure implemented. Redefining organisation's information requirements in collaboration with the TDA. Dec-13 Ongoing work to triangulate information and identify areas of focus *May-14* *Performance/quality metrics reporting being reviewed for Board and Q&S. Reviewing QGAF.*	end Jun- 13 end Dec-13 end Mar-14 end Jun-14	↔	DN/ COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3	Robust complaints process in place that supports early local resolution Clinical audit plan Communications and marketing strategies developed and implemented Equality strategy and equality impact assessments Framework for delivery of mandatory training in place Appraisal policy and process in place	Internal patient experience surveys Complaints data and trends CQUINs Internal and external auditors Clinical audit FFT for Patient Experience Compliance rates for mandatory training and appraisal	Trust benchmarking by WM Quality Observatory Dr Foster/CHKS HSMR data Trust data and possible benchmarking for FFT	Change in process/contract for patient transport services having a detrimental impact on patient care and experience.		Review of Trust's SLA and KPIs with SECAMB and escalation of risks to commissioners. Incidents logged and reported monthly to SECAMB for investigation. Sep-13 SECAMB reviewed management arrangements. Ongoing review - issues escalated to commissioners. Feb-14 CSM for Whole Systems & Pt Flow attending stakeholder mtgs where timely discharge. Group trying to ascertain more accurate data from SECAMB. Problems encountered with late discharge will continue to be reported back to SECAMB.	end Nov-13 end Mar-14 with ongoing review	↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Inconsistent delivery of trust guidelines, policies and best practice is not addressed leading to variations in patient care and clinical outcomes. Poor quality of medical case note folders increases risk of inappropriate treatments, duplication of tests and interferes with patient care. Electronic records sitting outside of the nursing audit programme currently.		Action plans in place if deficiencies identified eg completion of nursing records, compliance with DNAR policy. Quality walks/assurance visits target specific areas. Nov-12 Establishing sub committee of health records steering group. Service, review by south coast audit and monitoring at patient safety committee. Sep 13- Quarterly audit of health records in place for 13/14. Reviewing how electronic records monitored. Keogh review evaluated and actions being implemented. Feb-14 continued work on ensuring revisions to policies are communicated. *May-14 work progressing re electronic record audit/audit of patient records agreed by HRSG*	Mar-14	↔	DN/ MD(G)

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 2.3 continued: We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.									
2.3				Mandatory training rates and completion of appraisal levels below expected levels.		Embed revised policy and compliance monitoring systems. Jun-13 - IT currently sourcing e-learning solutions. Aug 13- e-learning content issue resolved agreed with Kent & Medway to utilise their server. All modules now loaded and working. Oct 13 - Continuing to develop mandatory training staff passport across region; will focus on 10 key areas of mandatory training. Other training will be role related. Developing competency assessment process for some mandatory training to reduce need for staff to attend training. Feb-14 Staff Passport and competency assessments to be introduced Apr-14. Review compliance at y/end and revise risk to focus on high risk areas of Mandatory training. *May-14 - Staff Passport launched 1st April 2014*	Improved performanc e by Aug-12 ongoing throughout 2013 Work is ongoing but aim to complete passport and competency work by April 2014	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Strategic objective 3 – Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.									
Risk 3.1: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2014/16 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
3.1	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.	Activity plan Workforce planning Clinical Strategy Governance structure and performance meetings Monthly senior commissioner/provider meetings to review overall performance against 2014/15 contract Monthly KPIs monitored PMO office in place Monthly review by Finance and Investment Committee	Trust participates in Sussex wide networks eg stroke, cardio, pathology. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)		Require robust controls to ensure achievement of 2014/15 financial plan and prevent crystalisation of identified risks as follows: activity levels exceed plan, premium costs incurred to deliver 18 weeks, slippage on £20.4m savings plan, CQUIN income not received in full.	*May-14 All aspects of income/expenditure monitored on a monthly basis against plan. Turnaround management remains in place. Cash requirement to cover deficit included in Plan and will be drawn down quarterly pending application to ITFF via TDA.*	Commenced and ongoing review and monitoring to end Mar-15	↔	DF/DT

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.1 continued: We are unable to adapt our capacity in response to commissioning intentions, local needs and demand management plans resulting in our services becoming unsustainable, with an adverse impact on finance and liquidity. In setting a deficit budget for 2014/15 there is a risk that the Trust will not generate the required surplus of cash to pay staff and suppliers.									
				OPD referrals have reduced but not in line with original demand management expectations and there are some capacity constraints, especially in Trauma and Orthopaedics (T&O) and gastroenterology		T&O to model impact of loss of MSK contract, ongoing monitoring and review with commissioners. *May-14 CCGs tendering MSK prime provider model, impact on service to be modelled impact unlikely until 2015 at the earliest*	Feb-15	↔	COO
				Risk to achievement of referral to treatment timescales, particularly the admitted pathway. Actions taken by the Trust to maintain performance and reduce adhocs resulted in an increasing backlog.		*May 14: An action plan has been developed with support from the National Intensive Support team and the TDA to ensure that the organisation returns to achievement against the target in 2014/15 and this will be monitored by the Trust Board*		↔	COO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.2: We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements.									
3.2	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures Workforce assurance group disbanded and will be re-formed in line with CCG requirements which are still to be advised. Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data. Rolling recruitment programme	NHS Sussex workforce assurance process Staff utilisation reports. Integrated performance report. CQC staff survey	Training and resources for staff development CQC maternity report DGH Jul-13 Disclosure & barring check times avg reduced from 4wks to 48 hrs	Final workforce strategy will be developed once plans for clinical strategy and financial recovery/market testing further defined.		Further develop workforce strategy aligned to clinical strategy. Feb-14 Ongoing review of establishment. Currently recruiting to all vacant clinical posts.	Mar-14	↔	HRD

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
3.2				Inability to recruit to some specialties and significant vacancies in some areas . Some areas have identified that there could be shortages in the future due to ageing workforce and changes in education provision. Also national shortages in some areas eg cardiac physiologists, ODPs and anaesthetic staff Currently significant nursing and therapy vacancies - Oct 2013		Reviewed vacancies/ difficult to recruit to posts, establishment review -escalation for hospital at night team and cardiology rotas. Recruitment campaign in local and national press and action plan to reduce staff absence. Appointed 40 nurses, ongoing therapy recruitment. *May-14 - Review required to retain and attract Sonography staff. Newly qualified nurses review process being undertaken, implementing Values Based Recruitment and supported training programme; plan to extend this to other professional staff groups following trial. Speciality fill rate currently 84% - 100% fill rate unlikely, recruitment ready following final allocation.*	Ongoing throughout financial year - end of Mar-14	↓	HRD

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

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.3: We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.									
3.3	Leading for Success Programme Listening in Action Programme Feedback and implementation of action following "quality walks". PAPs clinically led with staff engagement Developing organisation values	CQC Staff Survey results Quality walks and assurance visits	Positive relationship with JSC Weekly CEO message to staff well received Effective clinical leadership of clinical units		CQC staff survey improved but in some areas the Trust is still in the bottom 20%	Implementing LiA programme/developing values. Conversations held and key themes developed. Taking forward quick wins, enabling projects and clinically led team projects to deliver improvements against themes. Aug-13 Participation in year two of LIA programme confirmed. Oct-13 Plans in place to work with Optimise in applying framework to multi-faceted challenges. Over 20 wards/teams working on improvement projects for first half of phase 2. Feb-14 Draft values developed, being progressed.	01/01/2013 Phase 2 to commence Jul-13	↔	CEO

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
				Need to develop clinical engagement		Working with Hay to develop Clinical Leadership Forum (CLF) *Oct-13 CLF development conversations taken place. TORs and membership in development.* Feb-14 CLF TOR to be approved by CME and Board in March 2014. First meeting scheduled	Mar-14	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.4: We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.									
3.4	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey to obtain core estate information, to include community hospitals; £300k secured invitation & award of service contract; survey with written report. Capital funding programme and development control plan	External company, T&T, produced six facet estate survey	Draft assessment of current estate alignment to PAPs produced	Significant investment in estate infrastructure, IT and medical equipment required 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-14 Essential work prioritised with Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.*	end Sep-2013	↔	DF

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
Risk 3.5: We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change									
3.5	Horizon scanning by Executive team and Board. Board seminars Board development programme. Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports	Minutes of Board seminars Attendance at FTN/NHS Confed events Developed and implemented effective marketing strategy	Policy documents and Board reporting reflect external policy. Strategic development plans reflect external policy. Board seminar programme in place	Trust has limited success in tender exercises. Specialist skills required to support Any Qualified Provider and tendering exercises by commissioners		Agreed method for handling tender opportunities and AQP which includes allocating an exec lead. Aug-13 Contract team strengthened to support AQP process. Ongoing monitoring of AQP and tenders. Oct-13 New MSK tender identified need to further increase leadership and skills of tendering team. Dec-13 Reviewing best practice in tendering - meeting with Hempson Jan 2014 Feb-14 Future responses to service tenders to be co-ordinated by DSDA. *May-14 Standardised approach and process to for tenders developed and being communicated.*	end Nov 13	↔	DSDA

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/update	Date/ milestone	RAG	Lead Director
						Commenced phase 2 to develop options for implementation of clinical strategy. Need to develop positive working relationship with new HOSC following elections. Aug-13 Steering Group and programme management established and assessment of services for inclusion underway. Oct-13 Agreed to restrict activity during intense action on FRP. Frailty work maintained as integral to successful achievement of FRP. Dec13 & Feb 14 2014-16 Business Plan development on schedule,arrangements in place for Board review. Five year strategy to be developed via NHSE/TDA commissioned process.	end Jul 2013	↔	DSDA

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Account 2013 – 2014
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

The purpose of this report is to present the draft Quality Account 2013-14 to the Board and agree that the final document be signed off by Chair's action.

Introduction:

Quality Accounts are annual reports to the public from NHS healthcare providers regarding the quality of services being provided; they are both retrospective and prospective in content. They allow us to provide assurances to our patients, the local public and our Commissioners in regards to the quality of care being delivered, and allow us to demonstrate our commitment to continuous, evidence-based quality improvement.

Our Quality Account for 2013-14 includes the identified and agreed priorities for quality improvement in 2014-15, whilst additionally reflecting on organisational achievement against last year's priorities.

In accordance with the statutory regulations, we have provided a copy of the draft Quality Account to the CCG, Healthwatch and to the Health Overview and Scrutiny Committee within the specified timeframe, inviting a review of the document. Written statements from these organisations will be included in the final document.

Please note that this is a draft document and some of the data is still to be finalised.

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

We have used the Department of Health's Quality Accounts toolkit as the template for our Quality Account.

In addition to ensuring that we have included all the mandatory elements of the account, we have engaged with stakeholders to ensure that the account gives an insight into the organisation and reflects the priorities that are important to us all. As a result, we have identified specific and measurable improvement initiatives in each of our priority areas. These initiatives will support improvement in the priority areas.

As previously presented and agreed by the Board, quality improvement priorities for 2014-2015 have been divided into three main categories, allowing the Trust to clearly focus on identified specific areas of concern in the year ahead. The three quality improvement categories are**:** Patient Safety**;** Clinical Effectiveness**;** Patient Experience.

Benefits:
The production of an annual set of Quality Accounts is mandatory for NHS provider organisations in England, as set out in the Health Act 2009. Identification of the quality improvement priority areas for 2014-2014 has been determined via an extensive review of patient, public and staff feedback, therefore accurately reflecting the trending areas of concern which warrant key focus in the year ahead.

Risks and Implications:
Failure to submit a set of Quality Accounts by the 30th June 2014 to the Secretary of State would result in non compliance with legislation.

Assurance Provided:
Assurance can be given to the Trust Board that the content of the draft Quality Account 2013-2014 accurately reflects statutory requirements. The document is subject to review by auditors.

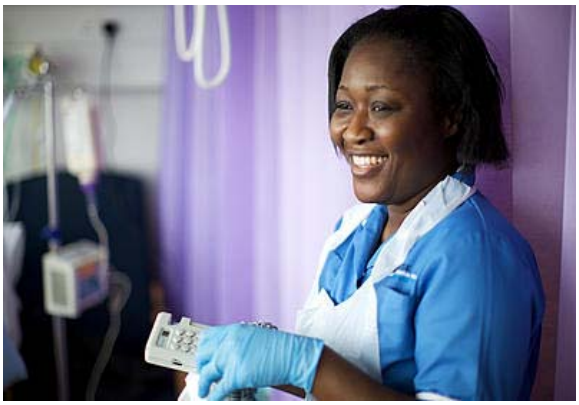
Review by other Committees/Groups (please state name and date):
Quality and Standards Committee 6th May 2014

Proposals and/or Recommendations
The Board is asked to review the draft 2013-2014 Quality Account and delegate authority for final sign off by Chair's action.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
No equality and human rights impact assessment has been conducted for this report.

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

East Sussex Healthcare NHS
NHS Trust



East Sussex Healthcare NHS Trust Quality Account 2013 - 2014

www.esht.nhs.uk

About this document

Why are we producing a Quality Account?

The purpose of the Quality Account is to share information about the quality of our services, and our plans to improve even further, with patients their families and carers. Since 2010 all NHS trusts have been required to produce an annual Quality Account.

What are the required elements of a Quality Account?

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for the Quality Accounts. We have used these requirements as a template around which our Account has been built. Our 2013/14 Quality Accounts are presented in three parts:

Part 1

- A statement on quality from the Chief Executive of East Sussex Healthcare NHS Trust (ESHT)

Part 2

- Priorities for improvement in 2014/2015 – this section identifies our priority areas for improvement and associated improvement initiatives.
- Statements relating to the quality of NHS services provided by East Sussex Healthcare NHS Trust.

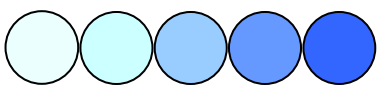
Part 3

- Review of our quality Performance in 2013/14
- Statements from our key stakeholders

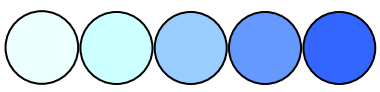
How did we produce our Quality Account?

In addition to ensuring that we have included all of the mandatory elements of the account, we have engaged with staff, patients, volunteers, commissioners and other stakeholders to ensure that the account gives an insight into the organisation and reflects the priorities that are important to us all. As a result, we have identified specific and measurable improvement initiatives in each of our priority areas. These initiatives will support improvement in the priority areas.

We appreciate that some of the language used may be difficult to understand if you don't work in healthcare. We have therefore included a glossary at the end of our Quality Account to explain some of the words that we use every day. We are keen to ensure that the account is a useful document which helps patients, families and the public to understand our priorities for delivering quality care. If you have any suggestions for next year's Quality Account, or any queries regarding this year's document, please contact us at enquiries@esht.nhs.uk.



Contents



Part 1

A statement on quality from our Chief Executive

Safety and the quality of care we provide is our number one priority and we focus on it each and every day and night. Our Quality Account provides us with an opportunity to outline our achievements and aspirations, identifying where the Trust is performing well and where we need to do better.

The NHS is facing interesting and challenging times ahead, which make it all the more important to keep safe, high quality patient care as our focus. There are increasing demands on services; a growing population with an extending lifespan, new medicines and rapid advances in technology. We must respond to these demands by finding and implementing new and better ways of working, using the creativity of our staff to help us transform the way we deliver services, driving up efficiency whilst raising quality and continuing to improve by constantly challenging ourselves to do things better.

In last year's Quality Account I mentioned that we would be implementing our Clinical Strategy: Shaping our Future. This commenced In July when we centralised hyper acute and acute stroke services at Eastbourne DGH and increased stroke rehabilitation beds at Bexhill Irvine Unit from 12 to 18. This was the biggest planned service change in East Sussex since our two acute hospitals were built more than thirty years ago. The changes were focussed on improving the quality of the service, making it safer with better outcomes for patients who suffer a stroke. This is demonstrated by the significant increase in the number of patients who are admitted directly to a Stroke Unit.

On the 8th March 2013 the Board agreed to take action to ensure the safety of obstetric and neonatal services through the temporary consolidation of a consultant led obstetric service, neonatal (including the Special Care Baby Unit), in-patient paediatric and emergency gynaecology services at Conquest Hospital only, along with the establishment of a stand alone midwifery led maternity unit and a Short Stay Paediatric Assessment Unit at Eastbourne District General Hospital. These changes were introduced from 7th May 2013 and the Board has closely

monitoring the services throughout the year. The evidence that has been collected on service safety and quality has indicated that improvements have been delivered following this change.

This is a temporary change and the local Clinical Commissioning Groups are currently undertaking a consultation on the proposed options for permanent changes to maternity and paediatric services. The consultation closed on 8th April and it is anticipated a decision will be made by the end of June 2014.

In December emergency and high risk general surgery services moved as planned to the Conquest Hospital. As a result more surgeons are now available to carry out planned procedures, we are able to treat people quickly, improve recovery and reduce the number of planned operations that we have to cancel.

Our nursing establishment has been strengthened by the successful appointment of 53 new staff nurses to work across the Trust in both acute and community settings. The "calling all nurses" recruitment campaign has had a significant impact on reducing our reliance on agency staff and improving the continuity of care for our patients.

As an integrated acute and community services organisation we also have a positive impact outside of the hospital setting; working with our partner organisations to reduce the time patients stay in hospital, provide care closer to home and improve the care pathways for people with long term and complex conditions. This is supported by innovations such as SystmOne, our new community software system which we are beginning to implement and will deploy in 2014/15.

The pursuit of quality is a constant journey and this document cannot cover everything we have achieved in the past year or aspire to achieve in the coming months. I hope however that this report provides some insight into the work being carried out by our services every day to make sure quality remains our central focus. I would also like to take this opportunity to thank our staff and volunteers for their commitment to delivering great care with compassion.

I confirm, in accordance with my statutory duty, that to the best of my knowledge the information provided in these Quality Accounts is accurate.

Darren Grayson
Chief Executive - East Sussex Healthcare NHS Trust

About our Trust

East Sussex Healthcare NHS Trust provides acute hospital and community health services for people living in East Sussex and surrounding areas.

Our services are provided from two district general hospitals, Conquest Hospital and Eastbourne DGH 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.

We also provide a minor injury unit service from Crowborough War Memorial Hospital, Lewes Victoria Hospital and Uckfield Community Hospital. A midwifery-led birthing service along with outpatient, rehabilitation and intermediate care services are provided at Crowborough War Memorial Hospital.

At both Bexhill Hospital and Uckfield Community Hospital we provide outpatients, day surgery, rehabilitation and intermediate care services.

Outpatient services and inpatient intermediate care services are provided at Lewes Victoria Hospital, and Rye Winchelsea and District Memorial Hospital.

At Firwood House we provide, inpatient intermediate care services jointly with Adult Social Care. Our community staff also provide care in the patient's own home and from a number of clinics and health centres, GP surgeries and schools.

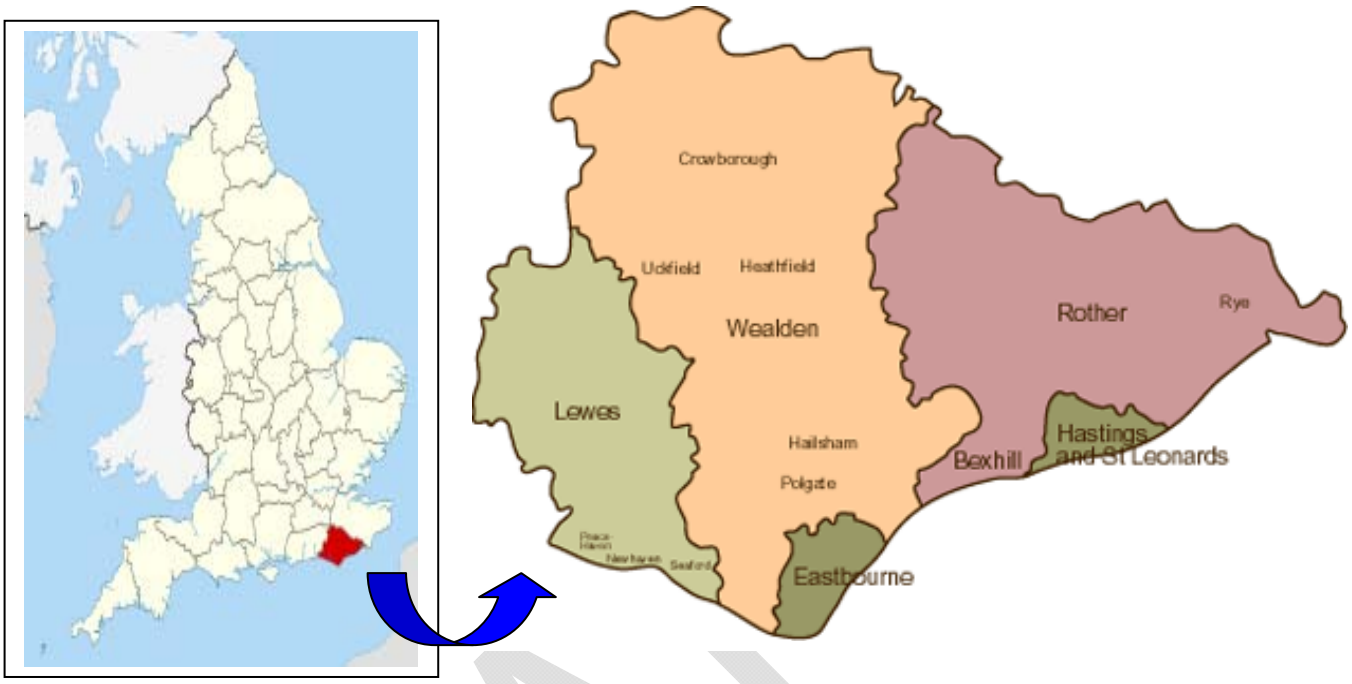
We are committed to providing the best possible healthcare service to patients, who come first in everything the organisation does.

Eastbourne District General Hospital

Conquest Hospital, Hastings

Uckfield Community Hospital

Around 525,000 people live in East Sussex and the Trust is one of the largest organisations in the county. We employ over 7,200 dedicated staff with an annual turnover of £365 million.



Our Vision is to be:
The healthcare provider of first choice for the people of East Sussex

Crowborough War Memorial Hospital

Lewes Victoria Hospital

Rye, Winchelsea and District Hospital

During 2013/14…

More than 142,000 patients were treated in our Emergency Departments, Minor Injury Units and associated areas for emergency treatment

Almost 3,600 babies were delivered by our midwives and obstetricians

More than 398,000 people attended outpatient clinics at our hospitals or outreach centres

Over 5.9 million pathology tests were performed

More than 98,000 people were provided with hospital care either as inpatients or as day cases

Over 220,000 patients had contact with our community nurses

Accolades for our staff during 2013/2014

Diabetes Specialist Nurse, Erwin Castro, has won a Quality in Care Award for Outstanding Educator in Diabetes.

Erwin has introduced various initiatives including a bi-monthly electronic newsletter called 'Diabytes' for trained nurses, which is also displayed in all the wards. He has been instrumental in ensuring that various medical teams receive updates on the management of diabetes. He is also regularly asked to deliver sessions on the different diabetes modules at the University of Brighton. Erwin has re-established regular training for Community Nurses on diabetes to ensure that the care for people with diabetes requiring input from the community teams is seamless with that from the hospital.

Diabetes Specialist Nurse, Erwin Castro

Erwin also won the Trust's "Using Technology to Improve Care Award and countywide 'Proud to Care Nursing Awards' for "Commitment" in April 2013.

Proud to care awards

The best nursing and care giving in Sussex was celebrated at the Proud to Care Sussex Nursing Awards held at the American Express Community Stadium in Brighton and staff from our Trust were awarded in five out of the fourteen awards and had ten shortlisted nominees.

There were individual and team awards for the best care delivered in hospitals, the community, primary care and nursing homes. Colleagues of individual nurses, care givers and teams sent in 110 nominations for the '6C' awards – Compassion, Communication, Care, Courage, Competence and Commitment.

Kerry Chidlow, Macmillan Breast Care Nurse won the Individual Care Award

Kerry with Alice Webster
(ESHT Director of Nursing)

"Kerry works tirelessly to maintain an extremely high standard of patient care and patients always speak very highly of her, highlighting her caring and compassionate manner. She frequently reviews the service to identify how it can be improved for the benefit of the patients and often brings in new initiatives. She has established two patient support groups and currently is leading in the establishment of a survivorship programme for patients and their families".

The Trauma Assisted Discharge Team won the Team Care Award

They are a unique team that supports patients, who have sustained fractures of the hip, to return home at the earliest opportunity under the care of a multi disciplinary rehabilitation team. The service has redefined the pathway for these patients, promoting rapid recovery in the best environment for the patient. An additional benefit is the significant reduction in the patient's length of stay in hospital.

MacDonald Ward Conquest won the Team Commitment Award

This ward has worked together to become champions of dementia care. They have gone the extra mile, for example coming in when off duty to help improve the environment and create the patient bus stop which has helped cognitively impaired patients. Care and compassion for elderly, frail and vulnerable patients clearly drives this extraordinary team.

Harlands Ward, Uckfield won the Team Competence Award

The ward has set up and run a day care IV service for antibiotic treatment for lower limb cellutis. Rather than admission to hospital, eligible patients are able to have a five day course of antibiotics as a day case at the community hospital making it a better experience for patients whose care can be provided closer to their home.

Jean Duffy a Learning Disability Liaison Nurse at the Trust has won the Sussex Partnership NHS Foundation Trust's Equality, Diversity and Social Inclusion Award.

Jean's role is to facilitate the care of patients with learning disabilities so they have equal access to healthcare. She offers advice, support and training to staff on aspects of care for patients with learning disabilities on such things as consent issues and adjustments to their care provision.

The citation read: "Jean has worked single handedly over the last 17 months to ensure that people with learning disabilities are given the highest quality care in hospital settings. She has developed an active network of 66 learning disability champions across most clinical areas and has trained new staff, consultants, junior doctors and nurses across all settings…"

Alice Webster, Director of Nursing said: "This award is well deserved. Jean is making a real difference to the learning disabled patients in our Trust. I have been struck by Jean's professionalism and inspirational approach to the very challenging programme of work that she supports. Jean is an inspiration and this award is very much justified."

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date: Stuart Welling, Chairman

Date: Darren Grayson, Chief Executive

Part 2

1. Our quality improvement priorities for 2014/2015
2. Statements of assurance from the Board

Our Quality Improvement Priorities for 2014/2015

The NHS identifies three fundamental areas of quality care and our 2014/2015 Quality Improvement Priorities are aligned to these.

SAFETY

1. **Patient Safety – patients are safe and free from harm**

EFFECTIVENESS

2. **Clinical Effectiveness – the treatment and care we deliver is the best available**

EXPERIENCE

3. **Patient Experience – patients, their carers and relatives have a positive experience that meets or exceeds their expectations**

.

How we chose our priorities for 2014/15

The Trust's improvement priorities for 2014/15 have been chosen following a process of listening to the views of our stakeholders and reviewing current services and developments such as the implementation of our clinical strategy.

The priorities reflect our commitment to delivering high quality care as an integrated organisation, as identified in our plans to implement a system to aid the early recognition and proactive action to support the care of the deteriorating patient and maximise our efforts to reduce healthcare associated infections.

We are committed to building on our quality priorities from one year to the next, so that everyone can see whether improvements are maintained over time. This is demonstrated in our ongoing commitment to improve patient experience and the continuation of initiatives such as the Safety Thermometer.

During November 2013, we held a Quality Engagement Event with members of the public. The purpose of the event was to provide an update of our progress on this year's quality improvement priorities and to receive feedback to inform the development of future quality improvements. It was encouraging to receive positive feedback about our services and staff. A number of areas were highlighted where we could do better; one consistent theme related to improving communication and this will be picked up through the implementation of our Patient Experience Strategy. Members of the public also said they would like more information on infection control and this has been included as a quality improvement priority for the coming year. Our thanks go to those who contributed through this event and other feedback mechanisms.

During 2014 we will be holding a number of patient engagement events, details of these are available by emailing us at esh-tr.enquiries@nhs.net or by telephoning the corporate governance team on 01323 417400.

Improvement priorities for 2014/15 have been chosen following a process of listening to the views of our stakeholders and reviewing current services and developments such as the implementation of our clinical strategy.

Listening into Action is a new way of working - staff from all levels of the organisation are able to get together to talk openly about the frustrations they have in their daily work, what prevents them from doing their job effectively and what we should all do to 'unblock the way' so we can provide the very best care for patients and their families.

Listening into action (LiA) is about achieving a fundamental shift in the way we work and lead, putting staff at the centre of positive change for the benefit of our patients, our staff and the Trust as a whole. The Framework provides a comprehensive and joined-up way to tackle improvements in specific service areas, delivered through the direct engagement of the people who work in the ward or department.

The Trust is committed to using LiA at every level and will ensure that it is seen as the "way we do things around here". The Chief Executive and agreed sponsors support the process and meet with the staff involved every 6 weeks collaborating on the outcomes and changes they want to see, and empowering local teams to own the improvements they want to make. The sponsors offer practical support and help to 'unblock the way'.

Since June 2013 15 'staff conversations' have taken place with over 600 staff attending.
These have been a chance for a mix of staff from across all levels and roles to get together and talk openly about what really matters to them, what gets in their way and what priorities need to change for the benefit of the patients and staff.

Improvement initiatives that have been implemented during 2013/14 include staff identifying that the storage areas in Jevington Ward at Eastbourne District General Hospital could be consolidated. In freeing up space they were able to develop an Ambulatory Respiratory Care Space (ARCS), which was officially opened in October 2013. Since the room started being used 90 outpatients have been seen in it, reducing unnecessary admissions.

On Berwick Ward at Eastbourne District General Hospital a number of themes emerged from staff conversations and quick progress was made to implement a quiet room to provide patients with more privacy and allow health professionals the time and space to listen to patients and their relatives.

Patient's own drugs in community hospitals are now being over-labelled as a result of a LiA project. Over-labelling patient's own medicines in the event of dose changes is standard practice in hospitals with on-site dispensaries, and is preferable in terms of patient safety and waste reduction. To date, the project has reduced medicines waste (£5,700 per annum projected) and helped prevent delayed or unsafe discharges and missed doses. A further project ensures that patient medication is transferred with the patient during every transfer, rather than pharmacy having to re-dispense it. The pilot project has cleared around £17,000 of stock; streamlined stock requisition and saved on nursing time that was previously spent on checking stock cupboards and completing administration.

A new initiative to support dementia patients is currently being implemented; themed rummage boxes are being developed to allow sensory stimulation or reminiscence. The boxes give patients the opportunity to engage in a purposeful occupation and support staff in communicating effectively with a range of patients, for example the 'Seaside box' has been found to create interest and discussion with restless patients, and can keep them sitting down for longer.

Following a conversation amongst staff providing stroke services a multi-disciplinary team training day was held, there were a wide range of speakers, and topics discussed covered many aspects of the stroke pathway from admission to follow up care in the community. Physiotherapy Assistants and Healthcare Assistants have also begun to shadow each other and work together to support patients for assessment enabling both teams to discuss their concerns and those of the patient, and improve patient experience.

A group working on Realising Staff Potential has been gathering a range of views from staff. A number of road shows have been held and staff were invited to complete a short questionnaire. There were over 1,700 responses and the information was used to develop a draft set of core values and behaviours based around four main themes: Working Together; Improvement and Continuous development; Respect and Compassion, and Engagement and Involvement.
Each value statement has a number of behaviours that apply to both our approach to caring for patients and service users and how we treat each other as staff. It is intended that these values and behaviours will become part of our processes and normal working life.

A number of key priority areas have already been identified for LIA projects during 2014/15.

Our quality improvement priorities for the year ahead are divided into three key areas:

Patient Safety

Patients are safe and free from harm:

Ensuring that safety always comes first within our organisation

This priority will focus on the following:

- Maximising our efforts to reduce healthcare associated infections

Clinical Effectiveness

Caring for vulnerable patients:

To consistently provide high quality patient care in line with identified best practice and evaluate the quality of our clinical care and outcomes

This priority will focus on the following clinical area:

- Early recognition and proactive action to support the care of the deteriorating patient

Patient Experience

Providing personalised, dignified, respectful and compassionate care:

To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patients and their carers

This priority will focus on the following areas:

- Continuing to implement the Patient Experience Strategy
- Ensuring we provide optimal care for patients in our care who have mental health disorders

Priorities for Improvement in 2014/15

2.1 Patient Safety

What is our Goal?

To ensure that safety always comes first within our organisation

This priority will focus on achieving the following:

Maximising our efforts to reduce healthcare associated infections

In the past, infection was considered an inevitable consequence of medical and surgical treatment. It is now increasingly recognised that by a combination of good hygienic practice, careful use of antibiotics and improved techniques and devices, rates of infection can be lowered significantly. We are proud that our organisation has consistently delivered a reduction of healthcare associated infections year on year but recognise that there is always more that can be done. During 2014/15 we intend to build upon and improve the systems we have in place in managing and monitoring the prevention and control of infection.

What is a Healthcare Associated Infection?

A healthcare associated infection (HCAI) can result from medical care or treatment in a hospital, or a patient's own home. Many are caused by micro-organisms ('germs') already present in or on the patient's own body; they are normally harmless but can cause problems when the body's defences are breached by surgery, or other medical procedures.

HCAI can affect any part of the body, including the urinary system (urinary tract infection), the lungs (pneumonia or respiratory tract infection), the skin, surgical wounds (surgical site infection), the digestive (gastrointestinal) system and even the bloodstream (bacteraemia).

With treatment most patients recover from a HCAI without any problems but these infections can extend a patient's stay in hospital, and in severe cases can cause prolonged illness.

What does this mean for you?

We want our patients and visitors to be assured that high standards are being met in relation to infection control.

- Well trained staff

  Our staff are educated in effective methods of preventing infection including how to care for patients with difficult wounds and how to insert intravenous (IV) lines safely.

  Staff are also trained in hand hygiene and you should observe them washing or applying gel to their hands before and after having contact with patients They will also use "personal protective equipment", where necessary, for example, disposable gloves and aprons to prevent contamination of clothing and skin.

- Environment

  You can expect the hospital or clinic environment to be kept clean and tidy. When we consider it might help prevent infection, we will also close down ward areas for deep cleaning. We may use our side rooms or smaller bays to care for patients who are at risk of serious infection.

- Screening

  To help reduce healthcare associated infections we routinely screen elective, emergency and day case patients for meticillin-resistant staphylococcus aureus (MRSA). This is so that we can find out if they are carrying MRSA harmlessly on their skin or in their noses before they have an operation, an outpatient treatment, or when they are admitted to hospital. This then allows us to plan care more effectively. We will ensure, so far as is reasonably practicable, that care workers are free of, and are protected from exposure to infections that can be caught at work, and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care .

We will provide adequate isolation facilities and plan to increase the number of isolation rooms to meet Department of Health advice.

- Antibiotics and Treatment

  Our clinicians will use antibiotics according to well-established guidelines, sometimes to prevent infection and sometimes to treat a known infection. The widespread use of antibiotics can lead to micro-organisms being present which are more antibiotic resistant so it is important that the right antibiotics are prescribed at the right time.

- Information

  You should have access to information on infection control and we will work with local service user representative organisations to ensure that information is developed, understood and accessible.

How will we monitor progress?

We will monitor practice by undertaking a programme of key infection control audits and surveillance findings. These will be incorporated into the Trust routine audit meetings for engagement and feedback to clinical staff.

Ward Matrons will be required to present reports every five weeks to demonstrate compliance with hand hygiene, as well as environmental and equipment cleanliness.

All incidences of MRSA or Clostridium difficile (CDiff) will be reported as incidents and investigated. Themes and trends from incidents and complaints will be reviewed and learning shared across the organisation.

Compliance with the Code of Practice for Health and Adult Social Care on the Prevention & Control of Infection (Outcome 8 Regulation 12 'Cleanliness and Infection Control' of the Health & Social Care Act 2008 (regulated activities) Regulations 2010) will be assessed every 3 months.

Where will we report upon our progress and achievements?

The Trust Infection Control Group meets every month and all infection control issues and progress will be reported to this group. Compliance with key metrics such as CDiff and MRSA limits are reported to the Trust Board at every meeting.

Priorities for Improvement in 2014/2015

2.2 Clinical Effectiveness

What is our Goal?

To consistently provide high quality patient care in line with identified best practice

This priority will focus on achieving the following:

Early recognition and action to support the care of the deteriorating patient

Our aim for 2014/2015 is to continue to improve the care and outcomes for our sickest patients. Deterioration in acutely unwell patients can happen quickly and have catastrophic effects if not identified.

A new clinical monitoring system using hand held mobile technology has been introduced at the Conquest Hospital and will become fully operational at both the Conquest and Eastbourne District General Hospital by October 2014.

The new system called VitalPAC monitors and analyses patients' vital signs and enables staff to automatically summon timely and appropriate help if a patient deteriorates. It also removes the need for paper based monitoring charts. In combination with other information available such as pathology or radiology reports it identifies high risk and deteriorating patients and will immediately alert the relevant doctor and any other non-ward based staff.

The Royal College Of Nursing recently recognised the burden that paperwork places on nurses- taking up to 17% of their shift. The new system will reduce this as the recording of vital signs will be paper free and observations will be rapidly input at the bedside via the handheld device.

Evidence from other hospitals where this system has been implemented has shown that it can take up to 40% less time for nurses to capture and interpret vital signs resulting in a faster escalation of care needs and a faster response.

What does this mean for you?

Implementing the system will improve patient safety and patient outcomes as it will identify deteriorating patients earlier and allow for quicker clinical intervention. It will enable specialist teams such as critical care outreach, infection control and pain services to intervene proactively.

We will be able to observe patients' vital signs 40% quicker than we do at the moment and in turn manage our patients more efficiently, with fewer patients going into intensive care and fewer cardiac arrests.

VitalPAC enables nurses to record seven routine observations such as temperature, pulse and blood pressure, and removes the requirement for a paper chart. The system's software analyses the patient's readings using a set of algorithms and doctors and other senior staff receive an urgent alert if they fall below safe levels. It is hoped that the system will also reduce length of stay by avoiding the complications that can arise in patients at risk of deterioration.

Consultants and senior nurses can check at any time that their patients are being monitored appropriately and care can be promptly escalated as required. The system will also be programmed to provide advice and guidance in accordance with local protocols.

Other benefits include:

- Enabling complete sets of observations to be captured concurrently and the highlighting of various risks, i.e. oxygen dependency;
- Automatically calculates the patient's National Early Warning Score (NEWS) in accordance with hospital protocol;
- Provides continual monitoring of Intravenous cannulae;
- Determines when observations should be repeated, escalates care to outreach teams and medical staff and tracks the response;
- Allows the "hospital at night" team to monitor patients from anywhere in the hospital.

How will we monitor progress?

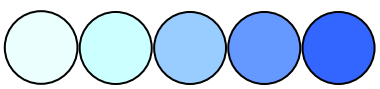
The system is fully transparent and auditable allowing for an in-depth analysis of activity and performance. This will enable the Trust to target those areas where additional support and education for medical and nursing teams may be required. Weekly and monthly performance reports will be produced for every ward area detailing the full sets of observations performed on patients; these reports will allow us to determine if appropriate escalation of care for sick patients took place at the right time. This information will be readily available for both the Heads of Nursing and Ward Matrons so that progress can be monitored and any issues promptly addressed. Our future goal is to display this information in a 'traffic light format' on every ward.

We also hope to clearly evidence (through the use of VitalPAC) a reduction in the number of cardiac arrest calls put out across the Trust. The introduction of this system should enable efficient, rapid escalation of sick patients through the Medical and Surgical Emergency Team calls, preventing patient deterioration into a full cardiac arrest. The Trust will be monitoring the cardiac arrest rate to evidence this.

Where will we report upon our progress and achievements?

The data that VitalPAC delivers will form part of the routine information delivered to the Heads of Nursing and Director of Nursing, this will allow for a focus on the ward areas where compliance to the Trust policy is low and will help to raise performance levels.

Our progress and achievements will be reported to the Patient Safety Group on a monthly basis alongside the Trust's cardiac arrest data. We will also be reporting regularly to the Board and will issue regular reports about both the implementation of the project and improvements in ward performance. This information will also be shared with the NHS Technology Fund who has funded 50% of the project costs.



Priorities for Improvement in 2014/15

2.3 Patient Experience

What is our Goal?

To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patients and their carers

This priority will focus on achieving the following:

Continuing to implement the Patient Experience Strategy

There is a growing amount of evidence to show that improving patient experience can reap rewards not only for the patient, but for their families and carers, staff and the organisation as a whole. It can reduce a patient's anxiety and fear, speed the healing process and shorten length of stay.

We want to ensure that all of our patients, their families and their carers are treated with respect, dignity, compassion, courtesy and honesty. Our Patient Experience Strategy outlines eight commitments which were made to ensure the services we provide are of the highest standard possible. We began to implement the Strategy last year - it outlines what we are trying to achieve, who will make this happen and how we will measure progress.

During 2014/15 we will ensure that this work is further developed - we will expand our Patient Experience Champion Programme, continue with the Friends and Family Test, learn and make changes from complaints and continue to engage with patients via quality engagement events.

What does this mean for you?

- You will be asked to give us your feedback on your experience and we will act upon this to make improvements and spread good practice.
- We will listen to concerns and do our best to resolve these locally.
- You will be involved in decision about your care, treatment and pain management.
- You will be treated with dignity, respect and understanding.
- You will be appropriately supported where required for example assistance at meal times.

How will we monitor progress?

The Patient Experience Champions will be supported by the Patient Experience lead and will work collaboratively through network meetings to share best practice and lessons learned across the organisation and through the Patient Experience Steering Group.

The Friends and Family Test results will be available for all staff to view in real-time. Matrons will view their results frequently and will be trained to access the results on-line, in order that they can be displayed within their clinical areas. Reports will be provided to managers for review, and will be discussed at the Trust Board on a quarterly basis. In line with national guidance the Friends and Family Test from staff will also be developed within 2014/15 and reported on.Patient Experience data is used in various ways across the organisation. The Board will continue to receive information from Board Quality Walks which includes Patient and Staff experiences as a regular agenda item, as will its subcommittee, the Quality and Standards Committee (Q&SC). Patient Experience Data will also be cascaded throughout the organisation, and we will ensure that all staff have the opportunity to feedback and inform the actions taken to improve patient experience.

The Quality and Standards Committee will also receive a quarterly Patient Experience report which pulls together all of the key elements of patient experience data from across the organisation.

Where will we report upon our progress and achievements?

Progress with achieving these Patient Experience quality improvement initiatives will be monitored on a quarterly basis by the Trust Board. The Patient Experience Steering Group is the forum for reporting all patient experience activities on a monthly basis; this Group ensures that lessons are learnt widely across the Trust.

The Trust held an event in March 2014, the aim of which was to allow staff to come together and reflect upon their clinical practice, identifying how improvements can be made whilst considering the impact on patients, and how good practice can be celebrated.

Priorities for Improvement in 2014/2015

2.4 Patient Experience

What is our Goal?

To improve our communication with patients; listening acting upon and being responsive to the feedback we receive from our patients and their carers

This priority will focus on achieving the following:

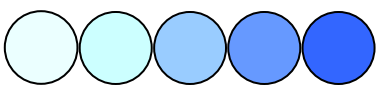
Ensure that we provide optimal care for patients in our care who have mental health disorders

Living with a mental health problem can often have an impact on day to day life, and make spending time in hospital a little more difficult - we want to ensure that people in our care receive any reviews or referrals to specialist mental health services promptly as required, that they are made fully aware of their rights, and that they are cared for by staff who have received adequate training in caring for people with mental health disorders.

What does this mean for you?

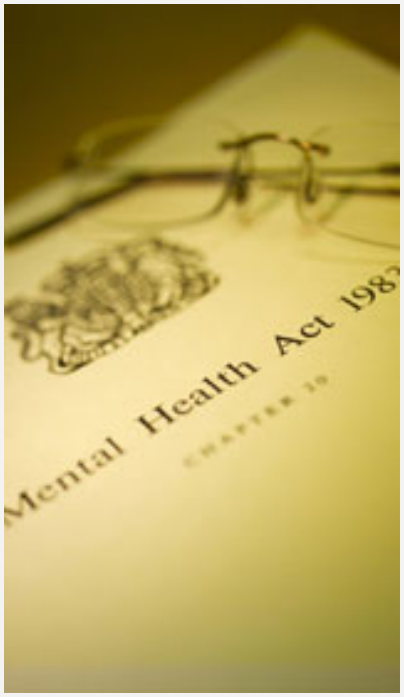
We will use a mental health triage tool to ensure that when people are admitted to hospital or need to attend the Emergency Department they have access to the appropriate resources in a timely manner.

Further training will be provided to all key staff to ensure that they have a full understanding of their responsibilities and legal obligations in relation to the Mental Health Act (MHA) 1983 and the associated Code of Practice. Senior staff will also have a working knowledge of relevant policies and guidelines to ensure that patients detained under the MHA 1983 whilst in our care are safe and that their rights are upheld. We will ensure that detained patients are given information about their rights under the Mental Health Act and that this information is explained on a regular basis and in a way that is easily understood. We will also ensure that this detail is recorded and that patients are given ready access to Advocacy services. All patients will be supported if they wish to appeal against their detention to the Tribunal and/or the Hospital Managers.



We will be working more closely with Sussex Partnership NHS Foundation Trust (SPFT) to reduce delays when a patient needs to be transferred, and will collaborate on how best to obtain specific views of detained patients about their experience whilst under the care of our staff. As part of service transformation we will also be taking action to improve the assessment areas in bothEmergency Departments with the intention of making sure that there are separate liaison assessment areas available.

How will we monitor progress?



Patient experience will be monitored and audited through the existing Family and Friends Test; results will be analysed to determine if delays are occurring in obtaining specialist reviews for applicable patients with the aim of reducing delayed patient transfers to SPFT.

The Trust will work with SPFT to undertake an annual audit of patients detained under the Mental Health Act to ensure compliance and identify further improvements. Regular partnership meetings will also be held between SPFT and the Trust to ensure we are informed and aware of detention activity.

Where will we report upon our progress and achievements?

Activity and performance contract data will be reviewed at the quarterly meetings held between the Trust, SPFT and the Mental Health Liaison team; this will include the provision and uptake of Mental Health Act training delivered to our staff. Potential risks relating to the transfer of patients will be monitored and reviewed at performance review meetings to ensure that there is a process for learning and improvement and under the terms of our contract with SPFT they will provide an annual report to the Trust Board on the use of the Mental Health Act across the organisation

2.5 Statement of Assurance from the Board

Review of Services

During 2013/14 the East Sussex Healthcare NHS Trust provided and/or sub-contracted 71 NHS services.

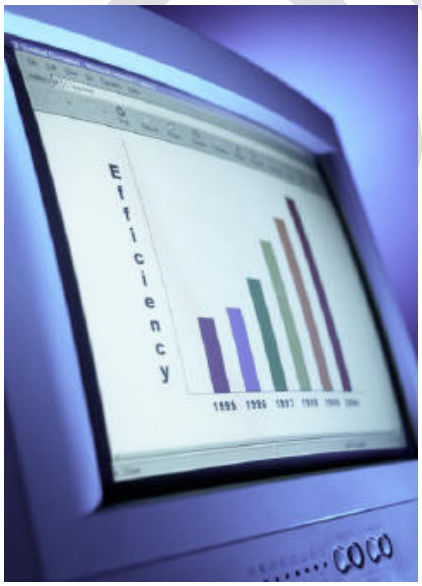
The East Sussex Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 71 of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by the East Sussex Healthcare NHS Trust for 2013/14.

Participation in clinical audits

Clinical audit is used within East Sussex Healthcare NHS Trust to aid improvements in the delivery and quality of patient care, and should be viewed as a tool to facilitate continuous improvement.

The key component of clinical audit is that performance is reviewed to ensure that what *should* be done is *being* done, and if not it provides a framework to enable improvements to be made. It is effectively the review of clinical performance against agreed standards, and the refining of clinical practice as a result.



During 2013/14, 34 national clinical audits and 4 national confidential enquiries covered NHS services that East Sussex Healthcare NHS Trust provides. During that period East Sussex Healthcare NHS Trust participated in 94% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust was eligible to participate in during 2013/14 are as follows:

Peri and Neonatal
♦ Maternal infant and perinatal mortality (MBRRACE-UK)
♦ Neonatal intensive and special care (NNAP)

National Confidential Enquiry into Patient Outcome and Death
♦ Lower Limb Amputation
♦ Tracheostomy Care
♦ Subarachnoid Haemorrhage Study
♦ Alcohol Related Liver Disease

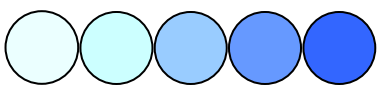
Children
♦ Childhood epilepsy (RCPH National Epilepsy 12 Audit)
♦ Diabetes (RCPH National Paediatric Diabetes Audit)
♦ Child Health Review
♦ Paediatric asthma (British Thoracic Society)

Acute Care
♦ Emergency use of oxygen (British Thoracic Society)
♦ National Cardiac Arrest Audit
♦ Adult critical care (ICNARC CMPD)
♦ National Audit of Seizure Management in Hospital (NASH)
♦ National Emergency Laparotomy Audit (NELA)
♦ Paracetamol Overdose (care provided in Emergency Departments) (CEM)
♦ Severe Sepsis & Septic Shock (CEM)
♦ Asthma (children) (CEM)

Long term conditions
♦ Inflammatory Bowel Disease Audit
♦ National Adult Diabetes Audit
♦ National Chronic Obstructive Pulmonary Disease (COPD) Audit
♦ Paediatric Bronchiectasis
♦ Rheumatoid and Early Inflammatory Arthritis

Elective Procedures
♦ Hip, knee and ankle replacements (National Joint Registry)
♦ Elective surgery (National PROMs Programme)
♦ Coronary angioplasty (NICOR Adult cardiac interventions audit)
♦ National Vascular Registry

Cardiovascular Disease
♦ Acute Coronary Syndrome / Acute Myocardial Infarction (MINAP)
♦ Heart failure (Heart Failure Audit)
♦ Stroke National Audit Programme (SNAP)
♦ Cardiac arrhythmia (CRM)



Cancer
♦ Lung cancer (National Lung Cancer Audit)
♦ Bowel cancer (National Bowel Cancer Audit Programme)
♦ Head & neck oncology (DAHNO)
♦ Oesophago-gastric cancer (National O-G Cancer Audit)

Trauma
♦ Falls and Fragility Fractures Audit Programme (FFFAP)
♦ Severe trauma (Trauma Audit & Research Network)

Blood Transfusion
♦ National Comparative Audit of Blood Transfusion: ♦ Audit of patient information and consent ♦ Audit of the use of Anti-D

East Sussex Healthcare NHS Trust participated in all of the above national audits during 2013/14 with the exception of the following:

- National Adult Diabetes Audit
- Paediatric Bronchiectasis

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust did not participate in throughout 2013/14 are listed below:

National Audit Title	Reason for non participation
Paediatric Intensive Care	Not Applicable to ESHT
Congenital Heart Disease	Not Applicable to ESHT
Adult Cardiac Surgery	Not Applicable to ESHT
Renal replacement Therapy	Not Applicable to ESHT
Mental Health Clinical Outcome Review Programme	Not Applicable to ESHT
National Audit of Schizophrenia	Not Applicable to ESHT
Prescribing Observatory for Mental Health	Not Applicable to ESHT
National Adult Diabetes Audit	Please see explanation below
Paediatric Bronchiectasis	Please see explanation below

National Adult Diabetes Audit: Reason for non participation by East Sussex Healthcare NHS Trust

The Trust was unable to participate in the 2013/14 National Adult Diabetes Audit as the required specialist data collection software is unavailable for use across the organisation. The Diabetes Consultant Lead has estimated that the cost of purchasing the required software to be around £40,000 - unfortunately funding is not currently available. Please note that the Trust was able to participate in the National Diabetes Inpatient Audit, and the National Pregnancy in Diabetes Audit, both of which form part of the main National Adult Diabetes Audit.

Paediatric Bronchiectasis Audit: Reason for non participation by East Sussex Healthcare NHS Trust

No cases were reported within the Trust during the data collection time frame.

NCEPOD issued 2 reports in 2013/14:

Subarachnoid Haemorrhage: Managing the Flow (2013)

This NCEPOD report highlights the process of care for patients who are admitted with aneurysmal subarachnoid haemorrhage, looking both at patients that underwent an interventional procedure and those managed conservatively. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have been identified in the clinical and the organisational care of these patients.

Alcohol Related Liver Disease: Measuring the Units (2013)

This NCEPOD report highlights the process of care for patients who are treated for alcohol-related liver disease and the degree to which their mortality is amenable to health care intervention. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have been identified in the clinical and the organisational care of these patients.

MBRRACE-UK (formally CMACE) Mothers and Babies Reducing Risk through Audits and Confidential Enquiries

The Women's Health unit continues to report information on the following:

- **Late fetal losses** – the baby is delivered showing no signs of life between 22^{+0} - 23^{+6} weeks of pregnancy
- **Terminations of pregnancy** – resulting in a pregnancy outcome from 22^{+0} weeks gestation onwards
- **Stillbirths** – the baby is delivered showing no signs of life after 24^{+0} weeks of pregnancy
- **Neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring <28 completed days after birth.

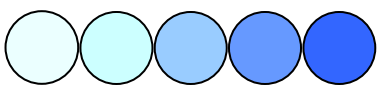
UKOSS UK Obstetric Surveillance System

The UK Obstetric Surveillance System is a national system established to study a range of rare disorders of pregnancy, including severe 'near-miss' maternal morbidity. The Women's Health unit contributes, where possible, to their studies. Currently, UKOSS is collecting information on cases of:

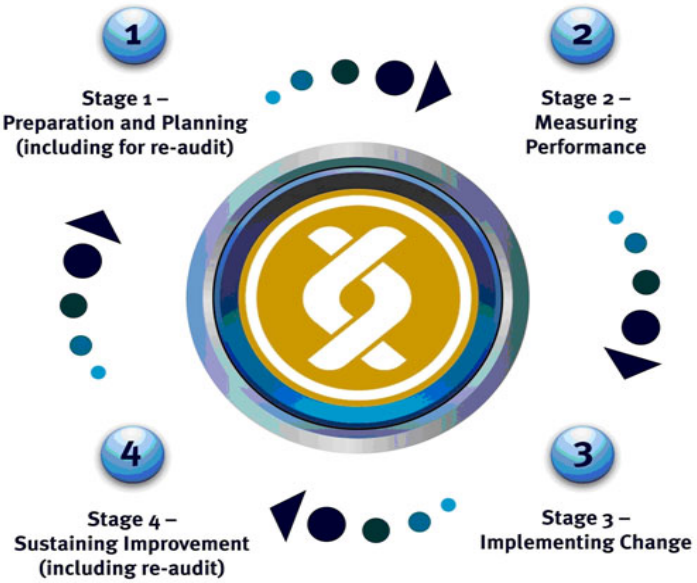
- Adrenal Tumours
- Advanced Maternal Age
- Amniotic Fluid Embolism
- Anaphylaxis in Pregnancy
- Artificial Heart Valves in Pregnant Women
- Aspiration in Pregnancy
- Cardiac Arrest in Pregnancy
- Primary ITP (Severe Primary Immune Thrombocytopenia (ITP) in Pregnancy)
- Stage 5 Chronic Kidney Disease (Chronic Renal Failure)

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of Cases submitted	% submitted of those required (where requested)
Lower Limb Amputation	7	100%
Tracheostomy Care	Included cases – 23 Case notes requested - 4	Insertion questionnaire 87% Critical care questionnaire 100% Wound care questionnaire 87% Case notes submitted 100%
Subarachnoid Haemorrhage	Secondary questionnaire 2 Organisational questionnaire 3	Secondary questionnaire 50% Organisational questionnaire 100%
Alcohol Related Liver Disease	Included cases – 6 Organisational questionnaire 2	Clinical questionnaire 83% Case notes 50% Organisational questionnaire 0%
Paediatric Diabetes	*Information unavailable from the national team*	*Information unavailable from the national team*
Paediatric Asthma	5 (EDGH only)	25% (EDGH only)
Emergency use of oxygen	29	100%
Seizure Management in Hospital	30 (Conquest only)	100% (Conquest only)
Audit of the use of Anti-D	51	100%



The Healthcare Quality Improvement Partnership (HQIP) Audit Cycle



The reports of 6 national clinical audits were reviewed by the provider in 2013/14 and East Sussex Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit	Background	Proposed local action / outcome / recommendations
Paediatric Pneumonia	A national audit looking at community acquired pneumonia ('CAP' - defined as the presence of signs and symptoms in a child previously healthy due to an infection which has been acquired outside the hospital). Aims: To enhance the Trust's management of, and compliance against the national British Thoracic Society (BTS) guideline standards, by examining cases over a three month period.	1. Reduce the number of investigations (e.g. chest x-rays, white blood cell counts) – provide teaching on pneumonia BTS guidelines and Trust standards, making staff fully aware how to treat and investigate patients (for example, chest radiography should not be considered a routine investigation in children thought to have CAP). 2. Participate in the national 2014/15 re-audit.
Enhancing Quality (EQ) Regional Pneumonia Audit 2013	The Trust actively participates in the EQ Audit programme which is an innovative clinician-led quality improvement programme across Kent, Surrey and Sussex. By clinicians analysing where to intervene for greatest quality improvement, EQ aims to improve patient outcomes and reduce variation in care for every patient, every time. Doctors and nurses are responsible for ensuring the clinical process measures are followed and that data is collected and outcomes monitored. This helps clinicians to identify where improvements can be made in care pathways and processes.	1. Timing of antibiotics – delays may be occurring due to an uncertainty about the diagnosis or that the drugs prescribed in A&E not given as a patient is moved to the Medical Assessment Unit (MAU). 2. Simple measures may improve clinical performance i.e. stickers, IT reminders. 3. To consider a more appropriate set of audit parameters for the next round.

National Audit	Background	Proposed local action / outcome / recommendations
Facing the Future RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health	The RCPCH has launched a new project called "Facing the Future Together for Child Health" to look across the urgent care pathway at how we can improve paediatric care and health outcomes for children and young people with acute illness. Aims: Firstly, to assess compliance against the standards across the UK and, through this process, build up a comprehensive picture of paediatric provision throughout the four nations. Secondly, and perhaps more vitally, the audit intended to assess the impact of the standards themselves. The project will build on the Facing the Future standards, expanding them into care outside the hospital setting with the aim of ensuring that high-quality care is always provided from first contact and reducing unnecessary attendances at emergency departments and admissions to hospital.	1. All Paediatricians must ensure they have successfully completed Level 3 in Child Protection training. 2. Consultant to ensure a reminder is sent out to staff regarding documentation (who the patient is seen by, and the time). 3. Clinical Governance Facilitator to provide administration to the department to ensure participation in the re-audit.
Blood Sampling and Labelling Audit NHS Blood and Transplant	The British Committee for Standards in Haematology (BCSH) requires that all blood samples and requests for transfusion must carry four points of patient identification. In addition, it is a Medicines and Healthcare Products Regulatory Agency (MHRA) requirement that laboratories should have policies in place for requesting tests and that these policies are strictly adhered to. Robust sample rejection policies reduce the risk of assigning the wrong result to a patient but potentially lead to delay in availability of results and in delivery of compatible blood. Consistent application of national recommendations for sample labelling and acceptance across both hospital and reference laboratories would be a major contribution to improving patient safety. Aims: ◈ To collect information on the quality of practice of collection and labelling of transfusion samples. ◈ To understand the reasons that sample labelling errors are made. ◈ To reduce the incidence of blood sample labelling errors.	The Associate Transfusion Practitioner examined rejection and error rates in sampling practice, as part of a national exercise to understand and address errors. Among the confounding factors relevant locally are issues faced by community-based practitioners who may not be fully aware of the requirements of the BCSH guidelines, such as signatory having been competency assessed, not using pre-printed labels, *etc*. Online training is available to address these factors in particular, where procedural misunderstanding rather than poor clinical practice is at issue.

National Audit	Background	Proposed local action / outcome / recommendations
Percutaneous coronary intervention (PCI) Audit   	Percutaneous coronary intervention (PCI) is used to treat patients with narrowed or blocked arteries that supply the heart muscle with blood. This national audit allows clinicians to assess key aspects of the patterns and quality of their care when performing PCIs. The British Cardiovascular Society (BCIS) has continuously audited PCI activity since 1988. Each hospital submits an annual paper return that summarises local PCI activity. The audit provides information on the: ◈ Structure of the provision of PCI services across the UK. ◈ Clinical care and the treatment provided by each hospital, measured against national aggregated data and agreed national standards. ◈ Outcomes for patients such as complications, adverse cardiac events and death.	The Consultant lead for this audit has advised that there had been good outcomes in respect of the percentage of actual vs. predicted risk in patients undergoing a PCI suffering a 'Major Adverse Cardiac and Cerebrovascular Event' (MACCE). They stated that the rate of mortality in patients who had undergone a PCI was 4 deaths out of 81 procedures, which was just 4.9%. Both hospital sites have been rated as 'excellent' by the national audit team for data completion.
National Audit of Dementia  	The National Audit of Dementia was established in 2008 with funding from HQIP to examine the quality of care delivered to this growing sector of the community who are likely to be particularly vulnerable to care shortfalls. Aims: For Trusts to be 90% compliant with the national core audit standards by July 2013 in order to deliver a world class service for patients with dementia and/or delirium that is clean, safe and personal every time.	Particular aspects of the Dementia management standards now form part of the Trust's Commissioning for Quality and Innovation (CQUINs) payments framework, absence of documented evidence of appropriate dementia care risks a substantial financial penalty. Action Plans have been produced to aid this required improvement with a particular emphasis placed on dementia education activity. It was noted that governance processes around dementia were considered sound; the drive will be towards improving compliance around clinical assessment.

The reports / results of 103 local clinical audits were reviewed by the provider in 2013/14. Examples of the actions the Trust intends to take to improve the quality of healthcare provided are detailed below:

Title / Recommendations
2998 - Stroke Thrombolysis Audit In July 2013 we centralised hyper acute and acute stroke services at the Eastbourne DGH and increased stroke rehabilitation beds at Bexhill Irvine Unit from 12 to 18. The changes were focussed on improving the quality of the service, making it safer with better outcomes for patients who suffer a stroke. These changes support the implementation of the learning from this audit: 1. It is important to thrombolyse stroke patients as soon as possible to give them the best chance of recovery. 2. Decision to thrombolyse should be made as soon as the National Institute of Health Stroke Scale (NIHSS) assessment is done so that thrombolysis can commence as soon as a CT report is received. 3. Stroke patients should be sent to the stroke ward within four hours of arrival to hospital for Hyper acute stroke care. 4. Audit to be presented additionally at the Eastbourne DGH to share learning.
3097 - A review of seizure related deaths and serious morbidity and sudden unexpected deaths in children and young people with epilepsy 1. There is a need for rigour in the diagnostic process; this is likely to be aided by the involvement of the paediatric neurologist. 2. There is a need for clear documentation of any reasons behind any divergence from the National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. 3. Different formulations of buccal midazolam give rise to potential medication errors – staff education is required with regard to this issue.
3153 – Community Services in Rehabilitation 1. Comprehensive geriatric assessments for all patients aged >75 using a clerking proforma to aid in a standardised assessment. This will enable recognition of acute and chronic medical conditions and optimise treatment to enable rehabilitation. It will also help to identify patients who have poor rehabilitation potential as a result of a significant level of frailty or life-limiting diagnoses and support discharge planning. 2. Admissions pathway for stroke and generic rehabilitation which involves: ◈ providing a structured admission whereby assessments made will allow early decisions on the need for further therapy or discharge planning if rehabilitation is not appropriate; ◈ regular meetings with patients to discuss goals to ensure a patient-orientated approach; ◈ encourage goal setting to be specific with aim to review progress at a set time by the MDT.

Research

The number of patients within East Sussex Healthcare Trust in 2013/14 recruited to participate in research studies and approved by a research ethics committee was 498. This demonstrates a continuing increase in enabling patients to participate in research activity. We undertake in depth interventional studies which enable patients with rare conditions to benefit from participating in novel research interventions and we aim to increase our overall recruitment by a further 18% in 2014/15 varying the portfolio to include new specialities and more observational studies.

Participation in clinical research supports the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. During 2013/14 the Trust was involved in conducting 76 clinical research studies, actively recruiting in Oncology, Cardiovascular, Haematology, Dermatology, Diabetes and Endocrinology, Stroke, Paediatrics, Ageing, Rheumatology and Musculoskeletal, Gastroenterology, Physiotherapy and Primary Care which is an increase of around 22% from the previous year. We have approximately 51 studies in follow up, these studies are closed to recruitment but the follow up period can last for several years and there are a further 27 studies where an expression of interest has taken place, or where studies are progressing through the Research and Development governance process.

74 members of clinical staff in the Trust participated in research approved by a Research Ethics Committee during 2013/14, covering 13 medical specialties. 46 publications have resulted from our involvement in National Institute for Health Research (NIHR), which demonstrates our commitment to transparency and the desire to improve patient outcomes and experience across the NHS. These were cited within a number of medical publications. The specialities included Cardiovascular, Orthopaedic, Stroke, Radiology, Histopathology, Haematology, Paediatrics, Rheumatology, and Ophthalmology. There are further papers arising from current studies that have yet to progress to publication.

Research activity throughout 2013/14 continued to be funded by Surrey and Sussex Comprehensive Local Research Network (SSCLRN). From April 2014 this organisation will merge with Kent and become the Kent Surrey and Sussex Clinical Research Network (KSS CRN). Funding for the new organisation has been agreed by the Department of Health and will remain unchanged for the forthcoming year. Funding is dependent on performance in meeting the set up and recruitment targets set by NIHR, since late April 2013 set up times have met the required metric (80% approved within 30 days).

The Trust will continue to increase the opportunities for patients to participate in research activities and support research active clinicians and practitioners, with an aim to develop research into novel areas for the Trust and also support clinicians new to research. We are committed to developing a research minded culture and the Trust Research and Development Department has developed Scientific Meeting events to enable research and audit studies undertaken within the Trust to reach a wider audience.

The first scientific meeting called was held in April 2014 and was attended by over 70 healthcare professionals from across the organisation. The event was organised to raise the profile of research and bring together clinicians in a scientific forum to share their research.

Our engagement with clinical research demonstrates East Sussex Healthcare NHS Trust's commitment to testing and offering the latest evidence based medical treatments and techniques.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of East Sussex Healthcare NHS Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between East Sussex Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2013/14 our CQUIN schemes covered:

National Schemes:

- VTE
- Dementia
- NHS Safety Thermometer
- Friends and Family Test

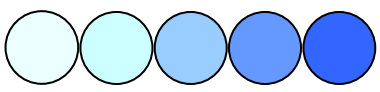
Local schemes:

- End of Life Care
- Urgent Care
- Clinical Correspondence
- Planned Care

Specialised Services schemes:

- Quality Dashboard for specialised services
- Reducing the incidence of preventable acute kidney injury
- Access to and impact of clinical nurse specialist support on patient experience

Details of some of the work to improve quality in these areas are already outlined in this Quality Account. Further details of the agreed goals for 2013/2014 are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html



What others say about East Sussex Healthcare NHS Trust…

Care Quality Commission (CQC)

East Sussex Healthcare NHS Trust is required to register with the Care Quality Commission and our current registration status is:

	Location																	
Regulated Activity:	Arthur Blackman Clinic	Avenue House	Bexhill Hospital (inc Irvine Unit)	Conquest Hospital	Crowborough Birthing Centre	Crowborough War Memorial Hospital	Eastbourne District General Hospital	Eastbourne Park Primary Care Centre	Hailsham Health Centre	Ian Gow Memorial Health Centre	Lewes Victoria Hospital	Orchard House	Peacehaven Health Centre	Rye Memorial Hospital	Seaford Health Centre	St Anne's House	Station Plaza Health Centre	Sturton Place Dental Clinic	Uckfield Community Hospital
Treatment of disease, disorder or injury	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈
Surgical procedures	◈		◈	◈			◈			◈	◈	◈	◈		◈			◈	◈
Diagnostic & screening procedures	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈	◈
Maternity & midwifery services				◈	◈		◈												
Termination of pregnancies				◈			◈												
Family Planning Services	◈	◈	◈	◈	◈	◈	◈		◈						◈		◈		◈
Assessment / medical treatment of persons detained under the Mental Health Act				◈			◈												
Management of supply of blood and blood derived products				◈			◈												
Accommodation for persons who require nursing or personal care														◈					

The Trust is registered with the Care Quality Commission with no conditions attached to registration.

The CQC have made several unannounced visits to various sites across the Trust during 2013/14 and found the majority to be fully compliant with the essential standards of quality and safety. They have not taken enforcement action against the Trust in 2013/14

Full copies of all the reports can be accessed at http://www.cqc.org.uk/directory/RXC.

Staff Survey 2013

The NHS Staff Survey has been completed by NHS organisations annually since 2003; its purpose is to collect staff views about working in their local NHS Trust. The CQC uses the staff survey to provide information on national performance measures and as part of the ongoing monitoring of registration compliance.

For the Trust, the survey helps to assess the effectiveness and application of policies and strategies on for example, training, flexible working policies, and safety at work, and helps to inform future developments in these areas. The survey also monitors performance against the four staff pledges of the NHS Constitution: these pledges clarify what the NHS expects from its staff and what staff can expect from the NHS as an employer.

The survey was conducted between October and December 2013; the results were published in February 2014, and an analysis of them has been undertaken to identify and agree actions to be taken to address any areas of concern.

37% of staff at East Sussex Healthcare NHS Trust took part in this survey compared with a response rate of 51% in 2012.

There are two ways of scoring responses to questions:

1. % scores which indicate the percentage of staff giving a particular response to a question or a series of questions.
2. Scale summary scores which convert staff responses to questions into scores, with the minimum being 1 and the maximum being 5.

The tables below summarise the Trust's top and bottom ranking scores:

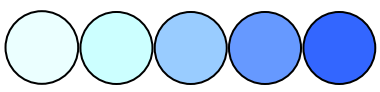
Top 5 Ranking Scores		
Key Finding	**ESHT 2013**	**Average Acute Trusts 2013**
KF13 - % of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	33%
KF16 - % of staff experiencing physical violence from patients, relatives or the public in last 12 months	13%	15%
KF5 – % of staff working extra hours	68%	70%
KF17 - % of staff experiencing physical violence from staff in last 12 months	2%	2%
KF20 - % of staff feeling pressure in last 3 months to attend work when feeling unwell	28%	28%

Bottom 5 Ranking Scores		
Key Finding	**ESHT 2013**	**Average Acute Trusts 2013**
KF25 – Staff motivation at work	3.66	3.86
KF6 - % of staff receiving job-relevant training, learning or development in last 12 months	75%	81%
KF15 - Fairness and effectiveness of incident reporting procedures	3.33	3.51
KF2 – % of staff agreeing that their role makes a difference to patients	87%	91%
KF1 – % of staff feeling satisfied with the quality of work and patient care they are able to deliver	70%	79%

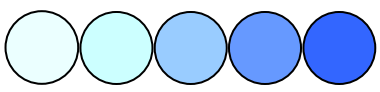
The five key findings where staff experiences have deteriorated at East Sussex Healthcare NHS Trust since the 2012 survey:

Key Finding	ESHT 2013	ESHT 2012
KF – 14 % of staff reporting errors, near misses or incidents witnessed in the last month	87%	94%
KF – 11 % of staff suffering work-related stress in last 12 months	42%	36%
KF – 25 Staff motivation at work	3.66	3.77
KF3 Work pressure felt by staff	3.24	3.13
KF 24 – Staff recommendation of the trust as a place to work or receive treatment	3.28	3.40

The following section presents each of the 28 Key Findings using data from the Trust's 2013 survey, and compares these to other acute Trusts in England and to the Trust's performance in the 2012 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity. Positive findings are indicated with a green arrow (e.g. where the 2013 Trust score has improved since 2012), negative findings are highlighted with a red arrow (e.g. where the 2013 Trust score has deteriorated since 2012) - where comparisons are possible.



Key Finding	ESHT 2013 (▲/▼ against ESHT 2012 score)	ESHT 2012	Average Acute Trust 2013
Staff Pledge 1 – To provide staff with clear roles, responsibilities, and rewarding jobs.			
KF1 - % of staff feeling satisfied with the quality of work and patient care they are able to deliver	70%=	73%	79%
KF2 - % of staff agreeing that their role makes a difference to patients	87%=	88%	91%
KF3 - Work pressure felt by staff	3.24 ▼	3.13	3.06
KF4 - Effective team working	3.66 =	3.65	3.74
KF5 - % of staff working extra hours	68% =	68%	70%
Staff Pledge 2 – To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.			
KF6 - % of staff receiving job-relevant training or development in the last 12 months	75%=	76%	81%
KF7 - % of staff appraised in last 12 months	79% =	79%	84%
KF8 - % of staff having well structured appraisals in the last 12 months	29% =	32%	38%
KF9 – Support from immediate managers	3.48 =	3.51	3.64
Staff Pledge 3 – To provide support and opportunities for staff to maintain their health, well-being, and safety.			
KF10 - % of staff receiving health and safety training in the last 12 months	73% =	70%	76%
KF11 - % of staff suffering work related stress in the last 12 months	42% ▼	36%	37%
KF12 - % of staff saying hand washing materials are always available	51% =	53%	60%
KF13 - % of staff witnessing potentially harmful errors, near misses or incidents in the last month	29% =	31%	34%
KF14 - % of staff reporting errors, near misses or incidents witnessed in the last month	87% ▼	94%	90%
KF15 – Fairness and effectiveness of incident reporting	3.33 =	3.35	3.50
KF16 - % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	13% =	14%	15%
KF17 - % of staff experiencing physical violence from staff in the last 12 months	2% =	2%	2%
KF18 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31% =	32%	29%
KF19 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	26% =	23%	24%
KF20 - % of staff feeling pressure in the last 3 months to attend work when feeling unwell	28% =	29%	28%



Key Finding	ESHT 2013 (▲/▼ against ESHT 2012 score)	ESHT 2012	Average Acute Trust 2013
Staff Pledge 4 – To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.			
KF21 - % of staff reporting good communication between senior management and staff.	19% ▼	21%	29%
KF22 - % of staff able to contribute to improvements at work.	61% =	63%	68%
Additional Theme – Staff satisfaction			
KF23 – Staff job satisfaction	3.45 =	3.49	3.60
KF24 – Staff recommendation of the Trust as a place to work or receive treatment	3.28 ▼	3.40	3.68
KF25 – Staff motivation at work	3.66 ▼	3.77	3.86
Additional Theme – Equality and Diversity			
KF26 - % of staff having equality and diversity training in last 12 months	53% =	51%	60%
KF27 - % of staff believing the Trust provides equal opportunities for career progression or promotion	84% =	89%	88%
KF28 - % of staff experiencing discrimination at work in the last 12 months	12% =	11%	11%

Staff Survey Comments from our Chief Executive

"We welcome the publication of the staff survey and will use the feedback to maintain and improve the working environment and experiences of our staff. Maintaining and developing a skilled and motivated workforce is a top priority for the Trust and we recognise that the majority of our staff are committed to providing the best possible care for patients.

The last year has been a particularly challenging one for both the NHS nationally and for East Sussex Healthcare NHS Trust, and the results of the survey will be used to help us concentrate our efforts to improve and we will be developing plans to achieve this.

Given the challenges facing the organisation over the past year, I don't think our results are a surprise. As an organisation we continue to perform well, for example, we have maintained the quality and safety of our services and are meeting our key performance indicators. We now need to work with staff to understand the issues they have and what we can do to resolve them. The health and well-being of our staff is extremely important to us and we will be working with our doctors, nurses and all other staff to ensure their concerns are addressed."

Friends and Family Test

The Trust has implemented the Friends and Family Test which provides and opportunity for patients to feedback on the care and treatment they receive and to influence service improvement. Patients are asked whether they would recommend hospital wards, Maternity services and A&E departments to their friends and family if they needed similar care and treatment. This means every patient in these departments are able to give feedback on the quality of the care. The scores are published on NHS Choices and NHS England score and are used to benchmark ESHT against other Trusts in the country including all specialist hospitals. East Sussex Healthcare Trust has maintained positive scores in all areas throughout 2013/14.

Data Quality

Data quality dashboards produced by the Health & Social Care Information Centre (HSCIC) indicate that East Sussex Healthcare Trust is the best performing trust in the Surrey & Sussex region for data validity. During 2014/15 we will be taking the following actions to maintain and improve data quality:

- Launching the Data Quality Steering Group to provide direction and ownership for the delivery of data quality.
- Providing regular data quality reports to the Quality & Standards Committee.
- Participation in both internal and external audits of clinical coding quality to ensure validity and accuracy of clinical coding.
- Undertaking a second re-audit of completeness of NHS Numbers to ensure continued progress.
- Validating correct attribution on the Patient Administration System of GP Practice through the national register (SPINE).
- Supporting Clinical Units to identify their areas for data quality improvement and provide training and education
- Identifying long term data issues and determine actions to overcome these.
- Collaborating with other Data Quality Unit's to share good practice.
- Striving to be in the top 30 best performers in England for Data Quality.

NHS Number and General Medical Practice Code Validity

East Sussex Healthcare NHS Trust submitted records during April 2013 – February 2014 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- **Which included the patient's valid NHS number was:**

99.6% for admitted patient care; (national rate 99.1%)

99.7% for out-patient care; and (national rate 99.3%)

98.5% for accident and emergency care. (national rate 95.8%)

- **Which included the patient's valid General Medical Practice Code was:**

100% for admitted patient care;

100% for out patient care; and

100% for accident and emergency care.

Information Governance Toolkit attainment levels

As a key part of the Information Governance agenda, the Department of Health and the NHS Connecting for Health (CfH) jointly produced an Information Governance Toolkit. This web-based tool was launched in late 2003 and represents DH policy on issues relating to safe and effective information governance.

The Toolkit has been made available to assist organisations to achieve the aims of Information Governance, and currently encompasses:

- Information Governance Management
- The Confidentiality NHS Code of Practice
- Data Protection Act 1998
- Information Security
- Information Quality
- Records Management
- Freedom of Information Act 2000

East Sussex Healthcare NHS Trust's Information Governance Assessment Report score overall score for 2013/14 was 69% and was graded **'green'** or 'satisfactory'.

Clinical coding

There is an ongoing internal audit process that is carried out within the Clinical Coding Department by the Clinical Coding Data Quality and Audit Manager. This looks at inpatient coding and ensures that areas of concern are checked and that clinical coding training needs are highlighted for appropriate attention. Compliance with the Information Governance Toolkit requirements (v.11) as described above is essential and has been reviewed by the Trust's independent internal auditors.

Recent internal audits have looked at:

- Emergency Respiratory admissions
- Enhanced cataract surgery
- Post-operative sepsis
- Out of Hospital Cardiac Arrests
- Orthopaedic fixations
- Community coding

This section of the report details our progress in delivering our improvement areas identified in last year's Quality Account, and our quality performance throughout 2013/2014.

Key to Quality Improvement Priority Achievements:

✓ Goal achieved

☑ Goal not fully achieved but improvements made

X Improvements not demonstrated

In last year's Quality Account five areas for improvement were identified:

Patient Safety

Patients are safe and free from harm:

1. **Patient Safety Thermometer**

◈ Maintaining harm free care at 90% and above

2. **Releasing Time to Care: the Productive Community Series**

◈ Improve processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety and efficiency

Clinical Effectiveness

Caring for vulnerable patients:

1. **Cardiology – Improve the patient experience for those diagnosed with heart failure**

- Increase community based services for cardiology patients
- Provide direct admission to cardiology services when required

Patient Experience

Providing personalised, dignified, respectful and compassionate care:

1. **Implementation of our Patient Experience Strategy**

- Introduce Patient Experience Champions across the Trust
- Implement the NHS Friends and Family Test
- Increase the amount of 'Easy Read' leaflets
- Introduce the use of Patients Diaries

2. **Supporting Children and Young People**

- Children with long term conditions and disability will be supported to stay at home
- Enable children to be discharged from hospital earlier

3.1 Patient Safety

Patients are safe and free from harm:
1. Patient Safety Thermometer ◈ Maintaining harm free care at 90% and above

✓ Patient Safety Thermometer

Improving patient safety involves assessing how patients could be harmed, preventing or managing risks, reporting and analysing incidents, learning from such incidents and implementing solutions to minimise the likelihood of them happening again.
The NHS Safety Thermometer helps NHS teams in their aim to eliminate harm in patients from four common conditions: **Pressure ulcers, Falls, Urinary tract infections in patients with a catheter and Venous Thromboemolism (VTE)**

Why we chose this priority:
These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400 million. The 'harm free care' programme supports the NHS to eliminate these four harms through one plan within and across organisations. This builds on existing improvement work and can be implemented at local level and integrated with existing routines. It helps organisations to consider complications from the patient's perspective, with the aim of every patient being 'harm free' as they move through the system.

Through using the NHS Safety Thermometer during their working day, teams can measure harm and the proportion of patients that are 'harm free', for example at shift handover or during ward rounds.
The Safety Thermometer provides a 'temperature check' and can be used alongside other measures of harm to measure local and organisational progress. It is a national tool that was not designed to compare organisations: it requires local discussion, interpretation and implementation and should be used to drive improvement. By adopting a 'harm free care' approach to patient safety ESHT have implemented many initiatives including the 'Essential Care Rounds' which ensure patients are approached on a regular basis and that their needs are promptly addressed.

What we were aiming to achieve in 2013/14:
As pressure ulcers are nationally the largest harm they were also chosen as our local improvement target. Using a baseline taken from the implementation of the NHS Safety

Thermometer in 2012/13, the Trust agreed to reduce the prevalence of all pressure ulcers across the whole health economy of East Sussex by 25% – 30%. This was a reduction in pressure ulcers that were acquired not only whilst patients were in the care of ESHT but also if they were living alone, receiving care from a care agency or residing in a care home. We agreed that this reduction would be made within 6 months and then maintained for a further 6 months.

2013/14 Results:

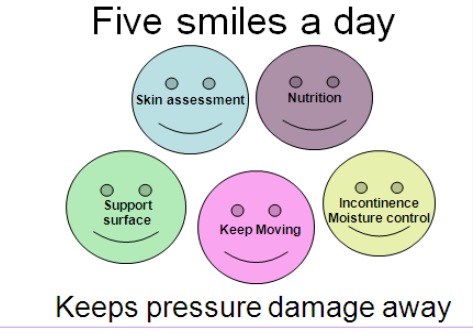
ESHT maintained an average of over 90% harm free care for 2013/14, with regards to pressure ulcers a reduction of 26.48% was made in the first 6 months of the year - the challenge has been in maintaining this reduction. To date 96.78% of this initial reduction has been maintained. Nationally and locally it is acknowledged that approximately 75% of pressure ulcers are acquired outside of provider organisations such as East Sussex Healthcare Trust.

In addition to the success of pressure ulcer reduction, the Safety Thermometer data has revealed a reduction in falls, urinary tract infections in patients with a catheter and incidences of venous thromboemolism (VTE).

Improvements delivered in 2013/14:

A number of initiatives have been put in place that has contributed to the reduction in pressure ulceration. They include:

- Development of a pressure ulcer prevention plan
- Development of a pressure ulcer prevention patient information leaflet
- Distribution of a pressure ulcer prevention staff leaflet to all ESHT staff
- A series of workshops held in by the Tissue Viability Nurse Service to promote the use of these documents
- Promotion of the global "Stop the Pressure Ulcer" day in November 2013
- The use of the "5 smiles" as a logo on emails to raise awareness of good pressure ulcer care and SSKIN (Skin assessment, Support surface, Keep moving, Incontinence/moisture control and Nutrition



- The formation of a Pressure Ulcer Prevention Multi-Agency Group to share ideas and processes and drive development in the wider health economy
- Participation in the organisation and delivery of a pressure ulcer conference for care home staff hosted by NHS Surrey and Sussex Senior Nurses Forum

3.2 Patient Safety

Patients are safe and free from harm:

2. Releasing Time to Care: the Productive Community Series

- Improve processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety and efficiency

✓ Releasing Time to Care

The Productive Community Series is an initiative developed by the NHS Institute for Innovation and Improvement with the ultimate aim of releasing more time for frontline staff to spend on patient care. The initiative focuses on improving processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety and efficiency.

Why we chose this priority:

The Productive Community Series is a system used to promote the engagement of staff in addressing not only patient safety and quality, but also the reliability of care, productivity, efficiency and staff well-being and was highlighted as an area for improvement by the CQC when they visited the District Nursing Service. As care shifts away from acute settings, community services play a crucial role and the use of the Productive Community Series Programme was an opportunity to revitalise our workforce and increase the Trust's capacity to care for patients in local settings.

What we were aiming to achieve in 2013/14:

We wanted all community nursing teams to complete the 'well organised workspace' module as a basis for future work to ensure that valuable clinician time could be made available by having well organised supplies and stores, and to pool the responsibility for stock control and ordering to ensure that there was consistency, cost effectiveness and efficient use of administrative resources in the community. We also wanted to use the principles of 'knowing how we are doing' to create a performance measurement tool for each locality team so that we could more accurately define our demand and capacity by consistently applying a methodology for knowing our 'patient status at a glance'.

2013/14 Results:

All community areas have implemented the foundation module 'well organised workspace' in their store areas. A proportion of stock control and ordering has been centralised to designated administrative staff for all locality teams, which has helped to reduce over-ordering and improve stock control. Administration time has been released and storage areas are being used more efficiently.

Improvements delivered in 2013/14:

The standard operating procedure for caseload management allows District Nurses to apply a consistent methodology when triaging their patients, and allows for greater transparency and communication about how we are assessing and responding to demands. The use of a colour coded system helps teams understand the status of their patients and caseloads at a glance.

A monthly performance template has also been developed, this allows Lead Nurses to share information at monthly team meetings about complaints, incidents that have occurred and workforce issues such as sickness rates and training needs, and allows them to plan improvements.

3.3 Clinical Effectiveness

Caring for vulnerable patients:

1. Cardiology – Improve the patient experience for those diagnosed with heart failure

- Increase community based services for cardiology patients
- Provide direct admission to cardiology services when required

✓ Cardiology

Over 900,000 people in the UK live with Heart Failure, early identification through assessment and positive intervention can improve quality of life. Heart Failure accounts for 5% of all admissions into hospital.

Our aim for 2013/14 was to improve the patient experience of those diagnosed with heart failure through the integration and development of specialist cardiac care.

Why we chose this priority:

We wanted to increase our community based services for cardiology patients with an emphasis on heart failure and provide direct admission to cardiology services when required.

Ensuring compliance with national standards for treatment times promotes more favourable outcomes for patients - in the past there has been a variation in the outcomes for patients with heart failure, including high death rates and re-admission rates nationally.

What we were aiming to achieve in 2013/14:

- Improve the overall patient experience
- Enable early discharge from the hospital, therefore reducing the length of stay for our patients
- Improve access to dieticians and physiotherapy specialists though cardiac rehabilitation service redesign
- Increase reviews by cardiac consultants
- Introduce telehealth for heart failure patients to remotely monitor blood pressure and weight

2013/14 Results:

Over the past year we have:

- Increased our community based services for cardiology patients with an emphasis on heart failure

- Reduced the number of hospital admissions
- Introduced a new way of managing and supporting symptom control in the community, for example the use of subcutaneous Frusemide
- Provided direct admission to cardiology services when required
- Improved the management of Heart Failure
- Built up links with GP's, hospital and community colleagues
- Reduced length of stay for patients with a primary diagnosis of heart Failure
- Improved our management of 'End of Life care' for Heart Failure patients
- Provided educational events i.e. for Emergency Department and hospice staff.

We carried out a small study of patient experience earlier this year, the key feedback so far has been that overall patients were satisfied with their care; 69% of patients really understood their diagnosis; 84% felt that they got the care that mattered to them; 100% of patients said that they had had their medicine/tablets explained in a way they could understand and100% of patients stated that they were aware who to contact if they were worried about their condition or treatment after they left hospital.

Improvements delivered in 2013/14:

We have tried to ensure that where clinically possible patients with heart failure are cared for on a Cardiology inpatient ward. Following the re-design of the medical model the emphasis is on patients receiving specialist care on dedicated wards to support the heart failure pathway.

We have developed the skills of the nurses that work on these wards so they are able to advise heart failure patients, and have established a community heart failure service to improve the treatment and subsequent outcomes for these patients. We are redesigning cardiac rehabilitation services to offer more choice of where this takes place alongside a multidisciplinary approach to the patient rehabilitation.

3.4 Patient Experience

Providing personalised, dignified, respectful and compassionate care:

1. <u>Implementation of our Patient Experience Strategy</u>

- To improve our communication with, and listen, act upon and be responsive to the feedback we receive from our patients and their carers

✓ Implementation of our Patient Experience Strategy

We outlined a number of initiatives in last year's Quality Account to support the implementation of our Patient Experience Strategy. This section highlights the work of our Patient Experience Champions.

The aim of the Patient Experience Champion Programme is to engage with and empower staff at all levels to deliver an excellent patient experience. This is achieved by providing a framework to enable local staff to continually listen and learn from our patients' experiences to make a real difference to patients receiving care in their ward, department or service. It supports partnership working with fellow colleagues by sharing and making trust wide improvements.

Why we chose this priority:

Patient Experience is about delivering high-quality care and is everyone's business; it requires champions in the board room and at the bedside. It is therefore imperative that health and social care organisations demonstrate behaviours which are consistent with high standards of care and compassion. To enable this to happen Patient Experience Champions have been identified and the role has been developed. Patient Experience, as with any development within an organisation, needs to be supported and addressed at every level and embedded into practice. Our Patient Experience Champions are a critical part of this process as they are continually listening and challenging practice to ensure that we learn from our patients' experiences.

What we were aiming to achieve in 2013/14:

The intention of this programme was to ensure that individuals within the organisation led and developed practice in their area by improving patient experience and satisfaction relating to privacy, dignity and respect. Our aim was to create a 'movement' of champions Trust-wide to own and drive the patient experience agenda and priorities at 'local level'.

The Patient Experience Champions used the 8 commitments within the Patient Experience Strategy as a core element of their focus.

They were encouraged to:-

- Stand up and challenge disrespectful behavior to staff and patients.
- Act as positive role models by treating others – staff and patients with respect, particularly those who are less able to stand up for themselves.
- Speak up about 'Patient Experience' and specifically 'dignity' to improve the way that services are organised and delivered.
- Listen to and understand the views and experiences of our patients / service users.

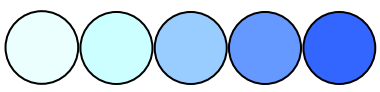
2013/14 Results:

Our year-on-year patient experience scores relating to patient experience (national inpatient survey)
have seen a steady rise. In addition, our patient experience bedside survey results indicate a considerable improvement over the past 12 months. This is attributable to a number of patient experience initiatives including the Patient Experience Champions.

Improvements delivered in 2013/14:

There are now over 100 Patient Experience Champions within the Trust who are active role models for all members of staff in continuously looking at ways in which we can improve the patient experience. They have been encouraged to be aware of feedback within their areas and act upon it. This includes feedback from patient surveys, PALS, complaints and media sites such as NHS Choices and Patient Opinion. Templates for displaying "you said, we did" have been delivered to all wards and departments to demonstrate our commitment to listening to patient feedback.

Recent meetings with Champions have included an important session on how we address people and the language we use. This is strengthening our commitment to being patient centred. A short workbook is also available for Champions to complete. Champions are encouraged to reflect upon how they can promote these commitments in their own areas and across the organisation. One of the Patient Experience Champions recently stated that *'Each patient is unique, with their own history, experiences, and expectations to share. Listening to our patient experiences and acting on them is a key factor in making positive supported changes through positive attitudes and behaviour. The opportunity to share and meet with other champions provides a great knowledge of resources to draw on. Sometimes just a smile, holding someone's hand or taking a few minutes to listen to concerns can make such a difference to the patient's perception of care received. Providing our patients with clear expectations of the care and services we can provide, with a forum to make positive changes is exciting and challenging and very rewarding.'*



On February 7th 2014 the Patient Experience Champions were involved in setting up displays around the Trust to promote National Dignity Day, a lot of work went into the displays and they were well received by visitors to the Trust.

National Dignity Day – February 2014

In addition to the Champions, we have held a number of engagement events throughout the year and a second patient experience conference on 24th March 2014 with positive feedback. A service user Champion commented: '*It was good to meet frontline staff and other service users at the Patient Experience Event in March. It was a great opportunity to hear about the patient experience from both sides, and also to be able to talk one to one with individual staff and gain an understanding of the reasons behind changes in practice.'*

The Intensive Therapy Units have continued to develop their work with 'ITU Steps' and the patient diary work outlined in the last Quality Account continue. Our Ward Matrons have continued to ensure they are available for patients, their families or carers. Our Patient Experience Strategy will continue as a quality improvement priority for the coming year

3.5 Patient Experience

Providing personalised, dignified, respectful and compassionate care:

3. <u>Supporting Children and Young People</u>

- Children with long term conditions and disability will be supported to stay at home
- Enable children to be discharged from hospital earlier

✓ Supporting Children and Young People

Children in the community with long term conditions and disability will be supported to stay at home and be enabled to be discharged from hospital earlier by having a specialist team of children's nurses available to them. If admitted to hospital they will have an identified trained nurse managing their care.

Why we chose this priority:

Supporting children and young people is integral to the development of the local children's clinical strategy 'Better Beginnings'. We therefore needed to ensure that the paediatric service provided high quality care that was safe, effective, met national and local quality standards and best practice guidelines and ensured that there was equity of access to all paediatric services.

What we were aiming to achieve in 2013/14:

To improve our communication with, and listen and act upon the feedback we received from our patients and their carers we developed a questionnaire with support from our stakeholders and the Trust patient experience team to obtain the views of people using our services.

2013/14 Results:

The questionnaire was sent to 281 patients and their carers, 93 were returned giving a response rate of approximately 33%. From the feedback received it was identified that:

- 95% of patients and their carers felt that their views and worries were listened to;
- 83% of parents or carers felt that they were involved in the action plans for their child;
- 85% of parents or carers felt that the services helped them to understand and manage their child's condition;
- 60% stated that they would know how to make a complaint if necessary
- 69% stated they would find it useful if the Community Children's Nursing Team was available at weekends and up until 22.00 hours each day;
- 69% rated the service as excellent, 18% as very good and 9% as good (total of 96% as good and above);
- 73% were extremely likely to refer to friends and family and 24% were likely;
- 56% did not consider service could be improved.

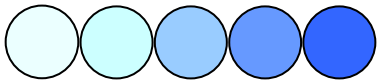
Improvements delivered in 2013/14

In response to the survey we have changed how we work with our patients and their families; the community children's nursing service leaflet will now include information about PALS and the Trust complaints department.

Specialist nurse roles are being developed across all community nursing services, and we now have two Diabetes Nurse Specialists, and one Epilepsy Nurse Specialist. We are also developing the Cystic Fibrosis Nurse Specialist role. One of our Community Children's Nurses is undertaking further training in advanced physical assessment skills and independent nurse prescribing and there are plans to further develop advance nurse practitioner roles within the service.

3.6 Review of our Performance Indicators in 2013/14

Performance Indicator	Thresholds		MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
	Performing	Under-performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%	95.01%	96.73%	95.41%	94.78%
MRSA (Cumulative)	0	>1SD	0	0	0	0	0	0	0	0	1	1	1	1.0
C Diff (Cumulative)	0	>1SD	4	10	11	14	18	23	27	31	35.0	36.0	39.0	43.0
RTT - admitted - 90% in 18 weeks	90%	85%	84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%	80.50%	73.66%	74.61%	74.85%
RTT - non-admitted - 95% in 18 weeks	95%	90%	96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%	94.65%	94.42%	93.99%	93.55%
RTT - incomplete 92% in 18 weeks	92%	87%	94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%	92.13%	92.71%	92.98%	92.77%
RTT delivery in all specialties	0	>20	11	9	11	4	5	6	9	9	16	15	16	19
Diagnostic Test Waiting Times	<1%	5%	0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%	4.70%	5.78%	5.09%	5.56%
Cancer 2 Week Wait	93%	88%	93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%	91.08%	94.23%	93.95%
Cancer 2 week wait - Breast	93%	88%	96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%	87.40%	94.78%	89.19%
Cancer 31 day - Subsequent Surgery	94%	89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.29%	100.00%	95.24%
Cancer 31 day - Subsequent Chemo	98%	93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer 31 day - Diagnosis to Treatment	96%	91%	96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.62%	97.89%	98.79%	100.00%
Cancer 62 Day Screening Service	90%	85%	77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%	100.00%	88.89%	81.82%
Cancer 62 Day Urgent Referral	85%	80%	85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	88.71%	89.57%	82.59%	84.69%
Delayed transfers of care	3.5%	5.0%	0.60%	0.68%	0.68%	0.63%	0.47%	0.61%	0.69%	0.57%	0.46%	0.64%	0.70%	0.38%
Mixed Sex Accommodation Breaches	0.0%	0.5%	0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%	0.17%	0.04%	0.00%	0.00%
VTE Risk Assessment	95.0%	80.0%	95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	97.13%	96.99%	97.90%	98.36%	98.25%



The National Quality Board has requested that all NHS Trusts report upon the following set of core quality indicators to help readers understand the comparative performances of Trusts.

NHS Outcomes Framework domain	Indicator
Domain 1: Preventing people from dying prematurely	→ **Summary Hospital-Level Mortality (SHMI)** ◈ SHMI value and banding ◈ % of admitted patients whose treatment included palliative care; and ◈ % of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (Context indicator)

Results

Summary Hospital Mortality Index (SHMI) is one of several statistical mortality indicators used to monitor and review the quality of care provided by the Trust. Also used are Hospital Standardised Mortality (HSMR) and the Risk Adjusted Mortality Indicator (RAMI).

The most recent SHMI value published for ESHT is 1.136. This is for the data period October 2012 to September 2013. The associated banding for this value by the NHS Health and Social Care Information Centre is 1 – "higher than expected" along with 7 other Trusts, however previous values have been within expected range. The next SHMI publication will be in July 2014.

Any raised mortality rate is a signal to undertake further analyses and examination. We have undertaken detailed investigations of mortality in low risk groups and specific areas where our statistical mortality indices have been increased. We are specifically looking at community settings and are working with our commissioners to achieve a better understanding of deaths in the community outside hospital or following discharge from hospital. All our investigations have not revealed any deficiencies in patient care that account for the raised SHMI.

The Trust faces some difficulties with the interpretation of these results as ESHT is one of a few Integrated Acute and Community Trusts which has multiple community hospital sites - patients are often admitted from other acute hospital providers. Although this indicator is an Acute hospital indicator, patient data for community hospitals have been included and therefore direct comparisons are difficult to achieve. The Trust continues to work towards unravelling these complexities and actively seeks to fully understand the indicator as part of a range of quality indicators.

◈ The percentage of admitted patients whose treatment included palliative care for ESHT is 1.5% compared to national rate for the same period of approximately 1.2% The range across all Trusts included with the indicator is 0% to 3.1%

◈ The percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care for ESHT is 22.5% compared to the national rate of approximately 20.9% for the same data period. The range across all the Trusts included within the indicator is 0% to 44.9%

Domain 3: Helping people to recover from episodes of ill health or following injury	→ **Patient reported outcome scores / measures (PROMS) for:** ◈ Groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery.

Results

All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in a 'PROMs' questionnaire. The NHS is asking patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards - this will help the Trust to measure and improve the quality of its care based upon the outcomes of surgical interventions. Questionnaires are issued to patients undergoing hip and knee replacements, groin hernia repairs and varicose vein surgery at the pre-assessment clinic and then either three or six months after surgery.

East Sussex Healthcare NHS Trust data (available data to Sept 2013)

Percentage Improving		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	**62.7%**	**46.2%**	**N/A**
	Hip Replacement	**96.4%**	**64.5%**	**100%**
	Knee Replacement	**84.2%**	**47.4%**	**95.5%**
	Varicose Vein	*	**No data**	**No data**

National data (available data to Sept 2013)

Percentage Improving		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	**50.3%**	**37.9%**	**N/A**
	Hip Replacement	**89.9%**	**66.9%**	**96.3%**
	Knee Replacement	**82.9%**	**56.5%**	**94.3%**
	Varicose Vein	**52.2%**	**39.9%**	**85.3%**

In summary, the data in these tables show that:

EQ-5D Index is a combination of five key criteria concerning general health

- ◈ 62.7% of groin hernia respondents recorded an improvement in their general health following their operation, against 50.3% nationally.
- ◈ 96.4% of hip replacements respondents recorded an improvement in their general health following their operation, against 89.9% nationally.
- ◈ 84.2% of knee replacement respondents recorded an improvement in their general health following their operation, against 82.9% nationally.
- ◈ The number of varicose vein questionnaires submitted were too low to provide data analysis. This is due to the low level of surgery undertaken by the Trust in this area.

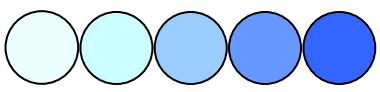
EQ-VAS assesses the patients' general health based upon a visual analogue scale

- 46.2% of groin hernia respondents recorded an improvement in their general health following their operation, against 37.9% nationally.
- 64.5% of hip replacement respondents recorded an improvement in their general health following their operation, against 66.9% nationally.
- 47.4% of knee replacement respondents recorded an improvement in their general health following their operation, against 56.5% nationally.
- The number of varicose vein questionnaires submitted were too low to provide data analysis. This is due to the low level of surgery undertaken by the Trust in this area.

Condition Specific Measures

- 100% of hip replacement respondents recorded joint related improvements following their operation as measured by their response to a series of questions about their condition (Oxford Hip Score), against 96.3% nationally.
- 95.5% of knee replacement respondents recorded joint related improvements following their operation as measured by their response to a series of questions about their condition (Oxford Knee Score), against 94.3% nationally.

No groin hernia completed questionnaires were returned by ESHT patients for this measure.



NHS Outcomes Framework domain	Indicator
Domain 3: Helping people to recover from episodes of ill health or following injury	→ **Emergency readmissions to hospital within 28 days of discharge**

Results

The percentage of patients of all ages and genders who were readmitted to hospital within the trust within 28 days of being discharged is shown below.

2013/14 Emergency Re-Admissions

	AGE GROUP		
	0-14	15+	Total
Discharges in 2013/14 *	5,028	39,763	44,791
Emergency readmission within 0-27 days of the precious discharge **	173	5,055	5,228
	3.44%	12.71%	11.67%

This is calculated using the specified technical advice exclusions usually applied to readmissions:

* Day cases and discharges due to death, maternity spells or cancer are excluded from these figures;

** Obstetric and cancer readmissions are excluded from these figures.

'Readmission' is an area for continued focus within the Trust

NHS Outcomes Framework domain	Indicator
Domain 4: Ensuring that people have a positive experience of care	→ **Responsiveness to inpatients' personal needs**

Results

The NHS Outcomes Framework for 2013/14 includes an organisation's responsiveness to patients needs as a key indication of the quality of patient experience. This score is based on the average of answers to five questions in the CQC national inpatient survey:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

The score for the Trust calculated from the CQC national inpatient survey 2013 is 67.9

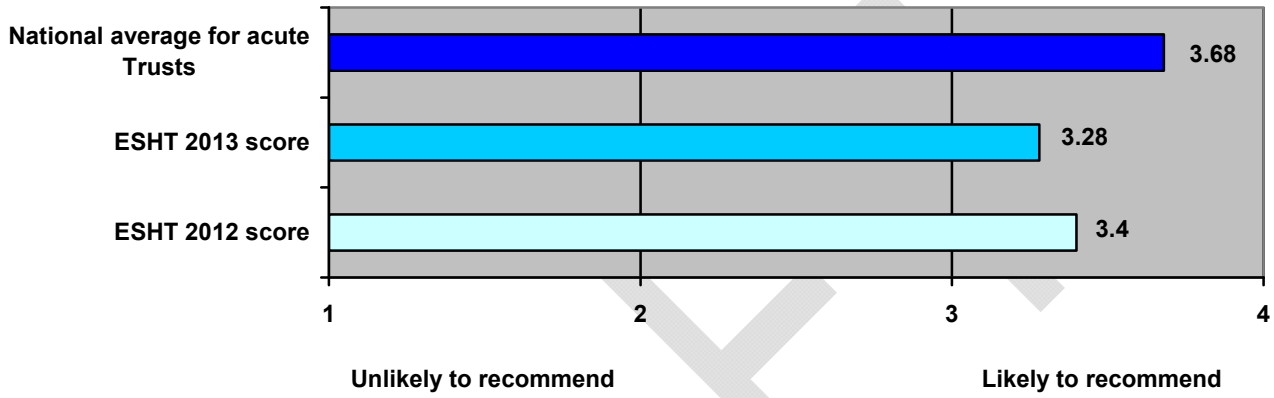
The National Average score is 67.6, therefore the Trust performed slightly better than the national average.

ESHT is currently ranked 67th out of 142 NHS Trusts. The Trust will continue to monitor performance through regular surveying, the results of which are reviewed through the organisation's committee structure.

NHS Outcomes Framework domain	Indicator
Domain 4: Ensuring that people have a positive experience of care	→ **%of staff who would recommend the provider to friends or family needing care**

Results

The results of Key Finding 24: *'Staff recommendation of the Trust as a place to work or receive treatment'*, are displayed as a 'scale summary score' (the higher the score the better - the minimum score is always 1 and the maximum score is 5):



The above score demonstrates that we are still adrift from the national average for Acute Trusts.

We will be continuing with and building upon the Listening into Action programme throughout 2014/15, actively engaging and encouraging staff to identify and implement changes and improvements to enhance their delivery of quality care.

NHS Outcomes Framework domain	Indicator
Domain 4: Ensuring that people have a positive experience of care harm	→ **%of patient's who would recommend the provider to friends or family needing care**

Results

The NHS Friends and Family Test was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment. This means every patient in these wards and departments is able to give feedback on the quality of the care they receive, giving hospitals a better understanding of the needs of their patients and enabling improvements.

The overall score for the Trust for 2013/14 was 87.56%

The individual monthly scores were was as follows:

Month	All questionnaires
Mar 2013	87.18
Apr 2013	86.42
May 2013	87.23
Jun 2013	87.85
Jul 2013	88.27
Aug 2013	87.25
Sep 2013	88.57
Oct 2013	87.41
Nov 2013	86.69
Dec 2013	86.41
Jan 2014	87.87
Feb 2014	87.75
Mar 2014	88.49
Apr 2014	89.00

The national benchmark was not available prior to publication to give a comparison.

NHS Outcomes Framework domain	Indicator
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	→ **Percentage of admitted patients risk-assessed for Venous Thromboembolism**

Results

Domain 5 of the NHS Outcomes Framework for 2013/14 includes incidence of VTE as an important indicator of improvement in protecting patients from avoidable harm, and the NHS Operating Framework for 2013/14 sets out an expectation that patients will be risk assessed for hospital-related VTE. The VTE Risk Assessment compliance percentages as submitted to Department of Health via UNIFY at East Sussex Healthcare Trust for 2013/14 are shown below.

Quarter 1			Quarter 2		
April	**May**	**June**	**July**	**Aug**	**Sept**
95.26%	96.75%	96.28%	97.16%	96.44%	97.04%
ESHT Q1 average = 96.11% National Q1 average = 95.45%			ESHT Q2 average = 96.89% National Q2 average = 95.74%		
Quarter 3			**Quarter 4**		
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
96.91%	97.13%	96.99%	97.90%	98.36%	98.25%
ESHT Q3 average = 95.8% National Q3 average = 97.1%			ESHT Q4 average = 98.17% National Q4 average = 96%		
* National data and ESHT average taken from http://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2013-14/					

Compliance with VTE risk assessments will continue to be monitored as part of the Trust's Patient Safety Thermometer as outlined in the Quality Improvement Priorities section.

NHS Outcomes Framework domain	Indicator
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	→ **Rate of C. Difficile**

Results

Domain 5 of the NHS Outcomes Framework for 2013/14 includes incidences of CDiff as an important indicator of improvement in protecting patients from avoidable harm, as does the NHS. The Trust's rate of CDiff compared to the national average are given below.

	Financial Year 2013/2014
The rate of CDiff infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust (ESHT)	**14.59**

	Q4 of Calendar Year 2013
The rate of CDiff infections per 100,000 bed days amongst patients aged two years and over (national average)	**14.41***

*data source: Quarterly Epidemiological Commentary: Mandatory MRSA, MSSA and E. coli bacteraemia, and CDiff infection data (up to October–December 2013), HPA, March 2014.

The Trust's final 2013/14 Outturn for CDiff was 43, this was above the very challenging ceiling of 25 set centrally. The 43 in 2013/14 is16 per cent fewer than in 2012/13. . The organisation is undertaking considerable work to improve infection control processes and management.

NHS Outcomes Framework domain	Indicator
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	→ **Rate of patient safety incidents and percentage resulting in severe harm or death**

Results

Domain 5 of the NHS Operating Framework for 2013/14 includes the rate of patient safety incidents reported and the proportion of these resulting in severe harm or death, as a measure of the willingness to report incidents and learn from them, and therefore reduce the number of incidents that cause serious harm. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the numbers of incidents resulting in severe harm or death should reduce.

The rate of patient safety incidents they have reported per 100 admissions

The rate of patient safety incidents reported to the National Patient Safety Agency for 2013/14 is 8.6 per 100 admissions. (8785 patient safety incidents sent to the NRLS / 101634 admissions)

It should be noted that an admission is defined as 'to a bed on a ward in a hospital' and therefore does not include other admissions for example to a community nursing caseload. However the patient safety data provided covers the whole spectrum of services provided by ESHT.

The proportion of patient safety incidents they have reported that resulted in severe harm or death

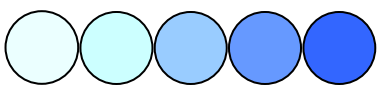
The proportion of patient safety incidents which resulted in severe harm or death for 2013/2014 was 0.69%. This is calculated by dividing the number of grade 4 (major) and 5 (catastrophic) patient safety incidents reported by East Sussex Healthcare Trust (61 in the year), by the total number of patient safety incidents reported to the National Patient Safety Agency (8785).

The latest report from the National Reporting and Learning System (NRLS) which was published in April 2014 and covering the period of 01.04.13 to 30.09.13 provided a reporting rate of 8.8 incidents reported per 100 admissions for East Sussex Healthcare Trust. This placed the Trust within the highest 25% of reporters.

The April 2014 report from the NRLS provided East Sussex Healthcare NHS Trust with a reporting rate of 0.4% of incidents leading to severe harm and death. The reporting rate of 'all large acute organisations' in the same report was 0.6%.

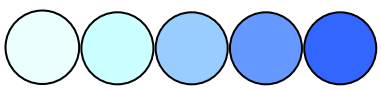
ESHT is categorised as a large acute organisation for the purposes of the NRLS reports; the Trust is an integrated organisation providing both acute and community services and there are very few comparator organisations. In addition, not all organisations apply the national coding of degree of harm in a consistent way which can make comparison of harm profiles of organisations difficult.

Serious Incidents are investigated via Root Cause Analysis and reports are presented to the Trust Serious Incident Review Group. At these meetings the severity risk score is reviewed to ensure it is appropriate for the incident. In addition, the central Datix Team review all incidents reported on Datixweb prior to 'approving' them for closure and the severity risk score is reviewed as part of this process.

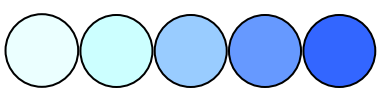


3.7 Statements from Key Stakeholders

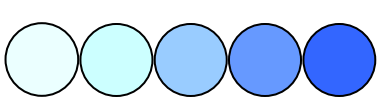
Statement from Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Havens CCG



Statement from East Sussex Health Overview and Scrutiny Committee

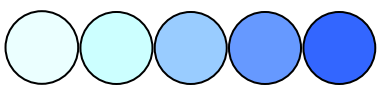


3.8 Independent auditor's report

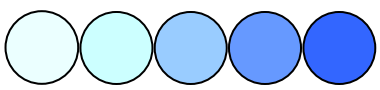


3.9 Glossary of terms

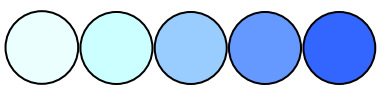
Abuse	Abuse is defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as: ◈ Sexual abuse ◈ Physical or psychological ill-treatment ◈ Theft, misuse or misappropriation of money or property, or ◈ Neglect and acts of omission which cause harm / place at risk of harm.
Avoidable Death	Deaths that could have been avoided given a different course of action
Avoidable Harm	Harm of patients that could have been avoided given a different course of action
Cardiology	Cardiology is a medical specialty dealing with disorders of the human heart. The field includes medical diagnosis and treatment of congenital heart defects, coronary artery disease, heart failure, valvular heart disease and electrophysiology. Physicians who specialise in this field of medicine are called cardiologists.
Care Quality Commission	The Care Quality Commission (CQC) replaced the Healthcare Commission and Mental Health Act Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk
Care Pathway	This is an anticipated care plan that a patient will follow, in an anticipated time frame and is agreed by a multi-discipline team (i.e. a team made up of individuals responsible for different aspects of a patient's care).
Clinical Audit	Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.
Clinical Coding	Clinical Coding Officers are responsible for assigning 'codes' to all inpatient and day case episodes. They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System. The coding process enables patient information to be easily sorted for statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provides a complete picture of the patient's care.
Clinical Management Executive	The Clinical Management Executive (CME) exists to ensure that the organisation is able to plan and undertake the actions required to effectively deliver its strategic objectives. It ensures the business of the organisation is run effectively, efficiently and in accordance with relevant statutory obligations. It makes decisions relating to planning and delivery across all aspects of the organisations functions within the strategic framework provided by the Board.



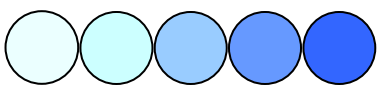
Clostridium difficile or C. Difficile / C.Diff	Clostridium Difficile also known as 'C.Difficle' or 'C. diff', is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or persons gut are wiped out by antibiotics. C. Difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. Difficile infection in the community and outpatient setting is increasing.
Commissioners of services	Organisations that buy services on behalf of the people living in the area that they cover. This may be for a population as a whole, or for individuals who need specific care, treatment and support. For the NHS, this is done by Clinical Commissioning Groups (CCGs) and for social care by local authorities.
Commissioning for Quality and Innovation	High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: www.dh.gov.uk/en/
Culture	Learned attitudes, beliefs and values that define a group or groups of people.
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative
DatixWeb	On 1st January 2013 East Sussex Healthcare NHS Trust introduced an electronic incident reporting software known as DatixWeb. Incidents are reported directly onto the system by any employee of the organisation, about incidents or near missing occurring to patients, employees, contractors, members of the public. The data provided by DatixWeb assists the organisation to trend the types of incidents that occur, for learning lessons as to why they occur and to ensure that these risks are minimised or even eliminated by the action plans that we put in place. DatixWeb is also used to comply with national and local reporting requirements.
Department of Health	The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.
Deteriorating Patient	A patient whose observations indicate that their condition is getting worse
Dignity	Dignity is concerned with how people feel, think and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual views and beliefs.
Discharge	The point at which a patient leaves hospital to return home or be transferred to another service or, the formal conclusion of a service provided to a person who uses services.
Enforcement action	Action taken to cancel, prevent or control the way a service is delivered using the range of statutory powers available to the Care Quality Commission. It can include action taken in respect of services that should be, but are not, registered.
Essential Care Rounds	Health professionals undertake hourly rounds to ask patients how they are feeling, make sure that they are comfortable, address their concerns and see if they require pain management. The approach can helps nurses to focus on clear, measurable aims and expected outcomes and frontline teams to organise workload and provide consistent care. Essential care rounding can reduce adverse events, improve patients' experience of care and also provide comfort and reassurance.



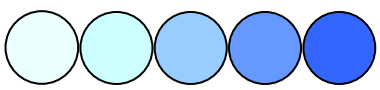
Friends and Family Test	An NHS 'friends and family' test was implemented by by Prime Minister David Cameron in April 2013 to improve patient care and identify the best performing hospitals in England. Patients are asked a simple question: whether they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment. Publishing the answers allows the public to compare healthcare services and clearly identify the best performers in the eyes of patients – and drive others to take steps to raise their standards.
Healthcare- associated infection	An avoidable infection that occurs as a result of the healthcare that a person receives.
Hospital Episode Statistics	Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.
Hospital Standardised Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR) is an indicator of whether death rates are higher or lower than would be expected.
Key Performance Indicators (KPIs)	Key Performance Indicators, also known as KPI help an organisation define and measure progress toward organisational goals. Once an organisation has analysed its mission, identified all its stakeholders, and defined its goals, it needs a way to measure progress toward those goals. Key Performance Indicators are those measurements. Performance measures such as, length of stay, mortality rates, readmission rates and day case rates can be analysed.
Multidisciplinary	Multidisciplinary describes something that combines multiple medical disciplines. For example a 'Multidisciplinary Team' is a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients.
MRSA	Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including the penicillins and the cephalosporins. MRSA is especially troublesome in hospitals, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.
Malnutrition Universal Screening Tool (MUST)	'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan.
National Confidential Enquiry into Patient Outcome and Death – NCEPOD	The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are published. Clinicians at East Sussex Healthcare NHS Trust participate in national enquiries and review the published reports to make sure any recommendations are put in place.
National Institute for Health and Clinical excellence	The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk
Never Event	A Never Event is a type of Serious Incident (SI). These are defined as '*serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers*'.



Palliative Care	Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.
Patient Experience Champions	Patient Experience Champions have been identified across the organisation and will work to raise awareness and facilitate improvements to the patient experience of patients on their wards / in their departments.
Patient Safety Thermometer	The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism - deep vein thrombosis and pulmonary embolism). It provides a quick and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm free care.
Periodic reviews	Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services.
Pressure Ulcers	Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time, or, they can occur when less force is applied but over a longer period of time.
Privacy and dignity	To respect a person's privacy is to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having. It also means respecting their confidentiality and personal information. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual beliefs.
Patient Reported Outcome Measures (PROMs)	Assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.
Providers	Providers are the organisations that provide NHS services, e.g. NHS trusts and their private or voluntary sector equivalents.
Registration	From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).
Releasing time to care – the productive community series	The NHS Institute for Innovation and Improvement has been working with nurses and therapists to develop ways to increase the amount of direct care time given to patients in community hospitals. The Productive Community Hospital programme is designed to help achieve this by improving the effectiveness, safety and reliability of inpatients, day hospitals and minor injuries units.
Research	Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.



Root Cause Analysis (RCA)	RCA is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing correction on root causes, problem recurrence can be prevented.
Safeguarding	Ensuring that people live free from harm, abuse and neglect, and in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults, on independence and choice.
Serious Incident (SI)	A Serious Incident is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death on hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.
Summary hospital-level mortality indicator (SHMI)	SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by that trust (where 1.0 represents the national average). Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Trust Board	The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.
Waterlow	The 'Waterlow' score (or scale) gives an estimated risk of a patient developing a pressure sore.
Venous Thromboembolism (VTE)	Blood has a mechanism that normally forms a 'plug' or clot to stop the bleeding when and injury has occurred, for example a cut to the skin. Sometimes the blood's clotting mechanism goes wrong and forms a blood clot when there has been no injury. When this happens inside a blood vessel, the blood clot is called a thrombus. When the blood clot is deep inside one of the veins in the body, most commonly in the leg, it is called deep vein thrombosis (DVT). If the blood clot comes loose it can travel through the bloodstream to the lungs. This is called pulmonary embolism and it can be fatal. DVT and pulmonary embolism together are known as venous thromboembolism.



3.10 Feedback

Feedback on this document is welcome…

Please visit our website for further information or contact details:
www.esht.nhs.uk/

Please email us at:

enquiries@esht.nhs.uk

Or write to us at:

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East Sussex Healthcare NHS Trust
Eastbourne DGH
Kings Drive
Eastbourne
BN21 2UD

Follow us on Twitter @ eshealthcarenhs

Follow us on Facebook @ eshtnhs

Accessibility

The Trust can provide information in other languages when the need arises. Furthermore, to assist any patient with a visual impairment, literature can be made available in Braille or on audio tape.

For patients who are deaf or hard of hearing a loop system is available around our hospitals and a British Sign Language service can be arranged. Information on these services can be obtained via the Patient Advice and Liaison Service (PALS).

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	8
Subject:	Performance Report – March 2014 (Month 12) Finance Report – April 2014 (Month 1)
Reporting Officer:	Alice Webster, Director of Nursing Dr David Hughes, Medical Director – Clinical Governance Richard Sunley, Chief Operating Officer Monica Green, Director of Human Resources Vanessa Harris, Director of Finance

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of March 2013/14 and full year 2013/14, against quality, financial and workforce indicators.

Introduction:

The monthly quality report details ESHT's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14. This report also details performance against other key Trust metrics as well as activity and workforce indicators.

As we move into reporting for 2014/15, the Trust will be reporting in line with the new TDA Accountability Framework rather than the National Performance Framework. This reporting structure also takes account of the Board Level reporting discussions which were undertaken earlier this year.

Caring
Inpatient scores from Friends and Family Test
A&E scores from Friends and Family Test
Complaints – rate per bed days, MH contacts or calls to ambulance services
Inpatient Survey: Q68 Overall I had a very poor/ good experience?
Community Mental Health : Q45 Overall, how would you rate the care you have received in the last 12 months?
Mixed Sex Accommodation Breaches

Well-led
NHS England inpatients response rate from Friends and Family Test
NHS England A&E response rate from Friends and Family Test
Data Quality of trust returns to the HSCIC
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment
Trust turnover rate
Trust level total sickness rate
Total trust vacancy rate
Temporary costs and overtime as % total paybill
Percentage of staff with annual appraisal

Effective
Summary Hospital Mortality Indicator (HSCIC Published data)
Hospital Standardised Mortality Ratio (DFI Quarterly)
Hospital Standardised Mortality Ratio – weekend
Hospital Standardised Mortality Ratio – weekday
Deaths in low risk conditions
Emergency re-admissions within 30 days following an elective or emergency spell at the trust
IAPT – The proportion of people who complete treatment who are moving to recovery

Safe
CDIFF
MRSA
Never Event incidence
Medication errors causing serious harm
Percentage of Harm Free Care
Maternal deaths
Proportion of patients risk assessed for Venous Thromboembolism (VTE)
Serious Incidents
Proportion of reported patient safety incidents that are harmful
CAS alerts
Admissions to adult facilities of patients who are under 16 years of age (Number)

Responsive
Proportion of patients spending more than 4 hours in A&E
RTT waiting times for admitted pathways: percentage within 18 weeks
RTT waiting times for non-admitted pathways: percentage within 18 weeks
RTT waiting times incomplete pathways
RTT over 52 week waiters
Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test
Proportion of patients receiving first definitive treatment for cancer within 62 days of referral from GP
Proportion of patients receiving first definitive treatment for cancer within 62 days of referral from screening
Proportion of patients receiving first definitive treatment for cancer within 31 days of decision to treat
Proportion of patients receiving subsequent treatment within 31 days (Drug)
Proportion of patients receiving subsequent treatment within 31 days (Surgery)
Proportion of patients receiving subsequent treatment within 31 days (Radiotherapy)
Proportion of patients seen within 14 days of urgent GP referral
Proportion of patients with breast symptoms seen within 14 days of GP referral

Responsive
Urgent operations cancelled for a second time
Proportion of patients not treated within 28 days of last minute cancellation due to non-clinical reasons
Certification against compliance with requirements regarding access to health care for people with a learning disability
The proportion of those on Care Programme Approach(CPA) for at least 12 months **A** Who had a CPA review within the last 12 months **B** Having formal review within 12 months **C** Receiving follow-up contact within 7 days of discharge
Admissions to inpatient services who had access to Crisis Resolution/Home Treatment teams
Meeting commitment to serve new psychosis cases by early intervention teams (Number)
Category A8 Red 1 calls
Category A8 Red 2 calls
Category A call – ambulance vehicle arrives within 19 minutes
12 hour trolley waits in A&E
Mental health delayed transfers of care

Finance
Bottom line I&E position – Forecast compared to plan
Bottom line I&E position – Year to date actual compared to plan
Actual efficiency recurring/non-recurring compared to plan – Year to date actual compared to plan
Actual efficiency recurring/non-recurring compared to plan – Forecast compared to plan
Forecast underlying surplus/deficit compared to plan
Forecast year end charge to capital resource limit
Is the Trust forecasting permanent PDC for liquidity purposes?

The detailed reporting structures, data definitions and weighting of the metrics are currently being finalised by the TDA and are expected to be agreed on 15th May. Once these are received the internal report will be developed and shared for future reporting.

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

Performance Report - March 2014 (Month 12)

Month 12 performance fell below the required standard and the Trust remained in "Under-Performing" Status. A recovery plan had been developed and was being discussed with the Commissioners and TDA. Key milestones were a recovery of RTT targets by November 2014, Diagnostics by May 2014 and Cancer by July 2014 and the Board is asked to endorse this approach.

Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 19 specialties failed to achieve.

Final month 11 Cancer performance shows the Trust failing against 2 week wait All Cancers and 2 week wait Breast Symptoms.

Diagnostic waiters remained above the 1% ceiling for the third consecutive month.

There were 4 C-Difficile cases reported in month 12. Final outturn for 2013/14 is 43 against a target outturn limit of 25.

Finance Report - April 2014 (Month 1)

Compared to the Trust Board provisional budget the Trust performance in month 1 was a run rate deficit of £2,365,000, with a small favourable variance compared to plan of £44,000. Income was £252,000 below plan and this shortfall was offset by an under spending on costs of £208,000.

The Cost Improvement Plan (CIP) achievement in April was £995,000 which was ahead of plan by £196,000.

The cash balance at the end of April was £3.8 million (4 days operating costs).

Benefits:
The report provides assurance that the Trust continues to deliver a high quality, safe service for patients combined with a high level of accessibility, and provides detail of where standards are not being met. The Board is aware of the month 1 financial position.

Risks and Implications
The final outturn C-Difficile target of <=25 cases has been breached, which will cause fines to be levied against the Trust. At this early stage of the financial year the financial risks are unchanged from those associated with the plan for the year.

Assurance Provided:
This report details the key performance measures for the Trust against its annual business plan and as measured by external partners and the Department of Health reflecting centrally reported and audited metrics. The financial performance at month 1 is marginally better than plan.

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment Committee 28th May 2014

Proposals and/or Recommendations
The Board is asked to note the following actions have been taken and are on-going: • Delivery of the key performance measures The Board is asked to note the financial report and position at month 1.

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

For further information or for any enquiries relating to this report please contact:	
Name: Andy Bailey, Senior Business Analyst	**Contact details:** andybailey@nhs.net

East Sussex Healthcare Trust
Quality Report
(Including Performance, Activity and Workforce)

Month 12
March 2014

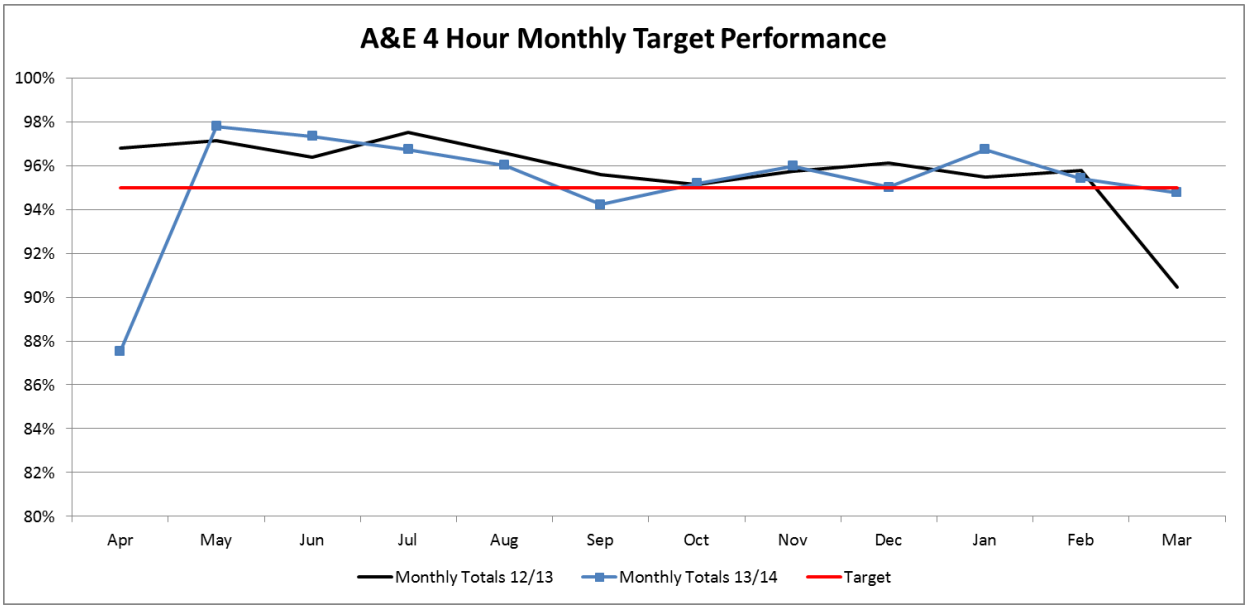
EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

Report Overview
Quality, Performance and Activity

National Performance Framework (NPF)

A&E performance

- Performance in March fell below the 95% target (94.78%), however Quarter 4 performance (95.60%) and Annual cumulative performance (95.25%) remained above target.



RTT performance

- RTT Performance failed against Admitted targets and Non-Admitted Targets. There were 19 specialty failures in March (compared to 16 in February). Detail as follows
    - Admitted pathways (Trust performance was 74.94% against a 90% Target):
        - T&O, ENT, Urology, Ophthalmology, Oral Surgery, General Surgery and Gynaecology were below target.
    - Non-Admitted pathways (Trust performance was 93.59% against a 95% Target):
        - T&O, Urology, Oral Surgery, Ophthalmology, General Surgery, Gastroenterology and Rheumatology were below target.
    - Incomplete pathways (Trust performance was 92.90% against a 90% Target): :
        - T&O, Oral Surgery, Gastroenterology, Neurology and Rheumatology were below target.

An RTT recovery plan has been developed in liaison with the Intensive Support Team and was signed off in early March. In addition to this and to ensure robust assurance is given, the Trust is undertaking to have weekly telephone conferences with the Trust Development Authority.

C-Difficile

There were 4 reported CDiff cases in March, confirming the final 2013/14 Outturn as 43, This was significantly above the very challenging ceiling of 25 set centrally. The 2014/15 ceiling will be 44.

Cancer Performance

Month 12 Cancer Performance is based on an early preview report. Final cancer performance for March will be available during the first week of May. As it stands, the trust is failing against 2WW (Breast Symptoms), 6*2 day Urgent GP referral* and *62 Day Screening Service*.

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

Mixed Sex Accommodation Breaches

There were no Mixed Sex Accommodation breaches in Month 12.

Diagnostics; % Patients seen < 6 weeks

Diagnostic Performance declined slightly in February, the number of patients awaiting diagnostic tests remains higher than target. Breaches are primarily within Endoscopy, due to a sustained period of time not utilising Ad_Hoc clinic sessions. Ad-Hoc sessions have been re-introduced together with the development of a formal recovery. It is anticipated that the number of patients waiting over 6 weeks will reduce in the next 2 months to bring performance levels below target.

Stroke

4 of 5 Stroke Metrics Achieved target in March. The percentage of patients admitted to the stroke unit within 4 hours fell below target due to 7 patients not being admitted to the stroke ward at EDGH with 4 hours of arrival at hospital. 3 of these patients presented at the conquest hospital.

Enhancing Quality of Life for People with Long Term Conditions

Unplanned Hospitalisations

The rate of unplanned hospitalisation for chronic ambulatory care conditions has reduced slightly in month, and remains below the monthly 12/13 baseline. The annual number for 2013/14 is confirmed as 3391, 4% lower than the 2012/13 outturn.

The rate of unplanned hospitalisation for specific conditions in U19s increased slightly in month, and remains below the monthly 12/13 baseline. The annual number for 2013/14 is confirmed as 241, 25% lower than the 2012/13 outturn.

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

Emergency Admissions

Emergency admissions for acute conditions not usually requiring admission continued on a downward trend, in line with plan and below the monthly 12/13 baseline. The annual number for 2013/14 is confirmed as 4677, 7% lower than the 2012/13 outturn.

Emergency Admissions for Children with lower respiratory tract infections continues to decrease following the expected seasonal spike in Dec.

Emergency Re-Admissions

The rate of Emergency Re-Admissions within 28 days remained stable at 9.41% and below the ceiling target of 10%. Work continues that will detail all readmissions at clinical unit level to identify common themes in discharging practice that will help eliminate avoidable emergency re-admissions in the second part of the year.

Ensuring that People have a positive experience of care

On the Day Cancellations of Elective Surgery per 1000 Procedures

There was a significant increase in Month 12 (5.74 compared to 3.07 in month 12).

MUST

MUST performance stands at 93%, but it should be noted that the new data capture mechanism has been fully implemented. Data against this indicator is now captured via a *Meridian* (3rd party also supplying the Trusts FFT solution) which enables greater sophistication and ability to capture all relevant information electronically. This ensures that wards maximise their ability to record MUST assessments undertaken. Thus, comparison against months prior to January 2014 is not possible.

Friends and Family Questionnaire

The trust achieved a 24.95% response rate in March.

The team continue to utilise volunteer services to telephone survey recent A&E attendees. This has so far proved successful in raising the response rate in this area. The Trusts Combined *Unify* Net Promotor Score (NPS) increased in March to 57.

Patient Centred Care Planning

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

Complaints responded to within timescales

Whilst the trust acknowledges all complaints within 3 working days, performance against the number of complaints responded to within 28 days remains slightly below target levels (95%) at 84%. Work continues to meet this target despite a number of complex complaints being submitted in year.

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

Patient Safety Incidents

There was a slight decrease in reported patient safety incidents in March, in line with Trust Baseline. The trust promotes a culture of incident reporting to ensure that key themes can be constantly identified and actions taken to reduce risks and maintain the safety of patients. The annual total patient safety incidents reported in 2013/14 was 8693, an increase of 7%

Severe Harm Incidents

There were 6 Severe Harm Incidents in Categorised as follows:

- Resus: 2 Incidents
- Treatment: 1 Incident
- Diagnosis: 1 Incident
- Care: 1 Incident
- Labour: 1 Incident

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

As with the MUST assessments, falls assessments are now captured via a Meridian supplied solution, electronically. As such, comparison against previous months is not possible. Performance stands at 93%.

Organisational Context

GP Referrals & Outpatient Activity

GP Referrals increased from February, primarily due to more working days within the month. At Specialty level there are no significant in-year upward trends in GP referrals, however cumulative year on year referrals have increased significantly from Hastings and Rother CCGs, in particular within Ophthalmology, Urology, Gastroenterology and ENT. Total Trust referrals are 5% higher than the same period last year. Outpatient Activity also decreased (both new and follow up), again primarily due to more working days. OP activity remains at levels required to support the trusts plan to reduce RTT backlogs but this will also (as planned and expected) contribute to reduced performance against non-admitted RTT targets.

Elective Activity

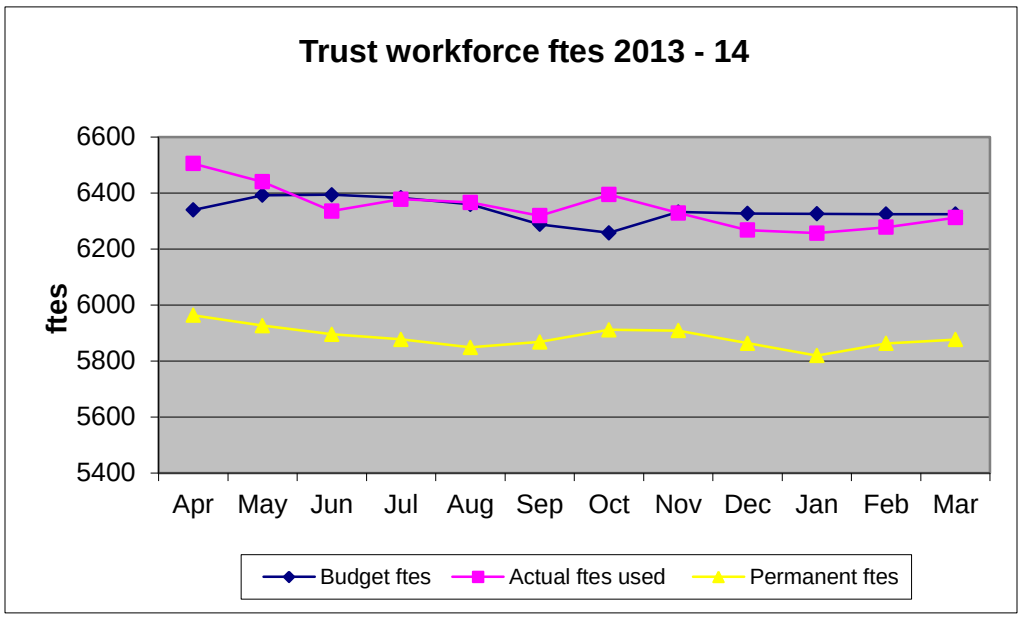
Elective activity showed a slight increase from February levels and significantly higher than the monthly average. This additional activity will have (as with OP activity) had a positive effect on RTT backlogs.

Non Elective Activity

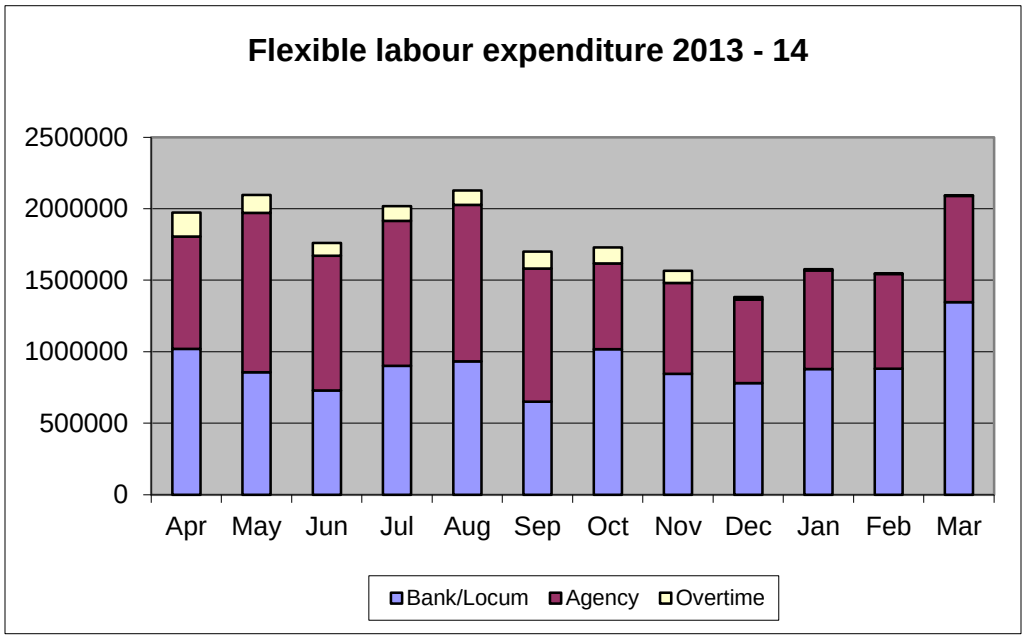
Non-Elective Activity increased in March. There were no significant specialty increases.

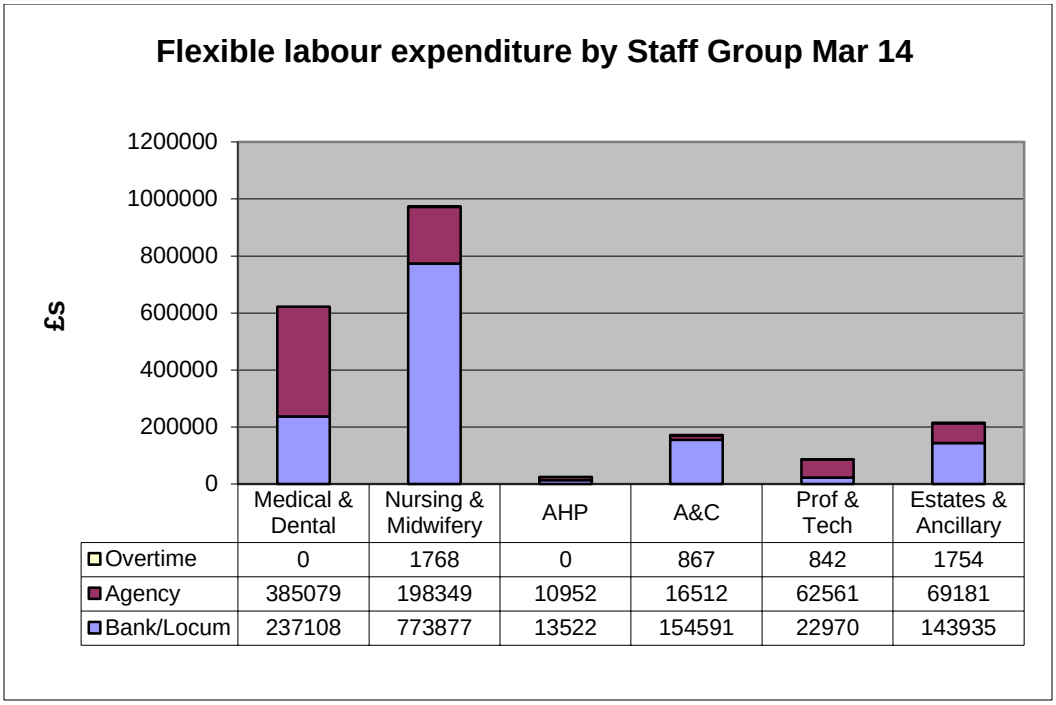
A&E, General Medicine, Obstetrics and Urology did see increases whilst other specialties remained stable, thus effecting an overall increase.

Workforce

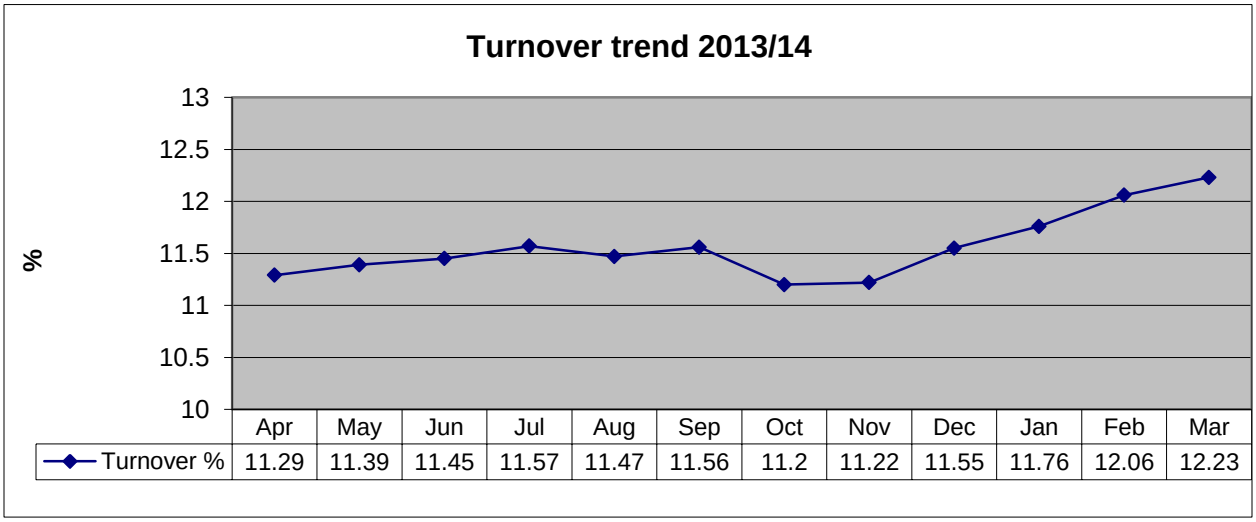


	Year to Date	
	Target	Actual
WTE in post (actual worked)	6324.71	6311.9
Paybill (£m)	244.98	254.15
Staff turnover	10%	12.2%
% of Bank, agency and overtime spend		8.54%





	Medical & Dental	Nursing & Midwifery	AHP	A&C	Prof & Tech	Estates & Ancillary
Overtime	0	1768	0	867	842	1754
Agency	385079	198349	10952	16512	62561	69181
Bank/Locum	237108	773877	13522	154591	22970	143935

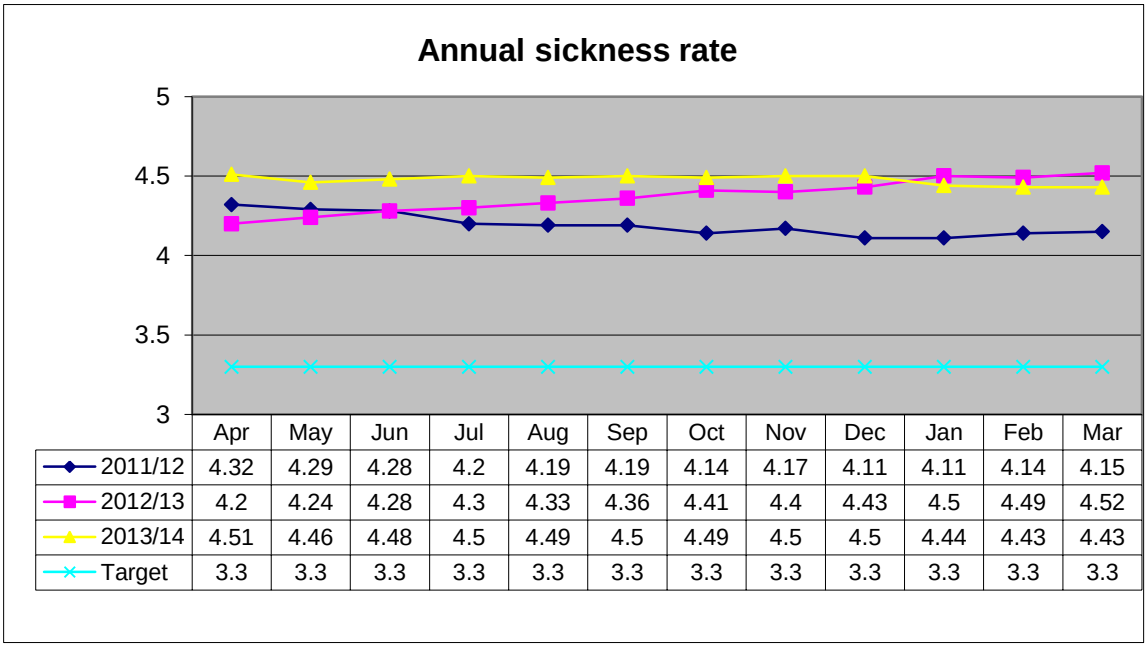


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Turnover %	11.29	11.39	11.45	11.57	11.47	11.56	11.2	11.22	11.55	11.76	12.06	12.23

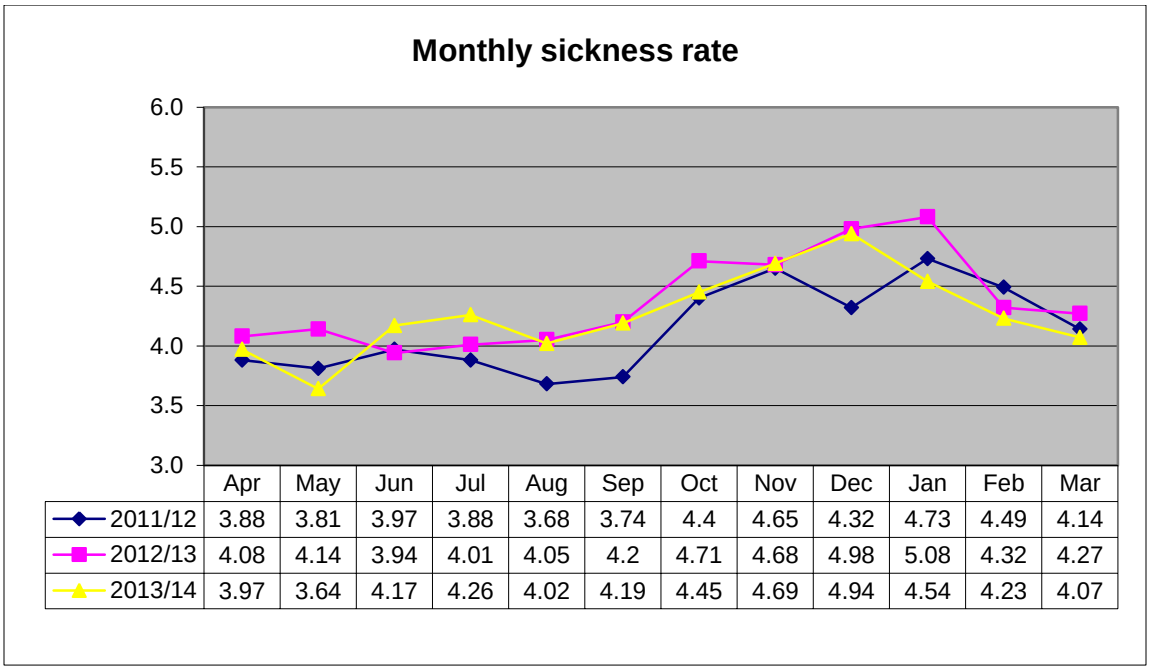
Actual ftes used in March are 34.43 higher than last month. There has been a small increase in permanent ftes used in month, with additional qualified nurses (these figures predate staff leaving under the Mutually Agreed Resignation scheme and the transfer out of Smoking Cessation and Healthy Weights services on the last day of the month). Agency usage is also showing as 20.90 ftes higher this month but this is largely due to delayed invoices/accruals at year end as well as some extra activity/ad hocs in Theatres to keep up with activity targets, some additional specialling of patients in Specialist Medicine and additional staffing in Finance for the production of the annual accounts. End of year accruals have also meant that temporary workforce expenditure has increased this month, particularly bank expenditure though bank fte usage in March was virtually unchanged. There was also some additional provision for accruals in overtime expenditure.

Turnover has increased across 2013/14 and has shown a steady increase in the last four months. The turnover rate of 12.23% for 2013/14 equates to 698.81 fte leavers in year (the rate for 2012/13 was 11.26%, equating to 654.76 fte leavers). 50.36 fte Medical & Dental staff left in year (not including junior doctor rotation) and 220.44 fte Registered Nurses & Midwives.

Sickness



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	4.32	4.29	4.28	4.2	4.19	4.19	4.14	4.17	4.11	4.11	4.14	4.15
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
Target	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	3.88	3.81	3.97	3.88	3.68	3.74	4.4	4.65	4.32	4.73	4.49	4.14
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

Monthly sickness fell, for the third successive month, by 0.16% to 4.07%. Annual sickness remains unchanged at 4.43%.

The Staff Groups with the highest monthly sickness were Additional Clinical Services (unqualified nurses and therapy helpers) at 5.28% (though down 0.63% compared to February), Qualified Nurses & Midwives at 4.92% (down by 0.23%) and Estates & Ancillary at 4.88% (up by 0.69%).

Training and Appraisals (incl. Divisional Summary)

Mandatory training compliance has remained largely static with marginal falls in Manual Handling, Infection Control, Induction and Mental Capacity Act training and marginal increases in Fire and Deprivation of Liberties training. Information Governance, however, is down by 2.19%.

From this month, we have been asked to add Health & Safety training compliance figures. This is mandatory for all staff but, currently, compliance is only at 31.24%.

Appraisals compliance continues to increase, up by 1.60% to 63.92%. From April, managers should be using the revised Performance Development Review process which has been launched with its focus on knowledge, skills, values and example behaviours as well as an explicit link between attendance and compliance with mandatory training and the performance rating. The launch is being supported by a programme of training.

Clinical Unit/Directorate	Annual sickness	Monthly sickness	Short term sickness <28 days	Long Term sickness >=28 days	Cumulative pay expenditure v budget (£000s)	Appraised/ exempt in last yr	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training
Trauma & Orthopaedic	2.60%	3.09%	62.02%	37.98%	£119	64.43%	73.66%	74.11%	89.66%	80.80%	54.91%	33.04%	91.58%	84.81%
Urol, Gen & Vasc Surg	3.63%	2.48%	92.90%	7.10%	£900	74.68%	75.00%	72.73%	94.87%	79.17%	73.48%	29.92%	95.09%	91.51%
Theatres Anaes & Crit Care	4.90%	5.51%	60.76%	39.24%	£292	72.21%	82.45%	73.76%	88.10%	82.09%	73.76%	20.74%	91.31%	88.35%
Head & Neck Surg	3.62%	2.66%	71.37%	28.63%	£1,408	74.91%	86.27%	83.10%	97.06%	87.32%	75.35%	43.31%	91.15%	90.57%
Planned Med & Adult OPD	4.65%	4.07%	59.25%	40.75%	£874	60.86%	85.82%	77.26%	94.74%	85.57%	74.57%	32.03%	89.40%	77.33%
Cardiovasc Medicine	3.82%	2.81%	55.15%	44.85%	£83	51.35%	74.36%	73.26%	97.06%	80.95%	56.78%	22.71%	82.73%	80.72%
Specialist Medicine	4.30%	3.43%	59.13%	40.87%	£720	69.23%	82.69%	74.56%	87.50%	83.04%	71.02%	25.09%	89.30%	86.32%
Complex Medicine	5.85%	6.37%	61.95%	38.05%	£839	50.08%	66.56%	64.54%	95.00%	72.01%	71.54%	21.77%	89.04%	87.10%
Acute Medicine	5.08%	4.54%	65.38%	34.62%	£2,548	51.04%	75.73%	69.42%	93.33%	75.00%	44.17%	39.56%	80.75%	75.54%
Clinical Support	3.19%	2.96%	77.77%	22.23%	-£785	70.89%	85.80%	80.68%	100.00%	83.71%	81.06%	42.23%	73.18%	53.01%
Children & Young People	5.09%	3.93%	66.40%	33.60%	£1,116	59.86%	81.34%	73.96%	94.87%	76.04%	69.35%	46.08%	82.45%	76.12%
Womens & Sexual Health	5.69%	3.97%	53.53%	46.47%	-£182	58.57%	84.85%	77.88%	95.00%	73.33%	54.85%	36.06%	86.76%	67.14%
Therapy Services	3.91%	3.85%	50.66%	49.34%	£106	65.14%	82.36%	75.95%	98.75%	73.15%	82.97%	46.69%	93.97%	89.84%
Commercial	5.01%	4.42%	59.10%	40.90%	-£975	64.54%	78.28%	50.53%	92.98%	90.53%	81.15%	10.81%	73.91%	100.00%
Corporate	3.07%	2.63%	70.95%	29.05%	-£802	73.91%	86.52%	83.04%	95.00%	88.04%	81.96%	46.74%	89.61%	80.65%
TRUST	**4.43%**	**4.07%**	**61.36%**	**38.64%**	**£9,166**	**63.92%**	**79.92%**	**71.25%**	**94.63%**	**81.38%**	**72.16%**	**31.24%**	**87.86%**	**81.54%**

n.b. Clinical Units are still in the previous structure pending changes to the Finance Ledger.

Medical Appraisal Compliance Status March 2014

	Number of doctors	Compliant	Percentage Compliant	Total expected to be compliant by 31/03/14	Percentage expected to be compliant by 31/03/14
Consultants (including honorary contract holders)	214	211	**98.6%**	211	**98.6%**
Staff grade, associate specialist, specialty doctor (including hospital practitioners / clinical assistants who do not have a prescribed connection elsewhere)	107	105	**98.1%**	105	**98.1%**
Total	321	316	**98.4%**	316	**98.4%**

The total number of doctors in the Trust are those doctors with a prescribed connection to the Responsible Officer.

Doctors who are compliant with medical appraisals are those who have either had an appraisal in the last 12 months (n = 299) and/or have been in the Trust for less than 6 months (n = 17).

Doctors who have not yet undertaken their medical appraisal for 2013 have been sent a letter to their home address reminding them of their obligations. These doctors are now at risk of being reported to the GMC for non-engagement in the medical appraisal and revalidation process unless they provide evidence of a medical appraisal in the next few weeks.

East Sussex Healthcare Trust
Service Performance for 2013/14

Performance Indicator	Thresholds		MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6	MONTH 7	MONTH 8	MONTH 9	MONTH 10	MONTH 11	MONTH 12
	Performing	Under-performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%	95.01%	96.73%	95.41%	94.78%
MRSA (Cumulative)	0	>1SD	0	0	0	0	0	0	0	0	1	1	1	1.0
C Diff (Cumulative)	0	>1SD	4	10	11	14	18	23	27	31	35.0	36.0	39.0	43.0
RTT - admitted - 90% in 18 weeks	90%	85%	84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%	80.50%	73.66%	74.61%	74.85%
RTT - non-admitted - 95% in 18 weeks	95%	90%	96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%	94.65%	94.42%	93.99%	93.55%
RTT - incomplete 92% in 18 weeks	92%	87%	94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%	92.13%	92.71%	92.98%	92.77%
RTT delivery in all specialties	0	>20	11	9	11	4	5	6	9	9	16	15	16	19
Diagnostic Test Waiting Times	<1%	5%	0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%	4.70%	5.78%	5.09%	5.56%
Cancer 2 Week Wait	93%	88%	93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%	91.08%	94.23%	93.95%
Cancer 2 week wait - Breast	93%	88%	96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%	87.40%	94.78%	89.19%
Cancer 31 day - Subsequent Surgery	94%	89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.29%	100.00%	95.24%
Cancer 31 day - Subsequent Chemo	98%	93%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer 31 day - Diagnosis to Treatment.	96%	91%	96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.62%	97.89%	98.79%	100.00%
Cancer 62 Day Screening Service	90%	85%	77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%	100.00%	88.89%	81.82%
Cancer 62 Day Urgent Referral	85%	80%	85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	88.71%	89.57%	82.59%	84.69%
Delayed transfers of care	3.5%	5.0%	0.60%	0.68%	0.68%	0.63%	0.47%	0.61%	0.69%	0.57%	0.46%	0.64%	0.70%	0.38%
Mixed Sex Accommodation Breaches	0.0%	0.5%	0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%	0.17%	0.04%	0.00%	0.00%
VTE Risk Assessment	95.0%	80.0%	95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	97.13%	96.99%	97.90%	98.36%	98.25%
		NPF SCORE	2.38	2.71	2.56	2.89	2.71	2.64	2.56	2.38	2.09	1.84	1.91	1.73

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

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A
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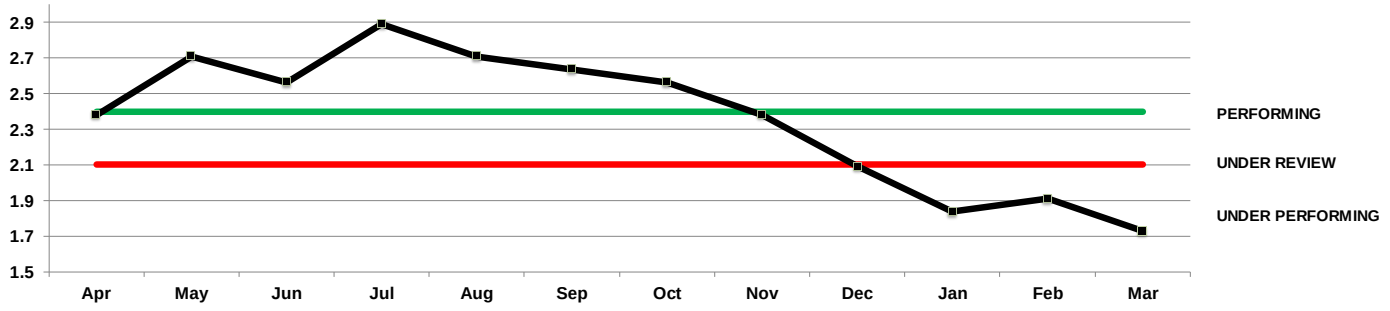
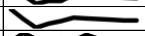
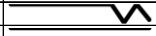
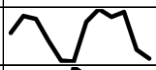


Clinical Effectiveness

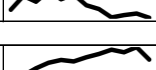
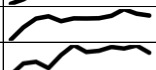
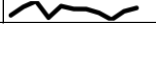
1. Preventing people from dying prematurely

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RAMI (Risk Adjusted Mortality Index)	100	100	NA		118	100	85	90	90	101.0	99.0	98.0	97.0	96.0	95.0	
SHMI (In Hospital) Sourced from CHKS			TBC		91	76	63	69.0	73.0	78.0	77.0	76.0	75.0	74.0	74.0	
Cancer waits 2 week	93%	88%	93.96%		93.91%	96.49%	94.69%	93.05%	94.95%	94.22%	95.95%	94.74%	93.41%	91.08%	94.23%	93.95%
Cancer waits 2 week – Breast	93%	88%	93.84%		96.30%	93.00%	96.74%	91.61%	91.23%	94.38%	93.14%	92.19%	94.95%	87.40%	94.78%	89.19%
Cancer 31 day – subsequent surgery	94%	89%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.29%	100.00%	95.24%
Cancer 31 day – chemo	98%	93%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer waits 31 days diagnosis to treatment	96%	91%	96.45%		96.11%	97.95%	98.58%	97.50%	98.13%	99.38%	98.52%	97.69%	97.62%	97.89%	98.79%	100.00%
Cancer waits 62 days > from urgent GP	90%	85%	83.28%		77.78%	100.00%	66.67%	91.67%	100.00%	77.78%	73.68%	83.33%	89.47%	100.00%	88.89%	81.82%
Cancer waits 62 days > from screening service	85%	80%	83.08%		85.71%	85.23%	82.21%	89.91%	77.68%	79.90%	81.19%	79.67%	88.71%	89.57%	82.59%	84.69%
Cancer waits 62 days > from consultant upgrade	No OS	No OS	NEW		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

2. Enhancing quality of life for people with long term conditions

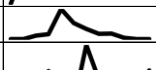
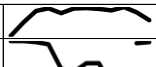
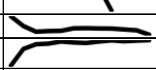
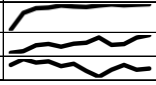
Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reduction in Unplanned hospitalisation for chronic ambulatory care conditions (adults)	Reduction	N/A	295		283	300	297	275	255	254	294	307	299	304	266	257
Reduction in Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Reduction	N/A	27		18	25	25	23	6	30	26	17	17	24	15	15

3. Helping people to recover from episodes of ill health or following injury

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency admissions for acute conditions which should not usually require hospital admission	RO	RO	422		464	396	334	369	428	364	409	416	411	341	386	359
Emergency admissions for children with lower respiratory tract infections	RO	RO	TBC		21	10	8	5	5	8	10	18	108	46	33	20
% Emergency Readmissions within 28 days	RO	11.00%	10.00%		10.44%	12.21%	11.48%	12.84%	11.78%	12.41%	11.02%	10.54%	9.46%	9.76%	9.96%	9.41%
ASI 1: Preventable stroke	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
ASI 2: Direct Admission to Stroke Unit	90.00%	90.00%	83.20%		65.12%	69.23%	75.86%	81.03%	83.67%	82.35%	86.27%	89.36%	93.33%	90.91%	95.83%	84.09%
ASI 3: 90% Acute Stroke Care	80.00%	80.00%	78.80%		61.11%	76.25%	86.76%	89.71%	83.67%	87.18%	86.89%	87.27%	90.24%	98.39%	92.86%	90.57%
ASI 4a: Access to Brain Imaging (1H)	50.00%	50.00%	57.60%		42.86%	59.38%	61.82%	52.54%	71.74%	86.21%	76.00%	77.78%	83.33%	81.13%	85.42%	75.00%
ASI 4b: Access to Brain Imaging (24H)	100.00%	100.00%	98.50%		95.24%	100.00%	98.21%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ASI 5: High Risk TIA	60.00%	60.00%	72.50%		71.43%	80.56%	86.67%	68.89%	81.40%	78.26%	78.13%	74.07%	66.67%	75.68%	79.31%	#N/A
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% MUST nutritional assessments undertaken					97.00%	94.00%	94.00%	99.00%	71.00%	70.00%	77.00%	62.00%	53.00%	89.00%	92.00%	93.00%

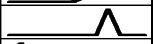
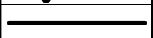
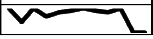
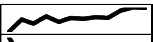
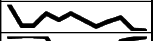
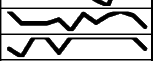
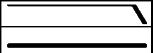
Patient Experience

4. Ensuring that people have a positive experience of care

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Diagnostics - % of patients waiting > 5 wks	1%	5%	0.42%		0.77%	0.13%	0.47%	0.35%	2.11%	0.71%	0.75%	1.62%	4.70%	5.78%	5.09%	5.56%
A&E Attendances	RO	RO	11292		11605	11963	11944	13324	12577	11631	11732	10803	11093	10818	10193	12230
Total time in A&E - 95% of patients should be seen within four hours	95%	94%	95.66%		87.53%	97.78%	97.34%	96.74%	96.01%	94.22%	95.19%	95.98%	95.01%	96.73%	95.41%	94.78%
Mixed sex accommodation breaches	0.00%	0.50%	0.02%		0.00%	0.00%	0.11%	0.15%	0.91%	0.48%	0.31%	0.16%	0.17%	0.04%	0.00%	0.00%
On the day cancellations of elective surgery per 1000 procedures for non-clinical reasons			TBC		4.43	4.09	3.04	5.68	2.63	2.09	8.57	4.72	4.95	3.89	3.07	5.74
Responsiveness to inpatient personal needs	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
Peoples experience of integrated care	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% Complaints responded to within timescales	100%	95%	55.00%		54.24%	71.21%	85.71%	89.09%	83.02%	88.89%	89.36%	88.33%	86.54%	90.74%	84.00%	74.07%
Patient centred care plans, responsive to individual preferences, needs and values - %					99.00%	99.00%	98.00%	96.00%	74.00%	71.00%	79.00%	79.00%	58.00%		97.00%	98.00%
Adult – BADS Efficiency Score	85%	75%	78.80%		80.97%	79.17%	78.16%	78.28%	78.32%	78.77%	78.79%	78.75%	78.72%	78.58%	78.42%	77.62%
Paediatric – BADS Efficiency Score	85%	75%	78.80%		84.60%	90.30%	91.90%	92.10%	92.80%	92.50%	92.30%	92.80%	93.20%	92.90%	93.10%	93.30%
FFT Response Rate	15%	13%	NEW		10.04%	11.46%	16.38%	17.48%	15.19%	17.66%	18.48%	22.85%	16.69%	17.35%	22.76%	24.95%
FFT NET Promotor Score			NEW		60.00%	65.00%	62.00%	63.00%	59.00%	61.00%	55.00%	50.00%	56.00%	60.00%	56.00%	57.00%

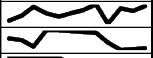
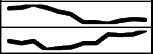
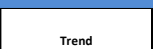
Patient Safety

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

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient safety incidents reported	RO	RO	675		778	732	665	786	694	764	881	689	696	707	660	641
Safety incidents involving severe harm or death	0	0	7		5	0	2	2	4	4	5	5	7	6	3	6
Incidence of hospital-related venous thromboembolism (VTE)	RO	RO	46.0		0	0	0	0	0	0	1	2	3	4	5	6
Incidence of healthcare associated MRSA infection	0	0	0		0	0	0	0	0	0	0	0	1	0	0	0
Incidence of healthcare associated *C. difficile* infection	2	2	4		4	6	1	3	4	5	4	4	4	1	3	4
Incidence of all category 2,3 and 4 pressure ulcers reported by ESHT	RO	RO	58		34	23	29	18	30	29	40	33	30	23	24	39
Incidence of medication errors causing serious harm	RO	RO	0		0	0	0	0	0	0	0	0	0	0	0	0
Admission of full-term babies to neonatal care	RO	RO	TBC		12	5	12	8	10	11	12	11	10	12	0	0
Incidence of harm to children due to 'failure to monitor'	DATA CAPTURE PROCESS UNDER DEVELOPMENT															
% of patients with VTE assessment	95.00%	85.00%	93.31%		95.26%	96.75%	96.28%	97.16%	96.44%	97.04%	96.91%	97.13%	96.99%	97.90%	98.36%	98.25%
Reduction in the outturn number of falls by at least 10%	178	178	198		241	175	176	213	194	214	193	173	187	201	163	161
At least 95% of patients to have a falls assessment on admission	95.00%	90.00%	TBC		96.00%	97.00%	97.00%	96.00%	71.00%	73.00%	74.00%	64.00%	58.00%	91.00%	94.00%	96.00%
Number of new serious incidents	RO	RO	15.0		21	12	12	12	15	7	19	13	18	21	18	10
% Submitted within timescale (month)	90%	85%	TBC		90.48%	83.33%	100.00%	100.00%	86.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.00%
Serious Incidents Open	RO	RO	30.0		57	68	77	71	61	54	53	44	44	42	35	30
Nice Technology Appraisal compliance	95%	95%	73%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Number of CAS alerts breaching timescales	0.0	0.0	TBC		0	0	0	0	0	0	0	0	0	0	0	0
Number of substantiated Safeguarding alerts	RO	RO	TBC		2	1	0	1	0	0	0	0	0	0	0	0
Compliance with cleaning standards	86%	80%	95.03%		93.89%	94.03%	93.19%	94.16%	89.45%	89.06%	90.32%	93.41%	#N/A	95.71%	95.85%	

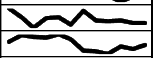
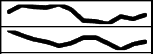
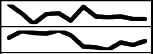
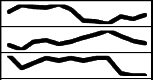
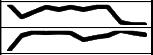
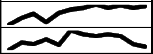
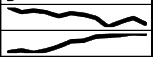
Organisational Context

6. Organisational Context

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Non elective FFCEs	RO	RO	3315		3,844	4,089	3,895	4,100	4,097	3,964	4,395	4,113	4,127	4,143	3,764	4,147
GP Referrals to hospital	RO	RO	7238		7,588	7,837	7,352	8,221	7,109	7,191	8,194	7,667	6,896	8,053	7,939	8,311
Other referrals for First OP appointment	RO	RO	3522		3,499	3,878	3,566	3,906	3,788	3,670	3,725	3,379	3,087	3,440	2,960	3,258
First OP attendances following GP referral	RO	RO	6927		6,375	6,770	6,519	7,418	6,068	6,515	7,232	6,749	6,056	7,053	6,760	7,713
All First OP attendances	RO	RO	10475		10,052	10,541	10,389	11,560	9,806	10,410	11,319	10,490	9,393	10,840	10,159	11,395
All subsequent OP attendances	RO	RO	23048		25,387	24,598	23,850	26,341	23,078	24,451	25,812	25,012	21,067	25,611	23,633	24,785
Elective FFCEs	RO	RO	799		730	772	846	787	760	790	822	868	700	833	813	852
RTT – admitted – 90% in 18 weeks	90%	85%	90%		84.62%	82.97%	76.78%	92.81%	92.43%	91.79%	91.41%	90.03%	80.50%	73.66%	74.61%	74.85%
RTT – non-admitted – 95% in 18 weeks	95%	90%	96%		96.57%	96.85%	96.60%	96.91%	96.79%	95.42%	95.77%	95.06%	94.65%	94.42%	93.99%	93.55%
RTT – incomplete 92% in 18 weeks	92%	87%	96%		94.81%	94.99%	95.50%	94.86%	94.24%	93.86%	92.42%	92.40%	92.13%	92.71%	92.98%	92.77%
RTT - Specialty Compliance	0	20	8		11	9	11	4	5	6	9	9	16	15	16	19
% Uncoded Spells	RO	RO	TBC		0.04%	0.01%	0.05%	0.03%	0.09%	0.02%	0.03%	0.04%	0.05%	0.01%	0.08%	5.77%

WorkForce

7. Workforce

Indicator	Target	Threshold	2012/13 Base-line	Trend	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Permanent FTE	RO	RO	6,048		5,964	5,926	5,895	5,877	5,848	5,868	5,911	5,909	5,864	5,819	5,863	5,877
Bank FTE	RO	RO	341		397	338	272	334	337	293	378	319	313	316	304	304
Agency FTE	RO	RO	181		145	175	168	167	180	158	105	101	90	122	111	131
% Permanent FTE	RO	RO	92.05%		91.67%	91.10%	90.62%	90.34%	89.90%	90.20%	90.87%	90.83%	90.14%	89.45%	90.12%	90.34%
% Bank FTE	RO	RO	5.19%		6.10%	5.20%	4.17%	5.14%	5.19%	4.50%	5.82%	4.90%	4.82%	4.85%	4.68%	4.67%
% Agency FTE	RO	RO	2.76%		2.23%	2.69%	2.58%	2.56%	2.77%	2.43%	1.61%	1.55%	1.39%	1.87%	1.70%	2.02%
Monthly Sickness	3.30%	3.80%	4.52%		3.97%	3.64%	4.17%	4.26%	4.02%	4.19%	4.45%	4.69%	4.94%	4.54%	4.23%	4.07%
Annual Sickness	3.30%	3.80%	4.52%		4.51%	4.46%	4.48%	4.50%	4.49%	4.50%	4.49%	4.50%	4.50%	4.44%	4.43%	4.43%
Induction Uptake	90.00%	75.00%	90.31%		91.10%	94.60%	95.30%	95.09%	95.22%	95.08%	93.62%	94.06%	94.48%	95.67%	95.17%	94.63%
Fire Training Uptake	90.00%	75.00%	75.10%		74.27%	76.18%	77.57%	75.12%	77.85%	78.87%	79.49%	80.50%	79.56%	80.24%	79.42%	79.92%
Manual Handling uptake	90.00%	75.00%	70.40%		70.83%	71.89%	71.69%	72.32%	71.50%	73.70%	73.06%	72.90%	73.10%	72.80%	71.67%	71.25%
Infection Control Training Uptake	90.00%	75.00%	78.73%		78.43%	80.24%	80.33%	80.75%	79.74%	80.71%	81.19%	82.32%	82.59%	82.08%	81.57%	81.38%
Information Governance Training Uptake	90.00%	75.00%	81.53%		79.04%	76.83%	77.53%	76.91%	75.34%	76.56%	75.77%	74.43%	70.75%	72.74%	74.35%	72.16%
MCA Training Uptake	90.00%	75.00%	80.56%		84.67%	84.86%	84.53%	84.93%	85.60%	86.56%	86.69%	87.45%	87.48%	87.74%	87.97%	87.86%
Deprivation of Liberty Training Uptake	90.00%	75.00%	72.60%		75.71%	76.19%	76.46%	77.15%	76.12%	78.29%	78.22%	79.40%	80.07%	80.73%	81.39%	81.54%
Appraisal Compliance	90.00%	75.00%	64.75%		63.68%	62.36%	62.12%	62.58%	60.12%	58.60%	57.76%	59.15%	60.80%	61.93%	62.32%	63.92%

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – April 2014

Vanessa Harris – May 2014

Financial Summary – April 2014

Key Issue	Summary	YTD
Key Performance Indicators	Measured against Monitor criteria the overall risk rating is a red rating of 1 as the Trust has a planned deficit budget.	R
Financial Summary	Compared to the Trust Board provisional budget the Trust performance in month 1 was a run rate deficit of £2,365k, with a small favourable variance compared to plan of £44k. Income was £252k below plan and this shortfall was offset by an under spending on costs of £208k.	R
Activity & Income	Total income received during April was £252k below plan.	G
Expenditure	Pay costs underspent by £213k in month 1. Non pay, including 3rd party costs over-spent by £10k.	G
CIP plans	The CIP achievement in April was £995k which was ahead of plan by £196k.	G
Balance Sheet	Improving the efficiency of debt collection is a key task for 2014/15, to help support the management of creditor balances and to retain liquidity.	G
Cash Flow	Cashflow forecasting and management will remain a key task for 2014/15, whilst the deficit position is covered by the agreed draw-down of PDC this will only be accessed on a quarterly in arrears basis, thus leading to challenges in timing of cashflows.	G
Capital Programme	The Capital Approval Group (CAG) will continue to review and monitor the capital programme on a monthly basis paying particular attention to the risks associated with limited capital funds.	G
Risk Summary	The overall Trust rating is a red rating of 1.	R

Income & Expenditure – April 2014

Headlines

- Total expenditure in the month was £31.8m. This was £0.2m below plan.
- The run rate deficit against plan was a small favourable variance of £44k.
- Cost improvements of £1.0m have been achieved in month 1 which is £0.2m ahead of the planned target.
- Total income in the month was £29.3m against a plan of £29.6m, producing an adverse variance of £252k.
- Pay costs in the month, including ad hoc costs, were below plan.
- Non Pay costs, including 3rd party costs, were in line with plan.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	26,820	27,012	192	26,820	27,012	192	323,730
Private Patient/ ICR	305	208	-97	305	208	-97	4,160
Trading Income	369	438	69	369	438	69	4,421
Education	691	691	0	691	691	0	9,651
Other Non Clinical Income	1,419	1,003	-416	1,419	1,003	-416	15,398
Total Income	**29,604**	**29,352**	**-252**	**29,604**	**29,352**	**-252**	**357,360**
Pay Costs	-20,697	-20,447	250	-20,697	-20,447	250	-241,875
Ad hoc Costs	0	-37	-37	0	-37	-37	0
Non Pay Costs	-9,745	-9,721	24	-9,745	-9,721	24	-114,922
3rd Party Costs	-4	-18	-14	-4	-18	-14	-123
Other	183	183	0	183	183	0	2,200
Total Direct Costs	**-30,263**	**-30,040**	**223**	**-30,263**	**-30,040**	**223**	**-354,720**
Surplus/- Deficit from Operations	**-659**	**-688**	**-29**	**-659**	**-688**	**-29**	**2,640**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,049	-1,031	18	-1,049	-1,031	18	-12,585
Impairment	0	0	0	0	0	0	0
PDC Dividend	-676	-689	-13	-676	-689	-13	-8,272
Interest	-25	-25	0	-25	-25	0	-295
Total Indirect Costs	**-1,750**	**-1,745**	**5**	**-1,750**	**-1,745**	**5**	**-21,152**
Total Costs	**-32,013**	**-31,785**	**228**	**-32,013**	**-31,785**	**228**	**-375,872**
Net Surplus/-Deficit	**-2,409**	**-2,433**	**-24**	**-2,409**	**-2,433**	**-24**	**-18,512**
Donated Asset/Impairment Adjustment	0	68	68	0	68	68	0
Adjusted Net Surplus/-Deficit	**-2,409**	**-2,365**	**44**	**-2,409**	**-2,365**	**44**	**-18,512**

Surplus/- Deficit from Operations	**-659**	**-688**	**-29**	**-659**	**-688**	**-29**	**2,640**
Debtors	91	-1,506	-1,597	91	-1,506	-1,597	1,926
Creditors	1,179	5,179	4,000	1,179	5,179	4,000	-2,601
Other	-7	-141	-134	-7	-141	-134	-380
CF from Operations	**604**	**2,844**	**2,240**	**604**	**2,844**	**2,240**	**1,585**
CAPEX	-2,498	-1,282	1,216	-2,498	-1,282	1,216	-28,514
Proceeds from Asset Sales	0	0	0	0	0	0	0
Interest Rec'd/Paid	2	6	4	2	6	4	24
Temporary Borrowing	0	0	0	0	0	0	35,912
Net movement in loans	0	0	0	0	0	0	-1,671
PDC	0	0	0	0	0	0	-8,273
Other	0	0	0	0	0	0	-320
Net Cash Inflow/Outflow	**-1,892**	**1,568**	**3,460**	**-1,892**	**1,568**	**3,460**	**-1,257**

Balance Sheet & Cash Flow – April 2014

Headlines

- The increase in trade receivables and payables is a result of raising May's contract invoices (£26.2m) to clinical commissioning groups (CCGs) in April.
- The cash balance at the end of the year was £2.3m and the Trust is planning for a £1m cash balance at year-end
- Revenue PDC is planned to be received quarterly in arrears to match the annual deficit plan. Clinical strategy capital PDC of £17.4m is also planned to be received during the financial year.

Cash Flow Statement April 2014 to March 2015

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2015	Feb	Mar
Receipts												
Revenue from patient care	28,569	27,460	26,962	28,347	26,882	26,563	28,579	28,118	26,532	28,737	26,619	27,138
Education & Training	800	763	763	763	763	763	763	763	763	763	763	767
PDC	0	0	4,628	0	0	22,028	0	0	4,628	0	0	4,628
Interest Receivable	4	2	2	2	2	2	2	2	2	2	2	2
Donated Assets	44	108	109	108	108	109	108	108	109	108	108	109
Other Income Generating Activities	3,029	1,216	1,154	1,277	1,221	1,221	1,210	1,225	1,213	1,213	1,212	1,208
Total Receipts	**32,446**	**29,549**	**33,618**	**30,497**	**28,976**	**50,686**	**30,662**	**30,216**	**33,247**	**30,823**	**28,704**	**33,852**
Payments												
Payroll costs	-20,134	-20,616	-20,566	-20,013	-19,991	-20,037	-19,940	-20,009	-20,135	-20,128	-20,124	-20,119
Non Pay expenditure	-9,462	-9,579	-11,722	-6,026	-6,276	-15,587	-14,979	-5,684	-11,321	-7,370	-8,864	-7,995
Capital programme	-1,282	-2,520	-1,777	-4,231	-2,551	-986	-3,382	-4,453	-2,209	-1,514	-1,308	-1,085
PDC dividend	0	0	0	0	0	-4,211	0	0	0	0	0	-4,209
Working Loan repayment	0	0	0	0	0	-691	0	0	0	0	0	-640
Capital Loan repayment	0	0	0	0	0	-170	0	0	0	0	0	-170
Finance Lease	0	0	0	0	0	-160	0	0	0	0	0	-160
Loan interest	0	0	0	0	0	-74	0	0	0	0	0	-73
Total Payments	**-30,878**	**-32,715**	**-34,065**	**-30,270**	**-28,818**	**-41,916**	**-38,301**	**-30,146**	**-33,665**	**-29,012**	**-30,296**	**-34,451**
Net inflow/outflow	**1,568**	**-3,166**	**-447**	**227**	**158**	**8,770**	**-7,639**	**70**	**-418**	**1,811**	**-1,592**	**-599**
Opening balance	2,257	3,825	659	212	439	597	9,367	1,728	1,798	1,380	3,191	1,599
Closing balance	3,825	659	212	439	597	9,367	1,728	1,798	1,380	3,191	1,599	1,000

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Non Current Assets			
Property plant and equipment	257,258	256,670	279,286
Intangilble Assets	826	855	1,593
Trade and other Receivables	708	708	647
	258,792	**258,233**	**281,526**
Current Assets			
Inventories	6,238	6,517	6,511
Trade and other receivables	25,426	49,432	20,274
Other current assets	0	0	0
Cash and cash equivalents	2,257	3,825	1,000
	33,921	**59,774**	**27,785**
Current Liabilities			
Trade and other payables	-32,063	-59,741	-29,652
DoH Loan	-1,674	-1,674	-340
Borrow ings - Finance Leases	-320	-320	-320
Provisions	-462	-587	-483
	-34,519	**-62,322**	**-30,795**
Non Current Liabilities			
DoH Loan	-3,535	-3,535	-3,198
Borrow ings - Finance Leases	-598	-522	-282
Provisions	-2,632	-2,632	-2,435
	-6,765	**-6,689**	**-5,915**
Total Assets Employed	**251,429**	**248,996**	**272,601**

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast Mar 2015
Financed by			
Public Dividend Capital (PDC)	-153,130	-153,130	-189,042
Revaluation Reserve	-106,395	-106,395	-109,885
Income & Expenditure Reserve	8,096	10,529	26,326
Total Tax Payers Equity	**-251,429**	**-248,996**	**-272,601**

Key Performance Indicators – April 2014

Headlines

KPIs

• The Trust has a planned annual deficit budget of £18.5m.

• The EBITDA Margin for the month was negative 2.5% compared to the planned negative 2.6% resulting in a red risk rating of 1.

• The EBITDA achieved as a percentage of plan is a risk rating of 1.

• The I&E surplus margin is a red rating of 1.

• The liquidity ratio, including the Working Capital Facility (WCF), now stands at 21 days, a risk rating of 3. Excluding the WCF the liquidity days would be -9 days.

• The overall KPI rating remains a red rating of 1.

KPIs	Outturn 2013/14	YTD Actual	YTD Plan
EBITDA Margin (%)	-1.8	-2.5	-2.6
EBITDA Achieved (% of plan)	259.4	95.4	100.0
Net Return After Financing (%)	-10.6	1.0	1.0
I&E surplus margin (%)	-6.4	-8.1	-8.2
Liquidity Ratio (days)	23	21	19
Overall Monitor Risk Rating	1	1	1

National & Local Measures	Outturn 2013/14	YTD Actual	YTD Plan
Income v Plan (£m)	364.2	29.4	29.6
Expenditure (before financing costs) v Plan (£m)	369.7	30.0	30.3
CRES Plans (£m)	17.5		0.8
BPPC – Trade invoices by value (%)	41.6	74.7	95
BPPC – NHS Invoices by value (%)	48.6	63.4	95

Monitor Ratings	YTD Risk Rating
EBITDA Margin	1
EBITDA % Achieved	1
Net Return After Financing	3
I&E Surplus Margin	1
Liquidity Ratio	3
Overall Risk Rating	1

Activity & Contract Income – April 2014

Headlines

- Contract activity income is £43k below plan excluding tariff excluded drugs and devices.
- Tariff-excluded drugs and devices income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £192k above planned levels.
- Inpatient Activity is £67k above plan in April. Elective Activity is £220k below plan. The main areas are T&O, General Surgery and Cardiology. This is offset by Emergency Activity which is £287k above plan.
- Outpatient Activity is £328k above plan, £280k relates to Dental services .

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,199	3,430	231	3,199	3,430	231
Elective Inpatients	792	675	-117	792	675	-117
Emergency Inpatients	3,533	3,594	61	3,533	3,594	61
Total Inpatients	**7,524**	**7,699**	**175**	**7,524**	**7,699**	**175**
Excess Bed Days	2,491	5,555	3,064	2,491	5,555	3,064
Total Excess Bed Days	**2,491**	**5,555**	**3,064**	**2,491**	**5,555**	**3,064**
Consultant First Attendances	5,414	6,870	1,456	5,414	6,870	1,456
Consultant Follow Ups	9,649	11,160	1,511	9,649	11,160	1,511
OP Procedures	4,126	4,860	734	4,126	4,860	734
Other Outpatients inc WA & Nurse Led	14,469	12,360	-2,109	14,469	12,360	-2,109
Community Specialist	257	282	25	257	282	25
Total Outpatients	**33,915**	**35,532**	**1,617**	**33,915**	**35,532**	**1,617**
Chemotherapy Unbundled HRGs	495	376	-119	495	376	-119
Antenatal Pathways	359	348	-11	359	348	-11
Post-natal Pathways	319	348	29	319	348	29
A&E Attendances (excluding type 2's)	8,783	8,607	-176	8,783	8,607	-176
ITU Bed Days	517	513	-4	517	513	-4
SCBU Bed Days	238	233	-5	238	233	-5
Cardiology - Direct Access	81	49	-32	81	49	-32
Radiology - Direct Access	4,908	4,749	-159	4,908	4,749	-159
Pathology - Direct Access	297,269	265,731	-31,538	297,269	265,731	-31,538
Therapies - Direct Access	3,594	3,341	-253	3,594	3,341	-253

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,430	4,210	-220	4,430	4,210	-220
Inpatients - Emergency	6,128	6,415	287	6,128	6,415	287
Excess Bed Days	570	459	-111	570	459	-111
Outpatients	3,442	3,770	328	3,442	3,770	328
Other Acute based Activity	2,511	2,450	-61	2,511	2,450	-61
Direct Access	817	768	-49	817	768	-49
Block Contract	6,016	6,192	176	6,016	6,192	176
Mandatory Fines & Penalties	0	-167	-167	0	-167	-167
Other	226	59	-167	226	59	-167
CQUIN	596	537	-59	596	537	-59
Subtotal	24,736	24,693	-43	24,736	24,693	-43
Exclusions	2,084	2,319	235	2,084	2,319	235
GRAND TOTAL	**26,820**	**27,012**	**192**	**26,820**	**27,012**	**192**

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

Headlines

Clinical Units (CUs)

During April the overall clinical unit performance was an under spending of £182k. The principal factor being an under spend on pay and non pay budgets partially offset by adverse other income performance. The pay under spending is due to vacancies in the month.

Generally CUs were underspent in the month with only Cardiovascular and Out of Hospital Care reporting overspendings.

Commercial Directorate

The commercial directorate underspent by £122k in the month largely due to non pay budgets under spending.

Corporate Services

Corporate services overspent in month 1 by £102k which was across pay £27k, non pay £42k and income £33k.

Income & Expenditure Performance	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Acute & Emergency Medicine	-1,808	-1,772	36	-1,808	-1,772	36
Specialist Medicine	-2,197	-2,086	111	-2,197	-2,086	111
Cardiovascular	-1,387	-1,522	-135	-1,387	-1,522	-135
Surgery	-2,384	-2,276	108	-2,384	-2,276	108
Women & Children	-2,585	-2,568	17	-2,585	-2,568	17
Out of Hospital Care	-2,794	-2,859	-65	-2,794	-2,859	-65
Theatres	-3,486	-3,411	75	-3,486	-3,411	75
MSK	-955	-948	7	-955	-948	7
Clinical Support	-3,314	-3,286	28	-3,314	-3,286	28
Total Clinical Units	**-20,910**	**-20,728**	**182**	**-20,910**	**-20,728**	**182**
Commercial Directorate	-2,433	-2,311	122	-2,433	-2,311	122
Corporate Services	-2,419	-2,521	-102	-2,419	-2,521	-102
Tariff-Excluded Drugs & Devices	-2,319	-2,294	25	-2,319	-2,294	25
Central Items	-1,846	-2,005	-159	-1,846	-2,005	-159
	-9,017	**-9,131**	**-114**	**-9,017**	**-9,131**	**-114**
Income	27,518	27,426	-92	27,518	27,426	-92
Donated Asset/Impairment Adjustment	0	68	68	0	68	68
Total	**-2,409**	**-2,365**	**44**	**-2,409**	**-2,365**	**44**

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
448	447	Acute & Emergency Medicin	-1,720	-1,680	40	-1,720	-1,680	40
684	653	Specialist Medicine	-2,092	-1,977	115	-2,092	-1,977	115
364	365	Cardiovascular	-1,281	-1,266	15	-1,281	-1,266	15
518	511	Surgery	-2,143	-2,030	113	-2,143	-2,030	113
654	642	Women & Children	-2,407	-2,398	9	-2,407	-2,398	9
849	869	Out of Hospital Care	-2,427	-2,483	-56	-2,427	-2,483	-56
562	541	Theatres	-2,217	-2,188	29	-2,217	-2,188	29
230	221	MSK	-897	-890	7	-897	-890	7
495	459	Clinical Support	-1,804	-1,784	20	-1,804	-1,784	20
4,804	**4,710**	**Total Clinical Units**	**-16,988**	**-16,696**	**292**	**-16,988**	**-16,696**	**292**
878	889	Commercial Directorate	-1,718	-1,731	-13	-1,718	-1,731	-13
513	510	Corporate Services	-1,587	-1,614	-27	-1,587	-1,614	-27
1,391	**1,399**	**Total Non-Clinical Divisions**	**-3,305**	**-3,345**	**-40**	**-3,305**	**-3,345**	**-40**
		Central Items	-404	-443	-39	-404	-443	-39
6,195	**6,108**	**Total Pay Analysis**	**-20,697**	**-20,484**	**213**	**-20,697**	**-20,484**	**213**

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

Headlines

Pay

Overall pay for Acute & Emergency medicine underspent by £40k due to establishment vacancies and reduced agency costs in the month.

Although pay has underspent overall in the month pay pressures exist within the Community Minor Injury Units (MIUs), due to the incidence of staff sickness, and Escalation staffing costs also amounted to £17k.

Non Pay

Non pay marginally overspent in the month in respect of medical equipment repair costs.

Income

Minor income variation against plan in respect of out of hours prescription charges at MIU's.

Workforce Plan FTE	Workforce Actual FTE	Acute & Emergency Medicine	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	3	2	-1	3	2	-1
		Total Income	**3**	**2**	**-1**	**3**	**2**	**-1**
448	447	Pay	-1,720	-1,680	40	-1,720	-1,680	40
		Non pay	-91	-94	-3	-91	-94	-3
448	**447**	**Total Expenditure**	**-1,811**	**-1,774**	**37**	**-1,811**	**-1,774**	**37**
448	**447**	**Gross Margin**	**-1,808**	**-1,772**	**36**	**-1,808**	**-1,772**	**36**

Clinical Unit Performance (budgets) Specialist Medicine – April 2014

Headlines

Pay

Pay underspent by £115k in the month due to medical staff vacancies and underspendings against establishment across a number of wards including Oncology , Wellington , MacDonald , Newington, Cuckmere wards and Endoscopy. The under spending in these areas was partly offset by overspending on Jevington ward which is due to the level of patient acuity being higher than plan levels.

Non Pay

Non-Pay marginally underspent by £6k in the month.

Income

Income underachieved by £10k in the month due variation in service level income.

Workforce Plan FTE	Workforce Actual FTE	Specialist Medicine	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	181	171	-10	181	171	-10
		Total Income	**181**	**171**	**-10**	**181**	**171**	**-10**
684	653	Pay	-2,092	-1,977	115	-2,092	-1,977	115
		Non pay	-286	-280	6	-286	-280	6
684	**653**	**Total Expenditure**	**-2,378**	**-2,257**	**121**	**-2,378**	**-2,257**	**121**
684	**653**	**Gross Margin**	**-2,197**	**-2,086**	**111**	**-2,197**	**-2,086**	**111**

Clinical Unit Performance (budgets) Cardiovascular – April 2014

Headlines

Pay

Pay underspent by £15k in the month with underspendings from Medical Stroke vacancies and vacancies within Michelham Unit being partially offset by pressures in the month on James Ward which overspent against establishment plan.

Non Pay

Non pay overspent by £43k due to Pacemaker and Electrophysiology consumable costs being above plan despite April activity being below plan.

Income

Income under achieved by £107k in the Michelham Unit. The unit had 41% occupancy during April. Activity is consistent with the last 3 months but down on plan. There was no NHS bed usage on the Unit in April.

Workforce Plan FTE	Workforce Actual FTE	Cardiovascular	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	252	145	-107	252	145	-107
		Total Income	**252**	**145**	**-107**	**252**	**145**	**-107**
364	365	Pay	-1,281	-1,266	15	-1,281	-1,266	15
		Non pay	-358	-401	-43	-358	-401	-43
364	**365**	**Total Expenditure**	**-1,639**	**-1,667**	**-28**	**-1,639**	**-1,667**	**-28**
364	**365**	**Gross Margin**	**-1,387**	**-1,522**	**-135**	**-1,387**	**-1,522**	**-135**

Clinical Unit Performance (budgets) Surgery – April 2014

Headlines

Pay

Pay underspent by £113k in the month due to , medical vacancies, reduced agency costs and under spending against establishment within the Richard Ticehurst SAU.

Non Pay

Non pay overspent by £2k in the month.

Income

Income underachieved by £3k due to reduced hearing aid recharges and low Private Patient income in the month.

Workforce Plan FTE	Workforce Actual FTE	Surgery	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	44	41	-3	44	41	-3
		Total Income	**44**	**41**	**-3**	**44**	**41**	**-3**
518	511	Pay	-2,143	-2,030	113	-2,143	-2,030	113
		Non pay	-285	-287	-2	-285	-287	-2
518	**511**	**Total Expenditure**	**-2,428**	**-2,317**	**111**	**-2,428**	**-2,317**	**111**
518	**511**	**Gross Margin**	**-2,384**	**-2,276**	**108**	**-2,384**	**-2,276**	**108**

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

Headlines

Pay

Pay underspent in month by £9k predominantly due to midwifery vacancies.

Non Pay

Non-pay expenditure is below plan, across a range of headings.

Workforce Plan FTE	Workforce Actual FTE	Women & Children	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	36	28	-8	36	28	-8
		Total Income	**36**	**28**	**-8**	**36**	**28**	**-8**
654	642	Pay	-2,407	-2,398	9	-2,407	-2,398	9
		Non pay	-214	-198	16	-214	-198	16
654	**642**	**Total Expenditure**	**-2,621**	**-2,596**	**25**	**-2,621**	**-2,596**	**25**
654	**642**	**Gross Margin**	**-2,585**	**-2,568**	**17**	**-2,585**	**-2,568**	**17**

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

Headlines

Pay

Pay overspent by £56k in Month 1 largely due to the Enhanced and District Nursing Service being above planned establishment levels(£36k) in addition to Therapy pay costs slightly above plan.

Non Pay

£2k underspent against the plan for April.

Workforce Plan FTE	Workforce Actual FTE	Out of Hospital Care	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	109	98	-11	109	98	-11
		Total Income	**109**	**98**	**-11**	**109**	**98**	**-11**
849	869	Pay	-2,427	-2,483	-56	-2,427	-2,483	-56
		Non pay	-476	-474	2	-476	-474	2
849	**869**	**Total Expenditure**	**-2,903**	**-2,957**	**-54**	**-2,903**	**-2,957**	**-54**
849	**869**	**Gross Margin**	**-2,794**	**-2,859**	**-65**	**-2,794**	**-2,859**	**-65**

Clinical Unit Performance (budgets) Theatres – April 2014

Headlines

Pay

Pay underspent by £29k in the month due to medical vacancies £15k and ITU & Critical Care under spending against establishment plan £10k

Non Pay

Non pay underspent by £56k in the month due to low expenditure on prosthesis, TSSU recharges and equipment £37k, ITU and low expenditure in the month for General Supplies £15k.

Workforce Plan FTE	Workforce Actual FTE	Theatres	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	12	2	-10	12	2	-10
		Total Income	**12**	**2**	**-10**	**12**	**2**	**-10**
562	541	Pay	-2,217	-2,188	29	-2,217	-2,188	29
		Non pay	-1,281	-1,225	56	-1,281	-1,225	56
562	**541**	**Total Expenditure**	**-3,498**	**-3,413**	**85**	**-3,498**	**-3,413**	**85**
562	**541**	**Gross Margin**	**-3,486**	**-3,411**	**75**	**-3,486**	**-3,411**	**75**

Clinical Unit Performance (budgets) MSK – April 2014

Headlines

Pay

Pay underspent by £7k in the month with under spending on Benson and Cookson Devas wards being partially offset by Specialist Nursing/ Technicians over established against plan .

Workforce Plan FTE	Workforce Actual FTE	MSK	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	8	8	0	8	8	0
		Total Income	**8**	**8**	**0**	**8**	**8**	**0**
230	221	Pay	-897	-890	7	-897	-890	7
		Non pay	-66	-66	0	-66	-66	0
230	**221**	**Total Expenditure**	**-963**	**-956**	**7**	**-963**	**-956**	**7**
230	**221**	**Gross Margin**	**-955**	**-948**	**7**	**-955**	**-948**	**7**

Clinical Unit Performance (budgets) Clinical Support – April 2014

Headlines

Pay

The April pay underspend of £20k is due to vacancies across the clinical unit.

Non Pay

Non-pay expenditure was £21k over plan in month. This was largely due to increased Pharmacy Manufacturing Unit (PMU) drugs orders. This increased PMU expenditure has been recovered through increased income.

Income

Income above plan by £29k mainly due to PMU increase in manufacturing turnover resulting in increased income generation.

Workforce Plan FTE	Workforce Actual FTE	Clinical Support	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	287	316	29	287	316	29
		Total Income	**287**	**316**	**29**	**287**	**316**	**29**
495	459	Pay	-1,804	-1,784	20	-1,804	-1,784	20
		Non pay	-1,797	-1,818	-21	-1,797	-1,818	-21
495	**459**	**Total Expenditure**	**-3,601**	**-3,602**	**-1**	**-3,601**	**-3,602**	**-1**
495	**459**	**Gross Margin**	**-3,314**	**-3,286**	**28**	**-3,314**	**-3,286**	**28**

Divisional Performance (budgets) Commercial Directorate – April 2014

Headlines

Pay

Pay in April was £13k overspent due to Porters & Housekeeping expenditure above plan.

Non Pay

Non pay in Month 1 was underspend due to under spending on utilities, catering provisions, TSSU recharges & cost of sales.

Income

Car Parking income slightly underachieved in month.

Workforce Plan FTE	Workforce Actual FTE	Commercial Directorate	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
		Other Income	712	708	-4	712	708	-4
		Total Income	**712**	**708**	**-4**	**712**	**708**	**-4**
878	889	Pay	-1,718	-1,731	-13	-1,718	-1,731	-13
		Non pay	-1,427	-1,288	139	-1,427	-1,288	139
878	**889**	**Total Expenditure**	**-3,145**	**-3,019**	**126**	**-3,145**	**-3,019**	**126**
878	**889**	**Gross Margin**	**-2,433**	**-2,311**	**122**	**-2,433**	**-2,311**	**122**

Divisional Performance (budgets) Corporate Services – April 2014

Headlines

Pay

Pay was overspent by £27k, mainly in the Department of Medical Education & Nurse Training and budget levels will be revised once final 2014/15 department funding plans have been agreed.

Non Pay

Non pay was overspent in relation to Hosted funds budgets.

Income

Occupational Health & Crèche income underachieved in the month.

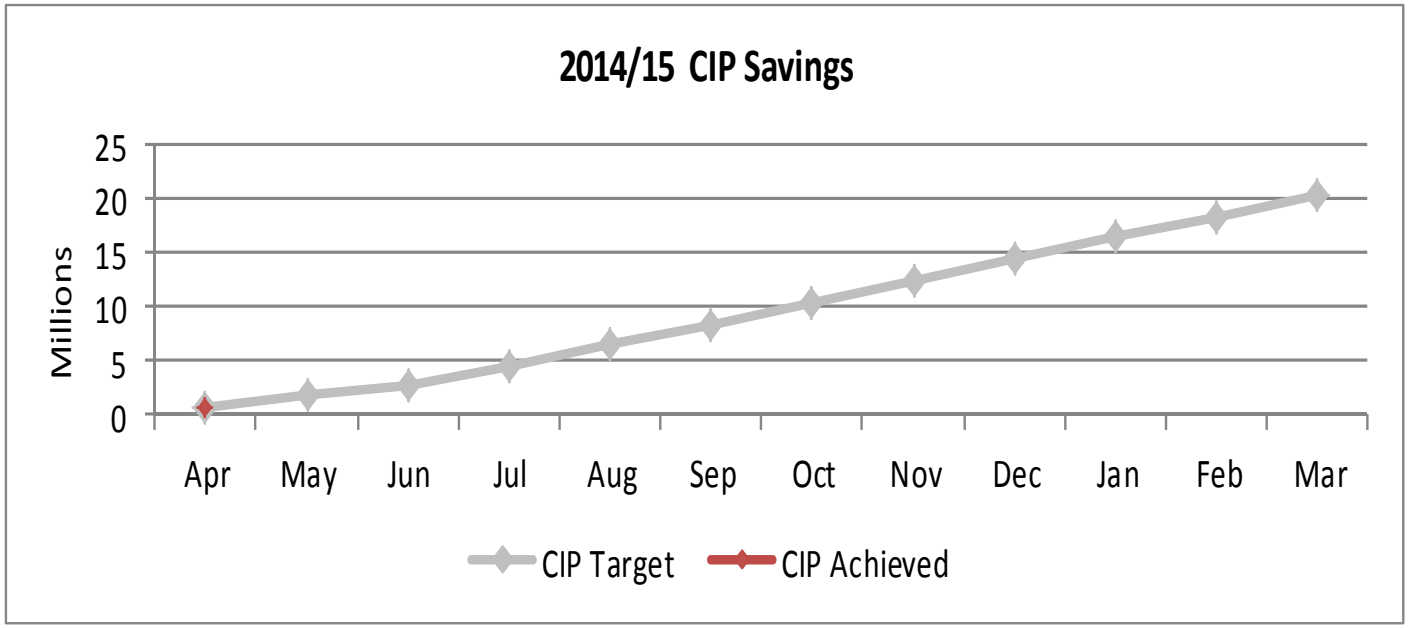
Workforce Plan FTE	Workforce Actual FTE	Corporate Services	In mth Plan £000's	In mth Actual £000's	In mth Var £000's	YTD Plan £000's	YTD Actual £000's	YTD Var £000's
		Other Income	440	407	-33	440	407	-33
		Total Income	**440**	**407**	**-33**	**440**	**407**	**-33**
513	510	Pay	-1,587	-1,614	-27	-1,587	-1,614	-27
		Non pay	-1,272	-1,314	-42	-1,272	-1,314	-42
513	**510**	**Total Expenditure**	**-2,859**	**-2,928**	**-69**	**-2,859**	**-2,928**	**-69**
513	**510**	**Gross Margin**	**-2,419**	**-2,521**	**-102**	**-2,419**	**-2,521**	**-102**

CIP Plans – April 2014

Headlines

• The total Trust CIP target for 2014/15 is £20,417k

• In month CIP achievement of ££995k was £196k ahead of the plan target level for the month.



Scheme	2014/15 CIP Target £000s	In-month CIP Target £000s	In-month CIP achieved £000s	In-month CIP variance £000s	YTD CIP Target £000s	YTD CIP achieved £000s	YTD CIP variance £000s
Clinical Services Productivity - Pay	5,469	183	299	116	183	299	116
Clinical Services VFM - Pay	7,348	309	287	-22	309	287	-22
Back Office - Pay	4,782	199	299	100	199	299	100
Medicines Management - Non Pay	414	0	79	79	0	79	79
Estates - Non Pay	1,228	37	10	-27	37	10	-27
Procurement - Non Pay	1,176	71	21	-50	71	21	-50
Total	**20,417**	**799**	**995**	**196**	**799**	**995**	**196**

Year on Year Comparisons – April 2014

Headlines

- Total Inpatients activity was 0.1% higher than last year's activity level.
- Total outpatients were 12.6% higher than last year.
- YTD A&E attendances were 0.3% higher than last year.

Activity	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Planned Same Day	3,430	3,599	-169	-4.7%
Elective Inpatients	675	739.4	-64	-8.7%
Emergency Inpatients	3,594	3,354	240	7.2%
Total Inpatients	**7,699**	**7,692**	**7**	**0.1%**
Elective Excess Bed Days	393	222	171	76.7%
Non elective Excess Bed Days	5,162	2,682	2,480	92.5%
Total Excess Bed Days	**5,555**	**2,904**	**2,651**	**91.3%**
Consultant First Attendances	6,870	7,373	-503	-6.8%
Consultant Follow Ups	11,160	12,232	-1,072	-8.8%
OP Procedures	4,860	4,275	585	13.7%
Other Outpatients (WA & Nurse Led)	12,360	7,554	4,806	63.6%
Community Specialist	282	127	155	122.0%
Total Outpatients	**35,532**	**31,561**	**3,971**	**12.6%**
A&E Attendances	8,607	8,585	22	0.3%
ITU Bed Days	513	497	16	3.2%
SCBU Bed Days	233	231	2	0.7%
Cardiology - Direct Access	49	95	-46	-48.3%
Radiology - Direct Access	4,749	4,879	-130	-2.7%
Pathology - Direct Access	265,731	275,437	-9,706	-3.5%
Therapies - Direct Access	3,341	2,097	1,244	59.3%

£000s	2014/15 YTD Actual	2013/14 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	27,012	27,683	-671	-2.4%
Private Patient/ RTA	208	224	-16	-7.1%
Trading Income	438	369	69	18.7%
Education	691	667	24	3.6%
Other Non Clinical Income	1,003	1,343	-340	-25.3%
Total Income	**29,352**	**30,286**	**-934**	**-3.1%**
Pay Costs	-20,484	-21,658	1,174	-5.4%
Non Pay Costs	-9,739	-9,211	-528	5.7%
Other	183	83	100	120.5%
Total Direct Costs	-30,040	-30,786	746	-2.4%
Surplus/-Deficit from Operations	**-688**	**-500**	**-188**	**37.6%**
Profit/Loss on Asset Disposal	0	0	0	
Depreciation	-1,031	-999	-32	3.2%
Impairment	0		0	
PDC Dividend	-689	-511	-178	34.8%
Interest	-25	-19	-6	31.6%
Total Indirect Costs	-1,745	-1,529	-216	14.1%
Total Costs	**-31,785**	**-32,315**	**530**	**-1.6%**
Net Surplus/-Deficit	**-2,433**	**-2,029**	**-404**	**19.9%**
Donated Asset / Other Adjustment	68	23	45	195.7%
Normalised Net Surplus/-Deficit	**-2,365**	**-2006**	**-359**	**17.9%**

Capital Programme – April 2014

Headlines

Summary

The Trust routine replacement capital programme is planned within the limit of depreciation.

Clinical strategy capital reconfiguration proposals are planned to be funded by additional exceptional public dividend capital (PDC). However, the final decision on clinical strategy full business case, submitted to the Trust Development Authority (TDA) in 2013/14, is yet to be notified to the Trust. Essential planned clinical strategy enabling works are therefore currently being funded from the Trust's routine capital programme.

The Trust continues to faces considerable capital pressure in relation to the value of capital resources available in 2014/15 to meet the needs of the Trust. The Capital Approvals Group (CAG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

Year to Date performance:-

After one month, capital expenditure amounts to £0.4m with commitments currently entered into amounting to £4.0m.

Capital Investment Programme £000s	2014/15 Capital Programme	Expenditure at Month 1
Capital Resources		
Depreciation	11,285	
Clinical Strategy exceptional additional PDC	17,400	
League of Friends Support	1,300	
Cap Investmnt Loan Principal Repayment	-340	
Gross Capital Resource	29,645	
Less Donated Income	-1,300	
Capital Resource Limit (CRL)	**28,345**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	
Clinical Strategy Essential Enabling Works	250	
Medical Equipment	2,599	
Information Systems	895	
Electronic Document Management	200	
Child Health Information System	619	26
Backlog Maintenance	1,071	
Infrastructure Improvements - Infection Control	700	
Electrical Supply to DGH	600	
Minor Capital Schemes	2,200	183
Pevensey Ward	1,000	
Other various	711	87
Brought Forward Schemes	811	138
Sub Total	**29,056**	**434**
Donated Asset Purchases	1,300	44
Donated Asset Funding	-1,300	-44
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,056**	**434**
Overplanning Margin (-) Underplanning (+)	-711	
Net Capital Charge against the CRL	**28,345**	**434**

Key Performance Indicators – April 2014

Headlines

• The EBITDA achieved YTD was -£0.7m compared to the planned value of -£0.8m. This has resulted in a 1.0% Net Return after Financing.

• The liquidity ratio, including the Working Capital Facility(WCF), stands at 21 days following the draw down of the temporary loans. Without the WCF the liquidity days would have been -9 days.

Underlying Performance	2013/14 Outturn	2014/15 Plan	2014/15 YTD
Surplus/-Deficit from Operations	-5,479	-659	-688
Donated Asset Income Adjustment	-999	-108	-44
EBITDA	-6,478	-767	-732
Divided by:			
Total Income	364,240	29,604	29,352
Donated Asset Income Adjustment	-999	-108	-44
EBITDA Margin	**-1.8%**	**-2.6%**	**-2.5%**
EBITDA % Achieved			
Actual EBITDA	-6,478	-767	-732
Divided by:			
Budgeted EBITDA	-2,497	-767	-767
EBITDA % Achieved	**259.4%**	**100.0%**	**95.4%**

Liquidity £000s	2013/14 Outturn	2014/15 YTD
Opening Current Assets	33,908	59,774
Opening Current Liabilities	-34,506	-62,322
Net Current Assets/Liabilities	-598	-2,548
Inventories	-6,238	-6,517
Adj Net Current Assets/Liabilitie	-6,836	-9,065
In year working capital facility	30,388	29,628
	23,552	**20,563**
Divided by:		
Total costs in yr x-1	369,719	30,040
Multiply by (days)	360	30
Liquidity Ratio	**23**	**21**

Financial Efficiency £000s	2013/14 Outturn Actual	2014/15 YTD Plan	2014/15 YTD Actual
Surplus / Deficit(-) from Operations	-5,479	-659	-688
Less:			
Donated Asset Income Adjustment	-999	-108	-44
Interest Expense	-287	-25	-25
Depreciation & Amortisation	-11,386	-1,049	-1,031
PDC Dividend	-6,251	-676	-689
Net Return	-24,402	-2,517	-2,477
Total Debt	-5,209	-5,209	-5,209
Finance Leases & Borrowings	-918	-842	-842
Taxpayers Equity	-251,430	248,996	248,996
Balance Sheet Financing	-257,557	242,945	242,945
B/fwd Debt	-6,883	-5,209	-5,209
Finance Leases & Borrowings	-1,224	-918	-918
Taxpayers Equity	-183,115	251,429	251,429
Balance Sheet Financing	-191,222	245,302	245,302
Net Return after Financing Score %	**-10.9%**	**1.0%**	**1.0%**
Net surplus/ deficit	-33,412	-2,409	-2,433
Less fixed asset impairments/disposals	10,318	0	68
	-23,094	-2,409	-2,365
Divided by:			
Total Income	363,240	29,496	29,308
I&E surplus margin	**-6.4%**	**-8.2%**	**-8.1%**

Financial Risks & Mitigating Actions – April 2014

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

East Sussex Healthcare NHS Trust

Date of Meeting:	03 June 2014
Meeting:	Trust Board
Agenda item:	8c
Subject:	Serious Incident Annual Report 2013/14
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To provide assurance on the Trust's process in respect of Serious Incident reporting, analysis and learning.

Introduction:

The report provides information regarding the Serious Incidents (SIs) that have occurred during the 2013/14 year. It provides an analysis of data by area, theme and of the supporting processes and actions in place.

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

The Trust has a good culture of incident reporting with 166 Serious Incidents being reported within the year (a slight decrease from 2012/13).

Pressure ulcers and falls continue to be the two most frequently reported types of SI and a number of actions are in place to ensure recommendations are implemented and learning is shared across the organisation.

Benefits:

An effective process for reporting, reviewing and learning from serious incidents supports the Trust's objectives to provide high quality, safe care.

Risks and Implications

If specific types of adverse events are seen to repeat themselves it may demonstrate that lessons have not been learned.

Assurance Provided:

This report provides an overview of the serious incident process which has been strengthened over the last year. This will be developed over the coming year with continued focus on organisational learning.

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

Patient Safety and Clinical Improvement Group/Quality and Standards Committee: 06.05.14
Clinical Management Executive: 12.05.14

Proposals and/or Recommendations

The Board is asked to review and note the report.

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

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

East Sussex Healthcare NHS Trust

Serious Incident Annual Report 2013/14

1. Introduction

1.1 Each quarter, a quarterly summary report of Serious Incident (SI) activity is produced and presented to the Trust Patient Safety and Clinical Improvement Group. This report builds on those earlier reports to provide the data for all four quarters of the year 2013/14.

1.2 This annual report provides information regarding the SIs that have occurred during the year as well as assurance on their management. The details of these incidents have been reported to the Corporate Leadership Team (CLT) each week and the Patient Safety and Clinical Improvement Group and Clinical Management Executive (CME) each month. The Board has also received previous reports on SIs and receives notifications of new SIs when they are declared.

2. Summary of Data

2.1 Serious Incidents are categorised as being either Grade 1 or Grade 2. Most SIs are Grade 1. Grade 2 SIs, requiring comprehensive or independent investigation, are generally incidents which are of high public interest or those which may attract media attention (National Patient Safety Agency – NPSA).

2.2 Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (NPSA).

2.3 The number of SIs reported by quarter, and broken down into Grade 1, Grade 2 and Never Events is as follows:

Table 1

Quarter	Total Number of SIs*	Grade 1	Grade 2	Never Events
Q1	41	41	0	0
Q2	34	34	0	0
Q3	44	44	0	0
Q4	47	47	0	0
Total	166	166	0	0

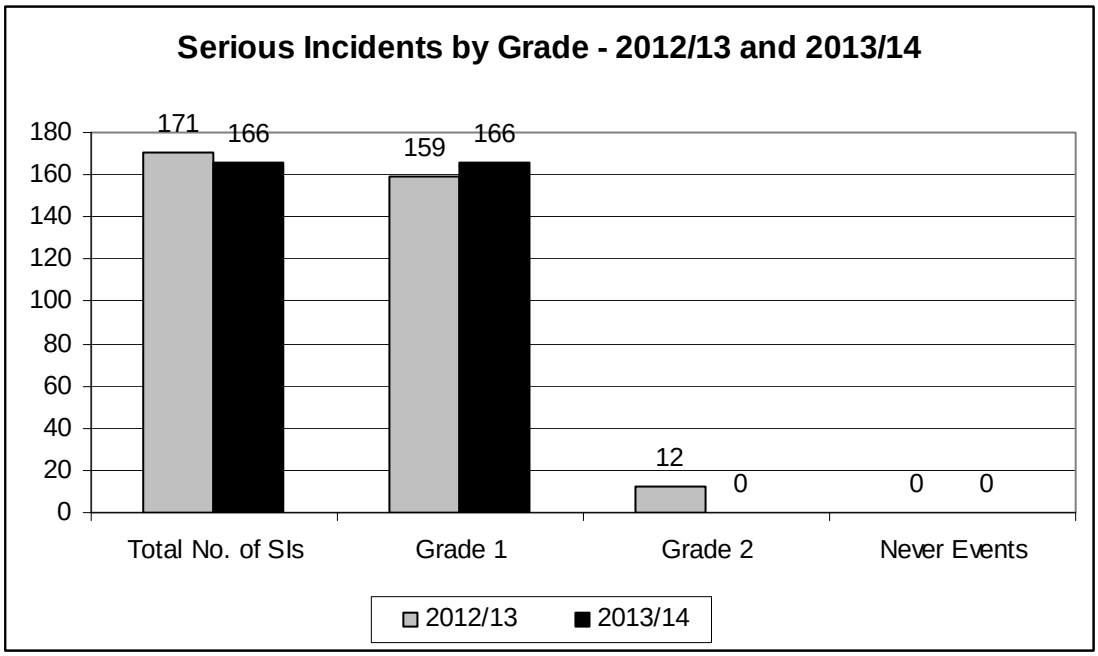
**This does not include SIs which were raised but subsequently downgraded prior to investigation. Please note three of the 47 incidents are still subject to downgrade request with the CCG.*

2.4 Forty-seven new SIs reported in quarter four is an increase from the previous three quarters, although a decrease from quarter 4 in 2012/13 and an overall decrease for the year as the following table shows:

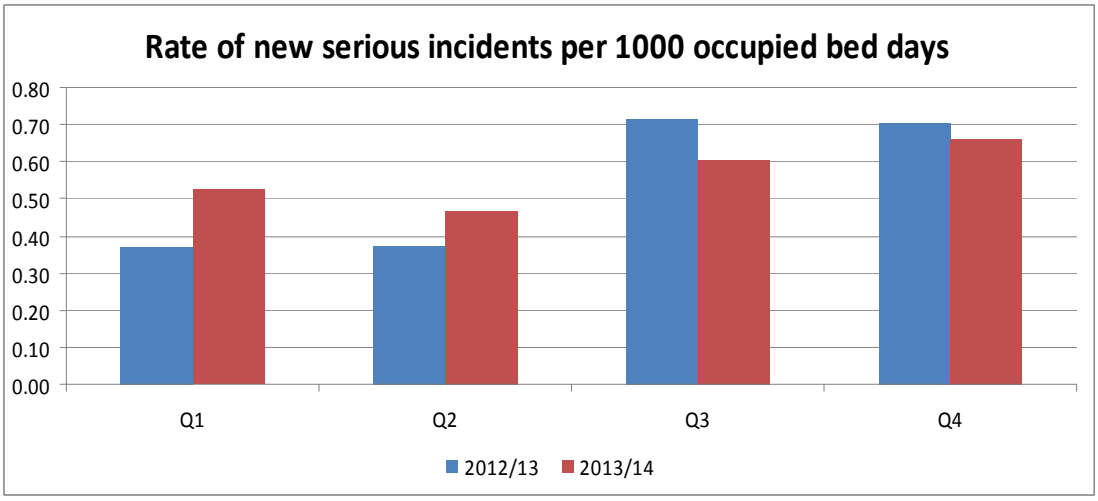
Table 2

Year	Total No. of SIs*	Grade 1	Grade 2	Never Events
2012/13	171	159	12	0
2013/14	166	166	0	0

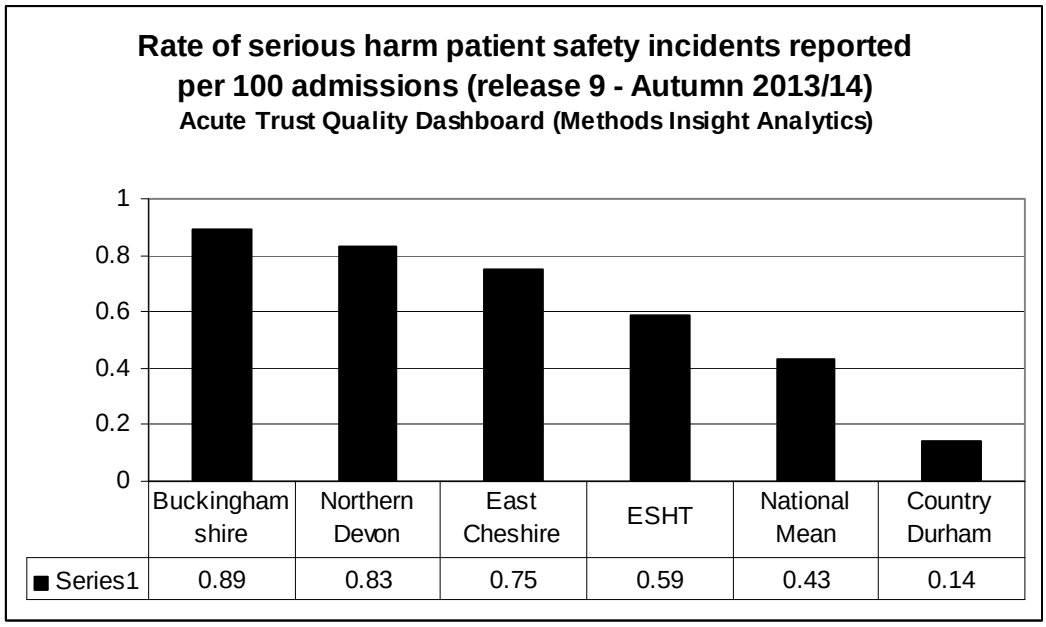
2.5 The following graph shows the breakdown of SIs by grade for 2013/14 compared to 2012/13. This shows an overall slight decrease, a decrease to zero grade 2 serious incidents and a second year of no never events reported:



2.6 The following graph shows the rate of SIs reported per 1000 occupied bed days each quarter (2012/13 and 2013/14). This shows that there was a rise in the rate of SIs in quarters 3 and 4 in both years with quarter 4 having the greatest rate in 2013/14 although this is lower than in 2012/13.



2.7 It is possible to benchmark the Trust against other, similar integrated organisations, using the Acute Trust Quality Dashboard (Methods Insight Analytics, grown out of the East Midlands Quality Observatory). The following graph shows the rate of "serious harm" patient safety incidents reported per 100 admissions for ESHT, compared to Northern Devon Healthcare NHS Trust, East Cheshire NHS Trust, County Durham and Darlington NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust and the National Mean.



Please note that "serious harm" is defined by Methods Insight Analytics as 'safety incidents where degree of harm is reported as moderate, severe or death'

2.8 This graph shows that whilst ESHT is not the highest reporting Trust out of those shown on the graph, it is above the national mean, with a rate of 0.59 compared to the national mean of 0.43. Data used in last year's annual report provided a rate of 0.44 for ESHT compared to a national mean of 0.41 which indicates that the rate of serious harm patient safety incidents reported per 100 admissions has increased within ESHT.

3. Incident Grading

3.1 All Trust incidents are risk graded for severity of consequence and likelihood of reoccurrence. The scores are on a scale of one to five, and for severity of consequence this is:

1	2	3	4	5
Negligible	Minor	Moderate	Major	Catastrophic

NPSA

3.2 The risk scoring is recorded on DatixWeb, the Integrated Software used for incident reporting and data management, and is also reported within Root Cause Analysis reports.

3.3 The following table (Table 3) shows how the SIs reported are broken down by severity of consequence per quarter as recorded on Datix (pre investigation – at the time the incident is reported):

Table 3

Quarter	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Total
Q1	1	3	30	3	4	41
Q2	4	3	22	3	2	34
Q3	2	4	28	7	3	44
Q4	2	4	33	6	1	46*
Total	9	14	113	19	10	165

** One incident is still awaiting review*

3.4 The Trust Serious Incident Review Group (SIRG) reviews the risk scores recorded on Datix against that within the Root Cause Analysis reports to ensure these are consistent with NPSA guidance and with each other. This process has been in place for over a year and is working well. Where it is felt that the risk score on Datix is incorrect, the responsible area/clinical unit is tasked with making the appropriate change.

4. Incidents by Division

4.1 The following table shows where the Grade 4 and 5 Incidents occurred in quarter 4:

Table 4

	Urgent Care	Integrated Care	Corporate (A&E)	Planned Care	Commercial
Grade 4	4	0	1	1	0
Grade 5	0	0	1	0	0

4.2 The following table shows how the number of reported SIs is divided by division:

Table 5

	Planned Care	Urgent Care	Integrated Care	Commercial	Corporate	Urgent / Integrated
Q1	4	24	6	2	5	-
	10%	58%	15%	5%	12%	-
Q2	6	20	1	1	5	1
	17%	59%	3%	3%	15%	3%
Q3	7	26	3	2	6	-
	16%	59%	7%	4%	14%	-
Q4	7	30	4	1	5	-
	15%	64%	8%	2%	11%	-

4.3 The following table shows the number of SIs reported as a percentage of <u>total</u> incidents (not just patient safety incidents) reported by division:

Table 6

	Planned Care	Urgent Care	Integrated Care	Commer-cial	Corporate	Total
Q1	0.6%	2.1%	1.1%	1.7%	1.6%	1.4%
Q2	0.9%	2.4%	0.4%	0.8%	0.9%	1.3%
Q3	1.0%	3.1%	0.7%	1.4%	1.2%	1.7%
Q4	1.1%	3.9%	1.0%	0.7%	1.0%	1.9%

The percentage of SIs from all incidents reported is between 0.4% within the Integrated Care Division and 3.9% within Urgent Care. The 'total' percentage in quarter 4 (1.9%) is the greatest figure compared to the other quarters.

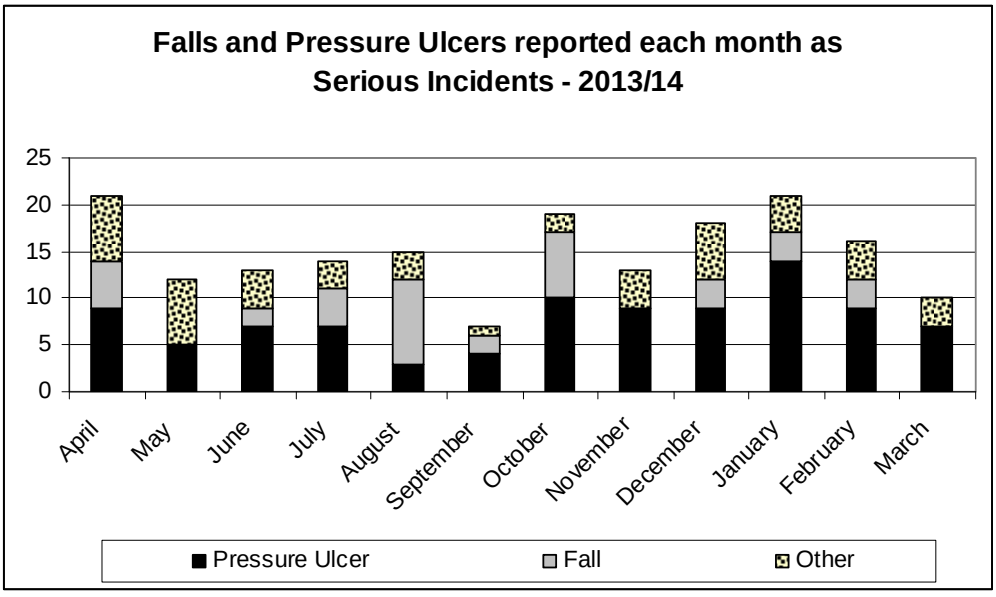
5. Incident Types

5.1 All SIs are categorised by type. The following table show the categories of SIs reported and number in each quarter in 2013/14:

Table 7

Incident Type	Q1	Q2	Q3	Q4
Pressure ulcer - category 3	19	13	21	27
Patient fall resulting in harm	7	15	9	6
Maternity – unplanned admission to NICU	3	1	1	1
Infection control – C Difficile	2	0	2	0
Infection control – GRE outbreak	0	0	0	1
Intrapartum death	2	0	0	0
Adverse media coverage	1	0	2	1
Child death	0	0	0	1
Delayed diagnosis	1	0	0	1
Drug error	0	0	0	1
Failure to act on test results	0	0	1	0
Fatal Hospital Acquired Thromboembolism	0	0	0	1
Information governance breach	1	0	0	0
Morphed patient records	1	0	0	0
Neonatal death	1	0	1	0
Other	0	2	1	1
Pressure ulcer – category 3 & 4	1	0	0	0
Pressure ulcer – category 4	0	1	3	3
Pressure ulcer – unstageable	1	0	1	0
Safeguarding	0	0	0	1
Sub optimal care of the deteriorating patient	0	0	1	0
Unexpected death	1	2	1	1
Unplanned maternal admission to ITU	0	0	0	1
Total	**41**	**34**	**44**	**47**

5.2 It is evident from the table above that pressure ulcers and falls which lead to serious harm, continue to be the Trust's most common types of SI reported. The following graph shows the number of falls and pressure ulcer SIs reported each month against the total number of SIs reported each month:

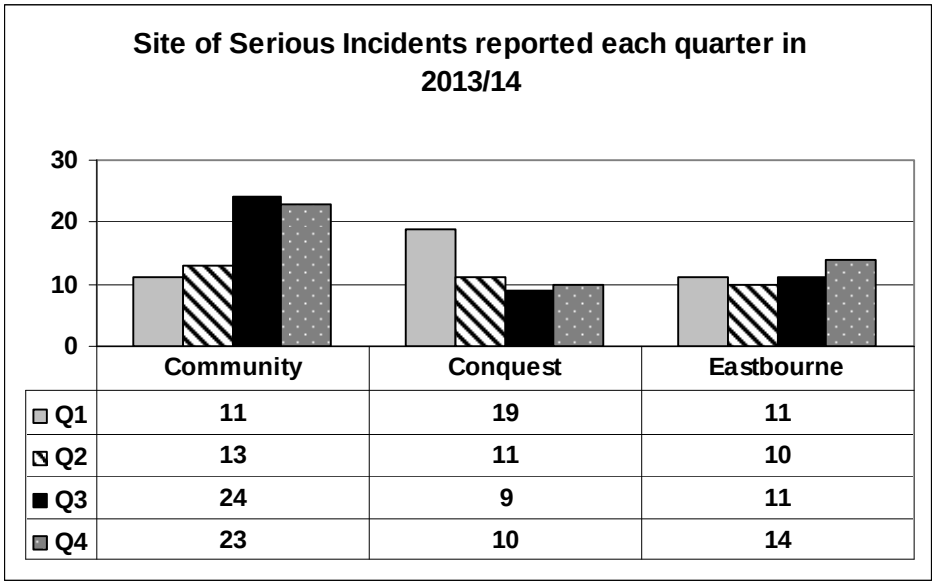


There were three months within 2013/14 where there were no SI falls. They were: May and November 2013 and March 2014. Pressure ulcer SIs are reported every month.

5.3 All actions resulting from investigations into falls and pressure ulcers are linked to the Trust wide action plans for falls and pressure ulcers which were developed in August 2012 and have been regularly reviewed and updated since then.

6. Location of Incidents

6.1 Of the 47 SIs reported in quarter 4, 23 (49%) occurred in the community (community nursing teams and community hospitals), 14 (30%) at Eastbourne DGH and 10 (21%) at Conquest Hospital:

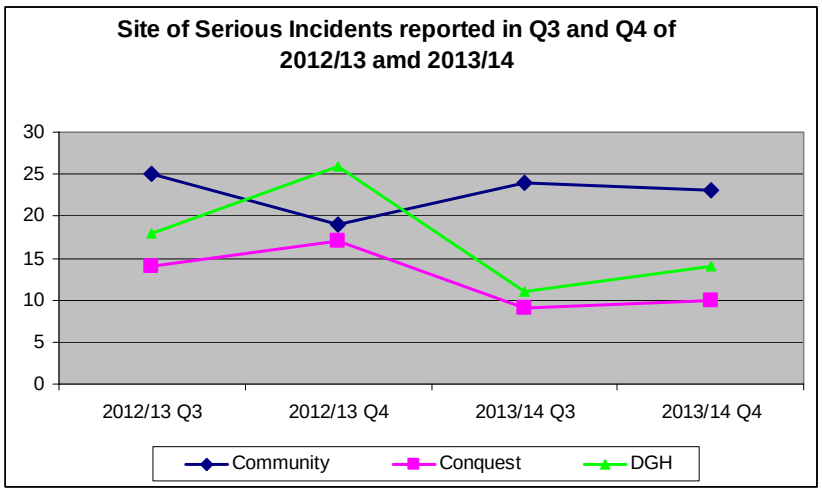


It is clear from this graph that the number of SIs reported from within community settings almost doubled in quarters 3 and 4 from that reported in quarters 1 and 2.

6.2 The following table (table 8) and graph show how the number of SIs reported in quarters 3 and 4 of 2012/13 compared to those reported in quarters 3 and 4 of 2013/14 in terms of the site of the incident.

Table 8

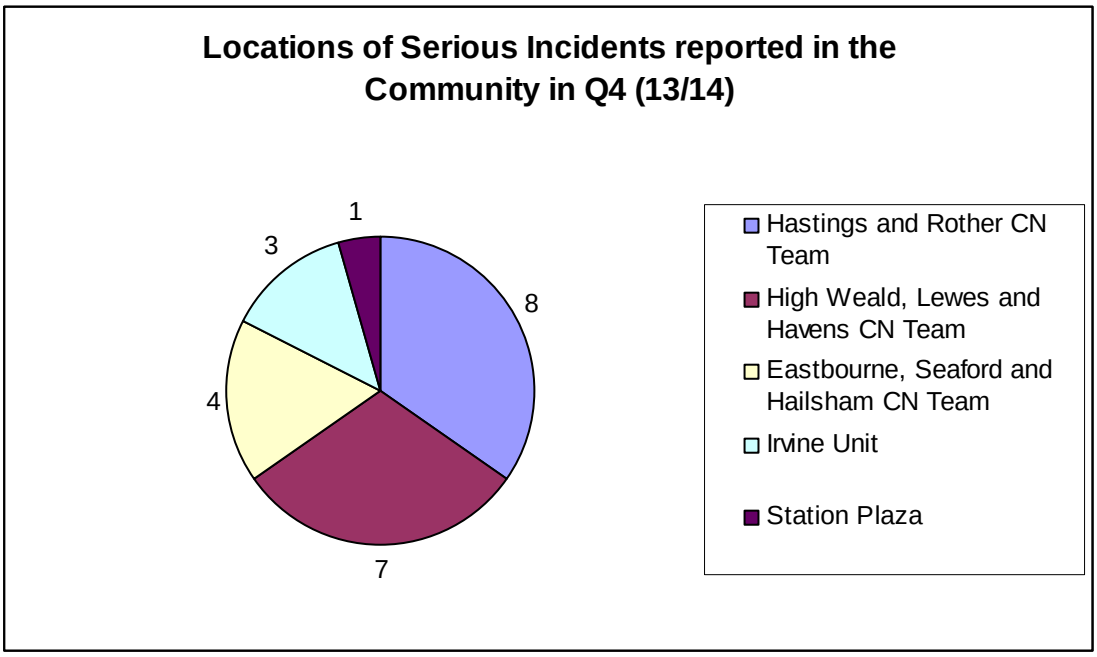
Year	Quarter	Community	Conquest	DGH
2012/13	Q3	25 (44%)	14 (24%)	18 (32%)
	Q4	19 (31%)	17 (27%)	26 (42%)
2013/14	Q3	24 (55%)	9 (20%)	11 (25%)
	Q4	23 (49%)	10 (21%)	14 (30%)



6.3 These show that the numbers of SIs reported in the community in quarters 3 and 4 in each year (2012/13 and 2013/14) vary by a total of 6 from 19 being the lowest (quarter 4 in 2012/13) to 25 (quarter 3 in 2012/13). Both years (2012/13 and 2013/14) have seen an increase in the number of incidents reported in the community in quarters 3 and 4 than in quarters 1 and 2 and these are nearly all pressure ulcers. No evidence has been identified that pressure ulcers are more likely to occur in the winter months.

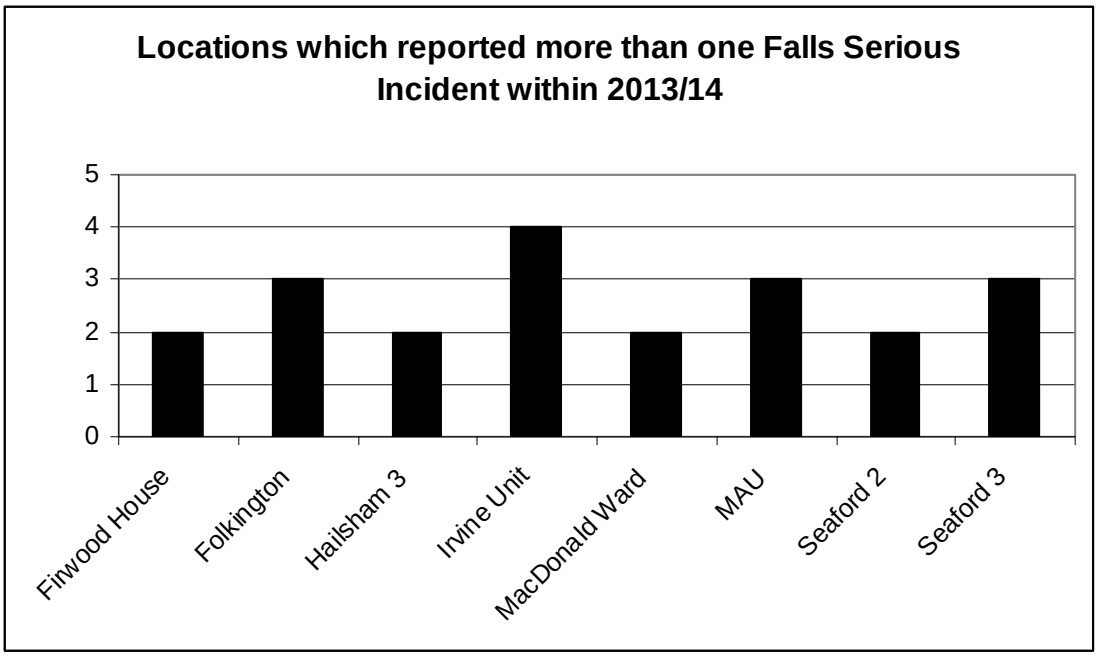
6.4 There were 24 SIs reported in the community in quarter 3 of 2013/14. This was an increase from 13 reported in quarter 2. Of the 24, 22 were pressure ulcers. These have all been reviewed at the Trust Serious Incident Review Group which identified that 10 (45%) were felt to be unavoidable, 7 (32%) were avoidable and 5 (23%) avoidable status not confirmed (e.g. not enough information provided).

6.5 Of the 23 SIs reported in the community in quarter 4, one was at Station Plaza (potential adverse media), three were at the Irvine Unit (a patient fall and two pressure ulcers) and the remaining 19 (all pressure ulcers) were reported by community nursing teams:



6.6 There were six falls SIs reported in quarter 4 of 2013/14 although these all occurred in different locations.

The following graph shows the locations which reported more than one falls SI within 2013/14. There were 16 locations which reported a single fall SI in the year.



The functions for these wards are as follows:

Firwood House – Intermediate Care
Folkington – Diabetes/Endocrine
Hailsham 3 – Elective Orthopaedics
Irvine Unit – Intermediate Care/ Stroke Rehab
MacDonald Ward – Complex Elderly
MAU – Medical Assessment
Seaford 2 – Medical Short Stay
Seaford 3 – Trauma/Orthopaedics

8. RCA Closure

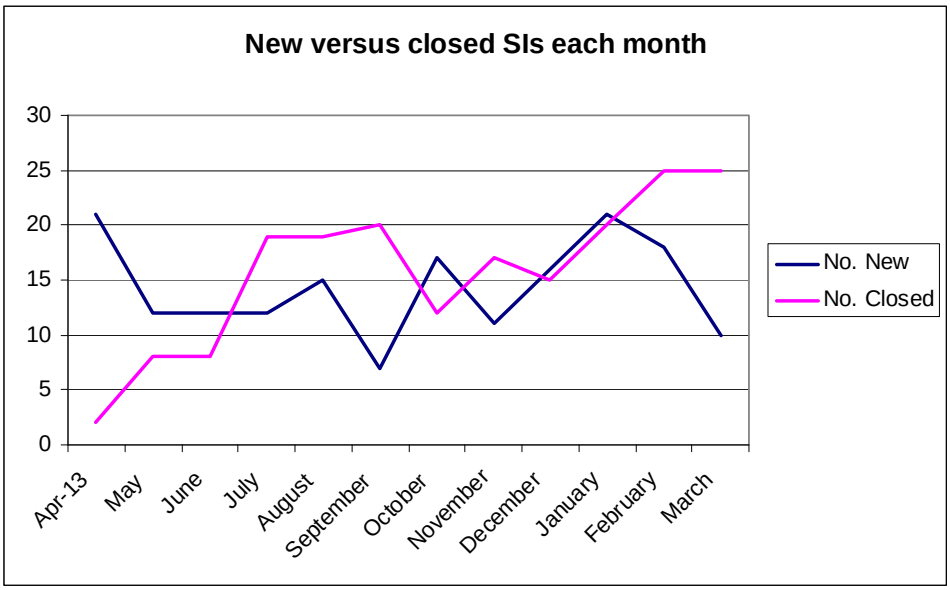
8.1 Following all SIs a root cause analysis (RCA) investigation must be conducted and report completed. All draft reports should be submitted to the Assurance Team at approximately 20 days post incident declaration for review at the next sequential Serious Incident Review Group (SIRG) which meets fortnightly and is chaired by the Deputy or Assistant Director of Nursing. Following scrutiny at SIRG, any amendments must be made prior to the submission of the report to the Clinical Commissioning Group (CCG) within the required timescales (45 days for Grade 1 SIs and 60 days for Grade 2).

8.2 During quarter 4, **70** SI RCA reports were closed relating to: Pressure ulcers (35), falls (20), unexpected death (3), potential adverse media coverage (3), infection control (2), unexpected admission to NICU (2), power dip/failure (2), intrapartum death (1), safeguarding (1), failure to act on test results (1).

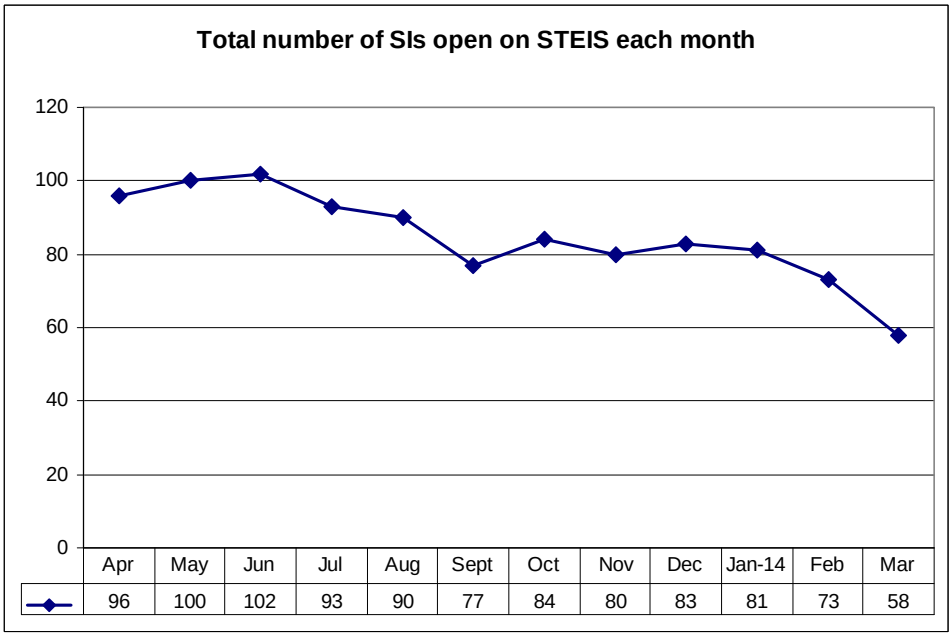
8.3 Whilst these incidents did not occur in quarter 4 it is not possible to analyse the SIs which did occur in quarter 4 for lessons learnt until the RCAs have been completed and closed.

8.4 The following graph shows the number of new SIs reported versus the number of SIs closed each month since April 2013. This clearly shows a shift from July – September 2013 with the number of closed SIs greater than the number of new SIs.

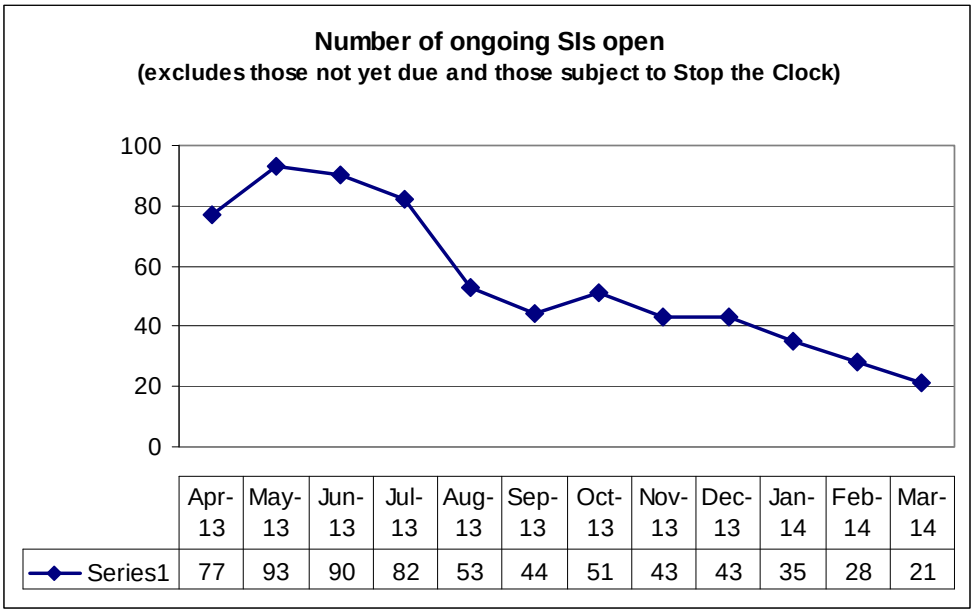
Unfortunately in October the number of new SIs reported outweighed the number closed. The last two months (February and March) have seen more SIs closed than new ones opened.



8.5 The following graph shows the total number of open SIs as recorded on the Strategic Executive Information System (STEIS) at the end of each month. This shows a reduction from June – September 2013, although unfortunately the number increased in October. This may have been in part due to one of the Sussex Scrutiny Group meetings being cancelled. This is the meeting where all of the submitted RCAs are reviewed for closure.



8.6 This graph also looks at the number of SIs open each month but omits those which are not yet due (are therefore in time). This shows a steady decrease in the outstanding RCAs since May 2013.



9. Themes of lessons learnt from patient falls SIs closed in 2013/14

Completed risks assessments:

- upon referral (to ensure appropriate placement)
- on admission / within 24hours
- following any sort of fall
- frequent reassessment
- followed up and translated into actions to reduce the risk

Falls care plans must be completed where indicated

Allocation of rooms / beds near nurses' station to ensure visibility

Consideration of falls prevention aids and strategies e.g. special observations, low profile beds, sensor pads escalating when this has been assessed as necessary but is not available

Clear documentation to ensure continuity of care and implementation of care plans including required patient handling techniques

Recognition and assessment of falls risk when attempting to maintain a patient's privacy and dignity or encouraging independent completion of daily activities

Remind patients of the need to call for assistance, bearing in mind individual needs and levels of capacity

10. Themes of lessons learnt from pressure ulcer SIs closed in 2013/14

Importance of clear documentation including pressure area assessment, risk assessments (Waterlow, MUST), preventative care planning and completion of wound and repositioning charts which must be updated as patient conditions change

The importance of clear communication across the multi-disciplinary team especially at handover or transfer / discharge

Staff to be reminded about the Trust's Policy for self neglect and capacity in relation to pressure area care

Appropriate and timely referrals to specialists where indicated including tissue viability, dietetics and continence services

Clear documentation when a patient declines to have pressure areas checked or reviewed as well as evidencing that the risks and benefits have been explained to the patient

Availability, lack of or removal of pressure relieving equipment to be clearly documented including patient choice and compliance

11. Lessons learnt from remaining SIs closed in 2013/14

11.1 It is not possible to identify themes of lessons learnt from remaining SIs closed in 2013/14 due to the variety of types of incidents however one common theme was the need to apply the Trust Being Open Policy.

12. Actions taken/being taken as a result of the pressure ulcer SIs:

- Standards of care audits review of safety processes and documentation relating to this through an ongoing audit process from which actions are highlighted and followed up.
- 'Preventing Pressure Ulcers – a guide for all staff' leaflet given to all staff in January 2014 – attached to payslips.
- Listening into Action (LIA) events took place in March 2014 on Preventing Avoidable Pressure Ulceration.
- Development of the pressure ulcer treatment plan related to preventing deterioration.
- Formation of an East Sussex Multiagency Pressure Ulcer Prevention Group.
- ESHT participation in the proposed NHS England Surrey and Sussex Senior Nurse Pressure Ulcer Prevention Event in March.
- Multiagency prevention promotion (conference, joint leaflets etc) that will impact on referral numbers and admissions.
- Pressure Ulcer Prevention and Management Training became mandatory.

13. Actions taken/being taken as a result of falls SIs:

- Staff information leaflet on how to prevent patient falls given to all staff attached to payslips in the summer 2013.
- Review of flooring in high risk falls areas has been completed and any identified issues are being addressed.
- A 'slipper sock' pilot is about to commence in three different areas.
- A pilot is planned being led by Opthalmology looking at when inpatients have last had a sight test to help reduce falls due to visual impairment.
- Review of floor cleaning in line with manufacturers' guidance to ensure the integrity of the floor is maintained.
- Attendance at Hastings and St Leonards Seniors Forum meeting to talk about falls prevention.

- Meeting with the Falls Management Service (commissioned by the three CCGs) to look at shared learning to reduce the number of falls, the number of ambulance call outs and hospital admissions. The service is based at Irvine Unit and Firwood House and cover ESHT community settings.

14. Implementation of Action Plans from SIs

14.1 In October 2013 and January 2014, the Director of Nursing, Head of Assurance and Assurance Manager – Patient Safety and Risk met with all clinical divisions in order to gain assurance that action plans were being followed up and lessons were being learnt and shared. It was evident from this review that whilst each division was working slightly differently and were at different stages of implementation with different levels of assurance provided, they did all have a process for following up the implementation of action plans from SIs.

14.2 Actions resulting from investigations into falls and pressure ulcers are linked to the Trust wide action plans for falls and pressure ulcers which are managed and regularly reviewed by the Deputy Director of Nursing and Falls Group chair and Assistant Director of Nursing (West).

15. Audit of the learning from Grade 2 SIs which have been closed (Audit Ref. 3323)

15.1 During November 2013 an audit was completed by the Assurance Team to determine if learning had taken place as a result of SIs, and to review the implementation of identified actions.

15.2 The audit was carried out as part of the monitoring function by the Assurance Team to ensure that actions identified following investigation and analysis of grade 2 SIs had been implemented, practice changed where necessary and learning shared to reduce the likelihood of the incident reoccurring.

15.3 All SIs are investigated and a resulting report and action plan is produced. This audit sought to provide assurance that learning had taken place as a result of grade 2 SIs and as such the likelihood of the incident reoccurring is reduced and the quality of patient care has improved.

15.4 A copy of the report was presented to the Quality and Standards Committee / Patient Safety and Clinical Improvement Group at its meeting in January 2014. The findings were that there was evidence that the majority of actions identified following these SIs had been completed and some learning shared, however the learning had mainly taken place within the clinical units and not necessarily across the organisation which needs to be built on.

16. Training

16.1 During the year, a new training course entitled ‘Investigating Matters’ was developed and rolled out. The course which aids members of staff who are required to undertake investigations was piloted in May 2013 followed by a course attended by over 40 members of staff in October.

16.2 An additional course was run in April 2014 and a further course is currently planned for May 2014. The positive feedback has meant that those who have attended are encouraging other members of staff to attend and therefore more courses are likely to be required.

17. Serious Incident Review Group (SIRG)

17.1 The Trust SIRG has met at least fortnightly within the year, more frequently if required due to the volume of reports requiring review prior to their submission to the Clinical Commissioning Group (CCG).

17.2 Although not regularly, the Head of Quality (Hastings and Rother CCG and Eastbourne, Hailsham and Seaford CCG) has attended the Trust SIRG to provide feedback first hand from the Sussex Scrutiny Group meetings.

18. Further Developments

18.1 As at the end of March 2014, just one SI remained open from 2012. The Trust, CCG and Area Team are working together to ensure this is closed as quickly as possible.

18.2 At the time of writing this report, there are 10 SIs open from 2013. Of this, 5 have 'stop the clock' status applied (due to an ongoing external investigation for example), 3 require revision and resubmission and the remaining 2 have been submitted to the CCG and are awaiting closure.

18.3 So far in 2014, three Shared Learning in Practice (SLiP) newsletters have been produced and circulated via the communications email covering general issues as well as dedicated newsletters for falls (February) and pressure ulcers (March). The April publication will be a general issues newsletters with May covering Medicines and June covering Health and Safety issues.

18.4 The SLiP page of the extranet is now up and running where the newsletters can also be found:
http://nww.esht.nhs.uk/risk-management/sharing-learning-in-practice/

18.5 The Quality and Patient Safety Manager (Sussex) has coordinated a new Patient Safety Task and Finish Group which met for the first time on 22nd April 2014 and was attended by the Head of Assurance and the Assurance Manager for Patient Safety and Risk. The group is currently looking at and trialling new checklists for the identification of unavoidable harm in pressure ulcers and falls. Whilst all pressure ulcers and falls would continue to be reported as SIs, if upon completion of the preliminary checklist it was identified that it was unavoidable, then it would be downgraded. If it was found to be avoidable then a RCA investigation report would still be required. ESHT will be participating in this work as a Trust trialling the new style paperwork.

18.6 The group will also be reviewing the definitions of serious harm as it was clear that there is inconsistency amongst Trusts locally and nationally regarding what is reported as SIs . ESHT has a good reputation for being an open Trust reporting all incidents.

Emily Keeble, Head of Assurance

April 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	3 June 2014
Meeting:	Trust Board
Agenda item:	9
Subject:	Response to external review of Maternity and Paediatric services
Reporting Officer:	Dr Andy Slater, Medical Director – Strategy

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

Purpose:

The purpose of this paper is to provide the Trust Board with the assurance that recommendations from the external visits by the Royal College of Paediatricians and Child Health (RCPCH) and the joint visit by the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Paediatricians and Child Health are being actioned and addressed.

Introduction:

At a risk summit that the Trust attended in February 2013 with NHS South of England; Trust Development Agency (TDA); NHS Commissioning Board; local Clinical Commissioning Groups (CCGs) and the Care Quality Commission (CQC); where the safety of maternity services was discussed it was agreed that the Trust would commission a joint visit by the RCOG and RCPCH to review the Trust's arrangements for clinical governance and clinical risk management including the processes in place to review and act on serious incidents. The review took the form of interviews with staff, assessment of governance documentation and a random case note review and resulted in a number of recommendations.

Following the temporary re-configuration of maternity, paediatrics and emergency gynaecology onto one site in May 2013 the Trust invited the RCPCH to review the operational policy that had been developed to support the service change. The review took the form of a tour of the services provided on the Eastbourne site post re-configuration and interviews with internal staff and commissioners as well as a review of relevant documentation and resulted in a number of recommendations

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

The updated action plans related to both reviews are attached.

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

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

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

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

Benefits:
That a revised risk management strategy for maternity will be developed that reflects trust wide improvements in the management of serious incident reviews and Root Cause Analysis. That a robust operational policy is finalised, ratified and adopted by all clinicians in support of the delivery of the current temporary configuration of paediatric services and that further service improvements are built in to the future service model to be delivered following once a commissioner decision is made on the long term future of the service.

Risks and Implications
That agreed timelines to address the recommendations are not met.

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

Review by other Committees/Groups (please state name and date)**:**
None

Proposals and/or Recommendations
The Board is informed of progress by exception through the Quality and Standards Committee.

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

For further information or for any enquiries relating to this report please contact:	
Name: Paula Smith, Associate Director Lindsey Stevens, Assistant Director of Nursing	**Contact details:** (13) 3754

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Review of Risk Management Strategy (RMS)	Risk Management Strategy in place; met with CNST approval at Level 2 assessment in 2013.	Strengthen by: Clearly defining roles and responsibilities. Reference guidelines; risk management co-ordination processes and responsibilities for Root Cause Analysis. Separate sections on incident reporting; serious incidents and links to Trust Risk Management committee. Reference maternity dashboard; mechanisms for minimising risk and future risk management planning. Evidence of compliance monitoring and audit and hyperlinks to documents. Include references and ensure Maternity RMS is linked to Trust's RMS. Put lists of incidents together under one heading Review to ensure user friendly.	Clinical Gov Manager	Head of Midwifery and Associate Director Maternity/Paeds	Re-drafted risk management strategy	End Feb-14	Apr.14 – policy re-written awaiting final ratification by Clinical Unit Lead

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Review the incident categorisation within the Maternity Risk Management Strategy	Risk management strategy in place; met with CNST approval at Level 2 assessment in 2013.	Break incidents into categories relating to antenatal; labour; and postnatal care. The reasons for increase in incidents should be explored and clarified.	Clinical Gov Manager	Head of Midwifery and Associate Director Maternity/Paeds	Re-drafted risk management strategy	End Feb-14	Apr-14 – policy re-written awaiting final ratification by CU Lead
Root Cause Analysis needs to be more forensic.	RCAs carried out in line with Trust policy.	Currently a Trust wide review of how RCAs are undertaken to ensure consistent processes across all areas . Introducing a process of undertaking interviews with key members of staff involved to corroborate written statements. Need to ensure robust processes to evidence closure after a Root Cause Analysis is completed.	Clinical Gov Manager/ Head of Assurance	Head of Midwifery and Associate Director Maternity/Paeds/ Director of Nursing	Re-drafted risk management strategy	End Feb-14	Apr-14 – policy re-written awaiting final ratification by CU Lead
Case note audits to be carried out	Monthly audit of 40 (random) case notes undertaken	Ensure random case note audit is undertaken and presented to the multi-professional team	Clinical Unit Lead	Clinical Audit lead	Presented at audit meetings to the multi professional team with documented learning points	In progress by Feb-14	Apr-14 – both random case note audit and annual audit undertaken awaiting presentation of findings in April.

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
		Introduction of an annual Supervisor of Midwives random audit of 100 sets of notes			Presented to Supervisors of Midwives; senior midwives; at consultant meetings and audit meeting	By Apr-14	
To ensure staff have appropriate knowledge and skills.	Staff undertake annual Trust mandatory training and annual mandatory obstetric related study days including management of obstetric emergencies.	Ensure a comprehensive review of staff numbers, knowledge and skills via the TNA to include medical staff.	Clinical Unit Lead/ Head of Midwifery/ Practice Develop. Midwife	Associate Director of Maternity/Paeds	**Workforce** numbers as agreed with HR	Baseline Apr-14/ then ongoing assessment	Apr-14 – baseline figures will be completed by end of April
	Practice Development midwife monitors attendance and records on a comprehensive Training Needs Analysis (TNA). Data also maintained within the Trusts Electronic Staff Records (ESR)	Ensure this references and reviews work being undertaken nationally regarding appropriate workforce numbers.		**Success measures:** **Knowledge** in accordance with grade – appraisal for consultants and specialty doctors/ e portfolio for trainees **Knowledge** for midwifery by ongoing assessment of clinical knowledge and skills using a clinical competency framework via supervision; line management and peer review **Skills** – Mandatory training			

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Ensure appropriate service management.	Currently have a management structure for Women's' health but this has not been reviewed since the temporary reconfiguration of services	Undertake a review of service management structures to ensure strong and effective clinical leadership – the Trust will commence a programme of organisational structure review in Apr-14.	Senior trust managers	HR	Appropriate management structure in place	End Apr-14	Re-structure planned for June / July 2014 and clinical leaders forum being established
		Continue to support clinical leaders via the clinical leaders forum that commences in 2014.					
Continuing Professional Development (CPD) for all clinical staff should focus on deficiencies in service delivery.	Skills training in relation to interpretation of CTGs; record keeping; neonatal resuscitation is offered within the mandatory obstetric study days that staff are required to attend annually		Clinical Unit Lead/ Head of Midwifery/ Practice Develop. Midwife/ Clinical Gov Manager	Associate Director Maternity/Paeds	Mandatory training / Remedial training as necessary	Baseline by Mar-14 then rolling	Apr-14 Skills training continues on mandatory days.
	Learning through complaints; incidents and SIs is taken forward on a one to one basis with individuals as appropriate.	Wider learning is undertaken through feedback to staff by the governance team on an add hoc basis this needs to be formalised with attendance at sessions mandatory					Trust wide complaints study day in place to share learning. Complaints discussed at Women's Health Risk Meeting

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Accountability and continuity of responsibility in respect of clinical risk and day-to-day management by a Band 7.	Every shift (day and night) is supported by a band 7	Advert out to appoint an identified labour band 7 lead rather than rely on a system of rotating the Band 7 co-coordinators.	Maternity Matron	Head of Midwifery	Appointment of band 7 matron as labour ward lead	End Jan-14	Apr-14 – appointment made and Band 7 in post
Consolidation of consultant presence on labour ward.	The role of the consultant on labour ward has been clearly clarified and consolidated since the temporary reconfiguration	Robust monitoring of consultant presence on labour ward needs to continue.	Clinical Unit Lead	Consultants	Continued robust evidence of consultant availability by use of 'consultant daily sign in' on labour ward	Ongoing	Apr-14 – evidence of sign in completed
	Consultants' are required to sign in x3 times daily to monitor labour ward presence	Further audit of presence of consultant on labour ward through the maternity documentation audit – audit to ask the question 'did consultant see the woman' (applicable to high risk women only)	Head of Midwifery/ Clinical Gov Manager	Supervisors of midwives (SoM)	Evidence in maternity records of consultant presence and involvement in care of the high risk women	Commence Mar-14 SoM audit	

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Supervision of trainees.	72 hour labour ward cover allows appropriate support and supervision of trainees. Needs to be specific guidance as to when consultants should be supervising trainees that is shared with the whole multi-disciplinary team.	Continued monitoring	Clinical Unit Lead	All consultants	Completion of recommended assessments	In place	
Review the level at which the SCBU is functioning at.	Currently level 1	Work in collaboration with a tertiary centre to review if SCBU should be a Level 2. This will require discussions with commissioners and the network as to the service that they wish to commission and is required by the network locally.	Associate Director Maternity/ Paeds Head of Nursing	Head of Midwifery	Report from tertiary centre	Jun-14	Apr-14 – await outcome of Better Beginnings Consultation
Ensure staff are writing trained in statement writing	There is a Trust wide review of how statements are written to ensure consistent processes across all areas. This will include a robust process to ensure statements are consistent in terms of format and presentation.	Training to continue and attendance at training to be monitored.	Clinical Gov Manager/Head of Assurance	Associate Director Maternity/Paeds/ Head of Midwifery/ Director of Nursing	Improved statement writing by all staff	By Apr-14	Apr-14 – one session held for Doctors in statement writing and sessions planned for midwives

The Joint RCOG / RCPCH ESHT Service Review Recommendations Action Plans, November 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Neonatal presence at daily incident reviews.	Paediatricians and SCBU staff are invited to join the daily incident review meetings.	Monitor attendance to ensure there is always a paediatrician available for any incident that involves a poor outcome for a neonate	Clinical Unit Lead	Paediatric Consultant	Attendance log	Jan-14	Apr-14 – Paediatric attendance at daily reviews in place
All staff to have an understanding of current guidelines.	A variety of systems in place to ensure that staff are aware of guidelines, that they understand these and can implement them	Monitor current process and ensure staff have a good working knowledge of guidelines	Specialist Midwife & Clinical Unit Lead as this requires Drs to be cognisant of these as well	Head of Midwifery & Matrons	Evidence of understanding at appraisals; SOM reviews Improvement in management of care evidenced through incidents and complaints	ongoing	

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Establish a formal mechanism for review of the operational policy.	Policy is being revised to reflect the comments made.	Address the areas identified in the report including the recommendations made by Dr Ryan Watkins.	General Manager Children and Young People's Services	Head of Nursing/ Paediatric Consultant	Policy ratified	end Jan-14	Apr-14 – policy fully revised awaiting final sign off
	A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree changes	Agree and ratify policy	Medical Director (Strategy)	Head of Nursing/ Paediatric Consultant			
Take positive steps to tackle the longstanding difficulties within the paediatric Consultant team and the relationship with senior Trust management.	New Clinical Lead recruited who is not an integral member of the paediatric Clinical Unit. Identified a Paediatric Consultant to act as operational lead for the day to day management of the service.		General Manager Children and Young People's Services/ Medical Director (Strategy)	All paediatric consultants	Regular attendance and contribution at Consultant meetings where majority decisions are made and then adhered to by whole consultant body.	Ongoing	Apr-14 – Consultant meetings in place; team job planning has occurred in both acute and community Paediatrics and individual ones commencing. Task force meetings were held and the acute work will be managed via the Consultant meetings and
	Monthly cross site face to face consultant meeting has been set up	Commitment by the Consultant body to engage in these actions; groups and meetings					
	Three paediatric taskforce groups overseen by an external facilitator - Acute, Community and Long Term Conditions.						

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Assess the current arrangements against the 'Tanner' report and the PICU standards	Ensure all areas of non compliance addressed. Policy being revised to reflect comments. Meeting of Consultant body planned to discuss operational policy in more detail and agree the changes	Agree and ratify policy	General Manager Children and Young People's Services/ Medical Director (Strategy)	Paediatric Consultant	Policy ratified	end Jan-14	Apr-14 – policy fully revised awaiting final sign off
Consider appointment of an 'independent' project manager to oversee the continued implementation and monitoring of the new operational arrangements.	New management structure has facilitated majority decisions within the paediatric unit	No action required	N/A	N/A	N/A	N/A	

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Recruit / commit to develop up to four further children-trained nurses to Cover the Emergency Department at the non acute site	Nurses have always been seconded from the Emergency department to undertake their paediatric training. This will be a rolling programme	Needs to be internal rotation of nurses between the SSPAU and the ED .	Head of Nursing/ Matron	General Manager Acute/ Emergency Care	Successful recruitment and sufficient paediatric trained nurses available in ED.	ongoing	Apr-14 – currently three paediatric trained staff; additional appointment and rotation between SSPAU and ED will be considered once outcome of Better Beginnings consultation known and any plans re co-location of ED and SSPAU are made.
Ensure there is at least one APLS-trained nurse or doctor on each shift in the ED who are familiar with spotting the sick child.	It is mandatory for all nurses to undertake annual basic life support training. Nurses from the ED are routinely offered APLs training	Specific training should be arranged for the ED staff, including anaesthetists until the team has gained Paediatric skills and there is confidence that the locum is no longer needed.	A&E Consultants/Head of Nursing	General Manager Acute/ Emergency Care	Successful training of staff in paediatric settings	Ongoing	Apr-14 – 5 members of staff have undertaken Paediatric module at Brighton
		Needs to be a rolling programme until all ED nurses have completed APLs			A rolling plan is in place to maintain training	Ongoing	Plan in place for all trained nurses to have combination of EPLS/BLS/ ALS in ED

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Identify clinical champions for children within the Trust. There should also be an identified executive lead for children and young people	Within the Paediatric clinical unit the clinical services manager/HoN is the link between paediatric and ED Services and there are ED/Paediatric meetings held regularly on both sites.	Clinical champions need to be identified at executive and non executive level. Consider establishing a Children and Young People's board chaired by an executive lead to enable strategic and operational cross-trust issues	The Trust Board need to identify the leads	Medical Director (Strategy)	Confirmation of Board leads	Apr-14	Apr-14 – discussed at Board and Board lead in place. Work still required on developing Children's & Young Peoples
Continue to invest in community children's nursing to allow development of a comprehensive children's community nursing team that can be available for extended hours 7 days a week	The current strategy developed by the CCG's in conjunction with representatives from Pan Sussex services features the development of community children's services	Work needs to continue across the clinical network to discuss the future model of children's acute and community service Pan Sussex.	Commissioners Head of Nursing	Medical Director (Strategy) General Manager Acute and Emergency Care/ Clinical Services Manager	Development of a 7 day community service	ongoing	Apr-14 – need to await outcome of Better Beginnings consultation
Agree an immediate course of action between the local unit and transport team to manage the occasional child who is unsafe to transfer but does not require intubation and ventilation.	On occasions a child may need to be kept in ED for observation until a safe plan can be made which may require a children's nurse to stay on site. Policy is being revised to reflect the comments made.	Agree and ratify policy	General Manager Acute and	Paediatric Consultant	Ratified policy	Feb-14	Apr-14 – policy fully revised awaiting final sign off
	A meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes		Medical Director (Strategy)/ ED consultants SECAMB				

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Agree arrangements for a consultant to attend a child death.	Currently there is a middle grade paediatric doctor working in ED when the SSPAU is closed. Policy is being revised to reflect the comments made. Meeting of the Consultant body is planned to discuss the operational policy in more detail and agree the changes	To consider developing a community on call rota	Medical Director (Strategy)	Paediatric Consultant	Ratified policy and introduction of an on call rota	Apr-14	Apr-14 – policy fully revised awaiting final sign off
Increase evening consultant presence during the opening hours of the SSPAU and at least part of the day at weekends to help with decision making and ensure more patients are discharged and transfers are appropriate and safe.	Currently there is an on-call Consultant for the SSPAU during opening hours	Need to assess requirements for consultant presence	Medical Director (Strategy)	General Manager Acute and Emergency Care	Children are assessed; discharged or transferred appropriately	Apr-14	Apr-14 – agreed in job planning to be present from 9 to 5 weekdays and at weekends

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
To urgently review the availability of on-call consultant paediatric expertise to the acute unit to ensure we are compliant with national standards that suggest 24-hour availability of a consultant paediatrician (or equivalent non-consultant career-grade doctor) trained and assessed as competent in advanced neonatal life support, who can attend within 30 minutes".	Trust is compliant with this as they have resident trained middle grade doctors 24/7.	No further action required	N/A	N/A	N/s	N/A	
Consider alternative models for the SSPAU with the consultants and commissioners as part of the work on the future of maternity and paediatric services.	CCG's announced their proposals for the future model of acute paediatrics across Sussex; public consultation commenced Jan-14	No further action for the Trust	N/A	N/A	N/A	N/A	

THE RCPCH ESHT Service Review Recommendations Action Plans Nov 2013

Update April 2014

Recommendation	Current position	Action required	By whom	Supported by	Success measures	By when	Progress and completion
Consider relocation of the SSPAU to be adjacent to the ED on the non acute site.	CCG's announced their proposals for the future model of acute paediatrics across Sussex; public consultation commenced Jan-14	No further action for the Trust until outcome of consultation	N/A	N/A	N/A	N/A	

East Sussex Healthcare NHS Trust

Date of Meeting:	4th June 2014
Meeting:	Trust Board
Agenda item:	10
Subject:	Staff Survey 2013 Summary
Reporting Officer:	Monica Green

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

Purpose:

The attached report provides a summary and analysis of the 2013 staff survey results.

Introduction:

The staff survey was conducted between October and December 2013 with the results published on 25th February 2013. The survey was conducted across all ESHT staff with a response rate of 37%. For 2013 we are again compared with Acute Trusts as there is still no mechanism to compare with Integrated Trusts.

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

The outcomes of the question responses compared to 2012 are:

Improved - 11 questions
Worsened - 66 questions
Same - 13 questions

The majority of questions with a worse response worsened by around 1-2%.

The outcomes also worsened in some key areas:

- A decrease in overall staff engagement and motivation;
- A decrease in staff recommending the Trust as a place to work or receive treatment;
- An increase in staff reporting work related stress and work pressure.

Benefits:

The staff survey is a key mechanism to understand staff perceptions and concerns, and identify areas for action. The benefits of addressing these areas of concern should be improved staff engagement which should in turn have a positive impact on patient experience.

Risks and Implications

The risks of not addressing staff concerns include poor staff morale leading to impacts on patient experience and organisational reputation.

Assurance Provided:

The survey results were published in the public. A press statement and staff communications were prepared. Following this the Trust needs to identify and agree the areas of focus during 2014, and what actions will be taken to address the areas of concern.

Further to presenting the results to the Corporate Leadership Team (CLT), it has been determined to focus on staffing engagement during 2013/2014. This will be taken forward via a number of mechanisms:

- Using the Listening into Action (LiA) to engage with staff around what matters to them.
- A particular focus on the forthcoming CQC visit, and directly engaging frontline staff to support them and address their concerns.
- Continuation and development of the 'Leadership Conversations', held every 6-8 weeks with all senior leaders.
- Continuation of focused conversations with specific staff, eg. Healthcare Assistants.
- Utilisation of the outcomes of the newly introduced Staff Friends and Family test, to identify specific staff groups/departments needing further engagement.

Review by other Committees/Groups (please state name and date)**:**
CLT – 25th February 2014

Proposals and/or Recommendations
The Board is requested to agree the Trust-wide approach to addressing the areas of concern.

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Edel Cousins, Assistant Director – Workforce Development	Edel.cousins@esht.nhs.uk

2013 National NHS staff survey

Brief summary of results from East Sussex Healthcare NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2013 national NHS staff survey conducted in East Sussex Healthcare NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 28 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus two additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

- Additional theme: Staff satisfaction

- Additional theme: Equality and diversity

Please note that the NHS pledges were amended in 2013, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2013 survey results for East Sussex Healthcare NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

The Q12d score is related to CQUIN payments for Acute trusts participating in the National NHS Staff Survey. 2013/2014 guidance on CQUIN payments can be found via the following link https://www.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf.

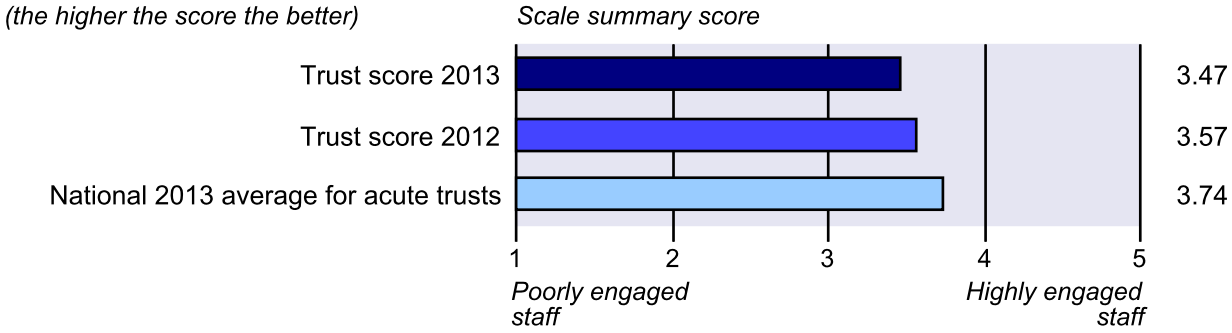
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2013	Average (median) for acute trusts	Your Trust in 2012
Q12a	"Care of patients / service users is my organisation's top priority"	49	68	51
Q12b	"My organisation acts on concerns raised by patients / service users"	53	71	57
Q12c	"I would recommend my organisation as a place to work"	41	59	46
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	51	64	57
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.28	3.68	3.40

2. Overall indicator of staff engagement for East Sussex Healthcare NHS Trust

The figure below shows how East Sussex Healthcare NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.47 was in the lowest (worst) 20% when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how East Sussex Healthcare NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2012 survey.

	Change since 2012 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	! Decrease (worse than 12)	! Lowest (worst) 20%
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Lowest (worst) 20%
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	! Decrease (worse than 12)	! Lowest (worst) 20%
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	! Decrease (worse than 12)	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2013 Key Findings for East Sussex Healthcare NHS Trust

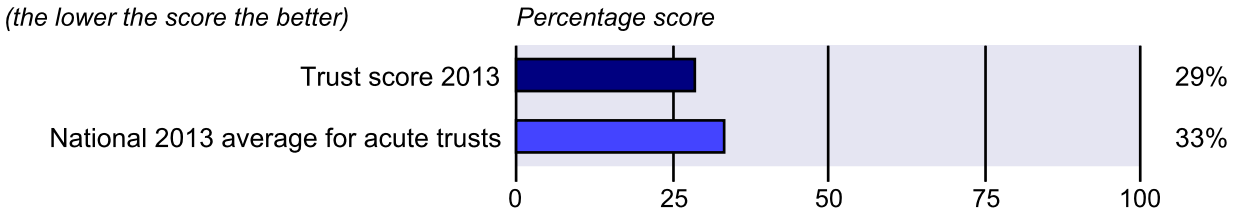
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which East Sussex Healthcare NHS Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

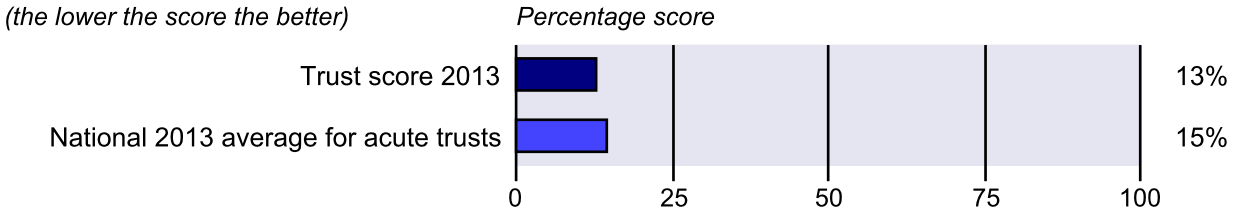
✓KF13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



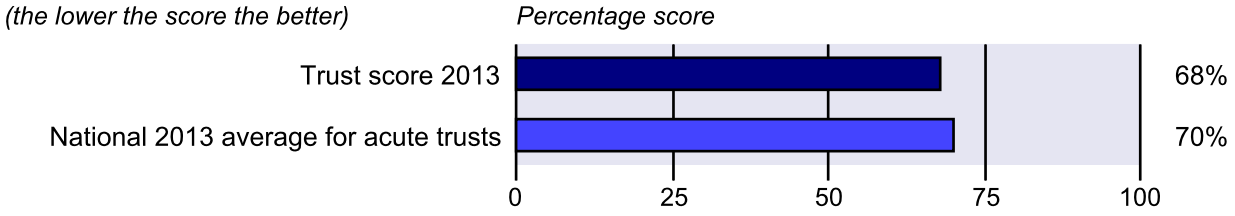
✓KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



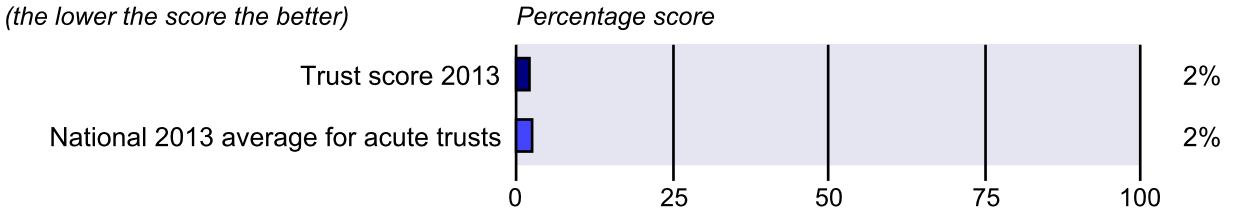
✓KF5. Percentage of staff working extra hours

(the lower the score the better)



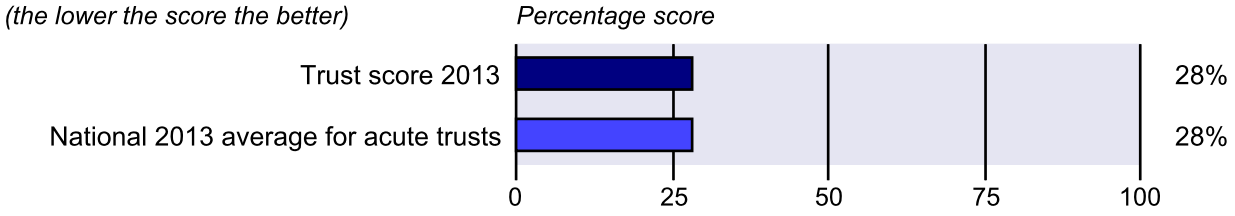
✓KF17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



✓KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

(the lower the score the better)



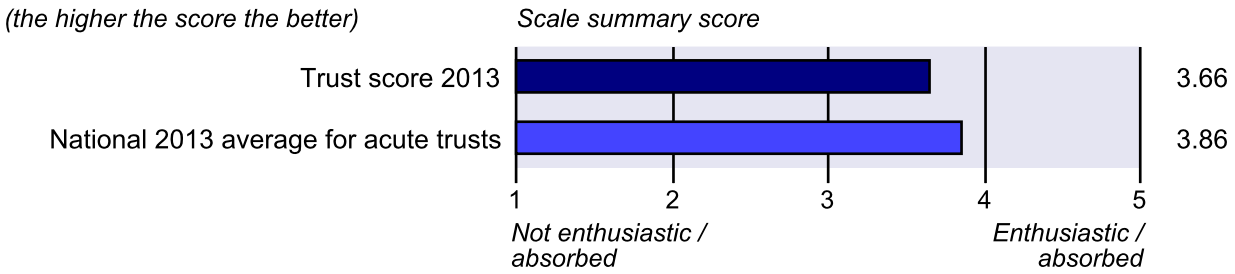
For each of the 28 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 141 (the bottom ranking score). East Sussex Healthcare NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which East Sussex Healthcare NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

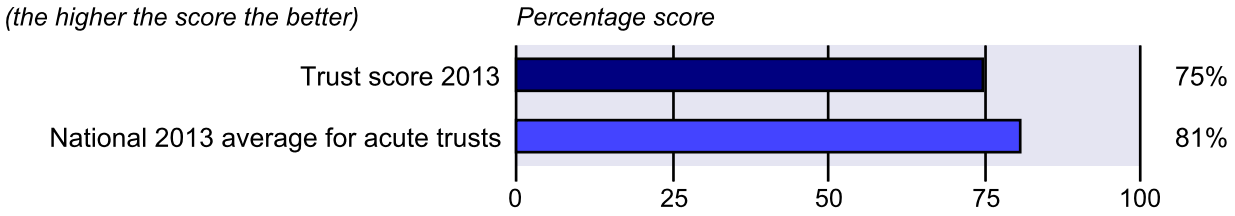
! KF25. Staff motivation at work

(the higher the score the better)



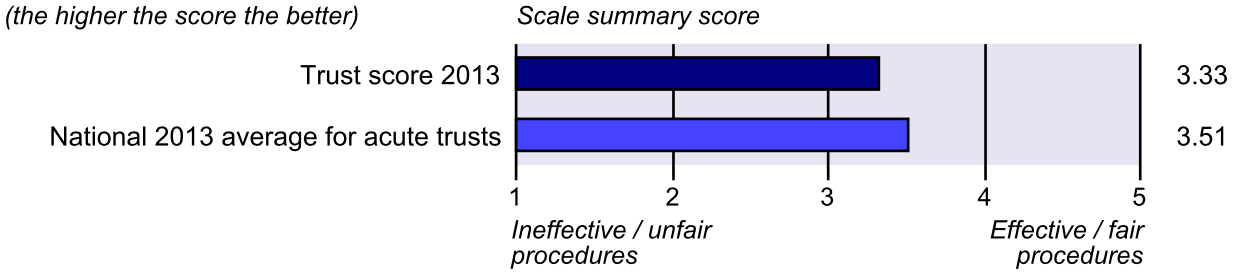
! KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



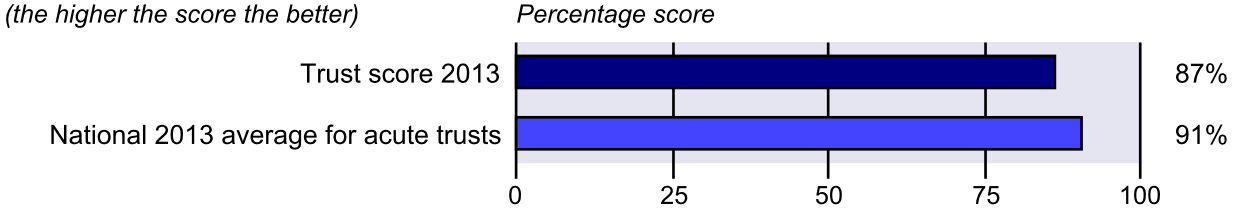
! KF15. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



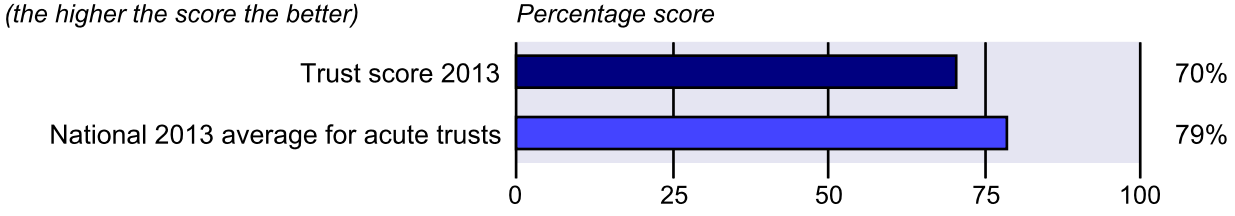
! KF2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)



! KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



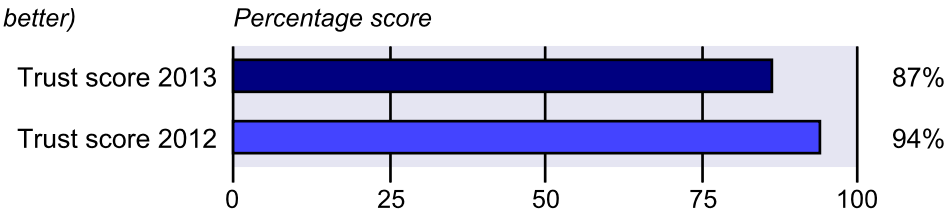
3.2 Largest Local Changes since the 2012 Survey

This page highlights the five Key Findings where staff experiences have deteriorated since the 2012 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

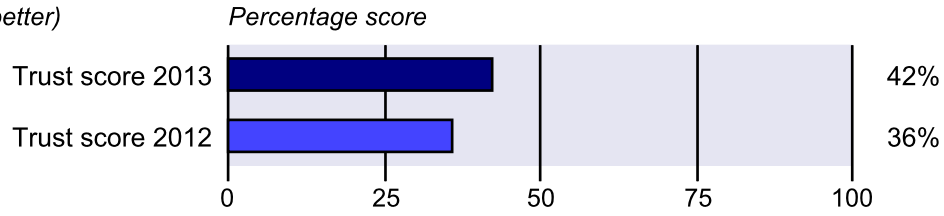
! KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



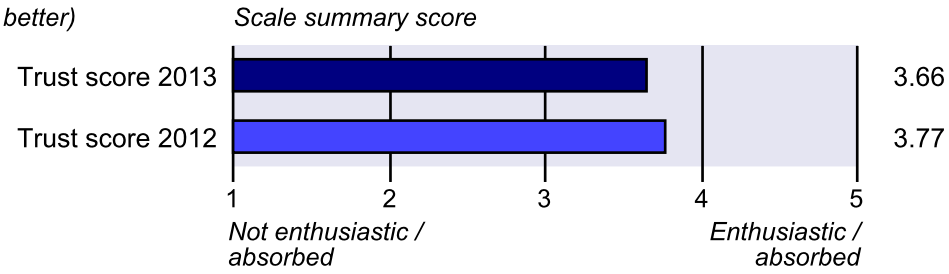
! KF11. Percentage of staff suffering work-related stress in last 12 months

(the lower the score the better)



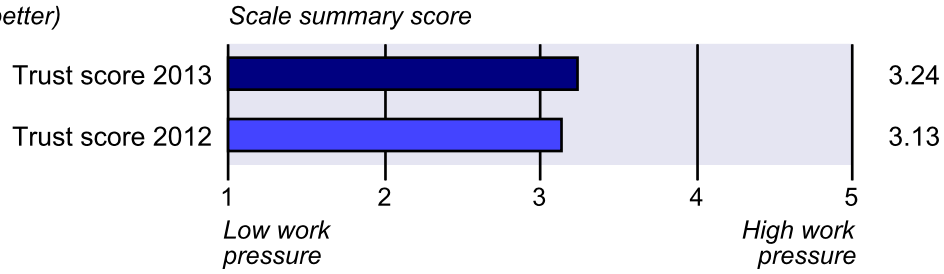
! KF25. Staff motivation at work

(the higher the score the better)



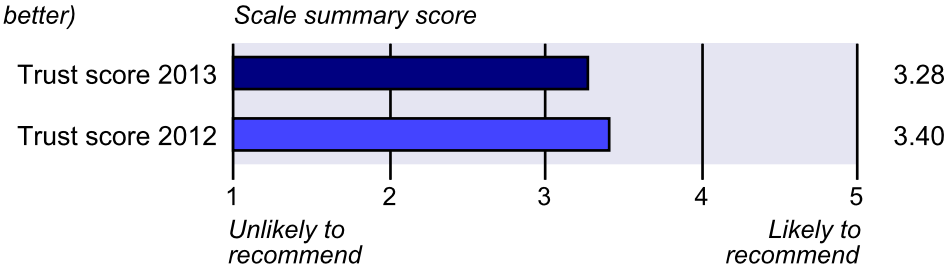
! KF3. Work pressure felt by staff

(the lower the score the better)



! KF24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



3.3. Summary of all Key Findings for East Sussex Healthcare NHS Trust

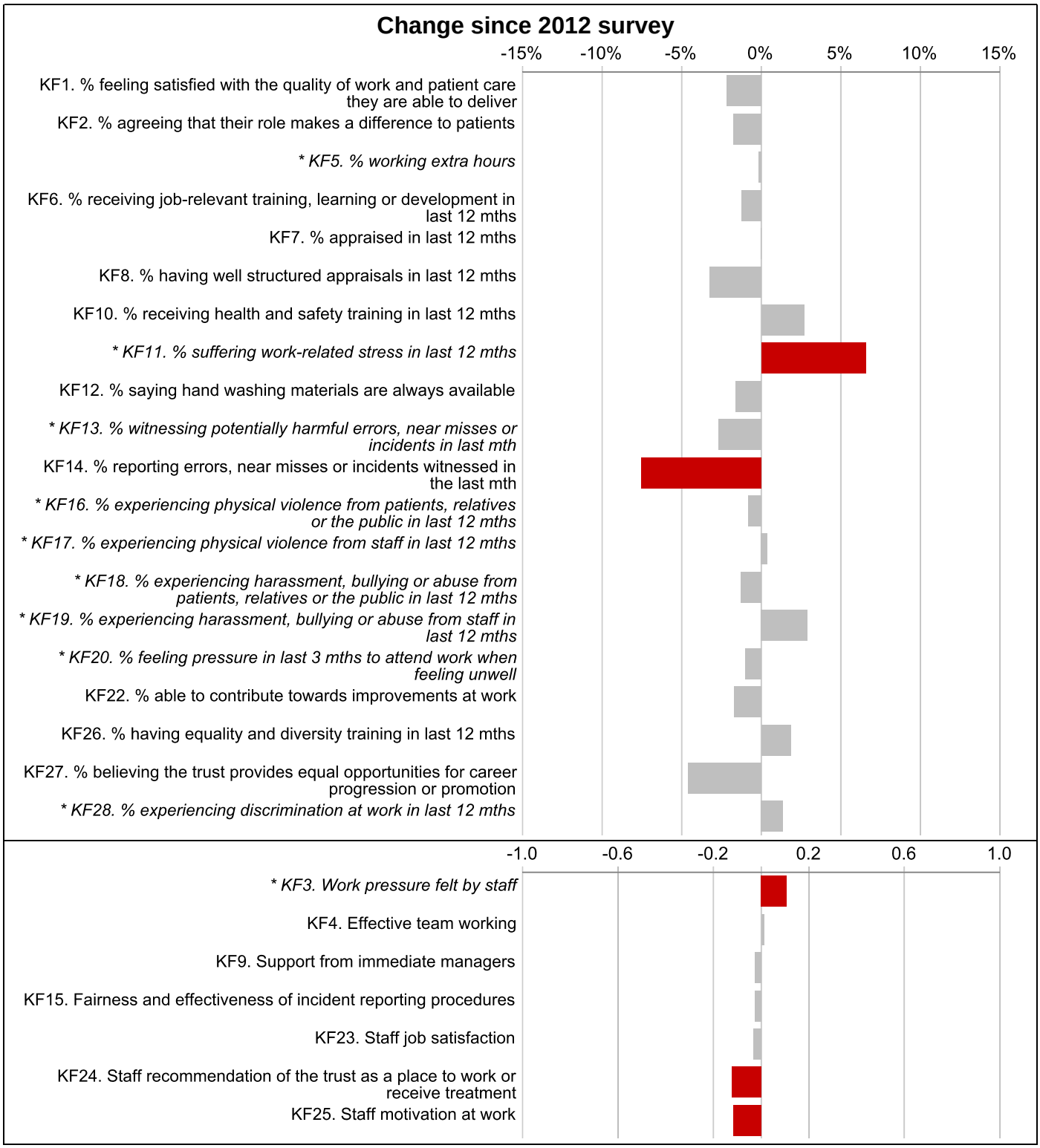
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2012 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2012 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2012 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for East Sussex Healthcare NHS Trust

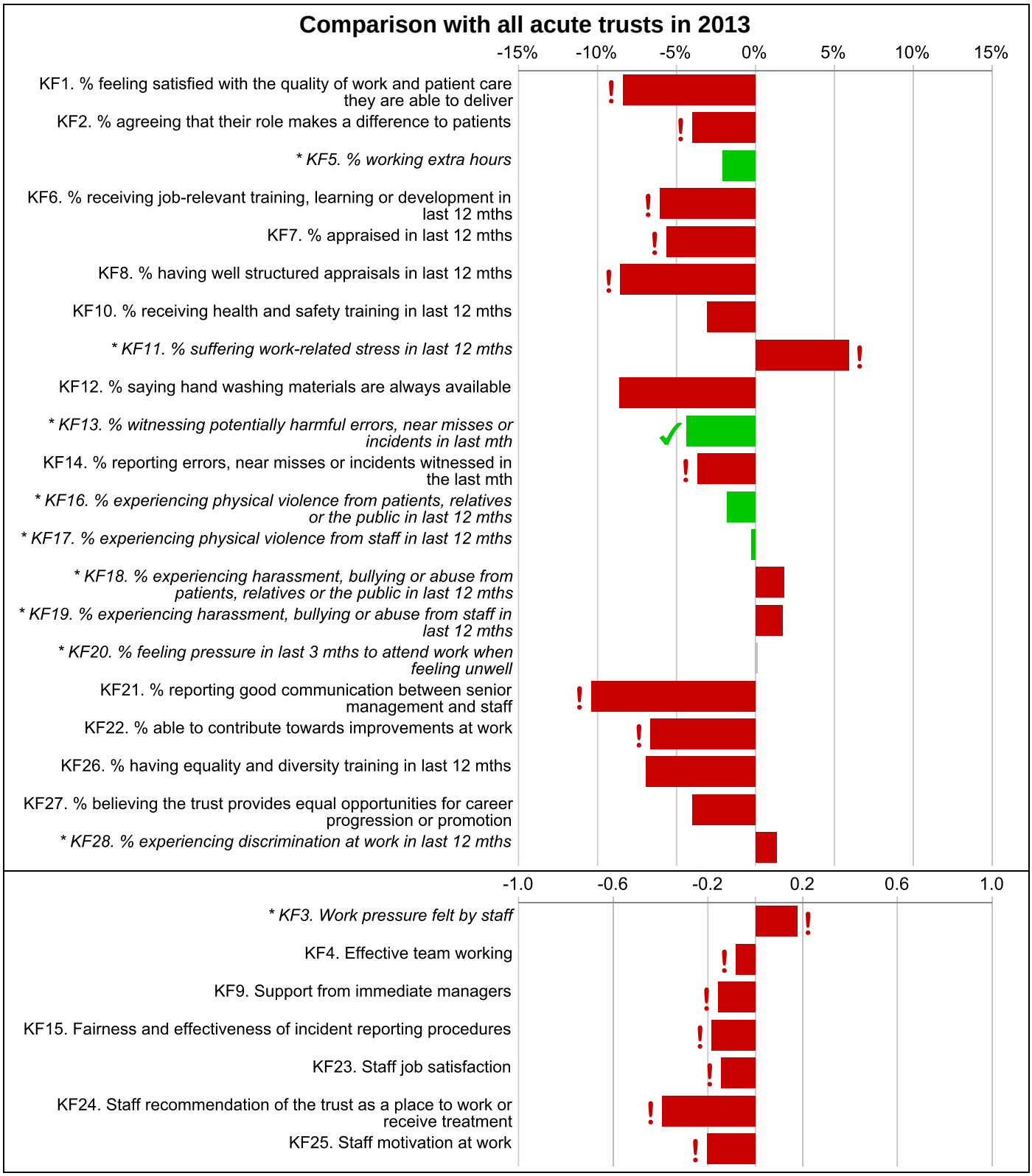
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than avearge. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.4. Summary of all Key Findings for East Sussex Healthcare NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2012.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2012.

'Change since 2012 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2012 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2012 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	! Lowest (worst) 20%
KF2. % agreeing that their role makes a difference to patients	• No change	! Lowest (worst) 20%
* *KF3. Work pressure felt by staff*	! Increase (worse than 12)	! Highest (worst) 20%
KF4. Effective team working	• No change	! Lowest (worst) 20%
* *KF5. % working extra hours*	• No change	✓ Below (better than) average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	! Lowest (worst) 20%
KF7. % appraised in last 12 mths	• No change	! Lowest (worst) 20%
KF8. % having well structured appraisals in last 12 mths	• No change	! Lowest (worst) 20%
KF9. Support from immediate managers	• No change	! Lowest (worst) 20%
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	• No change	! Below (worse than) average
* *KF11. % suffering work-related stress in last 12 mths*	! Increase (worse than 12)	! Highest (worst) 20%
Infection control and hygiene		
KF12. % saying hand washing materials are always available	• No change	! Below (worse than) average
Errors and incidents		
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Lowest (best) 20%
KF14. % reporting errors, near misses or incidents witnessed in the last mth	! Decrease (worse than 12)	! Lowest (worst) 20%
KF15. Fairness and effectiveness of incident reporting procedures	• No change	! Lowest (worst) 20%

3.4. Summary of all Key Findings for East Sussex Healthcare NHS Trust (cont)

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	• Average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	--	! Lowest (worst) 20%
KF22. % able to contribute towards improvements at work	• No change	! Lowest (worst) 20%
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	! Lowest (worst) 20%
KF24. Staff recommendation of the trust as a place to work or receive treatment	! Decrease (worse than 12)	! Lowest (worst) 20%
KF25. Staff motivation at work	! Decrease (worse than 12)	! Lowest (worst) 20%
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	• No change	! Below (worse than) average
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	! Below (worse than) average
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average

4. Key Findings for East Sussex Healthcare NHS Trust

2361 staff at East Sussex Healthcare NHS Trust took part in this survey. This is a response rate of 36%[1] which is in the lowest 20% of acute trusts in England, and compares with a response rate of 51% in this trust in the 2012 survey.

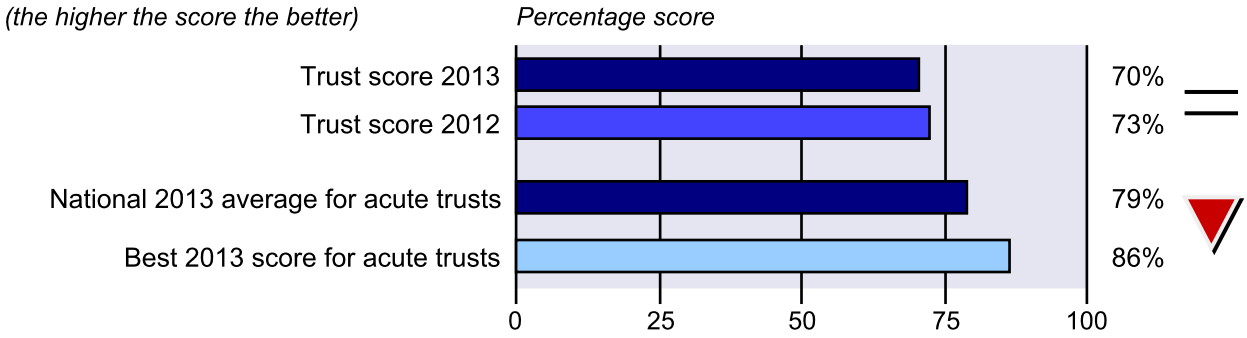
This section presents each of the 28 Key Findings, using data from the trust's 2013 survey, and compares these to other acute trusts in England and to the trust's performance in the 2012 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2012). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2012). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

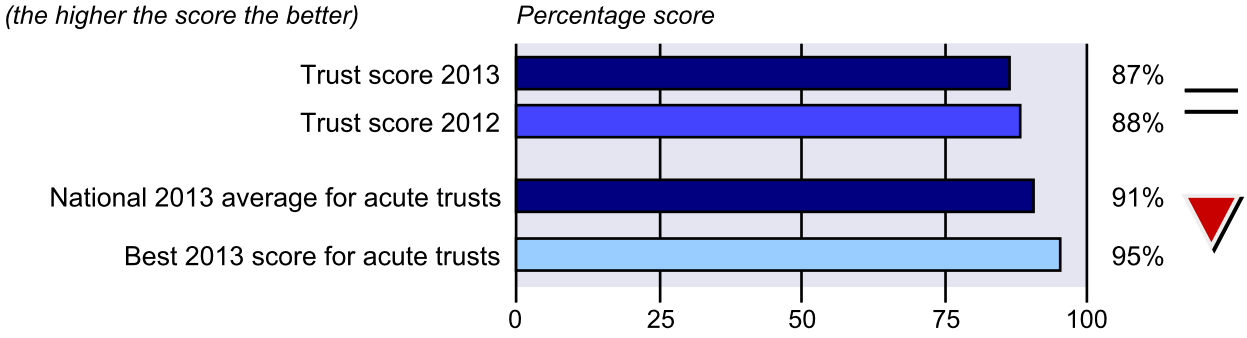
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

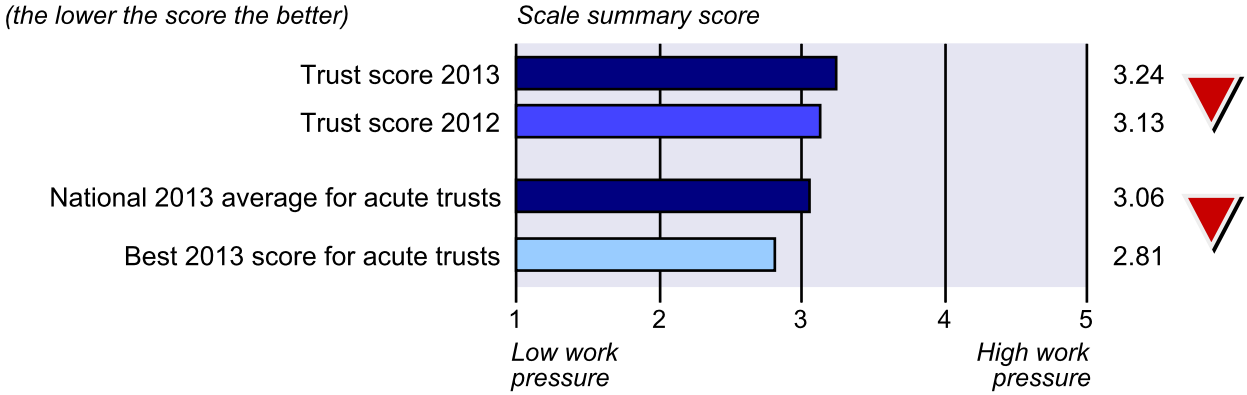
(the higher the score the better)



[1]Questionnaires were sent to all 6603 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

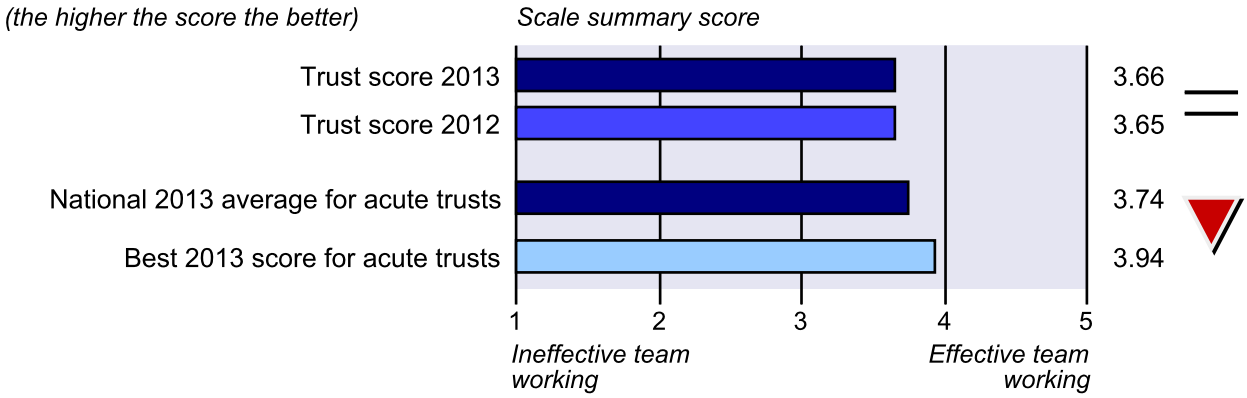
KEY FINDING 3. Work pressure felt by staff

(the lower the score the better)



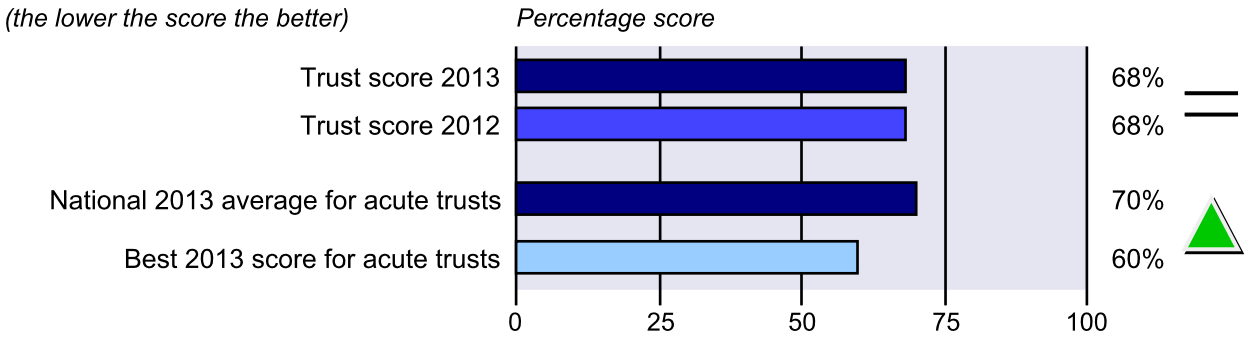
KEY FINDING 4. Effective team working

(the higher the score the better)



KEY FINDING 5. Percentage of staff working extra hours

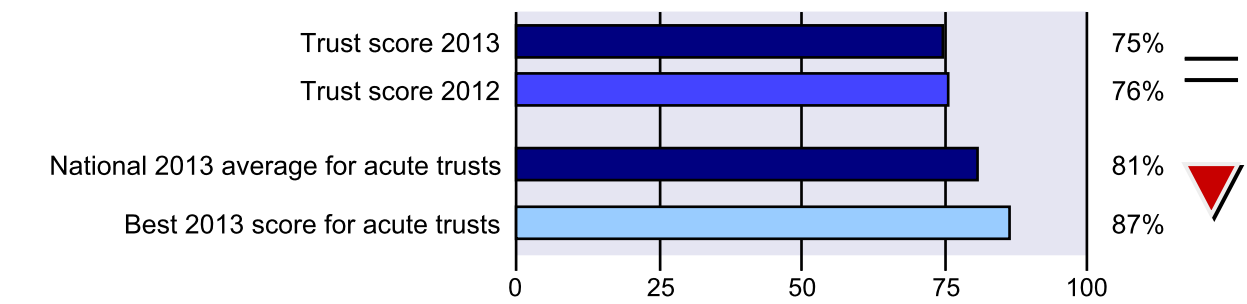
(the lower the score the better)



STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

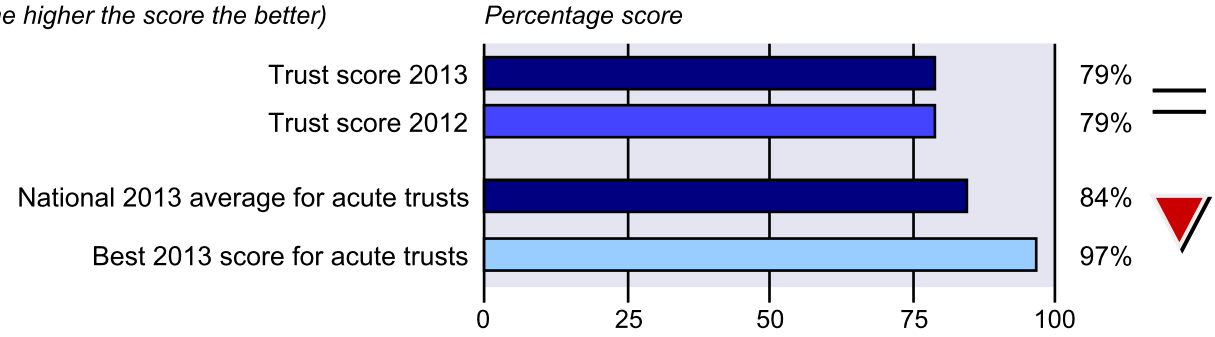
KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



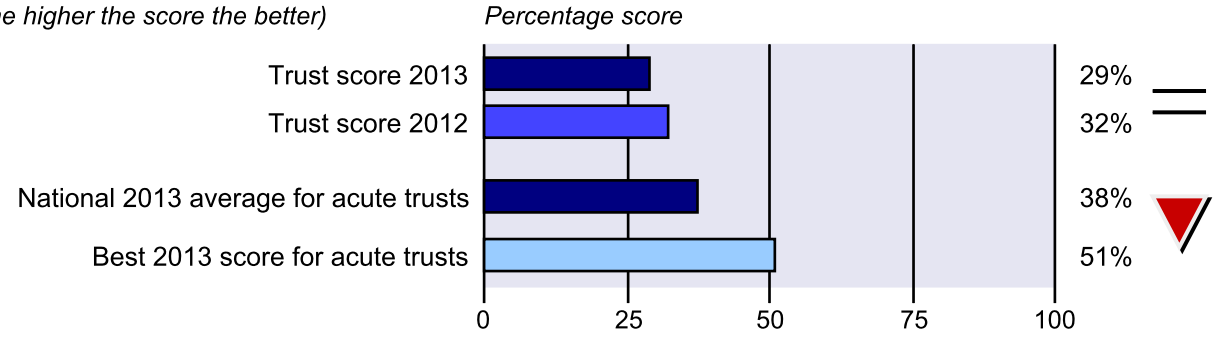
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better)



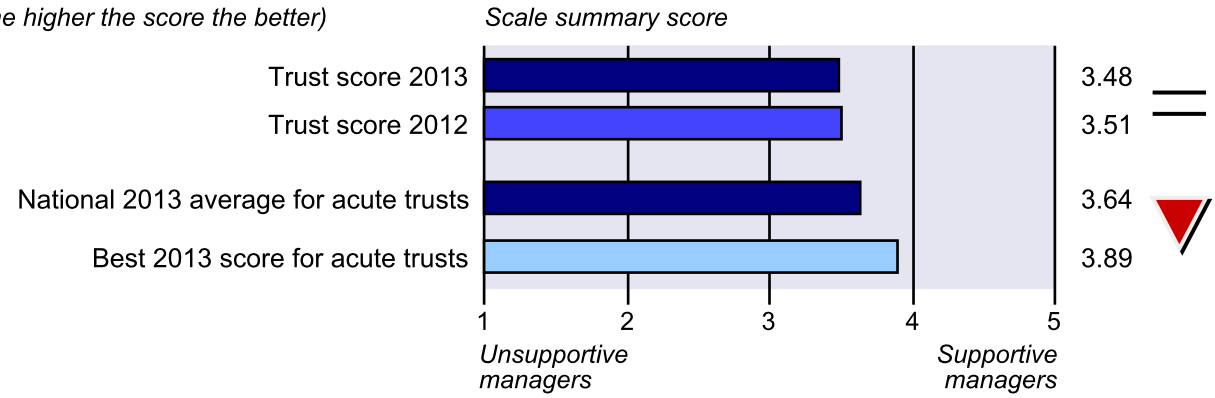
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



KEY FINDING 9. Support from immediate managers

(the higher the score the better)

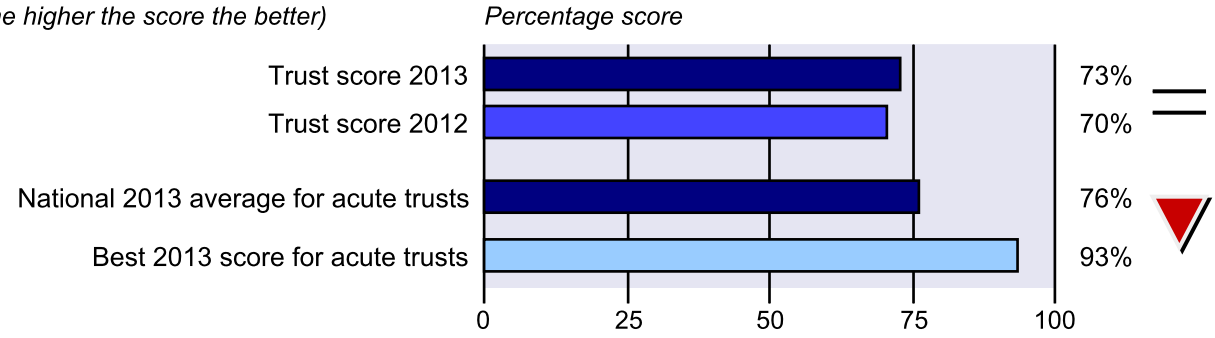


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Occupational health and safety

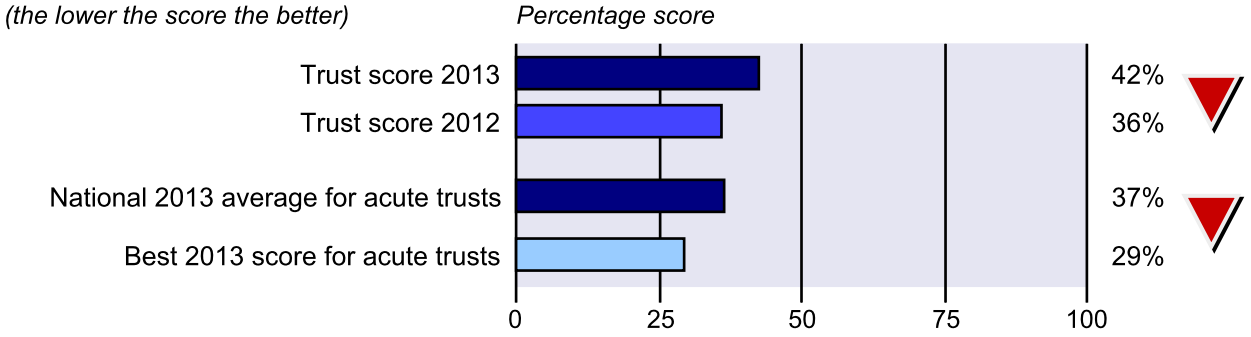
KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

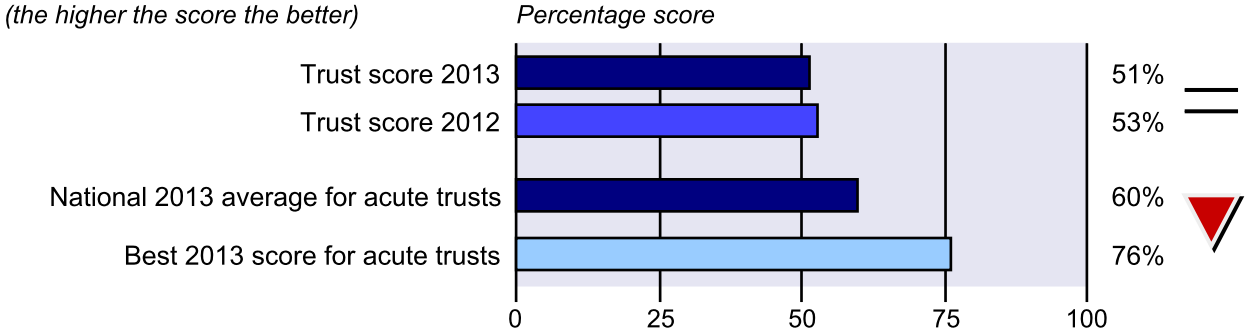
(the lower the score the better)



Infection control and hygiene

KEY FINDING 12. Percentage of staff saying hand washing materials are always available

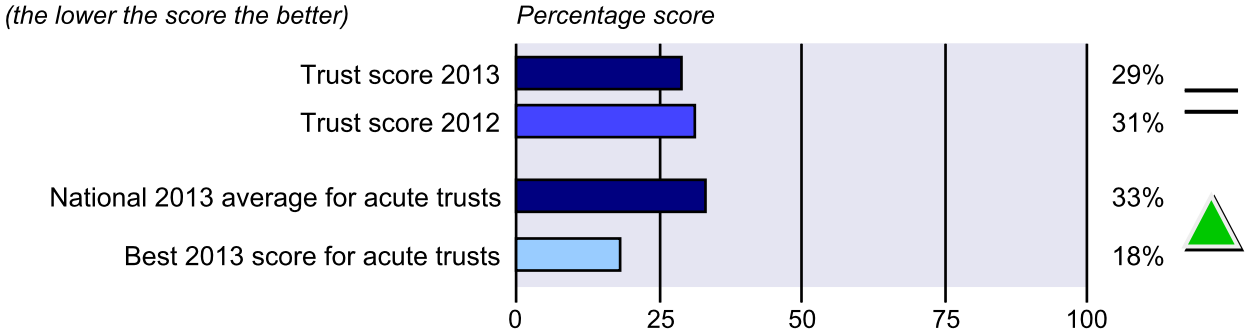
(the higher the score the better)



Errors and incidents

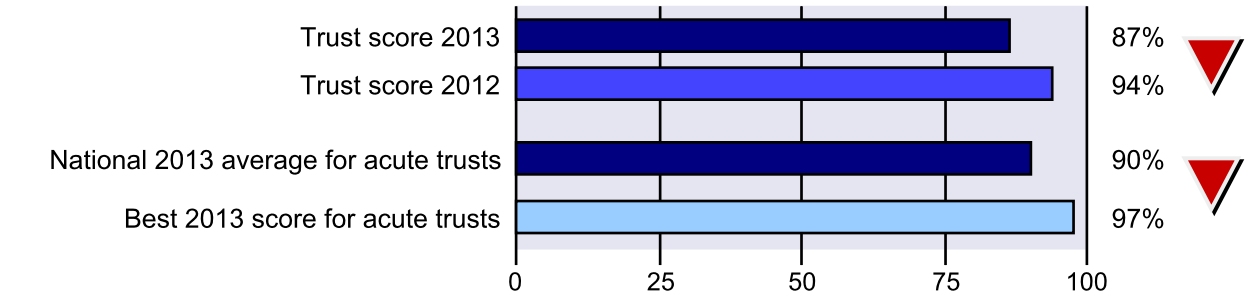
KEY FINDING 13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



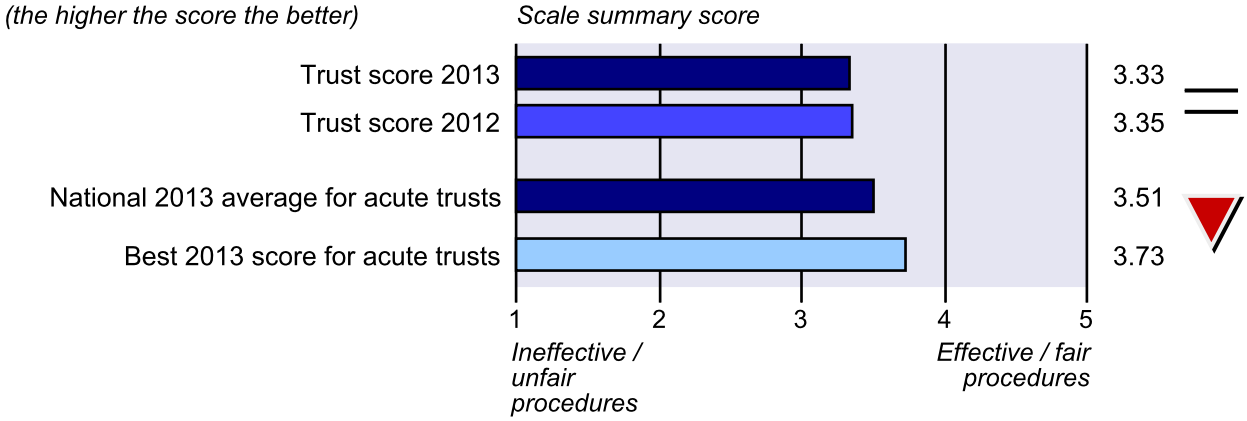
KEY FINDING 14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



KEY FINDING 15. Fairness and effectiveness of incident reporting procedures

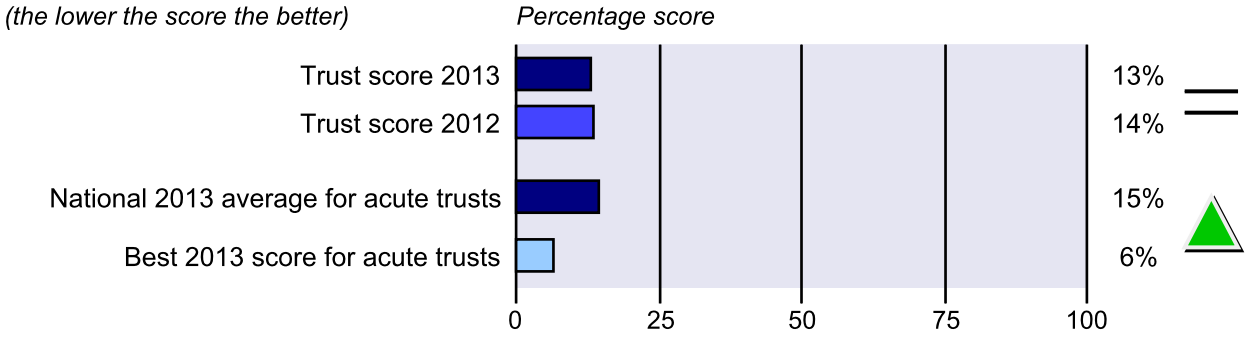
(the higher the score the better)



Violence and harassment

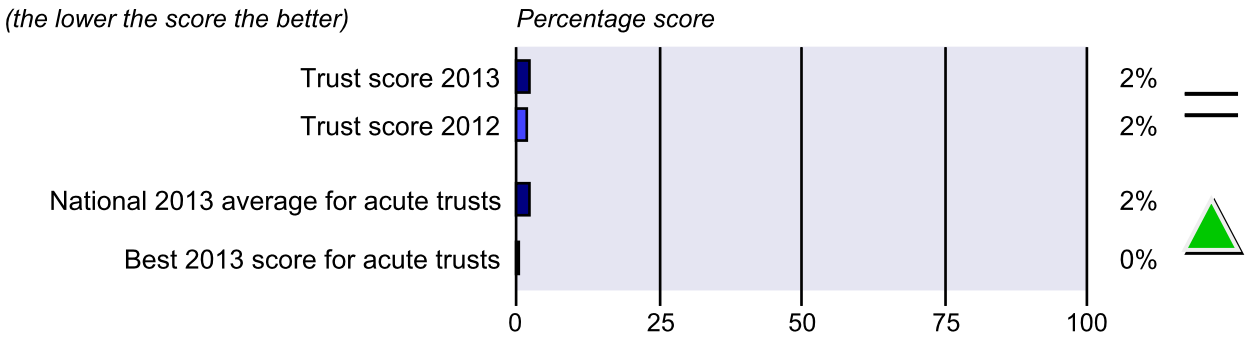
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



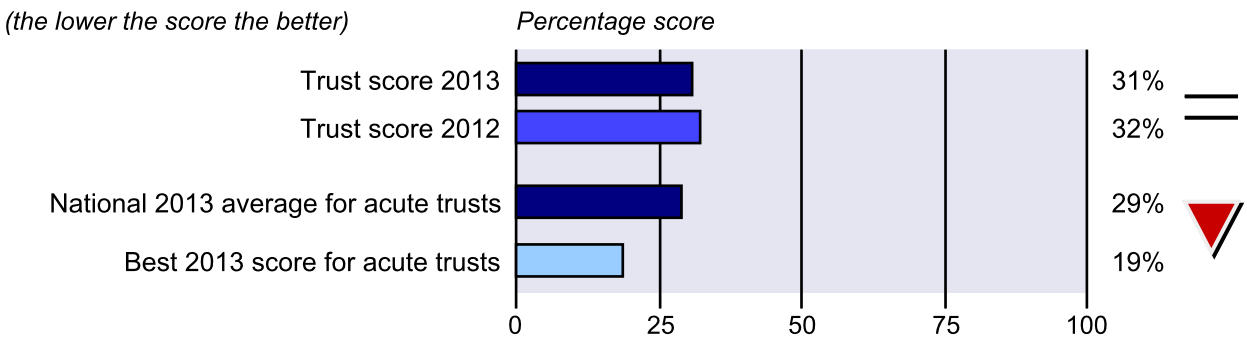
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



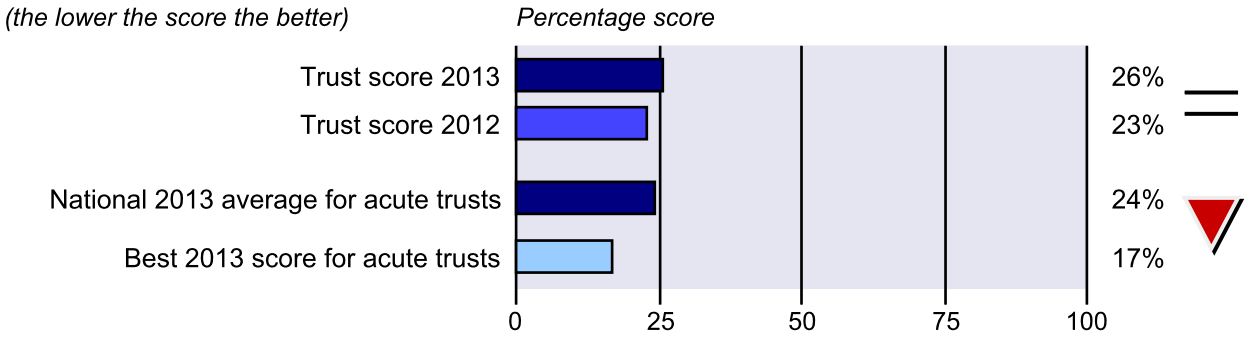
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

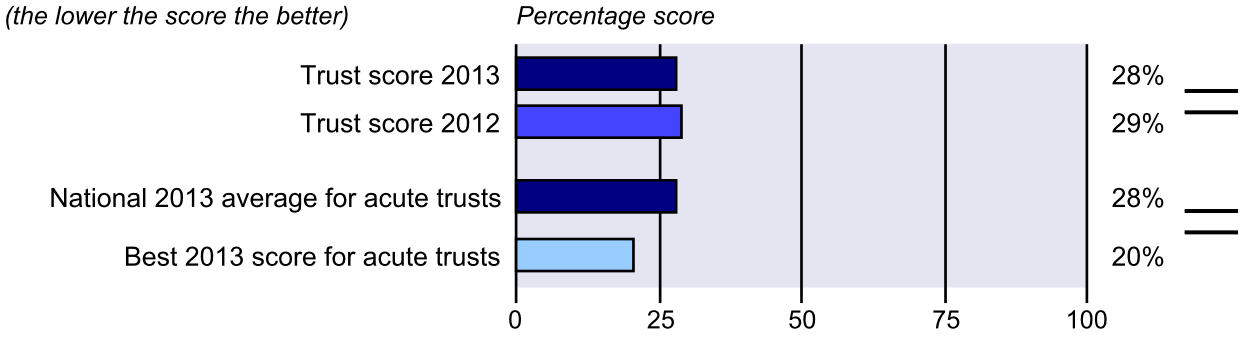
(the lower the score the better)



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

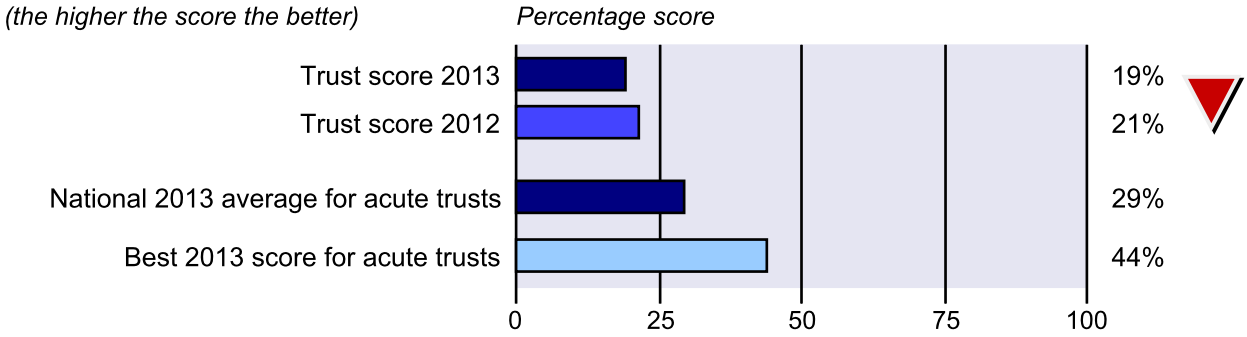
(the lower the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

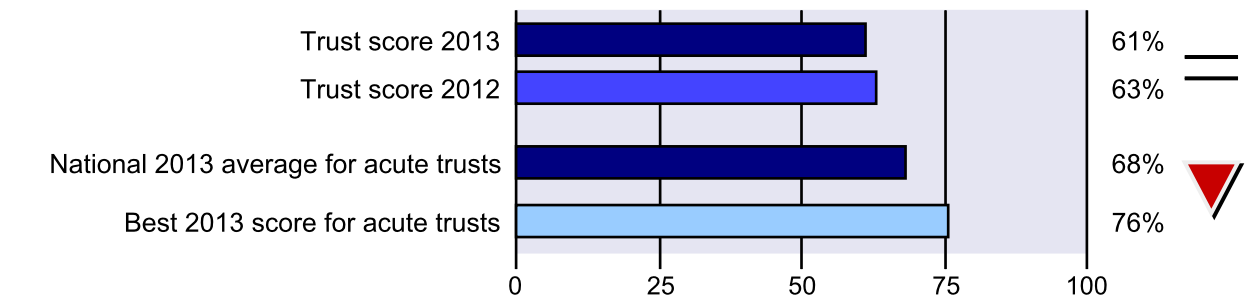
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

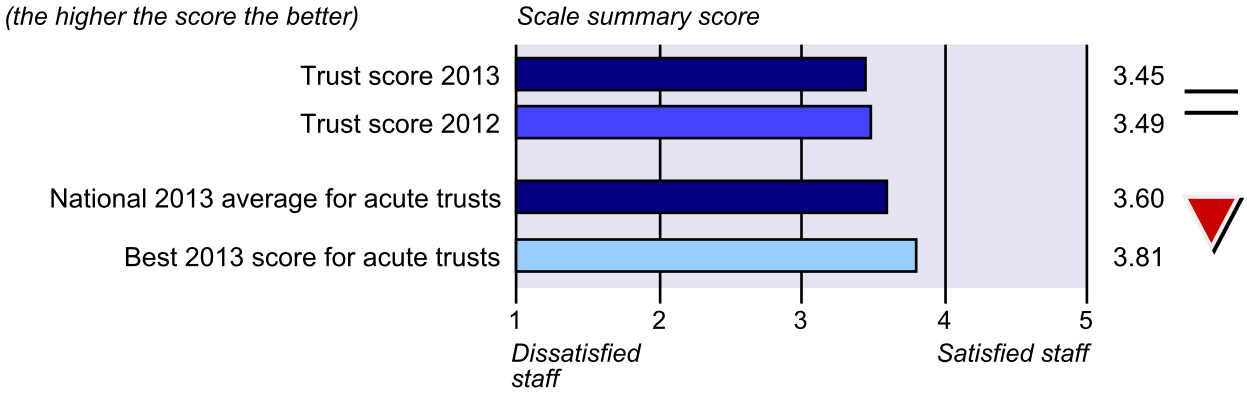
(the higher the score the better)



ADDITIONAL THEME: Staff satisfaction

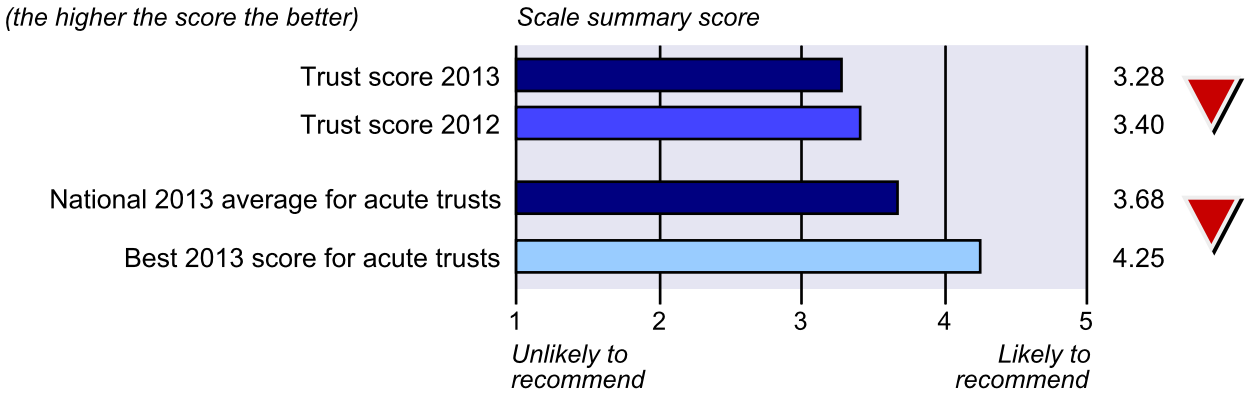
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



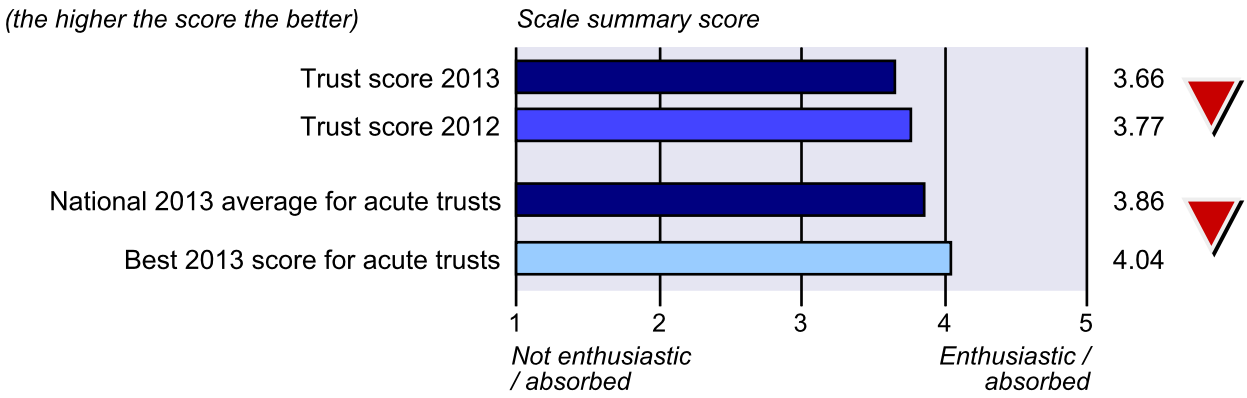
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

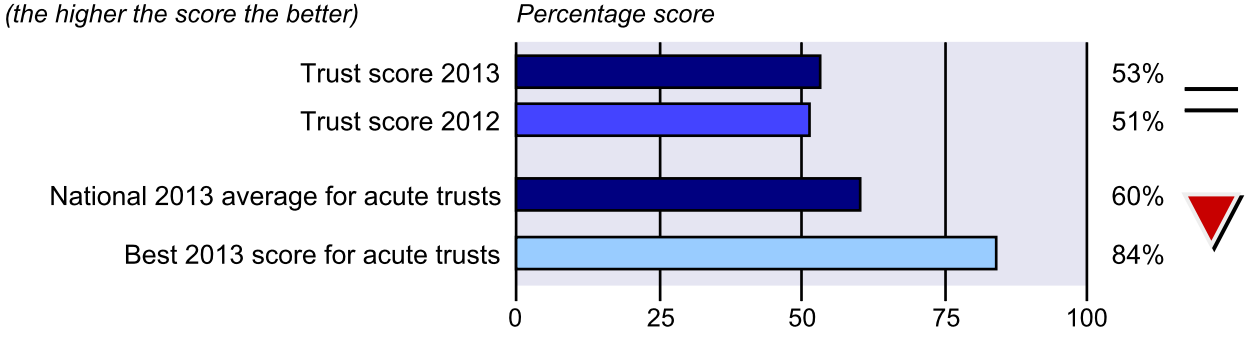
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

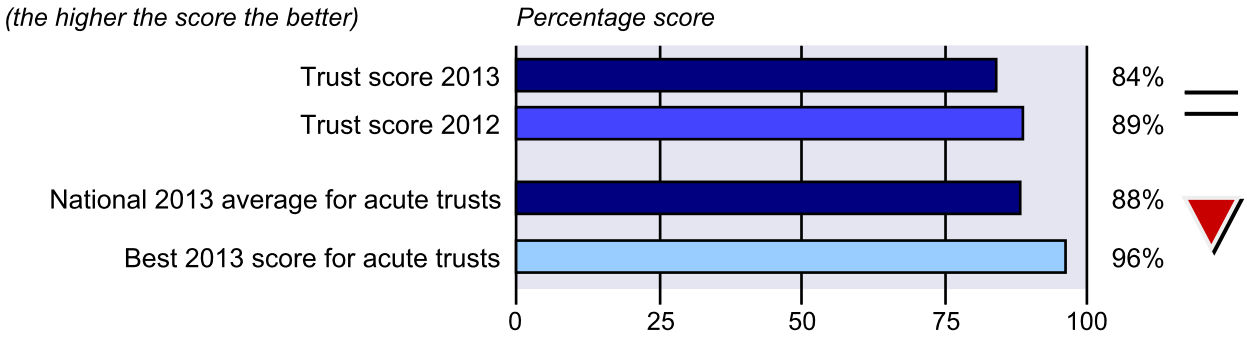
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



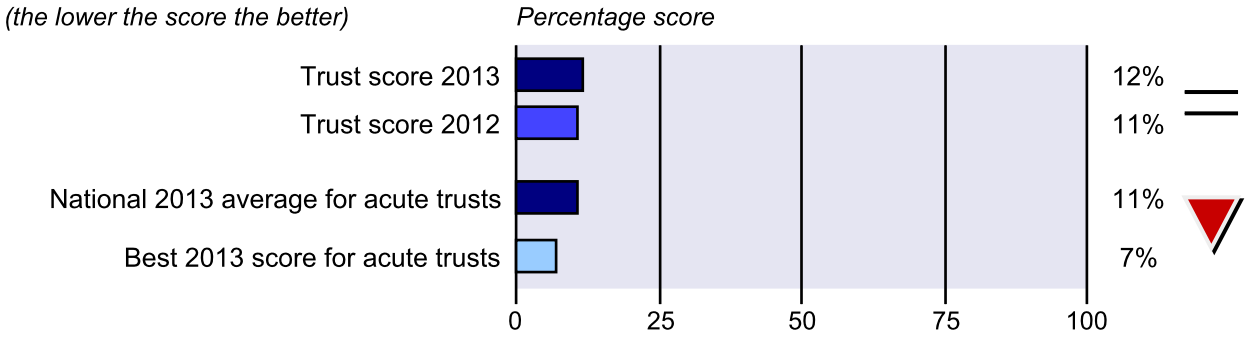
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	11
Subject:	Research and Development Report
Reporting Officer:	Dr David Hughes, Medical Director – Clinical Governance

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

Purpose:

This report is intended to update Trust Board on the research activity undertaken within ESHT, including risks, benefits and recommendations.

There are 2 recommendations that require Trust Board consideration.

Introduction:

This paper is intended to update the Trust Board on research and development (R&D) from November 2013 to April 2014.

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

R&D staff reconfiguration – 1/4/14
Annual Scientific Meeting – 4/4/14
R&D relocation – 9/4/14
Kent, Surrey & Sussex Clinical Research Network (KSS CRN) – 1/4/14 Targets
South Coast Audit (now known as tiaa) – audit report
SPA - research activity
Inclusion of information on Trust research activity in footer of all Trust letters

Benefits:

Patients have opportunities to participate in high quality research that is part of the NIHR portfolio.

Research active organisations have better health outcomes and NHS constitution (2009) asserts that the NHS will do all it can to ensure that patients from every part of England are made aware of research that is of particular relevance to them.

Risks and Implications

Insufficient allocated research time for Chief Investigators/Principal Investigators (CI/ PI) to undertake activity will impact on Kent, Surrey and Sussex Clinical Research Network (KSSCRN) designated patient recruitment target for ESHT.

Targets for recruitment numbers are not met, and also set up time and time to recruit to target. If so, KSSCRN funding will be reduced 2015/16, with risks to staff. Although funded externally, staff are employed by Trust and burden lies with the organisation.

Assurance Provided:

Research governance processes are assured.

R&D are committed to recruiting staff to budget to enable support for CI / PI activity and increase recruitment of patients to studies.

Review by other Committees/Groups (please state name and date)**:**
R&D Clinical Lead and Associate Medical Director - 20/5/14 Future reports to be reviewed by R&D Operational Working Group for agreement prior to submission.

Proposals and/or Recommendations
5 year R&D strategy in draft for agreement by R&D Steering Group which will then requires ratification and implementation by CME and Trust Board, assisted by R&D.

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

For further information or for any enquiries relating to this report please contact:	
Name: Liz Still. R&D Manager	**Contact details:** Liz.Still@esht.nhs.uk

East Sussex Healthcare NHS Trust

Research and Development Report

1. Introduction

1.1 The intention of this brief report is to update the Trust Board on developments within research and development (R&D) from November 2013 to April 2014. There are two recommendations which require consideration by Trust Board

2. Background

2.1 R&D also encompasses Orthopaedic Research unit (CQ), Sussex Cancer Research Network, Cardiology research dept (CQ and EDGH). It also comprises research nurses working individually within designated specialities. Historically this group have not had a base and have been line managed by various heads of nursing, clinical services manager and clinical consultants. R&D funded the posts, but did not manage them.

2.2 R&D governance office at EDGH was crowded and not fit for purpose.

2.3 Surrey and Sussex Comprehensive Local Research Network (SSCLRN) has ceased. This was replaced on 1st April 2014 by Kent Surrey and Sussex Clinical Research Network (KSS CRN) with a new structure and delivery mechanisms. The host organisation for the network is Royal Surrey County Hospital NHS Trust with hubs across the region.

2.4 KSS CRN funding has been granted to ESHT with a 5% shortfall related to previous year. The recruitment target for patients for 2014/15 is increased (Table 1). This is a stretch target and is related to a successful bid for contingency funding granted in November 2013 to develop the research team. The target was not met in 2013/14 due to maternity leave, sickness and vacant posts. Because funding is allocated year on year, initial contracts for research staff are for a 12 months fixed term and this is not an attractive option and recruitment remains problematic.

Table 1

	2013/14	2014/15
Recruitment Target	613	937
Recruitment -Actual	463	135 (to date)
Funding	535K	515K
NIHR Total Staffing	12.09 wte	13.2 wte

2.5 The KSS CRN will closely performance manage Trusts in relation to recruitment and allocation of funds. Monthly return required.

2.6 There are a total of 8.4 whole time equivalent (wte) research nurses (14 individuals) funded by KSS CRN. There are currently 72 research studies open to recruitment with approximately 20 in follow up. There are around 27 active Chief Investigator/Principal Investigators (CI/PI) involved in research within ESHT. R&D intend to use capacity building funds to increase staffing. There are currently 0.5 wte on mat leave, 2 wte on sick leave.

2.7 Portsmouth NHS Trust developed a 5 year plan which saw recruitment rise from around 900 participants in 2009 to 3,500 in 2014. The ESHT R&D manager has contacted the Portsmouth Trust and is drafting a strategy for submission to Board to reflect this success. (For info - Portsmouth has 1200 beds, National Institute for Health Research (NIHR) budget of £1.9 million and an R&D funded staffing of 67 individuals. On this basis it could be argued ESHT is achieving relatively well)

2.8 Southampton NHS Trust include R&D Supporting Professional Activities (SPA) time in the job plans of new consultants as this is identified as fundamental to the quality of patient care.

2.9 The NIHR recommends that Trusts insert a standing research reference in all Trust patient letters to inform patients that the Trust is research active.

2.10 Following an unfavourable internal audit inspection in Nov 2012, ESHT requested South Coast Audit (now known as tiaa) to undertake an appraisal of research governance processes. This was arranged for January 2014 to enable policy and processes to be reviewed and implemented as necessary.

3. Current Position

3.1 The R&D staffing reconfiguration business case was agreed. From April 2014 all KSS CRN funded posts are line managed within R&D (Appendix 1). This enables planning of workload and exploration of involvement into novel specialities for the Trust. This requires allocation of CI/PI designated research time if studies appropriate to our patients can be opened and successfully recruited. Consultant SPA time requires continued Trust support and allocation to enable CI /PI activity

3.2 The appointment of the Associate Medical Director for Academic, Educational & Research Development, together with the R&D Clinical Lead and R&D Manager, demonstrates commitment to the leadership required to increase research activity. Many Trusts have dedicated research directorships.

3.3 The Research and Development Department has moved to Polegate Ward. This comprises three offices which enable R&D research governance activity to be located next to a base for research nurses to hot desk and collaborate, as well as a patient interview / treatment room. This area has been named the Clinical Research Department, as it also takes advantage of its location near to the infusion suite at EDGH. R&D therefore is the overarching dept which encompasses the various locations.

3.4 R&D organised a Trust Scientific Meeting in April 2014 which was a success. This showcased the research, audit, service evaluation and case study activity undertaken within ESHT. There were over 50 posters presented and 6 candidates were selected for oral presentations. Speakers included Dr Simon Walton, Chairman, South East Coast – Brighton and Sussex NRES Committee, Professor Ann Moore, Professor of Physiotherapy, University of Brighton, and Heather Gillham, Chief Operating Officer of KSSCRN. The intention is to hold an annual meeting.

3.5 South East Audit (tiaa) completed their in depth inspection in March 2013 and were able to provide a significant assurance opinion. No major or unmanaged risks were identified.

3.6 R&D are approaching recruitment innovatively. Two recent clinical nurse specialist posts, where full time funding was not available, have been allocated research funding of 0.2 wte. This means that research activity can become part of the specialist role and widens the opportunities to enable patients to take part.

3.7 The Health Records Steering Group agreed in March 2013 that information to patients re research could be added to outpatient appointment letters, but inclusion within the text has proved problematic for the PAS user group. A potential solution is to place information within the footer of all Trust documents.

3.8 The R&D Steering Group meets quarterly and the R&D Operational Working Group meets monthly. The policies and Standard Operating Procedures (SOPs) ratified since November 2013 include the Standard Operating Procedure manual, Intellectual Property Policy. All are available on the Extranet. The SOP for archiving and delegated consent is in draft.

4. Conclusion/Recommendation

4.1 The 5 year R&D strategy is in draft utilising examples from Trusts which have increased research activity. This document will be submitted for discussion and approval by R&D Steering Group in June 2014. This will require agreement, ratification and supportive action by the Clinical Management Executive and the Trust Board if risks to recruitment and funding for 15/16 are to be reduced.

4.2 The Trust Board is asked to approve in principle the addition of the following information to the footer of all Trust correspondence:

‘This Trust supports research to improve patient care in the NHS. If you would like to find out more about research please ask your doctor or nurse’

4.3 The Trust Board is asked to support appropriate SPA time for research.

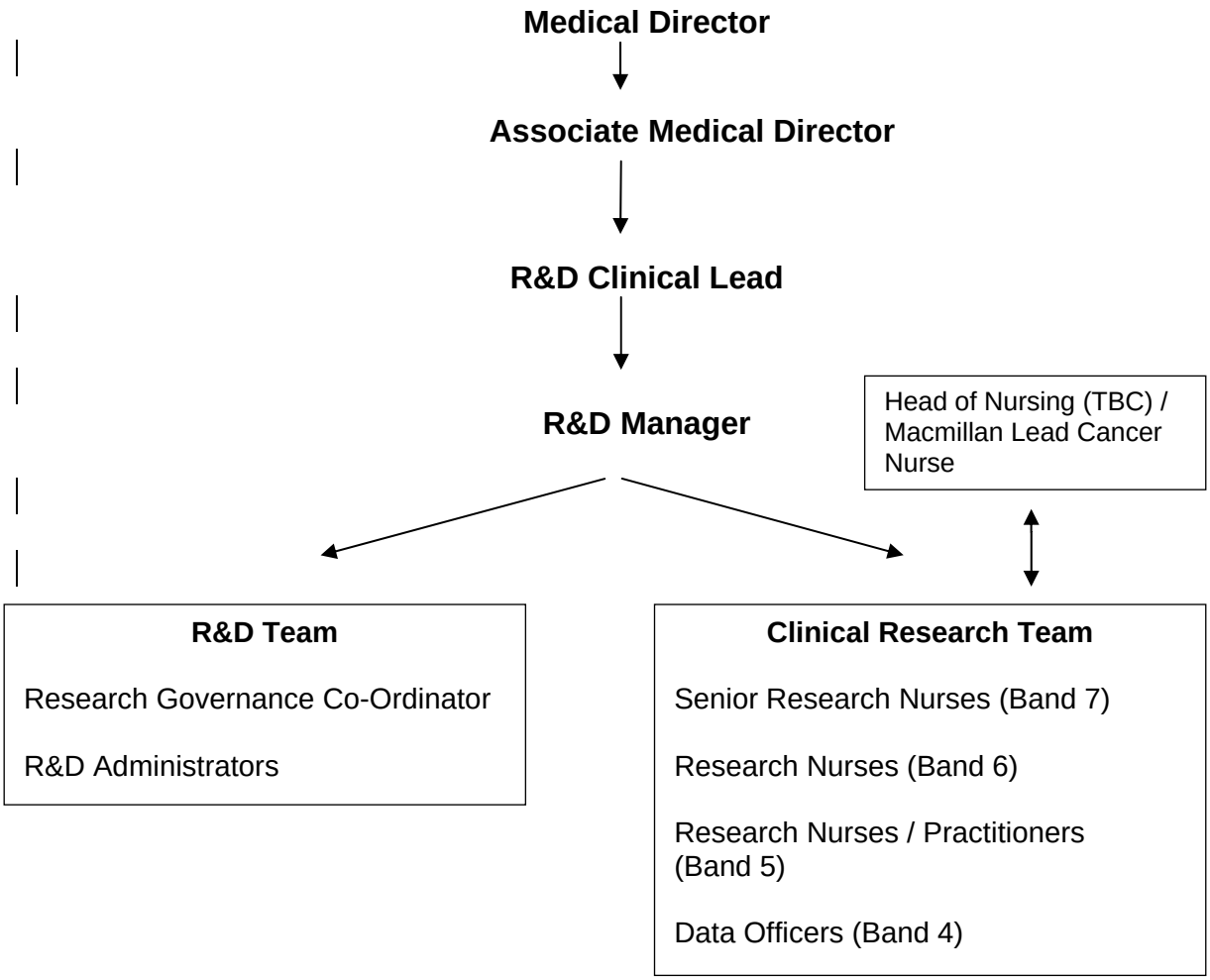
Liz Still
Research and Development Manager
(In agreement with Dr Walmsley, Associate Medical Director - Academic**, Educational & Research Development and Dr Panthakalam, R&D Clinical Lead)**

27th May 2014

Appendix 1

Revised staffing configuration

Research and Development Department is placed within Corporate Division (all in post)



References

NIHR 2013 We do Clinical Research: a guide to support materials that help Trusts promote clinical research in the NHS. http://www.crn.nihr.ac.uk/Resources/NIHR%20CRN%20CC/Documents/Guidance%20and%20process%20docs/We%20do%20clinical%20research%20-%20resource%20guide.pdf (accessed March 2013)

Portsmouth Hospitals NHS Trust (2009) Research Strategy. http://www.porthosp.nhs.uk/Research-Department/research-strategy.htm (accessed May 2014

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	12
Subject:	Response to the Better Beginnings Consultation
Reporting Officer:	Amanda Harrison, Director of Assurance and Strategic Development

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

Purpose:

The attached paper is the Trust's response to the Better Beginnings consultation which was submitted within the timelines set out in the Clinical Commissioning Groups consultation process

Introduction:

The East Sussex Health Overview and Scrutiny Committee (HOSC) agreed in January 2014 that the Clinical Commissioning Groups' (CCGs) proposals for the future delivery of NHS maternity, in-patient children's and emergency gynaecology services in East Sussex represented significant service change and that a full public consultation should take place.

The CCGs have developed their proposals for future service provision through a clinically led process. They considered the work undertaken across Sussex to develop a case for change for delivering improvements in Maternity and Paediatric services. The case for change was based on an analysis of existing services across Sussex against an agreed evidence based set of requirements for the provision of safe and sustainable services for maternity care and emergency and in-patient paediatric care that was developed through the "Sussex Together" programme in 2012.

The CCGs' proposals have also taken into account the evidence provided by Trust about the quality and safety of these services following the temporary reconfiguration of consultant obstetric and in patient paediatric services in May 2013.

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

The consultation document proposes six options and asks for responses to a number of questions. During the consultation period the Trust has supported the CCGs at a number of consultation events and has also participated in the HOSC's independent evidence gathering process.

The Trust proposed response to the consultation identifies the strengths and weakness of each of these options from the Trust's perspective and provides a synopsis of the evidence that supports this analysis. The evidence cited in the response has been provided either by the CCGs, the Trust or another body in the pre-consultation business case or during the consultation period

A number of other pieces of work are taking place or will be commenced in the future which, whilst not directly relevant to ESHT's recommendations or the decision making process of the CCGs, will have a bearing on the future provision of these services. These include:

- Work to develop plans for sustainable healthcare across East Sussex: delivered through the Better Together and Challenged Health Economy Programme
- Work to consider the optimal operating models of services including the short stay paediatric assessment unit
- Work to develop clinical pathways where patients are cared by a number of providers
- Consideration of future service models within the agreed configuration and procurement options for these

Benefits:
The consultation process has been robust and offers the opportunity to secure safe and sustainable services for the people of East Sussex. Once an decision is made by the CCGs on the future configuration of these services the Trust will be able to work with the CCGs to develop detailed service delivery models to secure ongoing sustainability for these services particularly in relation to financial sustainability

Risks and Implications
There is a risk that the CCGs select an option that requires significant capital investment and cannot be delivered within a reasonable timeframe. There is a risk that future sustainability cannot be secured within any of the options consulted on. There is also a risk that the future sustainability of these services and the Trust as a whole is impacted by decisions made on the future financing or provider model..

Assurance Provided:
The consultation provides the Trust with the ability to deliver a safe service and provides the basis for the development of a sustainable service in the future

Review by other Committees/Groups (please state name and date):
Trust Board Seminar 16th April 2014

Proposals and/or Recommendations
The Trust Board is asked to ratify the Trust's response to the consultation within the context set out in the paper.

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: Amanda Harrison, Director of Assurance and Strategic Development	**Contact details:** Amanda.harrison11@nhs.net

Please find enclosed the response made on behalf of the Board of East Sussex HealthCare Trust.

1. After reading the consultation document, to what extent do you understand **why** clinicians believe that maternity services in East Sussex have to change?

Fully understand ~~Mostly understand~~
~~Understand a little~~ ~~Do not understand at all~~

2. After reading the consultation document, to what extent do you understand **why** clinicians believe that in-patient paediatric services in East Sussex also have to change?

Fully understand ~~Mostly understand~~
~~Understand a little~~ ~~Do not understand at all~~

3. After reading the consultation document, to what extent do you understand **why** clinicians believe the emergency gynaecology services in East Sussex also have to change?

Fully understand ~~Mostly understand~~
~~Understand a little~~ ~~Do not understand at all~~

4. Six options have been identified that we believe would result in safe and sustainable services (see pages 24 to 35 of the consultation document). Which of these six options would you prefer? (Please only select ONE option)

~~Option 1~~ ~~Option 2~~ ~~Option 3~~ ~~Option 4~~ ~~Option 5~~ Option 6

5. What were the main factors that influenced your choice? (please choose ONE OR MORE factors)

The location of the consultant-led (obstetric) maternity unit
The location of the inpatient paediatric unit
The inclusion of an alongside midwife led unit
Better geographical spread of maternity services
Other – if other, please describe…

6. Have you attended a Better Beginnings consultation event and spoken to a clinician or NHS staff member about the proposals?

Yes ~~No~~

Board members, clinicians and other members of staff have supported and attended consultation events.

7. Anything else you would like to tell us?

The Trust Board, clinicians and members of staff have been extensively involved in the preparation and undertaking of the consultation process. We fully understand the case for change in respect of these services. I

In March 2013 the Board set out the reasons why the Trust needed to take rapid action to ensure that obstetric, gynaecology and paediatric services it delivered could be operated safely reducing the risk of future harm to the health and well being of the mothers, babies and children using the Trust's services.

The primary driver for this action was the need to ensure that the shape of these services supports the delivery of safer obstetric and neonatal services for every woman and baby whatever their risk or place of birth

The rationale for action was based on the risks to patient safety which were that:

- for some patients some of the time the safety and quality standards we would expect and require are not being met
- our dependency on mitigating actions means that the cumulative risk of service failure is at an unacceptable level
- the delivery of a safe service could become rapidly unsustainable leaving us little time to implement effective mitigating actions.

In the Board's view these risks were driven by five factors:

- the increase in the number and proportion of mothers whose pregnancies are considered higher risk and are more likely to need senior medical support (including increases in women with co-morbidities and obesity)
- medical and midwifery staff with the required competencies are not available 7 days a week 24 hours a day
- an ongoing dependency on temporary medical and midwifery staff
- the risk mitigations in place may fail at short notice resulting in the need to take unplanned action to ensure safety (including diverting mothers between sites)
- the availability of clinical leadership in a service that is delivered on multiple sites.

The background to that decision and the evidence that supported it have not changed in the intervening period. Since the temporary reconfiguration we have gathered extensive evidence that demonstrates not only that quality and safety of services has improved but also the impact the temporary changes. This evidence has been supplied to the CCGs and has been used to support the preparation for and undertaking of the public consultation. We will not repeat that information in this response.

We are fully in agreement that the options developed through the CCG process will deliver safe care for the population of East Sussex. We do not consider that there are any other viable options. In particular we have not seen any evidence produced during the consultation process or in the Health Overview and Scrutiny evidence gathering that has supported the continuation of a two site model for consultant led obstetrics or inpatient paediatric services.

We are aware that once the CCGs preferred option has been agreed further work will be required to develop detailed models of care that will be delivered within the agreed service configuration and that the future provider model will also require review. It will be this work that secures the sustainability of the future service.

The Trust Board have undertaken an analysis of the strengths and weaknesses of each of the options from the perspective of the Trust have highlighted the evidence that has supported this assessment and informed our preference for Option 6.

OPTION	STRENGTHS	WEAKNESSES	EVIDENCE
1.	Alongside midwifery led unit (AMU) enables small economies of scale sue to ability to flex staffing across AMU and consultant led services	Perceptions about the relative safety of an AMU compared to a stand alone midwifery led unit (SMU) may lead to the SMU being unable to attract sustainable levels of births. Poorer levels of access to maternity services than provided by other options meaning a significant centre of population has no birthing service other than home birth provision High levels of capital cost associated with provision on the Eastbourne site	Cost analysis of development requirements Evidence of sustainability of MLUs in East Kent and elsewhere Feedback on perceptions of relative service safety
2	Alongside midwifery led unit (AMU) enables small economies of scale sue to ability to flex staffing across AMU and consultant led services	Perceptions about the relative safety of an AMU compared to a stand alone midwifery led unit (SMU) may lead to the SMU being unable to attract sustainable levels of births. Poorer levels of access to maternity services than provided by other options meaning a significant centre of population has no birthing service other than home birth provision Investment required to deliver SMU on Conquest site	Cost analysis of development requirements Evidence of sustainability of MLUs in East Kent and elsewhere Feedback on perceptions of relative service safety
3	Alongside midwifery led unit (AMU) enables small economies of scale sue to ability to flex staffing across AMU and consultant led services	Perceptions about the relative safety of an AMU compared to a stand alone midwifery led unit (SMU) may lead to the SMU being unable to attract sustainable levels of births. Poorer levels of access to maternity services with no MLU provision in the north of the county High levels of capital cost associated with provision on the Eastbourne site	Cost analysis of development requirements Evidence of sustainability of MLUs in East Kent and elsewhere Feedback on perceptions of relative service safety

OPTION	STRENGTHS	WEAKNESSES	EVIDENCE
4	Alongside midwifery led unit (AMU) enables small economies of scale sue to ability to flex staffing across AMU and consultant led services	Perceptions about the relative safety of an AMU compared to a stand alone midwifery led unit (SMU) may lead to the SMU being unable to attract sustainable levels of births. Investment required to deliver SMU on Conquest site Poorer levels of access to maternity services with no MLU provision in the north of the county Investment required to deliver SMU on Conquest site	Cost analysis of development requirements Evidence of sustainability of MLUs in East Kent and elsewhere Feedback on perceptions of relative service safety
5	Highest level of access with services maintained in all current location Temporary reconfiguration has provided evidence of improved safety within this model and this can be extrapolated to this option	High levels of capital cost associated with provision on the Eastbourne site	Cost analysis of development requirements Service quality and safety information
6	Highest level of access with services maintained in all current location Temporary reconfiguration has provided evidence of improved safety with this option Service already in place and small requirement for capital investment will mean delivery timelines will be shortened Trust will have capacity to work with CCGs to deliver detailed service models within already established configuration		Cost analysis of development requirements Service quality and safety information

East Sussex Healthcare NHS Trust

Date of Meeting:	3 June 2014
Meeting:	Trust Board
Agenda item:	13
Subject:	Annual Business Plan 2014-15
Reporting Officer:	Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

This papers sets out the key elements of the Annual Business Plan (ABP) for 2014/15 with information on the supporting documents and processes to assure its delivery. It includes the Trust's approach to planning for 2015/16.

Introduction:

The ABP has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery. To facilitate and support the delivery of the ABP objectives, the following have been developed:

- Performance Management and Accountability Framework
- A process for monitoring the impact of service changes on quality
- Programme Management arrangements.

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

The Trust is working with stakeholders of the local Challenged Health Economy and the outputs from that work are expected in June 2014.

Existing priorities include the implementation of Phase 2 of the clinical strategy including the development of the model of care for frail elderly people; the further review of specialties and subspecialties including Maxillofacial surgery, Breast Surgery and ENT.

Key areas of the cost improvement plans which have been assessed for the impact on quality include:

- Implementation of a new medical model
- Improvement in theatre productivity and utilisation
- Implementation of the agreed reconfiguration of emergency and high risk orthopaedic services
- Changes to hospital at night arrangements at Eastbourne District General Hospital.

Key financial risks include:

- Fines and penalties exceeding planned levels
- Commissioners' QIPP plans being more successful than assumed by the Trust

- Failure to absorb increases in demographic growth activity through assumed improvements in productivity
- Additional unplanned cost pressures including premium cost delivery
- CQUIN targets not being achieved.

The key areas for quality improvement have been identified as:

- To maximise our efforts to reduce healthcare associated infections
- Early recognition and action to support the care of the deteriorating patient
- Continue to implement our patient experience strategy
- Ensure that we provide optimal care for patients who have mental health disorders

Benefits:
There is clarity about the organisational priorities and targets for 2014/15 and the risks attached.

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

Assurance Provided:
The ABP has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery.

Review by other Committees/Groups (please state name and date)**:**
Trust Board Seminar 12.03.14 Business Planning Steering Group 22.04.14, 29.04.14 and 13.05.14

Proposals and/or Recommendations
The Board is asked to review the Annual Business Plan and approve the actions highlighted therein. A quarterly report will be supplied to the Board on progress on the Annual Business Plan.

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

For further information or for any enquiries relating to this report please contact:	
Name: Jane Rennie, Associate Director – Business Planning	**Contact details:** Janerennie1@nhs.net

East Sussex Healthcare NHS Trust

Annual Business Plan 2014/15

1. Introduction

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

1.2 The Trust needs to ensure that the work programme is in place to secure the delivery of that plan from April 2014 and that progress on the plan is reported to the Board in a timely manner. This document sets out the key objectives of the ABP along with information about how the delivery of the plan will be managed, monitored and reported.

2. Background

2.1 East Sussex Healthcare Trust (ESHT) is currently three years into a five year improvement journey to improved clinical sustainability and financial viability. In close collaboration with key stakeholders in East Sussex the Trust agreed the strategic framework for its Clinical Strategy: Shaping our Future in 2011 against the strategic objectives the Board have agreed for the organisation

2.2 Based on this framework the first phase of the clinical strategy developed the business model for the Trust by defining the change required to eight key services in order that they were able to deliver the Trust's aims and objectives. These eight services that comprise about 80% of the business of the Trust are:

- Acute Medicine
- Orthopaedics
- Cardiology
- Emergency care
- Maternity
- Stroke
- Paediatrics and child health
- General Surgery

2.3 The conclusions reached about the future configuration and design of the above eight services has defined the business model for the Trust as the provision of integrated community and acute care with 'one hospital on two sites'. Delivering this business model currently requires redesigned emergency care, acute medicine and cardiology to be provided on both acute sites with the other five services provided differentially on each site. The model also required integration with a range of community services which include those being developed to improve the management of patients with long term conditions and complex co-morbidities in community rather than acute settings.

2.4 In order to implement the strategy and business model acute and hyper acute stroke services were centralised on the Eastbourne site in July 2013; emergency and high risk surgery services were centralised on the Hastings site in December 2013 and the centralisation of emergency and high risk orthopaedics at Hastings took place in May 2014.

Consultant led Maternity services and in-patient paediatric services were temporarily centralised on the Hastings site in May 2013 on the grounds of safety. A decision on the long term configuration of these services will be made by the three local Clinical Commissioning Groups (CCGs) in the summer of 2014 following a formal public consultation which concluded in April 2014. The options consulted on do not include the provision of consultant led maternity and inpatient paediatric services on both acute sites.

2.5 The full business case in support of the capital investment required to realise the full benefits of the clinical strategy has been developed and approved by the Trust Board and is currently awaiting consideration by the Trust Development Authority (TDA). In addition to the centralisation of services for stroke; emergency and high risk surgery and trauma and orthopaedics, the business case describes the redesigned and improved care pathways being implemented in acute medicine, emergency care and cardiac care and the infrastructure investment necessary to support this redesign. It details the improvements that will be made in patient flow and length of stay as well as the reductions that will be made in inappropriate admissions. The focus is on delivering quality improvements including increased senior decision making, improved discharge planning and infrastructure and fabric upgrades that will improve infection control. Following the decision on the future configuration of maternity, paediatric and gynaecology services an analysis of the capital consequences of each of the options will inform the CCGs' decision making process.

3. Strategic Objectives

3.1 In 2013/14 the Trust Board confirmed its mission and revised and simplified its strategic objectives as follows:

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

Strategic Objectives

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

Aims
In delivering its strategic objectives the Board has stated that its aim is that all services delivered by the Trust are:

- Safe
- Effective
- Caring
- Responsive and
- Well led.

4. Plans for 2014/15 and 2015/16

4.1 The Trust has been identified as one of eleven Challenged Health Economies meaning that there are significant risks to the overall financial sustainability of providers and commissioners in the local health economy. The TDA, NHS England and Monitor have commissioned a programme of support for these economies which aims to produce evidence based proposals for delivering sustainability. This work is currently underway and the outcomes of it will be the first stage of defining the approach to securing future sustainability. The Trust will need to reflect these outcomes in its future plans and ensure that there is alignment with these outcomes and the future business model for the Trust.

4.2 Whilst the above work is underway the Trust's ABP for 2014/15 is based on the extant Clinical Strategy which identifies the following broad clinical priorities for the planning period up until 2018/19

- The ongoing development and implementation of a model of care for the management of frail adults across the Trust and more widely including:
- Agreeing pathways for adult acute care which embed the model of care for frail people and support our local demography
- Redesigning community services to realise the benefits of integrated provision and to ensure the prevention of inappropriate admissions and to facilitate timely discharge
- Developing delivery models for clinical support services including ITU, diagnostics and pathology in order to ensure alignment with optimal service configuration and that maximum efficiency and value is derived from their operation.
- Reviewing medical and surgical specialties and subspecialties against efficiency and sustainability criteria (operational, clinical and financial) to identify priorities for transformation and opportunities for differentiation followed by a review of the models of care and delivery options for the clinical services identified.

4.3 The ABP contains plans for cost improvement, quality improvement, delivery of the clinical and operational capacity required to meet key access targets and the enabling corporate workstreams that will support these plans. Further details are given in the following sections.

5. Cost Improvement

5.1 In the light of the above priorities and in order to address the continuing financial challenges in East Sussex health economy the clinical units and corporate departments have developed ambitious cost improvement plans (CIPs) for 2014/15 including:

- Implementation of a new medical model which will result in reduced lengths of stay
- Improvement in theatre productivity leading to increased efficiency
- Implementation of the agreed reconfiguration of emergency and high risk orthopaedic services
- Improved arrangements for Hospital at Night at Eastbourne District General Hospital.

6. Quality Improvement

6.1 The Trust agreed the following quality priorities through a series of stakeholder engagement events across East Sussex. These priorities have informed the development of the Trust's Quality Account. Progress against the quality account measures is reported to the Board on a quarterly basis.

- Maximise our efforts to reduce healthcare associated infections
- Early recognition and action to support the care of the deteriorating patient
- Continue to implement our patient experience strategy
- Ensure that we provide optimal care for patients who have mental health disorders.

6.2 Further quality improvements have been identified by considering any risks to compliance with statutory and regulatory standards and to the delivery of the key recommendations as set out following the Keogh Review, Francis Report, Berwick review, Cavendish review and Clywd-Hart review and in guidance from the National Quality Board.

6.3 The quality improvement elements of the ABP are aligned to the Trust's aims for service provision and the five CQC domains of quality. A detailed Quality Improvement Plan will be developed to ensure that implementation of these aspects of the ABP are fully co-ordinated.

7. Quality Impact Assessments (QIAs)

7.1 A robust process in now in place to assess the impact of all CIPs on the quality and safety of services**.** The quality impact assessment assesses quality risks in relation to the following three quality and safety domains:

- Patient safety
- Clinical effectiveness
- Patient experience.

7.2 The assessments are undertaken by a panel comprising the Medical Directors and the Director of Nursing and recommendations are made to the Business Planning Steering Group who make the final decision to approve or reject plans. A record is kept of these decisions for audit and assurance purposes. As plans are implemented the panel is responsible for monitoring the outcome and alerting the business planning steering group about any reduction in quality or safety.

7.3 In developing the ABP and CIP all clinical units have undertaken these in line with the process outlined in detail at Appendix One of this paper.

8. Delivery of operational performance standards

8.1 Delivery of operational performance standards in 2014/15 will be based on the need to make identified improvements in efficiency and the ongoing development and implementation of the Clinical Strategy. The Trust has clear processes in place to identify areas of underperformance and risks to future achievements and these have informed the development of 2014/15 and 2015/16 plans. Plans have also been informed by reviews of best practice evidence and the evidence on optimum models of care. The Trust has been working with the Intensive Support teams for acute medicine and planned care to identify areas where workflow and processes can be improved to drive efficiency and deliver more effective and efficient outcomes for patients.

8.2 In October 2013 the Trust commenced a turnaround programme, as part of this programme of work a bed management review has been completed and actions that will reduce length of stay and delayed discharges have been identified and incorporated into 2014/15 and 12015/16 plans. Surgical specialities have been required to plan for improving the use of theatres through more effective and targeted list management, booking and preoperative assessment to reduce cancellations and Did Not Attends (DNAs). Staff working patterns have also been reviewed and rationalised to ensure they are matched to demand.

8.3 Seven day working is being introduced in support services including therapies to improve throughput and the patient experience by reducing length of stay in hospital and a new medical model is being introduced to provide senior expertise at the front door of the hospital seven days a week.

8.4 A review of the utilisation of outpatient services is being undertaken to reduce DNAs and future care pathways will be based on a review of outpatient services and diagnostics that has identified improvements that can be delivered by applying lean methodology. A demand and capacity plan has been drawn up which will reduce the need for ad hoc clinics and outsourcing to third party suppliers.

9. Key risks

9.1 As part of the multidisciplinary review of the ABP a risk assessment of the deliverability of all elements of the plan has been undertaken. The key risks to deliverability and quality have been identified and fed into the financial analysis of the plan. The key risks identified include:

- An adverse impact on quality arising from the implementation of elements of the plan
- Non delivery of key operational requirements and NHS Constitution commitments
- Delays in the implementation of the new medical model
- Inability to define or deliver clinically and financially sustainable models of care that improve day case rates and ensure clinical standards, training and development requirements are met.for those acute surgical specialties and sub-specialties not already considered through the development of the Clinical Strategy.
- Ability to deliver changes to provision of minor injury services
- Delays in the delivery of theatre efficiency
- Adverse impact of a revised contract for community services
- Delays in the delivery of hospital at night at Eastbourne DGH
- Fines and penalties exceeding planned levels
- Impact of activity reductions beyond those assumed in plans
- Failure to absorb increases in activity through assumed improvements in productivity
- Additional unplanned cost pressures including premium cost delivery
- CQUIN targets not being achieved.

10. Supporting Plans

10.1 The above quality, cost and operational improvement plans are supported by a number of aligned plans that ensure the organisation is able to deliver key improvements. These include:

10.2 Workforce Plans

Workforce planning and service redesign for ESHT in 2014 - 2016 and beyond is aligned with the implementation of the clinical strategy and the savings plan. The reductions in total workforce numbers that are the consequence of improved efficiencies will be achieved through skill mix reviews and increased productivity through continuous improvement in job planning and rota reviews.

10.3 Specific areas of workforce focus during 2014 – 2016 include:

Clinical Services:

- Ensuring recruitment to all vacant posts
- Investment in nursing posts in areas of need – approximately an additional 40 wtes
- Improved roster management
- Enhanced role for support workers
- Full review of medical staffing requirements – review of job plans and proposed moves to team based job plans.

Productivity:

- Full review of clinical administrative support
- Reduction in Theatre lists resulting in two theatre closures
- Proposed closure of two medical wards
- 7 day working for support services including therapies in key areas described previously.

Back Office and Commercial:

- Potential market testing of some services (eg. Occupational Health, Facilities Management)
- Efficiencies in management and staffing costs
- Skill Mixing.

10.4 **Financial and Investment Plan**

The Trust has submitted a two-year plan that shows deficits of £18.5 million for 2014/15 and £14.0 million for 2015/16. The contract with CCGs for 204/15 is a standard contract which recognises the heavy burden of risk on provider and commissioner alike within the challenged local health economy and the importance of a collaborative approach. The contract value includes all contract elements except for tariff-excluded drugs and devices, which will continue on a 'pass-through' basis. The specialist contract with NHSE is also a standard contract and includes investment for areas such as Health Visiting.

10.5 The Trust faces a number of financial pressures in 2014/15. These include:-

- Loss of income through QIPP plans (£4.0 million assumed)
- Loss of Health and Wellbeing income stream (net £0.5 million assumed)
- CNST increase (£0.7 million in 2014/15).

10.6 Expenditure budgets have been set following detailed, zero-based reviews with each clinical unit. To meet the various financial pressures and achieve the planned deficits the Trust has set itself cost improvement targets of £20.4m (5.2 per cent of baseline expenditure) in 2014/15 and £20.0m (5.2 per cent) in 2015/16. These values are net of cost pressures. A contingency of 1 per cent of turnover has been set aside in both years. The Trust will require additional PDC funding to cover the cash shortfalls arising from its deficit plans. Further applications will be made to the Independent Trust Financing Facility via the TDA in due course.

10.7 The Trust's capital plans include investment to support delivery of the clinical strategy at £17.4 million in 2014/15 and £11.6 million in 2015/16. In addition, the Trust is planning significant investment in the following areas:-

- Medical equipment - £2.6m in 2014/15 including new MRI
- New IT Systems and Infrastructure - £1.7m in 2014/15
- Backlog maintenance and other infrastructure improvements - £2.6m in 2014/15
- Ward redevelopment – £1.7m (net of charitable contribution) over the two years.

11. Annual Business Plan Objectives for 2014/15

11.1 The objectives have been written taking account of the following:

- The Trust's strategic objectives
- Feedback from the Trust Development Authority about the elements they expect to see in the 2014/15 Business Plan
- Key actions arising from the Cost Improvement Programme
- Completion of 2013/14 objectives.

11.2 A process is in place which will identify key milestones and deliverables as well as assigning leadership roles. This will enable the Board to be provided with a quarterly progress report.

11.3 The objectives are shown at Appendix Two.

12. Performance Management

12.1 A performance management framework has been developed to ensure that all individuals and teams within the Trust have clear accountabilities for the management of all aspects of organisational performance so that the Trust can achieve its strategic objectives to:

12.2 The purpose of the Performance Management Framework is to support the delivery of the Board's plans by ensuring alignment between the four domains of operational performance (clinical and non-clinical), activity, finance and quality to enable the Board and the Trust's clinical and non-clinical management and staff to:

- Assess current performance and performance trajectories against organisational targets and goals
- Determine what action is necessary to address performance issues and manage performance risks
- Develop and implement plans to secure the required performance
- Focus resource and attention in the required areas to maintain and where necessary improve performance.

12.3 The full framework is at Appendix Three.

13. Programme Management

13.1 Through the Programme Management Office reporting mechanisms will be in place for all key programmes which support the delivery of the Annual Business Plan. Each programme of work will have a risk and issues log which identifies mitigation.

13.2 Quarterly progress reports will be made to the Board on the Annual Business Plan which will highlight key risks.

14. Risk Management

14.1 Risk management is embedded within the Trust's processes. The Board Assurance Framework describes the key risks to delivery of the corporate objectives and outlines relevant controls and assurances, together with any further actions required to mitigate the risks. The Board Assurance Framework will be updated in the context of 2014-15 corporate objectives for Trust Board approval.

15. Planning for 2015/16

15.1 An evaluation of the 2014/15 process for developing the Trust Cost Improvement Programme has been undertaken in May 2014. The lessons learned have been used to inform the Integrated Annual Business Planning process for next year. Appendix Four sets out the programme of work required in the coming months to develop an integrated plan which will build on the work undertaken this year.

Appendix One

Quality Impact Assessment Guidance

1. Introduction:

1.1 The National Quality Board has produced a useful and informative document that outlines how Cost Improvement Plans (CIPs) should be assessed for their potential impact on quality. The key points they make are

- The majority of CIPs should be on changes to existing processes, rather than top slicing current budgets
- Where possible CIPs should have a neutral or positive impact on quality
- CIPS should not bring quality below essential common standards
- CIPs should be categorised by their potential impact on quality
- Quality Impact Assessments (QIA) should cover safety, clinical outcomes and patient experience
- Board Assurance is required that CIPs have been assessed for quality
- Must be a mechanism for capturing front line staff concerns
- CIPs should be subject to an on-going assessment of their impact on quality.

2. QIA Process

2.1 When any CIP skill mix review, service change or service development is being considered, a QIA must be carried out. Undertaking a QIA will be an integral part of the planning process. Further QIAs may be undertaken as the proposal or plan proceeds to implementation and delivery.

2.2 The quality impact assessment assesses quality risks in relation to the following three quality and safety domains:

- Patient safety
- Clinical effectiveness
- Patient experience.

2.3 Where there is a question about whether a proposal or plan requires a quality impact assessment the Clinical Unit (CU) should consult the Executive Lead and Business Development Team. A recommendation that a QIA is not required must be presented for agreement to the Trust's Business Planning Steering Group (BPSG) by the appropriate Executive lead.

2.4 The CU will complete the QIA and provide the relevant information to support the assessment. A standard template and guidance has been developed for undertaking a QIA against the three quality domains. The approach is based on Monitor and the National Quality Board guidance. The QIA will identify the key benefits for service users, the quality risks, any mitigating actions required to address these risks and the indicators that will enable the quality impact to be monitored and assessed.

2.5 The QIA completed by the CU will be reviewed by the QIA Panel in line with its Terms of Reference . The panel will ensure that all relevant information is provided and that the QIA is robust and evidence based. The panel will also assess the strength of any mitigations to quality risks that have been identified. It will make recommendations to the BPSG on whether or not a proposal should proceed on the basis of the QIA.

2.6 The outcome of an initial QIA will inform the decision on whether or not to proceed with a proposal based on the strength of any actions proposed to address quality risks. The CU will need to incorporate these actions into the implementation and delivery plan for the proposal. Ongoing QIAs may form part of the monitoring and assessment of the implementation and delivery plans and to identify any unintended consequences following implementation; this will support identifying and sharing learning. An adverse QIA has the potential to result in a rejection of a proposal or to delay or stop delivery if suitable remedial actions cannot be identified and taken.

2.7 Proposals and plans cannot proceed until the BPSG has approved the QIA and any actions arising from it are incorporated into the implementation and delivery plan.

2.8 Reporting on all QIAs and their outcomes, the actions taken to address quality risks and the decisions made on whether or not to proceed with a proposal or plan will be to the Clinical Management Executive (CME) through the BPSG and to the Trust Board through the Quality and Standards Committee. Reporting will be integrated into reporting on progress against the development and delivery of the Trust's Annual Business Plan (ABP).

3. Roles and Responsibilities

3.1 The Trust Board has corporate responsibility for ensuring that the organisation develops appropriate plans for the delivery of its strategic objectives and that the implementation and delivery of these plans are not detrimental to the quality of services.

3.2 The Board gains assurance on the quality and safety of the service that the Trust operates through its Quality and Standards Committee. The Committee receives reports on a number of quality metrics and on progress with the implementation of the ABP. It will triangulate quality outcomes with progress against the delivery of the plan ensuring that there is no detrimental impact on quality arising from the implementation of the plan. Where significant risks to quality have been identified by a QIA the Committee will monitor the specific quality indicators related to those risks.

3.3 The Medical Directors, the Chief Operating Officer and the Director of Nursing form the QIA Panel and are responsible for scrutinising individual QIAs. The QIA panel will meet with the CUs in order to review and assess the QIAs. The Panel will:

- Ensure that this guidance is used consistently across the organisation
- Ensure that the evidence provided to support the QIA process is robust
- Ensure that the potential or actual quality risks are identified and understood
- Assess the deliverability and effectiveness of any proposed mitigations put in place to address the quality risks
- Make recommendations on whether the proposal or plan should proceed to the BPSG
- Make recommendations for any ongoing monitoring or review process.

3.4 The BPSG has oversight of the development and delivery of the ABP. It will:

- Consider the recommendations of the QIA Panel
- Decide whether a proposal should be rejected or the implementation of a plan should be delayed or stopped on the basis of the quality risk and robustness and deliverability of any proposed mitigations
- Report to the CME on any risks or issues arising from its decisions
- Escalate to the Board any risks to the delivery of the ABP resulting from its decisions.

3.5 CUs are responsible for ensuring that QIAs are completed in line with this guidance and ensuring that they are presented to the QIA Panel. They are also responsible for ensuring that any actions required to mitigate quality risks are incorporated into the proposals and/or subsequent implementation and delivery plans. They will be required to report on progress with delivering mitigating actions as part of the overall requirement to report on the delivery of the ABP.

3.6 Where necessary the CU lead will also be responsible for developing alternate proposals/plans to ensure the delivery of the ABP where the original proposal/plan is not agreed on the basis of the QIA.

Quality Impact Assessment Group

Terms of Reference

1. Purpose

The Quality Impact Assessment (QIA) Group has the responsibility for assessing how proposed cost improvement programmes (CIP) and service transformations plans affect the quality of services in the Trust in terms of patient safety, patient experience and clinical effectiveness. The Group has the responsibility for making recommendations to the Trust's Business Planning Steering Group (BPSG) and where appropriate to the Trust Board for approving or rejecting schemes where quality is adversely affected; and for recording those decisions so that the Trust Board has assurance that the QIA process is in place and functions appropriately.

2. Duties

- Ensure that the QIA guidance is used consistently across the organisation
- Ensure that the evidence provided to support the QIA process is robust
- Ensure that the potential or actual quality risks are identified and understood
- Assess the deliverability and effectiveness of any proposed mitigations put in place to address the quality risks
- Make recommendations on whether the proposal or plan should proceed to the BPSG
- Monitor and review CIPs to ensure that quality is not affected in the longer term
- Maintain appropriate records.

3. Membership

Membership of the Group will comprise:

- Director of Nursing or a deputy
- Medical Directors Governance and Strategy
- Chief Operating Officer/Deputy Chief Executive

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

4. Chair

All meetings of the Group will be chaired by the Director of Nursing or in her absence by either of the Medical Directors.

5. Secretary

The Programme Management Office will support the Group having responsibility for:-

- Drafting and agreeing the agenda with the Chair
- Receiving and finalising papers for distribution
- Preparing a note of actions arising from, and decisions taken at, each meeting
- Ensuring that appropriate records are kept of decisions.

6. Quorum

Meetings will not be quorate unless there is at least one nursing and one medical representative present.

7. Frequency of meetings

Unless otherwise agreed the group shall meet weekly during the Annual Business Planning process and monthly at other times of the year.

8. Notice of meetings

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

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

9. Conduct of meetings

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

10. Notes of meetings

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

11. Reporting

The Quality Impact Assessment Group is accountable to the Business Planning Group. Notes of the meetings will be made available to the Clinical Management Executive and when required to the Quality and Standards Committee and the Trust Board.

12. Review of Terms of Reference

The terms of reference will be reviewed annually or as required by the Group

Appendix Two

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)
Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority	Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards	Completion of the Quality Governance Assessment Framework	DIRECTOR OF STRATEGIC DEVELOPMENT
		Refresh of the Board Governance Assessment Framework	DIRECTOR OF STRATEGIC DEVELOPMENT
		Development and implementation of a Knowledge Management Strategy	DIRECTOR OF STRATEGIC DEVELOPMENT
		Publication of clinical quality measures and survival rates in line with national guidance	MEDICAL DIRECTOR GOVERNANCE
		Undertake Quality Impact Assessments for all programmes of service change	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE
		Institute a process to allow staffing at ward level to be monitored in line with national requirements	DIRECTOR OF NURSING
		Respond to national plans for the revalidation of nursing staff	DIRECTOR OF NURSING
		Further strengthen Clinical Audit reporting to the Board and its Committees	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE
	Ensure the organisation takes action to improve quality and outcomes for patients	Implementation of mortality screening tool and review of all deaths	MEDICAL DIRECTOR GOVERNANCE
		Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans	DIRECTIOR OF NURSING MEDICAL DIRECTOR GOVERNANCE DIRECTOR OF FINANCE CHIEF OPERATING OFFICER

		Review and redesign of key specialties and subspecialties	CHIEF OPERATING OFFICER DIRECTOR OF STRATEGIC DEVELOPMENT
		Monitor and review the outcomes of service reconfiguration	CHIEF OPERATING OFFICER MEDICAL DIRECTOR STRATEGY
		Implementation of Vitalpac	DIRECTOR OF NURSING MEDICAL DIRECTOR GOVERNANCE

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)
Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to	Implementation of a tender review and response process	DIRECTOR OF STRATEGIC DEVELOPMENT
		Development and implementation of a marketing and engagement strategy	DIRECTOR OF STRATEGIC DEVELOPMENT
	Ensure active participation in joint programmes of work to improve clinical service design and delivery	Engage in the further development of the commissioner led Better Together programme	DIRECTOR OF STRATEGIC DEVELOPMENT
		Engage in the further development of the Trust Development Agency/NHS England led Challenged Health Economy programme	DIRECTOR OF STRATEGIC DEVELOPMENT
		Engage in the programme of work to support the re-design of community services	MEDICAL DIRECTOR STRATEGY CHIEF OPERATING OFFICER DIRECTOR OF STRATEGIC DEVELOPMENT
		Establish the Clinical Leadership Forum as a key vehicle for clinical engagement within the Trust and ensure its members are able to engage in external clinical fora as appropriate	MEDICAL DIRECTOR STRATEGY

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)
Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability	Development of an IBP and LTFM based on the outcome of the Better Together and Challenged Health Economy programmes	DIRECTOR OF FINANCE DIRECTOR OF STRATEGIC DEVELOPMENT
	Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme	Act to reduce spend on medical agency	MEDICAL DIRECTOR GOVERNANCE
		Improve efficiencies in clinical administration	CHIEF OPERATING OFFICER
		Improve theatre utilisation and productivity	CHIEF OPERATING OFFICER
		Implementation of a revised Hospital at Night provision at EDGH	CHIEF OPERATING OFFICER
		Development and implementation of a revised medical model across the Trust	CHIEF OPERATING OFFICER MEDICAL DIRECTOR STRATEGY
		Delivery of the clinical correspondence programme	CHIEF OPERATING OFFICER
	Implement plans for the delivery of key operational requirements	RTT compliance plan	CHIEF OPERATING OFFICER
		Diagnostic waits compliance plan	CHIEF OPERATING OFFICER
		Ambulance handover improvement plan	CHIEF OPERATING OFFICER
		Cancelled operations improvement plan	CHIEF OPERATING OFFICER

STRATEGIC OBJECTIVE	ANNUAL BUSINESS PLAN OBJECTIVE	KEY PLANS	LEAD(S)
Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust	Development of an estates strategy that supports the Trust's agreed clinical services model	CHIEF OPERATING OFFICER
		Development of a Sustainability Management plan	CHIEF OPERATING OFFICER
		Development of an IT strategy and delivery plan	DIRECTOR OF FINANCE
		Review and further development of the Major Incident and Business Continuity Plans	CHIEF OPERATING OFFICER
		Review and revision of the Workforce Plan and Trust wide workforce risk register	DIRECTOR OF HUMAN RESOURCES
		Conclude the implementation of the Health Rostering programme	DIRECTOR OF HUMAN RESOURCES
		Embed programme management processes in support of delivery of the ABP	DIRECTOR OF STRATEGIC DEVELOPMENT
		Embed the Performance Management Framework in the operational management of the Trust	CHIEF OPERATING OFFICER
		Develop and implement a Procurement Strategy	DIRECTOR OF FINANCE
		Implement key IM&T programmes including PAS upgrade, NHS mail, SystmOne	DIRECTOR OF FINANCE
		Development and implementation of an Innovation Strategy	MEDICAL DIRECTOR GOVERNANCE

Appendix Three

East Sussex Healthcare NHS Trust

Performance Management and Accountability Framework 2014/2015

1. Introduction

1.1 East Sussex Healthcare NHS Trust (ESHT) recognises the importance of developing and implementing a clear and robust performance management and accountability framework which underpins the overarching objectives and principles of the organisation in delivering high quality services and working towards the requirements to become a Foundation Trust.

1.2 The Framework has been developed to ensure that ESHT successfully delivers national standards for quality, performance, finance, patient experience and workforce as outlined in the NHS Operating Framework and the Trust Development Authority (TDA) Accountability Framework and local contractual requirements. It takes into account the recommendations of the Francis Report and the Keogh Report. Along with other local and national quality requirements

1.3 This paper therefore describes:

- The overarching performance and accountability framework in detail including its key components
- The environment, aims and intentions of the framework
- The accountabilities and responsibilities for executing the framework
- The process, enables and outcomes to ensure delivery
- The consequences of underperformance and the associated recovery actions

1.4 It sets out the performance environment we aim to create and describes the framework and approach we have put in place to support achieving the objectives of the organisation.

2. Aim and Purpose of the Performance Management and Accountability Framework

2.1 The aim of the framework is to ensure that all individuals and teams within the Trust have clear accountabilities for the management of all aspects of organisational performance so that the Trust can achieve its strategic objectives to:

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

2.2 The purpose of the Performance Management Framework is to support the delivery of the Board's plans by ensuring alignment between the four domains of operational performance (clinical and non clinical), activity, finance and quality to enable the Board and the Trust's clinical and non clinical management and staff to:

- Assess current performance and performance trajectories against organisational targets and goals
- Determine what action is necessary to address performance issues and manage performance risks

- Develop and implement plans to secure the required performance
- Focus resource and attention in the required areas to maintain and where necessary improve performance

3. Principles of Performance Management

3.1 The following principles underpin the Trust's Performance Management Framework:

- **Quality focused.** Performance management will focus on all aspects of quality and will ensure that the Trust is able to evidence, maintain and improve the delivery of quality services across all its functions. This will require fully integrated performance management bringing together quality, operational and financial performance. Quality Impact Assessments are an integral part of the Trust's approach to quality and will be undertaken for all programmes and projects during their development and implementation.

- **Creating a performance culture:** These arrangements are intended to support the development of a culture of continuous performance and improvement, delivered for the benefit of patients. This will be supported by clear objectives for all individuals at all levels which drive a culture of high performance and accountability. The performance culture is supported by the Trust's performance management arrangements including the Performance Development Review (PDR) process for individuals. The Performance Management and Accountability Framework should be used as a driver for cultural change across the organisation.

- **Transparency**: The measures and evidence used to assess performance will be clear. All Trust staff in Clinical Units and corporate teams will understand what is required; know how their performance is being assessed and what to expect if performance falls below expected levels. Performance will be reported in a clear and transparent way at all levels of the organisation from Board to ward and beyond.

- **Alignment**. Internal performance management arrangements and the data used to support these will be aligned to the arrangements in place for external performance management and regulatory monitoring wherever possible. This will include the use of common metrics and assessments where these are available

- **Delivery focus**: The performance management approach will be integrated, action oriented and focussed on delivering optimal performance.

- **Proportionality and balance**: Performance management arrangements will seek to ensure that performance management interventions and actions are proportional to the scale of the performance issue or risk and that a balance between challenge and support is maintained.

- **A single conversation**. In recognition of the interconnectedness of all aspects of performance the principle will be to have performance management arrangements that encompass quality, operational and financial performance.

- **Clear lines of accountability**: Performance management arrangements will ensure that all parties are clear where lines of accountability lie.

- **Earned autonomy**: achievement of performance requirements will earn greater levels of autonomy with greater levels of performance management. Intervention will be focused on areas of sub-optimal performance and on risks to future performance.

4. Performance measurement and metrics

4.1 The Annual Business Plan (ABP) will be developed in light of the performance and regulatory requirements set for the organisation by the Board. The Board will ensure that these requirements reflect the national and local context in which the organisation is operating. The ABP will include the targets and outcomes that the Board expect to be delivered through the delivery of the plan and will describe the monitoring and its delivery is supported by this Programme Management and Accountability Framework.

4.2 The Trust will use appropriate indicators and metrics when assessing performance. The performance indicators and metrics used by the TDA will form the backbone of performance measurement within the Trust. In outline the TDA will assess Trust performance in three domains; quality, finance and sustainability. Within the quality domain the assessment will be aligned to the five key questions the Care Quality Commission (CQC) asks when assessing services; namely are services:

- Caring
- Effective
- Responsive
- Safe
- Well led

4.3 Performance metrics will be relevant to Board, corporate directorate , Clinical Unit sub speciality and ward or service level whenever possible and where this supports effective performance management. Financial reporting is provided at service line level and to individual budget holders enabling them to actively manage all aspects of their costs.

5. Performance reporting

5.1 The vision for the Trust is to streamline performance reporting with an overarching single performance report for Board reporting which covers the key national and local performance and regulatory requirements. The Trust will ensure that the performance report reflects a learning culture and is adapted to include indicators that are relevant to current priorities and key issues of importance to the Board and stakeholders.

5.2 The single performance report used at Board level will be built up from reports at clinical unit and corporate team level. This will be supplemented by ward/clinical area level dashboards and access to business intelligence software such as CHKS and EIS which support internal performance management. The intention is for performance reporting at every level to reflect the requirement for information and intelligence to support actions that deliver optimal performance

5.3 The Trust's performance management framework will be regularly reviewed to ensure consistency with any new or emerging national, local or regulatory requirements.

6. Planning for performance

6.1 The planning process within the Trust will seek to ensure that the foundations for effective delivery and high performance are in place. Strategic and Annual Plans will be built on a sound understanding of historic performance and the factors that have influenced underperformance.

6.2 The development of plans will also need to take into account future risks to performance and to ensure that actions to address these risks are included in the plans. The Board will ensure that the following elements are in place to support the development and delivery of plans:

- A clear organisational structure, objectives and accountabilities so that there is a good understanding of individual responsibilities and the decision making processes that underpin performance assessment and improvement.

- A strategic and annual planning process which enables service line clinicians and managers to identify opportunities and risks to performance within their areas and to work towards agreed performance objective

- Clearly articulated monitoring arrangements overseen by a cycle of performance management meetings at Trust, corporate and clinical unit level which are linked to team and individual objective

- Provision of knowledge management information by regular and timely information which builds a clear and consistent picture of financial and operational performance.

7. Overview of the Performance Management and Accountability Framework

7.1 The Performance Management and Accountability Framework relies on a hierarchy of performance management and accountability arrangements which starts with all individuals employed by the Trust and ends with the Board.

7.2 These arrangements seek to develop a culture of devolved decision making and accountability encouraging clinical units and corporate directorates to manage their own performance. To reflect this, a risk based approach will be used to determine the frequency of the Performance Management meetings for each clinical unit or directorate and the degree of earned autonomy granted to the respective management teams.

8. Roles and Responsibilities

8.1 The Board is responsible for setting the strategic direction for the Trust and for ensuring that it is meeting the duties for which it is publicly accountable. The Board is committed to driving a culture of performance through providing a clear vision underpinned by Trust priorities, goals and objectives for which all staff will be held accountable. All individuals within the Trust have an accountability and responsibility for performance and performance management.

8.2 Effective performance management requires the setting of clear objectives along with the outcomes through which achievement of these objectives will be measured. It also requires the definition of the accountabilities and responsibilities that are associated with individual's roles. A summary of these responsibilities are set out below

Chief Executive

8.3 The Chief Executive (CEO) has overall statutory responsibility for patient safety, governance, finance and performance management and its accountable to the Trust Board for the delivery of the outcomes associated with these.

8.4 The CEO has delegated responsibility for all aspects of performance management to individual Directors within the Corporate Leadership Team.. The directors are accountable to the CEO for the discharge of these responsibilities. The CEO works through the directors to ensure effective performance management arrangements are in place across the Trust.

Chief Operating Officer

8.5 The Chief Operating Officer (COO) is accountable to the CEO and has the lead responsibility for all aspects of operational performance. They must work with other directors as well as their own team and others across the organisation to ensure the delivery of operational performance standards can be achieved within the agreed quality and financial requirements set by the Board. They must ensure that human resources are used effectively and efficiently to achieve the required performance standards..

8.6 They must ensure that all operational plans reflect the need to meet performance and regulatory requirements and that plans are developed to address areas of underperformance and performance risks.

8.7 The COO is accountable for the performance of the Clinical Units and the Operations Directorate and for ensuring that the performance management and governance arrangements for Clinical Units and directorate team are robust, effective and well managed.

Director of Finance and IT

8.8 The Director of Finance (DoF) is accountable to the CEO and has the lead responsibility for all aspects of financial performance and IT operations. They must work with other directors as well as their own team and others across the organisation to ensure that the delivery of financial performance can be achieved within the agreed quality and operational requirements set by the Board. They must ensure that human resources are used effectively and efficiently to achieve the required performance standards.

8.9 They must ensure that all financial plans reflect the need to meet performance and regulatory requirements and that plans are developed to address areas of underperformance and performance risks.

8.10 The DoF is accountable for the performance of the Finance and IT Directorate and for ensuring that the performance management and governance arrangements for their directorate team are robust, effective and well managed

Medical Directors and, Director of Nursing

8.11 The Medical Directors (MDs) and Director of Nursing (DoN) are accountable to the CEO and have the lead responsibility for all aspects of quality performance. They must work with other directors as well as their own team and others across the organisation to ensure the delivery of quality performance standards can be achieved within the agreed financial and operational requirements set by the Board and that human resources are used effectively and efficiently.

8.12 They must ensure that all plans reflect the need to meet quality standards and regulatory requirements and that plans are developed to address areas of underperformance and performance risks.

8.13 They have the lead responsibility for ensuring that all clinical professionals meet the prescribed professional standards and take a role in delivering key performance indicators. They also have the lead responsibility for enabling clinical ownership and leadership across the Trust in support of optimal performance and an open and transparent performance reporting culture.

8.14 The MDs and DoN are accountable for the performance of the Medical Directorate and the Nursing Directorate respectively and for ensuring that the performance management and governance arrangements for their directorate teams are robust, effective and well managed

Director of HR

8.15 The Director of Human Resources (DoHR) is accountable to the CEO and has the lead responsibility for the development and implementation of the individual performance review process and for the HR polices and processes that support this. They must work with other directors as well as their own team and others across the organisation to ensure that implementation aligns the contribution made by individual staff to delivering quality operational and financial requirements set by the Board and that human resources are used effectively and efficiently to achieve the required performance standards..

8.16 They must ensure that all workforce and learning and development plans reflect the need to meet performance and regulatory requirements and that plans are developed to address areas of underperformance and performance risks.

8.17 The DoHR is accountable for the performance of the HR Directorate and for ensuring that the performance management and governance arrangements for their directorate team are robust, effective and well managed.

Director of Strategic Development

8.18 The Director of Strategic Development (DoSD) is accountable to the CEO and has the lead responsibility for the development of the Performance Management and Accountability Framework. They must work with other directors as well as their own team and others across the organisation to ensure that its implementation supports the delivery of quality operational and financial requirements set by the Board and that human resources are used effectively and efficiently to achieve the required performance standards.

8.19 They must ensure that all strategic and organisational development plans reflect the need to meet performance and regulatory requirements and that plans are developed to address areas of underperformance and performance risks.

8.20 They are responsible for ensuring that the assurance and corporate governance arrangements are in place and are robust and that these are supported by accurate, timely and comprehensive performance reporting. They are responsible for ensuring that the Integrated Performance Report highlights areas of “off plan” performance or adverse performance trajectories.

8.21 The DoSD is accountable for the performance of their directorate and for ensuring that the performance management and governance arrangements for their directorate team are robust, effective and well managed

Knowledge Management Team.

8.22 The Knowledge Management is accountable to the DoSD and is responsible for the provision of accurate and timely analysis and interpretation of performance data for performance review and follow up purposes. They ensure that robust systems are in place for reporting against national, local and internal targets and for preparing the Integrated Performance Report highlighting to the Board areas of “off plan” performance.

All Staff

8.23 Directors are responsible for ensuring that their objectives are cascaded through their directorate so that all staff have a set of objectives which demonstrate how they contribute to the success of the Annual Business Plan. All staff are required to have a minimum of two performance appraisals per annum. All staff should understand the contribution they make to the delivery of the organisation’s objectives and to its performance. They should ensure they are aware of and own the performance data relevant to their work and that they understand how this relates to the corporate performance of the organisation.

All staff contribute towards performance improvement and management by identifying areas of performance risk and performance improvement opportunities. Staff should feel empowered within their role and responsibilities to take the required action to mitigate any performance risk and improve performance

8.24 All staff should make an active contribution to the individual performance review process and the identification of their development needs. They should take responsibility for ensuring that their personal development plan meets these needs and that they attend the relevant learning and development opportunities.

Execution of the Performance Management and Accountability Framework

Committee	Membership	Reporting Documents
Trust Board	Full Board	Integrated Performance Report Board Committee minutes Board Assurance Framework Board papers
Finance and Investment Committee	Non Executive Directors Executive Directors and other staff	Integrated Performance report Financial reports Committee papers
Quality and Standards Committee	Non Executive Directors Executive Directors and other staff	Integrated Performance report Quality reports Committee Papers
Clinical Management Executive	CEO, Executive Directors and other staff	Integrated Performance report Financial reports Quality reports Compliance assessments Risk registers
Clinical Unit Performance Meetings	COO, DoF, DoN, MDs, DoHR, ,Clinical Unit Teams AD Knowledge Management	Clinical Unit performance reports Progress on delivery of Annual Business Plan Performance recovery plans Risk registers
Individuals	Individual and Line Manager	Agreed objectives PDR Appraisal documentation

9. Performance Framework: Categories of performance and consequences

9.1 Each directorate and clinical unit will be expected to sign up to delivering the expectations set for them by the Board.

9.2 A set of prioritised indicators will be agreed and Clinical Units and corporate directorates will be supported in, and held accountable for delivery of the key metrics specific to each Clinical Unit or directorate's core business. In addition Clinical Units and directorates may take a corporate lead for an individual target area and hold their peers to account for its delivery.

9.3 Performance will be judged against these indicators and proportionate interventions will be enacted for under-performance in these areas. Clinical Units and directorates will be rated according to the categories set out below and it is the Trust's clear and explicit intention to have the systems, structures and enablers in place for each clinical unit directorate to be categorised as performing:

- Performing: All performance requirements are met and trajectories are for continued performance. Earned autonomy classification. Effective risk management is in place and mitigations are identified and are being delivered. Quarterly performance reviews supported by monthly performance monitoring. Levels of freedom to act are wide ranging.
- Performance under review: Some performance requirements are not met or trajectories are for underperformance. Planned interventions and recovery plans are agreed and their delivery is on plan with evidence of improvement. Monthly performance reviews with weekly reviews for underperforming or at risk areas if required. Levels of freedom to act and redefined and circumscribed in some areas.
- Underperforming: Some performance requirements are not met or trajectories are for underperformance. Planned interventions and recovery plans are not agreed or their delivery is not on plan and/or there is no evidence of improvement. Weekly performance reviews for all areas. Intervention will be in the form of a turnaround package and a redefinition of the levels of freedom to act in all areas.

10. Freedoms to act

10.1 Clinical Unit leads will hold the primary responsibility for delivery within each clinical unit supported by the relevant Head of Nursing and General/Service managers. Clinical Units and directorates which are defined as 'Performing' will have earned freedoms through: the delivery of the agreed ABP, quality, operational and financial targets. Clinical Units will also be expected to be meeting clinical and corporate governance requirements before being granted freedom to act.

10.2 The intention is to ensure income is more directly related to service lines and individual budgets are locally owned both from an income and expenditure perspective. This direction of travel will continue and be further strengthened.

10.3 Clinical units with the freedom to act will have:

- Less regular and intensive performance management
- Freedom to manage their own internal recruitment and operate within normal delegated financial authorities
- Priority for service development and capital funding
- The flexibility to determine spend on additional income lines.

Appendix Four

Annual Business Plan Development Process

1. Introduction

1.1 This paper proposes the Annual Business Plan (ABP) development process for 2015/16. It distils and builds on the learning from this year. The Turnaround Director, on his arrival in October 2014, concentrated initially on financial recovery in 2013/14 and commenced business planning in January 2014 which meant the timetable was of necessity compressed. This year there is an opportunity to start earlier which will mean there is some time for reflection and iteration of the plans. We have a clear process in place for Quality Impact Assessment (QIA) and a Performance Management Framework (PMF) will be in place. Robust Programme management arrangements will support the ABP process.

2. Background

2.1 We need to build on the work which has already been undertaken and the outputs from the delivery of the 2014/15 ABP which will provide a useful baseline for the organisation including:

- Intelligence about the impact of existing schemes on quality
- Better understanding of demand and capacity in operations
- Clearer information on spend
- Workforce projections
- Activity information
- A clearer idea of % savings required.

3. Setting the Context

3.1 By July the outputs of the work of the Challenged Health Economy should be emerging. The results of the first quarter's performance will also be available both in terms of quality, through the work of the Quality Impact Assessment (QIA) Group, activity and financial performance. By the end of July we will need to provide the organisation with a report which sets out the context within which the 2015/16 ABP will be developed including the key challenges and priorities, commissioning intentions, financial and activity parameters; quality improvement requirements and other intelligence which is available for example on future tendering activity. This will facilitate a "state of readiness" for the year ahead.

3.2 Although there will need to be further iterations of this context setting information through out the planning process producing the initial document in July is necessary because many staff are on holiday in August and the organisation will be gearing up for the CQC inspection in September which will clearly absorb a significant number of staff.

3.3 By the end of September a planning process programme will have been developed identifying key milestones, risks and mitigations. This will provide the basis for reporting to the Business Planning Steering Group (BPSG), Clinical Management Executive (CME) and the Board.

4. Launch of the process

4.1 In early October we will need to gear the organisation up for the plan development process and reiterate what the parameters are for the coming year.

4.2 A clear communications strategy will ensure that the whole organisation understands the challenges ahead and the successes to date. This will be an opportunity to engage the whole organisation on the big issues.

4.3 The launch could comprise some workshops for staff to consider and feedback on opportunities for efficiency and service redesign and identify key themes and areas which should be explored, eg:

- Reducing waste
- Better value for money
- Clinical Administration
- The role of support services.

4.3 It will be important for the discussions to be recorded and utilised where possible and the resultant actions should be fed back in a timely fashion.

5. Service Planning

5.1 The Chief Operating Officer (COO) will be responsible for setting up regular and frequent planning meetings with each clinical unit throughout October in line with the ABP development programme.

5.2 The purpose of this work will be to produce initial draft plans for review by the BPSG for the first week of November. We will build on the documentation used this year. Support will be provided by Finance, IT, Knowledge Management, Estates and HR. At least one meeting will need to be set up for cross cutting issues and to ensure that clinical support services, therapies, radiology, pathology, etc, are sighted on the impact on their areas of responsibility.

5.3 There are a number of areas which are emerging which will require further consideration and the launch workshops may identify further areas:

- Shift patterns
- Specialist nursing
- Grouping management of wards.

5.4 The PMO will have developed a process for identifying which plans will require significant project support; together with a toolkit for managing smaller projects.

6. Refining Plans

6.1 Planning meetings will continue throughout November and by December TDA guidance will be available and there will be a clearer view on parameters for plans to allow for further iteration. The QIA Group will have made recommendations on draft plans to the BPSG.

7. Governance

7.1 The BPSG will be responsible for overseeing progress on the planning process and for reviewing the risks and issues logs. It will also be important to appraise the Finance and Investment Committee on planning issues and the Board will have been engaged in July in discussions on the Context Document. In January a draft plan will need to go to the Board and it is suggested that clinical units are invited to present their plans to the Board in a standard agreed format. This will provide the Board with assurance about the process and an understanding of the key risks and proposed mitigations.

7.2 Final plans will need to be approved by the Board in March 2015 so that clinical units are able to implement plans from April 2015.

8. Risks

- There will be insufficient scrutiny and challenge with the departure of the Turnaround Director in July
- Staff will not engage with the process during the CQC inspection
- Senior managers are involved in urgent actions which will affect capacity for planning
- Staff are distracted from planning activities due by operational or organisational issues
- The challenged health economy work does not provide clarity for future planning
- Service changes proposed are so significant so that they necessitate formal consultation
- Service plans affect quality of care to an unacceptable level.

9. Key milestones

9.1 The following is a high level timetable and will be developed in more detail.

Actions	Dates	Who
Baseline assessment: Financial Quality Performance	End June	All
Context paper to Board and circulated to senior managers	July	DSDA
Launch and state of readiness	Early October	CEO
Planning meetings with CUs scheduled and commenced	Early October	COO
Draft plans to Business Planning Steering Group for review	Beginning of November	COO
Financial baseline	December	FD
Draft Plans to Finance and Investment Committee	January	
Board seminar on key issues and risks	January/February	
Final ABP to Board	March	

East Sussex Healthcare NHS Trust

Date of Meeting:	3 June 2014
Meeting:	Trust Board
Agenda item:	14
Subject:	Financial Plan and Annual Budget 2014/15
Reporting Officer:	Vanessa Harris, Director of Finance

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

Purpose:

The purpose of the paper is:

1. To advise the Board on the short to medium term financial context and the assumptions used in developing its plans for 2014/15 and beyond;
2. To seek Board approval for the revenue and capital plans for 2014/15; and
3. To highlight the requirement to produce and submit a 5-year plan.

Introduction:

This report is being brought to the Trust Board to seek approval of the 2014/15 financial plan and budget.

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

The current and projected scale of challenge for the NHS is unprecedented, as the tight fiscal position joins with rising patient expectations against a backdrop of major changes in the NHS infrastructure. The Trust set a planned deficit for 2013/14 of £19.4 million. This deficit was based on delivery of a cost improvement programme of £20 million. Slippage on the savings programme of £2.5 million and cost pressures of £1.2 million meant that the outturn for that year was a deficit of £23.1 million. The Trust needs to return to 'run rate' surplus as swiftly as possible to demonstrate that it can continue to provide high quality services in a financially sustainable way and achieve independent Foundation Trust status in the foreseeable future.

The plan for 2014/15 is a deficit of £18.5 million after application of the internal cost improvement programme of £20.4 million and after providing for known cost pressures and inflationary increases.

The Trust has reached a contract agreement with its CCG commissioners for 2014/15 which recognises the heavy burden of risk on both provider and commissioner within this challenged health economy and the need for a collaborative approach to managing that risk.

Benefits:

Board scrutiny and approval of the Trust's annual plan is a key element in providing the necessary governance and assurance oversight of the Trust's finances.

Risks and Implications
There are significant risks to the delivery of the plan arising from the pressures and uncertainties faced by NHS providers in general and those within the local 'Challenged Health Economy' in particular. The structure of contractual arrangements agreed with local commissioners will help to reduce the income risk relative to 2013/14 but inevitably a number of financial risks still exist. Further details are set out in section 9 of the attached report.

Assurance Provided:
The 2014/15 planning process has been extremely robust with plans developed by clinical units being assessed for quality impacts by senior clinical and other ESHT directors as well as scrutiny by the Board at a whole day Scrutiny and Review event on 12 March 2014. The provisional plan was approved by the Board on 26 March 2014. Cost improvement targets have been developed within clinical units who own and understand the assumptions made.

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment Committee - 26 February 2014 (planning update) Finance and Investment Committee – 19 March 2014 (planning update) Quality Impact assessment Group Board Seminar Review of clinical unit plans - 12 March 2014 Board Meeting 26 March 2014 (approval of provisional plan) Capital Approvals Group (Capital Programme) 14 May 2014 Finance & Investment Committee – 28 May 2014

Proposals and/or Recommendations
The Board is asked to: • Note the short to medium term financial context for the Trust and the assumptions used in developing its plans for 2014/15 and beyond; • Note the indicative plan for 2015/16; • Approve the revenue financial plan and budget for 2014/15; and • Approve the capital programme for 2014/15 • Note the requirement to develop and submit a five-year plan to the TDA by 20 June 2014

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

For further information or for any enquiries relating to this report please contact:	
Name: Vanessa Harris, Director of Finance	**Contact details:** Vanessa.harris2@nhs.net

East Sussex Healthcare NHS Trust

Financial Plan and Annual Budget 2014/15

1. Introduction

1.1 At its March 2014 meeting the Board approved a provisional financial plan for 2014/15 within the context of the provisional two-year plan submitted to the Trust Development Authority (TDA) on 5 March 2014. The Board also approved a provisional working budget to support the financial and operational management of the Trust from the outset of the new financial year.

1.2 The Trust submitted its final plan to the TDA on 4 April 2014. In overall terms this was not materially different from the earlier submission. This report sets out the main features of the two-year plan, including contractual arrangements with commissioners, key planning assumptions, cost improvement plans and the main risks. Although the plan submitted to the TDA is for two years, the main focus of this report is on 2014/15.

1.3 The two-year plan will form the basis of an updated 5-year plan that will need to be submitted to the TDA by 20 June.

2. Background

2.1 East Sussex Healthcare Trust (ESHT) has embarked on a major turnaround programme to improve clinical sustainability and financial viability. In close collaboration with key stakeholders in East Sussex, the Trust has agreed the framework for its Clinical Strategy: 'Shaping our Future', designed to meet its key strategic objectives:-

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

2.2 The full business case in support of the capital investment required to realise the full benefits of the clinical strategy was approved by the Trust Board in December 2013 and is currently awaiting consideration by the TDA.

2.3 The current and projected scale of challenge for the NHS is unprecedented, as the tight fiscal position joins with rising patient expectations against a backdrop of major changes in the NHS infrastructure. The Trust set a £19.4 million deficit plan for 2013/14. This was based on delivery of a cost improvement programme of £20 million. Slippage on the savings programme of £2.5 million and cost pressures of £1.2 million meant that the outturn for that year was a deficit of £23.1 million. The Trust needs to return to 'run rate' surplus as swiftly as possible to demonstrate that it can continue to provide high quality services in a financially sustainable way and achieve independent Foundation Trust status in the foreseeable future.

3. Plan Overview

3.1 The following is a summary of plans for the two years by main subjective heading:-

Summary Income & Expenditure Statement	2014/15 £m	2015/16 £m
Income	357.4	355.5
Pay Costs	(259.5)	(243.4)
Non pay Costs	(115.7)	(121.9)
Depreciation/PDC/Interest	(21.1)	(24.2)
Sub Total	(38.9)	(34.0)
CIP	20.4	20.0
Net Deficit	**(18.5)**	**(14.0)**

A more detailed income and expenditure summary, with comparison to 2013/14 outturn, is included at Appendix 1.

3.2 The April TDA submission projects two years' of planned net deficits; £18.5 million for 2014/15 and £14.0 million for 2015/16. To achieve these improvements in run rate the Trust has set itself cost improvement targets of £20.4 million (5.2 per cent of baseline expenditure) in 2014/15 and £20.0 million (5.2 per cent) in 2015/16. These values are net of cost pressures. A contingency of 1 per cent of turnover has been set aside in both years.

The Trust faces a number of new financial pressures in 2014/15, notably:-

- Loss of income through Quality, Innovation, Productivity and Prevention (QIPP) plans (£4.0 million assumed)
- Loss of Health & Wellbeing income stream (net £0.5 million assumed)
- Clinical Negligence Scheme for Trusts (CNST) increase (£0.7 million in 2014/15)

3.4 Expenditure budgets have been set following detailed, zero-based reviews with each clinical unit. Detailed budgets, setting out income and expenditure plans, workforce numbers and activity plans for all clinical units and departments will be issued to budget holders with the month 1 budget reports.

4. Activity and Income

4.1 Activity plans have been agreed with local CCGs based on forecast outturn for 2013/14 uplifted by £2.8 million demographic growth and reduced by £4 million of QIPP.

4.2 As in 2013/14 the contract with CCGs is priced at national tariff where relevant and at local price where national tariff doesn't apply. The contract has been structured to recognise the heavy burden of risk on provider and commissioner alike within this challenged health economy and the importance of a collaborative approach.

4.3 The contract value includes all contract elements except for tariff-excluded drugs and devices, which will continue on a 'pass-through' basis.

4.4 It is assumed that the first £1.5 million of any winter pressure funding available to the CCGs will be passed to the Trust.

5. Expenditure and cost improvement plans

5.1 In common with the rest of the NHS, East Sussex Healthcare and its local health economy face a considerable financial challenge over the next five years. In response to this challenge, and in order to gradually reduce the Trust deficit, cost reduction measures of at least £20 million will be required in each of the next few years. A plan has been developed to deliver £40 million of improvements over the two years from April 2014. This section outlines plans for 2014/15.

- There are full plans in place to deliver the £20.4 million of savings in 2014/15. These vary in terms of difficulty, complexity and risk. Contingency plans will be developed over the coming months to offset any slippage that may occur.

- The Board can be assured that :

  - Robust performance management and governance arrangements will remain in place to ensure delivery;
  - Plans have been rigorously tested both in terms of deliverability and any potential adverse quality impact
  - There are appropriately detailed plans in place for all initiatives
  - The plan is entirely consistent with budget setting.

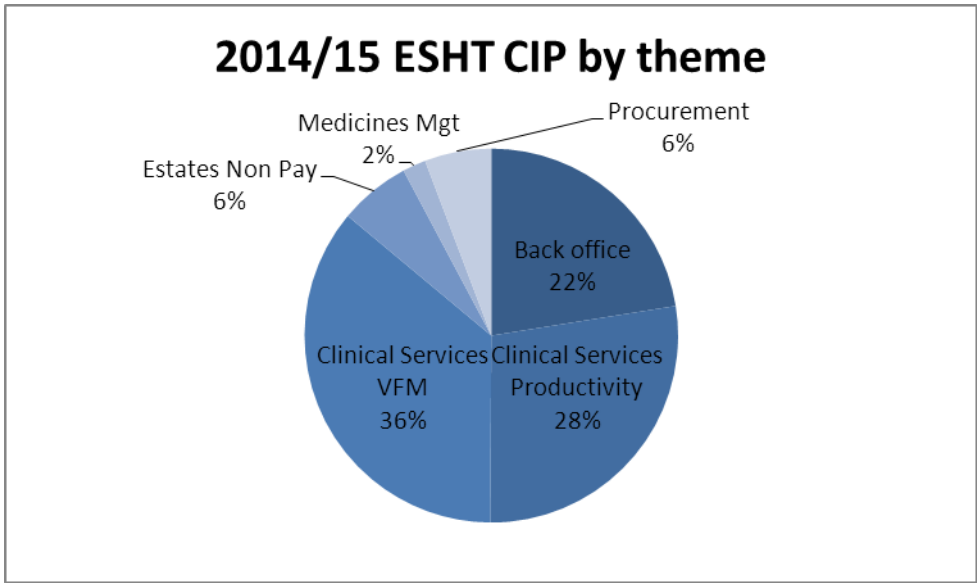
5.2 The unprecedented productivity challenges facing the Trust and the wider NHS emphasises the need for a clear framework for delivery. The Trust has developed a stratified cost improvement programme based on 5 key themes to ensure substantial cost savings and efficiencies can be delivered over the next two financial years, based upon the following principles:

- A move away from the traditional 'salami slicing' savings programme towards more fundamental change
- Clinical frontline services must be prioritised over non-clinical support expenditure.
- Emphasis will be placed on waste reduction, productivity improvement and enhancing value for money.
- Income generation opportunities will also be targeted
- Service quality must not be compromised

5.3 A matrix approach to developing initiatives has been adopted, whereby corporate areas and clinical business units were asked to generate ideas around the following themes and areas:

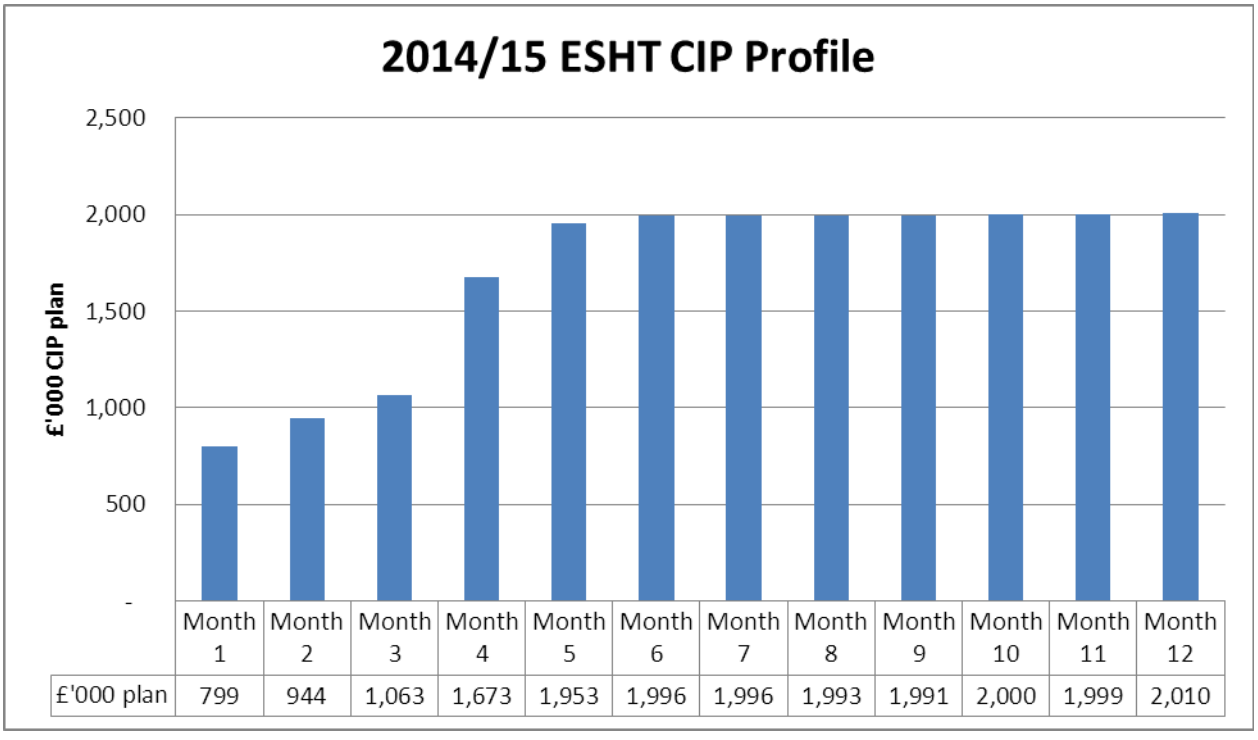
- Clinical Services Value for Money – Nursing, Medical, Allied Health Professionals (AHPs)
- Clinical Services Productivity – Beds, Theatres, Adhoc payments
- Back office – Management, Corporate & Clinical Administration
- Non pay Cost Control/Avoidance – Procurement, Blood products, Medicines Management
- Estate review and Commercial Directorate Efficiency

5.4 The Clinical Units have developed plans to deliver a total of £20.4 million savings in 2014/15 against these overall themes, as shown in the chart below:



5.5 As part of the multidisciplinary review of all cost improvement plans a risk assessment of the deliverability of the plan has been undertaken. The key risks to deliverability and quality have been identified which has been fed into the financial analysis of the plan.

5.6 The cost improvement plan is profiled to deliver as evenly as possible across the year, and all efforts have been made to ensure that the Trust is prepared at a granular level to deliver from Month 1. The monthly and cumulative profile is shown below:



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
£'000 plan	799	944	1,063	1,673	1,953	1,996	1,996	1,993	1,991	2,000	1,999	2,010

5.7 Cost improvement plans are being developed for 2015/16 at a total value of £20 million. Further work will be undertaken over the next few weeks to finalise the detail to support these.

6. Workforce Plans

6.1 Workforce planning and service redesign for ESHT in 2014/2015 and beyond are aligned to the implementation of the clinical strategy and the cost improvement plan. The reduction in total workforce will be achieved through skill mix reviews and by increasing productivity by various means, including continuous improvement in job planning and rota reviews.

7. Capital Programme

7.1 The provisional 2014/15 capital programme approved by the Trust Board at its meeting in March has been reviewed and revised by the Capital Approvals Group (CAG) and the Finance & Investment Committee. An updated programme is attached at Appendix 2. A revision of medical equipment, information technology and estates backlog maintenance priorities was undertaken in order to limit the 'over planning' margin to a sensible level based on the content of the programme. The CAG will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital funds.

7.2 As in previous years the Trust has had to scale back its capital plans for 2014/15 based on the funding available. This has meant limiting spend on replacement medical equipment, backlog maintenance and IM&T. The following are the key features of the capital programme:-

- The Trust's routine replacement capital programme is planned within the projected level of depreciation.

- Significant capital expenditure is planned to deliver the clinical strategy proposals including the reconfiguration of wards to provide more single en suite rooms and to manage service rationalisations. It is now planned, subject to TDA approval, that this capital expenditure is funded by exceptional public dividend capital rather than an external prudential borrowing loan. The projected drawdown is phased 2014/15 £17.4 million; and 2015/16 £11.6 million.

- The cost of upgrading and improving Pevensey Ward on the DGH site is included in the £30m 'Shaping Our Future' Clinical Strategy full business case, which is currently with the TDA for approval. Should there be an unexpected delay with this approval the contingency position around this important project is that the Trust will ensure the necessary work is carried out in 2014/15 to progress the scheme. The project is estimated to have a total cost of £2.2 million, including a £0.5 million contribution from the Friends of the Eastbourne Hospitals. The timing and profile of payments means that the cost will fall across 2 financial years. This is reflected accordingly in forward capital plans.

- It is planned that medical equipment will be replaced through capital purchase rather than leasing in 2014/15.

- The minor improvements budget has been set at £2.2 million in 2014/15.

- The 'over planning margin' (excess of planned expenditure over the capital resource limit) has been set at a level deemed reasonable given the proposed content of the capital programme and this will be kept under review throughout the year. This margin is based on the general assumption that there will be a degree of slippage on capital plans.

- In addition, based on historic levels, significant donated funds, principally from the Friends of the Hospitals, are anticipated to be available to the Trust during the financial year.

8. Cash

8.1 To meet the various financial pressures and achieve the planned deficits the Trust will require additional PDC funding to cover the cash shortfalls arising from its deficit plans. In the short term it has been agreed by the TDA that cash funding will be provided in the form of temporary PDC quarterly in arrears. During the course of the year an application will need to be made to the Independent Trust Financing Facility via the TDA, as in 2013/14, with a view to converting the temporary PDC into permanent PDC.

8.2 A cash flow statement is attached as Appendix 3. This formed part of the planning submission to the TDA. It shows the Trust starting the year with cash of £2.25 million and ending the year with a balance of £1.0 million. This assumes the receipt of permanent revenue PDC of £18.5 million in four equal quarterly instalments to cover the planned deficit.

9. Risks

9.1 The Trust has significantly reduced its exposure to income risk as a result of the agreement that has been struck with CCGs. Inevitably a number of material risks remain, most notably the following:-

- Activity exceeding the contracted level resulting in extra work being undertaken with no additional income;
- Potential need to outsource elective activity to meet Referral to Treatment targets agreed with CCGs;
- Failure to achieve cost improvement targets;
- Additional unplanned cost pressures including premium cost delivery (agency and ad hocs)
- Insufficient capital funds to meet the Trust's capital infrastructure requirements (see para 9.3 below).

9.2 The following table presents a downside scenario, incorporating the key revenue risks to delivering the Trust's plan:-

	£m	£m
Deficit before unplanned risks		(18.5)
Fines & penalties	(0.5)	
Non-receipt of winter funds	(1.5)	
Income risk		(2.0)
CIP slippage (12.5%)	(2.5)	
Activity & capacity pressures	(2.0)	
Operational cost pressures	(2.0)	
Transition Costs	(1.0)	
Expenditure risk		(7.5)
Trust downside risk		(28.0)
Contingency		4.0
Downside deficit risk (2013/14 £35m)		(24.0)

9.3 The availability of cash to finance the Trust's capital infrastructure needs is a substantial and growing risk for the organisation. The following are the most significant areas of concern in the short term:-

- The Estates Department has identified the requirement for significant capital backlog maintenance and infrastructure improvements, including electrical supply issues. The 2014/15 provisional capital programme approved by the Trust Board in March included £3.1 million for backlog maintenance, infrastructure and supply expenditure. The reduction of the 'over planning' margin to a more reasonable level has resulted in this funding being reduced to £2.4 million. Expenditure of £2.8 million per annum is projected for the remainder of the 5 year planning period and beyond in order to reduce the continuing backlog maintenance risk.

- Whilst the additional £5 million capital resource approved by the Independent Trust Financing Facility (ITFF) in 2013/14 has enabled some additional medical equipment replacement, a review of medical equipment has identified the need for significant on-going investment to address current and projected requirements. The Medical Equipment Replacement Group has been asked to prioritise the equipment replacement programme for the next five years in order to remain within the available capital resources. The CAG has reviewed and agreed priorities for 2014/15. However, the reduction necessary to the over planning margin has resulted in a reduction in medical equipment replacement funding in 2014/15 from £3.2 million to £2.2 million. On an on-going basis CAG will need to assess the longer term risks arising from unmet demands for medical equipment expenditure as the level of risk rated as high priority for replacement in 2014/15 is estimated at between £3.6 million and £4.8 million.

- The IM&T strategy currently being developed is also likely to place significant demand on available capital funds. CAG has approved an information systems allocation of £0.6 million for 2014/15, which is a reduction of £0.3 million from the provisionally approved allocation.

The risks arising from the need to limit the 'over planning' margin will be included within the relevant sections of the Trust risk register.

10. Five Year Plan Submission

10.1 Following the submission to the TDA of operational plans for 2014/16, there follows a requirement to submit a five-year strategic plan by 20 June 2014. This requirement was included in the November 2013 letter headed 'Strategic and operational planning in the NHS' signed jointly by the TDA, Monitor, NHS England and the Local Government Association. This highlighted the challenges facing the service and the need for 'bold and transformative long-term strategies'. It also referenced the need to create a fully integrated service between the NHS and local government, supported in due course by the £3.8 billion Better Care Fund. Initial guidance was included with the letter and more detailed guidance has subsequently been received.

10.2 The five-year plans will incorporate the two years' of operational plans already submitted and a further three years' of less detailed strategic plans. The financial projections will need to be expressed in a Long Term Financial Model (LTFM). Only a base case LTFM is required and not a downside or mitigated downside case. However, Trusts will be expected to identify their key risks and articulate their mitigation plans.

10.3 In addition to the LTFM Trusts will need to produce an Integrated Business Plan (IBP), an activity plan and a workforce plan. These will have to be consistent with the LTFM. There is a new requirement within the LTFM to include contract income by commissioner by point of delivery for the full five years.

10.4 The IBP should reflect the requirements of Monitor's Guide to Applicants.

10.5 Trusts are expected to develop their own planning assumptions for the five year plan, building on those already used in the submitted two year plans. While the planning assumptions will be developed to fit local circumstances, it is expected that account will be taken of national guidance. In particular, where applicable, Monitor's Annual Plan Review Guidance should be followed.

10.6 As far as possible, the Trust's activity planning assumptions will need to be aligned with those of local commissioners.

10.7 As part of a 'Challenged Health Economy' the Trust's longer-term strategy is inevitably bound up in the project support work being undertaken by Price Waterhouse Cooper (PwC). However, it seems unlikely that the timing of the outcomes from that work will be available in time to inform a June 2014 five year plan submission.

10.8 The Trust will need to show a trajectory of improvement that is not too dissimilar to that within the Financial Recovery Plan (FRP) that was previously shared with the TDA. The actual outturn for 2013/14 is slightly worse than was assumed in the FRP and this is reflected in the changes to projected deficits for 2014/15 and 2015/16.

11. Going Concern

11.1 In planning a deficit budget at a point when the Trust is closing its 2013-14 Accounts, the Trust needs to consider the "going concern" principle. This is one of the fundamental underpinning accounting concepts for the preparation of the financial statements, where organisations are usually viewed as continuing in operation for the foreseeable future.

Detailed guidance in respect of going concern is set out in the relevant International Accounting Standard (IAS1) and its interpretation for the public sector context is set out in the Financial Reporting Manual 2012-13 (FREM) paragraph 2.2.15 and the Department of Health Manual for Accounts 2013-14 (MfA) Chapter 4 Accounting Principles.

11.2 The Manual for Accounts sets out the interpretations of "going concern" for the public sector. An NHS body would not need to have concerns about its "going concern" status unless there is prospect of services ceasing altogether. For ESHT there are no uncertainties in this respect and the position is as follows:

- Continuity of service provision in the future - the signed contracts with commissioners demonstrate this.

- Access to sufficient cash – discussions are taking place with the TDA to make an application for permanent PDC. In the meantime the Trust will apply for a temporary loan to cover immediate cash pressures.

12. Conclusion and Recommendation

12.1 The financial landscape for 2014/15 and beyond is increasingly challenging and sustained focus will be required to deliver and maintain the required improvement in the Trust's underlying financial position.

12.2 The Board is asked to:

- Note the short to medium term financial context for the Trust and the assumptions used in developing its plans for 2014/15 and beyond;
- Note the indicative plan for 2015/16;
- Approve the revenue financial plan and budget for 2014/15; and
- Approve the capital programme for 2014/15
- Note the requirement to develop and submit a five-year plan to the TDA by 20 June 2014

Vanessa Harris
Director of Finance

20 May 2014

East Sussex Healthcare NHS Trust

Summary Income & Expenditure Forecast Outturn & Plan 2013/14 - 2014/15

Summary Income & Expenditure Statement	**2013/14 Unaudited Outturn**	**2014/15 Plan**
	£000's	**£000s**
NHS Patient Income	331,039	323,730
Private Patient/ ICR	3,209	4,160
Trading Income	4,518	4,421
Education	9,988	9,651
Other Non Clinical Income	15,486	15,398
Total Income	**364,240**	**357,360**
Pay Costs	-251,867	-259,474
Ad hoc Costs	-2,283	0
Non Pay Costs	-114,676	-115,663
3rd Party Costs	-712	0
CIP		20,417
Total Direct Costs	**-369,538**	**-354,720**
Surplus/-Deficit from Operations	**-5,298**	**2,640**
Less: Donated Asset Income	*-1,243*	*-1,300*
EBITDA	***-6,541***	***1,340***
Profit/Loss on Asset Disposal	9	0
Depreciation	-11,386	-12,585
Impairment	-10,018	0
PDC Dividend	-6,432	-8,272
Interest	-287	-295
Total Indirect Costs	**-28,114**	**-21,152**
Total Costs	**-397,652**	**-375,872**
Net Surplus/-Deficit	**-33,412**	**-18,512**
Donated Asset / Impairment Adjustment	10,318	0
Normalised Net Surplus/-Deficit	**-23,094**	**-18,512**

East Sussex Healthcare NHS Trust

Appendix 2

2014/15 Capital Programme

Capital Resources	2014/15 £000
Capital Resources:	
Depreciation	11,285
League of Friends Support/Donated Income	1,300
Clinical Strategy - Additional exceptional PDC	17,400
Interest Bearing Capital Loan Repayment	-340
I&E Surplus	0
Sub Total Gross Capital resources	29,645
Less Lof F/Donated Income	-1,300
Total NHS Capital Financing (Capital Resource Limit CRL)	**28,345**

Capital Investment Programme	2014/15 £000
Planned Capital Expenditure:	
Clinical Strategy Reconfiguration	17,400
Medical Equipment:-	
Medical Equipment Replacement	2,229
MRI Scanner Upgrade	370
IM&T:-	
Information Systems	600
Oracle Licences/MDM video conferencing refit	295
Electronic Document Management	200
Community & Child Health Information Systems	619
Commercial Division:-	
Backlog Maintenance	1,071
Infrastructure Improvements - Infection Control	700
Electrical supply Issues - DGH Site	600
Clinical Strategy enabling works - T&O	250
Pevensey Ward	1,000
Minor Capital	2,200
Vital PAC	211
Pathology CLD	500
Other	811
Sub Total	**29,056**
Donated Asset Purchases	1,300
Donated Asset Funding	-1,300
Net Donated Assets	**0**
Sub Total	**29,056**
Overplanning Margin (-)	**-711**
Total Capital Investment	**28,345**

East Sussex Healthcare NHS Trust

2014/15 Statement of Cash Flows

	2014/15 Full Year £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s	Jan-15 £000s	Feb-15 £000s	Mar-15 £000s
Cash Flows from Operating Activities:-													
Operating Surplus/(Deficit)	(9,945)	(1,695)	(1,412)	(1,921)	304	(1,185)	(1,583)	576	181	(1,553)	607	(1,432)	(832)
Depreciation and Amortisation	12,585	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,048	1,057
Dividend & Interest (Paid)/Refunded	(8,420)						(4,211)						(4,209)
(Increase)/Decrease in Trade and Other Receivables	1,926	91	92	91	92	91	921	91	91	92	91	92	91
Increase/(Decrease) in Trade and Other Payables	(2,601)	1,179	3,109	(2,499)	3,031	2,772	(7,410)	(5,955)	3,220	(2,407)	1,596	25	738
Provisions Utilised	(227)	(19)	(19)	(19)	(19)	(19)	(18)	(19)	(19)	(19)	(19)	(19)	(19)
Net Cash Inflow/(Outflow) from Operating Activities	**(6,682)**	**604**	**2,818**	**(3,300)**	**4,456**	**2,707**	**(11,253)**	**(4,259)**	**4,521**	**(2,839)**	**3,323**	**(286)**	**(3,174)**
Cash Flows from Investing Activities													
Interest Received	24	2	2	2	2	2	2	2	2	2	2	2	2
(Payments) for Property, Plant and Equipment	(28,514)	(2,498)	(2,520)	(1,777)	(4,231)	(2,551)	(986)	(3,382)	(4,453)	(2,209)	(1,514)	(1,308)	(1,085)
Net Cash Inflow/(Outflow) from Investing Activities	**(28,490)**	**(2,496)**	**(2,518)**	**(1,775)**	**(4,229)**	**(2,549)**	**(984)**	**(3,380)**	**(4,451)**	**(2,207)**	**(1,512)**	**(1,306)**	**(1,083)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(35,172)**	**(1,892)**	**300**	**(5,075)**	**227**	**158**	**(12,237)**	**(7,639)**	**70**	**(5,046)**	**1,811**	**(1,592)**	**(4,257)**
Cash flow from Financing Activities													
New Public Dividend Capital received in year: PDC Capital	17,400						17,400						
New Public Dividend Capital received in year: PDC Revenue	18,512			4,628			4,628			4,628			4,628
Loans repaid to DH - Capital Investment Loans Repayment of Principal	(340)						(170)						(170)
Loans repaid to DH - Revenue Support Loans Repayment of Principal	(1,331)						(691)						(640)
Capital element of payments relating to PFI, LIFT Schemes and finance leases	(320)						(160)						(160)
Net Cash Inflow/(Outflow) from Financing Activities	**33,921**	**0**	**0**	**4,628**	**0**	**0**	**21,007**	**0**	**0**	**4,628**	**0**	**0**	**3,658**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(1,251)**	**(1,892)**	**300**	**(447)**	**227**	**158**	**8,770**	**(7,639)**	**70**	**(418)**	**1,811**	**(1,592)**	**(599)**
Cash and Cash Equivalents at Beginning of the Period	**2,251**	**2,251**	**359**	**659**	**212**	**439**	**597**	**9,367**	**1,728**	**1,798**	**1,380**	**3,191**	**1,599**
Cash and Cash Equivalents at the end of the period	**1,000**	**359**	**659**	**212**	**439**	**597**	**9,367**	**1,728**	**1,798**	**1,380**	**3,191**	**1,599**	**1,000**

East Sussex Healthcare NHS Trust

Date of Meeting:	16th April 2014
Meeting:	Trust Board Seminar
Agenda item:	15
Subject:	Clinical Strategy Phase 1 - Emergency and High Risk Trauma and Orthopaedic Move
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

This paper outlines proposals and assurances to expedite the single siting of emergency and high risk trauma and orthopaedic (T&O) services to the Conquest site on 13th May 2014.

Introduction:

Following the CLT meeting of 25th February 2014 it was agreed that the reconfiguration of emergency and high risk T&O should be implemented on 3rd May 2014. Subsequently, the implementation date was extended by the T&O Implementation Group to 13th May to allow some contingency for estates work to be completed on Egerton ward.

The service reconfiguration planned was that Seaford 3 ward (29 beds) would be transferred to Egerton ward (28 beds) at Conquest and 17 elective beds would remain on Hailsham 3 at Eastbourne DGH. The number/length of trauma lists at the Conquest would be extended both during the week and at the weekend.

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

At the Trust Board seminar on 16th April 2014 assurances were provided in relation to estates works, staffing, theatres, medical staffing, the ward moves, the operational policy, bed management, the impact on radiology and the impact on neighbouring Trusts and the South East Coast Ambulance Services.

At the meeting the following areas were highlighted:

Internal

- medical staffing – rotas were in place and were EWTD compliant.
- theatre staffing – agency use would need to increase by 4.0 WTE in the short term until permanent staff were in post.
- Wards – with the anticipated staffing at 13th May it would be possible to open 16 beds on Egerton and, once the full complement of staff was recruited to, 28 beds would be opened.
- bed management & A&E – there were a number of initiatives underway to improve the utilisation of existing beds and support the move and he was confident that they would be able to cope.

External

- Brighton and Sussex University Hospitals NHS Trust (BSUH) – discussions were continuing with BSUH on how patients in the Seaford area would be managed as the move only affected patients on a 999 pathway.

- South East Coast Ambulance service (SECamb) – no additional activity but patients needed to be re-routed to Conquest and discussions continued with SECamb and the commissioners over this.

The Board agreed that further assurances were required around internal capability and capacity to implement the move from 13th May which would be provided to the Corporate Leadership Team and the final decision on the date would be taken by the Chief Executive following discussions with BSUH, SECamb and the commissioners.

Benefits:

The qualitative benefits of progressing the move are:

- Supports the delivery of best practice by centralising trauma services on one site, in particular the need for adult medicine to work constructively with orthogeriatric colleagues to support the management of frail elderly patients.
- Supports the delivery of multi-disciplinary care particularly 7 day working by therapists.
- Centralisation will allow medical and nursing staff to develop greater expertise in managing complex cases and use their skills / expertise fully. It will also be possible to develop dedicated specialist theatre / anaesthetic teams, rather than the mixed teams that currently exist.

In addition, centralisation will enable the realisation of efficiencies:

- Combining on call rotas will enable more efficient job planning that support theatre efficiency, a team approach to managing trauma cases and increased consultant supervision on site.
- Centralising on one site will facilitate managing fluctuations in workload more effectively.
- Theatre capacity will be improved as elective and non-elective lists will no longer be mixed. This in turn will support a reduction in elective list cancellations and 18 Week RTT.

In summary, this move not only completes the key service moves included in the Clinical Strategy and enhances quality and efficiency; it also facilitates wider benefits for the organisation, in particular releasing space adjacent to A&E to provide additional CDU capacity.

Risks and Implications

The risks associated with delivering the move are:

Nurse and theatre staffing – mitigations were in place to address this

Bed capacity and management post move – mitigations were in place to address this

The risks associated with delaying/not moving:

Quality - the quality benefits would not be realised.

Staffing - continuing uncertainty about location and the timing of service moves would mean that staffing problems on both sites would remain unresolved.

CIP and Service Efficiencies - CIP and other service efficiencies would not be delivered as planned. If the move was delayed beyond the end of May it would cost over £150,000 per month (£1.8 million full year effect) in unachieved CIPs, plus there would likely be additional cost pressures as staffing problems on the Eastbourne site intensified.

Winter Pressures
A May 2014 implementation date provided the Trust with spring/summer to establish the new service before winter pressures started.

Assurance Provided:
As outlined above.

Review by other Committees/Groups (please state name and date)**:**
T&O Implementation Group 09.04.14 Board seminar 16.04.14

Proposals and/or Recommendations
The Board is asked to formally ratify the single siting of emergency and high risk T&O services with effect from 13th May 2014, noting that a robust monitoring mechanism is in place.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
An EHRIA assessment was undertaken as part of the Clinical Strategy business case.

For further information or for any enquiries relating to this report please contact:	
Name: Liz Costigan, Project Manager	**Contact details:** elizabeth.costigan@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	16a
Subject:	Fire Safety Annual Report 2013
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

The purpose of this report is to provide the Trust Board with an overview of Fire Safety management.

The report seeks to provide assurance of the implementation of Fire Safety policy and procedures, Fire Safety risk assessment and Fire Safety mandatory training compliance.

An important part of this report is also to provide the Trust Board with a summary of the risk carried by the Trust in relation to Fire Safety in order that the Trust can make informed decisions regarding the allocation of capital funding to remedy shortfalls in fire safety.

The annual Fire Safety report has traditionally covered the period January to December. The Board are asked to confirm the period for future reports, as the Trust Health and Safety Group has suggested April to March.

Introduction:

Effective management of Fire Safety is an essential to preserve life and contribute to continuing occupation of properties.

Effective Fire Safety management is also a legal requirement under Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) 05-01.

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

1. Fire Training

Now at 81% of staff trained with 100% staff places provided during 2013.

2. Fire Risk Assessments

100% of the departments/services at the two acute hospital sites have now had risk assessments completed during the past 12 months.

100% of the Community sites transferred to ESHT from the Primary Care Trusts have now had risk assessments completed during the past 12 months.

48% of the “undocumented” properties occupied by ESHT in the community have been risk assessed and a strategy is required to ensure full completion.

100% of all properties owned by NHS Property Company Ltd in East Sussex, covered by the current service level agreement, have a current fire risk assessment

3. Main Risks (Capital)

The investment in fire safety standards continues to demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues and risks.

3.1 Fire alarm system at the Conquest Hospital – Risk Rating 15

The installation of the L1 fire alarm system is complete. Cause and effect work, stripping out of old wiring and panels, will carry on until March 2014. The system will be fully operational by 1st April 2014.

- **Total Cost £960,000**
- **Risk Rating after completion 5**

3.2 Fire Compartmentation at the EDGH: Risk Rating 15

A comprehensive compartmentation report has been received from the Fire Protection Association; subsequently a full intrusive survey of the EDGH has been carried out by staff.

Every recommended hour compartment line and hour fire door has been examined and placed on a project record list. All breaches in the penetrations through the EDGH flooring have been identified and intumescent collars purchased ready to install.

The major aspects of the project have not yet progressed due to funding not being provided.

As this project is an intrusive one, the release of one large capital amount to Firecode will mean massive logistical issues in tackling the remedial measures and will adversely affect the care of patients. Also there is the possibility of monies not being spent in the timeframe allowed.

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It is recommended that up to £150k is allocated per calendar year as soon as practicable after 1st April, then each year over a 3 year period.

- **It is estimated that £450,000 will be required to complete the project.**
- **Risk Rating after completion 5**

3.3 Fire Compartmentation at the Conquest: Risk Rating 15

A full survey has taken place and a report received from the Fire Protection Association.

Action to improve compartmentation will be taking place between December 2013 and December 2016.

The 2013 Firecode budget is being used to improve the Theatre area compartmentation.

There are issues regarding fire door deficiencies and existing evacuation procedures have been amended while the project is researched.

The Fire Protection Associations Fire Engineers survey has recommended Level 3, 30 minute fire doors are not replaced with 60 minute fire doors as recommended by East Sussex Fire and Rescue Service in 2012.

- **It is estimated that £200,000 will be required to complete the project.**
- **Risk Rating after completion 5**

3.4 Emergency Lighting at the Conquest: Risk Rating 15

Maternity delivery, SCBU, Maternity Theatre and Frank Shaw ward at Conquest require an upgrade to the emergency lighting.

The area is not currently compliant to BS5266 Part1 and not covered by the current central emergency lighting battery system.

This scheme should be looked at as the first phase of a total replacement at Conquest,

As the current central battery system is now unsupported and on failure of any part of the system parts are unlikely to be able to be sourced.

The replacement system will need to be phased over a period of 4-5 years due to logistical constraints.

The emergency lighting deficiencies have been noted by East Sussex Fire and Rescue Service. On their next inspection, if no action plan has been put in place the Trust can expect the upgrade to be made a requirement.

- **It is estimated that £500,000 will be required to complete the project.**
- **Risk Rating after completion 5**

Benefits:

Preservation of life and business continuity restricting the spread of fire, heat and smoke.
Means of escape illuminated in an emergency (not necessarily fire) less injuries and casualties.
Compliant with legislation.
Compliance with the Regulatory Reform (Fire Safety) Order 2005.
Compliance with CQC Outcome 10 – 'Safety and Suitability of Premises'

Risks and Implications

Fire Compartmentation at the EDGH: Risk Rating 15
A comprehensive compartmentation report has been received from the Fire Protection Association; subsequently a full intrusive survey of the EDGH has been carried out by Staff.
The compartmentation deficiencies have been noted by East Sussex Fire and Rescue Service. On their next inspection, if no funding has been allocated the Trust can expect an official response.

Emergency Lighting at the Conquest: Risk Rating 15
Areas at the Conquest require an upgrade to the emergency lighting system and the current central emergency lighting battery system is no longer supported.

The emergency lighting deficiencies have been noted by East Sussex Fire and Rescue Service. On their next inspection, if no action plan has been put in place the Trust can expect the upgrade to be made a requirement.

Fire Compartmentation at the Conquest: Risk Rating 15
A full survey has taken place and a report received from the Fire Protection Association. Theatres and Maternity highlighted for improvement.

The compartmentation deficiencies have been noted by East Sussex Fire and Rescue Service. On their next inspection, if no funding has been allocated the Trust can expect an official response.

Assurance Provided:

Levels of completion of Risk Assessments
Levels of completion of Fire Safety Training
Compliance with CQC Outcome 10 – 'Safety and Suitability of Premises'
Compliance with the Regulatory Reform (Fire Safety) Order 2005.

Review by other Committees/Groups (please state name and date)**:**
Trust Health & Safety Steering Group – December 2013 Clinical Management Executive – 24th March 2014

Proposals and/or Recommendations
The Board is asked to review and note the report and in particular the requirements for capital funding.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
No assessment undertaken.

For further information or for any enquiries relating to this report please contact:	
Name: Jan Ingram, Fire Safety Officer	**Contact details:** Norman.ingram@esht.nhs.uk

East Sussex Healthcare NHS
NHS Trust

Fire Safety Annual Report

January 2013- December 2013

V1.0

In accordance with HTM 05-01 2013 “Managing Health Care Fire Safety”, the role of Fire Safety Manager is undertaken by Richard Sunley, Deputy Chief Executive & Chief Operating Officer.

Compiled and completed by

Tony Humphries
Operational Property Manager
Property Management

Norman (Jan) Ingram
Senior Fire Advisor
Property Management

January 2014

East Sussex Healthcare NHS
NHS Trust

Fire Safety
Annual Report

January 2013 - December 2013

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Fire Safety
Annual Report

January 2013 - December 2013

1.0 INTRODUCTION

The NHS workplace and working environment changes significantly from year to year. The delivery of safe and effective health services has become more important as public attitudes to risk, redress, blame and compensation have escalated.

The key challenge for this organisation is to ensure a dynamic healthcare environment compliant with all relevant fire safety legislation.

Effective Management of Fire Safety is an essential to preserve life and contribute to continuing occupation of properties.

Effective Fire Safety Management is also a legal requirement under Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) 05-01.

1.1 Context

ESHT has a staff base of approximately 7,500 operating from over 120 sites and covers 770 square miles. The main sites are Eastbourne District General Hospital and the Conquest Hospital at Hastings. The Trust gained property stock on the1st April 2013 from the outgoing Primary Care Trusts.

To ensure the continuing identification of Fire Safety Matters, including Risk, quarterly fire reports feed into the Health and Safety Steering Group (HSSG). This is chaired by the Director of Nursing who oversees the health and safety action plan that includes elements of Fire, Security and compliance with other statutory regulations.

The purpose of this report is to provide the Fire Safety Manager and Trust Board with an overview of fire safety management.

The report seeks to provide assurance of implementation of Fire Safety Policy and Procedures, Fire Safety Risk Assessment and Fire Safety Mandatory Training compliance.

An important part of this report is also to provide the Fire Safety Manager and Trust Board with a summary of the Risk faced by the Trust in relation to Fire Safety in order that the Trust can make informed decisions regarding the allocation of capital funding to remedy shortfalls in Fire Safety.

1.2 Legal background

The Fire Safety Order 2005, which came into effect on 1 October 2006 and applies to England and Wales, replaces previous fire safety legislation.

Fire Safety
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2.0 FIRE SAFETY POLICY

A new Fire Policy was developed and ratified at the beginning of 2013. Following changes to National Guidelines (HTMs) in mid 2013 the original Fire Policy has now been reviewed, updated and is due to be presented to the board in January, with a view to implementation early in 2014.

2.1 Fire Safety Protocols

As identified in the new Fire Safety Policy, Fire Safety Protocols will be developed for all aspects of Fire Safety identified in HTM 05-01. This includes Emergency Procedures, Arson, Training and Risk Assessment.

3.0 RISK ASSESSMENTS

3.1 The Regulatory Reform (Fire Safety) Order 2005 focuses on the requirement for all premises to have a suitable and sufficient Fire Safety Risk Assessment. The suitability being assessed against a series of guidance notes specific to the accommodation type. For EDGH housing stock the LACORS document also applies.

3.2 100% of the departments / services at the 2 Acute Hospital sites have now had risk assessments completed during the past 12 months.

100% of the Community sites transferred to ESHT from the PCTs have now had risk assessments completed during the past 12 months.

48% of the “undocumented” properties occupied by ESHT in the community have been risk assessed and a strategy is required to ensure full completion.

100% of all properties owned by NHS Property Company Ltd in East Sussex, covered by the current service level agreement, have a current fire risk assessment.

3.3 The current documentation has been reviewed during 2012/13 to reflect the principles of PAS79 2012 and current HTMs.

3.4 A Fire Emergency Plan containing individual Personal Emergency Evacuation Plans will be completed for each site/Ward in conjunction with the Responsible Person.

4.0 FIRE REMEDIAL WORKS

The Trust has a comprehensive list of remedial works that have been identified on the Trust fire risk assessments. These assessments form the Trust’s investment in fire safety issues over the next financial year.

The schedule includes both the work needed to meet Firecode standards and items which are not mandatory but are considered to be best practice. These are primarily the works necessary as legislation changes and new systems and procedures are introduced.

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The changing nature of legislation regarding the Trust's estate, the take over of new buildings and the continual change of use of rooms, will attract additional risk assessments and therefore additional remedial work year on year.

4.1 CAPITAL PROJECTS - MAIN RISKS

The investment in fire safety standards continues to demonstrate that the Trust has a responsible and proactive approach to dealing with fire safety issues and risks.

4.1.1 Fire alarm system at the Conquest Hospital – Risk Rating 15

The installation of the L1 fire alarm system is complete. Cause and effect work, stripping out of old wiring and panels will carry on until March 2014. The system will be fully operational by 1st April 2014.

Total Cost £960,000

Risk Rating after completion 5

4.1.2 Fire Compartmentation at the EDGH: Risk Rating 15

A comprehensive compartmentation report has been received from the Fire Protection Association; subsequently a full intrusive survey of the EDGH has been carried out by Staff.

Every recommended hour compartment line and hour fire door has been examined and placed on a project record list. All breaches in the compartment through the EDGH flooring have been identified and intumescent collars purchased ready to install.

The major aspects of the project have not yet progressed due to funding not being provided.

As this project is an intrusive one, the release of one large capital amount to Firecode will mean massive logistical issues in tackling the remedial measures and will adversely affect the care of patients. Also there is the possibility of monies not being spent in the timeframe allowed.

.

It is recommended that up to £150k is allocated per calendar year as soon as practicable after April 1st 2014 then each year over a 3 year period.

It is estimated that £450,000 will be required to complete the project.

Risk Rating after completion 5

4.1.3 Fire Compartmentation at the Conquest: Risk Rating 15

A full survey has taken place and a report received from the Fire Protection Association.
Action to improve compartmentation will be taking place between December 2013 and December 2016.

The 2013 Firecode budget is being used to improve the Theatre area compartmentation.

There are issues regarding fire door deficiencies and existing evacuation procedures have been amended while the project is researched.

The Fire Protection Associations Fire Engineers survey has recommended Level 3, 30 minute fire doors are not replaced with 60 minute fire doors as recommended by East Sussex Fire and Rescue Service in 2012.

It is estimated that £200,000 will be required to complete the project.

Risk Rating after completion 5

4.1.4 Emergency Lighting at the Conquest: Risk Rating 15

Maternity Delivery, SCBU, Maternity Theatre and Frank Shaw ward at Conquest require an upgrade to the emergency lighting.

The area is not currently compliant to BS5266 Part1 and not covered by the current central emergency lighting battery system.

This scheme should be looked at as the first phase of a total replacement at Conquest,

As the current central battery system is now unsupported and on failure of any part of the system parts are unlikely to be able to be sourced

The replacement system will need to be phased over a period of 4-5 years due to logistical constraints.

The emergency lighting deficiencies have been noted by East Sussex Fire and Rescue Service. On their next inspection, if no action plan has been put in place the Trust can expect the upgrade to be made a requirement.

It is estimated that £500,000 will be required to complete the project.

Risk Rating after completion 5

Fire Safety
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January 2013 - December 2013

5.0 FIRE TRAINING

The current level of mandatory Fire Training is at 81%, which is increasing however well below the required target of 95%.

The Fire Trainer has provided the necessary spaces to achieve required target of 100% of Staff trained by the end of 2013.

The training has either not been supported sufficiently by Managers or the Trust cannot physically release the numbers required to achieve 100%.

Therefore the percentage of staff trained as required by East Sussex Fire and Rescue has increased but the target has not yet been reached.

The training figures for the past three years are shown below for comparison.

Year	2011	2012	2013
Number of ESHT Staff	6917	6808	**6727**
Number of ESHT Staff in date	4515	5116	**5415**
Percentage	65.27%	75.15%	**80.50%**
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	No records	No Records	564

5.1 Fire Warden Training- Internal

The first Fire Warden Training course has taken place and included practical extinguisher use. This course received excellent feedback from Staff.

5.2 Fire Team Training- Internal

The first Fire Team Training course has taken place and included practical extinguisher use. This course received excellent feedback from Staff.

5.3 Practical evacuation exercises.

Ward based training has been well received and practical evacuation exercises have taken place including Theatre areas. Practical evacuation exercises have been identified as an area for improvement during 2014.

5.4 Fire Drills:

Organised and carried out by the Fire Advisors and /or Site Managers.
Fire drills have been identified as an area for improvement during 2014.

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6.0 INCIDENT REPORTS (FIRE CALLS)

The installation of the new Conquest Fire Alarm and the installation of the new fire alarm at the Irvine Unit have increased the number of alarm activations (faults and accidental) and will continue to do so until April 2014.

6.1 There were 4 fires during 2013 with no injuries reported.
Department of Psychiatry (Sussex Partnership) Notice Board -Arson
ESHT Crèche –Tumble Dryer fault.
EDGH Switchboard- Light Fitting overheated.
EDGH Residency – Cooking –Accidental.

There was one malicious fire call made during 2013 from the Intensive Care Unit on 1st April 2013. Caller not identified despite an investigation.

6.2 The table below indicates calls and classifications of calls for 2013.

The figures below represent all calls generated within Trust controlled buildings on the two acute sites, Bexhill, Uckfield, Crowborough Community Hospitals and Arthur Blackman Clinic during the preceding year.

The Trust has continued to achieve a low number of unwanted calls being made to East Sussex Fire and Rescue Service due to the three minute delay in place.

Hospital sites and residencies are shown separately

Summary of Fire Calls		**Hospital Residences**			**Conquest ,EDGH, Bexhill, Irvine Unit,**		
		2011	2012	**2013**	2011	2012	**2013**
Fire calls made	Accidental		2				
	Arson				2	0	1^
	Fires						4(1^)
	Smoking					1	
	Automatic calls via dialler system						20
Unwanted activations	Accidental Damage		2		4	5	7
	Alarm activated by patient or public				4	6	9
	Environmental – cooking	54	57	50	11	17	16(3^)
	Environmental – insects						
	Environmental – other(steam deodorants)	4	2		18	15	31
	Environmental – smoking				1	2	8^
	Good Intent				1	1	4
	Malicious						1*
	System fault/design	9	18	28	8	9	41

Fire Safety
Annual Report

January 2013 - December 2013

	System procedures not complied with	1					
	Unknown	6	9		2	7	3
	Other						
	Management procedures not complied with.		5		4	11	0
Total number of alarm activations		74	95	78	55	74	145

***Intensive Care Unit on 1st April 2013**
^ Sussex Partnership (Woodlands/DOP)
Fires = DoP-Notice Board
Crèche –Tumble Dryer
Switchboard-Light Fitting
Residency – Cooking
Please note Lewes Site and Crowborough have not submitted any records of fire calls/alarm activations.

7.0 AUDIT AND REVIEW

An audit of Trust Fire Safety Management Systems by the Fire Protection Agency is planned for March 2014.

8.0 LEGISLATION UPDATES

8.1 The Regulatory Reform (Fire Safety) Order 2005 is a risk based law with responsibility for fire safety resting with the several responsible persons. The most recent Trust Fire Safety Policy identifies the “responsible person” for each workplace and defines the lines of responsibility from employees to the Chief Executive.

8.2 The Fire Policy has been ratified and will be fully implemented early in 2013.

8.3 A new HTM was issued in 2013. HTM 05/01 Managing Healthcare Fire Safety Second Edition April 2013.

9.0 INSPECTIONS BY THE ENFORCING AUTHORITY.

All recommendations following audits are being acted upon and Action Plans forwarded to the relevant local ESFRS Fire Safety Manager.

Details of the outstanding issues are detailed in section 4

There have been no enforcement actions during 2013.

N Ingram
Senior Fire Safety Advisor
31st December 2013

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	16b
Subject:	Fire Safety Policy
Reporting Officer:	Richard Sunley, Chief Operating Officer

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

Purpose:

The purpose of this report is to present the revised Trust wide Fire Safety Policy for approval.

Introduction:

It is mandatory that all NHS organisations (excluding foundation trusts):

- comply with legislation relating to fire safety;
- follow evidence-based best practice guidance where reasonably practicable;
- ensure that suitable and sufficient governance and assurance arrangements are in place to manage fire-related matters and demonstrate due diligence;
- have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures, which is shared across the organisation;
- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;

facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

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

The first Trust Fire Policy was ratified in February 2013 and has now been revised to meet the recently published Second Edition of the Health Technical Memorandum 05-01: managing healthcare fire safety. As required by HTM 05-01 procedures and protocols are to be developed separately to the Trust Policy.

Benefits:

Compliance with statutory legislation and DOH Policy.

Risks and Implications

The document provides for a policy for producing protocols for risk assessment and controls.

Assurance Provided:

This policy has been written to comply with Health Technical Memorandum 05-01: managing healthcare fire safety (Second edition: April 2013)

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

Estates Senior Management Team 06/09/2013
Commercial Directorate Management Group 10/09/2013
Health and Safety Steering Group 17/09/2013 and 03/12/2013

Clinical Management Executive 24/03/2014

Proposals and/or Recommendations
The Board is requested to approve the Fire Safety Policy for Trust-wide implementation.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
The Equality Act 2010 requires the adjustment of policies, practices and procedures and, where necessary, the building fabric, so as not to discriminate against disabled people. Site Risk Assessments and Operating procedures (including Emergency Action Plans and PEEPS) must take account of the requirements of the act. The main principle of fire safety is that all people should be evacuated from a building in the event of fire. In terms of healthcare premises, this may not necessarily be the case for all situations. In hospitals, the concept of progressive horizontal evacuation is the norm. Existing fire legislation requires suitable evacuation procedures to be in place for all people using the building. The Fire Safety Manager must ensure that any staff required to assist with evacuation are adequately trained.

For further information or for any enquiries relating to this report please contact:	
Name: Tony Humphries, Estates and Facilities Manager	**Contact details:** tony.humphriers@esht.nhs.uk

East Sussex Healthcare NHS
NHS Trust

Fire Safety Policy

Version:	*2.0*
Ratified by:	*Trust Board*
Date ratified:	
Name of author and title:	*Tony Humphries,* *Operational Property Manager*
Date Written:	*August 2013*
Name of responsible committee/individual:	*Fire Safety Manager* *Richard Sunley,* *Chief Operating Officer*
Date issued:	
Issue number:	
Review date:	*2 years from ratified date*
Target audience:	*All Trust staff, agents and contractors*
Compliance with CQC outcome:	*Outcome 10 – 'Safety and Suitability of Premises'*
Compliance with NHSLA/CNST:	
Compliance with any other external requirements (e.g. Information Governance):	*The Regulatory Reform (Fire Safety) Order 2005 (RRO)* *DOH Policy* *The Health and Safety Management Regulations 1999*
Associated Documents:	*ESHT Health and Safety Policy* *ESHT Major Incident Plan* *ESHT Induction Policy* *ESHT Learning and Development Policy* *ESHT Mandatory Training Policy* *ESHT Risk Management Policy* *ESHT Incident Reporting and Management Policy* *ESHT Trust Security Policy* *ESHT Waste Policy*

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the policies and can only guarantee that the policy on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
2.0	November 2013	Tony Humphries	Revision to comply with HTM 05-01 (second edition) April 2013	Details of management procedures removed. To be provided in separate management "Fire Safety Protocols"

Consultation Table

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

Name of Individual or group	Title	Date
Jan Ingram	Senior Fire Safety Advisor	August 2013
Estates SMT	Mark Paice, Mike Chewter, Mark Neal, Tony Humphries, Simeon Beaumont	September 2013
Commercial DMG	George Melling, Mark Paice, Stuart Barnhill, Vicki Rose, John Kirk	September 2013
Health & Safety Steering Group	All members and advisors	September 2013

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

Table of Contents

1. INTRODUCTION

East Sussex Healthcare NHS Trust (ESHT) is committed to the health, safety and welfare of all relevant persons in premises owned, occupied or the responsibility of ESHT.
ESHT will ensure that the risk of fire is reduced to the lowest possible level. When fires do occur, ESHT will ensure that they are rapidly detected and effectively contained.

The Trust fire safety management system comprises of the following:

- **Fire Safety Policy;**
- **Fire Safety Protocols:**
  - Fire prevention;
  - Risk assessments;
  - Fire strategies;
  - Emergency planning and procedures;
  - Fire safety training;
  - Construction and refurbishments;
  - Fire detection and alarm systems;
  - False alarms and unwanted fire signals;
  - Fire extinguishers;
  - Security;
  - Arson;
  - Hot works;
  - Maintenance of fire equipment;
  - Fire stopping;
  - Portable appliance testing;
  - Medical gases;
  - Purchasing;
  - Laundry;
  - Information for the fire and rescue service;
  - Salvage and continuity planning.
- **Fire safety information manuals;**
  - A description of the ward/department/area.
  - A brief description of the area, its extent, location and use.
  - A fire safety plan of the ward/department/area.
  - A fire safety checklist.
  - Emergency action plan specific to the ward/department/area.
  - Staff fire safety training records.
  - Records of fire drills and emergency fire action plan rehearsals.
- **Fire audit**

1.1. FireCode (HTM 05-02 & 05-03)

Firecode is a suite of guidance specifically covering fire safety in the NHS in England. It considers management, functional requirements, and operational provisions.
Whilst Firecode provides a means of achieving an acceptable standard of fire safety, the Department of Health recognises that alternative ways of achieving the same objectives may be possible. Where an alternative solution to Firecode is proposed, the designer must demonstrate that the approach does not result in a lower standard of fire safety than if Firecode had been applied.

1.2. Arson

Arson is a significant cause of fire in all types of premises. It is a cause for concern to those who are required to meet the costs of such fires, especially trusts because of the inherent life risk in most of the premises they occupy and the impact that fire damage may have on the wider provision of healthcare.

Key to the prevention of fire because of arson is effective security measures and housekeeping practices relating, in particular, to waste materials.

Trust Security and Waste Policies and Procedures will address the issues of arson as described in *Firecode – fire safety in the NHS Health Technical Memorandum 05-03: Operational Provisions, Part F: The prevention and control of arson in NHS healthcare premises.*

2. PURPOSE

Purpose
To provide an unambiguous statement of fire safety policy applicable to East Sussex Healthcare NHS Trust and to premises where patients of East Sussex Healthcare NHS Trust receive treatment or care, excluding a single private dwelling.

2.1. Rationale

Policy aims
This fire safety policy aims to minimise the incidence of fire throughout all activities provided by, or on behalf of, East Sussex Healthcare NHS Trust.
Where fire occurs, this policy aims to minimise the impact of such occurrence on life safety, the delivery of patient care, the environment and property.

2.2. Principles

Application
This policy applies wherever East Sussex Healthcare NHS Trust owes a duty of care to service users, staff or other individuals.

2.3. Scope

All East Sussex Healthcare NHS Trust staff and properties (leased or owned) fall within the scope of this policy.

All staff and properties must comply with legislation relating to fire safety.

ESHT must be satisfied that all new buildings, leased, or occupied under a PPP/PFI contract must comply with legislation relating to fire safety.

East Sussex Healthcare NHS Trust will ensure that appropriate and competent advice and guidance on all matters related to fire safety is available.

3. DEFINITIONS

Assembly point: a pre-determined area of safety where persons should assemble in the event of an emergency.

Authorising Engineer (Fire): a chartered fire engineer, or a chartered member of an appropriate professional body, with extensive experience in healthcare fire safety.

Child: a person who is not over the compulsory school age.

Compartmentation: the fire-resisting elements including walls, floors, and where applicable, roofs and/or other structures used in the separation of one fire compartment from another.

Competence: where a person is required to be competent, he/she must be able to demonstrate through training and experience or knowledge and other qualities that they have the ability to properly assist in undertaking the preventative and protective measures.

Competent Person (Fire): a person who can provide skilled installation and/or maintenance of fire-related services (both passive and active fire safety systems).

Complex healthcare organisations: hospitals or other healthcare premises that perform invasive procedures and other treatments that place a dependence on staff for evacuation.

Fire emergency action plan: the pre-determined plan that describes the actions necessary in the event of a fire to protect relevant persons and facilitate their safe evacuation.

A fire safety checklist: A schedule of the fire safety checks that should be undertaken on commencement of work by the person in charge of the area during that work period, including for example:

- check that the nearest fire alarm repeat panel displays a healthy condition;
- check that the manual call points are unobstructed;
- check that the fire extinguishers are in place and readily accessible;
- check that escape routes are clear and unobstructed;
- check that the fire doors that should be kept shut are fully closed;

Fire engineering: the application of scientific and engineering principles to the protection of people, property and the environment from fire.

Fire-fighting equipment: the fire extinguishers, fire blankets and other equipment made available to trained personnel for the purpose of fighting fire.

Fire resistance: the ability of an element of building construction, component or structure to fulfil, for a stated period of time, the required load-bearing capacity, fire integrity and/or thermal insulation and/or other expected duty in a standard fire resistance test.

Fire risk assessment: the process of identifying fire hazards and evaluating the risks to people, property, assets and the environment arising from them, taking into account the adequacy of existing fire precautions, and deciding whether the fire risk is acceptable without further fire precautions.

Fire Safety Adviser (Authorised Person: Fire): a person who has sufficient training and experience or knowledge and other qualities to enable them to properly assist in undertaking preventative and protective measures.

Fire safety management system: a robust framework of protocols and processes used to ensure that an organisation can fulfil all tasks required to achieve the fire safety objectives set out in the fire safety policy.

Fire Safety Manager: the person within the organisation tasked with coordinating fire safety issues throughout the organisation's activities.

Fire Safety Order: The Regulatory Reform (Fire Safety) Order 2005.

Fire safety policy: a high level statement of intent, as expressed by the board, partners, or equivalent controlling body, setting out clear fire safety objectives for the organisation.

Fire safety procedure: a detailed document setting out each step of a process intended to prevent fire, maintain fire precautions, minimise fire hazards or effectively respond to a fire incident.

Fire safety protocols: a set of organisation-specific guidelines that set the fire safety parameters of any activity that may impact on fire risk.

Healthcare building: a hospital, treatment centre, health centre, clinic, surgery, walk-in centre or other building where patients are provided with medical care, diagnostics or other associated treatment.

Hot works: Operations involving the use of open flames or the local application of heat or friction such as welding, soldering, cutting or brazing.

Material change: A change in arrangements or circumstances that may have an impact on the validity of fire risk assessments, fire precautions, fire emergency action plans etc.

Management level: standard or quality of the organisational fire risk management system.

Occupant dependency: the categorisation of occupants on the basis of their likely need for assistance to effect their safe evacuation in an emergency. The following categories are referred to in this Health Technical Memorandum:

- Independent: occupants will be defined as being independent: if their mobility is not impaired in any way and they are able to physically leave the premises without staff
    - if their mobility is not impaired in any way and they are able to physically leave the premises without staff assistance; or
    - if they experience some mobility impairment and rely on another person to offer minimal assistance. This would include being sufficiently able to negotiate stairs unaided or with minimal assistance, as well as being able to comprehend the emergency wayfinding signage around the facility.
- **Dependent**: all occupants except those classified as "independent" or "very high dependency".
- **Very high dependency**: those whose clinical treatment and/or condition creates a high dependency on staff. This will include those in critical care areas, operating theatres, coronary care etc and those for whom evacuation would prove potentially life-threatening.

Place of relative safety: an initial place away from the immediate danger of fire and from which further evacuation is possible to a place of safety.

Place of safety: a place where persons are in no danger from fire.

Premises: the land, building, or part of a building which is owned, occupied or managed by the organisation.

Preventative and protective measures: the measures which have been identified by the responsible person in consequence of a risk assessment as the general fire precautions necessary to comply with the requirements and prohibitions imposed by the Fire Safety Order.

Progressive horizontal evacuation: evacuation of patients away from a fire into an adjacent fire-free compartment on the same level.

Relevant person: any person who may be lawfully on, or in the immediate vicinity of, the premises and who is at risk from a fire on the premises.

Responsible person: the employer of persons working at the premises, a person who has control of the premises, or the owner of the premises.

4. Accountabilities and Responsibilities

Refer to Fire Safety Management Structure in appendix A

4.1. The "Responsible Person": Organisational Interpretation

The Regulatory Reform (Fire Safety) Order 2005 (RRFSO) states that the 'Responsible Person' is the Employer if the Workplace is to any extent under his control. Or

Any person who has control of a premise (occupier or otherwise) for the purpose of carrying on by him a trade, business or other undertaking (profit or not).Or

The owner where the person in control of the premises does not have control in connection with carrying on by that person a trade, business or other undertaking.

Article 5.3 RRFSO refers:

Duties on persons other than responsible persons to comply with the RRFSO to the extent they have control over the premises.

Article 5.4 RRFSO refers:

When a person has by virtue any contract or tenancy an obligation for the maintenance or repair of premises or the safety of premises they will be treated as the person who has control of the premises to the extent that their obligation so extends.

It is important to identify the 'Responsible Person(s) for each premises on the relevant Fire Risk Assessment and that their responsibilities are clearly defined in any Operating Procedures and Emergency Plans for that premises.

4.2. Executive Management

The Chief Executive has overall responsibility for the health, safety and welfare of all staff, service users, visitors and others within ESHT and is responsible for monitoring and reviewing health and safety in the Trust. This includes fire safety. The Trust Board will be informed of fire safety matters on a regular basis and ensure adequate resources are

made available to provide and maintain the necessary standards of fire safety in the Trust.

Members of the Executive Management Team have full responsibility for the health, safety and welfare of all staff, visitors and others within the wards, offices etc. under their specific management and will support the Chief Executive in fulfilling their responsibility.

All Directors have a corporate responsibility to promote a responsible approach in health, safety and fire in the Trust.

Appointing another person, who will undertake the duties of the 'Responsible Person' in his/her absence.

4.3. The Chief Executive

The Chief Executive is ultimately the Responsible Person for adherence to the RRFSO and is accountable for the establishment and achievement of fire policies within the Trust. The Trust Board is also responsible for establishing objectives, policy, priorities and the allocation of funds.

The Chief Executive will be supported in fulfilling this responsibility by other members of the Trust Executive Team.

4.4. Board Level Director (with responsibility for Fire Safety)

The Chief Executive will nominate a Board Level Director with responsibilities for Fire Safety.

The Chief Executive will be responsible for notification of any change of nominated Director.

The Director with Responsibility for Fire Safety is the Chief Operating Officer who is responsible for ensuring that all officers within the Trust, having a responsibility for fire safety matters, meet that responsibility.

The Director with responsibility for Fire Safety must be sufficiently empowered and have access to adequate resources and be able to influence and direct Staff.

4.5. Fire Safety Manager

The Chief Operating Officer is the Fire Safety Manager for East Sussex Healthcare and as such is responsible for, but not limited to, the following:

- An awareness of all fire safety features and their purpose;
- Fire safety risks particular to the organisation;
- Requirements for disabled staff and patients (related to fire procedures);
- Ensuring appropriate levels of management are always available to ensure decisions can be made regardless of the time of day;
- Compliance with legislation;
- Development and implementation of the organisation's fire safety policy;
- Development of the organisation's fire safety strategy;
- Development of an effective training programme;
- Cooperation between other employers where two or more share the premises;
- The reporting of fire incidents in accordance with current practice;

- Monitoring and mitigation of unwanted fire incidents;
- Liaison with enforcing authorities;
- Liaison with other managers;
- Monitoring of inspection and maintenance of fire safety systems.

The Fire Safety Advisor must be capable of assisting the Fire Safety Manager in discharging the roles and responsibilities outlined above.

4.6. Fire Safety Committee

The "Fire Safety Committee" will be incorporated in the Health & Safety Steering Group, which will include standard agenda items of fire incidents, unwanted fire incidents, enforcement action, and staff training"

4.7. Senior Fire Advisor and Fire Advisor (Authorised Persons: Fire)

East Sussex Healthcare Trust will directly employ Fire Safety Advisors, (Competent Persons) suitably qualified and in sufficient numbers.

The Fire Safety Advisor's role is to provide technical expertise to the Fire Safety Manager to enable them to fulfil their duties effectively.
The Fire Safety Advisors are responsible for the following:

- Ensuring that a fire risk assessment has been carried out
- Ensuring that regular fire safety training and fire drills are provided at suitable times to allow staff to participate. This training is to be appropriate to the needs of all staff and must reflect the diverse needs of all staff, e.g. limited English, visual impairment or hearing impairment.
- Providing expert advice on the application and interpretation of fire legislation and fire safety guidance, including FireCode;
- Advising on the content of the organisation's fire safety policy;
- Assisting with the development of the organisation's fire strategy;
- Helping with the development of a suitable training programme, including delivery of the training;
- Liaising with enforcing authorities on technical issues;
- Liaising with managers and staff on fire safety issues; and
- Liaising with the Authorising Engineer (Fire).

There may be occasions where specialist solutions are necessary to resolve fire safety issues, for example fire engineering. The Fire Safety Advisor would not necessarily be expected to have specialist skills, but would be expected to have sufficient knowledge to realise when they required specialised skills.

Trusts Fire Advisor(s) duties:

- When notified of a Fire, providing advice on formal responses to the Fire and Rescue Service during their enquiries.
- Provide specialist telephone support to enquiries from all relevant persons within the Trust.
- Provide a review of an existing Fire Risk Assessment within a reasonable time for premises that have been subject to material change
- Provide initial Fire Risk Assessments for new properties entering the Trust Portfolio
- Review existing Fire Risk Assessments annually

- Review fire risk assessments taking account building risks, e.g. compartmentation, fire detection etc.
- Provide an annual over view of the Trusts Fire Safety management procedures including :
  - Provide an annual review of the existing Fire Risk Assessments
  - Provide a review and learning outcomes of any fire related incidents as they occur
  - Review Unwanted Fire Alarm activations and indicate trends
  - Continuously improve the content of the Fire Safety training provided by the Trust and ensure bespoke training is provided
  - Provide specialist advice on Fire Safety management i.e. implementation of new policies and new technologies

4.8. Fire Safety Trainer

Responsibility for the development, delivery, recording and monitoring of the fire safety training within the Trust and elsewhere, in accordance with any service level agreement that may be in place.

Provide co-ordinated advice and guidance on all aspects of fire training and associated activities across all properties and services within the Trust

To develop, deliver and review fire training for all relevant persons. This may include working outside normal hours.

To plan and implement a training programme for ESHT with the Senior Fire Advisor

To manage the Trust fire training records, course bookings and produce reports as required.

Provide lists of staff trained for inclusion in property fire registers.

Provide a certificate of attendance to all persons attending the fire training.

To support the Fire Advisors and local managers in the organisation of fire warden training fire drills, witnessing the effectiveness of those drills and recommending appropriate remedial action where necessary.

To ensure any defects identified to either the passive or active fire safety provisions are reported immediately to the relevant officer/department to ensure that remedial work is undertaken.

4.9. All Managers

Heads of Department and Line Managers are responsible for the operational management of fire related matters as part of their overall responsibility for health, safety and welfare of their Staff.

Each Head of Department and Senior Manager is responsible for the day to day maintenance of fire related matters within their areas of responsibility. All faults, defects or omissions are reported and/or actioned. Close liaison with the responsible person is essential to ensure there is synergy within site fire safety management.

Managers are to ensure that all staff under their supervision participates annually in fire safety training and fire drills, and that a record of fire safety training is kept. Heads of

Departments, Senior Managers and Managers must also ensure that new staff attends induction training before commencing in their role.

Heads of Department, Senior Managers, and Managers shall ensure that all newly appointed staff (including temporary, agency and bank members of staff) are inducted in the local fire procedures and fire instructions relevant to their premises as required. This induction is to include:-

- The actions in the event of fire
- Who to report to in the event of a fire
- To walk all escape routes
- The location of the fire alarm call points and the presence of automatic fire detectors
- How to operate call points (some units have key operation)
- The position of all fire fighting equipment in the working area
- The type and use of fire fighting equipment
- That security doors unlock when the alarm is activated and if not location of the security door break glass points. Whether there is a time delay on them.
- Familiarisation with the evacuation plan including progressive horizontal evacuation.

This is to be completed on their first day of employment (refer to the Trust Induction Policy checklist).
Managers will provide the employer of any person from an outside organisation, e.g. an agency providing temporary staff, with clear and relevant information on the risks to those employees and the preventive and protective measures taken.

This Includes providing those employees with appropriate instructions and relevant information about the risks to them. This information must be available in formats, which are comprehensible to all relevant persons.

4.10. Ward/Team Manager

Ward/Team Managers are responsible for:

- Ensuring the Action Plan from the current Fire Risk Assessment is actioned in conjunction with the Fire Advisors and Head of Maintenance
- Liaising with the Fire Safety Advisors to write a Fire Evacuation Plan.
- Retaining the Fire Evacuation Plan, the Fire Risk Assessment and Fire Warden Weekly check sheets in their workplace in an agreed format.
- The day to day management of fire safety, including maintaining records, training and supervising the upkeep of precautions
- Acting upon reports from the Fire Safety Advisors, and liaising with the Lead Manager for Fire Safety and the Site Fire Safety Manager with regard to the contents of the reports received
- Co-operating and sharing responsibilities for fire arrangements as required in the Regulatory Reform (Fire Safety) Order 2005
- Ensuring that fire instructions are brought to the attention of, and observed by every member of their staff, and that all staff participates in the fire training.
- Ensure that visitors are aware of the local Fire Safety procedures for their area of control / building
- Ensuring that there is always one or more Fire Wardens designated to ensure that the duties and obligations of the post are always discharged.

4.11. Clinical Site Manager (Acute Hospitals)

Clinical Site Managers are responsible for:

- Ensuring their availability should a fire incident occur
- Attending the scene, taking control and delegating tasks
- Liaising with the Fire and Rescue Service Manager
- Ensuring a successful conclusion to the incident.

4.12. Nominated Site Fire Safety Coordinators (Community)

In order to provide a coordinated approach in the Community settings the Premises Liaison Managers in the Community Settings will:

- Ensure that an adequate number of written fire instructions are displayed in conspicuous positions. This information must be available in formats which are comprehensible to all relevant persons.
- Ensuring those switchboard operators, receptionists and any other members of staff with a responsibility for calling the Fire and Rescue Service have written instructions, detailing the actions required in the event of a fire.
- Prepare and keep up to date general emergency action plans for the safe evacuation of patients, visitors and staff, taking into account the diversity of these persons. Ensuring that the emergency action plan is understood by all individual staff members.
- Coordinate weekly tests of their area of responsibility are carried out using the '**Fire Wardens Inspection Record Sheet'.**
- Consider the presence of any dangerous substances and the risks these present to relevant persons - will there be an outbreak of fire, establishing a suitable means of providing the emergency services with any relevant information about dangerous substances.
- Liaise with the Fire Advisers for the premises in relation to all fire matters and ensure such matters are acted upon as appropriate. i.e. risk assessments, drills, housekeeping, inspections, action plans etc.
- Organise fire drills/exercises for their premises and ensure they are conducted at least once per year to form an important part of staff training.
- Make a record of drills including date, time and outcome which should be kept on site in the Log Book so that they are available for inspection should this be required by officers from enforcing authorities.
- Review the outcome of specified drills and if ineffective will consult the Fire Safety Advisor so that any necessary improvements may be made.
- Audit and ensure that fire log book records are kept up to date.

4.13. Incident and Evacuation Officer (Community Sites)

In the cases of shared sites, the person in charge in the event of a fire could be from the host Trust (who have provided a Ward/Team Manager or equivalent role). However, the Trust must still provide Fire Wardens who will be responsible for day-to-day needs and communication with the host Trust on fire issues. In these cases teams will operate to the buildings fire plan.

Their principle duties are:

- The Incident and Evacuation Officer is responsible for calling for emergency services (999 / 112) when there is a fire, even if the alarm is connected to a dedicated line, call centre etc.
- To act as a focal point on fire safety issues for local staff:
- To organise and assist in the fire safety regime within local areas:
- To raise issues regarding local area fire safety with line management:
- To assist with coordination of the response to an incident within the immediate vicinity:
- To be responsible for roll-call during an incident;
- To support line managers on fire safety issues.

They must also co-ordinate and direct staff actions at a serious fire in accordance with the fire procedure.

Incident Officers (jointly with Team/Ward Managers) must ensure that all fire alarm activations are reported to the Fire Safety Advisors.

4.14. Fire Wardens

Will act as a focal point on fire safety issues for local staff; organise and assist in the fire safety regime within local areas; raise issues regarding local area fire safety with line management; assist with coordination of the response to an incident within the immediate vicinity; be responsible for roll-call during an incident (one of the Fire Wardens will be take the role of Incident / evacuation officer for their area); be trained to tackle fire with first aid fire fighting apparatus where appropriate;

Support line managers on fire safety issues.

Staff will be nominated and trained to act as a local fire warden. They should supervise the day to day maintenance of fire precautions, ensure that all staff participates in training and fire drills and co-ordinate and direct the actions of staff in a fire emergency.

Their principle duties are to:

- Organise and assist with evacuations within local areas:
- Raise local issues regarding their local area fire safety (e.g. housekeeping, fire doors being held open etc.) with line management
- Assist with coordination of the response to an incident within the immediate vicinity:
- Be trained to tackle fire with first aid fire fighting apparatus where appropriate where safe to do so;
- Complete the Fire Wardens weekly checks and maintain a record
- They will report fire safety issues to the appropriate line manager who in turn will report the matter to the Fire Advisors and inform any other relevant person as necessary

4.15. Fire Team (Acute Hospitals)

The Fire Team is comprised* of:

- The Clinical Site Manager
- Nominated Maintenance , Security and Portering Staff

Nominated Staff are provided with handheld radios and bleeps.

Clinical Site Manager - on activation of the Fire Alarm

The Clinical Site Manager will attend the Switchboard to collect the fluorescent jacket and Fire Folder and proceed to the relevant area.

In liaison with the local Manager a plan of action will be formulated.

The Switchboard, on calling the Fire and Rescue Service are to confirm to the Clinical Site Manager that the call has been made. This can be done via the radio network.

The Clinical Site Manager should take control of any evacuation required.

The Clinical Site Manager should liaise with the switchboard and the Fire Team who will inform theatres etc. of the progress of the incident via the portable radios held by porters and maintenance staff.

For a more protracted incident, the involvement of the emergency services will mean a detailed handover of information to the Fire and Rescue Service is required.
An aide memoir is provided and may be used to bring the incident to a conclusion.

When satisfied that the situation is under control, or that a false alarm situation has arisen the Clinical Site Manager can authorise the fire alarm to be silenced. As necessary and only if the Fire and Rescue Service have not been called they may also authorise the resetting of the alarm system.

The Fire Team- on activation of the Fire Alarm

The team will be contacted by the Switchboard in the event of alarm activation by the internal pager system.

*The number of persons comprising the initial attendance of the fire team will vary according to the time of day or night.

When informed of the incident, members of the team are to;

Proceed to the locality of the alarm and in liaison with the Clinical Site Manager and Local Manager identify the cause of the alarm activation.

If a fire has occurred the Fire Team should carry out a dynamic risk assessment and if safe to do so, contain the fire until the arrival of the Fire and Rescue Service.

The Fire Team should assist the Clinical Site Manager and Local Manager to control any evacuation in the vicinity of the fire and prepare for further evacuation as necessary.

The Fire Team should control the perimeter of the area / building to prevent unauthorised entry into risk area

On information from the Clinical Site Manager or the Switchboard, the Fire Team will inform theatres etc. of the progress of the incident via the portable radios held.

One member of Fire Team will go to the main entrance and direct the emergency services to the most appropriate access point to the incident.

One member of Fire Team will ensure that the local access point is available for the emergency services to enter the building.

Once on site the Fire and Rescue Service will take charge of the incident. Any relevant information will be passed to the Senior Fire and Rescue Service Manager.

The Fire Team will attend the debriefing after any incident.

If fire fighting action is to take place it must be done in a manner that will not place any members of staff or others at risk. The action taken to attack the seat of the fire must be carried out only if those doing so can be certain that they can extinguish it, or contain it until the fire brigade arrive.

The identification of any other areas that may become involved should be addressed by setting a fire watch, closing doors, securing access points and clearing others at potential risk.

The On Call Manager (Conquest and Eastbourne DGH): Protracted Incident Procedure.

The On - Call manager will ensure that they attend the Fire and Rescue Service control point to undertake the management role on behalf of the Trust.
They will liaise with all other departments to ensure that they are kept aware of incident operations and trends.
They will inform the duty site manager that they have arrived and indicate whether or not they are taking over the control of the incident or providing an overview, with any necessary additional help or assistance being given.

The On-Call Manager together with the site manager will ensure that suitable staff are assigned to assist in the evacuation of the affected and adjacent areas in liaison with the Senior Fire and Rescue Service Manager.

Together with the senior nursing officer present, the On-Call Manager will ensure that patients are provided with any necessary medical assistance and as necessary liaise with designated hospitals in the transfer of patients for continuance of care.

The On-Call Manager may call upon the assistance of any other member of staff to assist them in the undertaking of their role at the time of the incident.

The On-Call Manager will ensure that the health, safety and welfare of each affected patient or member of staff involved in the incident is maintained at all material times.

4.16. Commercial Directorate

The Operational Divisions of the Commercial Directorate has the following responsibilities for fire safety:

Ensuring that contractors engaged on work that creates hazards, such as burning, welding, painting or woodworking are trained to a high standard of fire safety and, also, that 'hot work' procedures are followed, where appropriate. This training is to be appropriate to the needs of the relevant member of staff and must reflect his/her needs, e.g. limited English, visual impairment or hearing impairment.

Ensuring that the premises and any equipment provided in connection with fire fighting, fire detection and warning, or emergency routes and exits are covered by a suitable

system of maintenance and are maintained by a competent person in an efficient state, in efficient working order and in good repair.

- Ensure that the fire detection systems are tested in accordance with BS 5839, Part 1 (2002) - Testing & Maintenance
- Ensure that fire alarm systems are tested and maintained to the following regime:
- Bells / sounders tested on a weekly basis
- All initiating devices (call points, detectors etc.) tested on an annual basis
- Ensure that fire fighting appliances are maintained to BS 5306-3 2009.
- Ensure that all Fire Exit signs are checked at regular intervals to ensure compliance with the Safety Signs regulations 1996 and accordance with BS 5499, Part 1 "Specification for Fire Safety Signs" (which includes standard colour-coding)
- Ensure the storage of flammable liquids and the recommendations of FPN2 "Storage of Flammable Liquids" and HSG 51 "Storage of Flammable Liquids in Containers" have been followed
- Ensure the storage of flammable compressed gases and oxygen are safe and follow regulatory standards and Approved Codes of Practice.
    - Ensure that all personnel that work on and manage fire alarm systems, have appropriate and relevant training, and the details of their training have been documented
    - Cooperate with the Trust and its agents in monitoring the above responsibilities by evaluating that the above are carried out to the appropriate standards including the British Standards listed and recommendations made in the HTM 05 (FireCode) series of documents

4.17. Authorising Engineer (Fire)

There may be occasions where specialist solutions are necessary to resolve fire safety issues, for example fire engineering. The Fire Safety Advisor would not necessarily be expected to have specialist skills, but would be expected to have sufficient knowledge to realise when they required specialised skills.

NHS organisations are not required to appoint an Authorising Engineer (Fire) in a permanent capacity. Where deemed necessary by the Fire Safety Advisors a fire engineer will be engaged if a specific fire-engineered solution has been identified or is proposed, and the in-house resources have limited expert knowledge.

In seeking to appoint an Authorising Engineer (Fire), NHS organisations should approach the Institution of Fire Engineers (www.ife.org.uk) or the Association of Fire Consultants (www.afc.eu.com) for further guidance and information regarding fire engineers. An Authorising Engineer (Fire) should be able to demonstrate competence.

4.18. Competent Persons (Fire)

This will be a person external to the organisation who provides skilled installation and/ or maintenance of fire-related services (both passive and active fire safety systems). The Competent Person (Fire) must be able to demonstrate a sound knowledge and specific skills in the specialist service being provided.

4.19. Enforcing Authority visits to ESHT sites

In the event that the Fire Authority should request a visit to any ESHT site, a Fire Advisor will meet the Fire and Rescue Service representative.

If any notice or guidance is received the Fire Advisors must inform the most senior operational person on the site of the contents of the notice or guidance.

In the event that the Fire Authority should make an unannounced inspection of the suite, as with any regulatory Authority, the most senior operational person on the site or area will meet with the Fire Authority and subsequently contact the Fire Advisors to liaise regarding notices received or guidance given.

4.20. All staff, contract staff and volunteers

All staff, contractors and volunteers will:

- comply with the trust's fire safety protocols and fire procedures;
- participate in fire safety training and fire evacuation exercises where applicable;
- report deficiencies in fire precautions to line managers and Fire Wardens;
- report fire incidents and false alarm signals in accordance with trust's protocols and procedures;
- ensure the promotion of fire safety at all times to help reduce the occurrence of fire and unwanted fire alarm signals;
- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5. PROCEDURES AND ACTIONS TO FOLLOW

Facilitation

The Trust Board will:

- Discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;

- Provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;

- Facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

Implementation

The Trust Board expects those tasked with managing aspects of fire safety to:

- Diligently discharge their fire safety responsibilities as befits their position;

- Have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;

- Have in place a programme for the assessment and review of fire risks;

- Develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;

- Develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment;

- Develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

- Develop and implement a programme of appropriate fire safety training for all relevant staff;

6. EQUALITY AND HUMAN RIGHTS STATEMENT

The Equality Act 2010 requires the adjustment of policies, practices and procedures and, where necessary, the building fabric, so as not to discriminate against disabled people. Site Risk Assessments and Operating procedures (including Emergency Action Plans and PEEPS) must take account of the requirements of the act.

The main principle of fire safety is that all people should be evacuated from a building in the event of fire. In terms of healthcare premises, this may not necessarily be the case for all situations. In hospitals, the concept of progressive horizontal evacuation is the norm. Existing fire legislation requires suitable evacuation procedures to be in place for all people using the building. The Fire Safety Manager must ensure that any staff required to assist with evacuation are adequately trained.

7. TRAINING

Fire Safety training is a Mandatory requirement and is outlined in the **Fire Safety Training Plan,** developed in accordance with the Trust Training Needs Analysis (TNA). Training sessions will include the need for Personal Emergency Evacuation Plans and general awareness of access needs for Disabled People.

7.1. Fire Drills

Fire drills will be undertaken at least once a year in all premises occupied by East Sussex Healthcare NHS Trust staff. They shall be arranged by the Ward/ team manager or Premises Liaison Manager in community settings, supported by advice from the Fire Safety Advisors, upon request.

Fire drills are training sessions that test the effectiveness of the emergency plans and the fire safety training. They will rehearse procedures and do not necessarily involve the total evacuation of the building/area. Fire drills need not involve moving patients or visitors and at no time will fire drills endanger those taking part. In all cases, the interest of and care of patients and visitors will be a paramount consideration.

All new and temporary staff will be given an induction into the procedures and their responsibilities on their first day. They will attend an induction course within one month of their start date or for non-clinical personnel, complete the on line induction course.

Training arrangements are subject to a full Training Needs Analysis

8. MONITORING COMPLIANCE WITH THE DOCUMENT

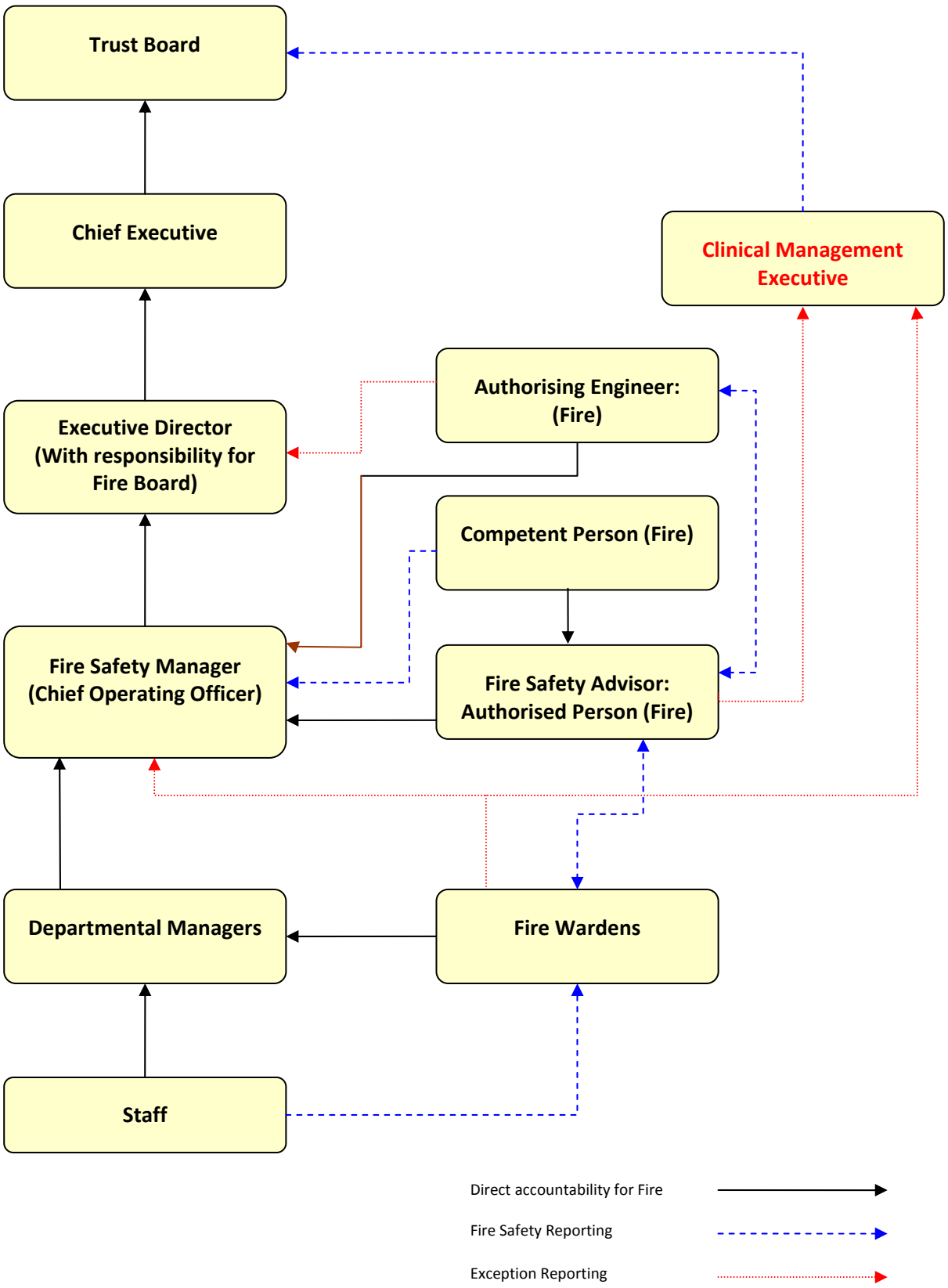
9.1 Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Review of fire and false alarm incident reports;	Senior Fire Advisor	Incident / reports / Data base	Monthly	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Richard Sunley, Fire Safety Manager
Review of fire safety training records	Senior Fire Advisor	Data base	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Richard Sunley, Fire Safety Manager
Review of fire service notices and communications;	Senior Fire Advisor	Risk Assessment	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Richard Sunley, Fire Safety Manager
Third-party fire safety audit	Operational Property Manager	Fire Safety Audit report	Annual	Fire Safety Team	Fire Safety "Committee". Hosted by The Trust Health and Safety Steering Group (HSSG)	Richard Sunley, Fire Safety Manager

9. REFERENCES

- Health & Safety at Work etc., Act 1974
- The Building Act 1984
- The Building Regulations 1985 (as amended 2000)
- Regulatory Reform (Fire Safety) Order 2005
- HTM 05-01: Managing Healthcare Fire Safety
- HTM 05-03: Part A-K: General fire safety
- HTM 05-03: Part B: Fire detection and alarm systems
- HTM 05-03: Part H: Reducing false alarms in healthcare premises
- Healthcare Commission Core Standards

Appendix A – Fire Safety Management Structure



Appendix B – Staff Feedback Form

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

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

Thank-you for your feedback

Please forward this form to: **Assurance Manager (NHSLA)**

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	17
Subject:	Trust Development Authority Monthly Self Certification
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

The purpose of this document is to provide assurance in respect of the Trust Development Authority's (TDA) monthly self certification return and to ensure that risks are articulated and escalated.

Introduction:

The NHS TDA's Accountability Framework for NHS Trust Boards details a clear set of rules and principles under which Trusts should operate. Within the document, the NHS TDA describe their monthly Self-Certification process which is based on compliance to a number of the conditions within Monitor's Provider Licence and a set of Board Statements. The Trust is required to submit two monthly returns to the TDA.

Appendix 1 details the Monitor Provider Licence conditions included in the self-certification return, ESHT's compliance against the condition and the evidence to support that decision.

Appendix 2 details the Board Statements and assurance in place. It should be noted that these mirror some but not all of the Board Statement's contained within Monitor's Guide for Applicants

The return is submitted monthly and signed off by the Chairman and Chief Executive.

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

The Trust is compliant with the requirements with the exception of the Board Statement governance requirement "The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward." Referral to treatment is highlighted as a risk; the Board is aware of this issue and is monitoring the action plan.

Benefits:

The monthly return provides an opportunity for the Trust to self assess against TDA and Monitor quality, delivery and sustainability requirements and to ensure that areas of concern are flagged to the TDA.

Risks and Implications:

Failure to submit a monthly return breaches the TDA Accountability Framework requirements.

Assurance Provided:

Assurance can be given that the Board appropriately assesses compliance and escalates identified risks.

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

None

Proposals and/or Recommendations
The Board is asked to review and note the content of the monthly self assessment.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
No equality and human rights impact assessment has been conducted for this report.

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

Monitor Provider Licence Conditions – Appendix One

License Condition	Requirement	Assurance	Compliant
G4 – Fit and proper persons as Governors and Directors	This condition requires that licensees do not allow unfit persons to become or continue as Governors or Directors. "Unfit persons" are: undischarged bankrupts, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified Directors. A company may also be an unfit person.	The Trust has a robust process in place for appointing fit and proper persons as Directors and follows TDA/national requirements.	Yes
G5 – Monitor Guidance	This condition requires licensees to have regard to any guidance that Monitor issues.	A significant amount of TDA guidance and requirements mirror those of Monitor to support achievement of Foundation Trust status and the Trust has due reqard to these.	Yes
G7 – Registration with the Care Quality Commission (CQC)	This condition reflects the obligation in the Health and Social Care Act 2012, for licensees to be registered with the CQC. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully provide services.	The Trust is registered with the CQC without conditions and compliance with this requirement is tested through: • Completion and monitoring of PCA compliance templates • Outcome of CQC inspections • Review of CQC Intelligent Reports • Quality Walks and Assurance Visits	Yes
G8 – Patient eligibility and selection criteria	The condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.	Agreed through service specifications with the CCGs. Developing a Referral and Treatment Criteria Policy	Yes

License Condition	Requirement	Assurance	Compliant
P1 – Recording of information	Under this licence condition, Monitor may require licensees to record information, particularly information on their costs, in line with approved guidance Monitor will publish. The licence condition is worded in a way that any costs and other information that may be required can be collected from both licensees and their sub-contractors. This licence condition may also require licensees to record other information, such as quality and outcome data, in line with Monitor guidance and for the purpose of carrying out Monitor's pricing functions.	Quality data and financial information considered by Board and sub committees Data uploaded to national systems as required.	Yes
P2 – Provision of information	Under this condition, once the information has been recorded in line with P1, Monitor can then require licensees to submit this information.	ESHT complies with any requests from the TDA and would comply with Monitor's requests for information.	Yes
P3 – Assurance Report on submissions to Monitor	Under this condition Monitor may require licensees to submit an assurance report confirming the accuracy of the data they have provided under P2.	ESHT complies with any requests from the TDA and would comply with Monitor's requests for information. Data accuracy is reported in the Trust's Quality Account and assurance is also provided from external and internal auditors.	Yes
P4 – Compliance with the National Tariff	This licence condition imposes the obligation to charge for NHS health care services in line with the National Tariff. The Health and Social Care Act 2012, defines the National Tariff as a document published by Monitor.	The Trust's prices for NHS care services comply with, or are determined in accordance with, the national tariff published by Monitor.	Yes
P5 – Constructive engagement concerning local tariff modifications	This licence condition requires licensees to engage constructively with Commissioners and to try and reach a local agreement before applying to Monitor for a local modification.	ESHT is committed to constructive engagement with Commissioners to try and reach a local agreement before applying to TDA (Monitor) for a local modification.	Yes

License Condition	Requirement	Assurance	Compliant
C1 – The right of patients to make choices	Requires licensees to tell their patients when they have a choice of provider and to tell them where they can find information about the choices they have – this must be done in a way that is not misleading Requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour one provider over another and is presented in a manner that helps patients to make well-informed choices and prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services	ESHT complies with patient choice in line with commissioning intentions and offers patients appropriate information. Choose and Book is offered but take up is limited. Gifts and benefits in kind are not offered for patient referrals or the commissioning of services.	Yes
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent it is against the interests of health care users. It also prohibits the licensee from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent it is against the interests of health care users.	The Trust does not enter into anti-competitive behaviour that is against the interests of health care users.	Yes
IC1 – Provision of integrated care	This condition requires the licensee to not do anything that could be reasonably be regarded as detrimental to enabling integrated care. The purpose of this licence condition is to enable Monitor to step in where integrated care is not being delivered, in spite of decisions and efforts made by commissioners	The Trust is an integrated provider	Yes

Board Statements – Appendix Two

Compliance element:	Requirement	Assurance	Compliant
Quality	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Regular quality reports to Board and sub committees. Board seminar for deep dive into issues Production and review of Annual Quality Account Quality walks/Assurance visits	Yes
Quality	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	Completion and monitoring of PCA compliance templates Outcome of CQC inspections Review of CQC Intelligent Reports Regular communication with local CQC team	Yes
Quality	The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements	Medical Director leading on revalidation Regular reports to Board and sub committees Board Seminar update Nov-13	Yes

Compliance element:	Requirement	Assurance	Compliant
Finance	The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Finance Reports Financial Plan (LTFM) Going Concern statement External Audit view	Yes
Governance	The Board will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	Monthly monitoring eg performance report including access, outcomes, patient experience, workforce and finance. Board Assurance Framework	Yes
Governance	All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner	Monthly monitoring eg performance report including access, outcomes, patient experience, workforce and finance. Concerns discussed with TDA at monthly meeting Risk registers Board Assurance Framework	Yes
Governance	The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	Monthly monitoring eg performance report including access, outcomes, patient experience, workforce and finance. Concerns discussed with TDA at monthly meeting TDA Accountability framework considered at Board Seminar	Yes

Compliance element:	Requirement	Assurance	Compliant
Governance	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Board are implemented satisfactorily	Annual plan in place and schedule of actions to address gaps developed and being monitored by Board. Audit recommendations tracker reviewed at each Audit Committee meeting.	Yes
Governance	An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury	Annual Governance Statement produced and subject to external audit review Board Assurance Framework and risk management follows HM treasury and best practice guidance. Annual review by internal audit.	Yes
Governance	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	TDA oversight domains now aligned to CQC: caring, well led, effective and safe. Board and committees agendas aligned to ensuring ongoing compliance and key metrics highlighted in performance and quality reports. Board sighted on any issues eg mortality outlier alerts and actions in place to review data and ensure ongoing compliance The Trust previously declared a risk in respect of infection control and referral to treatment. The RTT risk remains (latest return April 14) and is being monitored by the Board: “In the latter part of the financial year the Trust had issues in respect of the achievement of referral to treatment timescales, particularly the admitted pathway. Actions taken by the Trust to maintain	Risk

Compliance element:	Requirement	Assurance	Compliant
		aggregate performance and reduce reliance on ad-hocs resulted in an increasing backlog. An action plan has been developed with support from the National Intensive Support team and the TDA to ensure that the organisation returns to achievement against the target in 2014/15 and this will be monitored by the Trust Board."	
Governance	The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved level 2 of the IGT. Ongoing monitoring of progress for achieving 2014 submission.	Yes
Governance	The Board will ensure that the Trust will at all times operate effectively. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all board positions are filled, or plans are in place to fill any vacancies	Register of interests Vacancy for NED (Chair of Audit Committee) recruitment process underway anticipate appointment by end June 2014.	Yes
Governance	The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability	Robust Board appointment process and induction Board development programme Annual PDR of Board members Review by Remuneration Committee	Yes
Governance	The Board is satisfied that management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	Objective setting Annual PDR of Board members Review by Remuneration Committee	Yes

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	18
Subject:	Board Sub-committee Reports and Trust Board Seminar Notes
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

The attached report provides a summary of the meetings of the Board sub-committees and the notes of Trust Board seminars held since the last meeting.

Introduction:

The following committees have been established as formal sub-committees of the Board.

- Audit Committee
- Finance and Investment Committee
- Quality and Standards Committee
- Remuneration and Appointments Committee

It is best practice for each Committee to summarise key points from their meetings and share these with the Board along with formal minutes of the meeting. The Board has also agreed that notes of the Trust Board Seminars will be circulated with the Trust Board agenda papers.

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

The attached reports provide a summary of the key discussion points at each of the sub-committee meetings that have taken place since the Board last met.

Benefits:

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

Risks and Implications

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

Assurance Provided:

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

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

Not applicable.

Proposals and/or Recommendations

The Board is asked to review and note the documents.

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

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

East Sussex Healthcare NHS Trust

Finance and Investment Committee

1. Introduction

Since the Board last met a Finance and Investment Committee has been held on 30 April 2014. A summary of the items discussed at the meeting is set out below.

2. Performance Report – Month 11

The Committee received the month 11 Performance Report which detailed the Trust's performance against the National Performance Framework metrics, as described in the National Operating Plan for 2013/14, and performance against other key trust metrics as well as activity and workforce indicators.

It was noted that Month 11 performance fell below the required standard and the Trust remained in "Under-Performing" Status. It was highlighted that admitted and non-admitted elective referral to treatment targets failed the target and 16 specialties failed to achieve due to planned backlog clearance.

3. Finance Update – Year Ended 31 March 2014

Mrs Harris presented the Finance Report for M12 which set out the unaudited financial position for 2013/14. The unaudited year end deficit was £23.1m (as previously forecast) against an original plan of £19.4m deficit. The adverse variance of £3.7m comprises non-delivery of CIPs £2.5m and £1.2m being cost of the MARs scheme and a late adjustment to annual cost of capital

Income had been £10m higher in the second half of the financial year compared to the first six months. Pay costs had been £3.5m lower in the second half of the year; a large part of this was due to reduced agency costs. Non pay costs were higher in the second half of the year; some of this was due to cost of MARS, change in calculation of PDC and stock adjustments. In addition the second half is affected by winter pressures and other year-end adjustments.

5. Turnaround Update

Mr Murphy reminded the Committee of the financial challenges faced by the Trust over the next few months. It would be important to maintain financial and operational grip. There would need to be a focus on reducing medical agency and locum expenditure and a number of initiatives had been put in place to achieve this. No ad hoc clinics were planned in 2014/15.

6. EBITDA Quarterly Report

Mrs Harris presented the 2013-2014 Qtr 3 EBITDA statement. The Committee noted the number of service lines that had negative EBITDAs.

It was noted that this report was helpful in identifying the main problem areas and that there was a rotating programme in place whereby the clinical unit from those areas was invited to the Finance & Investment Committee to discuss any initiatives they were taking.

7. 5 Year Financial Plan

At its last meeting the Committee agreed that a provisional budget for a £18.5m deficit be set to enable budget holders to proceed with the operational management of the Trust pending agreement of the final 2014/15 plan. This provisional recommendation was subsequently approved by the Board at its meeting on 26 March 2014.

The 2014/15 Plan was submitted to the TDA on 4 April 2014 for a deficit budget of £18.5m this amount is unchanged from the previous submission. Feedback on the Plan from the TDA is awaited.

The financial plan for 2015/16 is for a deficit of £14.0m, this amount is unchanged from the previous submission to the TDA.

Approval was sought from the Committee for a recommendation to the Board to set a final budget for 2014/15 based on a £18.5m deficit (as per previous recommendation on 19 March 2014 for a provisional budget of the same amount).

A separate paper updating the Committee on financial planning for the final 3 years of the 5 year planning period was noted.

8. 2013-14 Reference Costs Submission

Mr Astell presented an update on the arrangements for the 2013-14 Reference Cost collection.

As was the case last financial year the Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with guidance. The Finance and Investment Committee, reporting directly to the Board was considered the most appropriate Committee to carry out this review.

The Committee agreed that as the same process and resource is still in place for the submission, it could place continuing reliance on the work carried out last year by the then Audit Chair which confirmed he was satisfied with those processes and systems.

9. Community Rebasing Project Briefing – Quarterly Update

Mr Astell gave a progress update on the status of the Community Rebasing Project.

It was noted that the cost matrix for community services needed to be refreshed to reflect outturn for 2013/14 and a more robust basis for attribution of overheads.

No changes had been proposed to community funding for 2014/15. Commissioners had indicated that an element of these services would be retendered and this was likely to affect contractual arrangements for 2015/16. The community rebasing work was critical in supporting the Trust's response to any invitations to tender and the emphasis of the next phase of work will be on strengthening service specifications and data quality.

The project team had been strengthened with additional community services managerial input.

10. Market Testing Update

Following Board approval of the first three services through the market testing process (Occupational health, Pharmacy Manufacturing Unit and Crèche) Mr Horne provided an update on progress within these services and also updated the Committee on the progress and challenges with Commercial and Corporate services.

It was noted that an 'exemplar' Standard Service Level Agreement Specification would be produced with the Interim Commercial Director and rolled out to all other commercial services departments.

11. Consultant and SAS doctor Job Planning Review

Dr Hughes gave an update on the progress relating to the review of the Trust's job planning processes, and outlined the anticipated benefits.

It was noted that the Trust's job planning process has been re-launched with an emphasis on gaining greater alignment between consultant and other medical staff's time and what the activity and service provision that the Trust required. It is anticipated that all consultants will have new job plans by end May 2014.

12. Community & Child Health Project Update

Mrs Harris gave an update on progress of the Community & Child Health System (SystmOne) project.

It was noted that Phase one: Child Health successfully went live on 8 April 2014, with very few issues.

Mrs Harris reported that the next go live was phase 1 of District Nursing on 13 May 2014. Preparations for this are going well and support is being received from Accenture.

13. Radiotherapy Treatment Centre Outline Business Case

Mr Saunders presented the Radiotherapy Treatment Centre Outline Business Case produced by the Brighton & Sussex University Hospitals (BSUH) in conjunction with East Sussex Healthcare NHS Trust (ESHT).

This recognised the need for the development of a satellite radiotherapy treatment centre at Eastbourne DGH. Radiotherapy had been previously underestimated and capacity in Cancer Networks needed to increase to ensure all patients who require Radiotherapy have appropriate access.

It was noted that the development would enable BSUH to provide clinical and outpatient services to patients who use their services and live in the east of Sussex and currently have to travel considerable distances for treatment.

It was noted that the paper was currently with the TDA for initial comment and the Committee were asked to approve the Heads of Terms for the proposed lease of land at Eastbourne DGH for development as a new Radiotherapy Treatment Centre.

It was agreed that the Committee would approve the Heads of Terms subject to reference being made within the Heads of Terms relating to car parking arrangements.

14. Work Programme

The revised 2014 work programme was reviewed.

15. Conclusions

The Trust Board to note:

- The Committee reviewed the Performance Report for month 11 and the unaudited year end financial position
- Turnaround progress
- The Committee noted the EBITDA Q3 position
- The Committee reviewed the 5 year financial plan and agreed the recommendation that a final budget for a £18.5m deficit be issued for approval at the next Finance and Investment Committee on 28 May 2014 and the Board on 3 June 2014.
- The Committee confirmed that it was satisfied that the Trust will submit its reference cost return in accordance with guidance
- The Committee noted the further progress made on the Community Rebasing Project
- The Committee noted the update on Market Testing
- The update on progress relating to Job Planning
- The Committee noted the update on the Community & Child Health system
- The Committee noted the Radiotherapy Centre OBC and approved the BSUH/EDGH Heads of Terms subject to a reference within the Heads of Terms regarding car parking arrangements
- The Committee reviewed the 2014 work programme

Barry Nealon
Chair of Finance and Investment Committee
6 May 2014

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 26 February 2014 at 9.30am in the Sara Hampson Room, EDGH

Present
Mr Barry Nealon, Non Executive Director (chair)
Mr James O'Sullivan, Non Executive Director
Professor Jon Cohen, Non Executive Director
Mr Darren Grayson, Chief Executive
Mr Stuart Welling, Chairman
Mrs Vanessa Harris, Director of Finance
Mr Philip Astell, Interim Deputy Director of Finance
Dr David Hughes, Medical Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer

In attendance
Mr Andrew Murphy, Turnaround Director (for items 5 &6)
Mrs Jo Brandt, Head of SLR (for item 8)
Mrs Paula Smith, Assistant Director of Nursing, Integrated Care Division (for item 8)
Mr Dexter Pascall, Consultant, Obstetrics and Gynaecology (for item 8)
Mr Andy Horne, Market Testing Programme Director (for item 9)
Mr Christian Lippiatt, General Manager Occupational Health (Staff child and family care)(for item 9)
Ms Jacqui Fuller, Child and Family Care Co-ordinator Human Resources (for item 9)
Mr Tony Deal, Associate Director of IT (for item 10)
Mrs Delly Dickson, Service Re-design Manager (shadowing Mr Grayson for the day)
Mrs Paulene Rhodes, PA to Commercial Director (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. No apologies were received.	**Action**
2.	**Minutes of Meeting of 22 January 2014** Page 2, Item 3, (iv) - Mr O'Sullivan pointed out confusion over references to "Chairman" in the minutes. To be amended accordingly. Page 8, Item 10, Action – should have read 'noted the amended version of the Full Business Case', the word Case was omitted. To be	

	amended. With the above amendments, the minutes of the meeting of 22 January 2014 were agreed as an accurate record.	
3.	**Matters Arising** (i) Turnaround Update Mr Astell confirmed that the increase in Scientific and Therapeutic pay costs in M8 related to recruitment to vacant posts. (ii) Finance Update – Provisional M9 flash Report Mr Astell confirmed that the increase in drug costs represented normal variation. (iv) Community Rebasing Project Update An update is provided under agenda item 7 (below). (v) EBITDA – T&O Service Review Follow Up It was reported at the last meeting that Physiotherapy and Occupational Therapy staff were not always available due to staff shortages. Dr Hughes reported that he would provide the Finance & Investment Committee with an update at the next meeting. (vi) Bedside Monitoring (VitalPAC) Reported under agenda item 10 (below). (vii) Business Case to replace the current PAS (Patient Administration System/Service) Mrs Harris confirmed that the business case was presented to the Board on 29 January 2014 and was agreed.	**DH**
4(i)	**Performance Report – Month 9** The Committee received the month 9 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics as described in the National Operating Plan for 2013/14. It was noted that Month 9 performance fell below the required standard moving the trust into "Under-Performing" Status for the first time. This was primarily due to the MRSA breach and under performance in RTT due to planned backlog clearance.	

	Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 16 specialties failed to achieve. Final month 8 Cancer performance shows the trust failing against both 62 day urgent referral targets. There were four C-Difficile case reported in month 9. Current outturn to month 9 is 35 against a limit of 25. There were 2 incidents and 9 breaches of mixed sex accommodation in month 9, causing the trust to fall below threshold. The Trust achieved all Accelerating Stroke Improvement Metrics in month 9. The current performance report format will be replaced by internally designed and improved report as discussed at a recent Board seminar. Mr O'Sullivan asked if the deterioration in the overall performance score was related to Turnaround. It was confirmed that the single MRSA case was not related to Turnaround but had significantly impacted the overall score. To avoid 3rd party costs the RTT backlog was being addressed in house and progress was being made. In response to a query from Mr Welling it was confirmed that additional planned Endoscopy lists would ensure an improved position at year end. Professor Cohen requested that the covering report should be more explicit about performance issues; where standards are not being met and assurance provided. Queries were raised about the Friends and Family compliance reporting. Stephanie Kennett confirmed that this is examined in the Quality and Standards Committee. Mr Grayson explained that measures had been taken to avoid future mixed sex accommodation breaches and that waiting time improvements were in hand such that the Trust would be compliant with the target, at aggregate level, from 1 April 2014. **Action** **The Committee noted the Performance Report for month 9.**	
4(ii)	**Finance Update – Month 10** Mrs Harris provided the Committee with an update on the month 10 financial position and the change in forecast outturn.	

	It was noted that there was an in month surplus of £1m which was £300k better than the expected recovery trajectory of £700k. Cumulatively the deficit had decreased to £21.3m but was £1.4m adrift from the expected recovery trajectory of £19.9m. Income was above Plan and equal to the expected trajectory. Expenditure excluding impairments was £31.7m in month and better than the expected trajectory. M10 paybill was £0.6m below the average for the first nine months of the year. As signalled at M9 the forecast outturn position had been reviewed in detail at M10 and the deficit is now expected to be £23.1m. This change in forecast outturn has been notified to the TDA. The committee received a detailed commentary on the M10 financial position. The income position had improved in month after taking into account agreement reached with commissioners over the value of fines and penalties to be applied/reinvested . Expenditure in Month 10 had slightly improved over M9 and there was a continued reduction against M1-6 average. The background to the impairment and its impact was explained. It was noted this largely related to community properties. Mr Welling queried the increase in month 10 agency pay over M9. It was noted that this is largely due to medical agency staff. **Action** **The Committee noted the month 10 financial position.**	
4(iii)	**PDC (Public Dividend Capital) Application** Mrs Harris reported that the Trust's application for 2013/14 cash in the form of non-repayable Public Dividend Capital (PDC) had been successfully concluded. The Trust submitted an application to the Trust Development Authority (TDA) for £39.4m cash support in the form of 'permanent' PDC. This was submitted to the Independent Trust Financing Facility (ITFF) in January which recommended it to the DH. Confirmation has now been received that this recommendation to issue PDC has been accepted by the DH. Feedback had been received from the ITFF and issues raised would need to be addressed in any future application. The Finance & Investment Committee had been appraised throughout the application, at every one of its committee meetings, on the rigorous process followed to secure the short-term finance required by the Trust.	

	Action **The Committee noted the issue of PDC of £39.4m in 2013/14.**	
4(iv)	**Cash Update at Month 11** Mrs Harris updated the Committee on the cash position at 18 February 2014. It was noted that the cash position has been very difficult throughout the financial year because of the planned deficit and historically high level of creditors. £34.4m of permanent PDC and £2.718m of Emergency Capital PDC was received on the 17 January 2014. A further £2.282m of Emergency Capital PDC will be received on the 3 March 2014. £29m of temporary borrowing was repaid on the 17 January 2014. Accrued contact income was also received in February. The cash received had relieved the pressure on supplier payments which should allow the Trust to meet BPPC targets for March. The Committee received a snapshot of the trade creditor position at 18 February 2014 which showed the much improved position compared with that at M10. The majority of the remaining 30 day+ creditors was a result of budget holders not approving invoices in a timely way, mostly because of unresolved queries over invoice amounts. Budget holders have been reminded to resolve outstanding issues as soon as possible. **Action** **The Committee noted the cash position and that temporary PDC had been replaced by permanent PDC in February 2014.**	
5.	**Turnaround Update** Progress was being made as demonstrated by the M10 financial results (see agenda item 4 (ii) above) **Action** **The Committee noted progress to date**	
6.	**Financial Planning 2014/16** Mrs Harris made a presentation on Business Planning 2014/16. A two year Plan submission was due to be filed at the TDA on 5 March 2014. A final two year plan is due on 4 April 2014. The strategic objectives and national and local contextual position of the Trust were reviewed and discussed. It was noted that the Trust had recently been identified as part of a “financially challenged economy”. Mr Grayson explained that support was being made	

	available to assist challenged economies to develop robust and sustainable five year plans. Work would begin in April 2014. Every clinical unit with support from their respective director, finance and turnaround has been involved in preparing their 2014/16 plans over the last few weeks. A ward establishment review has also been carried out at the same time and planned staffing levels adjusted accordingly. This rigorous approach has ensured all units understood and owned their financial plans. The income and expenditure position of the Trust over the next two years was described and noted. A deficit position was planned in both years. The 2014/15 position had worsened from a £14.9m deficit as at the initial submission date of 13 January 2014 to a £18.5m deficit. The reasons for this were explained. The two year positions did not include the impact of commissioner QIPP plans as no detail in respect of these plans had yet been received. In the meantime a provisional amount of £2m had been included as QIPP in ESHT's plans. CCG Commissioners have indicated their plans are likely to be very significantly more than this. Discussions with commissioners were still ongoing in respect of the 2014/15 contract and all associated values. Mr Murphy explained that the CIP plans were themed around five areas: Clinical Services value for money; clinical services productivity; back office; non-pay cost control/avoidance and estate review and commercial directorate efficiency. Current plans totalled £20.4m in 2014/15 and £20m in 2015/16. They represent 5.6% of turnover. Mr Murphy and Mrs Harris explained the key assumptions and issues within the plans. These will be discussed further at the Board scrutiny day with clinical units scheduled for 12 March 2014. Mr Murphy outlined the key clinical investments totalling £3.4m in quality/safety/operational delivery that had been agreed as part of the clinical unit/ward establishment reviews and 2014/16 budget setting. A bridge slide showed the changes from the 2013/14 forecast outturn position of £23.1m to the planned 2014/15 deficit of £18.5m. The Executive Plan approval process was noted. In addition to quality and safety sign off at clinical unit level an all-day Quality Impact Assessment workshop is scheduled for 4 March. Clinical units will present their detailed budgets to the Board on 12 March 2014. **Action** **The Committee noted the update on the financial planning process for 2014/16.**	

7.	**Community Rebasing Project Briefing** Mr Astell gave a progress update on the Community Rebasing Project. It was noted that the project was initiated within the Trust in May 2013 with a view to improving the alignment of funding for community services. The purpose of the project is to ensure that the Trust is appropriately reimbursed by each of the new commissioning bodies for the work it undertakes and to help inform decisions (by both the Trust and its commissioners) about the future provision and commissioning of individual community services. Initial work on the identification of costs by individual community service and the appropriate alignment of funding by commissioner had been completed and shared with the relevant CCGs. The two engagement meetings held to date had helped to strengthen the draft funding matrix, although there remained a small number of material queries. Some areas required further analysis and work was ongoing. Any alignment of funding between commissioners would be a matter for them to resolve. The committee asked if the next progress update could include more detail about any impact on future service provision. **Action** **The Committee noted the further progress made on this project and the associated opportunities, risks and challenges involved.**	**PA**
8.	**EBITDA – Gynaecology Review Follow up** A deep dive into the Gynaecology Qtr 4 2012-13 was undertaken and presented at the September 2013 Finance & Investment Committee. Attendees at the meeting gave an update on the follow up work that Gynaecology had undertaken since this presentation with comparisons to Qtr 2 2013-14. Total expenditure has reduced when pro-rated to a full year as has total income and activity. The deficit position continues, but day cases are now the main area of focus as opposed to elective inpatients in Qtr 4 2012-13. A visit had been made to a comparator Trust to understand its provision of gynaecology services and how it returns a positive EBITDA. The key lessons learned were noted. Benchmarking and comparative data including that from the recent visit was discussed and explained. Mr Pascall highlighted all the actions that were being taken to improve productivity and efficiency. The specialty has made	

	and continues to make operational changes to improve the position and the quality of care for the patient. **Action** **The Committee noted the Gynaecology EBITDA statement position and noted that they continue to strive to improve their EBITDA position whilst improving patient care.**	
9.	**Market Testing Programme – update and Crèche Transformation Plan** The Committee received the Crèche transformation plan which provided an improvement in efficiency and a number of options for consideration. It was noted that there was no 'do minimum' option as the Conquest nursery building was already beyond its useful life and therefore needed to be replaced. The existing Conquest crèche site has also been identified as potentially needed to meet the clinical strategy expectations. All options would involve costs; either through the cost of redundancy, the cost of a replacement building at the Conquest or renting a suitable building offside. The transformation plan was discussed at CLT and CME in February 2014. The recommendation is: • to agree that crèche is not a core service but a highly valued one • to note a 5% increase in average fees from April 2014 • to agree that if possible, crèche provision should continue on both sites • to agree that this is a service where a partnership approach is preferred to encourage private sector investment and the continuance of the service for Trust staff. Mr Horne explained the available options under the last bullet point above. An approach could be commercial or partnership based. The merits of either approach were debated but it was recognised that more detail would be needed before a decision could be made. **Action** **The Committee agreed to support the transformation plan.**	
10.	**IM&T Update** Mr Deal presented a progress report on the proposed implementation of the key IM&T projects due to be implemented in 2013/14 & into 2014/15. The report provided a summary status position for each of the following projects.	

	• Community and Child Health system • NHS Mail Migration • Southern Acute Programme - Electronic Document Management and Clinical Portal • Electronic clinical correspondence • Acute PAS re-procurement and PAS upgrade project • VitalPac patient bedside monitoring • Psuedonymisation • Windows 7 / Office 2010 migration • Philips PACS / RIS It was noted that all projects were on track to deliver within the project timescales despite a number of risks. Mr Deal highlighted that following changes to the Government's previous agreement with Microsoft the Trust is migrating to Windows 7 and Office 2010. This has meant testing all Trust applications for compatibility. It has been identified that some Trust clinical and corporate systems cannot work on Windows 7 without incurring financial costs. Local solutions will be needed and it is also hoped that a national solution will be provided. **Action** **The Committee noted the IT Projects Update**	
11.	**Work Programme** The revised 2014 draft work programme was reviewed. **Action** **The Committee noted the revised work programme**	
12. **(i)**	**Any Other Business** **Options Paper for MRI at Conquest** Mr Rayner presented a paper setting out the options for the MRI scanner at Conquest. The current model is basic and becoming unreliable. The paper set out two possible options: • A new 1.5T scanner machine with a one wide patient aperture and an upgrade of current scanner. • Upgrade of the present scanner until a new more modern MRI scanner can be acquired in 2015/16. It was noted that, due to time constraints the paper had not gone through the correct executive approvals. Mr Grayson asked that the paper be withdrawn and the proper internal process be followed in a	

	timely fashion. Professor Cohen expressed his concern that a refurbishment of the MRI is not the right solution and requested that the Executive put this in the context of an overall diagnostics strategy. **Action** **The Committee agreed that the options should be reviewed by the Executives and that the paper needs more work and detail. A recommendation could then be made by the Executive.**	**DG**
13.	**Date of Next Meeting** The next meeting will take place on Wednesday 19 March 2014 at 9.30am – 11.30 am in the Committee Room, Conquest.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 19 March 2014 at 9.30am in the Committee Room, Conquest

Present
Mr Stuart Welling, Chairman (Acting Chair)
Mr James O'Sullivan, Non Executive Director
Mrs Stephanie Kennett, Non Executive Director
Mr Darren Grayson, Chief Executive
Mr Philip Astell, Interim Deputy Director of Finance
Dr David Hughes, Medical Director
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer

In attendance
Mr Andrew Murphy, Turnaround Director
Miss Chris Kyprianou, PA to Finance Director (minutes)

1.	**Welcome and Apologies** Mr Welling welcomed members to the Finance & Investment Committee and advised that he was chairing the meeting in the absence of Mr Nealon. Apologies were received from Barry Nealon, Jon Cohen and Vanessa Harris.	**Action**
2.	**Minutes of Meeting of 26 February 2014** The minutes of 22 February 2014 were agreed as an accurate record subject to the following changes: Page 2, item 3, (v) EBITDA T&O Review – Last two sentences to be replaced with: *Dr Hughes reported that he would provide the Finance & Investment Committee with an update at its next meeting*. Page 5, Item 6, 2nd sentence should say: *A two year Plan submission was due to be filed at the TDA on 5 March 2014.*	
3.	**Matters Arising** (i) EBITDA – T&O Service Review Follow up Dr Hughes circulated an update provided by Pauline Butterworth, Deputy Chief Operating Officer, around the recognition of the therapy staffing issues and the actions being taken to address the shortage of therapists and reduce length of stay for non elective patients.	

	(ii) Community Rebasing Project Update An update, including further detail on the impact on future service provision, was provided under item 7 (below). (iii) Options Paper for MRI at Conquest Mr Grayson reported that the trust had agreed to proceed with the commissioning of the refurbishment of the scanner.	
4(i)	**Performance Report – Month 10** Mr Sunley presented the month 10 Performance Report which detailed the Trust's in month performance against the National Performance Framework metrics, as described in the National Operating Plan for 2013/14, and highlighted the key issues. It was noted that Month 10 performance fell below the required standard and the Trust remained in "Under-Performing" Status. The Trust continued to deliver on A&E targets in February and March. Performance was currently at 95% for March. Admitted and Non-Admitted Elective Referral To Treatment targets did not achieve target and 15 specialties failed to achieve. It was anticipated that the Trust would be back on track to deliver this target in April 2014. Final month 9 performance on Cancer Waits showed the trust failing against the 62 day referral (from screening service) target. It was noted that a recovery plan for Cancer Services, generally, was being presented to the Board at its meeting on 26 March 2014. There were 1 incident and 2 breaches of mixed sex accommodation causing the trust to fall below threshold. Mr Sunley reported that the minor building work that had been undertaken at the Conquest had helped to improve the situation, although this will not get back to full compliance until the refurbishment of the Conquest is done as part of the Clinical Strategy. Mr Welling asked what other mitigating action could be taken to avoid mixed sex breaches. Mr Sunley said that this was to do with capacity in A&E at any one time, and the mix of patients, so extra capacity would need to be put in and the layout in A&E would need to be reviewed. The Friends and Family Test response rate was noted. **Action** **The Committee noted the Performance Report for month 10.**	

4(ii)	**Finance Update – Month 11** Mr Astell gave an update on the month 11 financial position. It was noted that the Trust had made a net deficit of £1m against a planned deficit of £2.2m, a favourable variance of £1.2m. The deficit for the year was now £22.2m against a planned deficit of £18.7m, resulting in a plan shortfall of £3.5m. Total income was £1.7m better than plan in month, improving the cumulative favourable position to £3.6m. The position included £1.8m of benefits in the month and £3.7m year to date from fixing fines and penalties with commissioners. It was reported that in terms of income, there was an improvement in elective productivity, in month, with inpatients improving from 37 cases per working day to 40, and day cases improving from 161 to 177, partly due to turnaround and the focus in orthopaedics to drive work through. It was agreed that this was very encouraging. Mr Astell highlighted to the Committee, Appendix 1of the report, which showed the income and expenditure trends and how the position was changing relative to the first 6 months of the year (pre turnaround) and subsequent months. It was noted that pay had increased by £100k and non pay by £200k; however, this was after an adjustment to the cumulative PDC dividend of £0.5m and operating expenditure had fallen by £800k. Mr O'Sullivan asked to what extent the PDC dividend adjustment was due to the increased PDC. Mr Astell clarified that this was partly due to the PDC but mainly due to an adjustment to the way that PDC is calculated. This was a national adjustment to the calculation that was introduced in year. Mr Astell clarified that the PDC increase had a limited impact as this offsets the deficit and was planned. The commentary referred to a reduction in agency expenditure. Mrs Kennett queried this information as the month 10 Performance Report indicates that there has been an increase in agency usage of 31.65 FTE. Mr Astell agreed to look into this. It was noted that the Trust had reduced its trade creditors by £19.3m. The cash balance at the end of February was just below £4m. Mr Astell reported that the Trust remained on track to deliver a projected full year deficit of £23.1m, which was £3.7m worse than planned. Mr Grayson queried the position of the BPPC. Mr Astell reported that there would be an improvement in March; It was agreed that he would	**PA** **PA**

	provide Mrs Harris with an update prior to the Board Meeting on 26 March 2014. **Action** **The Committee noted the month 11 financial position.**	
5.	**Turnaround Update** There was no turnaround update. Mr Murphy said he would provide a planning update for next year under item 6 (below).	
6.	**2 year – 2014/16 Financial Planning Update** Mr Astell presented a report updating the Committee on business planning and assumptions, the financial outlook for the next two years and seeking approval for a recommendation to the Board to set a provisional budget for 2014/15 This was a provisional report which included cost improvement plans together with an initial allocation of budgets. It was noted that budget for 2014/15 was under significant pressure at a time when the organisation was implementing its clinical strategy. It needs to jointly manage demand with its commissioners as well as deliver a level of internal efficiency commensurate with national planning expectations. An initial budget assessment had resulted in a deficit of £18.5m for 2014/15 after application of the internal cost improvement programme of £20.4m and after providing for known cost pressures and inflationary increases. Currently £2m of CCG Commissioner QIPP impact had been factored into the Plan but it is known that CCG Commissioners demand management expectations significantly exceed this value. Work was ongoing to develop joint QIPP plans which would release cash savings and minimise stranded costs or underutilised capacity. It was noted that the contract with specialist commissioners was yet to be finalised and may represent a further financial risk. Mr Astell updated the Committee on progress of the discussion with the local health economy on the 2014/15 plan. . The proposal was to issue a provisional working budget for 2014/15 recognising there was currently still a gap to bridge, which would enable budget holders to proceed with the operational management of the Trust pending agreement of the final 2014/15 plan. The 2014/15 planning process had been extremely robust with plans developed by clinical units being assessed for quality impacts by senior clinical and other ESHT directors as well as scrutiny by the Board at a whole day Board Seminar on 12 March 2014. Cost improvement targets had been developed within clinical units who	

	own and understand the assumptions made. It was noted that draft plans had been submitted to the TDA on 13 January 2014 and 5 March 2014 and a final plan submission was due on 4 April 2014. A further requirement for a longer term plan was required by the TDA on 20 June 2014 which would need to be accompanied by an LTFM. Mr Welling queried whether the report had taken into account any of the issues that were identified at the Board Seminar on 12 March 2014. Mr Murphy confirmed that the report did not specifically take into account those issues but that these would be covered by his subsequent presentation. Mr Welling expressed his concerns over the Board approving a provisional plan with a number of key issues still to be resolved. Mr Grayson said that a risk assessment would be undertaken; however there were elements of the plan that were high risk and would remain high risk until they were delivered. Mrs Kennett asked if there was a table which showed the risk measurement. Mr Grayson said that it was not part of this presentation but asked if this could be provided for the April meeting. Mr Murphy reported that the Trust had an annual savings plan that was 100% identified. He assured the Committee that budgets had been reviewed in great detail with direct engagement with the Clinical Units, both the General Managers and the Clinical Leads. Mr Murphy said he hoped that the Board had received some reassurance at the Board Seminar on 12 March 2014, that the Clinical Units were signed up to the plans and committed to delivering them. Mr Welling acknowledged that the Clinical Units had shown a high level of commitment and understanding, which was very encouraging. Mr Murphy gave a short presentation on some of the issues raised in delivering the 2014/15 CIP. It was agreed that this would be discussed in Part 2 of the Board Meeting on 26 March 2014. Mr Murphy reported that he and Mr Sunley will in future meet with the General Manager from each Clinical Unit on a weekly basis to ensure weekly delivery drive. There will be a monthly formal review of each Clinical Unit to concentrate on financial performance and to pick up any significant performance issues. It was noted that the QIA Panel, chaired by the Director of Nursing, would continue in order to monitor the impact of approved plans, assess changes to the approved plans and assess new initiatives. The Panel will report quarterly to CLT and the Board. Mr Murphy reported that focussed support would be applied in the	**PA** **AM**

	following key areas: • Medical Agency Reduction • Bed Reduction • Theatre Productivity • Hospital at Night at Eastbourne DGH • Nurse Agency • Trauma move • Clinical Administration Review It was noted that the overall accountability framework for Clinical Units would be reviewed thoroughly in Q1 such that new arrangements can be approved and in place in Q2. Mr O'Sullivan said it would be helpful for the Board to have a table showing the breakdown, by initiative, of the £20.4m savings. It was agreed that this would be included in the Board report. The Committee were asked to agree and recommend to the Board: • The high-level outline Plan for the 2 years 2014/16. • The financial outlook for the 2 years 2014/16 based on the current planning assumptions. • The issue of a provisional 2014/15 working budget to enable budget holders to proceed with the operational management of the Trust pending issue of a final budget. Mr Grayson reiterated that this was a provisional budget pending a signed contract, and would be subject to further review. It was agreed that Mr Astell would provide, for the Board meeting, a high level summary income and expenditure statement for 14/15 with comparison to 2013/14. **Action** **The Committee agreed the recommendations in the paper.**	**PA** **PA**
7.	**Community Rebasing Project Briefing** Mr Astell gave a progress update on the status of the Community Rebasing Project with additional details regarding the individual services involved. The project was initiated within the Trust in May 2013 with a view to improving the alignment of funding for community services. The purpose was to ensure that the Trust is appropriately reimbursed by each of the new commissioning bodies for the work it undertakes and to help inform decisions (by both the Trust and its commissioners) about the future provision and commissioning of individual community	

	services. Initial work had been completed and shared with the relevant CCGs. The two engagement meetings held to date had helped to strengthen the draft funding matrix and most substantial queries and challenges had been resolved. Mr Astell referred to the appendix which showed the most recent matrix and provided both the latest summary and details of costs by individual service that make up the total. The recovery of overheads within a range had been previously discussed and the possible assumptions noted. Mr O'Sullivan queried what the overall Trust overhead percentage was. Mr Astell said he did not have this information to hand but noted that 11 per cent was used in reference costs for community services. He reported that the Trust was seeking relevant benchmarks. Mr O'Sullivan said it would be helpful to have further information on this for the April meeting. **Action** **The Committee noted the further progress made on this project and the associated opportunities, risks and challenges involved.**	**PA**
8.	**Capital Programme Review** Mr Astell presented a review of the 2013/14 capital programme as at 31 January 2014, together with a forward look over the next 5 years until 2018/19. It was noted that the capital programme had been under significant pressure throughout the financial year with demand for capital expenditure far out stripping available resources. In order to try to address the demand and the associated risks arising in the current financial year, an application for an additional £5m of capital resource, with cash funding, had been submitted via the Trust Development Authority (TDA) to the Independent Trust Financing Facility (ITFF). The ITFF, at its meeting on 17 January 2014 approved the Trust's application and this additional resource was now planned to be fully utilised before the financial year end on 31 March 2014, in line with the submission to the ITFF. It was noted that a further £1m resource had been received for the VitalPAC contract and nurse technology funding. Mr Astell reported that the future years' capital programme continues to be revised and developed by the Capital Approvals Group through	

	the capital planning process. The draft 5 year programme reflects the current proposals as submitted to the TDA on 5 March 2014 as part of the TDA financial planning timetable. Given the urgency around Pevensey ward, Mr Murphy queried why the capital expenditure was spread over two financial years. Mr Sunley agreed that the timing of this expenditure should be reviewed. The Committee were asked to: i) Note the current performance of the capital programme. ii) Note the approval of the Trust's additional £5m capital bid by the ITFF. iii) Note the capital programme will be managed to ensure the CRL is not breached at 31st March 2014. iv) Note the 5 year capital programme is the subject of on-going development to meet the changing needs of the Trust. **Action** **The Committee noted the above.**	**RS**
9.	**Community & Child Health Project Update** The Committee received an update on progress of the Community & Child Health System (SystmOne) project. It was noted that Non executive representation was through Mr Welling who had replaced Mrs Kennett from 5 March 2014. Mr Welling reported that the project going well and was on track. **Action** **The Committee noted the Community & Child Health System Project update**	
10.	**Work Programme** The revised 2014 draft work programme was reviewed. It was noted that the next meeting should include an item on longer term planning. **Action** **The Committee noted the revised work programme**	
11.	**Date of Next Meeting** The next meeting will take place on Wednesday 30 April 2014 at 9.30am – 11.30 am in St Mary's Board Room, EDGH.	

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a Quality and Standards Committee meeting has been held on 6th May 2014. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 3rd March 2014 are attached at Appendix 1.

2. Issues discussed at 6th May 2014 Meeting

2.1 Patient Story

A former patient's relative attended the meeting to provide her story. The committee listened to her 'story' of the care her partner received. There was discussion with her about how those present felt by her story and what actions needed to be taken to make a difference. The patient's relative made it clear she was delighted to tell her story and since her initial meeting with Alice Webster, Director of Nursing, she had written her story down and been included in some training with staff and also attended the dignity day.

2.2 Assurance Framework and High level risk Register

The assurance framework was received and the detail noted. Further discussion took place on the scoring of the high-risk entries and the relationships to the controls. This will be reviewed at the next meeting. It was also identified that there is closer scrutiny of the risk registers at the Clinical Management Executive.

2.3 Assurance Visits

The assurance team had undertaken 13 visits all of which were announced to ensure that the Matron or Ward Manager was available to answer the questions. It was identified that all the feedback from the visits is shared with the ward.

2.4 Mortality and Morbidity

Due to sickness the presentation was not made, however those present requested that this matter was raised to the attention of the board for further work and clarification.

2.5 Quality of Services

This was reviewed by the receipt of a number of different reports – safeguarding, Incidents, safety thermometer, morbidity and mortality. Those present noted the development and progress being made, however also noting that in some areas progress does need to be made more rapidly ie HCAI's.

The committee identified that there will need to be close scrutiny of the quality indicators.

Further work is being undertaken over the future of reporting. It was agreed that staff should not be writing multiple reports with no links and how this is best achieved is for discussion at the next meeting.

2.6 Review of the NHS Complaints system: Putting Patients back in the picture

The Committee were provided with an update in respect of the Trust's response to the Clywd-Hart review, which was published in late 2013. The committee agreed that the progress on actions would form part of the programme of monitoring.

3 Conclusion

The Trust Board is requested to note the summary of the Quality and Standards Committee meetings held on 6th May 2014 and the minutes of the meeting held on 3rd March 2014.

Charles Ellis
Quality and Standards Committee Chairman

May 2014

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee /Patient Safety and Clinical Improvement Group

Minutes of the Combined Quality and Standards Committee / Patient Safety and Clinical Improvement Group Meeting (PSCIG)

Monday, 3 March 2014
Committee Room, Conquest Hospital

Present:
Mrs Alice Webster, Director of Nursing, (Chair)
Mrs Sue Bernhauser, Non-Executive Director Designate
Mr Ian Bourns, Director of Pharmacy
Mr Kevin Burns, Data Quality Manager
Professor Jon Cohen, Non-Executive Director
Mrs Angela Colosi, Nurse Consultant for Advanced Practice
Mrs Janet Colvert, Ex-Officio Committee Member
Mrs Nicky Creasey, Assurance Manager, Health and Safety
Mrs Margaret England, Assurance Manager – Patient Safety and Risk
Mrs Liz Fellows, Assistant Director of Nursing
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director, Governance
Ms Stephanie Kennett, Non-Executive Director
Ms Brenda Lynes O'Meara, Assistant Director of Nursing Professional Practice and Standards
Miss Éanna McKnight, Head of Legal Services
Mrs Moira Tenney, Deputy Director of HR
Ms Anne Watt, Clinical Governance Manager
Mr Stuart Welling, Chairman
Mrs Lynette Wells, Company Secretary
Mrs Hilary White, Assurance Manager, Compliance
Dr James Wilkinson, Associate Medical Director

In attendance:
Mr Christian Lippiatt, General Manager for Occupational Health
Mrs Susan Cambell, PA to Director of Nursing (minutes)

1 Welcome and Apologies for Absence

Mrs Webster welcomed participants to the combined Quality and Standards Committee /Patient Safety Improvement Group meeting and confirmed that the Committee was quorate.

Mrs Webster noted that apologies for absence had been received from :

Mrs Christine Craven, Deputy Director of Nursing

Mrs Debbie Cooke, Head of Nursing
Mr Charles Ellis, Non-Executive Director
Ms Sarah Goldsack, Associate Director of Knowledge Management
Ms Katharine Horner, Deputy Clinical Governance Manager
Miss Emily Keeble, Head of Assurance
Mr John Kirk, Facilities and Security Manager
Dr Janet McGowan, Trust Clinical Governance Lead
Mrs Lindsey Stevens, Head of Midwifery, Assistant Director of Nursing
Ms Emma Tate, Clinical Outcome Improvement Manager

2 **Minutes of the Previous Meetings** 3

2.1 Minutes of the combined Quality and Standards Committee/PSCIG meeting held on 7 January 2014 were considered and agreed as an accurate record. 3.1

2.2 Minutes of the 7 February 2014 combined PSCIG /Essential Compliance Group (ECG) meeting were considered and agreed as an accurate record. 3.2

3 **Matters Arising**

The updated action log from the combined Quality and Standards Committee /PSCIG /ECG meetings would be circulated with the minutes.

4 **Shared Learning in Practice (SLiP)**

Mrs Fellows presented a SLiP report which had followed a level 1 Serious Incident (SI) review. Mrs Fellows confirmed that Her Majesty's Coroner had requested the SI investigation following an inquest into a patient's death where concerns had been raised regarding the care and treatment of a middle aged patient who had experienced severe symptoms of epigastric pain, retching and dysphagia on re-admission following an earlier episode of care. On re-admission, the patient underwent a CT scan that confirmed the patient had developed a gastric volvulus and arrangements were made to transfer the patient to another Trust for surgery, where sadly the patient had a cardiac arrest during surgery and died.

Mrs Fellows described the care and service delivery problems and noted that contributory factors had included poor communication with the patient's family, failure to complete fluid balance charts accurately in line with Trust policy and the failure of endoscopic equipment resulting, in a delay in obtaining a definitive diagnosis via a CT scan.

Mrs Fellows stated that the lessons learnt had been shared across the Trust and a number of actions had been put into place to prevent recurrence. Mrs Fellows gave assurance that significant investment in changes in practice, methods and leadership had been made to the area concerned and positive

outcomes had been noted, with a higher level of assurance in the standard of care being provided.

Mrs Fellows was thanked for providing the report on behalf of Mrs Cooke.

5 Board Assurance Framework (BAF)

Mrs Wells presented the BAF report and the Committee noted the following outstanding action; the inability to recruit to some specialties and the significant vacancies in some areas, which had been discussed in detail at the previous meeting.

Mr Welling assured the Committee that recent adverse public publicity regarding the BAF had been a misunderstanding as the BAF showed *potential* risks, not actual.

Professor Cohen sought clarification around the Gastroenterology Consultants job plan with regard to senior representation at weekly multi-disciplinary reviews and the reduction in the *Clostridium Difficile* infection (CDI) trajectory. Dr Wilkinson assured the Committee that Gastroenterologists on both sites were participating in this, with a single lead on each site who provided an overall perspective.

Ms Kennett sought assurance around the inability to meet national screening standards for diabetic retinopathy due to increased demand and limited capacity, despite there being a recovery plan in place and issues escalated. Mrs Wells explained that an in-house plan was in place which included a regional screening meeting and involved other Trusts and stakeholders. Mrs Fellows reported that although a robust screening service was in place, it struggled to cope with increased capacity and demand and had been escalated on the risk register.

Mrs Webster queried if there had been a reduction in the DatixWeb backlog and Mrs Wells agreed to provide an update at the next meeting. **LW**

6 Developing an Integrated Quality Report

Mr Bourns presented an update following a meeting of the working group tasked with developing an integrated quality report. He stated that having reviewed models from other integrated Trusts, there was ‘no one size fits all’ solution as data integration was required on both a trend and point prevalence basis. Mr Bourns highlighted the range of recommended indicators noted in the report and requested feedback from the Committee.

Professor Cohen stated that being able to provide high level assurance at Board on a regular basis, in as straightforward a format as possible was valuable and he encouraged the group to continue in their work. Dr Harrison explained that the report referred to integrated quality reporting at clinical unit level, and this would need to feed into an integrated performance report at Board level. Dr Harrison felt that the indicators identified were required at a clinical unit level.

Ms Kennett queried if the indicators would continue as they currently existed or if they would need to change. Mr Bourns confirmed that trend data would be of more value in some areas and a dashboard structure to assist with easy assimilation, provide assurance and highlight areas of concern was being investigated. Mr Burns confirmed that Business Intelligence was involved in the project.

Dr Wilkinson and Mr Bourns agreed to meet outside of the meeting to discuss the inclusion of mortality indicators. **IB/JW**

Mrs Webster agreed to discuss progress on a 'mock' version' of the integrated report with Miss Keeble and gave assurance that the report would incorporate Trust wide information. **AW**

7 **Patient Safety Incident Report for January 2014**

Mrs England presented the incident report for January 2014 and confirmed that there had been a slight reduction in the number patient safety incidents reported.

Mrs England highlighted that the data regarding incidents per 1000 occupied bed days related to acute data only.

Mrs England broke down the 198 slips, trips and falls data for January 2014 and stated that there had been 5 slips and 3 trips with the remaining incidents categorised as falls.

Mrs England confirmed that from 1 April 2014, it had been agreed with the Clinical Commissioning Groups (CCGs) that only category 3 and 4 pressure ulcers would be reportable.

Mrs England clarified the review of incidents that had been coded as 'of catastrophic severity', and explained that this had been due to miscoding.

Ms Kennett raised the issue of the falls trajectory which showed the number of falls exceeded the trajectory set by the CCGs.

Mrs Webster confirmed that the target was linked to a reduction in the number of falls based on the outturn of the previous year. She confirmed that this would continue to be monitored. Mrs England was not aware of a 2014/15 target set by the CCG to date.

Ms Kennett queried the higher number of health record and other documentation incidents reported by the outpatients departments at Eastbourne, compared with Conquest. Mrs Fellows commented that staff at the Conquest site had an electronic patient record system, JOE, as a back up measure, whereas EDGH were reliant on paper health records. Mrs England confirmed that this had been raised at the Health Records Steering Group meeting. Dr Hughes agreed to provide the Committee with a report regarding this on-going issue which would be circulated to the Committee. Mrs Tenney commented that the management of health records would be reassessed in the clinical administration review as it had been recognised that some areas required more resources. **DH /SC**

8 **Quality Improvement Priorities**

Mrs Wells presented an overview of the process and timescales for development of the Quality Improvement Account for 2014/15 report and explained this included Patient Safety, Clinical Effectiveness and Patient Experience, with at least one priority improvement needed in each category. Mrs Wells stated that a further community focused initiative was being sought, as unfortunately the benefits of the phased Community Health Care System would not be fully realised until the following year.

9 **Mandatory Training and Appraisal**

Mrs Tenney presented the mandatory training and appraisal report on behalf of Mrs Cousins and stated that in terms of mandatory training, compliance remained static. She confirmed that the Trust had requested each Clinical Unit submit a recovery plan, ensuring required compliance levels were achieved. Mrs Tenney assured the Committee that various methods were used to support staff, including increased e-learning opportunities, flexible training sessions and the assessment of staff using hand-held devices, although this was IT strategy dependent. Mrs Tenney explained that Staff Passports were a major development and allowed mandatory training to be moveable across organisations. She reported it had been estimated that approximately 15% of staff moved from different Trusts throughout the year, excluding junior doctors, and the passport would allow an agreed standard of competence to be accepted by the new organisation. Mrs Tenney explained that this linked to a core skills training scheme initiated by NHS Skills for Health.

She stated that NHS Skills for Health had also developed a number of packages to evaluate competences and help focus resources on training that needed to be delivered.

Mrs Tenney stated that appraisal compliance for medical staff had shown an increase which particularly related to revalidation, however, Agenda for Change appraisal compliance had decreased. Mrs Tenney described the new Performance Development Review process which linked to the Trust's new values and also to incremental pay which would become effective from 1 April 2014.

10 **External Visits Quarter 3 – 1 September – 31 December 2013**

Mrs White provided an updated summary of external agency, inspections and accreditation visits to the organisation between September and December 2013 and stated that to date, notification of a further six had been received.

Ms Kennett noted that some actions from the visits were significantly overdue and queried the follow up process. Mrs White confirmed that update reports were requested from the lead managers present at the visits and Mrs White agreed to provide further information and staff names. Mrs Webster commented that if staff were unable to provide action updates they should attend the Committee meeting and provide feedback directly. **HW**

Mrs Bernhauser raised the outstanding actions relating to the Inspection of the Trust's high and low voltage electrical infrastructure and Mrs Creasey confirmed that electrical high /low alerts were received by the Trust and agreed to find out further information regarding this. **NC**

11 **Quality Walks November and December 2013**

Mrs White provided a summary and focus of 20 Quality Walks carried out by Board members and members of the Senior Management team during November and December 2013. Mrs Webster informed the group that having undertaken quality walks, her experience was that staff were appreciative of the visits and feedback received.

12 **Review of Risk Management Strategy**

Mrs Wells presented an updated version (V1.3) of the Trust Risk Management Strategy and explained that this was reviewed annually and required Board approval. Mrs Fellows requested that 'risk' be replaced with 'quality and governance', where appropriate. Mrs Creasey highlighted 6.9 'Divisional Directors… would require amendment. Mrs Wells requested that any additional amendments be forwarded to her as soon as possible. LW/All

13 **Schwartz Centre Rounds®**

Mr Lippiatt outlined the Schwartz Centre Rounds® initiative that set out to support staff by exploring some of the challenging psychosocial and emotional issues when caring for patients. He stated that it would also enable them to deal with difficult situations and allow staff to spend more time focused on providing compassionate care to patients.

Mr Lippiatt explained that the Department of Health (DoH) had promoted the initiative following the Francis report on Mid-Staffordshire hospital and confirmed that it had been instigated successfully in a number of NHS Trusts and hospices.

Mr Lippiatt highlighted the benefits of the scheme and confirmed that it was open to all staff members via self selection and would take place during lunch time periods, with lunch provided by the Trust. Mr Lippiatt detailed the five thousand pound costs involved for each of the first two years, and was hopeful of gaining part funding through the Health Education Kent, Surrey and Sussex proposal to invest in this project. Mr Lippiatt explained the vision was for staff to participate with the minimum of travel i.e. meetings would be held on both main sites with possible video links for community staff.

The Committee were supportive of the initiative in principle and suggested medical students be included.

14 **Quality Governance Strategy**

Mrs Webster presented the Quality Governance Strategy for comment and discussion prior to submission to Trust Board. She explained that the overarching strategy outlined the framework for the delivery of quality governance at ESHT and supported the provision of high quality services for patients.

Mrs Webster confirmed that the strategy would support the implementation of the Quality Improvement Plan and would be discussed at Listening into Action (LiA) staff conversations scheduled during the month.

Ms Kennett highlighted that the Board Assurance Framework and Risk Register had been omitted from the Quality Governance Reporting Framework flowchart. Mr Bourns explained that with integration, the Drugs & Therapeutics /Medicines Management had now become the Medicines Management Group. **EK**

Mr Welling suggested that the number of groups and their functions noted on the strategy required review and both Dr Harrison and Mrs Webster agreed with this.

15 **Nurse Staffing Levels**

Mrs Webster tabled the Nurse Staffing Levels report which highlighted the initial issues, evidence and management of the way forward for staffing reviews and commented that this was an on-going piece of work. Mrs Webster informed the Committee that the staffing levels for the clinical areas that had been applied as recommended by the National Quality Board publication, ' How to ensure the right people, with the right skills are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability.

Mrs Webster explained that the overall forecast outturn had been looked at and this included temporary workforce, with a view to reducing the Trust's reliance on temporary workforce.

Ms Kennett and Professor Cohen requested a summary of the net changes, including any change in the skill mix as a result of the proposal, along with any implications for the organisation. Dr Harrison and Mrs Webster described the nurse to bed ratio figures and the complex national work that is being undertaken currently around this. Mrs Webster explained that Hurst modeling, an evidence based tool had been looked at and professional judgment applied to set safe staffing levels.

Dr Harrison stated that there was a need for clear justification to the Board on how the staffing levels had been decided to ensure confidence in how the numbers had been achieved. Dr Harrison described the future reporting of staffing on a daily basis and the issues that would bring. She suggested a protocol and rationale be used by the site teams to manage this.

Mrs Webster explained how other organisations managed their reporting via a variety methods, with some requesting funding for electronic patient systems via the Nursing Technology Fund. Mrs Webster confirmed that e-Rostering had been looked at to develop a reporting system, although this was unlikely to come into effective prior to 1 April 2014.

Mr Welling stated that it would be helpful to receive the actual number of staff in post by each ward, as this would allow the organisation to identify gaps in terms of risk associated with staffing levels. Mrs Tenney suggested that a smarter way of managing the flow of newly qualified nurses being integrated into the organisation would be desirable. She confirmed that currently, vacancies were filled by bank and agency prior to posts being taken up.

Dr Wilkinson sought clarity around the higher number of staff required by the Cuckmere unit at night and Mrs Fellows commented that this was possibly due to the isolation ward, with a large number of side rooms, and the necessity to build in capacity for extra staff to minimise the risk of cross infection.

Those present were asked to raise any further issues /comments to Mrs Webster by the end of the next week. **AW /All**

16 **Response to External Review of Maternity and Paediatrics Services**

Mrs Watt presented the recommendations and action plans from the joint Royal College of Paediatricians and Child Health (RCPCH) and the Royal College of Obstetricians and Gynecologists (RCOG) visits which had been commissioned following a risk summit in February 2013 where the safety of maternity services had been discussed.

Ms Kennett sought assurance around the action plan progress which showed as on target for completion, despite the completion date having passed. Mrs Watt acknowledged that these should have shown as target not incomplete, however, she anticipated the actions being completed prior to the next meeting.

17 **For Information**

The following items were noted by the Committee;

(i) Quarter 3 Serious Incident Report.
(ii) Minutes from the East Sussex Pain Interest Group Meeting 16 January 2014.

Ms Kennett highlighted the high number of apologies given to the East Sussex Pain Interest Group 16 January 2014 meeting and it was agreed that Dr McGowan would update the Committee regarding normal attendance figures. **JMc**

(iii) Consent and Clinical Ethics Committee Minutes from 18 December 2013.

Professor Cohen queried Patient and Public Involvement (PPI) representation on the Consent and Clinical Ethnics Committee and Dr Hughes agreed to contact Dr Simon Walton for further information. **DH**

18 **Any Other Business**

(i) On behalf of Mr Ellis, Mrs Webster sought opinion regarding the future structure of the combined Quality and Standards Committee /Patient Safety and Clinical Improvement Group meetings. Dr Hughes commented that the consolidation of meetings was a positive move and Dr Harrison agreed that the combined meeting should continue in its current format.

19. **Date of the Next Meeting**

(i) Quality and Standards Committee /Patient Safety and Clinical Improvement Group

Tuesday, 6 May 2014, 14.30 - 16.30hrs, St Mary's Meeting Room, Eastbourne District General Hospital.

(ii) Patient Safety and Clinical Improvement Group /Essential Compliance Group

Monday, 9 June 2014, 10.30 - 12.30hrs, Committee Room, Conquest Hospital.

EAST SUSSEX HEALTHCARE NHS TRUST

Notes of the Trust Board Seminar held on 12th February 2014 at 10.00 am in the St Mary's Board Room, Eastbourne DGH

Present:
Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Mr Charles Ellis, Non-Executive Director
Ms Stephanie Kennett, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr Darren Grayson, Chief Executive
Ms Monica Green, Director of Human Resources
Mrs Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development & Assurance
Dr David Hughes, Medical Director (Governance) (for items 1-3)
Dr Andy Slater, Medical Director (Strategy)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing
Ms Lynette Wells, Company Secretary

In Attendance:
Ms Ellen Lim, Head of Practice Quality, Sussex Partnership NHS Foundation Trust (for item 3)
Mrs Jane Rennie, Associate Director for Planning and Business Development (for items 2 and 3)
Ms Hilary White, Assurance Manager - Compliance (for item 3)
Mr Ian Bourns, Clinical Lead – Clinical Support Services (for item 4)
Mrs Trish Richardson, Corporate Governance Manager (notes)

ACTION

1. Apologies for Absence and Notes of the Seminar meeting held on 10th January 2014

a) Apologies for absence were received from:

Mr James O'Sullivan, Non-Executive Director

Mr Welling welcomed Professor Cohen to his first meeting as the Trust's new Non-Executive Director.

b) The notes of the seminar meeting held on 10th January 2014 were agreed as a correct record.

c) Matters Arising

Mr Grayson reported that recruitment had taken place to the vacant palliative care nurse post.

Mr Welling reported that he was meeting with Dr Hughes and Angela Colosi to progress the wider health economy meeting.

d) Update on Current Issues

i) CQC Intelligent Monitoring Report

Mr Grayson reported that the above report would be published on 17th February and noted that there had been a change in the methodology relating to whistleblowing in that the CQC only recorded if such an event was under way in a Trust at the time of reporting.

He advised that the Trust would be rated as an acute Trust, despite repeatedly explaining that the Trust provided an integrated service.

Ms Kennett asked how the Trust was performing in relation to flu vaccinations and Mr Grayson advised that acute staff were in the high 40s but as a whole the number was lower because 35% of staff not acute based.

ii) Mutually Agreed Resignation Scheme

In response to a query from Mr Nealon regarding progress with the above scheme, Mr Grayson reported that over 160 applications had been received and Ms Green advised that the applications were in the process of being reviewed and a proposal on the way forward would be submitted to the Remuneration Committee in the near future.

iii) Month 10 Flash Finance Report

Mrs Harris presented the January (month 10) flash finance report and reported that agreement had been reached with the Clinical Commissioning Groups (CCGs) on the amount of fines and penalties to be applied and re-invested into areas such as re-admissions, ambulance handovers and infection control. She reported that 100% of CQUIN funding would be reflected in this financial year.

She advised that as a result of the improvement in income and the continued control over costs there had been a £1 million surplus in month 10 resulting in the year to date run rate deficit decreasing to £21.3 million.

She reported that the District Valuer had undertaken the five yearly valuation of the Trust's assets during the summer of 2013 which had resulted in £10 million of impairments being added to the bottom line as a technical adjustment.

Mrs Harris advised that expenditure was £31.7 million in January and with the over-achievement in income during the month the Trust had over-achieved against the in year financial recovery plan surplus of £700,000 by £300,000.

Mrs Harris reported that the Department of Health had approved the Trust's application for non repayable public dividend capital and a significant amount of creditors would be cleared by the end of the following week and the aim in March was to clear 95% of creditors within 30 days.

Mr Grayson thanked Mrs Harris, who had been supported by Mr Murphy, in achieving a resolution around fines and penalties. He reported that an amount of £2.6 million had been agreed with the CCGs earlier in the week and this was already reflected in the month 10 position.

Mr Grayson reported that the expectation at the year end was that the Trust would have delivered £17.5 million savings which equated to 5% of its turnover.

Mr Grayson reported that the East Sussex health economy had been recognised as one of eleven challenged economies in the country and it would receive support from one of the national management consultancies in producing a plan to achieve sustainability going forward and further details were awaited from the TDA.

Mrs Harris reported that she, Mr Murphy and Dr Slater would be meeting with the CCG representatives to discuss plans for 2014/15 in the next week.

2. Mental Health Act

Ms Lim explained that she was the Sussex Partnership's lead for the Trust's contract with it in relation to ensuring compliance with its responsibilities under the Mental Health Act.

Ms Lim reported that the CQC would inspect the Trust every 12 to 18 months to ensure its continuing compliance and outlined the Trust's responsibilities and duties under the Mental Health Act.

She explained the key sections of the Act and detained patients' rights and outlined the service that Sussex Partnership Trust would provide for the Trust including:

- MHA Administration and Training contract: November 2013 – March 2015
- Rolling programme of MHA Overview and process training

- Record and monitor all reported detentions and provide an annual report to ESHT's Board
- Complete ESHT's KP90 return to DoH
- Lead in coordination of CQC MHA Monitoring visits and return of Provider Action Statement
- Develop suite of MHA policies
- Appoint and manage Associate Hospital Managers for ESHT
- Partnership meetings to monitor detention activity
- Identify and report invalid detentions
- Provide access to information leaflets and statutory and non statutory forms for use by ESHT staff
- Advice from MHA Office

Mr Welling thanked Ms Lim for her presentation.

3. Business Planning 2014/15 to 2018/19

Dr Harrison reminded the Board of the agreed process which was a risk based approach with clinical units developing service level plans for improvement and Board and executive scrutiny to ensure a coherent plan and strategic alignment.

She outlined the TDA and NHS England (NHSE) assurance process and discussion took place on the challenges around QUIP and CQUIN initiatives which had yet to be agreed with the CCGs.

Dr Harrison reported that the business plan would based on the Trust's strategic objectives and would include context around national policy and local policy.

She outlined the high level quality, performance and financial risks which were discussed in some detail and highlighted other risks which related to the Annexe E checklist in the TDA planning guidance.

Mrs Harris outlined the 2014/15 cost improvement plan (CIP) challenge and advised that £18 million had been identified so far. The CIP would be based on 65% productivity and value for money and 35% non pay and the clinical units and finance teams were working together to develop the plans.

She outlined the key issues and assumptions which included:

- Implementation of new medical model
- Improvement in theatre productivity
- Significant efficiency improvements in back office
- Trauma move complete in May 14
- Delivery of all patient service targets

Mrs Harris assured the Board that the clinical units were fully engaged in the development of their plans with support from finance, HR and turnaround and the Board would be able to test this when they reviewed the plans with the clinical units on 12th March.

4. Medicines Optimisation Strategy

Mr Bourns reported that medicines optimisation was the new approach being taken across the NHS to build on the previous Medicines Management requirements with additional areas of focus:

- Individual patient needs and their engagement
- Empowering patients in drug related decisions
- Enhanced monitoring of impact of drugs use
- Assessing the outcomes of drugs use

He reported that the TDA had developed a self assessment tool for Medicines Optimisation, against which the Trust had benchmarked itself and submitted its finding to the TDA in the summer of 2013. The Trust was mid range against the six domains.

He outlined the areas of good practice in the Trust which had been identified:

- Use of tablet devices and computer module that enabled pharmacy services redesign and enhanced efficiency
- 2 weekly review of all medication incidents by the himself to ensure action and cross divisional learning
- Medicines Information Bulletin sharing learning from incidents and best practice in medicines use
- Annual external review of pharmacy training subject by the Deanery

Mr Bourns highlighted that the key areas for action for the Trust were:

- Improve workforce planning for medicines optimisation and pharmaceutical services
- Develop comprehensive electronic prescribing systems
- Medicines reconciliation and clinical pharmacy services need to be comprehensively provided
- Need to develop and provide medicines optimisation training to all relevant staff

and an action plan had been developed.

Mr Bourns advised that electronic prescribing was already provided for cancer and critical care drugs but the Trust had not been successful in a bid for national monies to roll the system out further across the Trust.

Discussion took place around staffing and Mr Bourns advised that benchmarking demonstrated that the Trust had a lower number of pharmacists compared to an average Trust across the South East of England for the amount of activity generated. The department had therefore developed different ways of working including the use of hand held devices and this was now being recognised by other Trusts. The Board recognised this good practice and emphasised the need to continue to deliver improvements in the service within current resources.

Mrs Harris reported that capital investment had recently been agreed to provide automated drug storage cabinets on the wards which would help to free up nursing time.

Mr Welling thanked Mr Bourns for his presentation.

5. Date and Time of Next Meeting

Wednesday, 12th March 2014, 10am to 5pm, in the Committee Room, Conquest Hospital.

Following the meeting the following members of staff undertook their annual fire training:

Mr Welling, Mr Grayson, Professor Cohen, Ms Kennett, Mr Nealon, Ms Bernhauser, Mr Ellis and Mr Sunley.

East Sussex Healthcare NHS Trust

Date of Meeting:	3rd June 2014
Meeting:	Trust Board
Agenda item:	21
Subject:	Chairman's Briefing
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

Meetings attended in April and May included:

- Leader and Chief Executive East Sussex County Council
- Charles Hendry MP
- Meeting Chair and Acting Accountable Officer – High Weald, Lewes & Havens CCG
- Meeting Chair and Chief Executive Brighton & Sussex University Hospitals NHS Trust
- Meetings with Chairs of Brighton & Sussex University Hospitals NHS Trust, East Surrey Hospitals NHS Trust and South East Coast Ambulance Service NHS Foundation Trust
- Meeting Chairs of League of Friends
- Various quality walks

The following correspondence is attached to the report:

Letters to the following MPs Greg Barker, Stephen Lloyd and Charles Hendry.

Use of Trust Seal

The Trust Seal has not been used since the last meeting of the Board.

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net

SW/ajp

East Sussex Healthcare NHS
NHS Trust

10th April 2014

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Stephen Lloyd MP
100 Seaside Road
Eastbourne
East Sussex

Dear

I refer to your letter dated 2 April received 8 April which was unfortunately sent to Dane Road in Seaford which I assume was an administrative error in your office. It was also received after my response to your published letter in the Eastbourne Herald was submitted.

As you are aware I believe a face to face discussion would help you to understand the complexity of the issues that we need to manage within the Trust in order to deliver improvements in the safety and quality of the care we provide. The Board and I have been open in stating that quality and safety are our priority. All the actions we have taken have had this at their centre and we continue to work with our partners to ensure that we maintain and improve the quality of our services in a climate of increasing need and financial austerity.

The Trust has to ensure it provides the best possible services for all the people of East Sussex. This is our only agenda. You seem to be of the view that there is another one but this is far from the truth. I believe we both want the same thing: high quality and sustainable health services that deliver good outcomes for local people. I am surprised that you continue to advocate that we provide services in a way that national and local evidence indicates are not sustainable and cannot deliver the best healthcare for local people.

I note that you have chosen to focus on the financial position of the Trust when you must be aware that the Trust has to balance the delivery of increasingly challenging financial targets with meeting your government's policy requirements as well as making significant progress in improving safety and quality and outcomes for patients by implementing our clinical strategy.

You persist in describing the demonstrable service improvements that the Trust has delivered as having a negative impact on local people. This is demoralising for our hard working staff who take a pride in being able to deliver better care to their patients and meet national standards. The development of the Age Related Macular Degeneration service at Bexhill Hospital is a good example of how we achieve better care. We are now able to deliver a more efficient and effective service for the increasing number of patients that have this condition. Patients have shorter waits for appointments, spend less time in the clinic and get a one stop service of high quality. This change was clinically led, proposed and implemented by our Consultant Ophthalmologists and their teams with the involvement of patients. I cannot see how these improvements can be considered as failing patients and I am sure you can imagine how disappointed the staff will be to see that you consider this to be the case.

I am concerned that you continue to indicate that you have information about the quality of the services we provide and our approach to our staff but that you are not prepared to share these with us. The Trust is committed to addressing concerns raised by patients and staff so

that improvements can be made for the benefit of all local people. We regularly respond to issues raised directly by staff or patients, by our Joint Staff Committee, by our commissioners and by Healthwatch and other patient groups. We always learn from this feedback and that it helps us to improve services. We have provided you with information about how concerns can be raised without breeching individual confidentiality. Despite repeated requests you have not taken up any of these routes meaning the Trust has not been given the opportunity to address and where appropriate rectify these specific issues and this simply cannot be to the benefit of patients or staff.

You accuse me of trying to drive a wedge between you and Liz Walke which is just not true. There are times when a wider meeting is appropriate and other occasions when a 1:1 meeting is more so. Darren Grayson met regularly on a one to one basis with Mrs Walke on many occasions until she withdrew from these meetings. This was her decision. We have regular one to one meetings with other MPs and with the Chair of the Conquest campaign group. We believe that anyone who seeks to represent local people's views on the provision of health services should take the time to discuss their issues with the Trust and put themselves in the position of being in possession of all the facts prior to making public declarations. We are simply offering you the opportunity to do this.

I find your conclusion is insulting and inappropriate but in the best interests of local people I would urge you once again to take up the offer to talk to us in the same way as other local MPs do with a view to us working together to improve services for local people.

Yours sincerely

Stuart Welling
Chairman

cc Stephen Dunn, Director of Delivery and Development (South), NHS TDA
Liz Walke, Save the DGH Campaign
Keith Ridley, Managing Editor, The Eastbourne Herald

SW/ajp

East Sussex Healthcare NHS
NHS Trust

17th April 2014

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Charles Hendry MP
House of Commons
London
SW1A OAA

Dear

Crowborough

Thank you for meeting Amanda and me on Friday. I found the meeting useful and constructive and I hope it helped you to understand our position in relation to current and future provision of services in the Crowborough area. It was certainly beneficial for us to hear your aspirations for the future provision of maternity services which we would share. As you know the question we need to answer in conjunction with the High Weald Lewes and Havens Clinical Commissioning Groups is how these aspirations can be met within the processes and rules that govern service provision and procurement in the NHS.

During the meeting Richard said that his understanding was the recent notice of termination of the Community Services Contract that we hold with CCG included notice for Community Midwifery services. We did not have the full list of the 31 services included in the notice with us and assumed that this was correct information. Unfortunately it was not; the contract for community midwifery is separate to the community services contract and therefore notice has not been served on either the provision of community midwifery or on the Midwifery Led Unit at Crowborough Hospital. The CCG have been very clear that once a decision is made on the future configuration of maternity and paediatric services in East Sussex they will be in a position to consider how these services will be procured and provided in the future. In the meantime our Head of Midwifery continues to liaise with her counterparts at both Tunbridge Wells Hospital and the Princess Royal Hospital to make sure pathways for women are as clear and smooth as is feasible.

Thank you once again for arranging the meeting and I look forward to having further discussions with you in the future.

Yours sincerely

Stuart Welling
Chairman

SW/ajp

East Sussex Healthcare NHS
NHS Trust

7th May 2014

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 01323 417400
Website: www.esht.nhs.uk

Norman Baker MP
23 East Street
Lewes
East Sussex
BN7 2LJ

Dear Norman

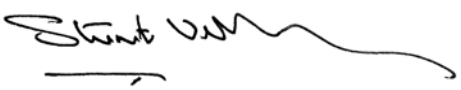
I was disappointed to read your press release about the Victoria Hospital Lewes. I think it would have been very helpful if we had discussed your concerns before you issued your statement.

I am a strong believer in face to face discussion as this would help you to understand the complexity of the issues that we need to manage within the Trust in order to deliver improvements in the safety and quality of the care we provide. The Board and I have been open in stating that quality and safety are our priority. All the actions we have taken have had this at their centre and we continue to work with our partners to ensure that we maintain and improve the quality of our services in a climate of increasing need and financial austerity.

The Trust has to ensure it provides the best possible services for all the people of East Sussex. The Victoria Hospital Lewes is an integral part of our service delivery arrangements and we are commissioned to provide services by the GP Clinical Commissioning Groups (CCGs). These arrangements are at the heart of your Government's policy on the NHS. As such it is for the CCGs to determine what services should be provided, where they are provided from and by whom.

I am not aware of any concerns on the services that are provided at Lewes however as you are aware a significant element of the services are provided by the Brighton & Sussex University Hospitals NHS Trust. If you have specific concerns I would be grateful if you could share them with me. Needless to say I would be pleased to meet with you if that would be helpful.

Yours sincerely



Stuart Welling
Chairman

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PRIVATE

A meeting of East Sussex Healthcare NHS Trust Board will be held in private on Tuesday, 3rd June 2014, following the public Trust Board meeting In the Oak Room, Hastings Centre

		Lead
1.	Apologies for Absence	Chair
2.	Declarations of Interest	Chair
3.	Minutes of the meeting held on 26th March 2014 (attached)	Chair
4.	Update on Current Issues	CEO
5.	Developing a corporate approach to responding to tenders and other business development opportunities	DSA/ DF

STUART WELLING
Chairman

28th May 2014