**EAST SUSSEX HEALTHCARE NHS TRUST**

**TRUST BOARD MEETING IN PUBLIC**

**A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 4th February 2015, commencing at 10.00 am in the St Mary's Board Room, Eastbourne DGH**

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

**QUALITY, SAFETY AND PERFORMANCE**

| | | | |
|---|---|---|---|
| 7. | Performance report month 9 (December) and Finance report month 9 (December) | Assurance | ALL |
| 8. | Safe Nurse Staffing Levels report | Assurance | DN |
| 9. | Patient Experience Report Quarter 3 (October – December 2014) | Assurance | DN |
| 10. | Research and Development Report | Assurance | MDS |

**DELIVERY**

| | | | |
|---|---|---|---|
| 11. | Annual Business Plan 2014/15 Quarter 3 | Assurance | DSA |

**GOVERNANCE AND ASSURANCE**

| | | | |
|---|---|---|---|
| 12. | Health & Safety Policy | Approval | DN |
| 13. | Fit and Proper Persons Directors' Requirements | Assurance | CSec / HRD |
| 14. | Board Sub-Committees:<br>a) Audit Committee 07.01.15<br>b) Finance and Investment Committee 29.10.14 and 19.11.14<br>c) Quality and Standards Committee Revised Terms of Reference and 13.01.15<br>d) Trust Board Seminar notes 05.11.14<br>e) Charitable Funds Committee – Terms of Reference | Assurance | Comm Chairs |

**ITEMS FOR INFORMATION**

| | | | |
|---|---|---|---|
| 15. | Chairman's Briefing | | Chair |
| 16. | Questions from members of the public (15 minutes maximum) | | Chair |
| 17. | Date of Next Meeting:<br>Wednesday, 25th March 2015 at 10.00 am in the St Peter's Community Centre, Bexhill-on-Sea | | Chair |
| 18. | **To adopt the following motion:**<br>*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*<br>*(Section1(2) Public Bodies (Admission to Meetings) Act 1960)* | | Chair |

**STUART WELLING**
**Chairman**

19th January 2015

| Key: | |
|---|---|
| Chair | Trust Chairman |
| CEO | Chief Executive |
| COO | Chief Operating Officer |
| CSec | Company Secretary |
| DF | Director of Finance |
| DN | Director of Nursing |
| DSA | Director of Strategic Development and Assurance |
| HRD | Director of Human Resources |
| MDG | 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:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 1c |
| **Subject:** | Quality Walks November/December 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 November and December 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 November and December has continued as previously. These were:

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

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

16 services/departments were visited as part of the Quality Walk programme during November and December as detailed below.

| Date | Time | Service | Site | Visit by |
|---|---|---|---|---|
| 3.11.14 | 9.30am | Crowborough Hospital | Crowborough | David Hughes |
| 4.11.14 | 2pm | Pevensey Day Unit | EDGH | Amanda Harrison |
| 5.11.14 | 3pm | Hailsham 3 | EDGH | Amanda Harrison |
| 14.11.14 | 11.30am | Mortuary | Conquest | Vanessa Harris |
| 14.11.14 | 10pm | Benson Ward | Conquest | Sue Bernhauser |
| 17.11.14 | 10.30am | Endoscopy Unit | Conquest | Vanessa Harris |
| 18.11.14 | | Estates and Facilities (Catering and Laundry) | EDGH | Sue Bernhauser |
| 27.11.14 | 9.30am | Wheelchair Service | EDGH | Vanessa Harris |
| 1.12.14 | 2pm | MIU and Radiology | Uckfield | Amanda Harrison |
| 4.12.14 | 2.15pm | Scott Unit | EDGH | Stuart Welling |
| 9.12.14 | 1pm | Dowling Unit | Bexhill | Stuart Welling |
| 11.12.14 | 6.30am | Newington | Conquest | Sue Bernhauser |
| 15.12.14 | 1pm | Physiotherapy | Conquest | Vanessa Harris |

| | | | | |
|---|---|---|---|---|
| 16.12.14 | 9am | Health Visitors/School Nurses | Centenary House Eastbourne | Stuart Welling |
| 19.12.14 | 3pm | Macdonald Ward | Conquest | Sue Bernhauser |

13 of these were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received). In addition the Medical Director carried out a visit to all Departments at Crowborough Hospital.
Feedback forms have been received to date relating to all 16 of the visits to individual services or departments, copies of which have 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**

Service Reconfiguration
One ward reported that they had settled into the consolidated surgical service and were now supporting colleagues in another ward to do the same, another ward was very positive about its ward environment since the changes. Excellent evidence of multidisciplinary team working was noted, along with an increase of referrals to physiotherapy since Trauma and Orthopaedics were centralised.
In the Endoscopy unit at the Conquest the inpatient demand has increased since the move of general surgery and there is now an on call service at weekends, however it is difficult to find enough endoscopists. Nurse endoscopists are being trained, but there is a significant time commitment involved in this.
Concerns were raised at Uckfield Hospital that good services may be affected by changes due to the potential impact of the MSK tender on the radiology department, along with the High Weald Lewes and Havens tender for the Minor Injuries Unit.
Issues were still being reported with the centralisation of outpatient bookings however staff did recognise the need for making changes. The impact and concerns were also noted of the school nursing and therapy services being commissioned by East Sussex County Council from Kent Health and Social Care

Information Technology (VitalPAC, SystmOne)
Staff on one ward stated that they were delighted with VitalPAC, they felt the technology helped them to manage their workloads more efficiently, and felt reassured that senior clinicians were able to monitor patient observations through the system, another area stated that they were looking forward to further applications being added to increase the functions.
SystmOne was also seen as a positive improvement for community services.
In the Endoscopy department the Endobase system is used, but it was reported that it is not working well as system to support audit. A local system has been designed to manage some audits but there are not sufficient computers with endobase licences.

Staff Survey
Some areas reported having completed the survey and managers stated that they had proactively encouraged staff to complete it. Staff in one unit reported that they hadn't completed the survey as they hadn't seen it, and others reported not wanting to complete it as they felt they would be identified, and didn't feel that their comments would make a difference.

Other key issues
Various members of staff both clinical and non-clinical stated that they were proud of their services, however high workloads were noted along with an increase in the complexity of patient/client problems particularly in the community within immigrant groups seen by the Health Visitors.

Staff working in the facilities department mentioned that they felt like a hidden service and unappreciated, they reported recruitment issues and also felt that investment was needed for equipment and improving the working environment.
Recruitment issues were also reported in therapies, and it was noted that following the MSK contract and CITS transfer to East Kent Community Service there was now a very narrow pathway offer which wasn't always meeting need. They also reported a lack of an OT specialist for Acquired Brain Injury and often have to use stroke resources. A decrease in complaints however was reported following an improvement in staff working together.
The current review of nursing staff levels was welcomed, and one area reported feeling frustrated when they have to 'lose' staff to help in other areas to cover absence.

Patient feedback
A medical patient spoken to who was an outlier on a surgical ward had nothing but praise for the care she had received and the dignity with which she had been treated. Positive feedback was also received from all other patients spoken to, and all but one were aware of their discharge plan, a concern was raised though about the length of time patients wait pre-operatively which leads to long periods of time without hydration.

## Benefits:

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

## Risks and Implications

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

## Assurance Provided:

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

Further visits are being scheduled to take place in January and February. It has been agreed that the current themes will continue throughout January.

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

## Proposals and/or Recommendations

The Board are asked to note the Quality Walks report for November/December 2014.

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

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

Not applicable.

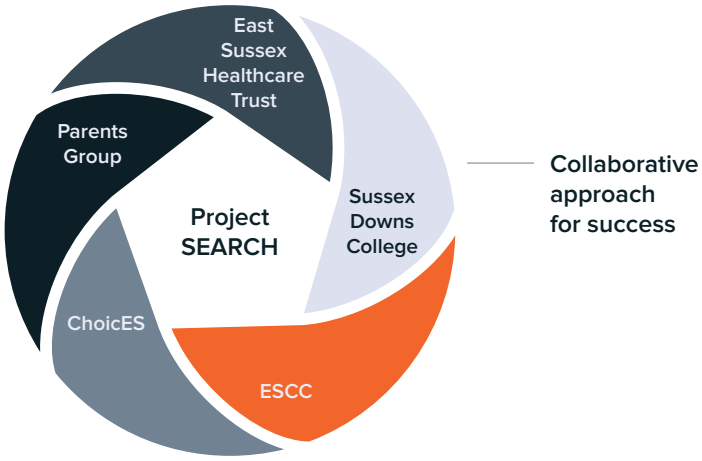
| For further information or for any enquiries relating to this report please contact: | |
|---|---|
| **Name:**<br>Hilary White, Head of Compliance | **Contact details:**<br>Hilary.White2@.nhs.net |

# What is Project SEARCH?

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

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

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




## What's involved in the programme?

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

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

## A Typical Day:

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

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

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

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

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

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

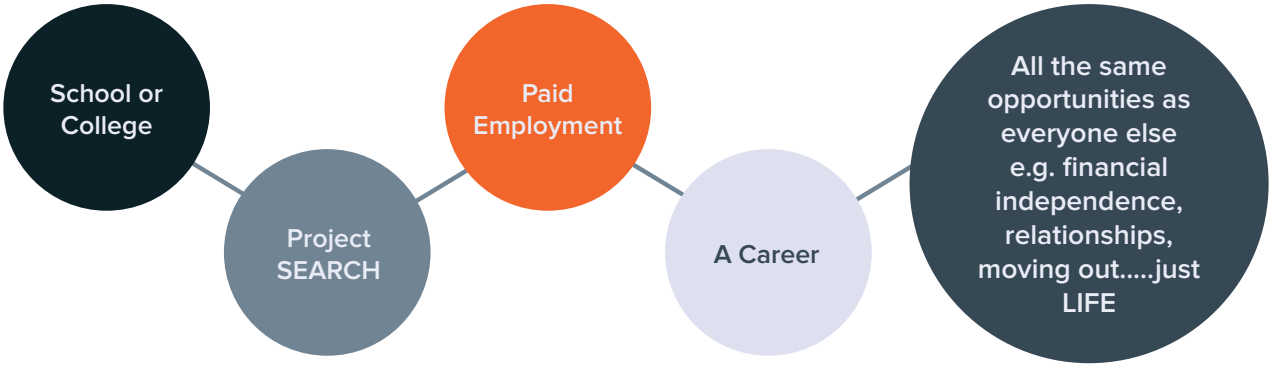
## Key info:

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

## Eligibility Criteria

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

# The Project SEARCH Journey




# Benefits of Project SEARCH

**Benefits to the intern:**

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

**Benefits to the host business and potential employers:**

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

# Key Contacts

**Sussex Downs College**
*Sarah Davies*
Project SEARCH Programme Co-ordinator
Tel: 07946 335 715
Tel: 01323 43 56 02

**East Sussex County Council**
*Julie Dougill*
Education Development Manager

**East Sussex NHS Healthcare Trust**
*Edel Cousins*
Assistant Director Workforce Development

*Jeanette Williams*
Listening into Action lead

**Sussex Downs College**
*Penny MacKay*
Curriculum Leader for Engagement

**ChoicES**
*Paul Green*
Employment Advisor

**Project SEARCH**
*Anne O'Bryan*
Project SEARCH Programme Specialist - Europe

# EAST SUSSEX HEALTHCARE NHS TRUST

## TRUST BOARD MEETING

**A meeting of the Trust Board was held in public on Wednesday, 26th November 2014 at 10.00 am in the Oak Room, Hastings Centre**

**Present**: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Dr Andy Slater, Joint Medical Director – Strategy
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing

**In attendance:** Dr Amanda Harrison, Director of Strategic Development and Assurance
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chairman
Dr Harry Walmsley, Associate Medical Director – Academia, Education and Research (item 106/2014)
Dr James Wilkinson, Associate Medical Director – Quality and Innovation (item
Mrs Trish Richardson, Corporate Governance Manager (minutes)

099/2014 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

Mr Welling welcomed everyone to the public part of the main Board meeting and, in particular, Angela Colosi, Assistant Director of Nursing for the Trust and Suzanne Cliffe and Ravi Baghirathan from the Trust Development Authority who were observing the Board Meeting.

He also welcomed Mrs Bernhauser to her first meeting as a substantive Non-Executive Director.

b) Apologies for Absence

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

Professor Jon Cohen, Non-Executive Director
Charles Ellis, Non-Executive Director
Dr David Hughes, Medical Director – Clinical Governance
Monica Green, HR Director

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

c) Feedback from Quality Walks

The Board noted the report on quality walks and Mrs Bernhauser reported on two visits that she had undertaken since the last Board meeting.

She reported that she had made an unannounced visit to Berwick ward on the Eastbourne DGH site with Mrs Webster and Dr Hughes following feedback from a patient story at the Quality and Standards Committee. She had spoken to staff and patients and received feedback from patients on the menu and one patient, a regular attender on the ward, had commented on the improvement in the availability of nursing staff on this admission and this had followed the revised nurse staffing levels being instigated. She also commented that the ward had been visited by the Care Quality Commission inspectors the day before and the staff had found the opportunity of presenting about their work very positive.

Mrs Bernhauser advised that she had also made a night visit to Benson ward on the Conquest site, an orthopaedic ward. She reported that the staffing was up to establishment at night although the ward did have staffing challenges due to long term sick leave. They had a number of elderly patients on the ward and she had met the ITU link nurse who was visiting a patient on the ward following feedback from the Vitalpac system. She highlighted that the staff had all welcomed Vitalpac as they saw it as a benefit to patients and being able to work differently and were keen to use different modules on the system. She had spoken to one patient who was very pleased with the care received.

Mr Welling reported on his visit to James ward at the Conquest and commented that they had an impressive and highly motivated team which was well led and mandatory training was also high on the agenda.. He advised that this team had also welcomed Vitalpac and were keen to expand the use of different modules. He reported that the patients were also highly satisfied with the service.

He reported that he had also visited Berwick ward and had again found that the team was highly committed with very good leadership but they were working under considerable pressure as result of short term staffing issues with Healthcare Assistants and the number of patients requiring specialing due to the Folkington ward move taking place. The team had highlighted that they occasionally experienced difficulties with supplies of linen. He reported that overall mandatory training was being completed and the doctors were also very supportive.

Mr Welling reported on a follow up visit to the Surgical Assessment Unit following the centralisation of surgery earlier in the year and he had found that the team seemed more settled with higher staffing levels in place and, whilst working under great pressure, the system was working and the patients seemed very satisfied with the care received.

**The Board noted the reports on quality walks.**

100/2014 **Monthly Award Winners**

Mr Welling reported that the winner for October was Jayne Thwaites, Clinical Role Development Co-ordinator, who had been nominated for her tremendous work in developing the role of Healthcare Assistants in the Trust.

He reported that winner for November was the Wellington ward team who had received a significant number of plaudits regarding the care they delivered, dignity and privacy, cleanliness and infection control and he would be presenting the award to the staff that afternoon.

101/2014 **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.

102/2014 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 24th September 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 updates on the matters arising log were noted.

103/2014 **Chief Executive's Report**

Mr Grayson reported that at the mid year point the Trust was making good progress on the safety agenda, performing consistently well on the Safety Thermometer including a significant reductions in pressure ulcers and falls, making good progress on the mortality indicators and delivering its financial plans.

He reported that the Trust had delivered quarter two in relation to A&E targets and this was a significant achievement in light of the considerable pressure across the NHS as a whole but this position would become harder as the Trust moved into winter. He reported that the RTT recovery was challenging although reasonable progress was being made and cancer performance remained patchy.The Trust was taking a number of approaches to address and improve the position.

Mr Grayson reported that the Trust had delivered its stretch plan so far by maintaining discipline on expenditure but also delivering on its cost improvement programmes.

He highlighted that the Five Year Forward View had now been published and the NHS was certain to be a major issue as the country moved towards the general election. The Trust was continuing to implement its clinical strategy and at this point having made the major service changes the Trust was now starting to measure the positive impact on patient safety and quality.

He advised that work was starting on planning for 2015/16 with a large event held with clinical units the previous day and the Clinical Commissioning Groups had attended to present their commissioning plans around East Sussex Better Together and the Better Care Fund. He noted that whilst there was further change to come it was clear that the Trust needed a period of stability as an organisation to consolidate and build on the changes already made.

**The Board noted the Chief Executive's report.**

104/2014 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework and noted that the Framework had been reviewed at the Board seminar on 5th November as well as the Quality and Standards and Audit Committees.

She reported that following review by the two Committees it had been recommended that the rating for two areas moved from amber to red – estates strategy and health records.

Mr Sunley commented that the health records department had suffered from a lack of capital investment over the years making it difficult for the department to run an effective service. He reported that a business case had been submitted to the TDA for funding extra storage space for paper records and investment in an electronic system going forward.

Mr Grayson agreed that the health records had suffered in part as a result of the failure of the national programme for IT and there were risks around the ability to have notes in the right place at the right time and the libraries' environment. These issues had been on the Trust's agenda for some time and had been highlighted as a risk to the CQC during their inspection.

Dr Slater commented that the Trust was procuring an electronic system for its document management but a solution for the current medical records was also required in order to provide the full benefits of the electronic system.

Mrs Harris queried the rating in relation to 3.3.2 as there were a number of "hard to recruit to" areas and the turnover rate for certain groups of staff was increasing. She reported that a report had been presented at the last Finance and Investment Committee in order to gain understanding on national recruitment issues, the gaps and how they were being addressed. Mrs Webster confirmed that within nursing and theatres a workforce task group was looking at different ways of recruiting, commissioning of training and "growing" their own staff. It was agreed that there would be a further discussion at a future Board seminar on this issue.

Mr Welling asked about progress on the achievement of 85% compliance with mandatory training by the end of December and Mrs Webster reported that all the clinical units had trajectories for achievement and they were being monitored through performance reviews. Mr Sunley anticipated that the clinical units would achieve their targets.

Mr Welling asked for an update on the estates strategy and Mr Sunley reported that the Trust did not have the skills internally to deliver the necessary estates control plan and the Trust had engaged with P21 and its partners Balfour Beatty to deliver this in the new year, once the updated Pevensey unit had been delivered.

**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.**

105/2014 **Performance Reports**

a) Performance Report – September 2014 (Month 6)

i) Responsiveness Domain

Mr Sunley reported that in relation to Referral to Treatment (RTT) times the Trust had agreed with the commissioners and the Trust Development Authority (TDA) that it would deliver the admitted target at an aggregate level by December. He confirmed that there was a very clear operational focus on this and it would be delivered.

In relation to non-admitted patients he reported that the original trajectory was to deliver this standard at the same time as admitted. However, more efficient systems that were in place following the centralisation of the booking service in the Trust meant that the numbers of patients being added to the non-admitted list had increased significantly and consequently the Trust had revised its trajectory for non-admitted patients to February.

He noted that this increase in non-admitted patients would at some point impact on the levels of patients moving onto the admitted list and they would need to be managed in a more timely way.

Mr Welling asked for assurance that the February date would be met and Mr Sunley explained that the implications of this increase needed to be worked through but the key specialities impacted were gastroenterology and rheumatology. He outlined the actions that were being taken in these two specialities to meet the increased demand.

Mr Sunley reported that the diagnostics targets had been delivered through to October.

Mr Sunley updated the Board following the anomalies identified within the Patient Target List (PTL) that had led to patients not being treated when they should have been and the actions taken to manage the risks of patient harm associated with this. He advised that all these patients had now been seen by a consultant and where appropriate had the appropriate treatment. The clinical outcomes group had reviewed all the cases to assess the impact of the delay in their treatment.

Mr Grayson stated that the Trust was acting appropriately to move patient onto the waiting lists more quickly through changes in the administration processes. In relation to the issue of the auto-validation protocols the Trust had acted correctly in raising this with the Intensive Support Team and the Trust Development Authority straight away for their guidance and the Board could take assurance that the correct action was being taken for patients with capacity being put in place to treat patients in a timely way.

Mrs Webster confirmed that the clinical outcomes group had reviewed the long waiting patients and their verdict had been that patients had suffered little or no harm.

Mr Sunley reported that the Trust had achieved the A&E target for quarter 2 but difficulties had been experienced during October and November. He highlighted that there had been issues with the volumes of admissions on both sites and extra beds had been opened.
He reported that the management team was working with the junior doctors at the Eastbourne site to achieve an increased level of productivity in line with that in the A&E department at Conquest . He also advised that the Trust was In discussion with the ambulance service over the high level of ambulance conveyances to the departments, particularly out of hours.

He advised that the Trust was also in discussions with its mental health partner regarding the unreasonable length of time for the admission of mental health patients to inpatient mental health beds from the department.

Mr Welling commented that the A&E performance been exceptional in achievement of the standard for quarter 2 but acknowledged the pressures that were occurring as the Trust moved into winter.

Mr Sunley reported that additional winter pressures funding was in the

system and he hoped that it would help to alleviate some of the pressures building up.

He reported that in relation to the cancer targets the Trust had not achieved the 2 week wait standards due to patients being unable to attend urgent appointments within fourteen days. He advised that the Trust was continuing to engage with the CCGs and stakeholders and additional clerical support had been put into the Trust team. He reported that an audit had been carried out between May and September of the referrals by GPs into the 2 week wait categories and those patients who had breached as unable to attend and the Trust had written out to 12 GP practices asking them to enusre that patients were aware of the potential seriousness of their position and provided a script and leaflet for them to use. He advised that two practices had responded asking for more information and a further audit had conducted in one practice with the main rationale for non-attendance being that patients had been elderly and confused.

Dr Harrison asked if the Trust had assurance from the CCGs that they were holding practices to account and Mr Sunley confirmed that the CCGs were attending stakeholder meetings and had helped in sending out the script and leaflet to GP practices. He advised that the Trust was not an outlier in this regard as it was a national issue.

Mr Grayson confirmed that the Chief Officers of the CCGs were signed up to this at a leadership level and it concerned changing clinical behaviour.

Mr Sunley reported that the Trust had been delivering the 31 day standard up until August but following a re-organisation of day surgery and theatre provision and an unprecedented level of vacancies there had been a drop in performance in dermatology .He anticipated that the Trust would be back on track in December.

He reported that the 62 day target continued to be missed and this related to urology, colo-rectal and histology. He advised that the issue in urology was due to complex pathways and the need for diagnostic support from radiology and to address this productivity had been increased through the theatres to provide extra capacity and have sufficient urologists to conduct tests. In relation to colo-rectal cancer he advised that the issue was due to timely access to endoscopy but following changes in the gastroenterologists' timeable a more sustainable position would be achieved. He reported that during the period there had also been vacancies in histopathologists and this had been resolved through the use of locums but a longer term solution was required to achieve a sustainable position. The Trust had advertised its vacancies internationally but there had been no interest at this point in time and the clinical unit was looking at different options to provide a solution.

<u>Effectiveness Domain</u>

Mr Welling reported that the mortality indicators would be considered later in the agenda under the mortality report.

Safe Domain

Mrs Webster reported that there had been 2 cases of Clostridium Difficile reported in September but that these had been assessed by the Clinical Commissioning Groups as not due to lapses in care. She advised that all cases were reviewed by the Clinical Commissioning Groups on a weekly basis.

She reported that all patient safety incidents were reviewed through the clinical units and the Patient Safety and Clinical Improvement Group and were referred up to the Quality and Standards Committee if required.

She reported that compliance with the VTE risk assessment was above target and one clinical unit had achieved 100%. The Trust was again the above target for the percentage of harm free care.

Caring Domain

Mr Sunley reported that there had been 20 mixed sex accommodation breaches in September and these had all been located in Herstmonceux Ward, EDGH due to issues with bed flow. As a result a system had now been put in place to ensure that all cases were reviewed in the bed meetings and there had been a subsequent reduction in following months.

Well Led Domain

Mr Grayson reported that the overall indicator was at 4 and the turnover rate rated at red related to changes in the management structure over the last six months. He reported that the Trust's sickness rate had increased in September and remained high in October and November.

Mr Nealon stated that as the monthly sickness rate had been significantly higher for three months in a row than the previous two years the Finance and Investment Committee would be undertaking a detailed review of this area.

Workforce Usage and Turnover

Mr Sunley reported that the clinical units had been given a target and trajectory to achieve 85% compliance with mandatory training by the end of December.

**The Board noted the performance report for September 2014.**

b) Finance Report – October 2014 (month 7)

Mrs Harris reported that the Trust had been notified by the Trust Development Authority that it was one of a cohort of NHS Trusts to receive non recurrent provider deficit funding in 2014/15 and for the Trust this would be £18 million. She advised that as a result of the notification the Trust had increased its savings target by £600,000 and was now forecasting a small surplus and as a result all the RAG ratings on page 1 had turned green.

Mrs Harris reported that the Better Payment Practice Code showed that the Trust was paying its trade invoices either on or above the 95% mark in the month.

She reported that the target for cost improvement programmes had been increased to £21 million in the year so that a breakeven position would be delivered. She advised that the savings target had been missed by £290,000 in the month but an additional £2 million of savings plans were in place and being implemented.

Mrs Harris advised that the financial risks set out at the beginning of the year remained the same but an additional one had been added in relation to the NHS England QIPP target issued in year which was very challenging and there was a risk of £700,000 on income and the Trust was in discussions to try to mitigate the risk.

She summarised that the receipt of non recurrent funding of £18 million had enabled the Trust to move its forecast outturn to a break even position and it was on plan to deliver this.

Mr Welling commented that the £18 million was very welcome but changed nothing in terms of the diligence required to ensure that the Trust achieved its financial targets.

Mr Grayson commented that the extra funding showed that there was a growing understanding of the structural deficit that the Trust had due to the way it was configured which had been recognised as part of the challenged health economy work which also recognised the progress made by the Trust in delivering efficiencies.

**The Board noted the finance report for October 2014.**

c) Current Quality Account Indicators

Mrs Webster presented the mid year report on progress against the Quality Account indicators for 2014/15 and noted that the Trust was on track to achieve the indicators.

**The Board noted the report on the Current Quality Account Indicators.**

106/2014 **Education Strategy**

Mr Welling welcomed Dr Walmsley to the meeting whose role as Associate Medical Director for Academia, Education and Research was to develop and raise the research and educational profile of the Trust.

Dr Walmsley reported that the Francis and Berwick reports had highlighted the importance of education and training in supporting the provision of high quality care. He reported that there were two elements to the strategy, one being the training of our current staff and providing lifelong development to encourage them to stay at the Trust and the second being training posts – medical, nursing and healthcare scientists – and both were of equal importance.

He advised that there had been a number of changes in the educational structure nationally and Health Education England (HEE) was now responsible for the commissioning of training for all staff which was devolved down to the Kent, Surrey and Sussex Local Education Training Board (KSS LETB) and the aim was to drive multi-professional integrated education which helped to improve multi-disciplinary working to improve patient outcomes. As a result future educational visits would not just concentrate on trainees but would review the whole patient pathway.

He reported that the number of trainees in medicine was falling and one of the aims of the strategy was to attract and retain quality staff in the Trust, cultivate leaders and develop partnership working including the aim of several joint appointments with the Brighton and Sussex Medical School (BSMS).

He highlighted that there were a number of challenges as highlighted in the SWOT analysis in appendix 2 but noted that there were opportunities for more e-learning, handheld devices and the development of new posts.

He reported that an Education Board had been set up in the Trust to bring together all the different groups of education together with 4 sub-groups sitting underneath it covering the delivery of training, e-learning, library & IT, quality and co-ordination and finance.

Mr Welling thanked Dr Walmsley for his work in taking this forward and looked forward to reviewing this area in detail at the next Board seminar. Dr Harrison asked how the performance against the implementation of the strategy for example thgouth GMC surveys, would be monitored and Dr Walmsley advised that this was part of the role of the quality sub-group and there was a quality impact tool being developed which would cover all specialities.

Mrs Bernhauser asked if other health professionals were represented apart from medical education and Dr Walmsley advised that Mrs

Cousins, Associate Director – Learning and Development, was chairing one of the sub-groups.
Dr Walmsley advised that Mrs Cousins was also leading on the education of non- medical staff. Mrs Webster confirmed that she supported the strategy at present in terms of nurse education but would continue to monitor the input.

Mr Grayson highlighted that the short term objectives in the strategy needed to be integrated into the Trust's business plan for 2015/16.

Mr Welling thanked Dr Walmsley for all this hard work and looked forward to a more detailed discussion on this subject at the Board Seminar on 10th December.

**The Board supported the Education Strategy and the education structure under the new Education Group.**

107/2014 **Mortality Indicators and Metrics**

Mr Welling welcomed Dr Wilkinson to the meeting to present the report on mortality indicators and metrics.

Dr Wilkinson reported that the first four pages of the report gave a summary of the main mortality indicators and the differences between them. He highlighted that the SHMI and HSMR indices received the most prominence and CHKS, the company employed by the Trust to provide mortality and quality intelligence also had its own index which was RAMI. He noted that the SHMI index included patients who died within 30 days of admission to hospital and therefore included patients within the Trust's community sites.

He highlighted that there had been concern earlier in the year that the Trust was a statistical outlier as its SHMI had peaked at 113.6 for the period October 2012 to September 2013 but since then it had gradually reduced and the most recent data published in October showed the Trust's SHMI to be 110.0 and within the expected range.

He reported that the HSMR index showed a 12 month rolling average and this had been reducing down consistently with each month since June/July last year and was at 91 in July 2014, compared to 105 in July 2013. He highlighted that as time progressed the increase in mortality experienced during the of 2012/13 was now having less impact on the indicators.

Dr Wilkinson reported that the HSMR ratio was generally rebased every year and therefore in the next report the figure would be different as it would have been rebased but the position of the Trust in respect of comparator Trusts would remain the same.

Dr Wilkinson referred to a new development available to the Trust by using the CHKS mortality profile tool to give more insight into alerts from increasing mortality associated with certain conditions and these were called CUSUM alerts. The Trust was able to use this tool to track individual conditions enabling it to investigate adverse variances in mortality much more rapidly.

Dr Wilkinson reported the three indicators only provided the headline figures and overview and there was a detailed process for monitoring and reviewing the indicators and metrics in the clinical units through the Mortality Review Group (MRG) and Mortality Overview Group (MOG) which he outlined.

He referred to the Trust electronic mortality database which recorded details of all deaths in the acute hospitals and the Irvine Unit at Bexhill including certified cause of death, post mortem and coroner referrals. Since April as part of a local CQUIN target the clinicians were to record on the database when they had undertaken reviews of patient deaths under their care and clinical units were expected to provide a report to the MRG each month on this. He advised that the quarter 2 CQUIN target had been met and the Trust was on track to achieve the quarter 3 target.

Dr Wilkinson highlighted that an area of concern for the Trust was the mortality review of deaths of patients in GP beds in the community hospitals and in the community itself. Discussions were taking place with the CCGs and GP practices on increasing the level of reviews. He reported that a review of deaths in the community hospitals earlier in the year had not revealed any major issues in clinical care.

He reported that the Mortality and Morbidity Policy had been ratified and was available on the Trust intranet and it described where the MRG and MOG sat within governance structures and outlined expectations in relation to mortality reviews.

Dr Wilkinson highlighted that improvements were being made in clinical coding through an education programme to encourage clinicians to record co-morbidities therefore enabling the coders to code more accurately.

Mr Welling thanked Dr Wilkinson for his hard work in this area and noted that the work of the MRG and MOG was critical in providing assurance that mortality was within the required parameters.

He asked if there would a similar bulge in mortality as in the winter of 2012/13 if there was another hard winter. Dr Wilkinson reported that all Trusts' average standardised mortality ratio went up if there was a hard winter but that the Trust's ratio went had increased above average in the winter of 2012/13. This was influenced by the high elderly population and the modelling for the indices did not accurately reflect this.

Dr Wilkinson highlighted that this was also influenced by coding as the Trust had previously not been good at capturing co-morbidities but with the improvements being made he anticipated that in future whilst there would be a higher than average rise this would not be so extreme.

Mr Sunley reported that there had also been operational learning and the winter plan allowed for additional capacity to be opened earlier, thereby reducing the number of medical patients outlying in different parts of the hospitals and Dr Wilkinson was working hard with the clinical teams to ensure there was a named doctor and team looking after any such outliers. Dr Slater reported that the introduction of Vitalpac would also help in this regard.

Dr Harrison asked how the consultant level outcome data around mortality provided by the CHKS system fed into the mortality and morbidity process and Dr Wilkinson advised that the data was reviewed over 3-6 months as there was a lot of variation month to month and the clinical units were asked to take ownership of this data at consultant and speciality level and highlight any variances coming out of the data. In addition, the MRG drilled down into the data on a monthly basis.

Dr Wilkinson highlighted that concerns had been expressed outside of the Trust that consolidating particular services onto one site could have an adverse effect but there had not been any perceived change in mortality associated with the move of acute surgical and trauma onto one site.

**The Board noted the progress being made in both nationally published and internally monitored mortality metrics and took assurance on the robustness of the Trust's review systems.**

108/2014 **Safe Nurse Staffing Levels**

Mrs Webster presented the report and highlighted that appendix 1 analysed the staffing levels for August and appendix 2 for September and the reasons why the three wards/departments were below 75% staffing for trained nurses was explained in the report. She noted that triangulation was provided against pressure ulcers, falls and medication errors.

Mr Grayson reported that future reports would provide triangulation with serious incidents, complaints and other indicators and Mrs Webster reported that unannounced quality review visits had been introduced to clinical areas where concerns were being highlighted.

Mr Welling commented that the relationship between staffing levels and incidences of healthcare acquired infection (HCAI) was critical and Mrs Webster reported that this was one of the indicators that had been reviewed and there was no evidence in the current serious incidents to indicate any correlation between low staffing levels and HCAI.

**The Board noted the report on Safe Nurse Staffing Levels for August and September 2014.**

109/2014 **Patient Experience Report Quarter 2**

Mrs Webster reported that the Trust was continuing to achieve its CQUIN target for the Friends and Family Test (FFT) and an analysis was provided in sections 2.1 and 2.2 of the report and section 2.4 provided examples of patient feedback. She advised that comments from the FFT were fed back down to the clinical areas and section 2.5 provided examples of how such feedback had been actioned and this was also shown on the boards on the wards.

She reported that comments about the Trust on NHS Choices were reviewed and these were themed and trended and reported to the clinical units, responses agreed with them and placed back on NHS Choices and individuals had made contact with the Trust following these responses.

She highlighted that section 4 referred to the staff FFT which was monitored by the HR department.

Mrs Webster referred to section 5 which provided the Patient Advice and Liaison service (PALs) summary and noted that there had been a spike in contacts during the latter part of July and August and this related to the changes in the outpatient booking-in system.

She reported that the number of complaints remained fairly static but there had been a reduction in compliance with the target in responding to complaints.

Mrs Webster summarised that the patient experience team reviewed all the experiences that patients had and this would be used as a central point in the development of services going forward.

Mrs Harris asked if there had been any feedback in relation to the comment on A&E waiting areas being dirty and Mrs Webster advised that there had been no specific feedback on that area and it was not a common comment.

**The Board noted the Patient Experience Report for quarter 2.**

110/2014 **Research and Development Report**

Dr Slater presented the report and noted that it included the Clinical Research Network (CRN) quarterly report relating to the Trust and the narrative described the progress made since the last quarter and also in relation to actions resulting from the strategy approved at the last meeting.

**The Board noted the Research and Development report.**

111/2014 **Procurement Strategy**

Mrs Harris presented the Procurement Strategy and noted that it had been reviewed in detail by the Finance and Investment Committee who recommended it to the Board for approval.

She reported that the strategy covered the next three years with the intention to save £6.5 million but this would involve spending money first in restructuring the procurement team to make it fit for purpose.

Mrs Harris noted that the policy was consistent with the Department of Health strategy and policy and the procurement team would take responsibility over all influencable spend, working collaboratively with other organisations and the procurement hub to obtain value for money.

Mr Nealon commented that the collaborative working in procurement would see an improvement in savings, particular in areas of bulk purchase.

Mr Welling reported that Professor Cohen had supported the principles of the strategy but had reservations about spending money on staffing to save money.

Mr Stevens commented that an appropriately staffed procurement operation would make savings.

**The Board approved the Procurement Strategy.**

112/2014 **Annual Business Planning Framework for 2015/16**

Dr Harrison presented the Annual Business Planning Framework for 2015/16 and noted that the key planning assumptions would develop over the next weeks and months and the clinical units and corporate services would develop and adapt their plans taking account of these. The plan also referred to the anticipated service changes in 2015/16 around musculo-skeletal work and the High Weald Lewes and Havens community services.

She referred to the timetable and noted that there were a number of meetings where the plan would be reviewed by the sub-committees and there would be an opportunity for the Board to review the clinical unit plans in detail in mid-March before the plan came to the Board at the end of March for final approval.

**The Board noted the Annual Business Planning Framework for 2015/16.**

113/2014 **Annual Review of Corporate Governance Documents**

Mrs Wells reported that the annual review outlined mainly administrative changes to the documents.

Mrs Wells noted that these changes had been considered by the Audit Committee who recommended them to the Board for approval.

**The Board approved the proposed change in the annual review of the corporate governance documents.**

114/2014 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Audit Committee

Mr Stevens presented the report which was self-explanatory.

**The Board noted the report.**

b) Finance and Investment Committee

Mr Nealon presented the report and noted the increased flow through of expenditure on infrastructure.

**The Board noted the report.**

c) Quality and Standards Committee

Mrs Bernhauser presented and noted that there had been a discussion on how the Patient Safety and Clinical Improvement Group reported into the Quality and Standards Committee.

**The Board noted the report.**

d) Trust Board Seminar Notes

The Board adopted the notes of the Trust Board Seminar held on 13th August, 17th September and 15th October 2014.

115/2014 **Chairman's Briefing**

Mr Welling presented the briefing which was self explanatory.

116/204 **Meeting Dates for 2015**

The Board noted the meeting dates for 2015.

117/2014 **Questions from members of the public**

Board agenda

Mrs Walke asked if it would be possible to have timings on the agenda. Mr Welling said that he would consider the request but the meeting had been slightly longer than usual as there were a number of issues which needed full decision.

Shuttle Bus

Mrs Walke asked the Board to consider funding a shuttle bus for patients, visitors and staff. Mr Grayson reported that the Trust was looking at this area in regard to its priorities in the business plan for next year.

Dr Harrison commented that staff transport had been provided following the centralisation of services on one site but it had not been used and therefore it had been discontinued.

Rheumatology

Mrs Walke asked what provision had been made following the retirement of a Rheumatology consultant and Mr Sunley reported that the substantive post had been advertised several times but the Trust had been unable to recruit as this was a national shortage area and it was also having difficulty in obtaining locums to cover.

Ebola

Mr Hardwick asked if any staff had volunteered from the Trust and Mr Grayson advised that he was not aware of any staff that had.

Procurement

In response to a question from Mr Hardwick on purchasing, Mrs Harris advised that the Trust had to follow all procurement law but was able to work with other partners in certain cases. She advised that there were a number of existing infrastructures where frameworks could be used to tender for certain services rapidly.

Mr Nealon reported that there was a national NHS group reviewing unit prices and the Trust was able to check that it was being consistent with the prices being charged.

118/2014 **Date of Next Meeting**

Wednesday, 4th February 2015, at 10.00 am in the St Mary's Board Room, Eastbourne DGH

119/2014 **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.

The proposal was seconded by Dr Slater.

Signed ……

Position ……..

Date ……

# East Sussex Healthcare NHS Trust

## Progress against Action Items from East Sussex Healthcare NHS Trust 26.11.14 Trust Board Meeting

| Agenda Item | Action | Actioned By | When | Progress |
|---|---|---|---|---|
| *104/2014 – Board Assurance Framework* | Discussion on recruitment to take place at a future Board seminar. | Company Secretary | 22.04.15 | On workplan for April Board Seminar |
| *105/2014a)i) – Performance Report – Responsiveness Domain* | Report from the Clinical Outcomes Group to be presented at next meeting. | Director of Nursing | 25.03.15 | Report to go to Quality and Standards Committee and then to Trust Board meeting on 25.03.15 |

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 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 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.

Three areas remain at red relate to Health Records, Mandatory Training and the Estates Strategy and an additional gap in control concerning the internet gateway has been added from the High Level Risk Register and is currently rated red.

At their January meetings the Quality and Standards Committee undertook a deep dive on health records and plain film reporting and the Associate Director of Information provided the Audit Committee with an overview of the national problems with the internet gateway.

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

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

**Benefits:**

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

**Risks and Implications**

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

**Assurance Provided:**

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

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

| Review by other Committees/Groups (please state name and date): |
|---|
| Quality and Standards Committee 13th January 2015<br>Audit Committee 7th January 2015 |

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

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

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

# Assurance Framework - Key

**RAG RATING:**

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

**Status:**

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

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

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

C indicated Gap in control
A indicates Gap in assurance

# Board Assurance Framework - Jan 2015

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

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 1.1.1 | C | There is a gap in control due to the number of policies that require review and updating. | Schedule of out of date policies produced and circulated to CU leads.<br>Dec-14 Process in place for reviewing and updating policies to meet Mar milestone.<br>Monitoring through CME. | end Mar 15 | ◄► | DN/COO | CME |
| 1.1.2 | A | The Board cannot be fully assured in respect of compliance with CQC outcomes until the regulator has issued the September inspection report. | Report expected by Jan 15 for factual accuracy review.<br>Project Group in place and action plan to be developed. | end Jan 15 | ◄► | DN | Q&S<br>CME |
| 1.1.3 | C | There is a requirement to improve controls in Health Records service; to encompass systems and processes, storage capacity and quality of case note folders. | Review of Health Records commissioned and business case being developed.<br>Dec-14 Business case submitted to TDA for consideration. | end Dec 14 | ◄► | COO | F&I<br>CME |

| | |
|---|---|
| **Strategic Objective 1:** | **Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority** |
| **Risk 1.2** | **We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.** |

# Board Assurance Framework - Jan 2015

| | |
|---|---|
| **Key controls** | Robust monitoring of performance and any necessary contingency plans. Including:<br>Monthly performance meeting with clinical units<br>Clear ownership of individual targets/priorities<br>Daily performance reports<br>Effective communication channels with commissioners and stakeholders<br>Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis<br>Single Sex Accommodation (SSA) monitoring<br>Regular audit of cleaning standards<br>Business Continuity and Major Incident Plans<br>Reviewing and responding to national reports and guidance<br>Monthly audit of national cleaning standards |
| **Positive assurances** | Integrated performance report that links performance to Board agreed outcomes, aims and objectives.<br>Exception reporting on areas requiring Board/high level review<br>Dr Foster/CHKS HSMR/SHMI/RAMI data<br>Low HCAI and SSA breaches<br>Performance delivery plan in place<br>Accreditation and peer review visits<br>Level two of Information Governance Toolkit<br>External/Internal Audit reports and opinion<br>Patient Safety Thermometer<br>Cancer - all tumour groups implementing actions following peer review of IOG compliance.<br>Trust Board reviewed analysis of Keogh, Berwick et al; actions agreed and monitored at Q&S Committee. |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 1.2.1 | C | Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice. | Focussed management and action plan in place.<br>Discussions with cancer network discussions re urology capacity/expectations.<br>Capacity and demand review of gastro and endoscopy being completed. | end Mar 15 | ◄► | COO | CME |
| 1.2.2 | C | Further controls required in emergency services as demand is impacting patient assessment-treatment time and subsequent discharge to other specialist/bed areas | Meet SECAMB monthly to review issues.<br>Action plan and escalation process in place<br>Capital bid with TDA to support expansion | end Dec 14 | ◄► | COO | CME |

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|---|---|
| **Strategic Objective 1:** | **Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority** |
| **Risk 1.2 Continued** | **We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.** |

| **Gaps in Control (C) or Assurance (A):** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.2.3 | C | Effective controls are required to minimise the risk to achievement of referral to treatment timescales, particularly the admitted pathway. | Action plan developed with support from National Intensive Support team and TDA, monitored by Trust Board. Revised trajectory agreed - admitted to be delivered in December then sustainability from February 2015. Non Admitted to be delivered from February 2015. | end Feb-15 | ◀▶ | COO | CME |
| 1.2.4 | A | Assurance is required that there are systems in place to develop and evidence shared learning from infection control incidents | Root Cause Analysis undertaken for all outbreaks and SIs and shared learning through governance structure, CU and nurse meetings. | end Mar 15 | ◀▶ | DN | Q&S |
| 1.2.5 | A | There is insufficient assurance that clinical laboratory diagnostics analytical equipment will be replaced in a timely way following internal approval of the managed service contract. | Agreed to replace via managed services contract. FBC to Finance and Investment Committee meeting approved.<br>Oct 14- FBC with TDA. | end Dec 14 | ◀▶ | COO | F&I<br>CME |
| 1.2.6 | C | Additional controls are required to reduce the backlog of plain film reporting and delay in reporting non urgent radiological investigations. | Process in place to reduce plain film backlog and patients being contacted. CCG appraised of position and comms sent to GPs.<br>Prioritisation process for urgent MRI/CT scans. | end Mar 15 | ◀▶ | COO/<br>MD(G) | CME |

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|---|---|
| **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.** |

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

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 1.3.1 | A | Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and are improving levels of mandatory training and completion of appraisals. | Initiatives such as mandatory training passport being rolled out and developing e-assessments to support competency based local training.<br>Robust actions planned to improve compliance by the end of the year.<br>Dec-14: Additional mandatory sessions now running to end Mar-15.<br>Temporary resource agreed to help develop competency assessments.<br>Compliance has shown an increase as at end Nov-14.<br>Target of 85%+ appraisal compliance set for end Dec-14. | end Dec 14 | ◄► | HRD | Q&S<br>CME |

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|---|---|
| **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.** |

| | |
|---|---|
| **Key controls** | Develop effective relationships with CCGs<br>Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work.<br>Relationship with and reporting to HOSC<br>Programme of meetings with key partners and stakeholders |
| **Positive assurances** | Trust participates in Sussex wide networks eg stroke, cardio, pathology.<br>Monthly performance and senior management meetings with CCG and TDA.<br>Working with clinical commissioning exec via Better Together and Challenged Health Economy to identify priorities/strategic aims.<br>Board to Board meetings with CCGs, SECAMB and other bodies.<br>Membership of local Health Economy Boards – UCN, Elective, Integrated.<br>Participant in emergency clinical senates |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 2.1.1 | C | Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises. | Trust proceeded to dialogue phase of tender process, ongoing risk assessment being undertaken as CCG requirement becomes clearer. Final tender evaluation scheduled end May. | end May15 | ◄► | DSDA | F&I<br>CME |
| | | | Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined. | end Mar 15 | ◄► | COO | CME |

| | |
|---|---|
| **Strategic Objective 2:** | **Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences** |
| **Risk 2.2** | **We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.** |
| **Key controls** | Develop and embed key strategies that underpin the Integrated Business Plan (IBP):<br>Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Membership Strategy<br>Effective business planning process |

| | |
|---|---|
| **Positive assurances** | Two year integrated business plan in place<br>Stakeholder engagement in developing plans<br>Finalising service delivery model for maternity and paediatrics |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 2.2.1 | A | There is insufficient assurance that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work. | Challenged Health Economy and Better Together Work ongoing. | end Mar 15 | ◄► | DSDA | F&I<br>CME |

| | |
|---|---|
| **Strategic Objective 2:** | **Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences** |
| **Risk 2.3** | **We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population or commissioners.** |
| **Key controls** | Embedding Patient and Public Involvement Strategy<br>Governance processes support and evidence organisational learning when things go wrong<br>Quality Governance Framework and quality dashboard.<br>Risk assessments<br>Complaint and incident monitoring and shared learning<br>Robust complaints process in place that supports early local resolution<br>Clinical audit plan<br>Equality strategy and equality impact assessments |

| | |
|---|---|
| **Positive assurances** | Integrated performance report that links performance to Board agreed outcomes, aims and objectives.<br>Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives.<br>Friends and Family feedback and national benchmarking<br>Patient surveys<br>Dr Foster/CHKS/HSMR data<br>Audit opinion and reports<br>Quality framework in place and priorities agreed eg for Quality Account, CQUINs |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 2.3.1 | A | Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience. | Incidents logged and issues escalated to SECAMB and commissioners. Service specification being reviewed by commissioners and Trust engaging with process. | end Mar 15 | ◄► | COO | CME |
| 2.3.3 | C | A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience. | Immediate action taken and full review instigated to understand activity and processes to support implementation of focussed actions. | end Jan 15 | ◄► | COO | CME |

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

| **Gaps in Control (C) or Assurance (A):** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.1.1 | C | Require evidence of robust controls to ensure achievement of 2014/15 financial plan and prevent crystallisation 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. | Monthly monitoring and review of income and expenditure. Financial position off plan at M8. Additional savings identified and further controls in place to close gap. | Commenced and ongoing review and monitoring to end Mar-15 | ◄► | DF | F&I |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic Objective 3:** | **Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.** | | | | | |
| **Risk 3.2** | **We are unable to invest in delivering/improving quality of care and outcomes for patients because we are operating in a challenged health economy and this could impact on our ability to make investment in infrastructure and service improvement.** | | | | | |
| **Key controls** | Development of Integrated Business Plan and underpinning strategies<br>Six Facet Estate Survey<br>Capital funding programme and development control plan<br>Monitoring by F&I Committee | | | | | |
| **Positive assurances** | Draft assessment of current estate alignment to PAPs produced<br>Essential work prioritised with Estates, IT and medical equipment plans.<br>Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC.<br>Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. | | | | | |
| **Gaps in Control (C) or Assurance (A):** | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.2.1 | A | Assurance is required that following approval of the FBC funding will be available to support the required investment in estate infrastructure, IT and medical equipment. | Business case submitted to TDA for early release of first tranche of FBC funds. Two applications made for emergency in year capital. £400k received for Conquest CDU improvements. Other application still pending. Capital Approvals Group is overseeing 2014/15 capital programme and ensuring essential expenditure is prioritised and is making regular reports to Finance and Investment Committee. | Ongoing review and monitoring to end Mar-15 | ◄► | DF | F&I |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic Objective 3:** | **Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.** | | | | | |
| **Risk 3.3** | **We are unable to effectively recruit and manage our workforce in line with our strategic, quality, operational and financial requirements** | | | | | |
| **Key controls** | Development of workforce strategy:<br>- to align workforce plans with strategic direction and other delivery plans;<br>- to ensure a link between workforce planning and quality measures<br>Development of Recruitment and Retention Strategy<br>Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies)<br>Rolling recruitment programme<br>Monthly vacancy report to CLT | | | | | |
| **Positive assurances** | Training and resources for staff development<br>Workforce planning aligned to strategic development and support<br>Workforce assurance quarterly meetings with CCGs<br>Implementing Values Based Recruitment and supported training programme<br>Success with some 'hard to recruit to' posts<br>Well functioning Temporary Workforce Service.<br>Full participation in HEKSS Education commissioning process. | | | | | |
| **Gaps in Control (C) or Assurance (A):** | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |

# Board Assurance Framework - Jan 2015

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.3.1 | C | There is a gap in control because the final workforce strategy has been delayed as a result of market testing and service reconfigurations that have arisen or may arise from tenders. Workforce plan to be aligned with business planning. | Number based workforce plans submitted to TDA and HEKSS to support development of specific plans. 14/15 Plan submitted in June 2014. First high level iteration of 15/16 plan to TDA on 13th January 2015.<br><br>Dec 14:<br>The workforce strategy is being developed for end March 2015 to incorporate:<br>15/16 Business Plans<br>Learning Plan 15/16<br>Recruitment Strategy<br>Staff Engagement Action Plan | end Jan-15<br><br>end Mar-15 | ◄► | HRD | CME |
| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
| 3.3.2 | A | Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties eg cardiac physiologists, ODPs and anaesthetic staff. | Development of Recruitment & Retention Strategy and associated action plan Trust-wide for all CUs which will identify hard to recruit posts and associated actions. | end Mar 15 | ◄► | HRD | CME |
| | | | Nursing establishment and skill mix review being undertaken again in Dec-14. To be signed off at Board in Jan-15 | end Mar 15 | ◄► | HRD | CME |
| | | | International Recruitment Programme for nurses to start in Jan-15 | end Jan-15 | ◄► | HRD | CME |
| | | | HCA local recruitment initiative to commence in Jan with aim to achieve full establishment by June-15. | end Jun-15 | ◄► | HRD | CME |
| | | | Track recruitment monitoring tool to be implemented. | end Mar 15 | ◄► | HRD | CME |
| | | | Weekly monitoring of recruitment to be implemented. | end Jan-15 | ◄► | HRD | CME |
| | | | Value based recruitment to be incorporated into the recruitment process for all posts. | end Jun-15 | ◄► | HRD | CME |

# Board Assurance Framework - Jan 2015

| | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 3:** | **Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.** | | | | |
| **Risk 3.4** | **We are unable to develop and implement effective cultural change programmes that lead to improvements in organisational capability and staff morale.** | | | | |
| **Key controls** | Leading for Success Programme<br>Leadership meetings<br>Listening in Action Programme<br>Clinically led structure of Clinical Units<br>Feedback and implementation of action following Quality Walks.<br>Organisation values and behaviours developed by staff and agreed by Board. | | | | |
| **Positive assurances** | Clinical engagement events taking place<br>Clinical Forum being developed<br>Clinical Units fully involved in developing business plans<br>Embedding organisation values across the organisation - Values & Behaviours Implementation Plan<br>Staff Engagement Action Plan<br>Leadership Conversations<br>National Leadership programmes<br>Surveys conducted - Staff Survey/Staff FFT/GMC Survey | | | | |
| **Gaps in Control (C) or Assurance (A):** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.4.1 | A | The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others. | Listening into Action Showcase events and continuation of the programme<br>Values launched and being embedded.<br>Dec 14: Staff Engagement Ops and Exec Groups established.<br>LiA continuing but being mainstreamed into wider engagement work.<br>Involved in national OD work on culture change - linked with Portsmouth for learning.<br>CU Lead / GM Development - being scoped.<br>Health & Wellbeing initiatives being developed.<br>Forward programme for Leadership conversations<br>Board and other committees receive regular reports and associated action plan updates on Staff survey, Staff FFT, GMC Survey etc. | end Mar 15 | ◄► | HRD | Q&S<br>CME |

| | |
|---|---|
| **Strategic Objective 3:** | **Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.** |
| **Risk 3.5** | **We are unable to effectively align our estate and IM&T infrastructure to effectively support our strategic, quality, operational and financial requirements.** |
| **Key controls** | Development of Integrated Business Plan and underpinning strategies<br>Six Facet Estate Survey<br>Capital funding programme and development control plan<br>Capital Approvals Group and Finance and Investment Committee |
| **Positive assurances** | Essential work prioritised with Estates, IT and medical equipment plans<br>Capital approvals group meet monthly to review capital requirements and allocate resource accordingly<br>Monitoring by Finance and Investment Committee |

| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
|---|---|---|---|---|---|---|---|
| 3.5.1 | C | There is a gap in control as a result of the Trust not having an aligned estates strategy in place. | Estates Strategy to be developed<br>Currently recruiting for substantive Head of Estates | end Mar 15 | ◄► | COO | F&I<br>CME |
| | A | Also refer to 3.2.1 | | | | | |
| 3.5.2 | C | Inability to use web based applications as the N3 Internet Gateway is running at capacity between 11:00 and 15:00 daily. | Staff requested to review and minimise internet usage. Investigating possible alternative route for clinical internet traffic. National issue - CSU have raised with N3 that the next upgrade expected Summer 2015 needs to be expedited. | end Mar 15 | **New** | DF | CME |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Objective 3:** | | | **Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.** | | | | |
| **Risk 3.6** | | | **We are unable to respond effectively to external factors and this affects our ability to meet our organisational goals and deliver sustainable strategic change** | | | | |
| **Key controls** | | | Horizon scanning by Executive team, Board and Business Planning team.<br>Board seminars and development programme<br>Robust governance arrangements to support Board assurance and decision making.<br>Trust is member of FTN network<br>Review of national reports | | | | |
| **Positive assurances** | | | Policy documents and Board reporting reflect external policy<br>Strategic development plans reflect external policy.<br>Board seminar programme in place<br>Business planning team established<br>Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources | | | | |
| **Gaps in Control (C) or Assurance (A):** | | | **Actions:** | **Date/ milestone** | **RAG** | **Lead** | **Monitoring Group** |
| 3.6.1 | A | Lack of assurance in respect of capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners. | Business planning team in place and supported by PMO. Ongoing review of processes and evaluation of outcomes to identify learning. Specification developed for targeted tendering support. | end Mar 15 | ◀▶ | DSDA | CME |

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 7 |
| **Subject:** | Performance Report Month 9 – December 2014<br>Finance Report Month 9 – December 2014 |
| **Reporting Officer:** | Richard Sunley, Chief Operating Officer<br>Alice Webster, Director of Nursing<br>Dr David Hughes, Medical Director (Clinical Governance)<br>Monica Green, Director of Human Resources<br>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 against quality and workforce indicators and finance to the end of December 2014.

**Introduction:**

The two reports detail ESHT's in month performance against key trust metrics as well as activity and workforce indicators.

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

Overall Performance Score: 4 (from a possible 5)

Responsiveness Domain: 3
The A&E performance dropped below the 95% standard in December and the diagnostic waiting times standard was also missed. The preview cancer performance shows that the Trust did not achieve the 2 week waits and 62 day standards but the 31 day standards and 62 day screening standard were achieved.

Effectiveness Domain: 5
Maintained at 5. The 2013/14 mortality indicators have been released and the Trust has improved in the low risk conditions indicator to fall within the expected level.

Safe Domain: 4
Has improved to 4 following a drop to 3 in November. There were 6 reported cases of C-Difficile in December which was above Trust trajectory and year to date outturn of 41 cases is above the target outturn of 33. There was 1 reported harmful incident in the month.

Caring Domain: 4
Remains at 4. A&E Friends and Family scores fell slightly below the required standard. There were 28 reported mixed sex accommodation breaches in December.

Well Led Domain: 3
A&E Friends and Family response rate, turnover, sickness and appraisal rates and temporary costs and overtime as % of total paybill are below the required standard, reducing the domain score to 3.

Community Therapy Waiting List Profiles
An unprecedented challenge is being experienced in the recruitment for the Speech and Language Therapists (SaLT) with a 40% vacancy factor. Trajectory figures have demonstrated the Community SaLT service would have adequate staffing levels to support the normal referral rates if it were fully staffed. The vacancy factor and pressures on staffing have been compounded across the service (acute community and SaLT Stroke) by the need to flex community and acute staff across the organisation to mitigate clinical risk.

The clinical unit has various strategies in place to aid recruitment but remains unsuccessful in much of the recruitment including the Clinical/Operational Lead 8a. Recruitment in this area is an issue both regionally and nationally and is compounded because neighbouring Trusts offer higher banded posts, e.g. regionally the clinical/operational role will be banded between 8b/c

Finance Report:
Following receipt of non-recurrent deficit funding of £18m of which £13.5m has been recognised in the M9 position the trust performance in month 9 was a year to date run rate deficit of £1,784k. This is a favourable variance against original deficit plan of £12,930k. The cost improvement programme achievement ytd was £13,745k which was below plan by £663k. The Trust has increased its savings target by £600k and the forecast outturn is now a small surplus of £88k, as a result the overall TDA RAG rating for finance has moved from red to green.

**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 9 financial position.

**Risks and Implications**

The Trust Score against the well led domain reduced to 3 in the month..

At the end of Month 9 the financial risks remain unchanged from those associated with the plan for the year except for the addition of a financial risk relating to a NHS England QIPP issued in year, value £665k.

**Assurance Provided:**

This report includes all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by the TDA.

| |
|---|
| Following receipt of non-recurrent deficit funding the financial performance at Month 9 is significantly better than original plan and the Trust is now forecasting a small surplus at year end. |

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

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

| **Proposals and/or Recommendations** |
|---|
| The Trust Board is asked to review the reports in full and note Trust performance against each domain. |

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

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

# East Sussex Healthcare Trust
# Integrated Performance Report

## Month 9
## December 2014

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

| | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
| **ESHT OVERALL QUALITY SCORE** (Out of 5: 1- Poor to 5-Good) | 4 | 4 | 5 | 5 | 4 | 5 | 4 | 4 | 4 |
| *Responsiveness* Domain Score | 3 | 2 | 3 | 3 | 2 | 3 | 2 | 3 | 3 |
| *Effectiveness* Domain Score | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| *Safe* Domain Score | 4 | 5 | 5 | 5 | 3 | 5 | 4 | 3 | 4 |
| *Caring* Domain Score | 5 | 4 | 4 | 4 | 5 | 5 | 4 | 4 | 4 |
| *Well Led* Domain Score | 3 | 3 | 4 | 4 | 4 | 4 | 4 | 4 | 3 |

## 2.0 Responsiveness Domain

| Responsiveness Domain | | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DOMAIN SCORE | | | | | | | | |
| **Indicator** | **Standard** | **Weighting** | 3 | 2 | 3 | 3 | 2 | 3 | 2 | 3 | 3 |
| Referral to Treatment Admitted | 90.00% | 10 | 82.68% | 84.06% | 85.84% | 80.88% | 75.60% | 82.74% | 85.67% | 78.26% | 91.18% |
| Referral to TreatmentNon Admitted | 95.00% | 5 | 94.08% | 94.12% | 91.81% | 92.66% | 91.16% | 89.56% | 91.42% | 91.49% | 90.55% |
| Referral to Treatment Incomplete | 92.00% | 5 | 92.37% | 92.89% | 92.80% | 92.35% | 92.22% | 93.39% | 92.97% | 92.04% | 90.19% |
| Referral to Treatment Incomplete 52+ Week Waiters | 0 | 5 | 4 | 6 | 4 | 3 | 1 | 3 | 2 | 4 | 6 |
| Diagnostic waiting times | 1.00% | 5 | 7.32% | 6.31% | 0.45% | 0.70% | 0.97% | 0.18% | 0.28% | 1.29% | 1.29% |
| A&E All Types Monthly Performance | 95.00% | 10 | 95.20% | 93.60% | 95.08% | 97.27% | 94.07% | 95.00% | 93.44% | 95.63% | 89.01% |
| 12 hour Trolley waits | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Two Week Wait Standard | 93.00% | 2 | 89.97% | 89.07% | 91.78% | 89.69% | 90.16% | 93.41% | 92.80% | 92.22% | 91.98% |
| Breast Symptom Two Week Wait Standard | 93.00% | 2 | 84.21% | 92.06% | 85.00% | 88.89% | 93.58% | 80.65% | 95.89% | 93.75% | 92.73% |
| 31 Day Standard | 96.00% | 2 | 97.33% | 96.71% | 98.35% | 99.34% | 95.57% | 94.87% | 86.14% | 90.74% | 96.43% |
| 31 Day Subsequent Surgery Standard | 94.00% | 2 | 100.00% | 100.00% | 94.74% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| 31 Day Subsequent Drug Standard | 98.00% | 2 | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| 62 Day Standard | 85.00% | 5 | 86.01% | 82.08% | 77.01% | 75.11% | 80.00% | 79.15% | 76.87% | 75.00% | 83.11% |
| 62 Day Screening Standard | 90.00% | 2 | 76.92% | 80.00% | 100.00% | 83.33% | 83.33% | 68.75% | 83.33% | 83.33% | 100.00% |
| Urgent Ops Cancelled for 2nd time (Number) | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Proportion of patients not treated within 28 days of last minute cancellation | 0.00% | 2 | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Delayed Transfers of Care | 3.50% | 5 | 4.47% | 5.90% | 4.23% | 5.01% | 3.95% | 5.43% | 4.63% | 7.81% | 12.15% |

### 2.1 RTT Performance

RTT Performance continues to align with the trajectory agreed with the TDA and local commissioners. As expected, admitted and non-admitted RTT performance achieved target in December. The Trust continues to treat patients with the longest pathways.

### 2.2 Diagnostics

The Trust did not deliver the 6 week diagnostic waiting time target for the month of December. The total number of breaches was 66, equating to 1.29% of the total waiting list. The breakdown of breach modalities is shown below:

- Audiology: 2
- Endoscopy: 51
- Radiology: 13

### 2.3 A&E Performance

The 4 hour A&E waiting time standard was not delivered in December; 89.01% of patients were treated within 4 hours of A&E attendance.

High levels of emergency ambulance calls and increased delayed transfers of care affected our ability to deliver the 95% Standard.

At the time of writing this report, cumulative year to date A&E performance stands at 94.35%. Quarter 3 performance was 92.70%.

2.4 Cancer Performance

Cancer performance for December is currently based on a preview. The final December performance will be reported next month.

The preview Cancer report for December confirmed that the trust did not see or treat the required number of patients against Two Week Wait Standard, Breast Symptom Two Week Wait and 62 Day standard. December is a month of reduced capacity and reduced patient compliance, which affects delivery.

The final Cancer report for November confirmed that the trust did not see or treat the required number of patients against 2 week, 31 day and 62 day standards.

Patient choice had a significant impact on the two week wait indicators, although the target was only missed by the smallest margins. The introduction of increased clerical input had a positive impact on Breast Symptom Two Week Wait, and early indications from our on-going audit of referrals is showing some progress with GP engagement and patient education.

Internal processes have been reviewed and amended to ensure all patients on the 62 day pathway have key milestone dates identified, together with a reorganised weekly performance meeting and the earlier involvement of Clinical Nurse Specialists.

2.5 Cancellations

During December there were 18 last minute cancellations. All were rebooked within 28 days.

There were no urgent operations cancelled for a second time.

2.6 Delayed Transfers of Care

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

During December the combined percentage of delayed beddays increased significantly for the second consecutive month, and remains higher than the 3.5% standard. The table below provides a breakdown of year to date performance.

| **Delayed Transfer of Care Breakdown** | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|
| Delayed Transfers of Care (Combined) | 3.50% | 4.47% | 5.90% | 4.23% | 5.01% | 4.33% | 6.67% | 4.92% | 7.81% | **12.15%** |
| Delayed Transfers of Care (Acute Only) | 3.50% | 2.38% | 4.75% | 3.28% | 3.96% | 3.27% | 5.11% | 3.96% | 5.61% | **10.73%** |
| Delayed Transfers of Care (Non-Acute Only) | 7.50% | 15.01% | 12.77% | 9.82% | 10.11% | 9.12% | 13.56% | 8.98% | 18.91% | **18.28%** |

Acute only delayed beddays have been impacted by both NHS and Social Care *delay reasons.*

During December, Social Care related delayed beddays remained significantly above average (avg- 82, Dec-321). This was primarily due to difficulties in the procurement process of Adult Social Care Packages, which is a social service responsibility in the JCR service.

## 3.0 Effectiveness Domain

| Effectiveness Domain | | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DOMAIN SCORE | | | | | | | | |
| Indicator | Standard | Weighting | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Hospital Standardised Mortality Ratio (DFI) | 103.32 | 5 | 103.08 | 103.08 | 103.08 | 103.08 | 103.08 | 103.08 | 103.08 | 103.08 | 103.08 |
| Deaths in Low Risk Conditions | 1.06 | 5 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 |
| Hospital Standardised Mortality Ratio - Weekday | 110.03 | 5 | 104.49 | 104.49 | 104.49 | 104.49 | 104.49 | 104.49 | 104.49 | 104.49 | 104.49 |
| Hospital Standardised Mortality Ratio - Weekend | 117.35 | 5 | 101.6 | 101.6 | 101.6 | 101.6 | 101.6 | 101.6 | 101.6 | 101.6 | 101.6 |
| Summary Hospital Mortality Indicator (HSCIC) | 1.066 | 5 | 1.104 | 1.104 | 1.104 | 1.104 | 1.104 | 1.104 | 1.104 | 1.104 | 1.104 |
| Emergency re-admissions within 30 days following an elective or emergency spell at the Trust | 10% | 5 | 7.15% | 7.55% | 6.38% | 8.49% | 7.61% | 7.76% | 7.91% | 7.74% | 5.38% |

## 3.1 Mortality

TDA guidance for mortality requests that Trusts use the Dr Foster web portal to view and report their mortality performance.

The 2013/14 Mortality indicators have been released and are shown in the table above. Significantly, the trust has improved in the low risk conditions indicator to fall within the expected level. This has consequently improved the domain score to a maximum of 5.

## 3.2 Emergency Re-Admissions

The rate of emergency re-admissions within 30 days of a previous discharge continues to meet the standard. The rate in 2014/15 is considerably lower than 2013/14. Regular analysis of emergency re-admissions now takes place, involving the key clinicians within clinical units.

## 4.0 Safe Domain

| Safe Domain | | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DOMAIN SCORE | | | | | | | | |
| Indicator | Standard | Weighting | 4 | 5 | 5 | 5 | 3 | 5 | 4 | 3 | 4 |
| Clostridium Difficile - Variance from plan | 4 | 10 | 5 | 3 | 4 | 2 | 6 | 2 | 7 | 6 | 6 |
| MRSA bactaraemias | 0 | 10 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| Never events | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Serious Incidents rate | TBC | 5 | | | | | | | | | |
| Patient safety incidents that are harmful | 0 | 5 | 3 | 4 | 5 | 1 | 2 | 2 | 1 | 3 | 1 |
| Medication errors causing serious harm | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Overdue CAS alerts | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal deaths | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| VTE Risk Assessment | 95.00% | 2 | 99.00% | 97.90% | 98.29% | 98.15% | 98.10% | 97.98% | 98.67% | 98.21% | 95.50% |
| Percentage of Harm Free Care | 92.00% | 5 | 93.96% | 94.07% | 94.29% | 93.90% | 97.53% | 94.60% | 94.97% | 97.67% | 97.83% |

## 4.1 Healthcare Acquired Infections

There were 6 reported cases of C-Difficile in December, which is above the trust trajectory. The year to date outturn of 41 is now above the target YTD outturn of 33.

Of these, fourteen have been confirmed as due to a lapse in care. For nineteen it has been determined that there was no lapse in care. A further eight are awaiting decision.

## 4.2 Patient Safety

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

The reported incident in December was related to *Transfer.*

## 5.0 Caring Domain

| Caring Domain | | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DOMAIN SCORE | | | | | | | | |
| Indicator | Standard | Weighting | 5 | 4 | 4 | 4 | 5 | 5 | 4 | 4 | 4 |
| Inpatient Scores from Friends and Family Test | 60 | 5 | 66 | 64 | 68 | 68 | 65 | 70 | 64 | 68 | 68 |
| A&E Scores from Friends and Family Test | 46 | 5 | 49 | 44 | 37 | 45 | 54 | 48 | 45 | 38 | 38 |
| Complaints | TBC | 5 | | | | | | | | | |
| Mixed Sex Accommodation Breaches | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 27 | 0 | 31 | 26 |
| Inpatient Survey Q 68 - Overall, I had a very poor/good experience | 7.8 | 2 | 7.9 | 7.9 | 7.9 | 7.9 | 7.9 | 7.9 | 7.9 | 7.9 | 7.9 |

## 5.1 Friends and Family Test (Patient Experience)

Inpatient scores remain above the required standard. A&E scores have fallen marginally below the standard. As such the Caring domain score remains at 4.

## 5.2 Mixed Sex Accommodation

There were 28 reported mixed sex accommodation breaches in December. These breaches were all located within the ITU, and were due to availability of private rooms for patients with complex needs.

## 6.0 Well Led Domain

| Well Led Domain | | | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DOMAIN SCORE | | | | | | | | |
| Indicator | Standard | Weighting | 3 | 3 | 4 | 4 | 4 | 4 | 4 | 4 | 3 |
| Inpatients response rate from Friends and Family Test | 30.00% | 2 | 46.43% | 44.22% | 44.01% | 46.84% | 39.40% | 46.21% | 47.94% | 48.62% | 46.48% |
| A&E response rate from Friends and Family Test | 20.00% | 2 | 13.59% | 15.76% | 35.03% | 24.41% | 28.75% | 30.40% | 25.10% | 20.87% | 16.66% |
| NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work | 40.70% | 2 | 41.00% | 41.00% | 41.00% | 41.00% | 41.00% | 41.00% | 41.00% | 41.00% | 41.00% |
| NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment | 42.30% | 2 | 51.00% | 51.00% | 51.00% | 51.00% | 51.00% | 51.00% | 51.00% | 51.00% | 51.00% |
| Data Quality of Returns to HSCIC | TBC | 2 | | | | | | | | | |
| Trust turnover rate | 10.00% | 3 | 12.45% | 12.89% | 12.72% | 12.81% | 13.19% | 13.41% | 13.32% | 13.60% | 14.09% |
| Trust level total sickness rate | 3.30% | 3 | 4.08% | 3.87% | 4.26% | 4.44% | 4.59% | 4.76% | 5.50% | 5.46% | 5.74% |
| Total Trust vacancy rate | 10.00% | 3 | 6.04% | 6.40% | 5.21% | 5.61% | 4.72% | 5.47% | 5.74% | 7.60% | 5.58% |
| Temporary costs and overtime as % of total paybill | 10.00% | 3 | 7.02% | 7.29% | 8.72% | 9.48% | 9.58% | 9.48% | 9.73% | 9.97% | 10.16% |
| Percentage of staff with annual appraisal | 85.00% | 3 | 63.37% | 63.84% | 63.74% | 62.34% | 67.02% | 67.54% | 68.34% | 70.01% | 68.28% |

## 6.1 Friends and Family Test (Response Rate)

Inpatient and A&E response rates have fallen below the required standard.

## 6.2 Workforce

Sickness rates continue on an upward trend, whilst Trust Turnover appears to be stabilising. Further detail is given in section 8.

## 7.0 Community Services

7.1 Intermediate Care Beds

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

| Occupancy Level | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 98.21% | 95.70% | 97.44% | 91.53% | 90.86% | 99.26% | 96.24% | 99.58% | 96.53% |
| Crowborough Hospital | 90.48% | 85.94% | 91.90% | 90.09% | 87.79% | 88.33% | 92.63% | 94.67% | 94.80% |
| Firwood House | 88.41% | 94.62% | 91.11% | 77.27% | 77.27% | 87.14% | 87.71% | 85.87% | 87.56% |
| Meadow Lodge | 80.36% | 68.32% | 73.57% | 82.26% | 86.29% | 82.86% | 79.26% | 83.21% | 82.95% |
| Uckfield Hospital | 87.38% | 88.25% | 93.10% | 90.78% | 94.01% | 86.90% | 93.55% | 87.86% | 90.09% |
| Rye Memorial Care Centre | 61.19% | 76.73% | 80.24% | 93.55% | 90.55% | 70.71% | 93.78% | 86.90% | 81.11% |
| Irvine Stroke Unit | 95.74% | 90.86% | 95.93% | 82.97% | 64.16% | 49.26% | 81.18% | 95.19% | 100.00% |
| **Total Occupancy** | **87.06%** | **85.30%** | **88.49%** | **86.15%** | **84.11%** | **82.06%** | **88.36%** | **90.32%** | **90.46%** |

| Total in Month Length of Stay (Days) | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 37.45 | 21.91 | 25.43 | 25.49 | 19.62 | 28.36 | 19.51 | 19.00 | 26.69 |
| Crowborough Hospital | 20.47 | 17.94 | 19.76 | 21.31 | 23.74 | 14.67 | 28.23 | 23.85 | 18.52 |
| Firwood House | 23.14 | 27.33 | 25.57 | 26.33 | 26.41 | 26.04 | 27.09 | 20.00 | 24.96 |
| Meadow Lodge | 26.04 | 23.61 | 23.19 | 20.09 | 32.79 | 36.80 | 30.52 | 27.75 | 24.67 |
| Uckfield Hospital | 25.10 | 19.79 | 20.19 | 23.00 | 20.46 | 22.65 | 25.77 | 22.40 | 14.71 |
| Rye Memorial Care Centre | 31.64 | 21.09 | 24.69 | 24.69 | 22.24 | 24.41 | 24.39 | 19.21 | 22.72 |
| Irvine Stroke Unit | 42.54 | 34.00 | 39.24 | 25.37 | 22.86 | 21.40 | 20.95 | 31.20 | 44.42 |
| **Total YTD ALOS** | **29.88** | **23.19** | **25.35** | **23.90** | **23.57** | **25.71** | **24.70** | **22.78** | **24.08** |

| Admissions | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 32 | 32 | 28 | 34 | 28 | 36 | 41 | 24 | 28 |
| Crowborough Hospital | 22 | 17 | 18 | 17 | 14 | 20 | 21 | 17 | 23 |
| Firwood House | 24 | 19 | 24 | 15 | 25 | 23 | 24 | 20 | 21 |
| Meadow Lodge | 19 | 26 | 35 | 26 | 15 | 20 | 30 | 25 | 30 |
| Uckfield Hospital | 14 | 14 | 17 | 19 | 24 | 18 | 11 | 18 | 25 |
| Rye Memorial Care Centre | 12 | 12 | 16 | 16 | 14 | 19 | 18 | 11 | 21 |
| Irvine Stroke Unit | 12 | 12 | 18 | 15 | 18 | 12 | 20 | 12 | 14 |
| **Total Admissions** | **135** | **132** | **156** | **142** | **138** | **148** | **165** | **127** | **162** |

| Step Up Admissions | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 2 | 1 | 0 | 2 | 0 | 0 | 1 | 1 | 1 |
| Crowborough Hospital | 4 | 5 | 9 | 5 | 7 | 10 | 5 | 11 | 4 |
| Firwood House | 2 | 0 | 0 | 1 | 3 | 2 | 3 | 1 | 0 |
| Meadow Lodge | 1 | 3 | 9 | 5 | 1 | 7 | 4 | 1 | 2 |
| Uckfield Hospital | 8 | 5 | 14 | 12 | 19 | 11 | 7 | 12 | 12 |
| Rye Memorial Care Centre | 2 | 4 | 3 | 5 | 3 | 2 | 6 | 2 | 3 |
| Irvine Stroke Unit | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| **Total Step Up Admissions** | **19** | **18** | **35** | **30** | **33** | **32** | **27** | **28** | **22** |

| Step Down Admissions | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 30 | 31 | 28 | 32 | 28 | 36 | 40 | 23 | 27 |
| Crowborough Hospital | 18 | 12 | 9 | 12 | 7 | 10 | 16 | 6 | 19 |
| Firwood House | 22 | 19 | 24 | 14 | 22 | 21 | 21 | 19 | 21 |
| Meadow Lodge | 18 | 23 | 26 | 21 | 14 | 13 | 26 | 24 | 28 |
| Uckfield Hospital | 6 | 9 | 3 | 7 | 5 | 7 | 4 | 6 | 13 |
| Rye Memorial Care Centre | 10 | 8 | 13 | 11 | 11 | 17 | 12 | 9 | 18 |
| Irvine Stroke Unit | 12 | 12 | 18 | 15 | 18 | 12 | 19 | 12 | 14 |
| **Total Step Down Admissions** | **116** | **114** | **121** | **112** | **105** | **116** | **138** | **99** | **140** |

| Available beds | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 |
|---|---|---|---|---|---|---|---|---|---|
| Irvine Unit | 28 | 24 | 26 | 24 | 24 | 27 | 24 | 24 | 26 |
| Crowborough Hospital | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 15 | 18 |
| Firwood House | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 |
| Meadow Lodge | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 |
| Uckfield Hospital | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 |
| Rye Memorial Care Centre | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 |
| Irvine Stroke Unit | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 |
| **Total Available Beds** | **137** | **133** | **135** | **133** | **133** | **136** | **133** | **134** | **139** |
| | | | | | | | | | |
| **Occupied Bed days** | **3578** | **3517** | **3584** | **3552** | **3468** | **3348** | **3643** | **3631** | **3898** |
| **Available Bed days** | **4110** | **4123** | **4050** | **4123** | **4123** | **4080** | **4123** | **4020** | **4309** |

7.2 Community Nursing

SystmOne is now in place within the Community Nursing teams. Staff are now using mobile devices to capture information, which represents significant progress. The next step for the Project team is to review the information being extracted to ensure data integrity is of a high level.

The first extract of activity information was made available to the Trust's information management team at the beginning of November, which has enabled the next phase to begin.

This involves scrutiny of referral and contact information to identify any additional training needs and/or configuration amendments.

This phase ensures the long term integrity of the activity information coming out of the system and feeding reports such as this one.

Information extracts are now being scrutinised on a weekly basis. Configuration amendments are being communicated directly to the configuration team.

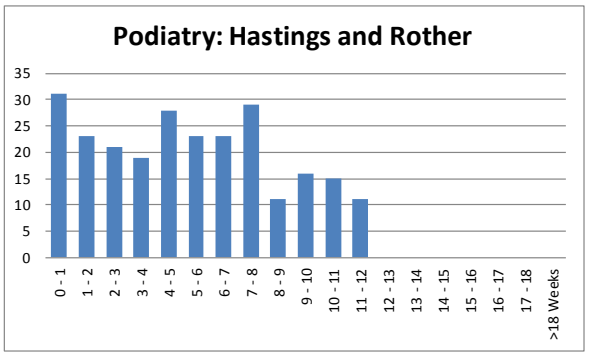
Any further training needs are being fed back to the Nursing teams promptly to enable immediate implementation. Furthermore, a succinct pack of training literature is being developed to be rolled out to the teams early in the New Year.

The Trust will be liaising with joint commissioners throughout this process to ensure that reports are developed in line with service specifications and key performance indicators.

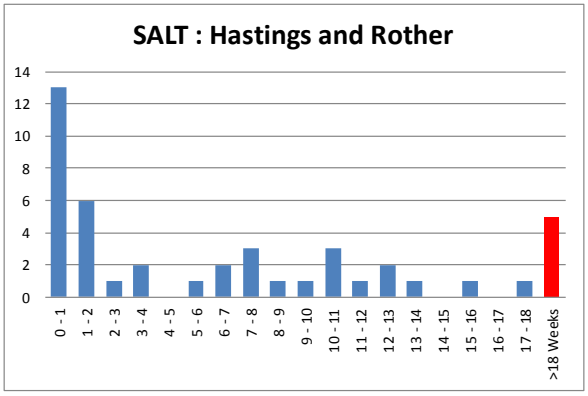
In the context of reporting, the next phase will be to publish an initial set of activity reports detailing referral patterns, contact and outcome analysis. An update will be provided in next month's report.

## 7.3 Community Therapy Waiting List Profiles

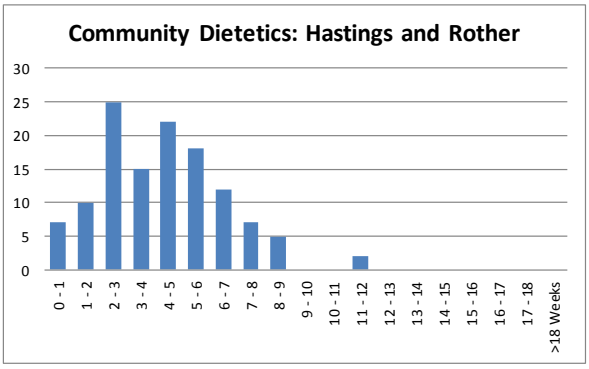
### Hastings and Rother



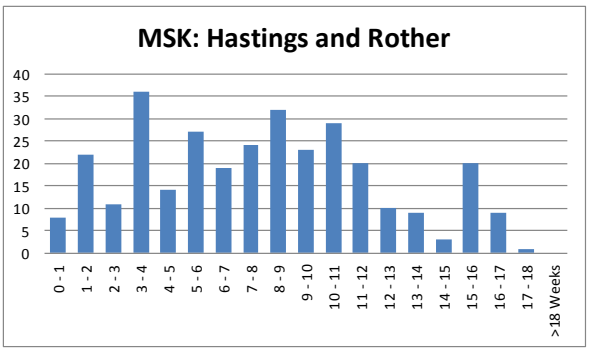

| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 250 | 281 |
| % <13 Weeks | 100% | 100% |




| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 44 | 86 |
| % <13 Weeks | 82% | 71% |

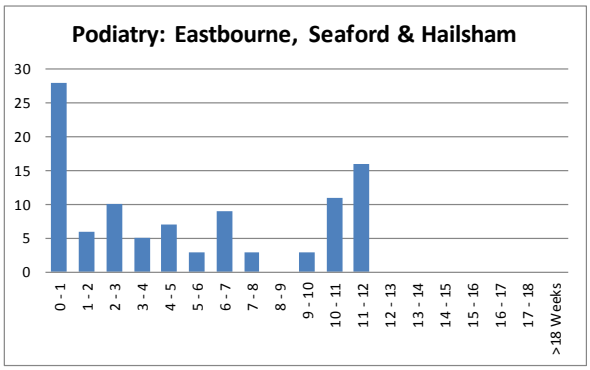



| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 123 | 148 |
| % <13 Weeks | 100% | 100% |

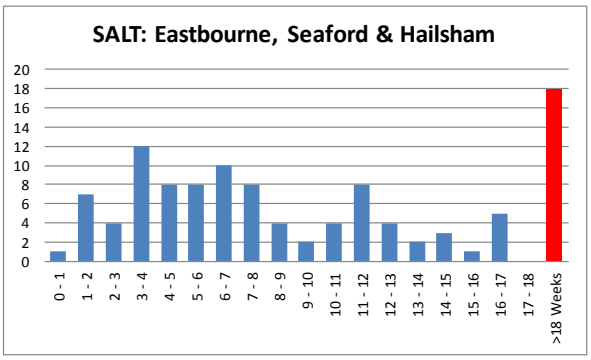



| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 317 | 223 |
| % <13 Weeks | 87% | 100% |

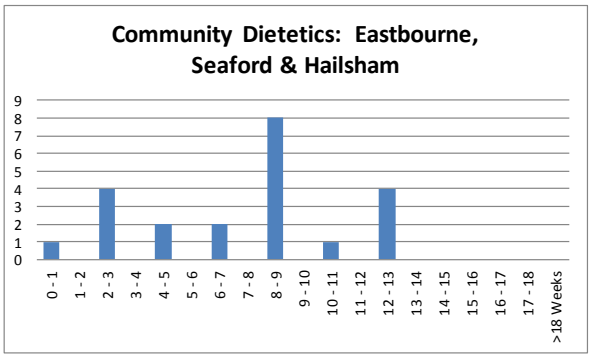
## Eastbourne, Seaford and Hailsham



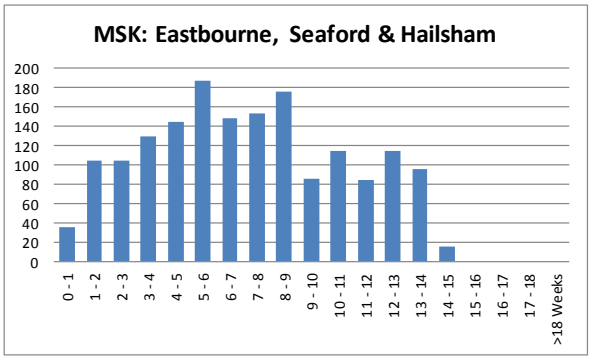

| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 101 | 136 |
| % <13 Weeks | 100% | 100% |




| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 109 | 92 |
| % <13 Weeks | 73% | 76% |

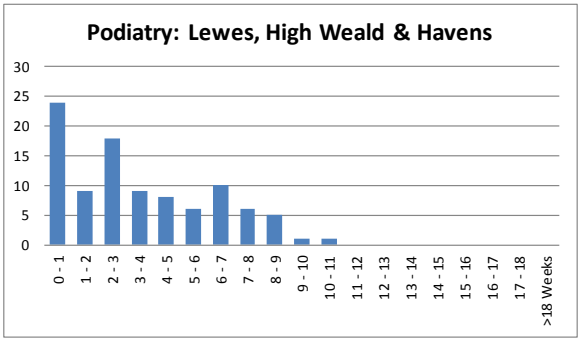



| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 22 | 117 |
| % <13 Weeks | 100% | 100% |

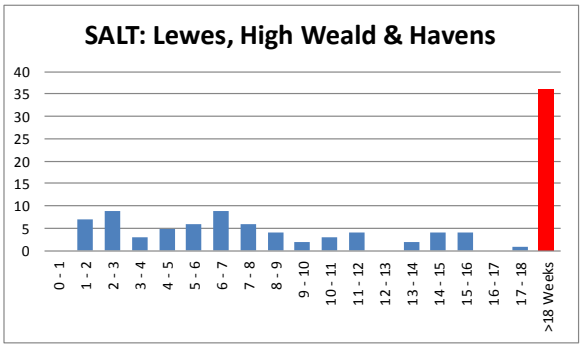



| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 1695 | 1299 |
| % <13 Weeks | 93% | 100% |

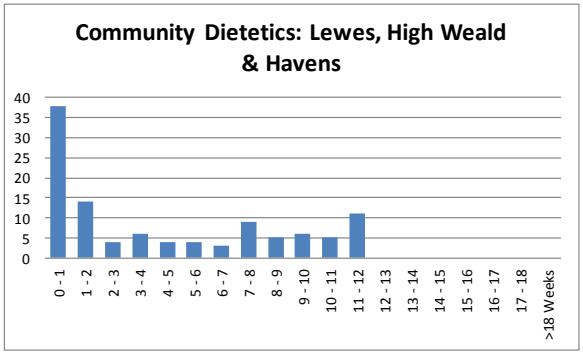
## High Weald, Lewes and Hastings



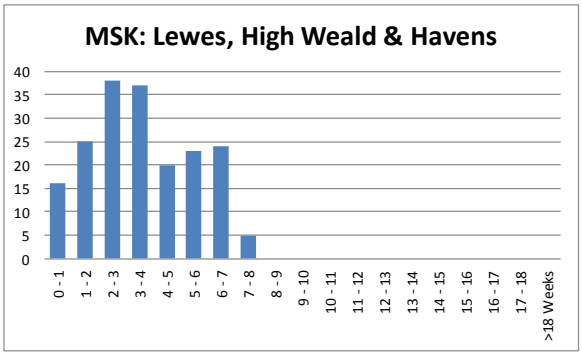

| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 97 | 79 |
| % <13 Weeks | 100% | 100% |




| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 105 | 100 |
| % <13 Weeks | 55% | 57% |




| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 109 | 140 |
| % <13 Weeks | 100% | 99% |




| | This Month | Previous Month |
|---|---|---|
| Total Waiting List | 188 | 205 |
| % <13 Weeks | 100% | 100% |

7.4 Community Paediatric Waiting List Profiles

The agreed trajectory- which aims to reduce the waiting list to zero by May 2015- is being maintained.

71 children have been seen and removed from the waiting list as at the time of writing this report. A further 105 children will be seen and removed by 31st January.

Agreement has been reached to transfer 43 referrals per month for the next 3 months to Sussex community trust. This will reduce the waiting list by an additional 129.

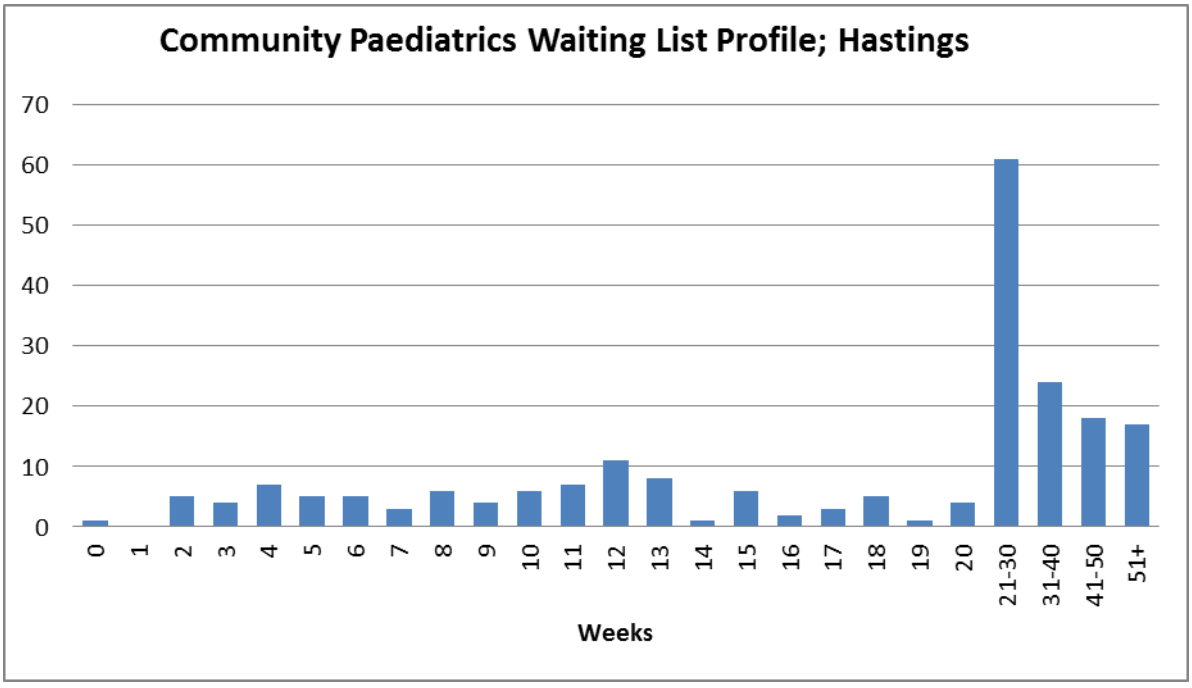
Additional initiatives will commence in February:

- Professional support telephone line commencing on 2nd February for 2 days per week
- The associate specialist will increase reviews from 6 to 12

Furthermore, a second locum consultant has been appointed and will begin in April.

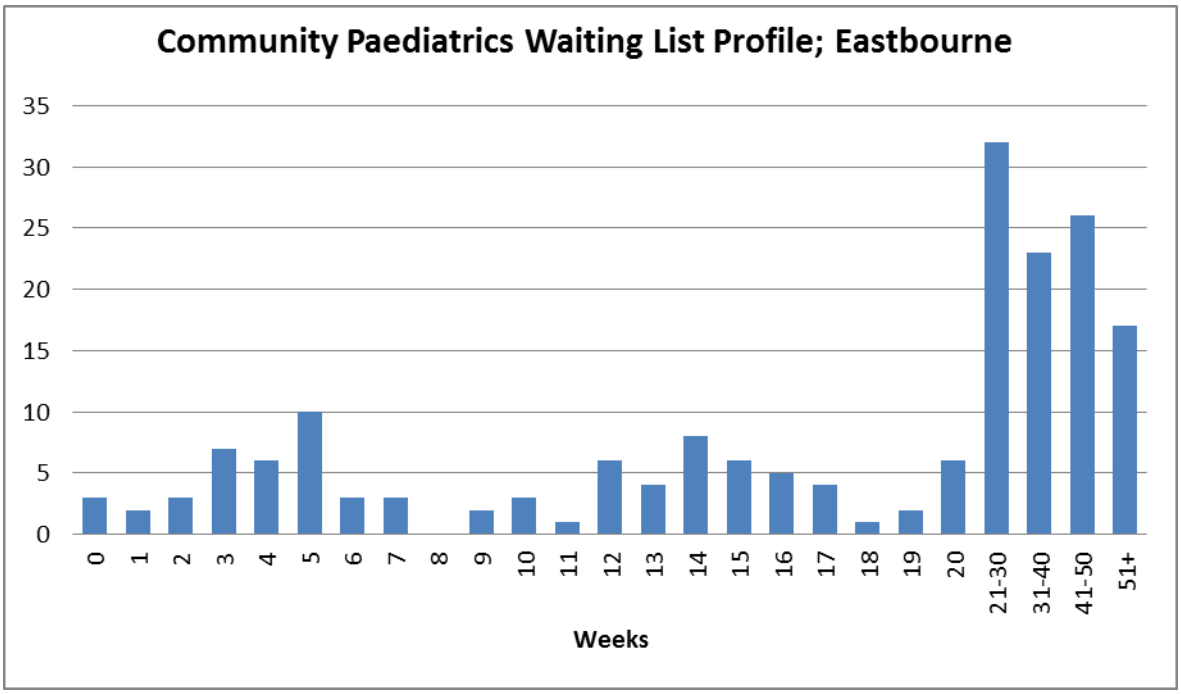
**Hastings - Weeks and Number of Patients Waitings**

| Month | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21-30 | 31-40 | 41-50 | 51+ | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2014 | 0 | 1 | 5 | 3 | 5 | 4 | 6 | 10 | 9 | 4 | 4 | 5 | 3 | 3 | 5 | 1 | 6 | 3 | 8 | 4 | 3 | 50 | 32 | 15 | 21 | 210 |
| December 2014 | 1 | 0 | 5 | 4 | 7 | 5 | 5 | 3 | 6 | 4 | 6 | 7 | 11 | 8 | 1 | 6 | 2 | 3 | 5 | 1 | 4 | 61 | 24 | 18 | 17 | 214 |



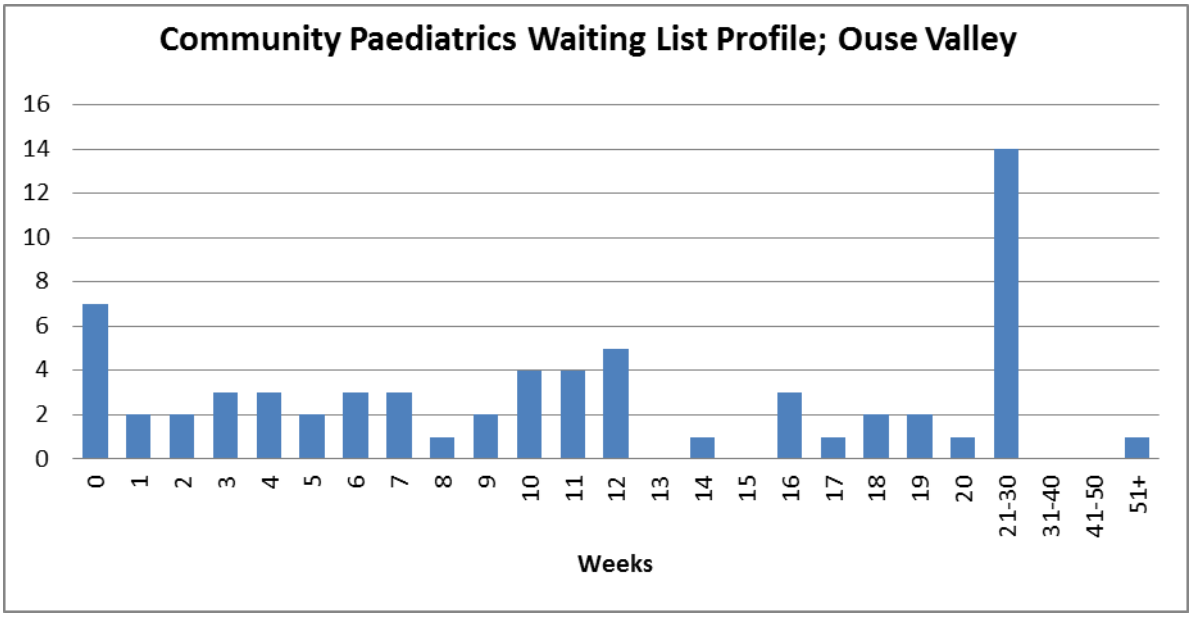
**Eastbourne - Weeks and Number of Patients Waitings**

| Month | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21-30 | 31-40 | 41-50 | 51+ | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2014 | 10 | 5 | 2 | 1 | 1 | 4 | 1 | 2 | 7 | 8 | 4 | 8 | 2 | 3 | 1 | 5 | 4 | 1 | 2 | 0 | 12 | 33 | 18 | 21 | 14 | 169 |
| December 2014 | 3 | 2 | 3 | 7 | 6 | 10 | 3 | 3 | 0 | 2 | 3 | 1 | 6 | 4 | 8 | 6 | 5 | 4 | 1 | 2 | 6 | 32 | 23 | 26 | 17 | 183 |



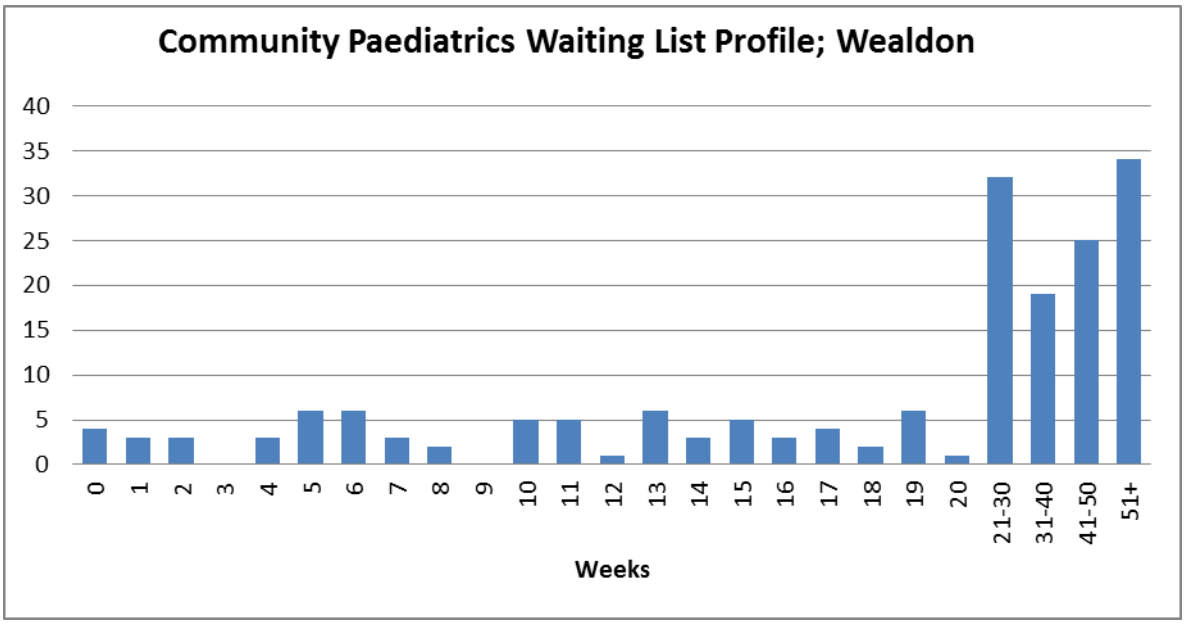

**Ouse Valley - Weeks and Number of Patients Waitings**

| Month | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21-30 | 31-40 | 41-50 | 51+ | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2014 | 4 | 1 | 4 | 2 | 1 | 3 | 3 | 4 | 5 | 1 | 2 | 2 | 1 | 1 | 2 | 2 | 1 | 5 | 2 | 1 | 5 | 16 | 16 | 14 | 12 | 110 |
| December 2014 | 7 | 2 | 2 | 3 | 3 | 2 | 3 | 3 | 1 | 2 | 4 | 4 | 5 | 0 | 1 | 0 | 3 | 1 | 2 | 2 | 1 | 14 | 0 | 0 | 1 | 66 |



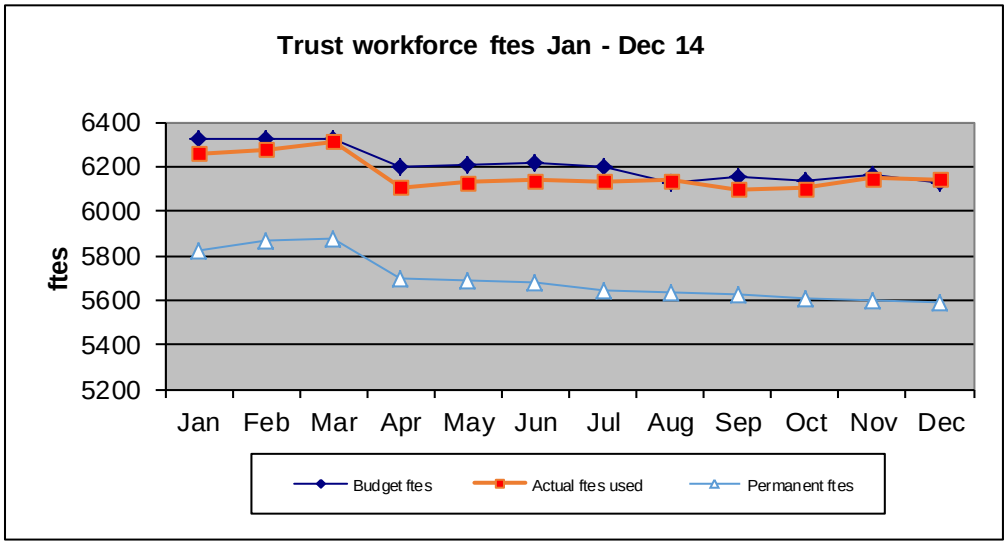
**Wealden - Weeks and Number of Patients Waitings**

| Month | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21-30 | 31-40 | 41-50 | 51+ | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2014 | 7 | 4 | 5 | 3 | 2 | 1 | 6 | 3 | 3 | 5 | 4 | 1 | 3 | 1 | 3 | 5 | 1 | 1 | 0 | 4 | 2 | 28 | 22 | 29 | 27 | 170 |
| December 2014 | 4 | 3 | 3 | 0 | 3 | 6 | 6 | 3 | 2 | 0 | 5 | 5 | 1 | 6 | 3 | 5 | 3 | 4 | 2 | 6 | 1 | 32 | 19 | 25 | 34 | 181 |



8.0 Workforce

## Workforce Usage




There continues to be demand for temporary workforce usage as the Trust attempts to tackle recruitment difficulties as well as an increased demand for services. This demand was particularly acute over the holiday period resulting in a requirement for additional clinical capacity and extra staffing.

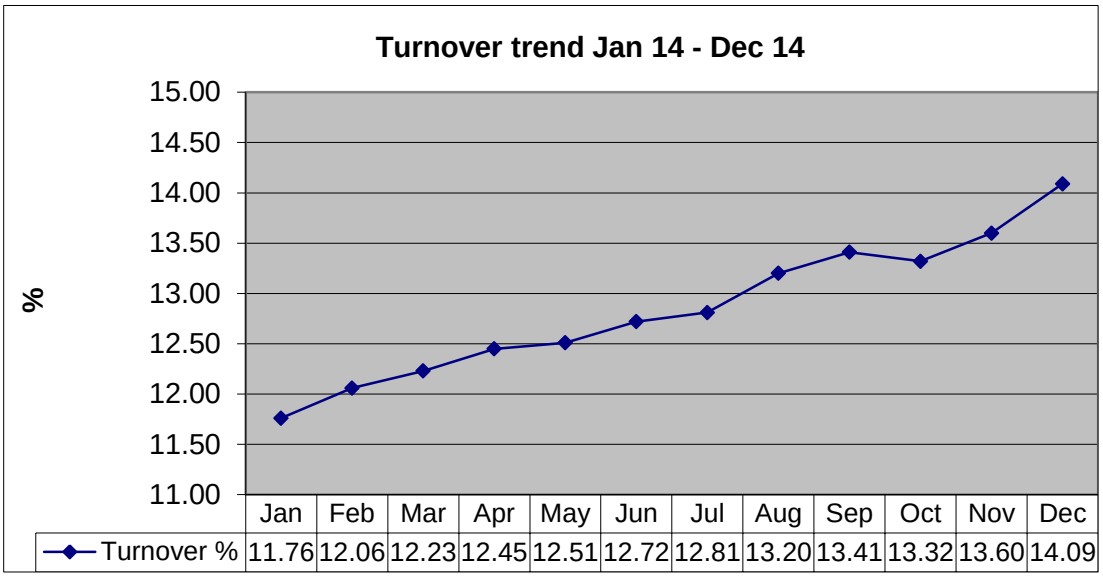
## Trust vacancies by Staff Group

| STAFF GROUPS | *Substantive budget ftes* | *Substantive actual ftes* | *Difference* | *Maternity ftes* | *Net vacancies* |
|---|---|---|---|---|---|
| MEDICAL & DENTAL | 556.71 | 516.74 | 39.97 | 4.40 | 35.57 |
| NURSING & MIDWIFERY REGISTERED | 1,931.69 | 1,761.09 | 170.60 | 49.82 | 120.78 |
| UNQUALIFIED NURSES | 763.18 | 694.67 | 68.51 | 23.00 | 45.51 |
| SC. THERAP & TECH (inc AHPs, Prof & Tech) | 904.43 | 868.23 | 36.20 | 17.18 | 19.02 |
| ADMINISTRATIVE & CLERICAL | 1115.11 | 1048.98 | 66.13 | 9.07 | 57.06 |
| ESTATES & ANCILLARY | 661.09 | 602.01 | 59.08 | 5.32 | 53.76 |
| **TRUST** | 5,932.21 | 5,491.72 | 440.49 | 109.53 | 330.96 |

39 qualified nurses have been appointed in the last month with 23 newly qualified staff in the pipeline and a further 59 anticipated in March – April. Given current turnover rates, however, we do need to replace around 20 nurse leavers a month in addition to current vacancies. Nurse recruitment is a national issue with estimated vacancy rates of 10%, according to NHS Employers (our rate is currently 6.22%).To address this, we are actively pursuing international recruitment in Spain and Portugal and looking to collaborate as part of a Sussex wide initiative for recruitment in India and the Phillippines.

We have appointed 24 new unqualified nurses, with 17 in the pipeline. We have been running a local recruitment campaign since the beginning of January as well the ongoing generic recruitment and additional induction sessions have been scheduled to support new starters.

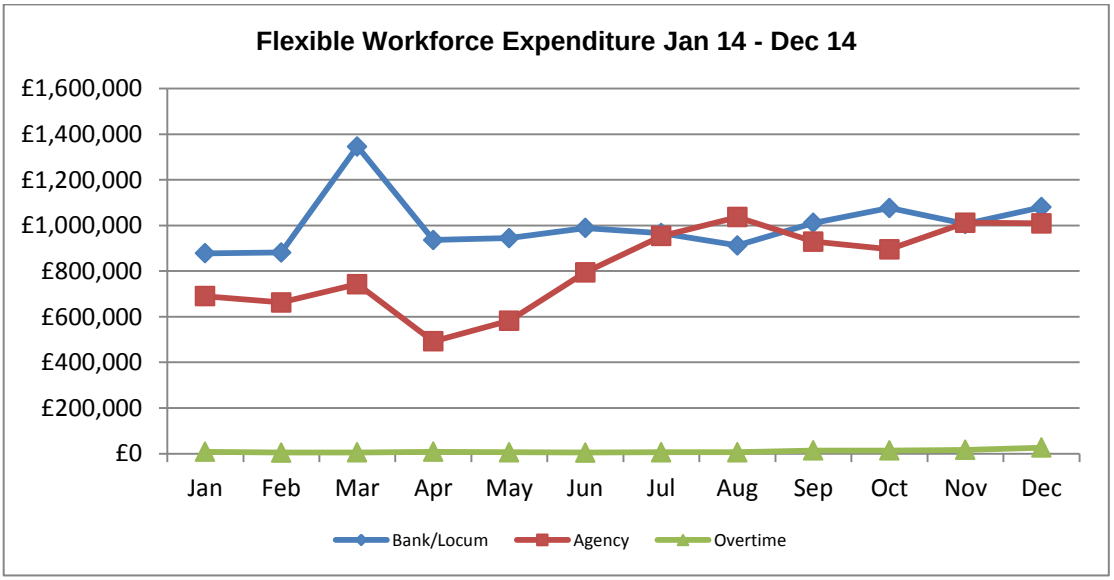
**Turnover**

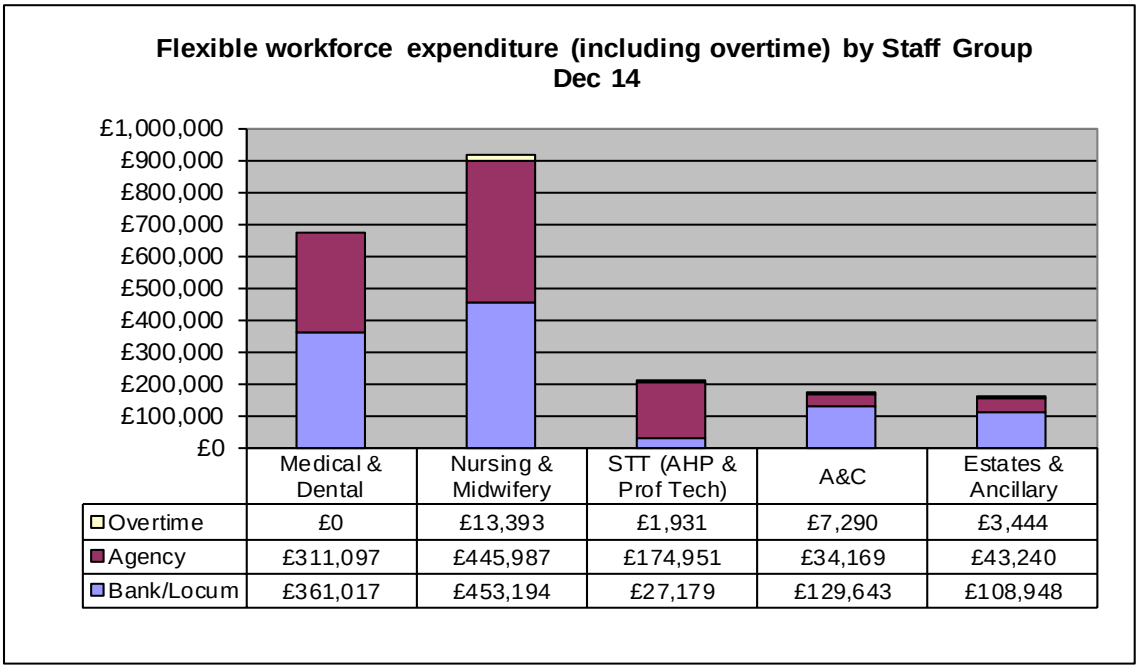



| STAFF GROUPS | FTE leavers in year | Annual Turnover % |
|---|---|---|
| MEDICAL & DENTAL | 47.02 | 15.59% |
| NURSING & MIDWIFERY REGISTERED | 247.75 | 13.52% |
| ALLIED HEALTH PROFESSIONALS | 75.46 | 20.00% |
| HEALTHCARE SCIENTISTS | 23.60 | 21.70% |
| PROF SCIENTIFIC & TECHNICAL | 27.44 | 12.69% |
| ADDITIONAL CLINICAL SERVICES | 98.92 | 10.82% |
| ADMINISTRATIVE & CLERICAL | 176.05 | 15.70% |
| ESTATES & ANCILLARY | 82.88 | 13.20% |
| STUDENTS | 5.50 | 7.77% |
| **TRUST** | **784.63** | **14.09%** |

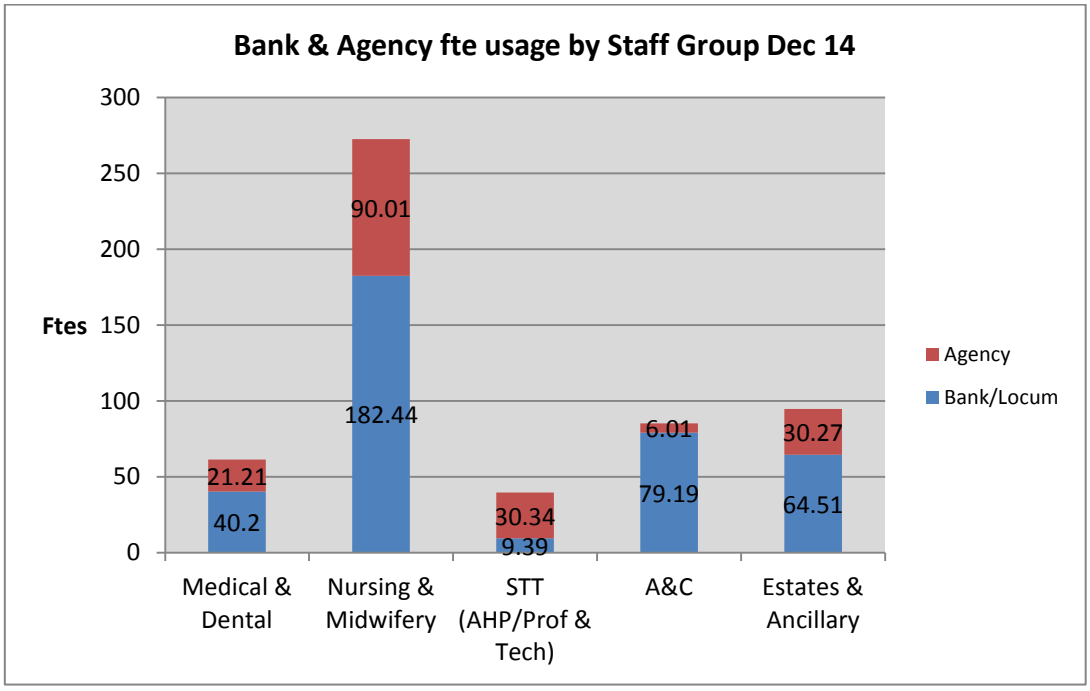
Turnover has continued to increase but the rise since last month is accounted for by the transfer out of the School Nursing service to Kent Community Health NHS Trust.

**Flexible labour usage**





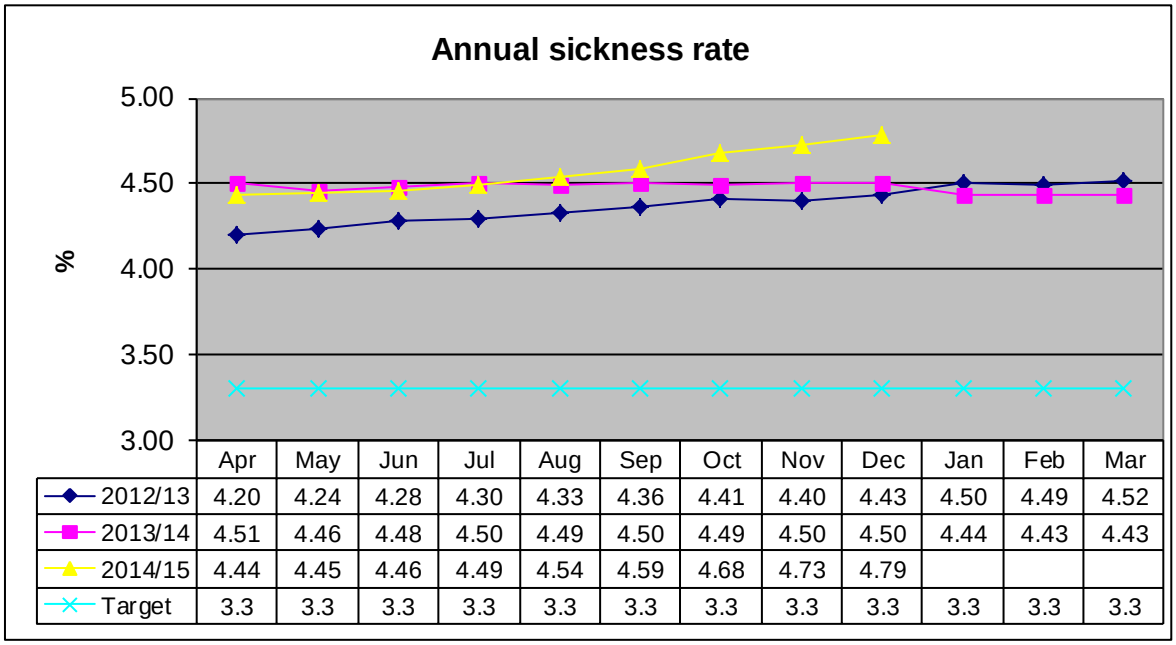

| | Medical & Dental | Nursing & Midwifery | STT (AHP & Prof Tech) | A&C | Estates & Ancillary |
|---|---|---|---|---|---|
| Overtime | £0 | £13,393 | £1,931 | £7,290 | £3,444 |
| Agency | £311,097 | £445,987 | £174,951 | £34,169 | £43,240 |
| Bank/Locum | £361,017 | £453,194 | £27,179 | £129,643 | £108,948 |



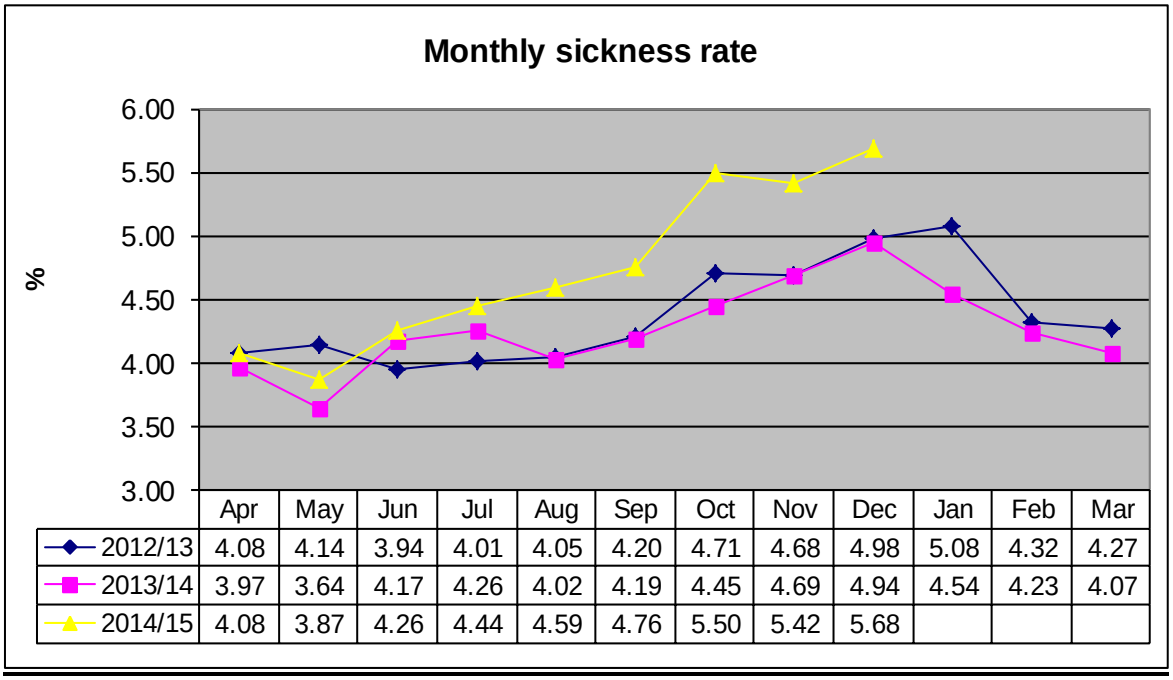

Pay expenditure was £310K above budget in the month of December and is £1980K over budget for the year to date.

With the Trust entering “Black” status from 20 December (the highest level in escalation plans) due to increasing demand, and increased sickness absence this month, temporary workforce expenditure increased by £81K in December. Bank expenditure was up by £73K whilst agency expenditure was £2K lower. There was an increase of £10K, however, in overtime expenditure which was sometimes used to meet short term need when bank or agency was difficult to source in the holiday period. Overtime was also used in Endoscopy to meet 18 weeks targets. At £26K this month, overtime expenditure was at its highest since controls were introduced in December 2013.

## Sickness




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012/13 | 4.20 | 4.24 | 4.28 | 4.30 | 4.33 | 4.36 | 4.41 | 4.40 | 4.43 | 4.50 | 4.49 | 4.52 |
| 2013/14 | 4.51 | 4.46 | 4.48 | 4.50 | 4.49 | 4.50 | 4.49 | 4.50 | 4.50 | 4.44 | 4.43 | 4.43 |
| 2014/15 | 4.44 | 4.45 | 4.46 | 4.49 | 4.54 | 4.59 | 4.68 | 4.73 | 4.79 | | | |
| Target | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 | 3.3 |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012/13 | 4.08 | 4.14 | 3.94 | 4.01 | 4.05 | 4.20 | 4.71 | 4.68 | 4.98 | 5.08 | 4.32 | 4.27 |
| 2013/14 | 3.97 | 3.64 | 4.17 | 4.26 | 4.02 | 4.19 | 4.45 | 4.69 | 4.94 | 4.54 | 4.23 | 4.07 |
| 2014/15 | 4.08 | 3.87 | 4.26 | 4.44 | 4.59 | 4.76 | 5.50 | 5.42 | 5.68 | | | |

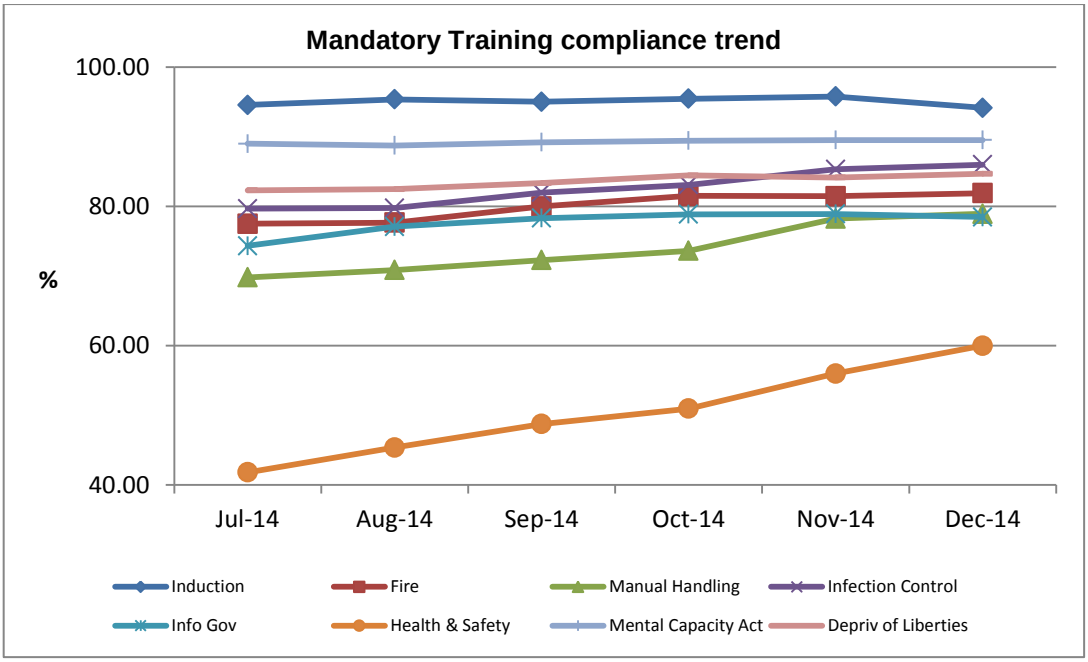
| Clinical Unit | Annual sickness | Monthly sickness | Short term sickness <28 days | Long Term sickness >=28 days |
|---|---|---|---|---|
| Theatres & Clinical Support | 4.88% | 4.84% | 57.93% | 42.07% |
| Cardiovascular Medicine | 3.62% | 4.84% | 67.67% | 32.33% |
| Urgent Care | 5.07% | 5.92% | 71.03% | 28.97% |
| Specialist Medicine | 5.08% | 7.18% | 50.27% | 49.73% |
| Out of Hospital Care | 5.74% | 5.43% | 64.16% | 35.84% |
| Surgery | 4.01% | 6.18% | 60.03% | 39.97% |
| Womens & Childrens | 4.44% | 6.15% | 69.42% | 30.58% |
| COO Operations | 4.70% | 6.58% | 51.66% | 48.34% |
| Estates & Facilities | 5.90% | 5.85% | 44.65% | 55.35% |
| Corporate | 3.66% | 5.46% | 66.27% | 39.33% |
| TRUST | **4.79%** | **5.68%** | **62.80%** | **37.20%** |

Disappointingly, sickness absence has increased again this month to 5.68%. The top three reasons for sickness absence were musculoskeletal (other than back injury), anxiety/stress/depression and cold/cough/flu.

Due to the high levels of sickness, the requirement for a doctors certificate from the first day of occupational sick pay was implemented over the Christmas and New Years holidays and extended by a further week.

A training plan has been developed to support the introduction of the new absence management policy. In addition, a training programme on managing workplace stress will be launched in February. Occupational Health have also introduced new processes to ensure that staff are reviewed in a timely manner.

## Mandatory Training & Appraisals




| Clinical Unit | 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 |
|---|---|---|---|---|---|---|---|---|---|
| Theatres & Clinical Support | 69.30% | 88.68% | 80.17% | 94.51% | 88.21% | 85.97% | 60.52% | 90.63% | 86.54% |
| Cardiovascular Medicine | 83.93% | 84.82% | 76.57% | 92.86% | 83.17% | 75.25% | 49.50% | 87.87% | 80.58% |
| Urgent Care | 69.06% | 74.85% | 66.40% | 95.95% | 75.05% | 62.58% | 54.53% | 83.61% | 83.33% |
| Specialist Medicine | 85.93% | 88.19% | 83.56% | 93.02% | 87.27% | 77.78% | 62.04% | 92.33% | 82.50% |
| Out of Hospital Care | 65.23% | 83.13% | 82.19% | 100.00% | 85.40% | 87.27% | 63.66% | 94.90% | 95.01% |
| Surgery | 86.00% | 81.11% | 78.55% | 89.34% | 79.83% | 71.73% | 57.10% | 88.65% | 86.16% |
| Womens & Childrens | 62.29% | 85.99% | 77.75% | 91.53% | 88.60% | 82.14% | 65.11% | 85.08% | 75.43% |
| COO Operations | 35.68% | 60.61% | 82.31% | 100.00% | 87.26% | 67.69% | 42.92% | n/a | n/a |
| Estates & Facilities | 52.52% | 73.46% | 70.31% | 100.00% | 91.52% | 71.55% | 54.45% | 75.00% | 100.00% |
| Corporate | 82.67% | 90.89% | 92.55% | 94.74% | 89.86% | 87.78% | 81.99% | 89.33% | 86.44% |
| TRUST | **68.28%** | **81.92%** | **78.95%** | **94.17%** | **86.00 %** | **78.49 %** | **60.01 %** | **89.54 %** | **84.68%** |

Following the setting of the 85% target for mandatory training, there has been a concerted effort by the Learning & Development team, specialist trainers, managers and the workforce in general to improve compliance. This has included visits to wards/services with low compliance rates, additional training delivery in lecture theatres, team training and a huge initiative to increase access to e-learning modules. Whilst the 85% target has not been met across the board, the increase in rates from May when we started are significant and this has been achieved against the backdrop of business continuity issues.

For Health & Safety, we are two years into a 3-year training plan and therefore a rate of 60% is expected at this point in time.

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Increase in compliance from May 2014 to December 2014

| | Fire | M&H | IC | IG | H&S | MCA | DoLs |
|---|---|---|---|---|---|---|---|
| % compliance at at May 2014 | 78.02 | 67.28 | 80.07 | 70.81 | 34.91 | 88.69 | 82 |
| % compliance as at Dec 2014 | 81.92 | 78.95 | 86.00 | 78.49 | 60.01 | 89.54 | 84.68 |
| Increase | 3.90 | 11.67 | 5.93 | 7.68 | 25.10 | 0.85 | 2.68 |

Unfortunately, appraisal rates have dropped by 0.73% since last month and may have been impacted upon by the Business Continuity status over recent weeks when attention has had to be diverted to operational issues.

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## Medical appraisal compliance status end December 2014

| Dec-14 | Total | Green | % | Amber | % | Red | % |
|---|---|---|---|---|---|---|---|
| Consultants | 220 | 183 | 83.2% | 35 | 15.9% | 2 | 0.9% |
| SAS/Trust Grade | 92 | 75 | 81.5% | 16 | 17.4% | 1 | 1.1% |
| LAS | 17 | 15 | 88.2% | 2 | 11.8% | 0 | 0.0% |
| Total Number of Doctors with Prescribed Connection | 329 | 273 | 83.0% | 53 | 16.1% | 3 | 0.9% |

| | |
|---|---|
| | Doctors who HAVE forwarded evidence of an appraisal since April 2014 OR have been in the Trust for less than six months and are not due an appraisal until the next year's appraisal cycle OR are on long-term/maternity leave |
| | Doctors who have NOT had an appraisal since 1st April 2014 but who are expected to have an appraisal before the end of December 2014 |
| | Doctors who have NOT had an appraisal since 1st April 2014 and are more than 3 months overdue for their 2014 annual appraisal OR have not produced evidence of an appraisal for 2013 |

East Sussex Healthcare NHS
NHS Trust

# FINANCE REPORT – December 2014

**Vanessa Harris – January 2015**

# Financial Summary – December 2014

| Key Issue | Summary | YTD |
|---|---|---|
| Overall RAG Rating | The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria remains at Green in month 9. | G |
| Financial Summary | The Trust is in receipt of £18m of non-recurrent deficit funding, of which £13.5m YTD has been recognised in the position at Month 9. The Trust performance in month 9 was a year to date run rate deficit of £1,784k, with a favourable variance against plan of £12,930k. Year to date, Income was £20,039k above plan whilst total costs, including the donated asset adjustment, were £7,109k overspent. | G |
| Activity & Income | Total income received during December was £2,830k above planned levels resulting in a year to date variance of £20,039k above plan. | G |
| Expenditure | Pay costs YTD are above plan by £1,978k and Non-Pay is £6,024k above plan. The Non-Pay variance is predominantly on tariff excluded drugs and devices which are recovered through income as above. | A |
| CIP plans | The CIP achievement YTD was £13,745k which was below plan by £663k. | A |
| Balance Sheet | It is now considered most unlikely that the clinical strategy capital PDC of £17.4m will be agreed by the TDA in 2014/15 and therefore this has been removed from the capital resource assumptions and forecast tax payers equity. | G |
| Cash Flow | The approved Conquest clinical decision unit funding (£0.4m) and health records storage bid (£0.9m) have been reflected in the cash flow and capital programme. | G |
| Capital Programme | The 2014/15 capital programme remains under severe pressure as demands for capital expenditure continue to far outstrip available resources. The Capital Approval Group (CAG) will continue to review and monitor the capital programme in order to achieve a balanced position at 31st March 2015 paying particular attention to the risks associated with limited capital funds. | G |

# Income & Expenditure – December 2014

## Headlines

• The Trust has received £18m of non-recurrent deficit funding of which £13.5m YTD is recognised in the month 9 position. Total income in the month was £31.7m against a plan of £28.9m, a favourable variance of £2,830k. YTD income is now £20,039k above plan.

• Total costs in the month were £32.4m. This was £1,263k above plan in month and brings the YTD position to £7,486k above plan.

• The run rate deficit against plan YTD was a favourable variance of £12,930k.

• Cost improvements of £13.7m have been achieved YTD month 9 which is £0.7m below the planned target.

• Pay costs in the month, including ad hoc costs, were £311k above plan. YTD pay is now £1,978k above plan.

• Non Pay costs, including 3rd party costs, were £1,005k above plan in the month and are £6,024k above plan YTD.

| £000s | In Mth Plan | In Mth Actual | Variance | YTD Plan | YTD Actual | Variance | Annual Plan |
|---|---|---|---|---|---|---|---|
| NHS Patient Income | 26,075 | 28,398 | 2,323 | 242,611 | 260,450 | 17,839 | 323,730 |
| Private Patient/ ICR | 323 | 415 | 92 | 2,587 | 2,554 | -33 | 4,160 |
| Trading Income | 390 | 526 | 136 | 3,503 | 3,922 | 419 | 4,421 |
| Other Non Clinical Income | 2,089 | 2,368 | 279 | 19,134 | 20,948 | 1,814 | 25,049 |
| **Total Income** | **28,877** | **31,707** | **2,830** | **267,835** | **287,874** | **20,039** | **357,360** |
| Pay Costs | -20,014 | -20,303 | -289 | -181,682 | -183,574 | -1,892 | -241,875 |
| Ad hoc Costs | -21 | -43 | -22 | -123 | -209 | -86 | 0 |
| Non Pay Costs | -9,519 | -10,502 | -983 | -86,189 | -92,115 | -5,926 | -114,922 |
| 3rd Party Costs | -10 | -32 | -22 | -344 | -442 | -98 | -123 |
| Other | 183 | 183 | 0 | 1,650 | 1,650 | 0 | 2,200 |
| **Total Direct Costs** | **-29,381** | **-30,697** | **-1,316** | **-266,688** | **-274,690** | **-8,002** | **-354,720** |
| **Surplus/- Deficit from Operations** | **-504** | **1,010** | **1,514** | **1,147** | **13,184** | **12,037** | **2,640** |
| P/L on Asset Disposal | 0 | 1 | 1 | 0 | 23 | 23 | 0 |
| Depreciation | -1,049 | -1,034 | 15 | -9,439 | -9,286 | 153 | -12,585 |
| Impairment | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PDC Dividend | -689 | -663 | 26 | -6,201 | -5,962 | 239 | -8,272 |
| Interest | -25 | -14 | 11 | -221 | -120 | 101 | -295 |
| **Total Indirect Costs** | **-1,763** | **-1,710** | **53** | **-15,861** | **-15,345** | **516** | **-21,152** |
| **Total Costs** | **-31,144** | **-32,407** | **-1,263** | **-282,549** | **-290,035** | **-7,486** | **-375,872** |
| **Net Surplus/-Deficit** | **-2,267** | **-700** | **1,567** | **-14,714** | **-2,161** | **12,553** | **-18,512** |
| Donated Asset/Impairment Adjustment | 0 | 26 | 26 | 0 | 377 | 377 | 0 |
| **Adjusted Net Surplus/-Deficit** | **-2,267** | **-674** | **1,593** | **-14,714** | **-1,784** | **12,930** | **-18,512** |

# Cash Flow – December 2014

## Headlines

- The cash balance is planned to be reduced to £1.0m at year-end.
- Temporary revenue PDC received will be repaid from the additional £18m non-recurrent deficit funding.
- The application to the Independent Trust Finance Facility (ITFF) for additional emergency capital PDC of £0.9m in respect of improvements in the storage and access to health records has been included in the cash flow together with the already approved £0.4m capital PDC for the Conquest clinical decisions unit development.
- The cash flow will remain under constant review through the remainder of the financial year and this will include taking into account the the ITFF final decision on the bids for additional capital resources.

## Cash Flow Statement April 2014 to March 2015

| £000s | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan 2015 | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cash Flow from Operations** | | | | | | | | | | | | |
| Operating Surplus/(Deficit) | -1,719 | -1,385 | -1,948 | 174 | -1,305 | 7,246 | 2,106 | 754 | -23 | 2,107 | 68 | 942 |
| Depreciation and Amortisation | 1,031 | 1,031 | 1,031 | 1,033 | 1,035 | 1,028 | 1,030 | 1,033 | 1,034 | 1,048 | 1,048 | 1,136 |
| Interest Paid | -31 | -31 | -31 | -31 | -31 | -31 | -31 | 87 | -16 | -5 | -5 | -9 |
| Dividend (Paid)/Refunded | | | | | | -3,897 | | | | | | -3,897 |
| (Increase)/Decrease in Inventories | -279 | 34 | 255 | -174 | 146 | -158 | -21 | 32 | -314 | | | 18 |
| (Increase)/Decrease in Trade and Other Receivables | 1,954 | 2,301 | -4,770 | 5,298 | 662 | -11,817 | 1,420 | -2,532 | -3,064 | -1,409 | -2,108 | 23,900 |
| Increase/(Decrease) in Trade and Other Payables | 1,719 | 440 | 1,369 | -269 | -1,272 | 4,117 | -4,804 | 972 | -127 | -2,695 | -1,369 | -4,148 |
| Provisions Utilised | 125 | 14 | 16 | -43 | 14 | -106 | -36 | 17 | 17 | -19 | -19 | -231 |
| **Net Cash Inflow/(Outflow) from Operating Activities** | **2,799** | **2,403** | **-4,077** | **5,988** | **-751** | **-3,618** | **-336** | **363** | **-2,493** | **-973** | **-2,385** | **17,711** |
| **Cash Flows from Investing Activities:** | | | | | | | | | | | | |
| Interest Received | 6 | 3 | 2 | 3 | 4 | 2 | 3 | 2 | 2 | 1 | 1 | 1 |
| (Payments) for Property, Plant and Equipment | -1,132 | -1,060 | -1,408 | -1,423 | -1,594 | -1,389 | -1,402 | -2,496 | -1,174 | -473 | -268 | -859 |
| (Payments) for Intangible Assets | -29 | -42 | -50 | -37 | -44 | -42 | -23 | -41 | -33 | -40 | -40 | -40 |
| **Net Cash Inflow/(Outflow) from Investing Activities** | **-1,156** | **-1,099** | **-1,456** | **-1,457** | **-1,634** | **-1,429** | **-1,422** | **-2,535** | **-1,205** | **-512** | **-307** | **-898** |
| **Net Cash Inflow/(Outflow) before Financing** | **1,644** | **1,304** | **-5,533** | **4,531** | **-2,385** | **-5,047** | **-1,758** | **-2,172** | **-3,698** | **-1,485** | **-2,692** | **16,813** |
| New Temporary PDC | 0 | 0 | 5,000 | 0 | 0 | 0 | 7,000 | 0 | 4,500 | 0 | 0 | 2,012 |
| Repayment for Temporary PDC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -18,512 |
| New Permanent PDC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 200 | 0 | 0 | 1,100 | 0 |
| Loans and Finance Lease repaid | -76 | 0 | 0 | -89 | 0 | -914 | 0 | 28 | -116 | 0 | 0 | -912 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | **-76** | **0** | **5,000** | **-89** | **0** | **-914** | **7,000** | **228** | **4,384** | **0** | **1,100** | **-17,412** |
| **Net Increase/(Decrease) in Cash** | **1,568** | **1,304** | **-533** | **4,442** | **-2,385** | **-5,961** | **5,242** | **-1,944** | **686** | **-1,485** | **-1,592** | **-599** |
| Opening balance | 2,257 | 3,825 | 5,129 | 4,596 | 9,038 | 6,653 | 692 | 5,934 | 3,990 | 4,676 | 3,191 | 1,599 |
| Closing balance | 3,825 | 5,129 | 4,596 | 9,038 | 6,653 | 692 | 5,934 | 3,990 | 4,676 | 3,191 | 1,599 | 1,000 |

# Balance Sheet – December 2014

## Headlines

- It is now considered most unlikely that the clinical strategy capital PDC of £17.4m will be agreed by the TDA in 2014/15 and therefore this has been removed from the forecast tax payers equity.

- However, the overall tax payer's equity is now planned to rise due to the increase in permanent public dividend capital (PDC) in respect of the approved ITFF funding for the Conquest clinical decisions unit (£0.4m) and also the bid submitted to the ITFF for the improvements in the storage and access to health records (£0.9m).

| BALANCE SHEET £000s | Opening B/Sheet | YTD Actual | Forecast Mar 2015 |
|---|---|---|---|
| **Non Current Assets** | | | |
| Property plant and equipment | 257,258 | 255,107 | 257,256 |
| Intangilble Assets | 826 | 1,168 | 686 |
| Trade and other Receivables | 708 | 1,192 | 647 |
| | **258,792** | **257,467** | **258,589** |
| **Current Assets** | | | |
| Inventories | 6,238 | 6,717 | 6,511 |
| Trade receivables | 21,825 | 11,030 | 14,718 |
| Other receivables | 3,601 | 24,213 | 3,818 |
| Other current assets | 0 | 0 | 0 |
| Cash and cash equivalents | 2,257 | 4,676 | 1,006 |
| | **33,921** | **46,636** | **26,053** |
| **Current Liabilities** | | | |
| Trade payables | -13,040 | -8,148 | -8,166 |
| Other payables | -19,023 | -21,913 | -19,680 |
| DoH Loan | -1,674 | -1,007 | -340 |
| Borrow ings - Finance Leases | -320 | -320 | -335 |
| Provisions | -462 | -464 | -483 |
| | **-34,519** | **-31,852** | **-29,004** |
| **Non Current Liabilities** | | | |
| DoH Loan | -3,535 | -3,365 | -3,198 |
| Borrow ings - Finance Leases | -598 | -269 | -263 |
| Provisions | -2,632 | -2,648 | -2,738 |
| | **-6,765** | **-6,282** | **-6,199** |
| **Total Assets Employed** | **251,429** | **265,969** | **249,439** |

| BALANCE SHEET £000s | Opening B/Sheet | YTD Actual | Forecast Mar 2015 |
|---|---|---|---|
| **Financed by** | | | |
| Public Dividend Capital (PDC) | -153,130 | -169,830 | -153,530 |
| Revaluation Reserve | -106,395 | -106,396 | -106,396 |
| Income & Expenditure Reserve | 8,096 | 10,257 | 10,487 |
| **Total Tax Payers Equity** | **-251,429** | **-265,969** | **-249,439** |

# Receivables, Payables & Better Payments Practice Code Performance – December 2014

## Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target, currently 95%, is for the value and volume of invoices that should be paid within 30 days.
- In month 95% of trade invoices by amount was achieved and 91% of NHS invoices by amount were paid. This has improved the year to date achievement to 90% by amount for trade invoices and 70% by amount for NHS invoices.

| Trade Receivables Aged Debt Analysis - Sales Ledger System Only | No of Invoices | | Value Outstanding | |
|---|---|---|---|---|
| | Current Month | Previous Month | Current Month £000s | Previous Month £000s |
| 0- 30 Days | 832 | 1,170 | 5,135 | 2,699 |
| 31 - 60 Days | 573 | 468 | 1,095 | 1,253 |
| 61 -90 Days | 252 | 256 | 802 | 415 |
| 91 - 120 Days | 187 | 125 | 232 | 441 |
| > 120 Days | 1,091 | 1,057 | 3,766 | 3,974 |
| Total | 2,935 | 3,076 | 11,030 | 8,782 |

| Trade Payables Aged Analysis - Purchase Ledger System Only | No of Invoices | | Value Outstanding | |
|---|---|---|---|---|
| | Current Month | Previous Month | Current Month £000s | Previous Month £000s |
| 0- 30 Days | 4,525 | 3,127 | 4,709 | 4,093 |
| 31 - 60 Days | 1,268 | 700 | 1,989 | 1,457 |
| 61 -90 Days | 361 | 323 | 622 | 954 |
| 91 - 120 Days | 124 | 137 | 423 | 290 |
| > 120 Days | 365 | 361 | 405 | 368 |
| Total | 6,643 | 4,648 | 8,148 | 7,162 |

| Better Payments Practice Code | Month Number of Invoices | Month By Amount | YTD Number of Invoices | YTD By Amount |
|---|---|---|---|---|
| Trade invoices paid within contract or 30 days of receipt | 99.07% | 95.23% | 90.89% | 90.06% |
| NHS invoices paid within contract or 30 days of receipt | 91.94% | 90.94% | 58.82% | 69.74% |

# Key Performance Indicators – December 2014

**TDA Finance Risk Assessment Criteria.**

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

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

• All risks are now considered "green" in the current month due to the receipt of non-recurrent deficit funding, replacing the need for PDC for liquidity purposes.

**Monitor Continuity of Service Risk Rating.**

• The Trust has a liquidity ratio rating of 4 and a capital servicing ratio of 3, resulting in an overall rating of 4.

**Better Payments Practice Code (BPPC)**
• In month performance has increased the YTD Better Payments Practice Code (BPPC) achievement for both Trade and NHS invoices.

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

| Monitor Continuity of Service Risk Ratings | YTD Actual | YTD Plan |
|---|---|---|
| Liquidity Ratio Rating | 4 | 3 |
| Capital Servicing Capacity Rating | 3 | 1 |
| Overall Monitor Risk Rating | 4 | 2 |

| Local Measures | YTD Actual | YTD Plan |
|---|---|---|
| BPPC – Trade invoices by value (%) | 90 | 95 |
| BPPC – NHS Invoices by value (%) | 70 | 95 |

# Activity & Contract Income – December 2014

## Headlines

- Contract activity income is £2.3m above plan in the month, increasing the YTD performance to £17.8m above plan.
- Tariff-excluded drugs and devices income has a neutral impact on ESHT as they are offset by expenditure. After allowing for these areas, total contract income is £14.1mill above planned levels YTD.
- Total Elective activity is £0.8m below plan YTD this is mainly T&O and Cardiology. The improvement in month is almost entirely to do with the phasing of the plan. Activity did not dip as much as the plan anticipated.
- Re-admissions fines have been accrued based on agreed planning assumptions.
- CQUIN performance is based on ESHT achieving 100%.

| Activity | Current Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| Day Cases | 2,959 | 3,112 | 153 | 30,476 | 31,801 | 1,325 |
| Elective Inpatients | 681 | 700 | 19 | 7,057 | 6,880 | -177 |
| Emergency Inpatients | 3,714 | 3,575 | -139 | 32,949 | 32,572 | -377 |
| **Total Inpatients** | **7,353** | **7,387** | **34** | **70,482** | **71,253** | **771** |
| Excess Bed Days | 2,633 | 2,072 | -561 | 23,583 | 18,169 | -5,414 |
| **Total Excess Bed Days** | **2,633** | **2,072** | **-561** | **23,583** | **18,169** | **-5,414** |
| Consultant First Attendances | 6,094 | 7,612 | 1,518 | 62,508 | 69,568 | 7,060 |
| Consultant Follow Ups | 9,838 | 11,489 | 1,651 | 101,907 | 107,103 | 5,196 |
| OP Procedures | 4,090 | 4,398 | 308 | 41,478 | 40,428 | -1,050 |
| Other Outpatients inc WA & Nurse Led | 11,637 | 11,459 | -178 | 120,836 | 109,508 | -11,328 |
| Community Specialist | 216 | 84 | -132 | 2,249 | 1,674 | -575 |
| **Total Outpatients** | **31,876** | **35,042** | **3,166** | **328,978** | **328,281** | **-697** |
| Chemotherapy Unbundled HRGs | 428 | 442 | 14 | 4,446 | 5,064 | 618 |
| Antenatal Pathways | 285 | 136 | -149 | 2,962 | 2,651 | -311 |
| Post-natal Pathways | 259 | 164 | -95 | 2,696 | 2,443 | -253 |
| A&E Attendances (excluding type 2's) | 8,501 | 8,643 | 142 | 79,562 | 79,687 | 125 |
| ITU Bed Days | 563 | 598 | 35 | 4,350 | 4,419 | 69 |
| SCBU Bed Days | 238 | 222 | -16 | 2,139 | 2,398 | 259 |
| Cardiology - Direct Access | 70 | 61 | -9 | 731 | 558 | -173 |
| Radiology - Direct Access | 3,911 | 4,294 | 383 | 40,628 | 42,036 | 1,408 |
| Pathology - Direct Access | 235,776 | 261,186 | 25,410 | 2,449,451 | 2,429,854 | -19,597 |
| Therapies - Direct Access | 2,937 | 2,843 | -94 | 30,509 | 28,755 | -1,754 |
| Audiology | 1,721 | 1,025 | -696 | 17,885 | 13,427 | -4,458 |
| Midwifery | 11 | 0 | -11 | 97 | 93 | -4 |

| Income £000's | Current Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | Contract | Actual | Variance | Contract | Actual | Variance |
| Inpatients - Electives | 3,912 | 4,522 | 610 | 40,451 | 39,617 | -834 |
| Inpatients - Emergency | 6,582 | 6,007 | -575 | 58,403 | 55,792 | -2,611 |
| Excess Bed Days | 601 | 472 | -129 | 5,387 | 4,142 | -1,245 |
| Outpatients | 3,309 | 3,785 | 476 | 34,077 | 34,900 | 823 |
| Other Acute based Activity | 2,410 | 2,283 | -127 | 21,903 | 21,998 | 95 |
| Direct Access | 651 | 712 | 61 | 6,774 | 6,863 | 89 |
| Block Contract | 5,877 | 5,704 | -173 | 51,967 | 51,719 | -248 |
| Re-admissions | -295 | -292 | 3 | -1,500 | -2,330 | -830 |
| Other | 440 | 2,195 | 1,755 | 1,661 | 20,571 | 18,910 |
| CQUIN | 581 | 581 | 0 | 5,421 | 5,421 | 0 |
| Subtotal | 24,068 | 25,969 | 1,901 | 224,544 | 238,693 | 14,149 |
| Exclusions | 2,007 | 2,429 | 422 | 18,067 | 21,757 | 3,690 |
| **GRAND TOTAL** | **26,075** | **28,398** | **2,323** | **242,611** | **260,450** | **17,839** |

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

## Headlines

Clinical Units (CUs)

The overall clinical unit performance was an over spending of £343k in the month which has resulted in a YTD over spending of £7,730k.

Commercial Directorate

The Commercial Directorate is underspent by £102k year to date with medical engineering, ancillary and property services driving the position this month.

Corporate Services

Corporate Services was better than plan in the month and is now £2k underspent YTD.

| Income & Expenditure Performance | In mth Plan £000's | In mth Actual £000's | Var £000's | YTD Plan £000's | YTD Actual £000's | Var £000's |
|---|---|---|---|---|---|---|
| Urgent Care | 2,261 | 1,517 | -744 | 20,566 | 15,135 | -5,431 |
| Specialist Medicine | 310 | 835 | 525 | 4,179 | 6,670 | 2,491 |
| Cardiovascular | -44 | 118 | 162 | -299 | -845 | -546 |
| Surgery | 3,795 | 4,080 | 285 | 39,223 | 36,448 | -2,775 |
| Women & Children | 1,173 | 818 | -355 | 11,775 | 11,001 | -774 |
| Out of Hospital Care | 630 | 679 | 49 | 5,392 | 4,864 | -528 |
| Clinical Support | -4,590 | -4,711 | -121 | -42,709 | -42,261 | 448 |
| Tariff-Excluded Drugs & Devices | 0 | -31 | -31 | 0 | 0 | 0 |
| COO Operations | -1,062 | -1,175 | -113 | -8,123 | -8,738 | -615 |
| **Total Clinical Units** | **2,473** | **2,130** | **-343** | **30,004** | **22,274** | **-7,730** |
| Commercial Directorate | -2,405 | -2,490 | -85 | -21,268 | -21,166 | 102 |
| Corporate Services | -1,949 | -1,560 | 389 | -17,040 | -17,038 | 2 |
| Central Items | -1,677 | -1,240 | 437 | -14,915 | -13,917 | 998 |
| **Total Central Areas** | **-6,031** | **-5,290** | **741** | **-53,223** | **-52,121** | **1,102** |
| Income | 1,291 | 2,460 | 1,169 | 8,505 | 27,686 | 19,181 |
| Donated Asset/Impairment Adjustment | 0 | 26 | 26 | 0 | 377 | 377 |
| **Total** | **-2,267** | **-674** | **1,593** | **-14,714** | **-1,784** | **12,930** |

| 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 |
|---|---|---|---|---|---|---|---|---|
| 495 | 508 | Urgent Care | -1,774 | -1,863 | -89 | -15,844 | -16,268 | -424 |
| 418 | 402 | Specialist Medicine | -1,488 | -1,446 | 42 | -13,615 | -13,817 | -202 |
| 292 | 352 | Cardiovascular | -1,206 | -1,345 | -139 | -11,081 | -11,468 | -387 |
| 676 | 686 | Surgery | -2,803 | -2,901 | -98 | -25,579 | -26,031 | -452 |
| 624 | 602 | Women & Children | -2,304 | -2,330 | -26 | -20,875 | -20,876 | -1 |
| 874 | 858 | Out of Hospital Care | -2,434 | -2,485 | -51 | -22,268 | -22,527 | -259 |
| 1,040 | 1,044 | Clinical Support | -3,916 | -4,169 | -253 | -36,530 | -36,906 | -376 |
| 415 | 452 | COO Operations | -862 | -960 | -98 | -7,543 | -8,018 | -475 |
| **4,834** | **4,903** | **Total Clinical Units** | **-16,787** | **-17,499** | **-712** | **-153,335** | **-155,911** | **-2,576** |
| 756 | 728 | Commercial Directorate | -1,477 | -1,412 | 65 | -13,367 | -13,387 | -20 |
| 537 | 513 | Corporate Services | -1,567 | -1,623 | -56 | -14,149 | -14,364 | -215 |
| **1,293** | **1,241** | **Total Non-Clinical Divisions** | **-3,044** | **-3,035** | **9** | **-27,516** | **-27,751** | **-235** |
| | | Central Items | -204 | 188 | 392 | -954 | -121 | 833 |
| **6,126** | **6,144** | **Total Pay Analysis** | **-20,035** | **-20,346** | **-311** | **-181,805** | **-183,783** | **-1,978** |

# Clinical Unit Performance (budgets) Urgent Care – December 2014

## Headlines

Pay

Overall pay for Urgent Care overspent by £89k in the month due to medical and nursing agency staff in A&E covering vacancies.

Non Pay

Non pay overspent in the month bringing the cumulative overspend to £23k.

Divisional Income

Contract income was below plan by £648k in the month and is now £5.0m below plan YTD.

| Workforce Plan FTE | Workforce Actual FTE | Urgent Care | In mth Plan £000's | In mth Actual £000's | In mth Var £000's | YTD Plan £000's | YTD Actual £000's | YTD Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 4,132 | 3,484 | -648 | 37,269 | 32,286 | -4,983 |
| | | Other Income | 0 | -1 | -1 | 12 | 11 | -1 |
| | | **Total Income** | **4,132** | **3,483** | **-649** | **37,281** | **32,297** | **-4,984** |
| 495 | 508 | Pay | -1,774 | -1,863 | -89 | -15,844 | -16,268 | -424 |
| | | Non pay | -97 | -103 | -6 | -871 | -894 | -23 |
| **495** | **508** | **Total Expenditure** | **-1,871** | **-1,966** | **-95** | **-16,715** | **-17,162** | **-447** |
| **495** | **508** | **Gross Margin** | **2,261** | **1,517** | **-744** | **20,566** | **15,135** | **-5,431** |

# Clinical Unit Performance (budgets) Specialist Medicine – December 2014

## Headlines

Pay

Pay underspent by £42k in the month principally due to vacancies. Cumulatively pay is now an overspend of £202k YTD.

Non Pay

Non-Pay overspent by £9k in the month taking the cumulative to £17k overspend YTD.

Income

Contract income was above plan by £503k in month and is now £2.8m above plan YTD.

| Workforce Plan FTE | Workforce Actual FTE | Specialist Medicine | In mth Plan £000's | In mth Actual £000's | Var £000's | YTD Plan £000's | YTD Actual £000's | Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 1,874 | 2,377 | 503 | 18,549 | 21,336 | 2,787 |
| | | Other Income | 183 | 172 | -11 | 1,648 | 1,571 | -77 |
| | | **Total Income** | **2,057** | **2,549** | **492** | **20,197** | **22,907** | **2,710** |
| 418 | 402 | Pay | -1,488 | -1,446 | 42 | -13,615 | -13,817 | -202 |
| | | Non pay | -259 | -268 | -9 | -2,403 | -2,420 | -17 |
| **418** | **402** | **Total Expenditure** | **-1,747** | **-1,714** | **33** | **-16,018** | **-16,237** | **-219** |
| **418** | **402** | **Gross Margin** | **310** | **835** | **525** | **4,179** | **6,670** | **2,491** |

# Clinical Unit Performance (budgets) Cardiovascular – December 2014

## Headlines

Pay

Pay overspent by £139k in the month due to increased agency costs and additional beds over plan. This brings the YTD position to £387k above plan.

Non Pay

Non pay budgets are overspent by £279k YTD due to cardiology consumables.

Income

Contract income has overachieved by £380k in month and is above plan by £650k YTD.

Other income underachieved by £72k in the month, with the YTD position being an under recovery of £530k. The Michelham Unit had 32% occupancy during December.

| Workforce Plan FTE | Workforce Actual FTE | Cardiovascular | In mth Plan £000's | In mth Actual £000's | In mth Var £000's | YTD Plan £000's | YTD Actual £000's | YTD Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 1,257 | 1,637 | 380 | 12,239 | 12,889 | 650 |
| | | Other Income | 270 | 198 | -72 | 2,104 | 1,574 | -530 |
| | | **Total Income** | **1,527** | **1,835** | **308** | **14,343** | **14,463** | **120** |
| 292 | 352 | Pay | -1,206 | -1,345 | -139 | -11,081 | -11,468 | -387 |
| | | Non pay | -365 | -372 | -7 | -3,561 | -3,840 | -279 |
| **292** | **352** | **Total Expenditure** | **-1,571** | **-1,717** | **-146** | **-14,642** | **-15,308** | **-666** |
| **292** | **352** | **Gross Margin** | **-44** | **118** | **162** | **-299** | **-845** | **-546** |

# Clinical Unit Performance (budgets) Surgery – December 2014

## Headlines

Pay

Pay overspent by £98k in the month and is now overspent by £452k YTD. The overspending in the month was in respect of medical staffing and agency cover.

Non Pay

Non pay overspent by £42k in the month and £229k YTD.

Income

Contract income has overachieved by £425k in the month and is under plan by £2.1m YTD.

| Workforce Plan FTE | Workforce Actual FTE | Surgery | In mth Plan £000's | In mth Actual £000's | Var £000's | YTD Plan £000's | YTD Actual £000's | Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 6,918 | 7,343 | 425 | 67,925 | 65,799 | -2,126 |
| | | Other Income | 46 | 46 | 0 | 419 | 451 | 32 |
| | | **Total Income** | **6,964** | **7,389** | **425** | **68,344** | **66,250** | **-2,094** |
| 676 | 686 | Pay | -2,803 | -2,901 | -98 | -25,579 | -26,031 | -452 |
| | | Non pay | -366 | -408 | -42 | -3,542 | -3,771 | -229 |
| **676** | **686** | **Total Expenditure** | **-3,169** | **-3,309** | **-140** | **-29,121** | **-29,802** | **-681** |
| **676** | **686** | **Gross Margin** | **3,795** | **4,080** | **285** | **39,223** | **36,448** | **-2,775** |

# Clinical Unit Performance (budgets) Women & Children – December 2014

## Headlines

Pay

Pay overspent by £26k in the month and is overspent YTD by £1k.

Non Pay

Overspend of £152k in the month due to spend on drugs, non-pay now overspent by £107k YTD.

Income

Contract income underachieved by £183k in the month and is YTD £818k below plan.

Other income was above plan by £6k in the month.

| Workforce Plan FTE | Workforce Actual FTE | Women & Children | In mth Plan £000's | In mth Actual £000's | In mth Var £000's | YTD Plan £000's | YTD Actual £000's | YTD Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 3,782 | 3,599 | -183 | 35,369 | 34,551 | -818 |
| | | Other Income | 29 | 35 | 6 | 314 | 466 | 152 |
| | | **Total Income** | **3,811** | **3,634** | **-177** | **35,683** | **35,017** | **-666** |
| 624 | 602 | Pay | -2,304 | -2,330 | -26 | -20,875 | -20,876 | -1 |
| | | Non pay | -334 | -486 | -152 | -3,033 | -3,140 | -107 |
| **624** | **602** | **Total Expenditure** | **-2,638** | **-2,816** | **-178** | **-23,908** | **-24,016** | **-108** |
| **624** | **602** | **Gross Margin** | **1,173** | **818** | **-355** | **11,775** | **11,001** | **-774** |

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

## Headlines

Pay

Pay overspent by £51k in the month due to pressure in clinical admin. Pay is now overspent YTD by £259k.

Non Pay

£1k overspent against the plan for the month and is now £33k overspent YTD.

Income

Contract income overachieved by £115k in the month, with £167k under recovered YTD.

Other income underachieved by £14k in the month.

| Workforce Plan FTE | Workforce Actual FTE | Out of Hospital Care | In mth Plan £000's | In mth Actual £000's | Var £000's | YTD Plan £000's | YTD Actual £000's | Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 3,431 | 3,546 | 115 | 30,991 | 30,824 | -167 |
| | | Other Income | 110 | 96 | -14 | 990 | 921 | -69 |
| | | **Total Income** | **3,541** | **3,642** | **101** | **31,981** | **31,745** | **-236** |
| 874 | 858 | Pay | -2,434 | -2,485 | -51 | -22,268 | -22,527 | -259 |
| | | Non pay | -477 | -478 | -1 | -4,321 | -4,354 | -33 |
| **874** | **858** | **Total Expenditure** | **-2,911** | **-2,963** | **-52** | **-26,589** | **-26,881** | **-292** |
| **874** | **858** | **Gross Margin** | **630** | **679** | **49** | **5,392** | **4,864** | **-528** |

# Clinical Unit Performance (budgets) Clinical Support – December 2014

## Headlines

Pay

Pay overspend of £253k in the month due to delayed delivery of savings. Pay is now £376k overspent YTD.

Non Pay

Non-pay expenditure was £232k over plan in month due to spend on mobile MRI scanners and increased pathology consumables, it is now overspent by £118k YTD.

Income

Contract income was above plan by £487k YTD.

Other income was over plan by £100k in the month relating to PMU.

Note that HSDU moved in month to this Clinical Unit from Commercial

| 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 |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 1,631 | 1,877 | 246 | 14,915 | 15,402 | 487 |
| | | Other Income | 330 | 430 | 100 | 2,965 | 3,342 | 377 |
| | | **Total Income** | **1,961** | **2,307** | **346** | **17,880** | **18,744** | **864** |
| 1,040 | 1,044 | Pay | -3,916 | -4,169 | -253 | -36,530 | -36,906 | -376 |
| | | Non pay | -2,719 | -2,951 | -232 | -24,814 | -24,932 | -118 |
| **1,040** | **1,044** | **Total Expenditure** | **-6,635** | **-7,120** | **-485** | **-61,344** | **-61,838** | **-494** |
| **1,040** | **1,044** | **Gross Margin** | **-4,674** | **-4,813** | **-139** | **-43,464** | **-43,094** | **370** |

# Clinical Unit Performance (budgets) COO Operations – December 2014

## Headlines

Pay

This was overspent by £98k due to clinical admin costs. Pay is now £475k overspent YTD.

Non Pay

Non pay is now £135k over plan relating to Clinical Admin.

Income

Income remains broadly on plan.

| Workforce Plan FTE | Workforce Actual FTE | COO Operations | In mth Plan £000's | In mth Actual £000's | In mth Var £000's | YTD Plan £000's | YTD Actual £000's | YTD Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Other Income | 10 | 4 | -6 | 77 | 72 | -5 |
| | | **Total Income** | **10** | **4** | **-6** | **77** | **72** | **-5** |
| 415 | 452 | Pay | -862 | -960 | -98 | -7,543 | -8,018 | -475 |
| | | Non pay | -210 | -219 | -9 | -657 | -792 | -135 |
| **415** | **452** | **Total Expenditure** | **-1,072** | **-1,179** | **-107** | **-8,200** | **-8,810** | **-610** |
| **415** | **452** | **Gross Margin** | **-1,062** | **-1,175** | **-113** | **-8,123** | **-8,738** | **-615** |

# Divisional Performance (budgets) Commercial Directorate – December 2014

## Headlines

Pay

Pay in month was £65k underspent, leaving the YTD position as £20k above plan.

Non Pay

Non pay was overspent by £117k with Community and decontamination services being the drivers. YTD underspend of £103k.

Divisional Income

Commercial income has underachieved by £33k in the month due to reduced PropCO income.

Note that HSDU moved in month from Commercial to Clinical Support

| Workforce Plan FTE | Workforce Actual FTE | Commercial Directorate | 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 | 521 | 488 | -33 | 5,343 | 5,362 | 19 |
| | | **Total Income** | **521** | **488** | **-33** | **5,343** | **5,362** | **19** |
| 756 | 728 | Pay | -1,477 | -1,412 | 65 | -13,367 | -13,387 | -20 |
| | | Non pay | -1,449 | -1,566 | -117 | -13,244 | -13,141 | 103 |
| **756** | **728** | **Total Expenditure** | **-2,926** | **-2,978** | **-52** | **-26,611** | **-26,528** | **83** |
| **756** | **728** | **Gross Margin** | **-2,405** | **-2,490** | **-85** | **-21,268** | **-21,166** | **102** |

# Divisional Performance (budgets) Corporate Services – December 2014

## Headlines

Pay

Pay was overspent by £56k in the month and is £215k overspent YTD.

Non Pay

Non pay was underspent by £29k due to consultancy costs and is now £1.2m overspent YTD.

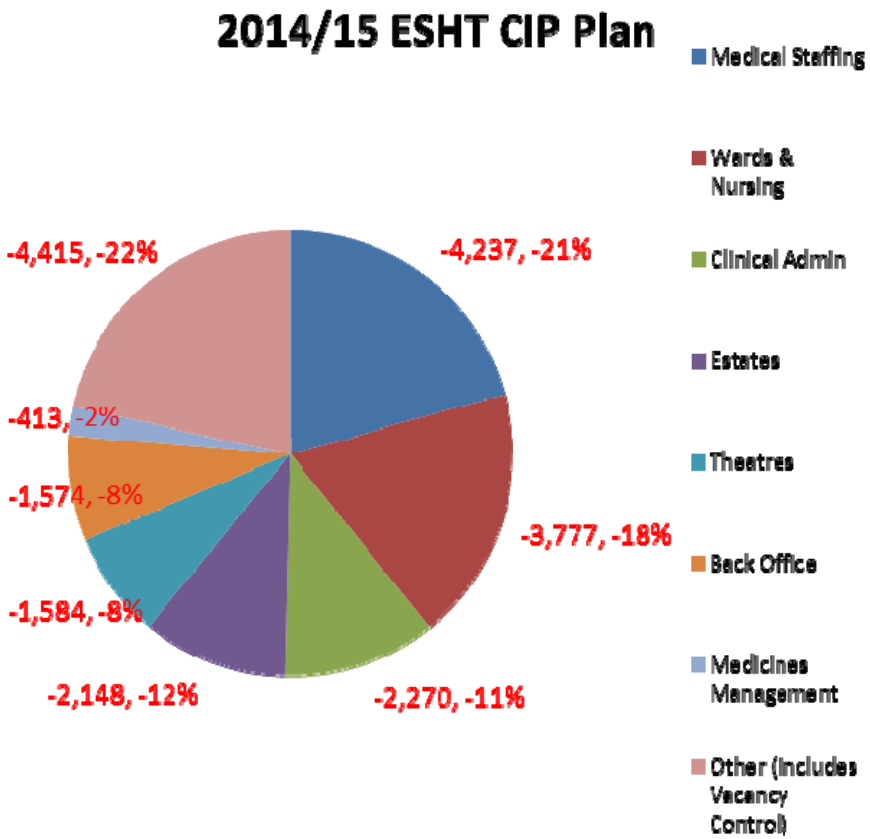
Income

£416k overachieved in month relating to additional education and training income. It is now £1.4m overachieved YTD.

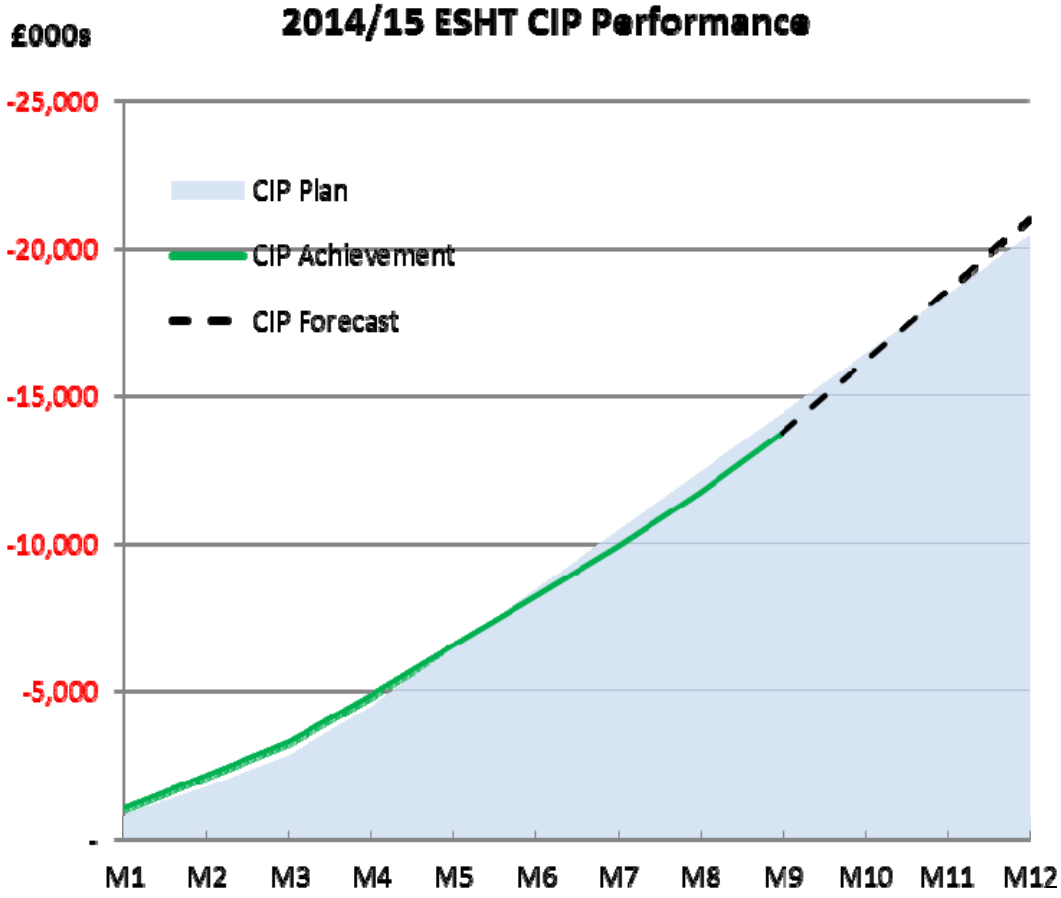
| Workforce Plan FTE | Workforce Actual FTE | Corporate Services | In mth Plan £000's | In mth Actual £000's | Var £000's | YTD Plan £000's | YTD Actual £000's | Var £000's |
|---|---|---|---|---|---|---|---|---|
| | | Contract Income | 2 | 2 | 0 | 19 | 19 | 0 |
| | | Other Income | 968 | 1,384 | 416 | 9,360 | 10,723 | 1,363 |
| | | **Total Income** | **970** | **1,386** | **416** | **9,379** | **10,742** | **1,363** |
| 537 | 513 | Pay | -1,567 | -1,623 | -56 | -14,149 | -14,364 | -215 |
| | | Non pay | -1,352 | -1,323 | 29 | -12,270 | -13,416 | -1,146 |
| **537** | **513** | **Total Expenditure** | **-2,919** | **-2,946** | **-27** | **-26,419** | **-27,780** | **-1,361** |
| **537** | **513** | **Gross Margin** | **-1,949** | **-1,560** | **389** | **-17,040** | **-17,038** | **2** |

# 2014/15 ESHT CIP Plan

| Themes | Full Year Plan | Key Dates | Status |
|---|---|---|---|
| Medical Staffing | -4,237 | on going | |
| Wards & Nursing | -3,777 | Oct-14 | |
| Clinical Admin | -2,270 | Oct-14 | |
| Estates | -2,148 | on going | |
| Theatres | -1,584 | Jul-14 | |
| Back Office | -1,574 | Aug-14 | |
| Medicines Management | -413 | on going | |
| Other (includes Vacancy Control) | -4,415 | on going | |




# 2014/15 ESHT CIP Performance to date – Month 9




| | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
| Plan | -799 | -1,743 | -2,806 | -4,479 | -6,432 | -8,428 | -10,424 | -12,417 | -14,408 | -16,408 | -18,407 | -20,417 |
| Actual | -995 | -2,102 | -3,272 | -4,851 | -6,512 | -8,181 | -9,888 | -11,661 | -13,745 | | | |
| Forecast | | | | | | | | | | -16,154 | -18,586 | -21,017 |

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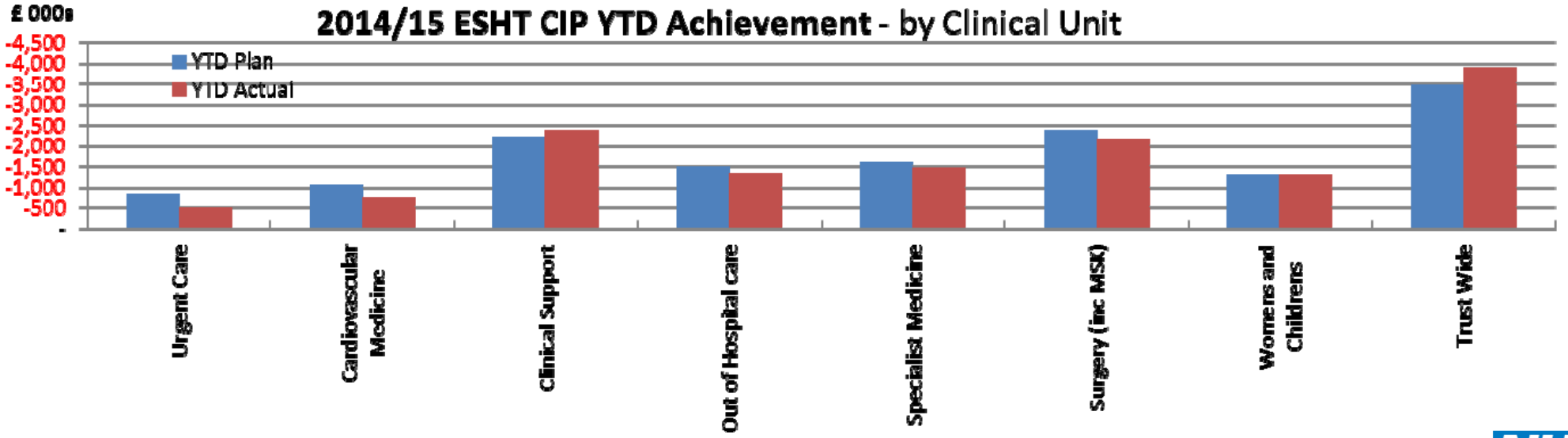
# 2014/15 ESHT CIP Performance by Clinical Unit – Month 9

| | In Month | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| Clinical Unit | Plan £000 | Actual £000 | Var £000 | YTD Plan £000 | YTD Actual £000 | YTD Var £000 | Full Year Plan | Full Year Forecast | Full Year Variance |
| Urgent Care | -117 | -51 | -65 | -854 | -481 | -373 | -1,204 | -670 | -534 |
| Cardiovascular Medicine | -162 | -190 | 28 | -1,065 | -757 | -308 | -1,551 | -1,517 | -35 |
| Clinical Support | -312 | -286 | -26 | -2,224 | -2,378 | 154 | -3,180 | -3,343 | 163 |
| Out of Hospital care | -177 | -145 | -32 | -1,500 | -1,320 | -181 | -2,031 | -1,933 | -98 |
| Specialist Medicine | -225 | -288 | 63 | -1,606 | -1,463 | -143 | -2,280 | -2,187 | -92 |
| Surgery (inc MSK) | -320 | -231 | -90 | -2,390 | -2,154 | -237 | -3,338 | -2,996 | -342 |
| Womens and Childrens | -181 | -148 | -33 | -1,311 | -1,301 | -9 | -1,853 | -1,856 | 2 |
| Trust Wide | -497 | -745 | 249 | -3,459 | -3,892 | 433 | -4,980 | -6,514 | 1,534 |
| Total | -1,991 | -2,084 | 93 | -14,408 | -13,745 | -663 | -20,417 | -21,017 | 600 |

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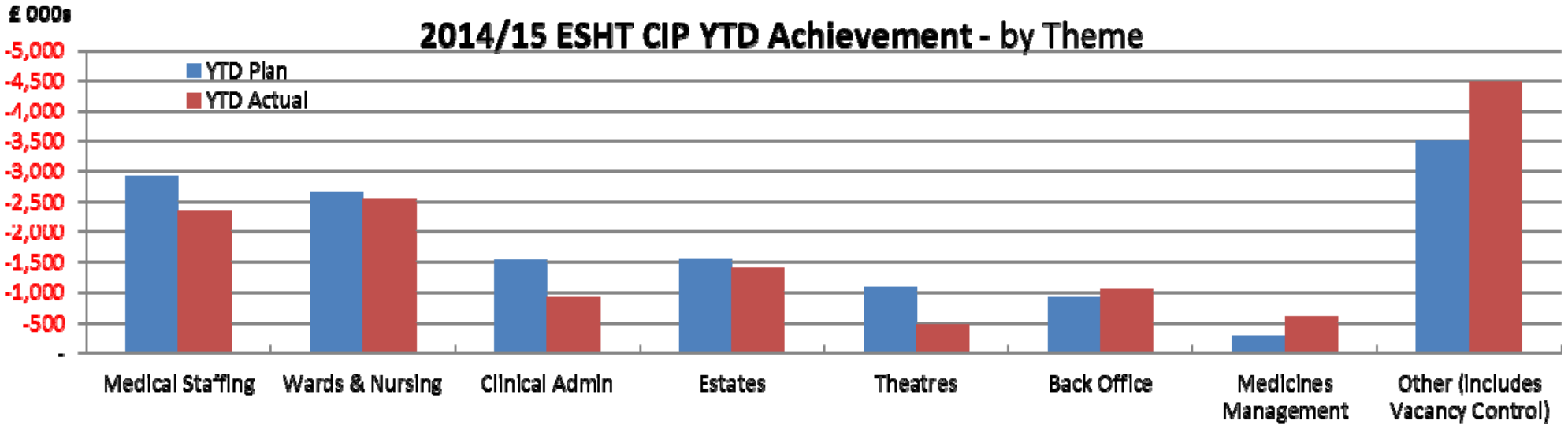
# 2014/15 ESHT CIP Performance by Theme – Month 9

| Themes | In Month | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000 | Actual £000 | Var £000 | YTD Plan £000 | YTD Actual £000 | YTD Var £000 | Full Year Plan | Full Year Forecast | Full Year Variance |
| Medical Staffing | -444 | -280 | -164 | -2,906 | -2,344 | -563 | -4,237 | -3,462 | -775 |
| Wards & Nursing | -375 | -437 | 62 | -2,653 | -2,534 | -119 | -3,777 | -3,819 | 42 |
| Clinical Admin | -232 | -105 | -127 | -1,528 | -904 | -624 | -2,270 | -1,236 | -1,034 |
| Estates | -201 | -228 | 27 | -1,546 | -1,398 | -148 | -2,148 | -1,999 | -148 |
| Theatres | -169 | -41 | -128 | -1,077 | -464 | -613 | -1,584 | -889 | -694 |
| Back Office | -219 | -173 | -46 | -917 | -1,040 | 123 | -1,574 | -1,634 | 60 |
| Medicines Management | -42 | -72 | 30 | -287 | -595 | 308 | -413 | -811 | 398 |
| Other (includes Vacancy Control) | -311 | -749 | 438 | -3,493 | -4,468 | 975 | -4,415 | -7,167 | 2,752 |
| Total | -1,991 | -2,084 | 93 | -14,408 | -13,745 | -663 | -20,417 | -21,017 | 600 |

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# Year on Year Comparisons – December 2014

## Headlines

- Total Inpatients activity was 0.8% lower than last year's activity level.
- Total outpatients were 2.4% lower than last year.
- YTD A&E attendances were 2.7% higher than last year.

| Activity | 2014/15 YTD Actual | 2013/14 YTD Actual | Increase / Decrease Yr on Yr | % Increae / Decrease Yr on Yr |
|---|---|---|---|---|
| Day Cases | 31,801 | 31,992 | -191 | -0.6% |
| Elective Inpatients | 6,880 | 7012 | -132 | -1.9% |
| Emergency Inpatients | 32,572 | 32,803 | -231 | -0.7% |
| **Total Inpatients** | **71,253** | **71,807** | **-554** | **-0.8%** |
| Elective Excess Bed Days | 1,605 | 1,542 | 63 | 4.1% |
| Non elective Excess Bed Days | 16,564 | 22,397 | -5,833 | -26.0% |
| **Total Excess Bed Days** | **18,169** | **23,939** | **-5,770** | **-24.1%** |
| Consultant First Attendances | 69,568 | 69,172 | 396 | 0.6% |
| Consultant Follow Ups | 107,103 | 110,244 | -3,141 | -2.8% |
| OP Procedures | 40,428 | 41,088 | -660 | -1.6% |
| Other Outpatients (WA & Nurse Led) | 109,508 | 113,855 | -4,347 | -3.8% |
| Community Specialist | 1,674 | 2,145 | -471 | -22.0% |
| **Total Outpatients** | **328,281** | **336,504** | **-8,223** | **-2.4%** |
| Chemotherapy Unbundled HRGs | 5,064 | 4,462 | 602 | 13.5% |
| Antenatal Pathways | 2,651 | 2,924 | -273 | -9.3% |
| Post-natal Pathways | 2,443 | 3,169 | -726 | -22.9% |
| A&E Attendances (excluding type 2's) | 79,687 | 77,584 | 2,103 | 2.7% |
| ITU Bed Days | 4,419 | 4,500 | -81 | -1.8% |
| SCBU Bed Days | 2,398 | 2,448 | -50 | -2.0% |
| Cardiology - Direct Access | 558 | 666 | -108 | -16.2% |
| Radiology - Direct Access | 42,036 | 41,425 | 611 | 1.5% |
| Pathology - Direct Access | 2,429,854 | 2,487,654 | -57,800 | -2.3% |
| Therapies - Direct Access | 28,755 | 30,301 | -1,546 | -5.1% |
| Audiology | 13,427 | 17,818 | -4,391 | -24.6% |
| Midwifery | 93 | 96 | -3 | -3.1% |

| £000s | 2014/15 YTD Actual | 2013/14 YTD Actual | Increase / Decrease Yr on Yr | % Increase / Decrease Yr on Yr |
|---|---|---|---|---|
| NHS Patient Income | 260,450 | 242,214 | 18,236 | 7.5% |
| Private Patient/ RTA | 2,554 | 2,007 | 547 | 27.3% |
| Trading Income | 3,922 | 3,394 | 528 | 15.6% |
| Other Non Clinical Income | 20,948 | 19,948 | 1,000 | 5.0% |
| **Total Income** | **287,874** | **267,563** | **20,311** | **7.6%** |
| Pay Costs | -183,783 | -191,521 | 7,738 | 4.0% |
| Non Pay Costs | -92,557 | -86,099 | -6,458 | -7.5% |
| Other | 1,650 | 1,188 | 462 | -38.9% |
| Total Direct Costs | -274,690 | -276,432 | 1,742 | 0.6% |
| **Surplus/-Deficit from Operations** | **13,184** | **-8,869** | **22,053** | **248.7%** |
| Profit/Loss on Asset Disposal | 23 | 0 | 23 | |
| Depreciation | -9,286 | -9,040 | -246 | -2.7% |
| Impairment | 0 | | 0 | |
| PDC Dividend | -5,962 | -4,367 | -1,595 | -36.5% |
| Interest | -120 | -232 | 112 | 48.3% |
| Total Indirect Costs | -15,345 | -13,639 | -1,706 | -12.5% |
| **Total Costs** | **-290,035** | **-290,071** | **36** | **0.0%** |
| **Net Surplus/-Deficit** | **-2,161** | **-22,508** | **20,347** | **90.4%** |
| Donated Asset / Other Adjustment | 377 | 198 | 179 | -90.4% |
| **Normalised Net Surplus/-Deficit** | **-1,784** | **-22,310** | **20,526** | **92.0%** |

# Capital Programme – December 2014

## Headlines

**Year to Date performance:-**

After nine months of the financial year capital expenditure has increased to £6.8m. Commitments entered into total £9.7m compared to the revised forecast total capital resource of £12.2m.

The Trust is currently waiting to hear whether the bid for additional resources to the Independent Trust Financing Facility (ITFF) have been successful. It is anticipated the outcome will be notified in January.

As a result the 2014/15 capital programme remains under severe pressure as demands for capital expenditure continue to far outstrip available resources. The over planning margin is currently £0.8m and in order to achieve a balanced position at 31st March 2015, demands for capital expenditure will have to be restricted to available resources and the impact on service delivery and quality will need to be carefully managed.

| Capital Investment Programme £000s | 2014/15 Capital Programme | Expenditure at Month 9 |
|---|---|---|
| **Capital Resources** | | |
| Depreciation | 11,285 | |
| Clinical Strategy exceptional additional PDC | 0 | |
| Additional Capital - Conquest Clinical Decision Unit | 400 | |
| Additional Capital Bid - Health Records Storage | 900 | |
| League of Friends Support | 1,300 | |
| Cap Investment Loan Principal Repayment | -340 | |
| Gross Capital Resource | 13,545 | |
| Less Donated Income | -1,300 | |
| **Capital Resource Limit (CRL)** | **12,245** | **-** |
| **Capital Investment** | | |
| Clinical Strategy Reconfiguration | 0 | 0 |
| Conquest Clinical Decision Unit | 400 | 291 |
| Health Records Storage - Funding not yet approved. | 900 | 0 |
| Clinical Strategy Essential Enabling Works | 250 | 262 |
| Medical Equipment | 2,814 | 1,465 |
| Information Systems | 823 | 383 |
| Electronic Document Management | 100 | 85 |
| Child Health Information System | 557 | 480 |
| Backlog Maintenance | 1,046 | 359 |
| Infrastructure Improvements - Infection Control | 630 | 419 |
| Electrical Supply to DGH | 540 | 0 |
| Minor Capital Schemes | 2,200 | 1,650 |
| Pevensey Ward | 710 | 249 |
| Other various | 1,076 | 480 |
| Brought Forward Schemes | 1,025 | 726 |
| **Sub Total** | **13,071** | **6,849** |
| Donated Asset Purchases | 1,300 | 546 |
| Donated Asset Funding | -1,300 | -546 |
| **Net Donated Assets** | **0** | 0 |
| **Sub Total Capital Schemes** | **13,071** | **6,849** |
| Overplanning Margin (-) Underplanning (+) | -826 | |
| **Net Capital Charge against the CRL** | **12,245** | **6,849** |

# Continuity of Service Risk Ratings – December 2014

## Headlines

**Continuity of Service Risk Ratings (COS):-**

- Liquidity (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital service capacity ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Monitor assigns ratings between 1 and 4 to each component of the continuity of service risk ratings with 1 being the worst rating and 4 the best. The overall rating is the average of the two.
- The Trust has a liquidity ratio of 8 days, a rating of 4.
- The capital servicing ratio of 1.76 results in a rating of 3.
- As a result the overall Trust rating is 4.

| Liquidity Ratio (days) £000s | 2013/14 Outturn | 2014/15 YTD |
|---|---|---|
| Opening Current Assets | 33,908 | 46,636 |
| Opening Current Liabilities | -34,506 | -31,852 |
| Net Current Assets/Liabilities | -598 | 14,784 |
| Inventories | -6,238 | -6,717 |
| **Adj Net Current Assets/Liabilities** | **-6,836** | **8,067** |
| | | |
| Divided by: | | |
| Total costs in year | 369,719 | 274,690 |
| | | |
| Multiply by (days) | 360 | 270 |
| **Liquidity Ratio** | **-7** | **8** |

| Capital Servicing Capacity (times) £000s | 2013/14 Outturn Actual | 2014/15 YTD Plan | 2014/15 YTD Actual |
|---|---|---|---|
| Net Surplus / Deficit (-) After Tax | -33,412 | -14,714 | -2,161 |
| Less: | | | |
| Donated Asset Income Adjustment | -999 | -975 | -631 |
| Interest Expense | 305 | 240 | 146 |
| Profit/Loss on Sale of Assets | -9 | 0 | -23 |
| Depreciation & Amortisation | 11,385 | 9,439 | 9,286 |
| Impairments | 10,018 | 0 | 0 |
| PDC Dividend | 6,251 | 6,201 | 5,962 |
| **Revenue Available for Debt Service** | **-6,461** | **191** | **12,579** |
| | | | |
| Interest Expense | 305 | 240 | 146 |
| PDC Dividend | 6,251 | 6,201 | 5,962 |
| Temporary PDC repayment | 29,000 | | |
| Working capital loan repayment | 1,334 | 861 | 837 |
| Capital loan repayment | 340 | 160 | 213 |
| | 37,230 | 7,462 | 7,158 |
| | | | |
| **Capital Serving Capacity** | **-0.17** | **0.03** | **1.76** |

# Financial Risks & Mitigating Actions – December 2014

| Summary | |
|---|---|
| **RISKS:-** | |
| The following areas of risk have been identified to achieving the projected year-end FOT | |
| 1) Application of fines and penalties and disputes. | |
| 2) Non-receipt of RTT and winter funds | |
| 3) Activity and capacity pressures. | |
| 4) Operational cost pressures. | |
| 5) Non delivery of CIPs . | |
| 6) Transition costs. | |
| 7) NHS England QIPP issued in year | |
| **MITIGATING ACTIONS:-** | |
| 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:** | 4th February 2015 |
| **Meeting:** | ESHT Trust Board |
| **Agenda item:** | 8 |
| **Subject:** | Nursing Establishment Review |
| **Reporting Officer:** | Alice Webster, Director of Nursing |

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

**Purpose:**

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

**Introduction:**

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

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

The methodology for undertaking the establishment review which included:

- Existing budgeted establishments
- Kingsgate Establishment calculator on which existing establishments were generated in 14/15
- Professional judgement including the use of patient experience feedback, quality and safety metrics that are monitored on a montghly basis throughout the year.
- Other factors that need to be considered when undertaking the review such as the increasing but intermittent requirement for 1:1 'specialling' of patients and care of patients requiring airway management in ward areas.
- Non clinical factors such as recruitment and retention, absence rates.

**Benefits:**

- The correct establishments are critical to providing safe patient care, reducing harm and poorer outcomes.
- The results of the review provide evidence that the nursing establishment, including Healthcare Assistants and Associate Practitioners meets the recommended levels, in line with the Safer Nursing Care Tool.
- There is no evidence that harm has been caused as a result of staffing levels.

---

**Risks and Implications**

- There are many other factors that influence the provision of appropriate staffing levels including difficulties in recruitment and sickness absence, high acuity patients requiring 1:1 supervision/care. The review does not incorporate these factors but the Trust does have an escalation policy to ensure that staff are able to seek support in managing these situations

safely.
- Any changes in service provision must include a nursing establishment review to ensure that safe levels are maintained.

| **Assurance Provided:** |
|---|
| The Trust has a budgeted nursing establishment to provide the correct level of staff, noting the risks detailed above. This has been demonstrated through a robust evaluation process that will be repeated in March 2015. |

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

| **Proposals and/or Recommendations** |
|---|
| ESHT Trust Board is asked to note and approve the budgeted establishment. |

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

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

# East Sussex Healthcare NHS Trust

# NURSE STAFFING LEVELS

## 1. Background

1.1 Following the initial nurse staff establishment review reported to the Trust Board in March 2014 the senior nursing team has undertaken the second, twice yearly review. This took place in December 2014, with the input of Ward Matrons, in all inpatient areas.

The review was planned to take place in October 2014 however it was postponed whilst awaiting the publication of an evidence based tool by the National institute for Clinical Excellence (NICE). NICE validated the Shelford Safer Nursing Care Tool (SNCT) and this was the used in the review alongside triangulation with:

- Existing budgeted establishments
- Kingsgate Establishment calculator on which existing establishments were generated in 14/15
- Patient experience feedback, quality and safety metrics
- Professional judgement.

1.2 A number of areas have independent tools for reviewing the nursing and midwifery establishment and were not included in this exercise. The 'out of scope' areas are:

- Accident &Emergency /Clinical Decision Units – NICE guidance will be published in 2015
- Kipling/Paediatric Assessment Unit – Agreed within the temporary reconfiguration of maternity and paediatric services
- Intensive Care - Established within National Guidance
- Theatres – Established within National Guidance
- Judy Beard/Pevensey Day Unit
- Maternity – operate under Birthrate plus but NICE Guidance will be published in 2015
- Outpatients

1.3 It is recognised that the SNCT tool is not designed for use in Assessment Units or Community Hospitals and can be influenced by other factors, hence the need to triangulate with other indicators of staffing levels.

1.4 Currently NICE are consulting on draft recommendations which set out the responsibilities of senior nurses and hospital managers, and the actions organisations can take, to ensure there are enough registered nurses and non-registered nursing staff to provide safe care at all times to patients attending A&E. This includes making sure that the department has the capacity to provide all necessary emergency care, as well as specialist input for children, older people or those with mental health needs.

The draft guideline includes recommendations for minimum ratios which can be considered by organisations. Planned publication of the full guidance is May 2015.

## 2. Methodology

2.1 All Ward Matrons and Heads of Nursing were advised of the plan to undertake data collection, using the SNCT. In ideal circumstances the data collection takes place for 4 weeks (Mon – Friday only). The SNCT records the acuity of patients, staffing levels and other influencing factors e.g. Number of admissions/discharges.

Due to the potential impact of the Christmas period it was agreed that data collection would occur for a period of 2 weeks with the intention of adopting the recommended months of March and October in the coming year.

2.2 Guidance was issued on the use of the SNCT and an electronic data collection tool was developed. This tool also enabled the calculation of suggested whole time equivalent levels, based on the SNCT.

2.3 A 'validation' team was established from the senior nursing team to review data entry, ensure consistent application of the SNCT and monitor the output.

2.4 Each area also recalculated the Kingsgate model, based on the current ward configuration, recognising some of the changes in models of care and specialty of wards since the prior review took place.

2.5 Following completion of the data collection a spreadsheet was developed to compare the results of the SNCT and Kingsgate model with the existing establishment for each area. These findings were discussed at a professional review meeting and proposals were put forward for the establishment for each area. There were a number of factors considered in this meeting such as the quality performance of each area, specialist requirements and the number of patient requiring 1:1 care for a variety of reasons.

2.6 Where the SNCT tool was not used the Kingsgate and professional judgement were used to form a proposed establishment.

2.7 All establishments were considered with a consistent approach to uplift in line with current Trust policy:

50% supervisory time for Ward matrons

18 % uplift for annual leave, training and absence

In addition a 3% uplift fund is held centrally for exceptional circumstances e.g. Maternity leave or long-term absence as this cannot be consistently applied across all areas

## 3. Findings/Recommendations

3.1 The results of this exercise are available in Appendix 1 and should be considered with the notes detailed at the bottom of the spread sheet, for example:

Hailsham 3/4 are under review as the need for inpatient beds is decreasing as day surgery rates increase.
MAU/AAU/SAU not able to use same formula as not within criteria for SNCT audit
Number of ward changes in 14/15, closure of Folkington but uplift to SF3 not finalised

3.2 Overall the existing nurse establishment in the areas included is sufficient to provide safe care to our patients.[1]

3.3 There are a small number of areas where the SNCT suggests a much higher level of staffing e.g. Berwick Ward. This was considered in the review process and in the majority of case this was accounted for due to high levels of 1:1 specialling/ change of specialty due to winter pressures, altering the acuity. In one area, MacDonald Ward it was identified that the tool may not be entirely suitable.

3.3 It is recognised that the agreed establishment does not reflect the entire requirement for nurse staffing levels that occur during periods of high activity or special requirements such as 1:1 care for airway management of personal safety. As a result there is a Safe Staffing escalation policy that is used on a daily basis within the Trust and two separate programmes of work are underway to review how these additional staffing requirements could be addressed.

3.3 This review will inform budget setting for 2015/16. There is however further work required to consider the current distribution of resources and the skill mix within each area. This will happen within the Clinical Unit.

3.4 Using the models available and the professional judgement a further:-

5.82 wte Unregistered nurses are required

11.21wte Registered nurse increase

14.95wte Workforce reviews are taking place led by the Clinical Units

## 4. Conclusions

The triangulation of the information and evidence, alongside professional scrutiny and organisational knowledge provides a strong indication of the required establishment and skill mix in all adult inpatient areas

[1] The models used imply levels of staffing on the wards at full establishment.

This paper details a robust method of determining the required establishment for each area and allows consideration of all key factors, with the exception of 1:1 specialling and airway management, which are subject to separate review and proposals.

This exercise will be repeated in March 2015 and the will extend to include Accident & Emergency Units and Outpatient departments. In addition to this exercise it will be necessary to consider the guidance recently published by the Chief Nursing Officer for England “Safer Staffing: A Guide to Care Contact Time”.

## 5. Recommendations

The board is asked to note the variances between the models used

The findings from the work with surgery will be picked up through the Clinical Unit reviews

Work will be completed regarding the ‘special 1-2-1 requirements’ of our patients

The Board is asked to approve the existing establishments detailed in Appendix 1to support safe and effective care of inpatients within the Trust.

Dec-14

| Ward/Area | Beds | SNCT Average WTE | Kingsgate 12/2014 WTE | Professional Judgement/ View | Difference Prof judgement, actual budget 14/15 | Comments/Notes |
|---|---|---|---|---|---|---|
| Baird MAU | 28.00 | 37.78 | 43.32 | 39.09 | 0.00 | 4.23 tracheostomy special 24/7 not included due to separate review |
| Benson Trauma | 28.00 | 38.76 | 34.42 | 34.42 | -1.00 | |
| Egerton Trauma | 28.00 | 33.04 | 34.42 | 34.42 | -0.72 | |
| Berwick | 28 | 43.51 | 33.25 | 32.02 | 0.00 | Folkington closure impacted -increased specialing (also impacted on SCNCT audit ). Recommendation current establishment correct with small uplift (1.23 WTE) to support additional specialing demands. |
| Cookson Attenborough Surgical Short Stay | 12 | 16.58 | 12.88 | 14.68 | 0.00 | Used as escalation area |
| Cookson Devas Elective | 21 | 17.82 | 24.25 | 24.25 | 0.00 | Establishment required to maintain high activity, turnover and variation in bed numbers up to 25 |
| Crowborough Intermediate Care Beds | 18 | 17.44 | 18.13 | 18.14 | 0.00 | Recorded 6 level 3 patients, removed from data |
| Cuckmere | 21.00 | 27.64 | 35.77 | 30.24 | 0.00 | An additional 5.53 for 24/7 cohort not included due to separate review |
| De Cham | 28.00 | 39.37 | 34.17 | 34.17 | -1.65 | ***Seeing patients with higher acuity. Likely to skill mix to introduce B4 role |
| Gardner | 28.00 | 37.17 | 34.17 | 34.17 | -1.65 | ***As above, likely to skill mix within current establishment |
| EDGH CCU | 11.00 | 14.84 | 28.93 | 28.93 | -1.80 | SNCT does not reflect Cardiac lab staff- 10 WTE allocation for Cardiac Lab |
| Hailsham 3 | 17.00 | 20.08 | 21.73 | 22.19 | 0.00 | |
| Hailsham 4 | 28 | 41.40 | 36.13 | 36.13 | -4.62 | **EPAC included in establishment. Experienced significant medical outliers during SNCT audit. Additional WTE recommended to cover weekend working that was not factored into original budget. |
| Irvine Generic | 21 | 27.63 | 25.69 | 26.07 | 0.00 | |
| Irvine Stroke | 21 | 27.07 | 25.69 | 26.07 | 0.00 | |
| James/CCU | 22.00 | 30.16 | 30.73 | 30.73 | -1.98 | Require additional 13.5 hours per week for cardioversion. |
| Jevington | 27.00 | 42.93 | 40.08 | 38.23 | 0.00 | |
| Lewes Intermediate Care | #REF! | 37.17 | 35.77 | 35.77 | 0.00 | |
| | | | | | 0.00 | |
| MacDonald Complex Elderly | 28 | 53.36 | 38.28 | 38.28 | -2.52 | ***Ward manages complex elderly (HCA addition rather than trained) |
| Mirrlees | 8 | 7.35 | 14.53 | 14.77 | 0.00 | |
| Newington | 28 | 56.36 | 38.28 | 38.28 | -3.77 | |
| Pevensey Unit | 17 | 18.26 | 18.59 | 19.21 | 0.00 | |
| Rye Intermediate Care Beds | 15 | 17.98 | 18.13 | 18.90 | 0.00 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Seaford 3 MSSU/Frailty | 22 | 40.21 | 38.28 | 38.28 | -6.63 | **New ward, Budget for 22 beds but 28 open model based on 28 |
| Seaford 4 - Urology | 27 | 33.28 | 36.67 | 36.89 | 0.00 | Assessment Unit not included in establishment. No change to establishment recommended. |
| Sovereign Ward | 32 | 53.56 | 55.92 | 55.92 | -3.24 | **32 bed establishment., operating at 38/high levels of specialing. Recommendation - internal skill mix change required - 4.0 WTE B6 to account for acuity of patients and ward layout. |
| Uckfield Harlands Intermediate Care Medical | 14 | 16.39 | 18.13 | 18.14 | 0.00 | |
| Wellington | 20 | 31.09 | 35.77 | 32.15 | 0.00 | Increase in establishment requested to cover cohorting, specials and bariatric to account for change in specialty to Gastroenterology. (Equivalent ward to Cuckmere) |
| **Sub Total** | **598** | **878.20** | **862.11** | **850.54** | **-29.58** | |
| Firwood Trained | 21.00 | | 8.06 | 8.06 | -1.94 | |
| MAU EDGH | 31.00 | | 48.36 | 48.36 | | |
| AAU Conquest | 21.00 | | 40.80 | 40.80 | | |
| SAU | 26 | | 38.28 | 38.28 | -0.46 | |
| **Total** | **619** | **878.20** | **997.61** | **986.04** | **-31.98** | |

**NOTES**

The SNCT audit was undertaen for 2 weeks not the recommended 4
Firwood not able to use same formula due to shared staffing with ASC
MAU/AAU/SAU not able to use same formula as not within criteria for SNCT audit
Number of ward changes in 14/15, closure of Folkington but uplift to SF3 not finalised
Hailsham 3/4 are under review as the need for inpatient beds is decreasing as day surgery rates increase therefore the increase has been removed fom the tota
There are a number of areas that reported a high wte within the SNCT - consideration was given to other influencing factors during this period

** area under review currently and the CU
working with the changes to bed numberrs
*** Unregistered workforce increase requested

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 9 |
| **Subject:** | Patient Experience Report – Quarter 3 |
| **Reporting Officer:** | Alice Webster, Director of Nursing |

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

**Purpose:**

The purpose of this paper is to provide the Board with information about patient experience within Quarter 3 of this year.

## Introduction:

Patient Experience provides feedback from patients and the public on their experience of the Trust.
The information in this paper outlines our position in Q3 in the following areas:

- Friends and Family Test;
- NHS Choices;
- PALS;
- Complaints

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

**Friends and Family Test (FFT)**

The overall satisfaction score of all patients surveyed during Q3 2014/15 is that 89.2% of all patients who used our services were satisfied (11782 responses). This is a very slight decrease in both the satisfaction score (from 89.4% in Q2) and the number of responders (from 12594) in Q2.

FFT has now been fully implemented within Maternity services. The overall satisfaction score of all maternity patients surveyed during Q3 2014/15 demonstrated that 87.18% of all women who used our services were satisfied (211 responses). This has increased very slightly from Q2 from 86%. Response rates do fluctuate according to the birth rate.

**Trust Improvement Indicators**

This data is collected from a variety of sources i.e. patient comment cards and further questions relevant to the ward areas (i.e. around food and noise on the ward) asked through FFT. The attached paper demonstrates little change in patient responses across the months from April.

**Ward feedback**

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

**NHS choices**

NHS choices is a website where Service users can post comments about their experiences of

using NHS services. A rating system of 1-5 is used. Whist there are some excellent examples of positive patient comments the rating system demonstrates significant room for improvement in particular around the booking system; communication and staff attitude.
A total of 31 narratives regarding ESHT services were posted on the NHS Choices website during Q3 – 21 of which gave three stars or above with positive comments and 10 comments gave three stars or below with negative comments.

**PALS**
Despite the increase in demand, PALS are continuing to provide a rapid access point of contact for patient's and the public with 84% of concerns being responded to within 2 working days. The response rate has declined from 94% in Q2 but remains higher than the 74% response rate in Q1.

**Complaints**
The number of overdue complaints has remained the same during Q3. Overdue complaints rose from 83 at the end of Q2 to 85 at the end of Q3. 67% of complaints were responded to within timescale. Compliance rose from 71% in October to 75% in December. The overall compliance was 87% for 2013/14.
The top 5 complaint themes remain unchanged from the previous two quarters and are – total care, attitude, communication, services total and patient pathway.

## Benefits:

The attached report demonstrates a number of ways in which the service has listened to patient concerns and made changes to improve. The "You said; We did' initiative on the wards shows that positive actions are taken having listen to patients and relatives. Changes have also been made following the receipt of formal patient complaints.

## Risks and Implications

It has been noted that during Q3 some of the "You Said, We Did" boards were not updated or displayed positive comments and no actions to improve the area according to patient feedback. Patient Experience Champions support this process and have been made aware of this, a reminder has also been sent to Ward Matrons to remind them of the use of Meridian.

The Quarter 1 and 2 reports highlighted a concern in a rise in the number of overdue complaints; unfortunately this has not improved in Quarter 3. This trend needs to be addressed and the number of complaints answered within the set time frame needs to improve significantly.

## Assurance Provided:

Overall the Trust is able to demonstrate a number of positive initiatives that are in place and working very well. Engagement with patients has led to improvements in systems and care delivery.

## Board Assurance Framework (please tick)

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

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

Some of this data has been received and reviewed by the Quality and Standards Committee at its meeting on 13th January 2015.

| **Proposals and/or Recommendations** |
|---|
| The report makes a number of recommendations for action:<br><br>Consider innovative forms of submission options of FFT, to improve our response rate - research what other Trusts use.<br><br>NHS Choices - continue to respond to comments and share practice amongst patient experience champions. Improve the rating scores and positive feedback from patients.<br><br>Continue to work towards the Trust commitments set out in the Patient Experience Strategy - re-establish the Patient Experience Steering group.<br><br>Responding to patient complaints - significantly improve on the number of out of time complaints<br><br>"One Click" is the forum in which GPs and CCG colleagues can raise issues regarding ESHT - formalise how ESHT manages and responds to these enquiries from Primary Care via CCG.<br><br>Healthwatch- feedback centre. The feedback centre is an online tool for patients to feedback their experience with local healthcare providers (similar to NHS Choices) - consider how ESHT will respond and ensure we are not collating duplicate information.<br><br>Recording of compliments - define what a compliment is and establish a recording and monitoring method.<br><br>PROMS - Patient Reported Outcome Measures - PROMS to become part of the Patient Experience Reporting to 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:** | **Contact details:** |
| Lindsey Stevens, Deputy Director of Nursing and Midwifery<br>Alice Webster, Director of Nursing | lindseystevens@nhs.net<br><br>alice.webster@nhs.net |

East Sussex Healthcare NHS Trust

# Patient Experience Report

## Quarter 3

## 1.0 Introduction

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

The information in this paper outlines the Trusts position in Quarter 3 (Q3) in the following areas:

- Friends and Family Test (FFT)
- NHS Choices
- PALS
- Complaints
- Action Plan
- Analysis and Conclusion

## 2.0 Friends and Family Test (FFT) Patient feedback

2.1 This is a simple question "How likely are you to recommend us". This provides a benchmark figure; the Net Promoter Score (NPS). The NPS is calculated between -100 and +100. The NPS for ESHT in Quarter 2 was 58. The NPS for Q3 is also 58.

2.2 The table below shows the total number of responses received for each department (as broken down by two A&E departments, Inpatient areas, Maternity and Trust), the total number of people eligible to respond from these areas and the percentage response rate. Maternity received the highest response rate at 70.70% with the Eastbourne A&E response rate being the lowest at 18.59%

| Q3 | Total number of responses for each department | Total number of people eligible to respond | Response rate for each department |
|---|---|---|---|
| **Conquest Hospital A&E** | 1486 | 7493 | 19.83% |
| **Eastbourne Hospital A&E** | 1421 | 7642 | 18.59% |
| **ESHT A&E total** | 2907 | 15135 | 19.21% |
| **ESHT Inpatient** | 2190 | 4347 | 50.38% |
| **Maternity** | 584 | 826 | 70.70% |

2.3 Inpatient areas achieved an overall satisfaction rating of **89.14%** (based on 2449 responses in Q3) compared to 89.5% in Q2 (based on 2770 responses) which is a very slight drop (of 0.36%).

2.4 The Emergency departments achieved an overall satisfaction rating of **83.28%** (based on 3469 responses in Q3) compared to 86.7% in Q2 (based on 2857 responses) which is a slight drop (of 3.42%).

2.5 The Labour and Birth departments achieved an overall satisfaction rating of **87.18%** (based on 211 responses in Q3) compared to 86% in Q2 (based on 460 responses) which is a slight increase (of 1.18%)

2.6 The dial below shows the overall satisfaction score of all patients surveyed during Q3 2014/15. This demonstrates that **89.2%** of all patients who used the Trusts services were satisfied (11782 responses). This has decreased slightly from Q2 (which had an overall satisfaction score of 89.4%), as has the number of responders (12594).


## 2.7 Sample Patient Feedback from Family and Friends Free Text

Toilets need to be checked more often, as they were in a bad state.

All the staff are wonderful, caring, kind, super-professional but overworked due to staff shortages.

The queuing in the main entrance for 20 minutes has made many people late for appointments and causes obstruction of main doors as ticket machine is also by the doors. This is the most ridiculous system I have ever seen in a hospital.

Very compassionate without being patronising. Enjoyed talking to staff and even though I was tucked out the way in a side room they always popped in to check on me and have a chat which made me feel at ease.

Great day care but night care not great (I understand this may have been due to staff shortages - which staff spoke about in front of patients). Staff don't appear to have time to complete their work/look after patients. Much talk about nurses leaving the profession and not being replaced.

Car park should be free at night since buses don't run that late. Called 111 first. Very bad. If the NHS is going to employ foreign nationals please, please ensure that their accents can be understood and they can understand ours especially over the phone (could be part of their recruitment procedure).

## 2.8 Trust Improvement Indicators

The Trust Improvement Indicator responses (weighted scores) are collected from a variety of sources i.e. patient comment cards and further questions relevant to the ward areas (i.e. around food and noise on the ward) asked through FFT. The table below demonstrates little change in patient responses across the months from April.

| Indicator | ESHT commitment | Apr | May | Jun | July | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|
| We will make sure you have the support and advice you need before being discharged from our care | 3 | 87 | 84 | 86 | 86 | 84 | 87 | 85 | 84 | 89 |
| We will give you clear high quality information about your condition, treatment and our services | 3 | 91 | 89 | 90 | 91 | 90 | 92 | 91 | 92 | 89 |
| We will treat you as an individual, listen to your views and respect your privacy and dignity | 2 | 95 | 94 | 93 | 94 | 95 | 95 | 95 | 93 | 94 |
| We will provide you with nutritious and appetising food, with as much support as you need, whilst in our care | 3 | 78 | 77 | 79 | 78 | 79 | 82 | 80 | 81 | 82 |
| Whilst you are an inpatient we will keep noise from staff at night to a minimum so that you can get the rest you need | 2 | 82 | 79 | 79 | 80 | 83 | 82 | 83 | 77 | 86 |
| Overall patient experience satisfaction | 1 | 89 | 88 | 88 | 89 | 89 | 90 | 89 | 88 | 89 |
| Responses | | 674 | 854 | 882 | 993 | 908 | 867 | 846 | 796 | 800 |

## 2.9 Ward feedback

As part of the FFT programme, the Trust has developed 'You said, We did' Boards. Ward Matrons can access the free text feedback from the Meridian system to populate these Boards. The following tables provide some extracts of these Boards taken from December 2014:

### Pevensey Ward

| You said | We did |
|---|---|
| There are not enough toilets to be used for patients on the ward and Day Unit. The food or meals could be served hotter with more choices. To dim the corridor lights at night | We have moved the Day Unit to another ward which now has more toilets. This has also made extra toilets for use on the ward. We have introduced a new lunch and supper menu and the food is steamed on the ward. We dim the light at night as soon as we can. |

### Cuckmere Ward

| You said | We Did |
|---|---|
| Food was not as good as expected. | Work closely with the kitchen and housekeeping staff, to ensure difficulties are rectified quickly. |

### Frank Shaw

| You said | We did |
|---|---|
| Patients requested that partners can stay overnight so they can offer support to both mother and baby | A contract, which outlines safety and security for both mother and baby, has been created and implemented, offering open visiting hours for parents. |

### Sexual Health Department - Eastbourne

| You said | We did |
|---|---|
| Patients requested other means of media in the waiting area for times when there was an extended wait | We purchased a television for the waiting room |

## 3.0 NHS Choices

3.1 NHS choices is a website where service users can post comments about their experiences of using NHS services.

There is also a facility for service users to give the service commented on a star rating from 1 to 5 stars with 1 being a poor rating to 5 being excellent.
The current overall rating for ESHT services is as follows (Conquest and Eastbourne Hospitals):

3.2 A total of 31 narratives were posted on NHS choices during Quarter 3, this is a reduction in posts compared to 35 in Q2. Of the 31 narratives posted 21 comments gave three stars or above with positive comments and 10 comments gave three stars or below with negative comments. Some examples of the comments received and the feedback provided are shown below.

3.3 The following table shows the themes from the 31 narratives received in Q3:

| **For excellent ratings**: | **For low ratings** |
|---|---|
| Staff kindness, efficiency and caring attitude.<br><br>Good communication.<br><br>Many staff praised for their standards of care. | Administration organisation and appointment delays<br><br>Staff attitude.<br><br>Communication.<br><br>Staffing levels (nursing and medical) |

3.4 The Trust regards NHS choices as a rich source of feedback information that helps to monitor the quality of our services. Compliments, comments, and concerns have been raised during Q3 via NHS Choices, this route of patient feedback allows the Trust to comment, thank and sign post our service users.

3.5 The information is disseminated to all staff through the Patient Experience Champions and a monthly report is sent out to all department and ward managers.

3.6 A learning exercise has been developed to focus Patient Champions on how to share and use this information to make improvements or share good practice. At future Patient Experience Champion meetings there will be a discussion about how this information from NHS Choices is influencing and changing practice.

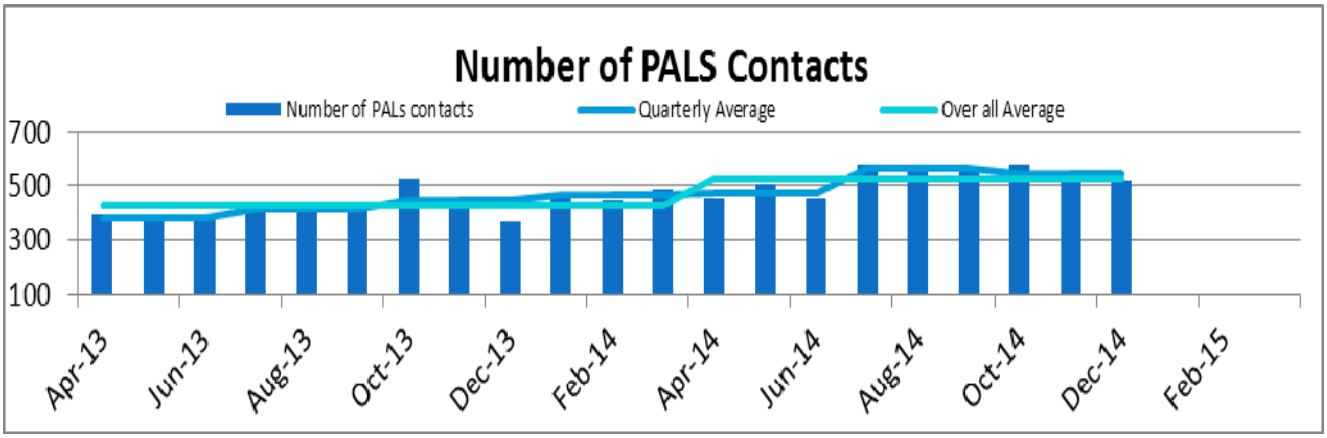
***Examples of comments received and responses provided***

| **Comments received** | **Our replies** |
|---|---|
| I recently attended the Cath Lab for an Angiogram from first entering the department to leaving I was treated with respect (almost as if I was the only patient). All members of staff introduced themselves on first meeting and more importantly they subsequently did not forget who I was. It seemed as though nothing was too much trouble all aspects of the process and procedure were explained and all questions were answered directly and honestly. During the actual procedure all staff in the treatment room were calm and confident this in turn meant that I felt reassured and at no time did I feel anything other than total confidence in the team conducting the procedure.<br>Soon after the procedure I was given the results and recommendations for future treatment, again all questions were answered and advice given.<br>If I have anything to add to this it is to trust the team put yourselves in their hands sit back read a book before and after the procedure and relax. | Thank you for letting us know about your positive experience of the Cath Lab at the Conquest Hospital. Staff work very hard to provide a high quality service and standard of care and your posting clearly reflects this. We shall be pleased to share your comments with the staff concerned as it's always encouraging to receive such feedback.<br><br>May we also bring to your attention, East Sussex Healthwatch who are also interested to hear from service users about their experiences. East Sussex Healthwatch are your independent consumer champion for health and social care. Their role is to make sure your views and feedback are heard and affect the decisions made by the people who deliver your services. |

| | |
|---|---|
| All staff in the cardiology department have my personal thanks and admiration for a job very well done. | |
| Turned up for my 9year old daughters appointment and was told orthodontist was ill. When I rang the orthodontic department when home was told they rang my daughters' mother who is a teacher so doesn't have her phone on while teaching, but is not a policy to ring the father even though they had my number. It taken 3months to get this appointment and pulled my daughter out of school for the afternoon. Is this how to treat a 9 year old girl who as any parent will no is a big deal and was very upset. Awful communication. Just hope the treatment is better than trained than the reception staff. | We apologise that you arrived for an Orthodontic appointment with your 9 year old daughter only to find that it had been cancelled due to sickness. The Outpatient Reception Manager has confirmed that we do endeavour to make contact with a parent (or carer) by telephone when a clinic is cancelled at very short notice, due to circumstances beyond our control. However, we would be very happy to look into why this did not happen in your daughter's case. In order for us to do this, we would require some further information from you. If you would like to provide further information, please contact our Patient Advice & Liaison Service (PALS) on 01424 758090 or by email at: PALSH@esht.nhs.uk.<br><br>Please accept our sincere apologies for the inconvenience you suffered and for your daughter's distress. |
| My wife had a cataract removal this week and the care of nursing staff and specialist was exceptional. The treatment we feel was first class and easily the same as any private treatment my wife has had in the past. Thank you to everyone involved. The wait for an appointment from a sight test to the operation was less than two months and could not have been quicker. | Thank you for letting us know about your wife's experience of cataract surgery at Eastbourne DGH. The staff will be very pleased to receive your feedback as they are committed to ensuring all patients receive a high standard of care and service. Positive feedback such as yours is testament to this. We send our best wishes to you and your wife and hope that she is recovering well from her surgery. |

## 4.0 Patient Advice and Liaison Service (PALS) Summary

4.1 The graph below shows the number of PALs contacts by month since April 2013.



4.2 PALS are continuing to provide a rapid access point of contact for patient's and the public with 84% of concerns being responded to within 2 working days. The response rate has declined from 94% in Q2.

4.3 Only 3% of PALS contacts went on to be investigated by the Complaints Team.

4.4 The Q3 PALS contacts have the following outcomes recorded on Datix:

84% were completed with no further action

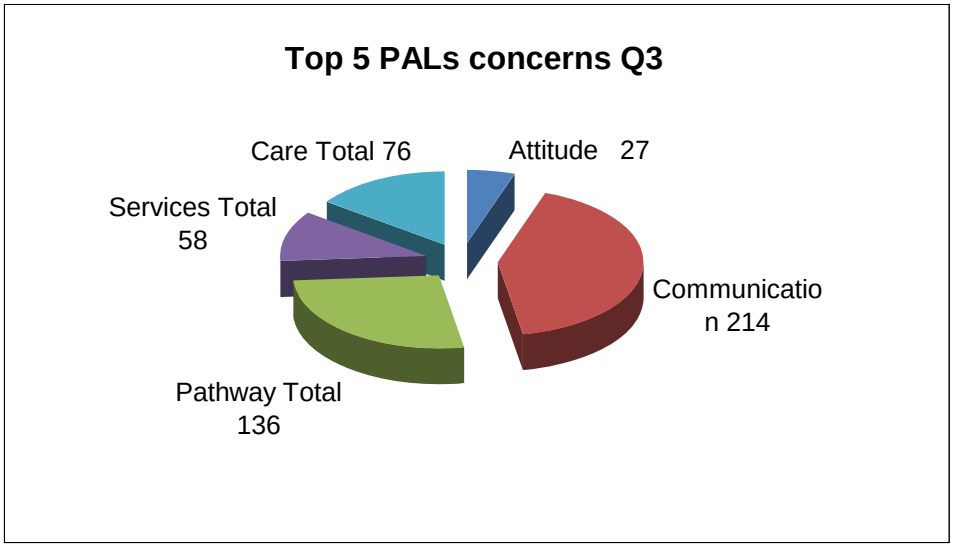
15% were provided with information

1% had lost contact with PALS

0% was referred to another agency

4.5 A pilot into how SEAP (Support, Empower, Advocate Promote: independent service which helps service users to pursue complaints within the NHS) could support ESHT PALS services was commenced during Q3. A SEAP advisor attended Conquest PALS for a session following which a report has been provided. The Patient Experience Manager will work with SEAP and PALS to take this piece of work forward.

4.6 The table below shows the breakdown of PALS concerns by category as recorded on Datix. The number of concerns handled by PALS decreased this quarter from 748 (Q2) to 660 (Q3). Surgery Clinical Unit have had the highest number of concerns, these being predominantly concerned with Communication, particularly the inability of patients to contact the department they wanted to speak to, closely followed by appointment issues across the organisation.



## 5.0 Complaints Summary

5.1 In Q3 the Trust received 189 complaints compared to 173 complaints in Q2 as shown in the following table:


5.2 The number of overdue complaints has remained the same during Q3. Overdue complaints rose from 83 at the end of Q2 to 85 at the end of Q3. 67% of complaints were responded to within timescale. Compliance rose from 71% in October to 75% in December. The overall compliance was 87% for 2013/14.

5.3 The following chart shows the top 5 themes of the complaints received in Q3 as recorded on Datix.


5.4 The number of complaints closed during Q3 was 124. 41.5% of Formal Non Complex complaints have taken longer than 25 days to close and 36% of Formal Complex complaints have taken longer than 45 days to close.

5.5 Extract of Outcomes for Complaints Received October 2014-December 2014:

| You said… | We did … |
|---|---|
| Why when I presented to the Emergency Department eight days after an operation having chest pains and poor breathing why was I not investigated for blood clots? | We apologised and assured that doctor will be given additional training by the consultant and development training is in place for him. |
| Care and aftercare provided to my friend by Kent Stroke Team was far more superior to the care I received by ESHT. | We have reviewed your care and wish to assure you that you received appropriate follow up care after your stroke. However we have made recent changes to the stroke service and this is now on one site which we hope will provide a more patient focused service. |

## 6.0 Recommendations and Actions from the Report

| Activity | Action | Timescale |
|---|---|---|
| Consider innovative forms of submission options of FFT, to improve our response rate. | Research what other Trusts use. | April 2015. |
| NHS Choices. | Continue to respond to comments and share practice amongst patient experience champions.<br>Improve the rating scores and positive feedback from patients. | Review March 2015 |
| Continue to work towards the Trust commitments set out in the Patient Experience Strategy. | Re-establish the Patient Experience Steering group. | PESG to re-commence March2015. The January meeting was cancelled due to “black status”. |
| Responding to patient complaints. | Significantly improve on the number of out of time complaints. | March 2015 |
| “One Click” is the forum in which GPs and CCG colleagues can raise issues regarding ESHT | To formalise how ESHT manages and responds to these enquiries from Primary Care via CCG. | March 2015 |
| Healthwatch- feedback centre. The feedback centre is an online tool for patients to feedback their experience with local healthcare providers (similar to NHS Choices). | Consider how ESHT will respond and ensure we are not collating duplicate information. | April 2015 |
| Recording of compliments | Define what a compliment is and establish a recording and monitoring method. | March 2015 |
| PROMS- Patient Reported Outcome Measures | PROMS to become part of the Patient Experience Reporting to Quality and Standards Committee. | March 2015 |

## 7.0 Analysis and conclusion

7.1 Patient pathway continues to be amongst the top five categories for both PALS and Complaints, further analysis is to be undertaken and actions to be set and reviewed. We may need to consider a specific survey relating to patient pathway to identify specific areas of improvement. Healthwatch have indicated they wish to undertake a "winter discharge survey" using a similar methodology as the survey they completed in the summer.

7.2 Again communication issues remain within the top five themes, some of the pathway issues may have been a result of communication however this needs a greater understanding before a conclusion is reached and action taken.

7.3 Triangulation at a team level consists of each department, service and ward regularly reviewing their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments. It has been noted that during Q3 some of the "You Said, We Did" boards were not updated or displayed positive comments and no actions to improve the area according to patient feedback.

7.4 Patient Experience Champions support this process and have been made aware of this, a reminder has also been sent to Ward Matrons to remind them of the use of Meridian.

7.5 Patient Experience Champions will be invited to the Patient Experience Steering group where this information will be analysed and shared amongst the group. The Patient Experience Steering Group will underpin the Strategy and will be evidencing how we are working towards the commitments set out in the policy. All Information is triangulated and reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing.

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

7.7 A further meeting with SEAP has been planned to consider how they can support PALs with those patients who may require advocacy, but as already highlighted in the report produced by SEAP we have a positive history of working closely with SEAP and referring patients appropriately.

Patient Experience Manager
January 2015

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 10 |
| **Subject:** | Quality, Safety and Performance |
| **Reporting Officer:** | Dr Hughes |

| **Action:** This paper is for **(please tick)** | | | | | |
|---|---|---|---|---|---|
| **Assurance** | X | **Approval** | | **Decision** | |
| **Purpose:** | | | | | |
| Update Trust Board on performance and R&D 5 year strategy outcomes to date. | | | | | |

| **Introduction:** |
|---|
| Participating in clinical research is in the interests of ESHT, and we have an obligation to contribute. (NHS Constitution 2009) |

| **Analysis of Key Issues and Discussion Points Raised by the Report:** |
|---|
| • Awaiting Q3 performance outcomes from KSS CRN<br>• The R&D 5 year strategy was approved by Trust Board in September and this report seeks to update re the completed strategy outcomes.<br>• This report also seeks to inform the Trust Board where potential risks are evident in relation to strategy outcomes. |

| **Benefits:** |
|---|
| High quality research is fundamental to our interests as an NHS care organisation. We have a duty to contribute.<br>Our patients, staff and trainees should be given every opportunity to participate wherever possible. This reflects our core values and is an aim of the National Institute for Health Research (NIHR) |

| **Risks and Implications** |
|---|
| Funding for research activity via NIHR is dependent on patient recruitment to research studies. If recruitment target is not met, this risks funding. |

| **Assurance Provided:** |
|---|
| Commencement of work streams to actively seek success within R&D performance and ESHT 5 year R&D strategy. |

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

| **Review by other Committees/Groups** (please state name and date)**:** |
|---|
| R&D Operational Working Group |

| **Proposals and/or Recommendations** |
|---|
| Key objectives within the strategy require high level, Trust board support to enable success. |

| **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 risks to EHRIA envisaged. Adherence to Trust requirements. |

| **For further information or for any enquiries relating to this report please contact:** | |
|---|---|
| **Name:**<br>Liz Still – R&D Manager | **Contact details:**<br>Liz.Still@esht.nhs.uk<br>01323 413880 |

# East Sussex Healthcare NHS Trust

## Research and Development - update

1. **Introduction**

1.1 Participating in clinical research is in the interests of ESHT, and we have an obligation to contribute. (NHS Constitution 2009)

2. **Background**

2.1 R&D 5 year strategy was approved at September 2014 Trust Board meeting.

2.2 Performance in initiating and delivering clinical research – submission to NIHR and publication on a publicly accessible part of the Trust website

2.3 ESHT Operational Capability Statement – required publication on NIHR website

3. **Main content of the report**

3.1 R&D 5 year strategy was approved at September 2014 Trust Board meeting.

3.1.1 A statement will be added to all Trust letters stating the trust is a research active organisation and to ask about studies they may wish to participate in. - incomplete

3.1.2 A statement regarding commitment to research will be in all staff job descriptions.

3.1.2.1 Awaiting confirmation of completion from Director(s) of Nursing and Human Resources - Incomplete

3.1.3 Ensure appropriate and effective allocation of Supportive Professional Activity (SPA) linked to specific research activity through job planning.

3.1.3.1 Potential risk to recruitment and research participation if job planning does not include appropriate research activity SPA or withdraws them from research active clinicians.

3.1.4 The R&D Steering Group will hold an annual research meeting – booked 20th March 2015. Applications for poster and oral presentations have been received as well as applications to attend. This has been extended to other Sussex Trusts. (Appendix 1)

3.1.5 The R&D group will have established a regular section in Connect within 12 months of the strategy being adopted. – Complete

3.2 Performance in initiating and delivering clinical research – Contract signed between ESHT and NIHR - Complete

3.2.1 First submission of required ESHT data was uploaded to NIHR by required target date - Complete

3.2.2 Links to ESHT data on publicly accessible part of the Trust website went live on 4/11/14. http://www.esht.nhs.uk/research-and-development/ and http://www.esht.nhs.uk/research-and-development/performance/ - Complete

3.3 ESHT Operational Capability Statement – publication on NIHR website - Complete

## 4. Conclusion/Recommendation

4.1 Positive outcomes have been achieved as indicated in the report. There are also several work streams which have commenced and are moving towards positive outcome.

4.2 R&D Manager has met with Director of Nursing and Medical Director responsible for governance and discussed the key objectives within the strategy which require high level, Trust board support to enable success. They include the following:

- Create effective and clearly defined lines of accountability to the Trust Board for research; its management, governance, delivery and performance -Complete
- Create accountability for the strategy within Clinical Units, departments and across professional groups; performance managing their commitment to research with appropriate SPA allocation
- Embed key research staff (eg Research Champions) as integral elements of Clinical Units, resulting in a seamless, transparent and productive integration of research and clinical delivery of services.

4.3 To underpin performance management and required collaborations with NIHR, ESHT needs adequate access to NIHR IT system requirements which is not currently available within the Trust.

**Name of Author** **Liz Still**
**Title of Author** **R&D Manager**

**Date** **14th January 2015**


East Sussex Healthcare NHS
NHS Trust
Annual Scientific Meeting
Friday, 20th March 2015
Medical Education Centre, EDGH
Improving Patient Care through our Research
We are seeking presentations/posters and attendees from ESHT and Local Trusts.
The Research and Development department would like to invite you to join us for this annual event. This is our second meeting.
Last year we received excellent presentations from Rheumatology, Cardiology, Physiotherapy, Orthopaedics, Pain Management and Surgery. We also displayed over 50 posters as part of this inaugural event. The meeting was very well received.
This year we have chosen a theme which seeks to celebrate the impact research has on improving patient care.
This is an opportunity to exhibit the research and audit work undertaken by those working within the Trust, or completed as part of health care improvements and self-development.
This is a great opportunity to network and enhance research activity further.
Provisional Programme:
10.00- Registration
- Full programme including guest speakers:-
Professor Gordon Ferns, (Clinical Director, Kent Surrey and Sussex Clinical Research Network)
Dr Anne Mandy, Director of Post Graduate Studies, Brighton Doctoral College
plus several oral presentations (TBC)
- Buffet lunch provided - An opportunity to view poster presentations
- Session to include local Education initiatives
Everyone is welcome to join us and we look forward to welcoming you
- so please register with R&D now as places are limited.
ResearchandDevelopmentDept@esht.nhs.uk
For more information on submitting abstracts for poster and oral presentations, please contact:-
Liz Still – R&D Manager or Teresa Baumber – R&D Governance Co-ordinator, 01323 417400 (13)3042 or e-mail
Teresa.Baumber@esht.nhs.uk

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 11 |
| **Subject:** | Annual Business Plan 2014-15<br>Quarter 3 report |
| **Reporting Officer:** | Dr Amanda Harrison, Director of Strategic Development and Assurance |

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

**Purpose:**

The attached high level report outlines progress against the objectives of the Annual Business Plan for 2014/15 which was approved by the Board at its meeting on 3 June 2014. Each Director has an underpinning plan which provides milestones for delivery to achieve the corporate objectives and demonstrates progress against these milestones.

**Introduction:**

The Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery. To facilitate and support the delivery of the ABP objectives, the following have been developed:

- Performance Management and Accountability Framework
- A process for monitoring the impact of service changes on quality
- Programme Management arrangements.

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

- The RAG rating for 1.1, 2.5, 4.3a and 4.4 has moved from amber to green and these plans are completed
- Plan 4.3b has improved from red to amber
- The rating for plan 8.1 has moved from amber to red due to the delay in the recruitment of a Head of Estates and Facilities

**Benefits:**

There is clarity about the organisational priorities and targets for 2014/15 and the risks attached.

**Risks and Implications**

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

| **Assurance Provided:** |
|---|
| The Annual Business Plan has been developed in collaboration with clinical units and corporate departments. It highlights the key objectives for the organisation and highlights the key risks to delivery. |

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

| **Review by other Committees/Groups** (please state name and date)**:** |
|---|
| Business Planning Steering Group 13.01.15 |

| **Proposals and/or Recommendations** |
|---|
| The Board is asked to note progress on the Annual Business Plan. |

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

| **For further information or for any enquiries relating to this report please contact:** | |
|---|---|
| **Name:**<br>Jane Rennie, Associate Director – Planning and Business Development | **Contact details:**<br>Janerennie1@nhs.net |

# Annual Business Plan 2014-15 - Key

**RAG RATING:**

| |
|---|
| Completed |
| No concerns to note and on plan to deliver |
| Overdue or concern to achieving the plan |

**Status:**

| | |
|---|---|
| ▲ | Rating improved |
| ▼ | Rating worsened |
| ◄► | Rating unchanged |

| **Key:** | |
|---|---|
| Chief Operating Officer | COO |
| Director of Nursing | DN |
| Director of Finance | DF |
| Director of Strategic Development | DSA |
| Director of Human Resources | HRD |
| Medical Director Strategy | MDS |
| Medical Director Governance | MDG |

| | | | |
|---|---|---|---|
| **Strategic Objective 1:** | **Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority** | | |
| **ABP Objective 1:** | **Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards** | | |
| **1.1** | **Completion of the Quality Governance Self Assessment/Well Led Framework** | | |
| **Outcome Measures**<br>Board has self assessed its compliance against the Well Led Framework and has evidence in support of each of the four domain and actions and timeframes to support areas of development | **Risks**<br>Several new non-executives who may have insufficient knowledge to form an evidence based view on some areas of the framework.<br>The Board has insufficient time and focus to undertake what is a significant piece of work. | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Initial review of framework by Co-Sec and development of template for Board use.<br><br>Board reviewed the ten high level questions at two Seminars in Sept/Oct and considered best practice examples and evidence. Co Sec pulling together final document.<br>Completed framework will be utilised to support future Board development programme. | | Completed Jul14<br>Completed Oct14 | G<br>▼ | **DSA** |
| **1.7** | **Respond to national plans for the revalidation of nursing staff** | | |
| **Outcome Measures**<br>Plan in place to ensure that the Trust is compliant with the agreed national requirement | **Risks**<br>Revalidation is not agreed nationally.<br>System is complex with large numbers of staff requiring revalidation<br>Medical revalidation system cannot be used to support the process<br>Capital investment required | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Review the consultation of the draft code .<br>Trust nurse lead for revalidation appointed<br>IT systems reviewed in readiness for revalidation<br>Awaiting confirmation from the NMC re exact requirements - delayed to early 2015 | | Completed<br>Completed<br>Completed<br>Early 2015 | A<br>◄► | **DN** |

| 1.8 | Further strengthen Clinical Audit reporting to the Board and its Committees | | |
|---|---|---|---|
| **Outcome Measures**<br>Clear process in place for Clinical Audit to ensure national and local requirements are met | **Risks**<br>Medical staff are not engaged in the process | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Centralise the governance team and develop a specific Audit team – interim structure<br><br>The central Clinical Effectiveness team working closely with each CU Lead to ensure a smooth transition of audit cover in interim phase. Improvements in engagement and focus already evidenced a reduction in outstanding audits from 2012/13 and 2013/14.<br>The Clinical Audit Steering Group has been reviewed and now meets bimonthly for an hour and these meetings will be regularly interspersed with larger presentation meetings which will be held in the Lecture Theatres and open to all staff. The larger presentation meetings will provide audits of Trust-wide relevance to be presented and discussed, enabling key lessons to be shared and disseminated effectively.<br>Clinical Audit Awards Seminar to take place at the Conquest Hospital on June 16th 2015. | Completed - Sep14 | R/A<br>◄► | **MDG/DN** |
| **ABP Objective 2:** | **Ensure the organisation takes action to improve quality and outcomes for patients** | | |
| **2.1** | **Implementation of mortality screening tool and review of all deaths** | | |
| **Outcome Measures**<br>Compliance with TDA guidance and achievement of CQUIN target | **Risks**<br>Loss of CQUIN monies and lack of compliance with TDA guidance | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Completion of reviews on trajectory for achievement of 90% CQUIN target<br>Quarter 2 targets achieved | Mar-15 | A<br>◄► | **MDG** |

| 2.2 | Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans |
|---|---|
| **Outcome Measures**<br>QUIPP and CQUIN programmes are developed for areas of most clinical quality concern, with a quality impact assessment completed on them with measurable performance indicators.<br>Organisation reporting framework to ensure annual plan met by Mar 15 with regular forecasts to confirm plan on target. Impact on 2015/16 and beyond understood.<br>Cash impact understood and managed | **Risks**<br>Programmes are not meeting the clinical requirements and have an appropriate purposefulness<br>QUIPP and CQUIN programmes are developed without clinician involvement<br>QUIPP and CQUIN lead sits within the COO structure and needs to be linked to the governance team<br>In year cost pressures not covered off by contingencies or other savings plans<br>Savings schemes slip in year<br>Stakeholders challenge Trust's plans |

| Actions: | Date/ milestone | RAG | Lead |
|---|---|---|---|
| Process in place to ensure a robust delivery of the key programmes with a strong focus on improving the quality and outcomes of our services. | CQUIN monthly report to CME<br>QUIP targets agreed with CCGs | A<br>◄► | **DN/ MDG/ DF/ COO** |
| Monthly accountability meetings held with Clinical Units | On-going | | |
| QUIP and CQUIN targets - Q2 achieved, on target for delivery for Q3 and Q4. Process now in place for the development and monitoring of CQUIN. | | | |
| At end Nov14 savings achieved year to date below plan by £756k. Additional savings schemes have been identified to close the gap by year end | Mar15 | | |

| 2.3 | Review and redesign of key specialities and sub-specialities | | |
|---|---|---|---|
| **Outcome Measures**<br>Specialties and sub-specialities requiring review are prioritised.<br>Outcomes of review fed into Annual Business Plan for 2015/6. | **Risks**<br>Reorganisation may mean that Clinical Units have insufficient capacity to undertake reviews<br>The outcome of the CHE work will affect key decisions and reviews will take longer | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Specialties Identified: Gastroenterology, Cancer Services, Community Paediatrics, Rheumatology | Mar-15 | R ◀▶ | **COO/ DSA/ MDS** |

| 2.5 | Implementation of Vitalpac | | |
|---|---|---|---|
| **Outcome Measures**<br>Adverse patient incidents as a result of deterioration significantly reduces by the responsive management of them.<br>Patient outcomes are improved. | **Risks**<br>The system is not 'rolled' out across the Trust.<br>The system is not used by staff.<br>Incidents are not responded to or learnt from. | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Vitalpac system in place across the area and supports the responsive management of deteriorating patients.<br>Data now produced on all acute patients monitoring and deterioration. Followed up by the outreach teams on a daily basis and by professional nursing on a monthly basis. | Complete Aug14 | G ▼ | **DN/ MDS/ MDG/ COO** |

| | | | | |
|---|---|---|---|---|
| **Strategic Objective 2:** | **Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences** | | | |
| **ABP Objective 3:** | **Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to** | | | |
| **3.1** | **Implementation of a tender review and response process** | | | |
| **Outcome Measures**<br>Decisions to tender for business are in line with Trust strategy and business model.<br>Successful bids for new or existing business are clinical, operationally and financially sustainable | **Risks**<br>The Trust is not able to offer services which are safe and clinically sustainable within the resources set out in tender documents.<br>Where contracts are let to other providers the Trust's overheads increase and are unsustainable. | | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| All business development opportunities are reviewed at the Business Planning Steering Group (BPSG)and risk assessed against sustainability critieria.<br>As incumbent provider the Trust highlights potential service risks to commissioners at the onset and at the conclusion of the competitive process.<br>Responses to competitive tenders are also reviewed at the BPSG to ensure that they are clinically operationally and financially sustainable.<br>External support has been procured to develop internal skills and expertise further. | | On-going<br><br>Jan-Mar15 | **A** ◄► | **DSA** |
| **3.2** | **Development and implementation of a marketing and engagement strategy** | | | |
| **Outcome Measures**<br>Strategy agreed by the Board leading to:<br>· clarity about key stakeholders;<br>· roles and responsibilities within the Trust;<br>· improved relationships with key stakeholders | **Risks**<br>Insufficient resources for relationship management actions identified in the strategy and action plan | | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| An engagement plan is being developed internally and will be submitted to the March Board together with an action plan for 2015/16 | | Mar-15 | **A** ◄► | **DSA** |

| ABP Objective 4: | Ensure active participation in joint programmes of work to improve clinical service design and delivery | | |
|---|---|---|---|
| **4.1** | **Engage in the further development of the commissioner led East Sussex Better Together (ESBT) programme** | | |
| **Outcome Measures**<br>ESHT active participant in further work<br>5 year plan aligned to commissioning intentions<br>Full alignment between ESBT and CHE work | **Risks**<br>Failure to draw together ESBT and CHE work leads to misalignemnt of ESHT 5 year plan and plan for sustainability not achieved | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Engagement ongoing - CCGs have 150 week implementation plan - discussions underway to ensure full Trust engagement. | Mar-15 | **A** ◀▶ | **DSA** |
| Detailed plans to underpin intended impact in 2015/16 not yet available therefore not yet incorporated into CU plans | Mar-15 | **R** ◀▶ | |
| **4.2** | **Engage in the further development of the TDA/NHSE led Challenged Health Economy (CHE) programme** | | |
| **Outcome Measures**<br>ESHT active participant in further work<br>5 year plan aligned to commissioning intentions<br>Full alignment between ESBT and CHE work | **Risks**<br>Failure to draw together ESBT and CHE work leads to misalignemnt of ESHT 5 year plan and plan for sustainability not achieved | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| PID and programme governance agreed by TDA, NHSE, CCGs and ESHT<br>Phase 2 of programme complete - outcomes to be considered by LHE and impact on current ESBT and Trust plans to be agreed | Mar15 | **A** ◀▶ | **DSA** |

| 4.3 | Engage in the programme of work to support the re-design of community services | | | |
|---|---|---|---|---|
| **Outcome Measures**<br>Clarity on which community services support Trust strategy and business model<br>Identification of service models which are clinically, operationally and financially sustainable | **Risks**<br>Re-organisation may slow down work<br>Staff engagement | | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Risk assessments undertaken on community services | | Jan-15 | G ▼ | MDS/ COO/ DSA |
| Risks assessments undertaken on redesigned services. Engaged with CCGs through new management structure.<br>Trust engaged in community service redesign through ESBT.<br>Further work on Clinical Strategy has been outlined for agreement by Board.<br>Trust engaged in bidding for tendered community services in HWLH.<br>Review of community paediatric services taking place jointly with CCG to conclude in March 2015. | | Oct14<br><br>Jan15<br>May15<br>Mar15 | A<br><br>▼ | |

| 4.4 | Establish the Clinical Leadership Forum as key vehicle for clinical engagement within the Trust and ensure its members are able to engage in external for a as appropriate | | | |
|---|---|---|---|---|
| **Outcome Measures**<br>Development of Forum to inform the clinical strategic development of the Trust | **Risks**<br>Engagement does not occur<br>Advice not in line with Trust objectives | | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Terms of Reference approved<br>Work plan in progress<br>Report to Clinical Management Executive | | Sep14<br><br>On-going | G<br><br>▼ | MDS |

| | | | |
|---|---|---|---|
| **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** | | |
| **ABP Objective 5:** | **Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability** | | |
| **5.1** | **Development of an IBP and LTFM based on the outcome of ESBT and CHE programmes** | | |
| **Outcome Measures**<br>IBP and LTFM agreed by TDA<br>5 year plans are cascaded through the organisation and developed into CU strategic plans<br>Receipt of capital from the TDA | **Risks**<br>CHE work cannot deliver a financially sustainable model for East Sussex<br>Current year's plans impact on future years<br>Delay in capital investment<br>Engagement with clinical units | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Ensure engagement with stakeholders in the programmes across the economy<br>Capital investment approved by the TDA<br>Development of IBP and LTFM ongoing in light of ESBT and CHE work. Impact of outcomes of Five Year Forward View and Dalton review to be assessed through next steps in development of the Trust Clinical Strategy implementation plan<br>IBP priorities feed into Annual Business Plan for 2015/16<br>Emergency capital applications made as appropriate | | <br><br><br><br>Mar15<br>Mar15 | R<br>◄► | DF/ DSA |
| **ABP Objective 6:** | **Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme** | | |
| **6.1** | **Act to reduce spend on medical agency** | | |
| **Outcome Measures**<br>Spend reduced and contained within total controls | **Risks**<br>Breach in control totals | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Spend being reduced but further work required to ensure local CU control totals are met<br>CU achievement against control totals monitored through monthly accountability meetings<br>Spend has increased from Dec14 due to winter pressures | | Mar-15 | A<br>◄► | MDG |

| | | | |
|---|---|---|---|
| **6.4** | **Implementation of a revised Hospital at Night provision at EDGH** | | |
| **Outcome Measures**<br>Safe service provision | **Risks**<br>Unable to recruit staff sufficiently skilled to provide a safe service | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Plans for re-provision H@N still being revised for winter<br>Identified clinical leads on both sites, services to be supported by next phase of Vitalpac implementation. | Mar15 | **A** ◄► | **COO** |
| **6.5** | **Development and implementation of a revised medical model across the Trust** | | |
| **Outcome Measures**<br>New model implemented on both acute sites | **Risks**<br>Unable to recruit senior clinicians to fill the rota | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Agreement on new structure to allow implementation as appropriate<br>Relevant posts have been advertised | Jan15 | **A** ◄► | **COO/ MDS** |
| **ABP Objective 7:** | **Implement plans for the delivery of key operational requirements** | | |
| **7.1** | **RTT compliance plan** | | |
| **Outcome Measures**<br>All specialities to be RTT compliant | **Risks**<br>Insufficient capacity available to achieve compliance in all specialities | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Achieve RTT compliance<br>Extra capacity identified both internal and external funded through CCG and Local Area Team | Feb15 | **A** ◄► | **COO** |

| ABP Objective 8: | Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust | | |
|---|---|---|---|
| **8.1** | **Development of an estates strategy that supports the Trust's agreed clinical services model** | | |
| **Outcome Measures**<br>New estates strategy in place | **Risks**<br>Re-organisation of estates and operational structures that would not give sufficient time for development | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Development of estates strategy in collaboration with P21 partners<br>Currently recruiting for substantive Head of Estates (interim manager in post) | Mar-15 | **R** ▲ | **COO** |
| **8.2** | **Development of a Sustainability Management Plan** | | |
| **Outcome Measures**<br>Approved plan in place | **Risks**<br>Development of plan delayed by corporate restructure and outsourcing of hard Facilities Management service | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Production of Sustainable Management Development Plan for estates and facilities for Board approval<br>Plan has been finalised in readiness for approval at February Board | Feb-14 | **A** ◄► | **COO** |

| 8.3 | Development of an IT Strategy and delivery plan | | |
|---|---|---|---|
| **Outcome Measures**<br>Strategy implemented and internal transformational plan developed | **Risks**<br>Delays in implementation<br>Key roles not recruited to<br>Impact of market testing<br>TDA approval | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| IT Strategy approved by Board<br>Transformation plan to be developed<br><br>Complete review of market testing possibilities and report to Board | | Jul14<br>commence<br>Jan15<br>Mar15 | **A**<br>◄► | **DF** |

| 8.4 | Review and further development of the Major Incident and Business Continuity Plans | | |
|---|---|---|---|
| **Outcome Measures**<br>Revised plans in place | **Risks**<br>Corporate and clinical unit restructure | | |
| **Actions:** | | **Date/ milestone** | **RAG** | **Lead** |
| Major Incident Plan reviewed and revised with new policies for EDGH and Conquest.<br>Business continuity policy and plan revised and re-issued<br>All are now available on Intranet and Major Incident Plan/Emergo training planned | | Sep14<br>Sep14<br>Mar15 | **A**<br>◄ ► | **COO** |

| 8.5 | Review and revision of the Workforce Plan and Trust-wide workforce risk register |
|---|---|
| **Outcome Measures**<br>A plan which identifies the capacity and capability of the future workforce which meets the aims and objectives of the organisation.<br>Specific workforce transformation plans identified and implemented<br>Register of all identified workforce risk across the organisation, both Trust-wide and area specific | **Risks**<br>Flexibility to respond to changing demands within the Trust<br>Ensuring that the workforce plan reflects requirements for all areas of the Trust<br>Engagement of the workforce<br>Contractual flexibility<br>Management/HR capacity<br>Ensuring that all risks are identified and appropriate mitigation in place |

| Actions: | Date/ milestone | RAG | Lead |
|---|---|---|---|
| Revised workforce plan | Sep14 | A | HRD |
| Development of Recruitment and Retention Strategy and Action Plan - identify hard to recruit areas and appropriate action | Jan15 | ◄► | |
| The Workforce Risks are now summarised as part of the Workforce Strategy/Plan. This document is in draft form and will be finalised by March 2015 to incorporate into business planning for 15/16. | Mar15 | | |
| Separately a meeting is planned for December with Risk leads to develop a process for HR to receive details of workforce risks. This meeting has been delayed due to long term sickness absence. | Dec14 | | |

| 8.6 | Conclude implementation of the Health Roster programme |
|---|---|
| **Outcome Measures**<br>Right staff in right place at right time<br>Reduced agency and bank usage<br>Real time reporting of staffing numbers and absence | **Risks**<br>System support resource not agreed<br>System use deteriorates due to lack of support<br>Inability to provide actual nursing numbers from Healthroster |

| Actions: | Date/ milestone | RAG | Lead |
|---|---|---|---|
| All clinical teams rostered electronically - end Aug14 all clinical teams now rostered with exception of one radiology area to be taken forward as business as usual | Sep14 | A | HRD |
| Facilities staff rostered - rostering commenced in Bexhill but technical issues have caused delays. Further upgrade to be implemented in mid Sep14 and should resolve technical issues. Once Bexhill working fine, implementation to continue but end date may need revision. | Sep14 | ◄► | |
| Bexhill - Allocate were unable to resolve the issues with the timeclock fingerprints in Bexhill. Testing being carried out by supplier on a PIN number clocking in process and so far is working. The full implementation in Bexhill will now happen in January 2015 and rollout across the rest of Facilities will then take place. | Jan15 | | |
| Once the Facilities implementation is fully underway the Healthroster support team will be able to move ahead with Corporate areas. | | | |

| 8.7 | Embed programme management processes in support of delivery of Annual Business Plan |
|---|---|
| **Outcome Measures**<br>Regular project reporting to the Board<br>Resources allocated to organisational priorities within the ABP<br>PMO recognised as useful organisational resource | **Risks**<br>Re-organisation of PMO may affect projects<br>Insufficient resource to support prioritised projects |

| Actions: | Date/ milestone | RAG | Lead |
|---|---|---|---|
| Programme Management office established in October 2014. | Oct14 | A | DSA |
| Key projects are being prioritised and resources allocated with protocols | On-going | | |
| Review of PMO effectiveness | Mar15 | ◄► | |

| 8.8 | Develop and implement a Procurement Strategy | | |
|---|---|---|---|
| **Outcome Measures**<br>Savings delivered<br>Procurement involved in service delivery<br>Staff recruited to permanently<br>Response to DH guidance agreed by Trust Board | **Risks**<br>Staff vacancies in key roles covered by interns<br>Savings plans slip<br>Investment may be required to implement strategy<br>DH guidance impacts on other strategies | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Strategy submitted and approved by Trust Board<br>DH guidance incorporated in strategy<br>Procurement savings identified<br>Investment requirements identified | Nov14<br>Nov14<br>Dec14<br>Dec14 | G<br>▼ | DF |

| 8.9 | Implement key IM&T programmes including PAS upgrade, NHSmail, SystmOne | | |
|---|---|---|---|
| **Outcome Measures**<br>IT systems implemented successful with minimal disruption | **Risks**<br>Delays in implementation | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Capital investment identified<br>Implementation plans complete and understood | On-going | A<br>◄► | DF |

| 8.10 | Development and implementation of an Innovation Strategy | | |
|---|---|---|---|
| **Outcome Measures**<br>Innovation Strategy implemented | **Risks**<br>Strategy not fully implemented | | |
| **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Associate MD Clinical Governance in process of drafting strategy | Mar-15 | A<br>◄► | MDG |

**ANNUAL BUSINESS PLAN 2014/15 -**
**Q3 UPDATE**

| **Strategic Objective 1:** | **Improve quality and clinical outcomes by ensuring that safe patient care is our highest priority** | | | |
|---|---|---|---|---|
| **ABP Objective 1:** | **Ensure the organisation is able to demonstrate the quality of its services and compliance with regulatory standards** | | | |
| **1.2** | **1.2 Refresh of the Board Governance Assessment Framework** | | | |
| **Outcome Measures** | **BGAF has been reviewed and considered by the Board. Areas identified for development have agreed actions and timeframes.** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Several new non-executives who may have insufficient knowledge to form an evidence based view on some areas of the framework. | BAF refreshed and considered by the Board.<br><br>RAG rating agreed and areas for development and actions identified. | Completed Jul14 | G<br>◄► | **DSA** |
| **1.3** | **Development and implementation of a Knowledge Management Strategy** | | | |
| **Outcome Measures** | **Approved by Board** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Further development required by Board | Review by Board in Seminar and approved by Trust Board | Completed Jul14 | G<br>◄► | **DSA** |

| | | | | |
|---|---|---|---|---|
| **1.4** | **Publication of clinical quality measures and survival rates in line with national guidance** | | | |
| **Outcome Measures** | **Patients are able to view local and national survival rates in identified specialties and compare performance with other Trusts** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| National guidance not met | A link has been set up to NHS Choices to provide the information | Completed Sep14 | G ▼ | **MDG** |
| **1.5** | **Undertake Quality Impact Assessments for all programmes of service change** | | | |
| **Outcome Measures** | **All service level changes have a QIA to assess against key quality indicators** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Changes occur without going through the process and are in contradiction of other changes.<br>Quality is adversely affected | Process in place to ensure that Quality Impact Assessments are completed for all services and reviewed in a timely way | 1st level Aug14 - completed | G ▼ | **DN/MDG / MDS** |

| | | | | |
|---|---|---|---|---|
| **1.6** | **Institute a process to allow staffing at ward level to be monitored in line with national requirements** | | | |
| **Outcome Measures** | **Clear robust process in place complaint with national guidance and supported by NICE guidance** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Non inpatient areas have not been reviewed, ie community.<br><br>CIPs could be used to affect the levels of staff<br><br>Recruitment and retention of staff is not maintained. | Staffing levels agreed<br><br>Exception reporting bi-monthly to Trust Board<br><br>Plans for review in late September/early October 14 | Mar 14<br><br>Completed - in TB work programme .<br><br>Late Sep/ Early Oct14 | G<br>▼ | **DN** |
| **ABP Objective 2:** | **Ensure the organisation takes action to improve quality and outcomes for patients** | | | |
| **2.1** | **Implementation of mortality screening tool and review of all deaths** | | | |
| **Outcome Measures** | **Compliance with TDA guidance and achievement of CQUIN target** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Loss of CQUIN monies and lack of compliance with TDA guidance | Screening tool data input – 100% compliance achieved | Mar-15 | G<br>▼ | **MDG** |

**ANNUAL BUSINESS PLAN 2014/15 -**
**Q3 UPDATE**

| **2.2** | **Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans** | | | |
|---|---|---|---|---|
| **Outcome Measures** | **QUIPP and CQUIN programmes are developed for areas of most clinical quality concern, with a quality impact assessment completed on them with measurable performance indicators.**<br><br>**Organisation reporting framework to ensure annual plan met by Mar 15 with regular forecasts to confirm plan on target. Impact on 2015/16 and beyond understood.**<br><br>**Cash impact understood and managed** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Programmes are not meeting the clinical requirements and have an appropriate purposefulness<br><br>QUIPP and CQUIN programmes are developed without clinician involvement<br><br>QUIPP and CQUIN lead sits within the COO structure and needs to be linked to the governance team<br><br>In year cost pressures not covered off by contingencies or other savings plans<br><br>Savings schemes slip in year<br><br>Stakeholders challenge Trust's plans | Budget completed and signed off by Trust Board. CU leads agree to budget plans.<br><br>Annual plan submitted to TDA and approved | 01/06/2014<br><br>Jun14 | G<br><br>◄► | **DN/MDG / DF/COO** |

| **2.3** | **Review and redesign of key specialities and sub-specialities** | | | |
|---|---|---|---|---|
| **Outcome Measures** | **Specialties and sub-specialities requiring review are prioritised. Outcomes of review fed into Annual Business Plan for 2015/6.** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Reorganisation may mean that Clinical Units have insufficient capacity to undertake reviews | Process in place to identify specialties and subspecialties which require review. | Complete Jul 14 | G ▼ | **COO/ DSA/ MDS** |
| **2.4** | **Monitor and review the outcome of service reconfiguration** | | | |
| **Outcome Measures** | **Achieved target** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Failure to achieve target | As agreed in CQUIN plan with CCGs | | G ◄► | **COO/ MDS** |

**ANNUAL BUSINESS PLAN 2014/15 -**
**Q3 UPDATE**

| | | | | |
|---|---|---|---|---|
| **Strategic Objective 2:** | **Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences** | | | |
| **ABP Objective 3:** | **Ensure opportunities and risks of the local health and social care market and of commissioning intentions are understood and responded to** | | | |
| **3.1** | **Implementation of a tender review and response process** | | | |
| **Outcome Measures** | **Decisions to tender for business are in line with Trust strategy and business model.** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| The Trust is not able to offer services which are safe and clinically sustainable within the resources set out in tender documents.<br><br>Where contracts are let to other providers the Trust's overheads increase and are unsustainable. | Process in place for risk assessment of services against tenders and business development opportunities. | Jul-14 | **G** | **DSA** |

**ANNUAL BUSINESS PLAN 2014/15 -**
**Q3 UPDATE**

| | | | | |
|---|---|---|---|---|
| **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** | | | |
| **ABP Objective 5:** | **Ensure the Trust's business model and long term strategic plan deliver clinical, operational and financial sustainability** | | | |
| **5.1** | **Development of an IBP and LTFM based on the outcome of ESBT and CHE programmes** | | | |
| **Outcome Measures** | **IBP and LTFM agreed by TDA**<br>**5 year plans are cascaded through the organisation and developed into CU strategic plans**<br>**Receipt of capital from the TDA** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| CHE work cannot deliver a financially sustainable model for East Sussex<br><br>Current year's plans impact on future years | Updated IBP and LTFM to TDA | Jun-14 | **G**<br>◄► | **DF/ DSA** |
| **ABP Objective 6:** | **Ensure efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme** | | | |
| **6.2** | **Improve efficiencies in clinical administration** | | | |
| **Outcome Measures** | **New service provision agreed** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Communication to patients and staff<br><br>Potential grievance by unions | Consultation completed and implementation plan being actioned | Nov-14 | **G**<br>◄► | **COO** |

| | | | | |
|---|---|---|---|---|
| **6.3** | **Improve theatre utilisation and productivity** | | | |
| **Outcome Measures** | **Closure of theatre sessions** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Physical changes required in both theatres and outpatients at Bexhill to allow safe move | Revised theatre timetable implemented Aug14.<br><br>On-going management of utilisation. | Complete | **G** ◄► | **COO** |
| **6.6** | **Delivery of the clinical correspondence programme** | | | |
| **Outcome Measures** | **Achievement of CQUIN target** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| IT interfaces with community system | Progress reported to Clinical Management Executive via monthly CQUIN report | Mar-15 | **G** ◄► | **COO** |
| **ABP Objective 7:** | **Implement plans for the delivery of key operational requirements** | | | |
| **7.2** | **Diagnostic waits compliance plan** | | | |
| **Outcome Measures** | **No more than 1% of patients waiting more than 6 weeks** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Capacity in radiology and endoscopy and unknown impact of public health campaigns | Regular updates via Board performance report | Sustainable May14 onwards | **G** ◄► | **COO** |

| | | | | |
|---|---|---|---|---|
| **7.3** | **Ambulance handover improvement plan** | | | |
| **Outcome Measures** | **Improved ambulance handover times** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| High levels of demand at Conquest<br><br>SECAmb unable to reduce conveyance, | Regular meetings between SECAmb and Trust to agree monthly performance | On-going | **G**<br>◄► | **COO** |
| **7.4** | **Cancelled operations improvement plan** | | | |
| **Outcome Measures** | **Numbers of cancelled operations reduced** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Theatre capacity and equipment<br><br>Winter bed pressures | Cancelled operations performance reported in Board performance report, Start the Week meetings and Theatre Utilisation weekly meetings | On-going | **G**<br>◄► | **COO** |
| **ABP Objective 8:** | **Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust** | | | |
| **8.3** | **Development of an IT Strategy and delivery plan** | | | |
| **Outcome Measures** | **Strategy implemented and internal transformational plan developed** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Delays in implementation<br><br>Key roles not recruited to | Strategy submitted and approved by the Board | Jul14<br><br>Mar15 | **G**<br>▼ | **DF/ DSA** |

| **8.4** | **Review and further development of the Major Incident and Business Continuity Plans** | | | |
|---|---|---|---|---|
| **Outcome Measures** | **Revised plans in place** | | | |
| **Risks** | **Actions:** | **Date/ milestone** | **RAG** | **Lead** |
| Corporate and clinical unit restructure | Revised plans to be available | Complete - Aug14 | **G** ◄► | **COO** |

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 12 |
| **Subject:** | ESHT Health and Safety at Work Policy |
| **Reporting Officer:** | Alice Webster, Director of Nursing |

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

**Purpose:**

It is the policy of East Sussex Healthcare NHS Trust to comply with both the letter and spirit of the Health and Safety at Work, etc Act 1974 and all other relevant legislation, and to regard the provisions of this legislation as minimum requirements.

The expectations are that Trust Board will receive and ratify this policy.

**Introduction:**

This policy lays down the organisation aims and objectives in the important area of health and safety. It sets out, in broad terms, how to implement these aims and objectives.

All employees must co-operate in this endeavour. The policy statement will be issued and/or on display to all employees. It incorporates our general approach towards compliance with prevailing health and safety legislation.

Where the Trust shares a workplace with another employer or organisation, or where another employer or organisation controls a workplace occupied by, or otherwise affecting, Trust staff, the Trust will co-operate with the other employer or organisation, so far as is necessary to protect the health, safety and welfare of Trust staff or others affected by the activities or processes involved.

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

The Policy was approved by Health and Safety Steering Group (HSSG) 24th November 2014 attended by union H&S representatives and management

The Clinical Management Executive approved the policy on the 8th December 2014 with the one amendment on page 12 which should read Infection Prevention Society.- this has now been amended on the version for the Trust Board.

**Benefits:**

To conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises.

To create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance.

| **Risks and Implications** |
|---|
| Organisation of this size and complexity must have a policy and appropriate management arrangements in place to comply consistently with the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 (as amended) and all other relevant statutory provisions, including health and safety approved codes of practice and guidance and relevant fire safety legislation. |

| **Assurance Provided:** |
|---|
| By having this policy and corresponding management arrangements it provides assurance and ensures the compliance of the organisation with the letter and the spirit of the legal requirements. |

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

| **Review by other Committees/Groups** (please state name and date)**:** |
|---|
| Health and Safety Steering Group 24th November 2014<br>Clinical Management Executive 8th December 2014 |

| **Proposals and/or Recommendations** |
|---|
| The Board is asked to ratify the Health and Safety at Work Policy. |

| **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:**<br>Nicky Creasey,<br>Trust Lead Health and Safety | **Contact details:**<br>Ext (14) 6545 |

East Sussex Healthcare NHS
NHS Trust

# Health and Safety at Work Policy

| | |
|---|---|
| Version: | V2.0 |
| Ratified by: | |
| Date ratified: | |
| Name of author and title: | Nicky Creasey, Trust Lead Health & Safety |
| Date Written: | August 2014 |
| Name of responsible committee/individual: | Health & Safety Steering Group |
| Date issued: | |
| Issue number: | |
| Review date: | |
| Target audience: | All Staff |
| Compliance with CQC outcome: | Outcomes 10, 11 & 14 |
| Compliance with any other external requirements (e.g. Information Governance): | Health & Safety Executive (HSE); Care Quality Commission (CQC) |
| Associated Documents: | See page 34 for the extensive list |

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# Version Control Table

| Version number and issue number | Date | Author | Reason for Change | Description of Changes Made |
|---|---|---|---|---|
| V4 2009186 | September 2009 | David James | Update | none |
| V1 2011252 | September 2011 | Tony Humphries | Update for merged organisation | Two organisation policies merged |
| V1.0 2012157 | June 2012 | Nicky Creasey | Update | reviewed |
| V2.0 | April 2014 | Nicky Creasey | Update & change in Trust Structures | Reviewed changes to HSE guidance POPIMAR replaced with new HSE management model Plan, Do, Check, Act |

# 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 |
|---|---|---|
| 2011252 - various | Sept 2011 V1; ratified 28/09/2011 | ESHT Board |
| Health & Safety Steering Group | | November 2014 |
| | | |
| | | |

## 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. Health & Safety Policy Statement

It is the policy of East Sussex Healthcare NHS Trust to comply with both the letter and spirit of the Health and Safety at Work, etc Act 1974 and all other relevant legislation, and to regard the provisions of this legislation as minimum requirements.

As with all other aspects of the Trust's undertakings, health and safety must be properly managed and cost effective being aware that some aspects will have to be changed regardless of the financial cost and other elements will be assessed and clear reasons and rationales provided where further changes and or expenditure is covered so far as reasonable and practicable.

Employees of the Trust have a right to work in safe and healthy conditions. These conditions will be created and maintained by the preparation of, and adherence to, this Health and Safety policy. The Directors/managers fully appreciate that responsibility for health and safety is an integral function of management, on a par with responsibilities for all other business operations and we recognise the benefits of a fit and healthy workforce. Patients, the public and visitors safety is also integral to our philosophy.

The Trust will undertake to provide relevant health and safety training and to provide relevant information to all employees to enable them to improve their knowledge base and awareness of health and safety so that as employees they can discharge their own health and safety responsibilities.

I believe that it is important for all personnel, whatever their position, to accept their personal responsibilities as detailed in this policy and I seek active co-operation between management and employees to promote a safe and healthy environment for ourselves and for those who avail themselves of our service.

Finally, we undertake to review and revise this policy as often as is required by changing legislation. All changes will be brought to the attention of all employees.

**Chief Executive Officer:** Darren Grayson

**Signed:**

**Date:**

## 2. Introduction

This policy lays down the organisation aims and objectives in the important area of health and safety. It sets out, in broad terms, how to implement these aims and objectives.

All employees must co-operate in this endeavour.

The policy statement will be issued and/or on display to all employees. It incorporates our general approach towards compliance with prevailing health and safety legislation.

Where the Trust shares a workplace with another employer or organisation, or where another employer or organisation controls a workplace occupied by, or otherwise affecting, Trust staff, the Trust will co-operate with the other employer or organisation, so far as is necessary to protect the health, safety and welfare of Trust staff or others affected by the activities or processes involved.

### 2.1. Aims of the Policy

To conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises.

To create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance.

These aims will be pursued regardless of whether the particular services which form part of the organisations' undertakings are performed by our employees, or by outside contractors acting on our behalf.

These aims will be borne in mind in all policy and operational decisions made by the organisation, especially in relation to the adequate provision of resources. It is recognised that managers could render themselves liable under criminal health and safety law should they place requirements upon staff that are contrary to this policy.

### 2.2. Objectives of the Policy

The organisation is committed to working towards the achievement of the following objectives in the field of health and safety:

- To comply consistently with the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 (as amended) and all other relevant statutory provisions, including health and safety approved codes of practice and guidance and relevant fire safety legislation.
- To effectively identify all significant hazards arising from our activities, to assess all the resultant risks to the health and safety of our employees, patients and visitors and other people who may be affected and to develop the appropriate preventive and protective measures necessary to control these risks.
- To align and apply the Plan – Do – Check – Act management model; HSE in August 2013 revised and replaced health and safety guidance HSG 65 'Managing for health and safety.

- To establish, and where necessary implement, appropriate emergency procedures to be followed in situations of serious and imminent danger and to; co-operate and co-ordinate with the emergency services and other employers as appropriate.
- To provide and maintain suitable and safe vehicles, plant, equipment and systems of work.
- To provide employees with relevant health and safety training and supervision and to take account of employees' capabilities as regards health and safety matters when assigning tasks to them.
- To provide employees with comprehensible information on health and safety risks identified by assessments and on the preventive and protective measures necessary to control these risks.
- To avoid safety, health and fire risks in connection with the use, handling and storage of articles and substances.
- To provide a safe place of work and a healthy working environment.
- Where appropriate on health and safety grounds, to ensure that employees are provided with, and use, suitable personal protective clothing or equipment. Also to make adequate arrangements for the storage and maintenance of such personal protective clothing and equipment.
- Where beneficial to the prevention of work related illnesses or ill health conditions, to provide employees with appropriate health surveillance.

## 3. Definitions

**CU**

Clinical Units

**HSE**

Health and Safety Executive

**HSSG**

Health and Safety Steering Group

**OHSMS**

Occupational Health Safety Management Systems

**PDCA management model**

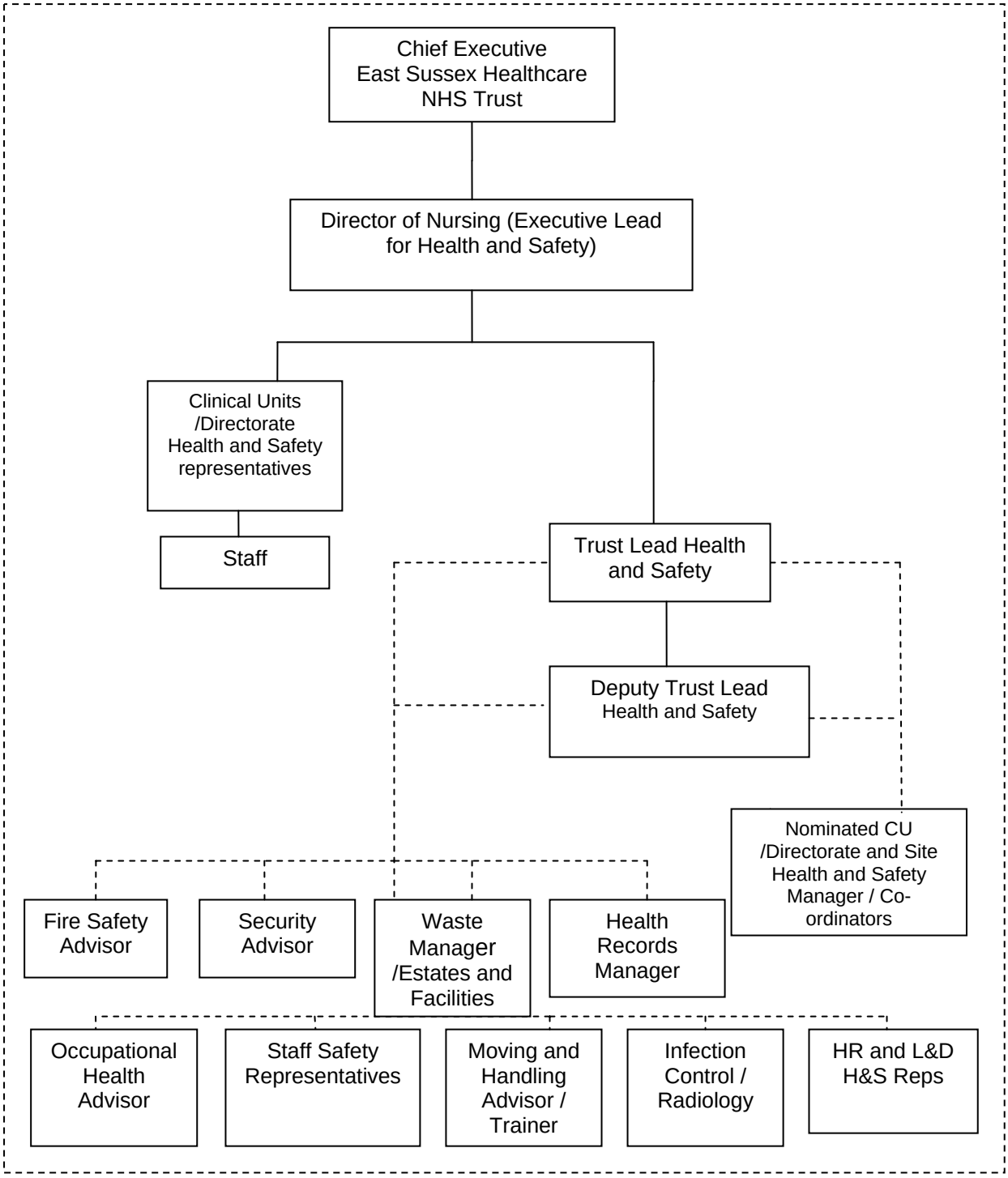
Plan, Do, Check, Act

**PPE**

Personal Protective Equipment

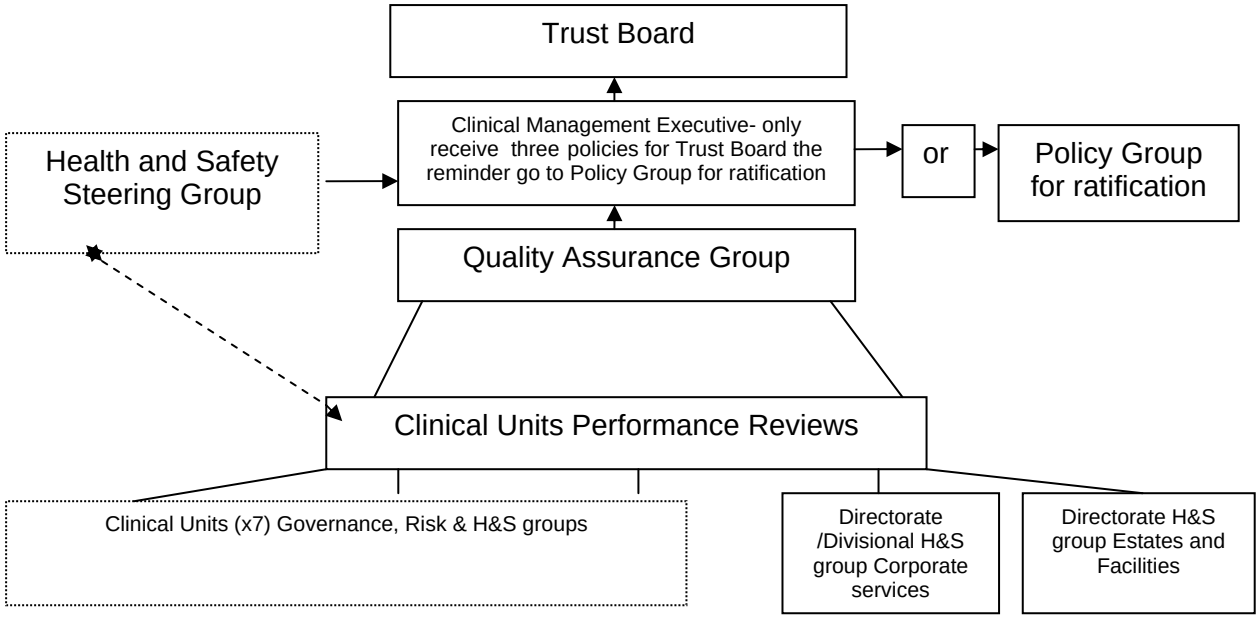
## 4. Accountabilities and Responsibilities

### 4.1. Health and Safety Management Structure




### 4.2. Health and Safety Steering Group Structure

A Health and Safety Steering Group has been established to provide the formal consultation group for the Trust, in accordance with the provisions of the Health and Safety at Work etc Act 1974 and the Safety Representatives and Safety Committees Regulations 1977 as amended by the Management of Health and Safety at Work Regulations 1999.




### 4.3. Responsibilities

4.3.1. Chief Executive

The Chief Executive has overall and final responsibility for the management of health and safety in East Sussex Healthcare Trust and for the health, safety and welfare of employees and others who may be affected, and:

- Will ensure that there is an effective policy for health and safety which is kept up to date within the organisations.
- Will ensure that relevant risks are assessed and will make available sufficient resources and funds to allow for the appropriate control of these risks.
- Will ensure implementation of the policy and fully support all persons who carry out the policy.
- Will have the responsibility of discharging the organisations' duty, under Section 2(3) of the Health and Safety at Work etc. Act 1974, of bringing the general statement of health and safety policy and the organisation and arrangements for the carrying out of that policy, to the notice of employees.
- Will ensure that the health and safety policy for the organisation is understood at all levels.
- Will fully support the training of staff / union health and safety representatives and arrange for consultation on health and safety matters as appropriate.
- Will ensure that an annual report on health and safety performance is produced.

4.3.2. Trust Board/Executive Team

- The Trust Board/Executive Team will accept their collective role in providing health and safety leadership in the organisations.
- Each member of the Trust Board/Executive Team accepts their individual role in providing health and safety leadership.
- All Executive Team/Trust Board decisions will reflect our commitment to achieving the objectives set out in this Health and Safety Policy Statement.

- The Trust Board/Executive Team will seek to engage the active participation of employees in improving health and safety.
- The Director of Nursing has Executive responsibility for health and safety within the Trust.

4.3.3. Trust Lead Health & Safety

The Trust Lead is responsible for Health and Safety and provides the management lead for the health and safety specialist function and acts as the 'competent person' as required by Regulation 6 of the Management of Health and Safety at Work Regulations 1999. The Trust Lead Health & Safety reports to the Director of Nursing on Health & Safety matters and is a member of the Health and Safety Steering Group. Duties include:

- Supporting Senior Managers of the organisation in setting a positive Health & Safety culture.
- Formulating Health & Safety strategy, policies and operating procedures;
- Producing reports to the board including the annual Health and Safety report;
- Being responsible for formulation and review of policies and procedures;
- Being the point of contact for external agencies such as the HSE;
- Advising on legislative requirements and best practice;
- Investigating accidents as appropriate;
- Advising on the undertaking of general or specific risk assessments in support of managers and others;
- Assisting managers, as appropriate, with workplace inspections;
- Liaising with union safety representatives on matters of health and safety;
- Undertaking health and safety audits Occupational Health Safety Management Systems (OHSMS);
- Ensuring health and safety training is provided as appropriate for managers and staff.

4.3.4. Deputy Trust Lead Health & Safety

The Deputy Trust Lead is responsible for Health and Safety reports to the Trust Lead Health and Safety and is responsible for providing assistance in the functions described in 4.3.3 above and will deputise in the absence of the Health & Safety Manager. They:

- Are responsible for facilitating the Health and Safety Steering Group;
- Undertake regular liaison with nominated Clinical Unit l Health & Safety Managers/ named representatives;
- Work with the Trust Learning and Development team and H&S team administrator on ensuring appropriate training and e-learning packages for all levels of staff are available.
- Are responsible for the development and implementation of the H&S Link staff process within the various services across the organisation.

4.3.5. Health & Safety Steering Group

The Health and Safety Steering Group is a focal point for effective staff consultation and participation in all aspects of Trust health and safety. Accredited union safety representatives nominated by nationally recognised negotiating organisations will represent all employees of the Trust.

Its main function is to promote co-operation between staff at all levels to ensure the health, safety and welfare of all staff and those who come into contact with the services of the Trust. A full list of functions can be found in the Steering Group's terms of reference.

4.3.6. Clinical Units/Directorate Health and Safety Groups

Health and Safety Groups have been established at departmental or service level to provide a focal point for effective consultation and participation in all aspects of health and safety at that level and to provide support to the Health and Safety Steering Group. The Clinical Unit (CU) reports are presented to the Health and Safety Steering Group.

4.3.7. Clinical Units/Directorate Health and Safety Representatives

Clinical Units Health and Safety leads will be appointed / nominated by the Clinical Unit Head of Nursing and / or Clinical Governance lead. Their role will include assisting managers with day to day health and safety issues such as:

- Undertaking regular workplace 13 week inspections in conjunction with Trade Union Health and Safety Representatives (as requested);
- Undertaking risk assessments; receiving completed risk assessment documentation and action plans; record risk assessments and to make available to colleagues;
- Monitoring the corresponding action plans through to completion
- All documentation to be readily available for the Health & Safety team to audit the quality and the completion of the action plans for organisational assurance;
- Liaising with the Estates and Facilities Department, Health and Safety Leads, Fire Safety Advisor, Security Advisor, Moving and Handling Advisor / Trainer and others as appropriate in relation to the undertaking of risk assessments, inspections, fire drills, maintenance issues and building repairs;
- Liaising with first aiders, and fire wardens in support of their duties;
- Covering any other health and safety related issues deemed appropriate to the role and the individual;
- Being at all times of aware of their level of competence and expertise and to liaise with the H&S team.

4.3.8. Fire Safety Advisor

The Trust will have a specialist Fire Safety Advisor who will report to the Health and Safety Steering Group quarterly and will:

- Advise on legislative requirements and best practice;
- Contribute to the formulation and review of policies and procedures;
- Investigate fire Incidents as appropriate;
- Undertake fire risk assessments in support of managers and others;
- Undertake fire safety audits;
- Provide fire safety awareness training as appropriate for managers and employees.

4.3.9. Occupational Health Service

The Trust will have in place the provision of an Occupational Health Service to provide for:

- Pre-employment health screening;
- Vaccinations and TB skin testing;
- Routine health surveillance of employees where appropriate;
- Site visits when requested;
- Advice on current health and safety legislation;
- Advice to managers and staff on sickness related absence and measures available to rehabilitate employees who have experienced ill health problems;
- Counselling for employees, including return to work and redeployment
- Confidential record keeping;
- Undertaking specific risk assessments as required.

The Occupational Health Specialist Nurse is a reporting member of the Health and Safety Steering Group.

4.3.10. Infection Control Department

Infection Control Nurses / Advisors have been appointed by the Trust. Their duties include:

- Advising on legislation and best practice relevant to infection control, including PPE, Control of Substances Hazardous to Health (COSHH), Clinical Waste Management Acts and NHS Decontamination Guidelines, contributing to the formulation and review of policies and procedures.
- Working in partnership with multi-professionals including internal and external agencies, acute hospital / community hospital teams, Infection Control Nurses Society, Occupational Health, Department of Health, Environmental Health Departments, and Public Health Department.
- Actively undertaking on-going surveillance by observing changes in the environment, and identification of individuals that may lead to an increase in disease / infection.
- Auditing of departments to monitor the safety and effectiveness of preventative and control measures.
- Providing information to clinicians, risk assessments and advice on control measures and evaluating actions taken for effectiveness.
- Report to the Trust Health and Safety Steering Group on an every other month basis.

4.3.11. Moving and Handling Manager and Trainers / Advisors

The Moving and Handling Trainer/Advisors will undertake all training in manual handling, assist managers to carry out manual handling risk assessments and provide manual handling advice to managers and staff as appropriate. Their duties include:

- To work with Managers and staff to ensure that risk assessments are written and that where appropriate, guidelines of safe practice are produced. This will include the use of manufacturer letters of recommendations and product advice notes.

- To co-ordinate moving and handling training within the Trust. To run courses for all staff grades to equip them with the skills and knowledge to assist in reducing moving and handling accidents/incidents in their areas. To ensure the content of training programmes is appropriate and relevant to the staff group. To keep comprehensive records of training they facilitate. To ensure that central records are updated in a timely way through provision of completed registers. To keep up to date with current research, equipment and techniques, and also to liaise with team and outside trainers to ensure parity and content of training.
- To provide training, support and advice for Managers on how to undertake risk assessments and how to implement controls. Carry out audits of the effectiveness of the Moving and Handling Policy.
- To provide advice and support on the sourcing and selection of moving and handling equipment to minimise risks in the workplace. To arrange trials of new equipment, in conjunction with other multi-disciplinary team, i.e. those that will be using the equipment and specialists. To advise on the purchase of other equipment, which impacts on moving and handling, e.g. trolleys, chairs, etc. To give ergonomic advice on workstation assessments, the design of new areas and upgrading of existing areas, where requested. To assist in carrying out departmental audit as required.
- To receive moving and handling accidents/incidents reports from the Risk Management department or Health and Safety office and to follow up where appropriate. To report to the Trust Health and Safety Steering Group, on an every month basis.
- Design and maintain lesson plans including the session objectives.

4.3.12. Managers and Supervisory Staff

Managers have responsibility for the effective management of health and safety within their area of control / Department(s) and for actively promoting the implementation of this Policy and associated Policy Arrangements and will:

- Fully familiarise themselves with the safety organisational structure and ensure that all people in their charge comply with the safety policy at all times.
- Undertake risk assessments and draw up safe systems of work for their areas of responsibility.
- Ensure that site inspections are undertaken at least every 13 weeks, and the results from inspections are recorded on the Trust Health and Safety 13 week Inspection Checklist, indicating actions, time scales and relevant persons responsible
- Ensure that employees in their charge undertake mandatory training and other health and safety training deemed appropriate to their posts.
- Ensure that the job descriptions of employees in their charge reflect their health and safety responsibilities and these responsibilities are reviewed on an annual basis or sooner as appropriate.
- Establish health and safety targets for their part of the service and monitor health and safety performance in relation to those targets (e.g. absence levels caused by work related accidents and incidents, undertaking of health and safety risk assessments, percentage of staff attendance at mandatory training, level of completion of planned preventative maintenance where appropriate).
- Ensure that all accidents and incidents are recorded, that they are investigated and accident reports are completed promptly.

- Ensure that all people in their charge are aware of the procedures on the Trust extranet system, to be adopted in the event of fire or other foreseeable emergency.
- Ensure that all people in their charge know the first aid arrangements.
- Ensure, where reasonably practicable, that adequate supervision is available at all times for employees in their charge.
- Devise safe working practices for tasks under their control and ensure that only safe working practices are used, in order to provide maximum safety for all people in their charge.
- Ensure sufficient persons in their department available and supported to discharge H&S responsibilities.
- Brief employees on health and safety procedures and policies.
- Maintain good housekeeping standards in their departments / sites at all times.
- Ensure that any health and safety problem, which cannot be resolved by them, is raised quickly with their line manager.

4.3.13. Employees

All employees have a legal duty to take reasonable care for their own health and safety and of others who may be affected by their acts or omissions, and will:

- Make themselves familiar with the organisations' Health and Safety Policy.
- At all times make full and proper use of the appropriate safe systems of work, safety equipment and protective clothing and make full use of appropriate safety devices.
- Report to their line manager any unsafe systems of work which develop contrary to instructions, unsafe working conditions, damage to plant, machinery or equipment and report accidents and incidents immediately.
- Take reasonable care for the health and safety of themselves and of other people who may be affected by their acts or omissions.
- Co-operate with the organisations so as to enable them to carry out their own duties and responsibilities.
- Not intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare by the organisations.
- Report any accident / incident which results, or could have resulted, in injury in accordance with the Trust Incident and Serious Incident Reporting Policy;
- Attend mandatory safety training as directed.

4.3.14. New Employees

In addition to the provisions of section 4.3.14 above, new employees shall:-

- Be inducted in all Trust and departmental relevant health and safety requirements before working unsupervised.
- Ensure that they have read and fully understood instructions in the event of fire or other serious or imminent danger.
- Familiarise themselves with the Trust Incident Reporting and Management Policy.

4.3.15. Employee Safety Representatives

The Trust actively seek to appoint staff safety representatives who will work with the Trust in ensuring that the workplace is a safe and healthy environment, playing a key

role in protecting members of staff at work from injury and disease. Safety Representatives are entitled to:

- Undertake, or accompany managers (and Union Appointed Health & Safety Representatives and others) in the undertaking of regular site safety inspections.
- Accompany the Health and Safety Co-ordinators/ Leads during Health and Safety Audits and Inspections.
- Investigate unsafe conditions.
- Identify potential hazards at work.
- Liaise with other specialists.
- Campaign to raise awareness of health and safety Issues.
- Attend meetings, study days and conferences.

4.3.16. Trade Union – Appointed Representatives

The role of the health and safety representative is independent of management. Representatives represent the interests and concerns of their co-workers and respond on their behalf. They may provide co-workers valuable insight, skills and resources that help employers.

Functions of union-appointed health and safety representatives:

- To represent employees generally, and
- Are consulted with about specific matters that will affect the health, safety and welfare of employees they represent
- To represent employees when Health and Safety inspectors from Health & Safety Executive (HSE) or local authority
- The representatives can investigate accidents, near misses, and other potential hazards and dangerous occurrences in the workplace
- To investigate complaints that has been made by an employee they represent about their health, safety or welfare in the workplace and share the findings of the investigation with the organisation
- To inspect the workplace with at least one other appointed representative, request in writing to the organisation Health and Safety Executive Lead
- Attend the organisation Health and Safety Steering Group

4.3.17. Contractors

All contracts for services in the Trust work places, or otherwise affecting Trust staff, shall comply with the terms of this policy and the Health and Safety Management Managing Contractors Policy Arrangements, so far as is appropriate to protect the health, safety and welfare of staff, patients, visitors and others who may be affected.

## 5. Arrangements

### 5.1. Management Arrangements

The objective of the Trust is to ensure continual improvement by utilising a planned, systematic approach to managing health and safety. The HSE in August 2013 revised its guidance and replaced HSG 65 'Managing for health and safety – POPIMAR model'. The 'new' version is simpler to understand, easier to apply and because it uses the – PLAN – DO – CHECK – ACT (PDCA) cycle it is easier to integrate health and safety with other systems, such as those for quality and environmental management. The removal

of Policy step 'P' of POPIMAR does not in any way change the legal requirement under section 2 of Health and Safety at Work Act 1974.

### 5.1.1. 'Plan'

'Planning' has a specific legal requirement under the Management of Health and The Trust Health and Safety at Work Regulations 1999, regulation 5 which requires the employer to make and give effect to such arrangements as are appropriate; the plan should be in writing. Therefore the policy details the commitment of the organisation, the key responsibilities for health and safety and outlines the safety arrangements.

The Health and Safety Policy is issued to all staff on appointment and when amendments are made. Clear communication of requirements is covered in the staff induction and always readily available for all staff at all times.

The Health and Safety Policy contains a commitment to continual improvement and to comply with current applicable health and safety legislation.

**Organisational Policy Arrangements**

- These Policy arrangements will be consulted on via the Health & Safety Steering Group, specialist individuals, Joint Staff Side Safety Representatives, Divisional / Directorate Health & Safety leads and their divisional Health & Safety Working Groups, and ratified by the Clinical Management Executive (CME).
- The Health & Safety Overarching Policy will be approved by Trust Board; as will Fire Policy and Security Policy; all other Health & Safety policies will be ratified at Trust Policy Group.

5.1.2. **'Do**' - Implementation

To implement the **'Do'** step of the PDCA, the right systems and procedures to manage the hazards that arise in the organisation. Risk assessments will identify the hazards and actions taken, or to be taken, to minimise the risk. This section implies that the organisation be less reactive and more active and dynamic in approach.

- The Chief Executive is ultimately responsible for health and safety within the organisation including the achievement of the health and safety objectives, provision of appropriate resources, competent appointments, training, systems of work, monitoring and review of safety performance.
- The Nominated Director (see 4.3.2) provides specific co-ordination of health and safety requirements.
- Managers are responsible for the safe operation of the services under their control.
- An operational group called the Health and Safety Management Group will be in place and meet regularly, consisting of the Health & Safety Assurance Team and the Clinical Unit former Divisional Health & Safety Leads, to implement and monitor Health & Safety Management systems.
- Employees are kept up to date on changes which may affect their health and safety and active communication takes place through the Health and Safety Steering Groups and Clinical Unit Health & Safety Groups.
- The Trust annual Action Plan specifies the actions to be taken to ensure that the organisation have a robust health and safety management system.

- Training of employees is fundamental to the organisation's approach to health and safety. The planned approach ensures:-

    a) Identification of training needs
    b) Training programme to ensure competence
    c) Effective training records
    d) Review and appraisal of employee performance

- The organisations are committed to ensuring employees are competent to do the job that they are required to do.
- The documentation that forms the Health and Safety Manual is kept up to date by Health & Safety Assurance Team and is available to all staff the Health & Safety extranet website.
- The organisation's extranet site provides information on the health and safety policy and supporting policy arrangements, together with safety information.

5.1.3. **'Check'** and **'Act'** - Monitoring and Measuring

**'Check** and Act' are the action-based elements of the cycle. 'Check' requires that the plan (policy) includes monitoring. Audits and inspections are vital tools in the 'Check' part of the PDCA. They are both preventative, active monitoring techniques. The other principal activity is 'reactive monitoring' reviewing accidents and incidents that have occurred and recorded in the risk management system – Datix web.
**'Act'** means that having set our plan (policy) in place the health and safety team will monitor the effectiveness and additional actions that maybe required.

- The Trust will ensure that a system of internal audit is undertaken in order to ensure that the management of health and safety at work systems are effectively monitored and reported on.
- Benchmark audits of the various clinical and non-clinical services will be completed by the Assurance H&S team and the outcomes of these audits will be reported to the service with corresponding actions (if applicable) and reported to the Trust Health and Safety Steering group highlighting the trends and actions that have been instigated or to make recommendations for changes.
- The benchmark audit programme once completed for all areas will clarify actions (if applicable ) that each need to complete and provide a re audit date by the H&S team.
- Clinical units will complete quarterly reports for the Health & Safety Steering Group utilising the key performance indicators (KPIs) that were developed with service.
- Staff/Union Safety Representatives have a statutory right to undertake workplace inspections every 13 weeks. This must be requested in writing to the Clinical Unit Head of Nursing. Staff/Union representatives will be invited to attend regular workplace inspection carried out by management.
- All accidents, incidents and non-conformances against requirements are appropriately documented, reviewed and investigated.
- Risk Assessments are completed and risk treatment plans are produced to reduce the risk and prevent harm. The effectiveness of such actions is reviewed at Clinical Unit Health & Safety Groups and reported as part of the services KPIs at the Trust Health and Safety Steering Group.
- The Health and Safety Steering Group meets every other month and carries out its functions in accordance with this Health and Safety Policy.

5.1.4. Changes in Legislation

- It will be the responsibility of the Trust Lead Health and Safety to ensure that the Directors, managers, Trust Safety Representative, Joint Staff Side for the attention of the health and safety representatives and staff of the Trust are aware of changes in legislation and/or associated good practice.
- Such changes will be notified to the Health and Safety Steering group and will also be distributed throughout the Trust using normal information channels.
- The Health and Safety Policy and associated Policy Arrangements will be updated as appropriate.

## 5.2. Operational Arrangements

5.2.1. Risk Assessment

The undertaking of risk assessments is a requirement of a range of health and safety regulations, for example:

- Management of Health and Safety at Work Regulations 1999;
- Control of Substances Hazardous to Health Regulations 2002 (as amended);
- Provision and Use of Display Screen Equipment Regulations 1992 (as amended);
- Manual Handling Operations Regulations 1992 (as amended);
- Provision and Use of Work Equipment Regulations (PUWER) 1998

Managers are required to ensure that proactive risk assessments are undertaken in accordance with legislation (see above section 5 of this policy).

Where health and safety regulations require the undertaking of risk assessments, it will be the responsibility of Clinical Unit and Senior Managers to ensure that they are undertaken within their entire area of responsibility, e.g. Directorate / service, and appropriate action taken to reduce the risk of illness or injury. It will be the responsibility of the Clinical Unit leads to nominate Managers and Supervisors to undertake risk assessments, who will be specifically trained to undertake this task, refer to the *Risk Assessment (General) Policy revised* March 2012 for the procedural detail.

Risk assessments are to be undertaken with full staff involvement. Safety representatives of recognised trade unions should be involved, as they are able to inform the risk assessment process, either through personal experience or through the organisation that they represent. Consultation with union representatives on health and safety matters is also a statutory requirement.

The Trust has produced General Risk Assessment Policy Arrangements and Risk Assessment Forms for the purpose of undertaking risk assessments.

Completed risk assessments are to be retained by managers locally for future reference and inspection by internal and external agencies and regulatory bodies.

Risks relating to Health & Safety are captured through the risk assessment process. Risk information will be discussed at clinical unit H&S/Risk meetings and where applicable it will be transferred from Risk Assessments onto the clinical unit Risk Register.

All **extreme** and **high** rated assessments (plus any assessments where "multiple fatalities" or "fatality" are identified) will be reported to the Health and Safety Assurance Team.

Each Clinical Unit will review their risk assessment actions at the local Health and Safety Working Groups covering the service /clinical services concerned.

Extreme and High Risks recorded on the Health and Safety Assessment Action Plans will be reviewed at the Trust' Health and Safety Steering Group and Clinical Units Groups.

5.2.2. Safe Systems of Work and Permits to Work

A Safe System of Work (SSW) is defined as a formal procedure which allows a specific task to be carried out safely after systematic examination of that task has identified all of the associated hazards and risks. Safe systems of work are required to be put in place when the hazards identified cannot be eliminated and a level of risk remains. Managers are responsible for ensuring that a risk assessment is undertaken in respect of all tasks where there is a risk to safety or health (as required by the Management of Health and Safety at Work Regulations 1999) and for reducing those risks to an acceptable level with the introduction of appropriate control measures. Where this cannot be achieved, a Safe System of Work must be introduced. This should be developed in conjunction with the Trust Health and Safety department.

Where a task is considered to be potentially hazardous or dangerous, a permit to work (PTW) system must be introduced. This consists of the establishment of a formally written procedure involving a permit or formal written approval to undertake part of a safe system of work. This should be developed in conjunction with the Trust Health and Safety Department. PTW's must be completed for the following high risk work:

- Hot Work (Fire precautions)
- Working in Confined Spaces
- Low voltage electrical working
- High voltage electrical working
- Medical gas pipelines (low and high hazard)
- Working on roofs
- Working on ventilation
- Fire alarm isolation
- Work on steam boilers
- Work on generators
- Work on bacteria filters
- Microbiology fume extraction cabinets + containment level 3 (CL3)

5.2.3. Training and Induction

Training of employees is fundamental to the organisation's approach to health and safety. The planned approach ensures:-

a) Identification of training needs
b) Training programme to ensure competence
c) Effective training records
d) Review and appraisal of employee performance

The organisation is committed to ensuring employees are competent to do the job that they are required to do.

The Trust will undertake to provide adequate health and safety training and information to all employees to enable them to improve their knowledge and awareness of health and safety and to discharge their own health and safety responsibilities.

General and site specific health and safety training is mandatory and is included in the Trust Mandatory Training Programme and site induction programmes.

Managers, in conjunction with the Learning & Development Team, must ensure that employees in their charge undertake mandatory training and other health and safety training deemed appropriate to their posts, within available resources.

**The following training will be provided and mandatory:**

**Induction**

- E-learning package – all staff

**Chief Executive / Directors and Assistant Directors:**

- IOSH Safety for Senior Executives or equivalent
- 1 day
- Every 3 years

**Heads of Service / Senior Managers:**

- IOSH Managing Safely for Healthcare Professionals or equivalent
- 5 days
- Every 3 years

**Managers and Supervisors:**

- Health and Safety in the Workplace
- 1 day
- Every 3 years

**All other Employees:**

- E-learning package
- 30 minutes
- Every 3 years

*(Refer to the Trust Learning & Development Policies and Mandatory Training Programme)*

5.2.4. Incident Reporting & RIDDOR reporting

The Trust will have in place robust accident/incident reporting systems which requires that all accidents involving injury, however trivial, should be notified to the immediate supervisor on duty by or on behalf of the individual concerned. An

incident report form must be completed without delay. The primary purpose of incident reporting is not to apportion blame but to enable prompt remedial action.

It is important for managers to take statements as soon as possible from people who have witnessed an accident, to ensure that a full and accurate picture is obtained of why and how the accident occurred.

Where health and safety at work is concerned employers are bound by both common and statute law to take reasonable care of the health, safety and welfare of their employees at work. It is important therefore for managers to bear in mind the possibility of a civil claim if an accident occurs. If the accident resulted from a breach of law, the organisation, or one of its officers, could face a criminal prosecution.

It is the line manager's responsibility to ensure that the system works and that staff involved in completing incident report forms should receive training in the purpose for which the forms will be used and how to fill them in.

**RIDDOR Reporting**

The Trust, as an Employer and/or in control of premises has a duty to report some* accidents and incidents at work under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) to the Health & Safety Executive (HSE).

The report to the **HSE Incident Contact Centre (ICC)** will be made by the quickest means possible by the Health and Safety Manager or Deputy to submit the RIDDOR report to HSE.

**By telephone direct to HSE only for *Fatalities or Major Injuries only***
0845 300 9923 *(Monday to Friday 8.30 am – 5.00 pm)*
The ICC advisers will help make a report over the phone. They will send you a copy of the completed form for our own records and we will have the opportunity to correct any errors or omissions. The report will then be passed on to the HSE.

**Online**

Further information can be found: visit www.hse.gov.uk/riddor/index.htm.

*the following must be reported by the Trust Lead or Deputy:

- Deaths;
- Specified injuries;
- Over-7-day injuries – where an employee or self-employed person is away from work or unable to perform their normal work duties for more than 7 consecutive days;
- Injuries to members of the public or people not at work, where they are taken from the scene of an accident to hospital;
- Some work-related diseases;
- Some dangerous occurrences – a near miss, where something happens that does not result in an injury, but could have done;
- Gas Safe-registered gas fitters must also report dangerous gas fittings they find, and gas conveyors/suppliers must report some flammable gas incidents.

Deaths, major injuries and dangerous occurrences must be notified without delay, however only the following need to be notified out of normal working hours:

- Fatal accidents at work;
- Accidents where several workers have been seriously injured;
- Accidents resulting in serious injury to a member of the public;
- Accidents and incidents causing major disruption, such as evacuation of people, closure of roads, large numbers of people going to hospital etc.

**Organisational arrangement**

- All fatalities and near fatal injury must also be reported to the Executive lead or, if out of hours, the Director on call, to confirm that the incident will be entered on to the organisation Serious Incident STEIS database. The line manager for the service will carry out a formal investigation and complete a root cause analysis report.

- The process since the 6th April 2012 is that only 7-day plus days off sick whereby injuries were sustained as a consequence must be reported within 15 days.

- Cases of work related ill-health MUST also be reported on an incident form to both the Occupational Health and Health and Safety Departments and on their advice inform the HSE.

- It is the responsibility of the Clinical Unit /Directorate to ensure that they inform the health and safety team where a member of staff is off sick due to an incident whereby the staff member has sustained an injury due to that incident whilst at work; so that a RIDDOR form can be completed and forwarded to the HSE.

- The reporting rules on specified injuries also apply to dangerous occurrences, even if no injury is caused.

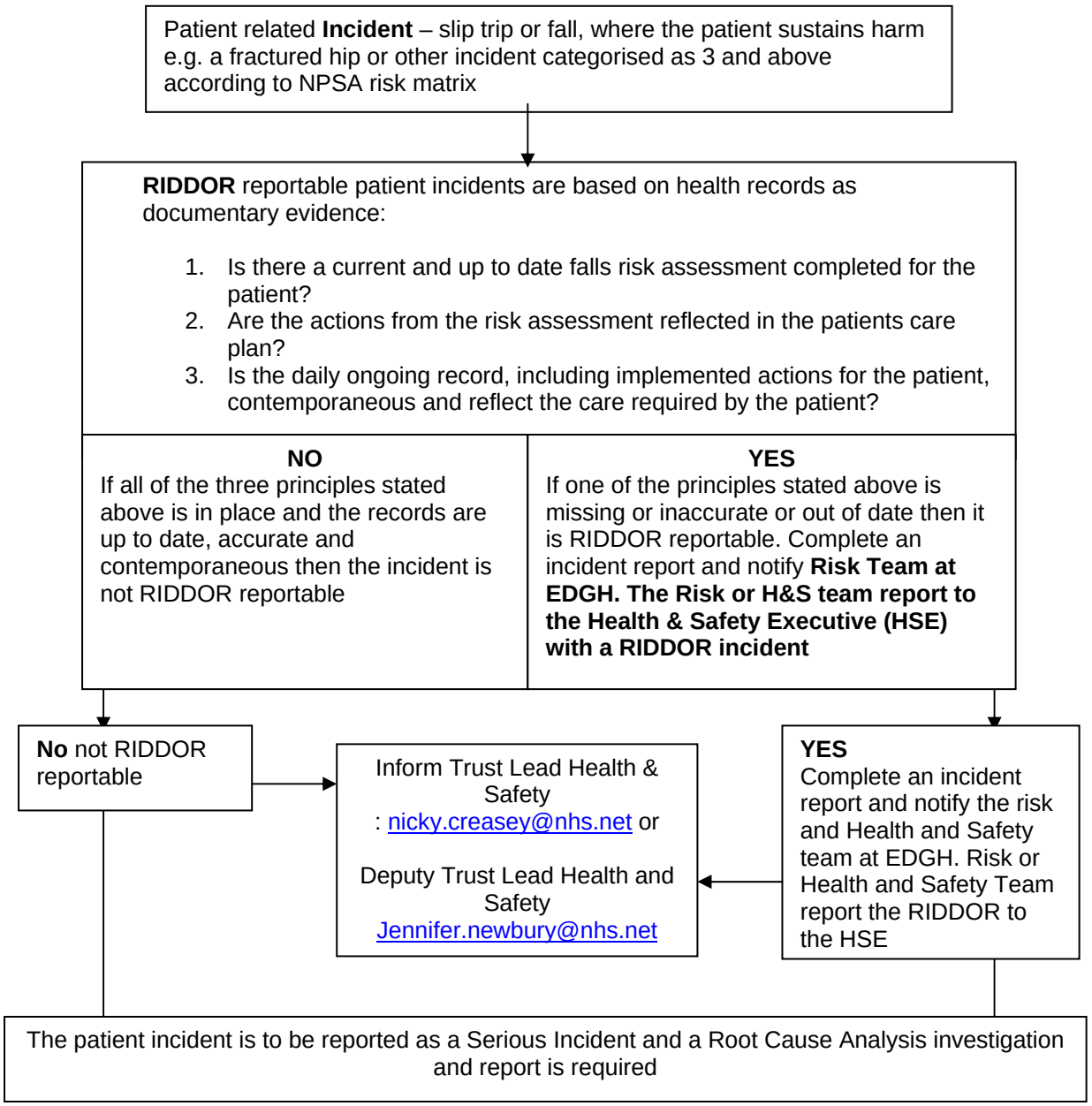
- A copy of the RIDDOR Report will be attached to the appropriate datix incident by the Assurance Manager Health & Safety or Deputy Assurance Manager Health and Safety.

**Patient RIDDORs**

See the flowchart below for the system and processes to be utilised.

**East Sussex Healthcare NHS Trust – flowchart**

**Incident patient related RIDDOR reporting flowing chart**




- Reporting Injuries, Diseases and Dangerous Occurrences Reports (RIDDOR) – guidance for employers, Health services Information Sheet No. 1 (Revision2), April 2012.

**Accident Follow-ups**

The Occupational Health Service and the Health &Safety Team will scrutinise staff accident forms and will contact the employee involved or their manager to ensure that proper preventative action has been taken.

Where there are cases of work related ill-health they MUST be fully investigated by the Clinical Unit/Directorate in conjunction with Occupational Health and the Health and Safety Department as appropriate.

5.2.5. Occupational Health

All staff have the facility for direct access to the Occupational Health Department through self-referral. Where necessary, managers may refer staff to the Occupational Health Department for an assessment of their abilities and/or fitness for work. The Occupational Health Department is responsible for assessing the capability of newly appointed staff to undertake their role and recommend any reasonable adjustments (required due to health conditions due to on-going health surveillance, i.e. audiology) (for specific work related areas), latex glove usage – etc.

5.2.6. Asbestos Management

Asbestos has been widely used, e.g. as lagging on plant and pipe work in insulation products such as fireproofing panels, in asbestos cement roofing materials, and as sprayed coating on structural steelwork to insulate against fire and noise. All types of asbestos can be dangerous if disturbed. The danger only arises when asbestos fibres become airborne and are breathed in. Exposure can cause diseases such as lung cancer.

Persons responsible for the maintenance and repair of work premises must find out if there is any asbestos and where it is. If this cannot be done, then it must be presumed that it exists. Risks from the asbestos must be managed and anyone who may disturb it must be told where it is and what condition it is in. **Well-sealed, undamaged asbestos is best left alone.**

The condition of asbestos-containing material (ACM) must be inspected on a regular basis. If it begins to show signs of deterioration and is liable to give off dust, it may need to have it removed.

If any work has to be carried out on asbestos you must:

- Carry out an assessment of the risks to the health of employees from exposure n to asbestos;
- Use the working methods and precautions described in the asbestos Approved n Codes of Practice, or other equally safe methods such as those detailed in HSE's *Asbestos essentials task manual*.

Products containing asbestos must carry a warning label.

5.2.7. Contractors

Where contractors are working on Trust sites, notification of such, together with the intended work schedule must be made to the Trust site manager or service manager. Contractors will be given a copy of the Trust Health and Safety Policy, together with the general information document on health and safety for contractors, plus any other

specific information concerning hazards on site. All contractor work will be the subject of the requirements of the Construction (Design and Management) Regulations 2007 as appropriate, and the requirements of the Management of Health and Safety at Work Regulations 1999 plus any other prevailing legislation governing that activity..

Where contractors are engaged locally to undertake services or work not subject to the above regulations and which are not commissioned through the Trust Estates Department, a copy of the contractor's health and safety policy will be obtained and the contractors will be provided with appropriate safety information including risk assessments in relation to the site and/or task.

5.2.8. Control of Hazardous Substances to Health (COSHH)

No member of staff will be required to work with substances which are classified as hazardous to health in accordance with the Control of Substances Hazardous to Health Regulations 2002, until a risk assessment has been undertaken in accordance with those regulations and appropriate control measures have been introduced to reduce the level of risk to health to an acceptable level. Staff must be trained in the proper use of the substances and given appropriate information with regard to the use and control measures.

5.2.9. Working with Display Screen Equipment (DSE)

The Provision and Use of Display Screen Equipment Regulations 1992 apply throughout the Trust. A self assessment of the workstation by members of staff appropriate to the work they undertake must be undertaken in respect of every DSE workstation and appropriate furniture and equipment supplied to enable staff to work with DSE in a manner which does not present a risk of ill-health or injury. A VDU self-assessment will be completed by each DSE user annually.

5.2.10. Driving at work

The Health and Safety at Work etc Act 1974 requires that employers ensure, so far as is reasonably practicable, the health and safety of all employees while at work. Driving is considered a place of work and employers have a responsibility to ensure that others are not put at risk by work-related driving activities. Under the Management of Health and Safety at Work Regulations 1999, employers have a responsibility to manage health and safety effectively. Employers are required to ensure our employees are fit to drive and that any vehicles used for work purposes are fit for use and fully insured for business use.
Health and safety law does not apply to commuting, unless the employee is travelling from their home to a location which is not their usual place of work.

These requirements are in addition to the duties you have as an employer under road traffic law, e.g. the Road Traffic Act and Road Vehicle (Construction and Use) Regulations, which are administered by the police and other agencies such as the Vehicle and Operator Services Agency.

5.2.11. Electrical Equipment

All electrical equipment used by Trust staff, plus any electrical equipment owned by patients and used on Trust premises, will be subject to an annual (or otherwise agreed) test Portable Appliance Testing (PAT) by a competent person through a

contractual agreement with the Trust Estates Services providers. Users of electrical equipment should undertake basic checks on a regular basis.
Fixed installations will be inspected at a frequency dictated by the Electricity at Work Regulations 1989.

5.2.12. Work Equipment and Machinery

It is the policy of East Sussex Healthcare Trust to comply with the letter and spirit of the Health and Safety at Work etc, Act 1974, the Provision and Use of Work Equipment Regulations (PUWER) 1998 and all other relevant legislation, and to regard the provisions of this legislation as minimum requirements. The Trust accepts the importance of well-organised, proactive risk assessment and management which results in improvements to the health and safety of staff and others affected by the undertaking of the Trust.

5.2.13. Fire Safety

Every site shall maintain a fire property log, the purpose of which is to ensure that all fire safety information relating to that property is made accessible to managers, staff and regulatory authorities. Managers will ensure, in conjunction with the Fire Safety Adviser, that fire and emergency evacuation procedures are developed for every property and that these are appropriately displayed within the property. Further details of fire safety procedures are set out in the Trust Fire Safety Policy.

5.2.14. Flammable and Explosive Substances

Some gases, liquids and solids can cause explosions or fire.

Common materials may burn violently at high temperature in oxygen-rich conditions, e.g. when a gas cylinder is leaking. Some dusts form a cloud which will explode when ignited. A small explosion can disturb dust and create a second explosion severe enough to destroy a building. Serious explosions can occur in plant such as ovens, stoves, workshops and boilers.

Some materials are explosives and need special precautions and licensing arrangements.

The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) require you to carry out a risk assessment of any work activities involving dangerous substances so that you can eliminate or reduce any risks identified.

5.2.15. First Aid

The Health and Safety (First Aid) Regulations 1981 require that an assessment (not necessarily written) of first aid needs appropriate to the circumstances of each workplace should be made and sufficient first aid personnel and facilities should be available to give immediate assistance to casualties and to summon emergency or other professional assistance. As a minimum provision, every member of staff will have access to suitably stocked and properly identified first aid supplies, which must be regularly checked to ensure that the contents are complete and up-to-date. Managers are required to ensure the provision of first aid equipment and trained First Aiders as appropriate. In healthcare settings nominated First Aiders can be doctors and nurses providing they are available at all times to attend to an emergency ‘First Aid’ incident. Likewise First Aid supplies can be drawn from clinical supplies, but again, providing they are available at all times to attend to an emergency ‘First Aid’ incident

5.2.16. Gas and Oil Fired Equipment

There is a danger of fire and explosion and of toxic fumes (carbon monoxide) from piped gas supplies and appliances if they are not properly installed and maintained. Explosions can occur in gas- and oil-fired plant such as ovens, stoves and boilers.

The Gas Safety (Installation and Use) Regulations 1998 cover gas appliances, both natural gas and LPG, in most premises except in factories, where the Health and Safety at Work etc Act 1974 (the HSW Act) requires an equivalent or higher standard to be met.

5.2.17. Legionella

Legionnaire disease is a potentially fatal form of pneumonia which can affect anybody, but which principally affects those who are susceptible because of age, illness immuno suppression, smoking etc. It is caused by the bacterium legionella pneumophila and related bacteria. Legionella bacteria can also cause less serious illnesses which are not fatal or permanently debilitating.

The Trust recognises its responsibility to ensure that the facilities it provides always meet essential standards and that those standards are regularly monitored. In doing so it accepts that it must take every necessary and reasonable precaution to protect the people occupying, working within, visiting and passing by its premises. Of paramount importance is the standard of water quality. This is emphasised by the natural vulnerability of patients and an increasing awareness of the measures required to control and maintain standards as highlighted by the outbreaks of Legionnaires' disease reported in the media.

It is the objective of the organisation to comply with its legal duty to prevent or control legionellosis. We aim to:-

a) Prevent the proliferation of the organisms in the water system and
b) Reduce so far as is reasonably practicable exposure to water droplets and aerosol.

A detailed Policy will be in place to meet the requirements of Health & Safety Commissions' 'Approved Code of Practice & Guidance (L8) and the DOH Health Technical Memorandum (HTM) 04-01: The control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems.

5.2.18. Lone Working

The Trust recognises that lone workers can be at particular risk and have developed Policy Arrangements to assist in the implementation of this Policy. All managers have a responsibility, as part of their management role, to ensure that measures are in place to reduce the level of risk to lone workers. The risk assessment undertaken as part of the requirements of the Management of Health and Safety at Work Regulations 1999 will include the risks to lone workers.

5.2.19. Lifting Equipment and Lifting Operations

Refer to the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) which came into force on 5 December 1998. The Regulations aim to reduce risks to people's health and safety from lifting equipment provided for use at work. In addition

to the requirements of LOLER, lifting equipment is also subject to the requirements of the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The Trust will put in place Policy Arrangements to meet the LOLER Regulations, to ensure, in particular, that lifting equipment provided for use at work is:

- Strong and stable enough for the particular use and marked to indicate safe working loads;
- Positioned and installed to minimise any risks;
- Used safely, i.e. the work is planned, organised and performed by competent people; and
- Subject to on-going thorough examination and, where appropriate, inspection by competent people.

5.2.20. Manual Handling

The provisions of the Manual Handling Operations Regulations 1992 (as amended) apply throughout the Trust. No member of staff may be asked to carry out a task which may present a risk of injury until a risk assessment has been undertaken in relation to that task, control measures have been introduced to reduce the level of risk involved and the member of staff has attended manual handling training.

5.2.21. New and Expectant Mothers

Pregnancy should be regarded as part of everyday life and therefore is not equated with ill-health. However, on occasion, the workplace or workplace conditions and process may pose a hazard to the expectant, new or nursing mother and this may be compounded by pregnancy related health conditions.

A detailed Policy document will be in place set a standard template for assessing the risks to 'Women of Child Bearing Age' and New and Expectant Mothers (NEMS) and to provide clear information for implementing control measures and the allocation of suitable resources in order to identify, address and reduce the health, safety and welfare risks involved for New and Expectant Mothers employed by the organisation and also to her unborn child. The aim of this guidance is to ensure all employees who become pregnant undergo a risk assessment as early in their pregnancy as possible and that all reasonable and practical measures are taken to avoid or reduce hazards to new or expectant mothers and their unborn child.

5.2.22. Noise at Work

Hearing damage caused by exposure to noise at work is permanent and incurable. Research estimates that over 2 million people are exposed to noise levels at work that may be harmful. There are many new cases of people receiving compensation for hearing damage each year, through both civil claims and the Government disability benefit scheme, with considerable costs to industry, society and, most importantly, the people who suffer the disability.

Hearing loss is usually gradual due to prolonged exposure to noise. It may only be when damage caused by noise over the years combines with normal hearing loss due to ageing that people realise how deaf they have become. Hearing damage can also be caused immediately by sudden, extremely loud noises. Exposure to noise can also cause tinnitus, which is a sensation of noises in the ears such as ringing or buzzing. Tinnitus may occur in combination with hearing loss.

A Policy Document will be in place to meet **The Control of Noise at Work Regulations 2005** (The regulations do not apply to members of the public exposed to noise from their non-work activities, or making an informed choice to go to noisy places), in particular:

a) Take action to reduce exposure to noise and provide personal hearing protection and health surveillance to employees;
b) Procurement of tools and machinery to operate more quietly; and
c) Make use of the personal hearing protection or other control measures supplied.

5.2.23. Personal Protective Equipment (PPE)

Employers have basic duties concerning the provision and use of personal protective equipment (PPE) under the requirements of the **Personal Protective Equipment at Work Regulations 1992 (as amended).**

PPE is defined in the Regulations as 'all equipment (including clothing affording protection against the weather) which is intended to be worn or held by a person at work and which protects him against one or more risks to his health or safety', e.g. safety helmets, gloves, eye protection, high-visibility clothing, safety footwear and safety harnesses.

A Policy document will be in place to meet the PPE at Work Regulations 1992, in particular;

- That personal protective equipment is to be supplied (free of charge) and used at work wherever there are risks to health and safety that cannot be adequately controlled in other ways.

And also that PPE;

- Is properly assessed before use to ensure it is suitable;
- Is maintained and stored properly;
- Is provided with instructions on how to use it safely; and
- Is used correctly by employees.

5.2.24. Radiations

Every day in the UK, all manner of radiation types are used in a diverse range of industrial, medical, research and communications applications and, although these have brought increasing prosperity to people living in the UK, some applications cause harmful exposure risks that must be effectively controlled. A detailed Radiations Policy will be in place to provide a framework for controlling harmful radiations, in particular to meet the requirements of the '**Work with ionising radiation: Ionising Radiations Regulations 1999 Approved code of practice and guidance'.**

5.2.25. Pressurised plant and Equipment

If pressure equipment fails in use, it can seriously injure or kill people nearby and cause serious damage to property. The Trust recognizes and accepts its

responsibilities and will put in place Policy Arrangements to meet the Pressure Equipment Regulations 1999 and the Pressure Systems Safety Regulations 2000.

Examples of pressure systems and equipment are:

- Boilers and steam heating systems;
- Pressurised process plant and piping;
- Compressed air systems (fixed and portable);
- Pressure cookers, autoclaves and retorts;
- Heat exchangers and refrigeration plant;
- Valves, steam traps and filters;
- Pipework and hoses; and
- Pressure gauges and level indicators.

5.2.26. Security

ESHT has a duty to provide and maintain a safe and secure environment for patients, staff and visitors. A detailed Security Policy will be in place to include the application of the provisions of the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999 (as amended), Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (as amended), and other relevant legislation.

5.2.27. Slips, Trips and Falls

Slips, trips and falls are a major cause of accidents in the workplace. Many of these accidents can be avoided by regular workplace inspections, good housekeeping and proper reporting of potential hazards. All managers have a responsibility, as part of their management role, to ensure that measures are in place to reduce the level of risk caused by slips, trips and falls. If a risk assessment is required and undertaken as part of the requirements of the Management of Health and Safety at Work Regulations 1999 will include these risks. See also ESHT Health and Safety Management Slips Trips and Falls (Non Patient) Policy Arrangements.

5.2.28. Stress

Stress is recognised as a health and safety hazard and the Trust will have in place Policy Arrangement and implementation plan which assists the implementation of this Policy in regard to the management of stress at work. All managers have a responsibility, as part of their management role, to ensure that measures are in place to recognise the symptoms of stress and reduce the level of risk. The risk assessment undertaken as part of the requirements of the Management of Health and Safety at Work Regulations 1999 will include the risk of stress.

5.2.29. Violence and Aggression

The Trust will not tolerate violence or aggression towards any of its staff and actively seek to eliminate or control to an acceptable level potential situations that may give rise to violent or aggressive incidents. A separate document to provide detailed Policy Arrangements on Management and Assessment to address violence and aggression will be produced to implement the Trust Policy.

5.2.30. Workplace Health, Safety and Welfare

The provisions of the Workplace (Health, Safety and Welfare) Regulations 1992 apply throughout the Trust. The Trust will actively seek to ensure that workplace temperature, ventilation, lighting and room space is reasonable and does not compromise the safety or health of staff or others using Trust buildings.

Quarterly visual inspections will be carried out in each department or site and recorded by the divisional Health & Safety Teams.

Bi-annual audits will be made of each premises by the Estates Department team and monitored by the organisation Assurance Manager and Deputy Assurance Manager Health & Safety.

5.2.31. Workplace Transport and Vehicle Safety

A variety of vehicles are used for many different tasks every day in workplaces and some of these tasks can be dangerous. Every year, about 50 people die as a result of vehicle accidents in the workplace, and thousands are seriously injured.
A detailed Policy document will be in place to help managers and supervisors assess the risk associated with Workplace Transport, put in place safe systems of work to make vehicle accidents in the workplace less likely.

5.2.32. Waste Management

ESHT recognises and accepts that it must take all reasonable steps to dispose of waste legally in those premises it owns or operates within.
A comprehensive Waste Management Policy will be in place which will include objectives to:

- Ensure compliance with all legislation
- Provide all staff with explicit guidance in the safe handling and disposal of wastes.
- Enable all staff to recognise and comply with all legal requirements.
- Identify specific responsibilities.
- Identify and promoting safe methods of segregation.
- Reduce the impact the Organisations' business has on the environment.

Knowledge of the minimum Health and Safety requirement for the handling and disposal of healthcare waste is regarded as the mandatory for all staff employed by the Trust.

5.2.33. Working at Heights

Falls from height result in around 60 deaths at work and about 4000 major injuries every year. One of the main causes is falls from ladders.

It is the policy of East Sussex Healthcare Trust to comply with the letter and spirit of the Health and Safety at Work, etc Act 1974, the Working at Height Regulations 2005 and all other relevant legislation, and to regard the provisions of this legislation as minimum requirements. The Trust accepts the importance of well-organised, proactive risk assessment and management which results in improvements to the health and safety of staff and others affected by the undertaking of the Trust.

A detailed Policy Document will be in place to confirm the organisations commitment to Working Safely at Heights and to provide practical advice on how to eliminate or reduce the risks from working at heights.

5.2.34. Young Persons (in employment)

Young people, especially those new to the workplace, will be facing unfamiliar risks from the job they will be doing and from the working environment. They are seen to be particularly at risk because of their possible lack of awareness of existing or potential risks, immaturity and inexperience. For example, young people may find themselves in the presence of powerful chemicals or machinery, or may be in an occupation with the potential for violent or aggressive behaviour towards them. They are also likely to lack confidence and be eager to impress or please other people around them. Those who employ young people have an opportunity to instil within them an understanding of the importance of health and safety which will serve them well throughout their working life.

A Detailed Policy document will be in place to confirm the organisations commitment to and to implement the health and safety protection for young employees introduced by the European Directive on the Protection of Young People at Work (the Young Workers' Directive) through the Management of Health and Safety at Work Regulations 1999 (the Management Regulations).

There are also some special provisions for young people in the Working Time Regulations 1998 (the Working Time Regulations) introduced by the Department of Trade and Industry (DTI) to give all workers above the minimum school leaving age rights and protections in respect of their hours of work, night work, rest from work and paid annual holidays.

### 5.3. Health and Safety Manual and Records

Given the extent and variation in the Trust undertakings, separate Health and Safety Manual containing both generic and specific health and safety arrangements, tailored to provide a system of procedures to control the principal hazards within the specific location or department, must be maintained (and will be added to as new Policy Arrangements and local procedures are finalised) and made available to all staff by Heads of Service to ensure all managers implement the Policy Arrangements within the scope of their responsibilities.

***Depending on the staff group and access to computer systems, Manuals may be in the form of an electronic version (i.e. on the Trust Intranet) or In Hard copy form.***

Health & Safety records, such as Risk Assessments, COSHH Assessments, VDU checklists, Safe Systems of Work (SSW) and training must be produced and maintained by each department. **These records may be subject to internal and external audit.**

## 6. Equality and Human Rights Statement

This document has been assessed for Equality and Human Rights infringements and it is considered that it does not affect one group less or more favourably than another on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability.

## 7. Monitoring Compliance with the Document

**Monitoring Table**

| **Element to be Monitored**<br><br>**PDCA cycle** | **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** |
|---|---|---|---|---|---|---|
| Policy Manual (**P**lan) | Trust Lead H&S | Annual action plan | Monitored quarterly | HSSG | HSSG | HSSG |
| Implementation (**D**o) | Appropriate service manager | Annual action plan | Monitored quarterly | HSSG/Clinical unit | HSSG/Clinical unit | HSSG/Clinical unit |
| Measuring and Monitoring (**C**heck & **A**ct) | Deputy Trust Lead and appropriate CG /CU manager | Performance report/s | Monitored quarterly | HSSG/Clinical unit | HSSG/Clinical unit | HSSG/Clinical unit |
| | | | | | | |

## 8. Associated Polices/Documentation

- **Asbestos policy**
- **COSHH Policy Display Screen Equipment Policy**
- **Incident and Risk Management Policies**
- **Clinical Governance strategy**
- **Fire Safety Policy**
- **Moving and Handling Policy**
- **Induction Policy**
- **Legionella Policy**
- **Lone worker Policy**
- **New and Expectant Mothers Policy**
- **Waste Management Policy**
- **Workplace Stress Policy**
- **Latex Gloves Policy**
- **Central Alerts System (CAS) Policy**
- **Medical Devices Policy**
- **Slip, Trips and Falls (staff and public) Policy**
- **Security Policy**
- **Violence and Aggression Policy**
- **Contractors Policy and Booklet**
- **Driving for Work Policy**
- **Electrical Safety Policy**
- **First Aid at Work Policy**
- **Risk Assessment (General) template**

**(This list is not exhaustive)**

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 13 |
| **Subject:** | Fit and Proper Persons Requirements for Directors |
| **Reporting Officer:** | Lynette Wells, Company Secretary<br>Monica Green, Director of Human Resources |

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

**Purpose:**

The purpose of this report is to provide the Trust Board with a briefing on the fit and proper person requirement for directors and sets out how the Trust will provide assurance of compliance.

**Introduction:**

New fundamental standard regulations – the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – will come into force for all providers on 1 April 2015, subject to Parliamentary process and approval. However, within the new regulations, the fit and proper person requirements for directors have come into effect immediately for NHS providers.

.

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

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors disqualification order) and significantly, excluding from office people who:

*"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider."*

This is a significant restriction which, it is stated, will enable the Care Quality Commission ("CQC") to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider.

**Benefits:**

Provides assurance that directors are fit and proper persons.

**Risks and Implications**

Failure to comply could breach legislation and lead to regulatory action.

**Assurance Provided:**

This paper provides assurance of the processes the Trust has in place to meet the legislative requirements.

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

| Review by other Committees/Groups (please state name and date): |
|---|
| Remuneration Committee discussed this at their meeting in September 2014. |

| Proposals and/or Recommendations |
|---|
| The Trust Board is asked to review the requirements and agree the recommendations:<br>That the scope of this regulation will cover all those who attend the Trust Board on a regular basis; to include all Non-executive Directors, all voting and non voting Directors.<br>These directors will complete the enhanced self-declaration form in March/April each year. |

| 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:**<br>Lynette Wells, Company Secretary | **Contact details:**<br>lynette.wells2@nhs.net |

# EAST SUSSEX HEALTHCARE NHS TRUST

# FIT AND PROPER PERSON REQUIREMENT FOR DIRECTORS

## 1. INTRODUCTION

1.1 New fundamental standard regulations – the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – will come into force for all providers on 1 April 2015, subject to Parliamentary process and approval.

1.2 However within the new regulations, the fit and proper person requirements for directors have come into effect immediately, for NHS providers.

1.3 This paper outlines how the Trust will meet the requirements of the "fit and proper persons" standard.

## 2. THE REGULATION: FIT AND PROPER PERSON REQUIREMENT FOR DIRECTORS

2.1 Currently providers have a general obligation to ensure that they only employ individuals who are fit for their role and they are required to assess the fitness of nominated individuals (organisationally determined, but usually directors) to ensure that they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for the role, and can supply certain information (including a Disclosure and Barring Service (DBS) check and a full employment history).

2.2 The new fit and proper person requirement for directors has a wider impact, in both the scope of its application and the nature of the test. It makes it clear that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements.

2.3 The new standard will apply to all directors and "equivalents". This will include both Executive and Non-Executive Directors. It will be the responsibility of the Chair to ensure that all directors meet the fitness test and do not meet any of the "unfit" criteria.

2.4 In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors disqualification order) and significantly, excluding from office people who:

*"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider."*

This is a significant restriction which, it is stated, will enable the Care Quality Commission ("CQC") to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider.

## 3. REQUIREMENTS

3.1 The regulations will require the Chair to:

- confirm to the CQC that the fitness of all new directors has been assessed in line with the regulations; and
- declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role.

3.2 The CQC will cross-check notifications about new directors against other information that they hold or have access to, to decide whether we want to look further into the individual's fitness. They will also have regard to any other information that they hold or obtain about directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

3.3 Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing director come to the attention of the CQC, they may also ask the Trust to provide the same assurances.

3.4 Should the CQC use their enforcement powers to ensure that all directors are fit and proper for their role, they will do this by imposing conditions on the provider's registration to ensure that the provider takes the appropriate action to remove the director.

## 4. STANDARDS

4.1 To meet the requirements of this regulation, the Trust must carry out all necessary checks to confirm that persons who are appointed to the role of director (or similar senior level role, whatever it might be called) are:

- of good character (Schedule 4, Part 2 of the regulations);
- have the appropriate qualifications, are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude);
- have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments); and
- exhibit appropriate personal behaviour and business practices.

4.2 In addition, people appointed to these roles must not have not been responsible for, or known, contributed to or facilitated any serious misconduct or mismanagement in carrying on a regulated activity.

4.3 The CQC does recognise that a provider may not have access to all relevant information about a person, or that false or misleading information may be supplied to them. However, they expect providers to demonstrate due diligence in carrying out checks and that every reasonable effort is made to assure themselves about an individual.

4.4 For Non-executive directors this will be carried out in conjunction with the TDA who manage the Non-executive director recruitment process and undertake their own fit and proper person tests.

## 5. ASSURANCE

The table at Appendix A identifies the specific requirements of the fit and proper persons test and sets alongside those requirements how the Trust intends to assure itself about the suitability of individuals.

## 6. RECOMMENDATIONS

6.1 It is recommended that the scope of this regulation will cover all those who attend the Trust Board on a regular basis. This will include all Non-executive Directors, all voting and non voting Directors.

6.2 It is recommended that those identified in 6.1 above complete the enhanced self-declaration form shown at Appendix B on an annual basis.

6.3 It is recommended this annual exercise will be undertaken in March/April each year in line with the annual Declaration of Interests exercise.

Lynette Wells
Company Secretary

**Appendix A**

| Care Quality Commission Regulation 5: fit and proper person requirement for directors | | |
|---|---|---|
| **STANDARD** | **ASSURANCE** | **EVIDENCE** |
| Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations.<br>*(Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)* | Employment checks are undertaken in accordance with NHS Employers pre-employment check standards and include:<br>• Two references, one of which must be most recent employer<br>• qualification and professional registration checks<br>• right to work checks<br>• identity checks<br>• occupational health clearance<br>• DBS checks<br><br>For Non-executive directors this is co-ordinated by the the TDA appointments team. | References<br><br>Other pre-employment checks<br><br>DBS checks where appropriate<br><br>Signed declarations from applicants<br>Register search results |
| If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. | Disciplinary policy and procedure provides for such investigations.<br>Revised contracts allow for termination in the event of non-compliance with regulations and other requirements. | Contracts of employment (for EDs and director-equivalents)<br>Terms and conditions of service agreements (for NEDs) issued by the TDA.<br>Disciplinary policy and procedure |
| Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware. | This would be the subject of debate at the Remuneration Committee (for EDs and director-equivalents) and in liaison with the Appointments team at the TDA (for NEDs). The minutes would record such decisions.<br>The Chair would take advice from internal and external advisors as appropriate. | Minutes of meetings. |
| Where specific qualifications are deemed by the | This requirement is included within the job description for | Person specification |

| | | |
|---|---|---|
| provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator. | relevant posts and is checked as part of the pre-employment checks. | Recruitment policy and procedure |
| The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept. | Employment checks include a candidate's qualifications and employment references.<br>The recruitment process also includes values-based questions. | Recruitment policy and procedure<br>Values-based questions |
| The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. | Any such decision would be discussed by the Remuneration Committee or TDA Appointments team. Actions would be subject to follow-up as part of ongoing review and appraisal. | NED appraisal framework<br>Executive Director pdr. |
| When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role. | All executive directors are subject to clearance by occupational health as part of the pre-employment process. | Occupational health clearance |
| Wherever possible, reasonable adjustments are made in order that an individual can carry out the role. | This is already included in the Trust's disability policy. | Disability Policy |
| The provider has processes in place to assure itself | This will be incorporated as a specific declaration as part | Pre-employment declaration |

| | | |
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| that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.<br>*("Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.*<br>*"Privy to" means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.*<br>*"Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.")* | of the pre-employment process.<br><br>It will be incorporated into the reference request for all director and director-equivalent posts. | Reference Request for ED<br><br>TDA appoint process for NEDs |
| The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. | This will be incorporated as a specific declaration as part of the pre-employment process.<br>I<br>t will be incorporated into the reference request for all director and director-equivalent posts | Reference Request for Executive Directors<br>TDA appoint process for NEDs |
| Only individuals who will be acting in a role that falls | DBS checks will be undertaken as part of the recruitment | Disclosure and Barring Service |

| | | |
|---|---|---|
| within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS).<br>*(CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.)* | process and for Non-executive director's prior to the renewal of the term. | Policy<br>DBS checks for eligible post-holders |
| As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list. | Will be assessed through the recruitment process DBS checks. | DBS policy |
| The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. | Post-holders undertake annual declarations of fitness to continue in post.<br>Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process. (*) | Annual declaration<br>NED appraisal process<br>ED appraisal process |
| The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to. | The disciplinary policy provides these arrangements, and revised contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement. | Disciplinary policies<br>ED contracts of employment<br>NED agreements |
| The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions. | This will be undertaken if concerns are identified and revised contracts provide for termination if individuals fail to meet necessary standards | Director of HR reviewing employment contracts for ED<br><br>TDA appointments team issuing guidance re NEDs. |
| Where a person's fitness to carry out their role is | This would be reviewed when concerns are identified | Disciplinary policy. |

| | | |
|---|---|---|
| being investigated, appropriate interim measures may be required to minimise any risk to service users. | | |
| The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others. | This would be completed if any concerns were identified. | Referrals made to other agencies |
| *(*) indicates newly-introduced requirements to address the regulations*<br>*In the table above, unless the contrary is stated or the context otherwise requires, "ED" means executive directors and director-equivalents.* | | |

**Appendix B**

**EAST SUSSEX HEALTHCARE NHS TRUST**

**Annual declaration for director and director-equivalent posts**

**("the Trust")**

**"FIT AND PROPER PERSON" DECLARATION**

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's constitution.

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

3 An "unfit person" is defined as:
(a) an individual:

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

**Regulated Activities Regulations**

4. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:
(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any

corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

**I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post come to my attention.**

**Name:** _____ **Signed:** _____

**Position:** _____ **Date:** _____

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 14 |
| **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.

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

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

| **Review by other Committees/Groups** (please state name and date): |
|---|
| 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:**<br>Lynette Wells, Company Secretary | **Contact details:**<br>(13) 4278 |

# EAST SUSSEX HEALTHCARE NHS TRUST

## AUDIT COMMITTEE

**Minutes of the Audit Committee meeting held on Wednesday 12th November 2014 at 10.00am In the St Mary's Board Room, Eastbourne DGH**

**Present**: Mike Stevens, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director
Mr Barry Nealon, Non-Executive Director

**In attendance** Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Medical Director (Clinical Governance)
Mrs Lynette Wells, Company Secretary
Mr Robert Grant, BDO
Mr Mike Townsend, TiAA
Mrs Jenny Robson, Account Manager, TiAA
Mr Steffan Wilkinson, Counter Fraud Manager, TiAA
Ms Deidre Connors, Head of Nursing – Specialist Medicine (for item 4)
Dr Janet McGowan, Associate Medical Director – Clinical Governance (for item 5)
Mrs Emma Moore, Assurance Manager- Clinical Effectiveness (for item 5)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

**Action**

**1. Welcome and Apologies for Absence**

Mr Stevens opened the meeting and introductions were made.

Apologies for absence had been received from:

Charles Ellis, Non-Executive Director
Dr Amanda Harrison, Director of Strategic Development and Assurance
Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Alice Webster, Director of Nursing

**2. Minutes of the meeting held on 3rd September 2014**

i) The minutes of the meeting were reviewed and agreed as an accurate record.

ii) Matters Arising

The updates on the matters arising log were noted.

**3. Board Assurance Framework and High Level Risk Register**

Mrs Wells presented the Board Assurance Framework (BAF) and high level Risk Register (RR).

Mrs Wells referred to the BAF's new format and noted that the BAF had been considered at the Quality and Standards Committee (QSC) on 11th November. The QSC had requested that the rating for health records should move to red as there was not sufficient assurance around the progress being made and it was planned to carry out a deep dive in this area at the next meeting.

She reported that the QSC had also requested the rating in relation to the estates strategy be moved to red following an update by Mr Sunley at the meeting. He had advised that there was a delay to the appointment of a substantive Head of Estates which was in turn was holding up the production of an estates strategy.

Mr Nealon noted that the monitoring group for the estates strategy was the Finance and Investment Committee and he would ensure that a progress report was included in the work plan for two-three months' time. **BN**

In response to a query from Mr Stevens, Mrs Wells advised that there was a gap in assurance in relation to the regular appraisal of staff as this could not be evidenced. She advised that once the appraisal rate had improved, then this would become a positive assurance.

Mr Nealon queried the monitoring group in respect of responding to tenders and it was agreed that this should be changed to the Clinical Management Executive from Finance and Investment Committee. **LW**

Mrs Wells referred to the high level Risk Register and noted that the QSC had expressed concern re the backlog in plain film reporting and had requested that there be an update at its next meeting.

**The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks. The Committee supported the changes in rating proposed by the Quality and Standards Committee in relation to health records and the estates strategy.**

**4. Specialist Medicine Risk Register**

Mr Stevens welcomed Ms Connors to the meeting. Ms Connors reported that the clinical unit currently had 9 open risks:

- 1 rated at 16 (extreme)

- 4 rated at 8/9 (high)
- 4 rated at 4/6 (moderate)

Ms Connors updated the Committee on progress against the following risks:

- Compliance with cancer targets (16)

Mr Stevens asked where the issues were in relation to compliance with cancer targets and Ms Connors advised that the challenged areas were in gastroenterology with 2 week waits but a locum had been recruited to undertake additional clinics. Mr Stevens requested that Ms Connors provide a more detailed follow up report for circulation to the Committee. **DC**

- Emergency endoscopy out of hours

Ms Connors advised that meetings were underway to plan future provision of this service.

- Administration of Pentamidine on Pevensey Ward

She advised that this risk would be resolved once the new unit had been built.

- Administration of Pentamidine on the Judy Beard Unit

Ms Connors reported that a minor improvements case had been submitted for the ventilation grid to be moved which would resolve the risk.

- Chemocare system

Discussion took place on the rating for this risk as whilst the frequency of incidents was low the possible impact was high. Mrs Wells agreed to discuss this further with Mr Bourns. **LW**

- Staffing

Mr Nealon queried whether the staffing issue related to vacancies and Ms Connors advised that the vacancies were being recruited to but the issue was cover for short term sick leave as the bank did not have enough staff to cover such absences. Mrs Bernhauser asked if this was exacerbated as more specialised nursing staff were required and Ms Connors agreed that this was partly the case.

- Anti-coagulation clinics

Ms Connors reported that this risk would be removed in the new year as the service was being re-commissioned.

- C Diff outbreak – increased incidence

Ms Connors reported that, whilst Cuckmere ward was being re-modernised and developed, the ward had moved to a temporary location which did not have enough side rooms but the staff had managed to contain the infections. This risk would be resolved as the ward would be moving back to Cuckmere on 17th November.

- Conquest Endoscopy Unit – trip hazard

Ms Connors reported that a business case was being submitted to move cables currently trailing across the floor into the ceiling. Mrs Harris requested that Mrs Connors advise her if there was any delay to this case being approved.

Mrs Connors confirmed that mitigations were in place and regularly reviewed to address the risks on the register.

Mr Stevens thanked Ms Connors for her report.

## 5. Clinical Audit Update

Mrs Moore presented the overview of the Clinical Audit Forward Plan and noted that the 9 red rated outstanding audits from 2012/13 had been sent to the new clinical leads to confirm their status and a further update would be provided at the next meeting. **EM**

Mrs Moore reported that the National Vascular Registry audit, a NCAPOP audit, was rated red as the audit had not been progressed since December 2013. Dr Hughes outlined the background relating to the delay in the move of the elective vascular service to Brighton and the impact on the workload of the two surgeons. Discussion had been taking place with Brighton over the data collection for this audit but as yet no progress had been made. He advised that the Trust's vascular nurse had been trained in the data collection but due to clinical pressures she did not have the time to complete the audit.

Dr McGowan asked whether the appointment of a second vascular nurse was being progressed and Dr Hughes stated even if there was a second appointment their clinical time would still be pressured as they would be covering all acute and community sites.

Mr Stevens clarified that a backlog had been built up since December 2013 and no new cases had been input and Dr Hughes confirmed that this was the case. It was noted that failure to complete the audit would have a reputational impact as the Trust had to identify in its Quality Account each year which national audits it participated in and also inform the Care Quality Commission and the Clinical Commissioning Groups (as part of the Trust's contract) the reasons why the Trust was not participating in a national audit.

Mr Nealon was of the opinion that non-participation in the audit should be escalated to the executive team as this was a risk for the Trust and the Audit Committee agreed and asked Dr Hughes to raise the issue at the next executive team meeting. **DH**

Mrs Moore reported that the National Rheumatology Audit was now rated at amber as a new audit facilitator had been appointed and the staff had confirmed that data would be activity submitted for the duration of the audit.

Mrs Moore referred to the Acute Pain Management audit discussed at the last Committee meeting when further clarification had been sought in relation to the audit recommendations. She advised that Dr MacGregor had clarified that the 95% target was an aspiration and not a national standard which the Trust was held to account for.

Dr McGowan stated that this had only been a small audit on one site which had not been particularly rigorous and she would discuss with Dr MacGregor how the next audit could be improved to ensure that it was cross-site and had consistency.

Mrs Moore reported that attendance at the Clinical Audit Steering Group over the last few months had been relatively poor but with the introduction of the new governance structure the group was being revamped to improve effectiveness. Dr Hughes commented that the restructure of the clinical units was re-energising the leadership culture and clinical audit featured as a part of this.

Mr Nealon asked how the Trust compared with other Trusts in respect of clinical audit and Mrs Moore advised that the Trust was similar to other Trusts in the region and not an outlier.

It was agreed that the clinical unit leads would be asked to report on progress with their clinical audits at the same time as they updated on their risk registers.

Mrs Bernhauser suggested that clinical audit could be picked up as a topic during quality walks.

**The Committee noted the report on the Clinical Audit Forward Plan.**

## 6. Internal Audit

a) Progress Report

Mrs Robson reported that three audits had been completed since the last meeting, two of which were IM&T audits from 2013/14 and the third was on recruitment from this year's plan. A limited assurance opinion had been given for the audits on disaster recovery and recruitment.

She advised that draft reports had been issued on a further three audits – computing facilities, ward visits, reference costing - and another 11 reviews were at field work stage.

Mr Nealon queried how the high risk recommendations were followed up and Mrs Harris advised that the specific recommendations were listed in the audit recommendations tracker and progress monitored. In addition, each lead would be expected to check that any high risks were identified in the relevant risk

register.

Mrs Robson stated that internal audit also checked that recommendations had been implemented when they were identified as completed on the tracker.

Mrs Harris also noted that the Audit Committee provided additional scrutiny if the priority was not felt to be challenging enough.

**The Committee noted the Internal Audit Progress Report.**

b) Audit Recommendations Tracker

Mrs Wells presented the Audit Recommendations Tracker and advised that following her recent review there were currently 44 actions on the tracker with 18 recommended for closure at this meeting. There were also 8 where confirmation was being sought on closure and these would come to the next meeting. She had been able to take assurance from her review that actions were being progressed by leads.

She advised that a number of the closed high risks recommendations would be re-audited to check implementation and a number of the older closed actions would also require re-auditing and these would be included in 2015/16 audit plan.

**The Committee noted the report.**

**6. Local Counter Fraud Service**

a) Progress Report

Mr Wilkinson reported that there were currently 6 open reactive investigations, one of which was being dealt with by Mazar and two were about to be closed. He updated the Committee on the details of these investigations.

He reported that in relation to proactive work he had received 4 responses from senior staff in relation to an introductory e-mail sent offering a 1:1 meeting. He advised that a document training session was being organised for recruitment staff with the UK Border Agency later in November.

He reported that discussions had taken place with the payroll and finance teams to ensure that all parties were aware of and working to the new salary overpayment protocol. Mrs Harris advised that this would be followed up at the next meeting.

He reported that a major fraud awareness event was taking place across the Trust later in November and follow up work was continuing from the NHS Protect inspection and Mazar reports in the

previous financial year.

**The Committee noted the report.**

**8. External Audit**

a) Progress Report

Mr Grant presented his report and advised that the planning process had started for financial statements and value for money audits.

He noted that there had been a number of red flags relating to workforce and he would be discussing with human resources any advice/help BDO could provide in that area.

Mr Stevens asked if any issues had been picked up from the previous year's audit and Mr Grant advised that there had not been any issues.

Mr Grant noted that the impact of the legal ruling on holiday pay and overtime had not been picked up on the high level risk register. Mrs Harris reported that guidance was awaited from NHS Employers with the possibility that the ruling could be further appealed.

**The Committee noted the BDO progress report**

**9. Tenders and Waivers Report**

Mrs Harris presented the report and noted that a percentage comparison was also provided between the total numbers of waivers and the total value of non pay expenditure, as requested at the last meeting.

**The Committee noted and approved the Tenders and Waivers Report.**

**10. Information Governance Toolkit (IGT) Update**

Mrs Wells presented the report which gave a breakdown of the information governance incidents since the last meeting and updated on progress against the IGT.

She advised that a mid year submission of 47% on the IGT had been made and she anticipated that the Trust would achieve Level 2 (66%) by the final submission. Mr Townsend noted that the audit of the IGT evidence was scheduled for January/February.

Mrs Bernhauser queried why it would not be possible for all areas to achieve level 3 and Mrs Wells explained that in some cases it was not possible to meet the requirements of level 3 and the table on page 6 was a realistic assessment of possible achievement.

**The Committee noted the progress against the Information Governance Toolkit and approved the Information Governance Management Framework**.

**11. Review of Corporate Governance Documents**

Mrs Wells presented the annual review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation and highlighted the amendments to be made.

**The Audit Committee approved the amendments and recommended them to the Board for ratification at its next meeting.**

**12. Local Audit Accountability Act Consultations – National Audit Office and Financial Reporting Council**

Mrs Harris reported that there had been two consultations on the Local Audit Accountability Act which she had drawn to the attention of the Audit Chair and the Chief Executive. She had commented on the value of the Value For Money conclusion in response to a question in the National Audit Office consultation.

**The Committee noted the consultations.**

**13. Meeting Dates and Workplanner for 2015**

Mrs Wells advised that following the discussion earlier the clinical units would be asked to present on their clinical audit programme as well as their risk register in future and this would be added to the work programme. **TR**

**The Committee noted the meeting dates and work planner for 2015.**

**14. Date of Next Meeting**

Wednesday, 7th January 2015, at 10.00 am in the Committee Room, Conquest Hospital.

Signed: ……..

Date: ……

# East Sussex Healthcare NHS Trust

## Audit Committee

### 1. Introduction

Since the Board last met an Audit Committee has been held on 7th January 2015. A summary of the items discussed at the meeting is set out below.

### 2. Board Assurance Framework and High Level Risk Register

The Company Secretary presented the High Level Risk Register and the Board Assurance Framework and noted that the human resources department had reviewed and refined some of their controls and actions and one new area had been added from the high level risk register regarding the Internet gateway.

### 3. Cardiovascular Clinical Unit Risk Register

The Head of Nursing for the Cardiovascular Clinical Unit gave an update on the unit's Risk Register and noted that there were five open risks, of two would be removed following the unit's next risk meeting. The three remaining risks related to medical and nurse staffing.

### 4. Urgent Care Clinical Unit Risk Register and Clinical Audit Plan

a) Risk Register

The General Manager reported that the unit had 13 risks open, of which six were identified as inadequate controls and related to medical staffing, mental health assessments, lack of integrated IT services and ambulance offloads. She advised on the mitigating actions been taken in respect of these risks.

b) Clinical Audit Plan

The General Manager presented the audit plan for emergency, geriatric and acute medicine and advised that a large number of the audits were undertaken by SHOs and presented at the end of their 4 month placement.

She was that this was an area requiring development by the unit and a nurse practice educator had recently been appointed to the Conquest site to support audit and training and this mirrored a similar post at the Eastbourne DGH site.

### 5. Clinical Audit Update

An overview was given of the clinical audit activity that had taken place across the Trust in this year and the Clinical Effectiveness Lead confirmed that all outstanding audits from 2012/13 were underway and had reduced to 5. She reported that the outstanding audits from 2013/14 had reduced to 20.

The Committee noted that agreement had been reached on the Trust's participation in the Vascular Registry Audit, a national NCEPOD audit, and this was now rated at amber.

The Clinical Effectiveness Lead reported that it was planned to hold a Clinical Audit Awards seminar on 16th June 2015 for all staff to participate in.

## 6. Internal Audit

The Committee received the Internal Audit Progress Report and was updated on the progress against the action plan. It was noted that since the previous update one further audit had been finalised in relation to reference costs and this had received a substantial assurance opinion.

The Associate Director of IT had attended the meeting to provide background on the content of draft audit in relation to computing facilities which would be receiving a limited assurance outcome. He had outlined the actions that were being taken to address the issues raised.

The updated Audit Recommendations Tracker was presented. It was noted that good progress was continuing to be made in closing down actions arising from audits.

## 7. Local Counter Fraud Service

The Committee received the progress report and noted actions being taken on current reactive investigations. The LCFS manager also highlighted the proactive work being taken in relation to document training by the UK Border Agency, fraud awareness sessions, medical certification and the expiry of work visas.

## 8. External Audit Progress Report

The External Auditor presented a progress report on the planning work for the financial statement and the value for money audits for 2014/15.

## 9. Tenders and Waivers Report

The Committee noted the Tenders and Waivers report.

## 10. Information Governance Toolkit Update

The Committee received an update on progress against the Information Governance Toolkit (IGT) requirements and noted that compliance for the year so far was at 58%. The Committee also received a summary of the IG incidents reported from April 2014 onwards and noted that the Trust was not an outlier in this area.

## 11. Losses and Special Payments Review

The Committee noted the report.

**Mike Stevens**
**Chair of Audit Committee**

16th January 2015

**EAST SUSSEX HEALTHCARE NHS TRUST**

**FINANCE & INVESTMENT COMMITTEE**

**Minutes of the Finance & Investment Committee held on Wednesday 29 October 2014 at 9.30am in the Committee Room, Conquest**

**Present**
Mr Barry Nealon, Non-Executive Director/Chair
Mr Michael Stevens, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Mrs Stuart Welling, Chairman
Mrs Vanessa Harris, Director of Finance
Mr Gary Bryant, Deputy Director of Finance
Mr Peter Trethewy, Assistant Director – Performance & Delivery – for item 4 (i) (for Mr R Sunley)
Mr Simon Wombwell, Transformation Manager

**In attendance**
Ms Sarah Goldsack, Associate Director of Knowledge Management (for item 7)
Mr Tony Deal, Assistant Director of IT (for item 8)
Mr Ian Humphries, Estates & Facilities Adviser (for item 10)
Mr Andy Horne, Programme Director (for item 12)
Miss Chris Kyprianou, PA to Finance Director (minutes)

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| **1.** | **Welcome and Apologies**<br><br>Mr Nealon welcomed Mr Wombwell and Mr Trethewy to their first Finance & Investment Committee.<br><br>Apologies were received from Mr Darren Grayson, Mr Richard Sunley and Dr David Hughes. | **Action** |
| **2.** | **Minutes of Meeting of 27 August 2014**<br><br>The minutes of 27 August were agreed as an accurate record subject the following alteration:<br><br>Item 12, paragraph 3, should say: 'Following the restructure there is now a team dedicated to this.....' | |
| **3.** | **Matters Arising**<br><br><u>(i) Performance Report – M2</u><br><br>It was noted that community indicators were now included in the Performance report. | |

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| | (ii) EDM and Clinical Portal Collaborative FBC<br><br>It was confirmed that the Electronic Document Management and Clinical Portal Collaborative FBC had been added to the work programme for the November meeting.<br><br>(iii) Terms of Reference<br><br>The Committee received the revised Terms of Reference. It was agreed that an amendment should be made to the constitution to read: 'The Committee is a committee of the Board .....' | |
| **4(i)** | **Performance Report – Month 5**<br><br>Mr Trethewy presented the month 5 Performance Report which detailed ESHT's in month performance against key trust metrics as well as activity and workforce indicators.<br><br>This report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15.<br><br>It was noted that the overall Performance Score was 4 (from a possible 5)<br><br>Responsiveness Domain: 2<br>A decline from July. A&E performance was below the 95% standard. In addition to this Cancer performance (preview data) was below standard within 2WW, 31 days and both 62 day indicators. The cancer team was working to improve delivery by the end of Q3. A recovery plan was due to be filed with the TDA on 31 October and a piece of internal audit work had started to gain assurance on data quality and waiting list management.<br>RTT performance continues to align with the trajectory agreed with the TDA and local commissioners although there are risks in gastroenterology and rheumatology specialties. There is a recovery plan to deliver activity within existing resources. The number of over 52 week waiters was noted. The diagnostic performance had now recovered and performance had been delivered 3 months in a row. It was noted that the additional RTT and tranche 1 winter funding had not yet been received by ESHT from its commissioners.<br><br>Effectiveness Domain: 4<br>Remains at 4. All but one indicator in this domain is sourced from the Dr Foster mortality web portal. This is only updated annually, so as it stands mortality performance appears static, as will the domain score.<br><br>Safe Domain: 5<br>Remains at 5. There were 6 reported cases of C-Dificile, but no reported harmful incidents. | |

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| | Caring Domain: 5<br>An improvement from July due to A&E Friends and Family scoring reaching the required standard for the first time. All standards within this domain were achieved in August.<br><br>Well Led Domain: 4<br>Turnover, sickness and appraisal rates remain below the required standard, holding the domain score at 4.<br><br>The Community services report was noted. The Trust intends to further develop reporting of this area.<br><br>The workforce report was noted. The Committee needs to understand the recruitment issues that currently face the Trust. It requested that HR be asked to prepare a report on "difficult to recruit areas". This report to be made to the most appropriate sub-committee.<br><br>**Action**<br>**The Committee noted the Performance Report for month 5 and noted the Trust Performance against each domain.** | **MG** |
| **4(ii)** | **Finance Update – Month 6**<br><br>Mrs Harris presented the Finance Report for Month 6 and highlighted the key issues.<br><br>At the end of M6 financial performance was a year to date run rate deficit of £11,575k, which was a favourable variance against plan of £201k. Income and expenditure were both over plan. The cost improvement achievement was £8,180k which was behind plan by £248k. The overall TDA RAG rating for finance is red because the Trust has set a deficit plan for 2014/15.<br><br>At the end of Month 6 the financial risks remain unchanged from those associated with the plan for the year save for the addition of an income risk following the issue on an in-year QIPP by NHS England.<br><br>**Action**<br>**The Committee noted the Month 6 financial position.** | |
| **4(iii)** | **Mid Year Financial Review**<br><br>Mr Bryant gave an overview of the financial performance at the end of month 6.<br><br>It was noted that during the first 6 months of the year, the Trust was marginally ahead of plan by £0.2m, with a deficit of £11.6m, every month with the exception of month 6, being on or better than plan.<br><br>RTT funding of £1m is assumed within the M6 position and £2m of | |

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| | contingency has been issued into the position against specific items.<br><br>CIP plans for the year were £20.4m, £8.4m of which is the YTD target. After 6 months, ESHT is £0.3m behind target, which is reflected within the overall position described above. The Trust is forecasting to hit the overall target by year-end but some areas are showing that they will not achieve their original targets. To help mitigate the risk on non-delivery an additional £2.0m target has been issued amongst all clinical and non-clinical units.<br><br>ESHT set an overall deficit plan for the year of £18.5m, on an income level of £357.4m. Based on the performance to date, the Trust is forecasting to meet this plan.<br><br>**Action**<br>**The Committee noted the report and took assurance that the current financial performance was consistent with the overall plan for the year.** | |
| **4(iv)** | **Quarterly Review of Aged Debts**<br><br>The Committee received an update on the aged debt position for the Trust as at 30 September 2014 and a plan of action for addressing the level of 'over 90 day' outstanding debts.<br><br>It was noted that the level of 'over 90 days' outstanding debt, for both NHS and Non-NHS debt currently stood in excess of 5% of total debt. The TDA expects Trusts to ensure the level of this category of debt does not exceed a 5% maximum. The report highlighted strategies (planned and in place) as well as targets set which had been designed to bring the 'over 90 days' debt within the 5% maximum and to ensure overall aged debt is maintained within reasonable levels.<br><br>The Committee expects to see an improvement in this position within the next quarterly report.<br><br>**Action**<br>**The Committee noted the aged debt position as at the end of M6 and the plan of action for addressing the level of 'over 90 day' debts.** | |
| **5.** | **Transformation Update**<br><br>Mr Wombwell updated the Committee on the progress and process for supporting the Trust to meet its financial targets in 2014/15 (notably, deficit plan of £18.5m) and deliver a sustainable plan for 2015/16.<br><br>A review of the Month 5 financial forecast, supported by Month 6 results suggested the Trust was carrying some risk to the delivery of | |

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| | the financial target of £18.5m deficit. The proposals set out aim to address this risk through the identification and delivery of further in-year savings of £2m<br><br>The report demonstrated that the process for identification of further savings had involved the CU management team, including clinical leaders and had sought a direct contribution from all areas. The delivery of the savings would be supported by the Turnaround Adviser and be monitored through the CU Accountability Reviews, which monitors metrics for safety, quality, workforce as well as financial. Weekly meetings with General Managers would also be instigated to manage progress. Where applicable a full quality impact assessment (QIA) of schemes would be carried out.<br><br>The Committee asked that the savings target be increased so that some contingency was built into the plan to cover any risk of non-delivery. It also asked that the focus on the balance between quality, safety and money be vigorously maintained.<br><br>**Action**<br>**The Committee noted the Transformation update and supported the savings measures proposed.** | **SWo** |
| **6.** | **FBC: Update**<br><br>The Full Business Case (FBC) for £30m of capital expenditure to implement the Trust's clinical strategy had been approved by the Trust Board on 11 December 2013 and lodged with the TDA. This was still pending TDA approval.<br><br>Mrs Harris reported that following ongoing discussions with the TDA, the Trust had made an application for an early release of part of the capital included within the FBC.<br><br>The application also included some capital elements which were outside the FBC but had been identified as necessary to ensure delivery of winter resilience or quality and productivity improvement/ requirements.<br><br>Discussions were still ongoing with the TDA and it was hoped that it would be able to approve the release of the capital required to enable the rapid completion of the highlighted schemes.<br><br>The TDA have asked the Trust to review what has been put into the bid and re-present it to show top priorities and anything likely to be recommended as a result of the CQC inspection.<br><br>In the meantime a small part of the early release scheme has been accelerated and the Trust had made an emergency capital public dividend application for £400k to create 8 Major cubicles in the | |

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| | Emergency department at the Conquest by building a new 7 bedded Clinical Decision Unit (CDU) in space currently occupied by offices. This application has been approved by the Independent Trust Financing Facility (ITFF) and work has begun.<br><br>**Action**<br>**The Committee noted the bid for early release of first tranche FBC funds and the approval of emergency public dividend capital £400k had been given for a small Emergency Department scheme at the Conquest.** | |
| **7.** | **PAS Project Business Case – Oasis v16 Upgrade**<br><br>Mrs Goldsack gave an update on the position of the Patient Administration System/Service (PAS) which was re-tendered earlier this year.<br><br>Subsequent to the original business case there had been further PTL and RTT data validation and reassessment of the implementation of Clinic Manager to support the clinical administration review within the trust.<br><br>To enable the required implementation of Clinic Manager the Trust servers would need to be upgraded as the improvements required to support these systems were not possible on the current servers due to the risk to the live environment and the potential to cause the system to be unstable.<br><br>The need for service improvement to meet the Trust's clinical strategy required a modern PAS with additional functionality to support delivery of the strategy and improved ways of working within the Trust. The options within the business case covered these enhancements.<br><br>Mr Cohen queried whether there had been any consultation and agreement with the Consultants on the introduction of Clinic Manager. Mrs Goldsack confirmed that this had been supported by the Consultants.<br><br>The Committee supported the PAS upgrade. However it was agreed that evidence of clinical engagement into the Clinic Manager part of the project would need to be included in the business case that is presented to the Board.<br><br>**Action**<br>**The Committee supported the PAS upgrade and agreed that evidence of clinical engagement should be included in the business case to be considered by the Board.** | **SG** |

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| **8.** | **OBC Managed Enterprise Printing Solution**<br><br>Mr Deal presented a business case for approval to proceed to full tender for a fully managed enterprise printing solution.<br><br>It was noted that Trust currently uses a multitude of network printers and photocopiers to provide paper output for electronic documentation at significant cost.<br><br>In order to address these costs the IT and Procurement departments had instigated a full review of the printing and photocopier estate to assess potential financial savings and an improved printing facility.<br><br>As a result of the review it was evidenced that substantial savings could be made by adopting a fully managed print service.<br><br>Additional non cash releasing benefits had been identified that would improve user experience by offering greater flexibility and improved information governance.<br><br>The procurement process would be supported by the London Procurement Partnership who will provide specialist procurement support as the creators and operators of the Framework Agreement. The service will include running a mini-competition, assisting the Trust with its definition of requirement, selection of a preferred bidder and presentation of recommended award.<br><br>**Action**<br>**The Committee approved the OBC to move to a full tender process.** | |
| **9.** | **Pevensey Ward Business Case**<br><br>The Pevensey Ward Business Case was not available for review at this meeting.<br><br>As this was a high priority item it was agreed that this would be circulated for virtual approval.<br><br>**Action**<br>**The Business Case would be circulated for virtual approval.** | |
| **10.** | **Schneider Project Update**<br><br>Mr Humphries presented an update on the Schneider project, the current costs and savings and proposed next steps.<br><br>It was noted that the Committee had previously reviewed a business case for the progression of proposals from Schneider Electric involving an operating lease, revenue savings arising from energy | |

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| | conservation measures and investments to address backlog maintenance concerns.<br><br>The revised project proposal reduced the investment value proposed by Schneider to approximately £5m and provided a "worst case" net saving for the Trust of approximately £1.2m over a 9 year term. The net saving was a predicted £2.6m "best case".<br><br>It was now proposed that the Trust seek formal independent advice on certain aspects of the proposal.<br><br>**Action**<br>**The Committee approved the next steps noting the commitment of additional costs of approximately £70k.** | |
| **11.** | **Making Better Use of Government Resource Services Procurement & Service Delivery Platforms**<br><br>Mrs Harris gave an update on the progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms.<br><br>A Project Steering Group had been formed to oversee the project. It was noted that this was not a decision making body but was expected to reach conclusions and make recommendations to the Finance and Investment Committee where any formal decisions would be taken. Terms of Reference had been prepared and were available upon request. A Non Executive Director was part of the group and this was Mr Nealon, who was also the Non Executive champion for procurement.<br><br>Alongside this piece of work there was also a further review by Lord Carter to look at efficiency and productivity across a range of areas.<br><br>**Action**<br>**The Committee noted that:**<br>• **A Project Steering Group had been formed. The Non-Executive Director representative was Barry Nealon.**<br>• **Under the Terms of Reference any recommendations will be brought to this Committee where any formal decisions will be taken.** | |
| **12.** | **Market Testing Programme Update**<br><br>Mr Horne gave an update on the market testing programme in particular the following areas:<br><br>***Occupational Health***<br><br>The specification for this service had been discussed and agreed at | |

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| | the evaluation panel. This process was good and allowed discussion and agreement on the service required. The specification was currently in the process of being agreed by Maidstone and Tunbridge Wells NHS Trust (MTW) who were partnering the Trust through market testing.<br><br>The proposed framework agreement would be between ESHT and the successful Supplier, with both ESHT and MTW "calling-off" separate contracts for their respective requirements. Other public sector organisations that the Trust currently provided a service to would also have separate contracts.<br><br>The Committee was invited to confirm that this approach was the most appropriate for the tender of Occupational Health services and (following agreement by MTW) to agree to move to Tender stage.<br><br>***Nursery services***<br><br>A pre-procurement engagement day took place on 3rd September when interested suppliers discussed with the Trust the types of partnership on offer, viewed the identified development site at the Conquest Hospital and gained further information on the current service provided. It was confirmed by this process that there was *some* national and local interest in a partnership approach.<br><br>There would be new cost implications for the Trust in any case for continuing to run workplace nurseries. These additional costs would arise whether the Trust directly provides, outsources or ceases the nursery service.<br><br>The Committee was asked to approve the tender for nursery services, and approve that the capital cost of planning permission, site clearance and provision of base and services at the Conquest site of circa £55k in 2015..<br><br>***Corporate services and hard FM***<br><br>These services were suspended from the market testing programme following the decision in June. However, the Trust had recently agreed to join a small group of NHS organisations 'supporting better resource utilisation' , chaired by Lord Carter. Initially the Trust would be working with them to review parts of the finance service, procurement and soft FM services.<br><br>***Soft FM services***<br><br>As noted in the September update, it was agreed with the Interim Estates & Facilities advisor that an 'exemplar' Standard Service Level Specification was produced (for catering) and this was rolled out across all other commercial services departments. It was accepted | |

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| | that this was an internal document to be used for their transformation plan and will need some further development to turn it into an external specification document fit for tendering purposes.<br><br>The latest plan would see the service specifications completed in November and an aim to complete the soft FM transformation plans for a decision on whether to proceed to market testing by the Board in February.<br><br>The Committee was invited to note the possible procurement route and to agree the timetable to allow the Board/Committee decision by the end of February 2015<br><br>**Action**<br>**The Committee supported the tender to proceed for both Occupational Health and the Nursery, and noted the timetable and progress for Soft FM services.** | |
| **13.** | **EBITDA Quarterly Report Q1**<br><br>The Committee received the 2014-2015 Qtr 1 EBITDA statement and the 2014-2015 quarterly EBITDA comparison statement.<br><br>The Committee noted the 2014-2015 Qtr 1 EBITDA deficit position for the clinical units, the number of service lines that have negative EBITDAs and the 2014-2015 quarterly EBITDA variances.<br><br>It was noted that the Cardiology specialty review would be presented to the November meeting and this will be followed by the presentation of the 2014-15 Qtr 2 EBITDA statement in December.<br><br>It was suggested that it would be helpful to show benchmark information in future reports and to highlight the top 5 variances.<br><br>**Action**<br>**The Committee noted the EBITDA statement position. It recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews, and to return at a subsequent meeting to update on their progress.** | **GB** |
| **14.** | **Capital Programme Mid Year Review**<br><br>The Committee received an update on the mid-year review of the capital programme carried out by the Capital Approvals Group (CAG) in August 2014.<br><br>As there was no Finance & Investment Committee meeting in September, this item went directly to the Board meeting on 24 | |

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| | September 2014.<br><br>The report was just to record through the Finance and Investment Committee that process had been followed on the Capital Programme such that is it kept under review by the Trust Board.<br><br>**Action**<br>**The Committee noted that the Capital Programme Mid-Year Review item went directly to the Board meeting on 24 September 2014** | |
| **15.** | **Tender & Service Development Schedule**<br><br>The Committee received a schedule which provided an update on current tenders and service developments.<br><br>It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings.<br><br>All new Pre Qualification Questionnaire (PQQ) or tender proposals are considered by the BPSG to determine whether the Trust in bidding for the service will consider a number of criteria including that the proposal:<br><br>• meets the strategic direction of the Trust,<br>• is part of the core business of the Trust, or<br>• fits with the business model.<br><br>If a decision is made to consider a bid, a working group comprising the relevant clinical, operational and corporate services undertake a risk assessment and report back to the BPSG, following which a decision is taken as to whether to proceed with a bid.<br><br>The BPSG also considers business cases for service developments to ensure that these are picked up in the planning process.<br><br>The Current PQQ/tenders in the pipeline were noted:<br><br>• Fracture Liaison Service<br>• Non-invasive Ventilation Service<br>• High Weald Lewes and Havens community services<br><br>The date for the award decision for the Fracture Liaison Service had passed and the Committee asked if an outcome was known. Mrs Harris undertook to provide a same day update by way of the minutes. However upon enquiry she was advised that the outcome had not yet been announced.<br><br>The Committee expressed concern about the organisational capacity | |

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| | that would be needed to respond to so much tender activity. It was also suggested that the Board should schedule a discussion on strategic intent within this area.<br><br>**Action**<br>**The Committee noted the update on tenders and service developments.** | **SW** |
| **16.** | **Community & Child Health Project Update**<br><br>The Committee received an update on progress of the Community and Child Health System (SystmOne) project.<br><br>It was noted that preparatory work for the rollout of SystmOne to Therapy Services, INS and Specialist Nurses was underway. Completion of all phases would take longer than initially planned and was likely to extend beyond April 2015.<br><br>Approximately 440 staff were now live on SystmOne and there would be approx. 550 staff live on the system by December 12th.<br><br>Mrs Harris explained the difficulties that some staff were experiencing with using the mobile devices. It was noted that the devices were being changed for the later rollout and this would be reviewed to ensure that staff were getting the most benefits from the mobile devices.<br><br>**Action**<br>**The Committee noted the Community & Child Health Project update.** | |
| **17.** | **Work Programme**<br><br>The 2014 work programme was noted. It was agreed that a discussion on the Business Planning process would be scheduled into the work programme for the December meeting.<br><br>**Action**<br>**The Committee noted the revised work programme.** | |
| **18.** | **Dates of meetings for 2015**<br><br>The provisional dates for 2015 meetings were agreed. | |
| **19.** | **Date of Next Meeting**<br><br>The next meeting will take place on Wednesday 19 November 2014 at 9.30am – 11.30am in the Committee Room, Conquest. | |

**EAST SUSSEX HEALTHCARE NHS TRUST**

**FINANCE & INVESTMENT COMMITTEE**

**Minutes of the Finance & Investment Committee held on Wednesday 19 November 2014 at 9.30am in the Committee Room, Conquest**

**Present**

Mr Barry Nealon, Non-Executive Director/Chair
Mr Michael Stevens, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Mr Stuart Welling, Chairman (part)
Mr Darren Grayson, Chief Executive
Mrs Vanessa Harris, Director of Finance
Mr Richard Sunley, Deputy CE/COO (part)
Mr Gary Bryant, Deputy Director of Finance
Dr David Hughes, Medical Director

**In attendance**

Ms Monica Green, HR Director, (for item 4)
Mrs Jo Brandt, Head of Planning & Performance (for item 7)
Dr Nik Patel, CU Lead, Cardiovascular (for item 7)
Mrs Paula Smith, General Manager, Cardiovascular (for Item 7)
Ms Sue Carter, Cardiology Services Manager (for item 7)
Mr Les Saunders, General Manager – Estates & Project Planning (for item 11 & 12)
Mr Steve Garnett, Urology Consultant/Service Lead (for item 13)
Ms Claire Bishop, Theatre Matron EDGH (for item 13)
Ms Lucie Jaggar, Interim Head of Procurement (for item 15 & 16)
Miss Chris Kyprianou, PA to Finance Director (minutes)

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| **1.** | **Welcome and Apologies**<br><br>Mr Nealon welcomed members to the meeting. Apologies were received from Simon Wombwell. | **Action** |
| **2.** | **Minutes of Meeting of 29 October 2014**<br><br>The minutes of 29 October 2014 were agreed as an accurate record. | |
| **3.** | **Matters Arising**<br><br>(i) Performance Report – M5<br><br>A report was requested on Difficult to Recruit areas and this was presented under agenda item 4 (below). | |

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| | (ii) Transformation Update<br><br>Mrs Harris provided an update on the savings target under agenda item 6 below.<br><br>(iii) PAS Project Business Case – Oasis v16 Upgrade<br><br>Evidence of clinical engagement into the Clinic Manager part of this project was included in the business case due to be presented to the Board on 26 November 2014.<br><br>(iv) EBITDA quarterly Report Q1<br><br>It was noted that benchmarking information would be shown in future reports together with the top 5 variances which would be highlighted<br><br>(v) Tender & Service Development Schedule<br><br>Strategic intent within this area will be discussed at a future Board Seminar. | |
| **4.** | **Difficult to Recruit Areas**<br><br>Mrs Green presented a detailed report which identified the recruitment issues facing the Trust.<br><br>It was noted that there were recognised national skill shortages as identified by the Home Office, Health Education England, local shortages within the South East Region and specific short term staffing issues within the Trust.<br><br>Trusts in the South East all faced similar challenges in terms of skill shortages; however it was noted that East Sussex Healthcare faced particular issues in attracting staff from outside the area due to a number of factors.<br><br>Mrs Green highlighted the shortage/difficult to recruit areas within the East Sussex Healthcare workforce and explained the actions taken and initiatives to address recruitment and retention.<br><br>It was noted that the recruitment and retention strategy was being refreshed and developed to provide a menu of initiatives which can be applied to address specific issues across the Trust.<br><br>Incentives and investment in training is required to attract and retain staff, which would be less than the current temporary staff expenditure and provide safer staffing and improved quality. Consideration will need to be given to the future of medical education and the reduction in training placements within the acute setting | |

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| | It was agreed that recruitment issues would be discussed further at CME.<br><br>**Action**<br>**The Committee noted the recruitment issues faced by the Trust and the actions taken and initiatives to address recruitment and retention of the East Sussex Healthcare workforce.** | **DG** |
| **5(i)** | **Performance Report – Month 6**<br><br>Mr Sunley presented the month 6 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators.<br><br>This report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15.<br><br>It was noted that the overall Performance Score was 4 (from a possible 5)<br><br>Responsiveness Domain: 3<br>Improvement from August. A&E performance achieved the 95% standard. In addition to this Cancer performance (preview) achieved the 2WW standard, but did not deliver below 31 or 62 days indicators. Lack of progress against achievement of all cancer waits was discussed. Assurance was given that improvement will be made and a trajectory has recently been submitted to the TDA. The Board will review progress against the cancer action plan at its meeting in January 2015. The non-admitted pathway may not achieve the national target by the end of November. Discussions are underway with the TDA about a revised trajectory.<br><br>Effectiveness Domain: 4<br>Remains at 4. All but one indicator in this domain is sourced from the Dr Foster mortality web portal. This is only updated annually, so as it stands mortality performance appears static, as will the domain score.<br><br>Safe Domain: 5<br>Remains at 5. There were 2 reported cases of C-Dificile, but no reported harmful incidents.<br><br>Caring Domain: 5<br>Remains at 5 due to continued achievement of A&E Friends and Family standards. There were 20 mixed sex accommodation breaches. All other standards within this domain were achieved in September.<br><br>Well Led Domain: 4<br>Turnover, sickness and appraisal rates remain below the required standard, holding the domain score at 4. | **RS** |

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| | **Action**<br>**The Committee noted the Performance Report for month 6 and noted the Trust Performance against each domain.** | |
| **5(ii)** | **Finance Update – Month 7 Flash Report**<br><br>Mrs Harris presented a summary of the financial performance at Month 7.<br><br>The report provided an early snapshot of the M7 financial position allowing the Finance and Investment Committee to understand the progress being made to deliver the year end FOT, which following the issue of non-recurrent deficit funding of £18m, has moved to a FOT of £88k surplus.<br><br>Following confirmation of receipt of non-recurrent deficit funding of £18m, of which £10.5m (7/12) had been recognised at M7, the year to date (YTD) run rate was a deficit of £1.201m which was £10,713k better than plan.<br><br>In month there was a surplus of £1.374m. This position included £1.5m (1/12) of the non-recurrent £18m amount. When this is stripped out, the in month position is a deficit of £126k which is slightly favourable to the original plan of £138k deficit.<br><br>At the end of M7 there was maximum risk of £2m relating to non-delivery of CIPs and a maximum risk of £1.7m relating to income: principally late notification of QIPP and potential challenges to activity over performance from NHSE.<br><br>**Action**<br>**The Committee noted the Month 7 financial position.** | |
| **6.** | **Transformation Update**<br><br>Mrs Harris updated the Committee on the progress and process for supporting the Trust to meet its financial targets in 2014/15 and deliver a sustainable plan for 2015/16.<br><br>A review of the Month 5/August financial forecast, supported by Month 6/September results highlighted the Trust was carrying some risk to the delivery of the financial target. The Finance & Investment Committee received a summary of initiatives totalling £2m at its October Meeting and requested actions to increase this value by circa £600k to provide further comfort in the delivery of the financial target.<br><br>The key issue is the organisation's ability to deliver further actions over and above the £2m presented in the previous meeting, without compromising quality of care. The previous process interrogated run | |

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| | rates across the organisation, with a number of initiatives rejected due to quality impact risks.<br><br>Further work in November had been taken to tighten controls further and identify additional cost reduction measures. However, these initiatives did not demonstrate that the additional savings target had been identified although it was noted that this was still work in progress and some items had not yet been fully quantified. It was recognised that it will be difficult to drive out further savings at this late stage in the year but the Committee asked that a further update on how the gap will be closed, be brought to the next meeting.<br><br>**Action**<br>**The Committee noted the Transformation update; supported the savings measures proposed and asked for a further progress report at the next meeting.** | **SWo** |
| **7.** | **EBITDA - Cardiology**<br><br>Mrs Brandt presented the Committee with the findings of the Cardiology Service Review. The Cardiology service review was initiated following the positive response of similar service reviews in Gynaecology & Trauma & Orthopaedics.<br><br>An analysis of cost types, length of stay, diagnosis & procedure codes, site, age demographics and re-admissions information had identified areas requiring further understanding/investigation. The patient cost benchmarking system was used to enhance the findings.<br><br>The Clinical Lead and General Manager for Cardiovascular had worked alongside the Performance & Planning team. The Transformation Manager was also currently working with Performance and Planning to use SLR/PLIC to identify future CIP schemes.<br><br>Discussion took place on what could be done to try and increase profitability and reduce cost.<br><br>Mr Grayson asked how, as a result of the analysis of the information, as it stands, and any further comparisons, the Cardiology clinical unit would be making a greater contribution to next year's plan.<br><br>It was noted that an action plan developed from the next steps identified in the review would be presented to the Committee in February 2015.<br><br>**Action**<br>**The Committee noted the Cardiology EBITDA statement position. Cardiology will follow the next steps highlighted in the Cardiology Service Review paper and report back.** | **NP/JB** |

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| **8.** | **Community Re-basing Project**<br><br>Mr Bryant gave an update on the status of the Community Re-basing project.<br><br>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 was to ensure that the Trust was 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.<br><br>Against the back drop of the recent High Weald, Lewes and Havens CCG tender for community services the cost matrix for community services was currently being refreshed to improve the accuracy of the costs associated with the provision of these services.<br><br>Since the last update to the committee it was noted that there had been a significant change in scope to the project. The project was now focusing on the Trust's ability to respond to the known High Weald, Lewes and Havens CCG tender and the possibility of further future tendering.<br><br>Progression to activity based income was still the ultimate target with SystmOne reporting due to be available in April 2015.<br><br>**Action**<br>**The Committee noted the further progress and highlighted risk on the community rebasing project.** | |
| **9.** | **Capital Bids**<br><br>The Full Business Case for £30m of capital expenditure to implement ESHT's clinical Strategy was approved by the Board of ESHT on 11 December and lodged with the TDA. It is still pending TDA approval.<br><br>In the meantime the Trust needs to ensure that the necessary infrastructure and equipment investment can be made so that it can maintain performance and quality standards through the 2014/15 winter and beyond, on a sustainable basis.<br><br>As previously reported an emergency capital public dividend application for £400k had been agreed by the Independent Trust Financing Facility (ITFF) to improve the Emergency department space at the Conquest hospital.<br><br>Discussions were ongoing with the TDA about a more targeted capital application for items such as improvements in the storage and access to health records that may be highlighted by the CQC report (yet to be | |

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| | received).<br><br>**Action**<br>**The Committee noted that**<br>• **TDA discussions were ongoing about additional 2014/15 capital** | |
| **10.** | **Electronic Document Management & Clinical Portal FBC**<br><br>Mrs Harris presented a summary of the Sussex collaborative Full Business Case (FBC) for the provision of an electronic document management /clinical portal system and bulk scanning service to be delivered as a collaborative procurement and the East Sussex Healthcare Trust's element of the FBC.<br><br>The South Acute Programme (SAcP) was set up in place of the ASCC framework to provide an opportunity for Acute Trusts in the southern area to access central administrative and financial support on a voluntary basis on the proviso that they form collaborative groups to procure the solutions required.<br><br>It was noted that the following Trusts were participating in this project:<br><br>• East Sussex Healthcare NHS Trust (ESHT)<br>• Western Sussex Hospitals Trust (WSHT) and,<br>• Queen Victoria NHS Foundation Trust (QVH)<br><br>The Trust Board approved the Outline Business Case in October 2012 and gave approval to proceed to the next stage (FBC).<br><br>It was noted that the Collaborative project had been reviewed under the HSCIC Gateway and OGC review process As part of the Collaborative approvals process, approval was being sought to the FBC and the ESHT element of the FBC. ESHT will also need to obtain TDA approval.<br><br>In terms of clinical engagement, it was noted that Dr Slater was involved in this project and is a member of the project board. Other clinicians had been involved in the product evaluation stage. Once the FBC was agreed via the TDA the Senior Responsible Officer would move from Mrs Harris to Dr Slater as the project will need clinical leadership through the implementation stage.<br><br>It was noted that Kainos Software Ltd were identified as the preferred suppliers for the EDM/Clinical Portal and Hugh Symons were chosen for the scanning services.<br><br>**Action**<br>**The Committee recommended the FBC for approval by the Trust Board.** | |

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| **11.** | **Pevensey Ward Draft Business Case**<br><br>Mr Sunley presented the draft Pevensey Full Business Case (FBC) in support of the re-provision and redesign of Pevensey Ward at Eastbourne District General Hospital. This would ensure the provision of fit for purpose accommodation which meets best practice and compliance standards. It was noted that this project was part of the £30m Clinical Strategy FBC (currently with the TDA) and had previously been agreed by the Board as part of that case. Given its importance it had been also been identified as a project within the 2014/15 capital plan so that it could proceed in year should there be any delay in approval of the Clinical Strategy FBC.<br><br>It was noted that this would provide modern oncology & haematology services to achieve timely and accurate diagnosis and treatment regimes in line with: The Cancer Plan and Improving Outcomes guidelines. It would provide sufficient capacity and flexibility to meet current and projected future demand based on current data – future proofing for up to 5+ years and improve patient satisfaction and staff morale with the provision of a healing environment that enables efficient and effective working practices.<br><br>The GMP was yet to be agreed and the Trust was fully engaged with Balfour Beatty, Sweetts Ltd (Trust retained Costs Advisor) and the P21+ Senior Management in agreeing a Design and Build within the identified Trust Capital Allocation.<br><br>**Action**<br>**Subject to satisfactory agreement of the GMP within the amount identified in the FBC the Committee:**<br><br>- **agreed the strategic need for the re-provision of haematology and oncology services at DGH site,**<br>- **approved the recommendation of the Project Team to approve the FBC; and**<br>- **Recommended the FBC for approval to the Trust Board** | |
| **12.** | **OBC for East Sussex Linked Radiotherapy Unit**<br><br>The Committee received the Outline Business Case for the development of a linked radiotherapy unit in East Sussex between East Sussex Healthcare and Brighton & Sussex University Hospitals NHS Trust (BSUH). The Business Case identified that the preferred site to locate this unit at the Eastbourne DGH is under the endoscopy Unit.<br><br>Mr Saunders, who represents the Trust at the Steering Group in Brighton explained that unit will be managed and operated by BSUH with a lease agreement with ESHT, for the space and facilities occupied by the unit. | |

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| | This would be beneficial to patients for clinical and practical reasons because it would provide relevant clinical adjacencies, such as other cancer services or diagnostics. This means that the whole of the cancer pathway can be efficient with no or little disruption to patient care. The EDGH site has also been endorsed as a suitable location for an East Sussex linked unit by the local health community, including ESHT and BSUH management teams, local patient representatives and local specialised commissioners.<br><br>Discussion took place on the potential costs of the implementation of the project. The trust would also need to understand what, if any, the disruption costs would be.<br><br>The Full Business Case will be presented to the BSUH and ESHT Trust Board in January 2015 and then to the TDA for approval.<br><br>**Action**<br>**The Committee supported this joint venture and its location in the preferred site, under the Endoscopy Unit at Eastbourne DGH** | **RS** |
| **13.** | **DaVinci Robot System**<br><br>Ms Bishop and Mr Garnett presented a Business Case for the purchase and installation of the DaVinci Robot System.<br><br>Ms Bishop reported that in order to offer best practice and meet NICE and NHS England recommendations for urology pelvic oncology and in particular prostate cancer treatments the Trust needs to offer robotic assisted prostatectomy.<br><br>The proposal supports the overall vision and strategy of the Trust to develop the Eastbourne site as a credible specialist cancer centre with improved patient outcomes. The focus of the use of this robot will be primarily for pelvic urology oncology, in particular prostatectomy.<br><br>The Friends of the Hospital were committed to providing the capital costs of circa £1million for the robot.<br><br>The increased consumable cost and annual maintenance costs of £140K were covered & offset by a reduction in length of stay because of better patient outcomes and an increase in income through higher NHS and private patient referrals.<br><br>The DaVinci Surgical System was the most advanced robotic technology available and improves upon traditional open and laparoscopic surgery in several ways. The benefits of the system were noted.<br><br>The Business Case had been supported by the Clinical Management | |

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| | Executive at its meeting on 10 November 2014.<br><br>The Da Vinci Surgical System would be located in a dedicated theatre at Eastbourne DGH and will be available for at least ten sessions (five days) per week. The company will support a training and learning programme for both surgeons and theatre personnel. As a Regional Centre of Excellence this service will develop and include Surgeons from West Sussex and Brighton.<br><br>Mr Garnett reported that the suggestion from NHS England Commissioners was that the pelvic uro-oncology work should be carried out at Eastbourne and Clinicians have agreed with that.<br><br>**Action**<br>**The Committee recommend the Business Case for approval by the Trust Board.** | |
| **14.** | **Making Better Use of Government Resource Services Procurement & Service Delivery Platforms**<br><br>Mrs Harris gave an update on the progress with the DH (Department of Health) invitation to take part in a review of Government support services and delivery platforms.<br><br>A Project Steering Group had been formed to oversee the project. It was noted that this was not a decision making body but was expected to reach conclusions and make recommendations to the Finance and Investment Committee where any formal decisions would be taken. Terms of Reference had been prepared and were available upon request. A Non Executive Director was part of the group and this was Mr Nealon, who was also the Non Executive champion for procurement.<br><br>Alongside this piece of work there was also a further review by Lord Carter to look at efficiency and productivity across a range of areas.<br><br>Since the October meeting of the Finance and Investment Committee templates had been submitted to the DH by ESHT which should allow SBS and NHSP to complete their diagnostic and costing exercise. The Plan will now be to meet with each of SBS and NHSP to initiate a work programme. In addition and as reported through the market testing update at the last Committee meeting, the DH has provided some soft FM expertise to ESHT with a view to looking at any potential efficiency in this area. A progress update will be made to the next Finance and Investment Committee meeting.<br><br>**Action**<br>**The Committee noted that:**<br>• **A Project Steering Group had been formed. The Non-Executive Director representative was Barry Nealon.** | |

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| | • **Under the Terms of Reference any recommendations will be brought to this Committee where any formal decisions will be taken.** | |
| **15.** | **Procurement Update**<br><br>Mrs Jaggar updated the Committee of progress within the procurement function since 1 April 2014 when it moved into the finance directorate.<br><br>Mrs Jaggar presented a report which was part of an initiative to bring visibility to the work of the Procurement team, highlight achievements to date which make progress towards the national aim and give assurance that a robust 3 year Procurement strategy was under development.<br><br>The following key initiatives were noted:<br><br>• 3 year Procurement Strategy (discussed in greater detail under item 16. below)<br>• Significant savings achieved to date in line with CIP expectations<br>• Benchmarking of current ESHT Procurement service against DH metrics compare favourably with best practice expectations<br>• A draft Procurement Efficiency Programme for 2015/16 is being finalised with target savings of £2 in year.<br><br>The target savings for 2014/15 CIP was £2.5m. It was noted that the Procurement team was ahead of plan to deliver its CIP for 2014/15 and had started the process to deliver a comprehensive Procurement Efficiency Programme in 2015/16 to release further savings.<br><br>**Action**<br>**The Committee noted the progress made against the target and the key metrics.** | |
| **16.** | **Procurement Strategy**<br><br>Mrs Jaggar presented the Trust Procurement Strategy which was based upon the premise of invest to save and sought to give assurance to the Trust that through its execution the Trust will reduce expenditure whilst maintaining quality patient care and developing a strong commercial and 'value-based' approach across the departments.<br><br>As part of the strategy development, the previous Trust Procurement strategy had been reviewed and there had been discussion and informal benchmarking with NHS peer Trust Procurement teams, the Department of Health (DoH), NHS SBS and ESHT staff. | |

The key areas of future delivery within this proposal were:

- cost efficiencies (cash releasing and procurement savings) of £6.5m over 3 yrs
- skilled resources to support the immediate delivery of savings and projects requiring change management
- consistency with DoH strategies and implementation of DoH mandated policies
- service improvements through increased use of IT systems
- long term planning  flexibility to meet changes in clinical strategy
- compliance and promotion of good governance as best practice procurement is rolled out and adopted across the Trust

To deliver these benefits, we will;

- assume responsibility for the contracting of all non-pay spend excl. pharmacy where it makes sense to do so
- implement procurement product groups to ensure fully engaged clinical and department resource aligned to all projects
- restructure the existing Procurement team to ensure fully aligned resources and in-house catalogue capability; invest in current staff to increase levels of competence and capability
- review collaborative arrangements to ensure value for money
- review current just in time supplies policy and investigate benefits of bulk purchase
- provide support to the commercial bid team
- implement full catalogue management process to ensure correct ordering of products at correct prices.

The proposed new Procurement Team structure was reviewed and the key principles were noted.  Professor Cohen expressed his concerns over the cost increase of two new roles within the new structure, funded from additional savings generated.  Professor Cohen asked for it to be noted that he did not support these additional roles. Mr Grayson said that it would be up to Mrs Harris to determine what procurement capability she would need to build into the strategy.

Mrs Jaggar explained that the Trust had used some interim resource to help deliver some of the savings this year.

It was noted that the Procurement Strategy was due to be presented to the Trust Board at its meeting on 26 November 2014.

**Action**
**The Committee approved the Procurement Strategy but noted that it was beyond the remit of the Committee to approve the staffing levels.**

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| **17.** | **Tender & Service Development Schedule**<br><br>The Committee received a schedule which provided an update on current tenders and service developments.<br><br>It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings.<br><br>All new Pre Qualification Questionnaire (PQQ) or tender proposals are considered by the BPSG to determine whether the Trust in bidding for the service will consider a number of criteria including that the proposal:<br><br>• meets the strategic direction of the Trust,<br>• is part of the core business of the Trust, or<br>• fits with the business model.<br><br>If a decision is made to consider a bid, a working group comprising the relevant clinical, operational and corporate services undertake a risk assessment and report back to the BPSG, following which a decision is taken as to whether to proceed with a bid.<br><br>The BPSG also considers business cases for service developments to ensure that these are picked up in the planning process.<br><br>The Committee noted the position of the following PQQ/tenders in the pipeline:<br><br>• Fracture Liaison Service<br>• Non-invasive Ventilation Service<br>• High Weald Lewes and Havens community services<br><br>**Action**<br>**The Committee noted the update on tenders and service developments.** | |
| **18.** | **IM&T Update**<br><br>The Committee received a progress report on the proposed implementation of the following IM&T projects due to be implemented in 2014/15:<br><br>• Community and Child Health system<br>• NHS Mail Migration<br>• Southern Acute Programme - Electronic Document Management and Clinical Portal<br>• Electronic clinical correspondence<br>• Acute PAS upgrade | |

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| | • VitalPac patient bedside monitoring<br>• Windows 7 / Office 2010 migration<br>• Euroking maternity system upgrade<br><br>It was noted that all core projects were being facilitated by the Trusts PMO which was tasked with implementing these projects on behalf of the Trust. Each Project Board is chaired and led by a senior officer within the Trust.<br><br>All projects were on track to deliver within the project timescales despite a number of risks to delivery mainly driven by third party and recruitment risks.<br><br>**Action**<br>**The Committee noted the progress with projects.** | |
| **19.** | **Job Planning Update**<br><br>Dr Hughes provided an update on consultant job planning and the progress which has been made since July.<br><br>Job Planning is an annual requirement of all consultant medical staff and all staff have extant job plans. The Trust has introduced a more rigorous and robust method of job planning this year to ensure that consultant activity is fully aligned with Trust plans and there is the most productive use of consultant time and clinical facilities.<br><br>Each specialty is being reviewed to understand the demand for the service, the 'supply' of medical staffing resource available to meet that demand (including numbers of staff, how they use their time and productivity), so that consultant job plans can match organisational requirements.<br><br>Dr Hughes reported that 98% of the Consultants now have recognisable and functional job plans and there was a process in place to review and improve the standardisation and quality of the job plans.<br><br>**Action**<br>**The Committee noted the Job Planning update and recommended that this process continues.** | |
| **20.** | **Work Programme**<br><br>The 2014 work programme was reviewed. It was noted that the Business Planning Process would be included in December, and a Review of the Capital Programme Outcome would be presented in January 2015.<br><br>The draft 2015 work programme will be circulated with the agenda for | |

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| | the December meeting.<br><br>**Action**<br>**The Committee noted the revised work programme.** | |
| **21.** | **Date of Next Meeting**<br><br>The next meeting will take place on Wednesday 17 December 2014 at 9.30am – 11.30am in the Princess Alice Room at Eastbourne DGH. | |

# 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 13 January 2015. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 10 November 2014 are attached at Appendix 1.

### 2. Issues discussed at 10 November Meeting

#### 2.1 Patient Story

The agenda item focussed on two patient stories, one in an acute and one in a community setting, both of which recognised the contribution staff had made in providing excellent care and showing compassion, not only towards patients, but to the wider family members too.

#### 2.2 Sign up to Safety Campaign

Details were provided of the initiatives included in the Trust's Safety Improvement Plan. As part of the national Sign up to Safety Campaign, the plan will be submitted to the NHS Litigation Authority (NHS LA) for consideration for funding. It was noted that participation in the Sign up to Safety Campaign had progressed and initiatives to reduce harm and decrease claims had been considered.

#### 2.3 Care Quality Commission (CQC) Intelligent Monitoring Report (IMR)

A report summarising the findings from the IMR published by the CQC in December 2014 was presented. It was noted that East Sussex Healthcare Trust had not been categorised as a result of the report due to the recent CQC inspection in September 2015. The Committee recognised that the majority of the metrics in the report were already reviewed by the Trust as part of the Governance framework and these would continue to be validated and necessary actions taken if risks were identified.

#### 2.4 East Sussex Local Children Safeguarding Annual Report 2013-14 and Business Plan 2012-15

The Committee were assured that East Sussex Healthcare NHS Trust continued to work closely with Social Care and other key partners and the annual plan reflected the 2014-15 priorities.

#### 2.5 2014 National Cancer Patient Experience Survey Comments Report

This fourth annual report, commissioned by the Department of Health was presented and discussed. It was noted that generally the report reflected the high quality of Cancer services experienced by patients diagnosed with cancer. Particular consideration was given to participation in Cancer research, where it was noted that the Trust consistently underperformed.

2.6 **Mandatory Training and Appraisal Compliance**

The Committee noted that as a result of a specific focus on mandatory training and appraisals, compliance had increased during November 2015. Additional training sessions had been held and recovery plans had been received from Clinical Units.

2.7 **Health Records**

The Committee undertook a deep dive into the mitigating actions and longer term plans around identified health records issues. The key issues of concern were highlighted and it was noted that members of the executive and non-executive team had undertaken quality walks and personal visits to seek assurance regarding mitigating actions. A business case had been developed and submitted to the Trust Development Agency which, if agreed, would eliminate all the key concerns and risks.

## 3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 13 January 2015 and the minutes of the meeting held on 10 November 2014.

**Sue Bernhauser**
**Quality and Standards Committee**

14 January 2015

**Appendix One**

**East Sussex Healthcare NHS Trust (ESHT)**

**Quality and Standards Committee**

**Minutes of the Combined Quality and Standards Committee /**

**Monday, 10 November 2014**
**Committee Room, Conquest Hospital**

Present: Mrs Sue Bernhauser, Non-Executive Director Designate (Chair)
Professor Jon Cohen, Non-Executive Director
Mrs Janet Colvert, Ex-Officio Committee Member
Dr David Hughes, Medical Director
Mrs Lindsey Stevens, Deputy Director of Nursing
Mr Richard Sunley, Chief Operating Officer
Mrs Moira Tenney, Deputy Director of HR
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary

In attendance: Mrs Susan Cambell, PA to Director of Nursing (minutes)
Dr Rebecca Coles-Gale, Senior Clinical and Health Psychologist

1.0 **Welcome and Apologies for Absence**

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

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

Mr Charles Ellis, Non-Executive Director
Miss Emily Keeble, Head of Assurance
Ms Tina Lloyd, Assistant Director of Nursing, Infection Prevention and Control
Ms Emma Tate, Head of Clinical Improvement
Mr Stuart Welling, Chairman
Dr James Wilkinson, Assistant Medical Director, Quality
Dr Jamal Zaidi, Assistant Medical Director, Workforce

2.0 **Shared Learning in Practice (SLiP)**

A presentation was made by a service user and Senior Clinical and Health Psychologist following treatment whilst under the care of the Trust. The case presented was summarised as a positive outcome with collaborative working between the organisation and Sussex Partnership Foundation Trust. It was noted that the temporary buildings, currently used by the Psychology service, required capital investment and Mrs Webster and Mr Sunley agreed to look into this. **AW/RS**

3.0 **Revised Terms of Reference (ToR) and Structure of Future Meetings**

The Committee agreed to revise the Terms of Reference to include the Chair of Patient Safety and Clinical Improvement Group (PSCIG) and patient representation. It was noted that the Associate Director of Knowledge and Chair of Trust Infection Control Group would present reports by invitation. It was agreed that a visual chart

be created to show groups reporting into the Committee. **SC**

The 2015 work programme was agreed by the Committee.

4.0 **Minutes and Matters Arising**

4.1 **Minutes of the Previous Meeting**

Minutes of the combined Quality and Standards Committee /PSCIG meeting held on 2 September 2014 were considered and agreed an accurate record.

4.2 **Matters Arising**

The updated action log from the Quality and Standards Committee meeting would be circulated with the minutes.

5.0 **Compliance and Risk**

5.1 **Board Assurance Framework (BAF) High Level Risk Register**

Mrs Wells presented the BAF report along with the latest version of the High Level Risk Register and the Committee noted the detail. Mrs Wells agreed to update the RAG rating regarding gaps in controls for 1.1.3, Review of Health Records and 3.5.1, Estates Strategy to be Developed. Mr Sunley agreed to present a deep-dive into the review of health records at the January 2015 meeting and the relevant front-line staff would be invited to attend. **LW /RS**

Mrs Wells assured the Committee that both the high and low level risks were scrutinized at both Clinical Management Executive (CME) and Trust Audit Committee meetings. Mrs Wells agreed to explore if the DatixWEB system allowed for changes to the risk rating be identified on the report. **LW**

Mrs Wells sought assurance around risk ID 1189, reporting on plain film backlog which had been escalated to Care Quality Commission (CQC). Mr Sunley explained that the backlog from September 2013 had been cleared, but prior to this date IT issues had meant a delay in the external review of the information. He further confirmed that no chest or abdomen x-rays had been added to the backlog since April 2014. Mr Sunley agreed to present a report to the Committee at the next meeting. **RS**

5.2 **Care Quality Commission (CQC) update on Chief Inspector of Hospitals Visit and Project Group Actions**

Mrs Wells explained that there had been a delay to the expected timetable for the publication of the CQC report and the ESHT Quality Summit was now was now likely to take place in early January 2015.

5.3 **Legal and Claims**

**(i) Non Clinical Claims Report Quarter 1 2014/15**

Mrs Wells presented the updated position on behalf of the Head of Legal Services and it was noted that 10 new claims had been opened in the first quarter of the year. Mrs Wells stated that overall there were a comparatively small numbers of claims with no particular trending other than the relatively high number of slips,

trips and falls claims.

**(ii) Clinical Negligence Claims Report Quarter 1 2014/15**

Mrs Wells explained that the team had changed the procedure whereby actual claims brought against the Trust, rather than speculative letters, were logged, thus reducing the workload.

Mrs Wells agreed to present an update to the Committee regarding the Sign up to Safety campaign and the possibility of a 10% reduction in premiums by the NHS Litigation Authority (NHS LA) to Trusts who evidenced that they had implemented learning from claims. She advised there would be a focus on high value claims. **LW**

6.0 **Quality**

6.1 **Integrated Quality Report**

The Committee noted receipt of the Integrated Quality report outlining the organisational position for Quarter 2 with triangulated data from agreed quality sources. Professor Cohen commented that the report was very informative and formed the core of the meeting. He requested a clarifying statement with regard to the ESHT commitments and Mrs Webster confirmed these are from the Patient Experience Strategy and agreed to ensure that these are included in future updates. **AW**

Mrs Webster reported that comparative data between Quarter 1 and 2 showed a slight decrease in the number of patient safety incidents and noted that the number of patient falls, pressure ulcers and medication errors had reduced in line with this trend. Professor Cohen commented that the highest reporting issue remained pressure ulcers and Mrs Webster explained that the majority of these occurred in the community and patient choice was a factor. Mrs Webster confirmed that further work was being undertaken with public health to address this issue.

Mrs Webster summarised the emerging themes and trends from the quality walk programme and noted that changes to the organisational structure, VitalPAC and SystmOne had been positively embraced by staff.

Mrs Stevens assured the Committee that Patient Reported Outcome Measures (PROMs) would be included in future patient experience reports. Mrs Stevens further explained that she had met with Support Empower Advocate Promote (SEAP), an independent advocacy service who were keen to support the organisation with complaints that were complex, returning or had proven difficult to resolve. **LS**

Mrs Webster confirmed that the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report had been scrutinised at CME and timescales and compliance would be further monitored. Professor Cohen expressed his concerns regarding non-compliance with the recommendations and suggested work should be undertaken to rank the recommendations in order, prioritizing those that are critical. Mrs Webster and Dr Hughes agreed to explore this further. **AW /DH**

6.2 **Trust Infection Control Group – Self Assessment of Compliance Against Outcome 8 Regulation 12 'Cleanliness and Infection Control – Quarter 2, 2014-15.**

Mrs Webster presented the report on behalf of the Trust Infection Control Group

(TICG) Chair which showed improvements made year to date and identified areas of concern for action and /or escalation. Mrs Wells stated that she had felt assured by the comprehensive reports shared with CQC and Mrs Webster confirmed that the team had exceptional links across the organisation.

## 7.0 Human Resources

### 7.1 Mandatory Training and Appraisal Compliance Update

The Committee noted receipt of the mandatory training and appraisal compliance update and Mrs Tenney stated that progress in mandatory training was expected, with a 90% compliance target set for March 2015. She reported that additional clinical and non-clinical updates had been arranged to assist with this. Mrs Tenney explained that work had been undertaken to deliver a competency based assessment and this would be offered in 2015. Mrs Colvert sought assurance around work pressures and staff being released to attend training. Mrs Stevens said that in exceptional circumstances this might be an issue but it was noted that staff could only cancel a booked training session if the Head of Nursing or General Manager authorised it.

Mrs Tenney confirmed that currently there was a strong focus on appraisals with a message circulated to all staff from the Chief Executive for 100% compliance.

### 7.2 HR Incident Report

The Committee noted receipt of the HR Incident report and Mrs Tenney highlighted the significant reduction in the total number of formal incidents addressed under the organisation's workforce policies, compared with the same period in 2013. It was noted that a review of the data presented would be undertaken to identify specific areas and staff groups where a reduction had occurred.

Mrs Tenney highlighted the Dignity at Work Investigations and noted that the Trust had looked to develop a Learning into Action (LiA) approach to increase staff engagement in areas where poor working relationships had been identified.

Mrs Bernhauser sought clarity around the continued suspension of staff during lengthy police investigations which were not directly related to their employment and Mrs Tenney stated that she would be taking legal advice regarding this.

Mrs Tenney highlighted the work being undertaken around performance management issues and learning difficulties in an attempt to assist managers to consider signposting. Mrs Webster suggested that it might be helpful to know the number of referrals that had been made to professional bodies.

## 8.0 External Matters / Policy Requiring Consideration

### 8.1 Duty of Candour

Mrs Wells presented the report outlining the contractual requirement of the Duty of Candour which had become statutory on 1 October 2014. Mrs Wells cited the Being Open policy as evidence of the organisation being open and transparent. Mrs Wells stated that whilst robust systems were in place, the new regulations made clear that discussions with patients must be followed up with written confirmation. Mrs Wells confirmed that processes were being reviewed to incorporate this and would be submitted to the Trust Board for approval. Mrs Wells agreed to present a report in

May 2015 to assure the Committee that an audit trail was in place.

9.0 **For Information**

9.1 The following items were noted by the Committee;

Minutes from the Trust Health and Safety Steering Group meeting.
Minutes from the Consent and Clinical Ethics Committee meeting.

10.0 **Any Other Business**

None noted.

11.0 **Date of the Next Meeting**

Tuesday, 13 January 2015
2.30pm – 4.30pm
St Mary's Room, Eastbourne District General Hospital

# Quality and Standards Committee
# Terms of Reference

## 1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Quality and Standards Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Trust Board

## 2. Purpose

The main duties of the Committee are to ensure, on behalf of the Board, that taking account of best practice

- there are effective structures and systems in place that support the continuous improvement of quality services and safeguard high standards of patient care

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

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

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

## 3. Responsibilities

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

Review and monitor the effectiveness of Trust processes in respect of compliance with standards, national best practice and guidance. This will include scrutinising any concerns or adverse findings and monitoring actions taken by management to address these, for example mortality outlier alerts.

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

Review the risk register and BAF to identify relevant quality and safety risks and seek assurance that appropriate management action has been taken to manage and mitigate these risks. Reporting any gaps in control or assurance to the Board

Approve the quality improvement components of the Annual Business Plan prior to its approval by the Board seeking assurance that these are fully aligned to organisational priorities and the QIP and that appropriate and achievable timescales

for delivery have been identified. Agree the measures that will be used to evidence delivery

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

Periodically review governance arrangements in the Trust, both clinical and non-clinical, to ensure that they remain effective and compliant with best practice

Seek assurance that action is being taken to ensure compliance with regulatory and statutory standards and requirements and that performance management arrangements are effective in this respect. Identify gaps in control and assurance and report these to the Board.

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

To support the work of the trust's audit committee, which has responsibility for the oversight of the trust's risk management system. The chairman of the committee will liaise with audit committee chairman in order to ensure a unified approach to matters of common interest.

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

Review the Trust's quality performance using agreed national and local performance metrics. Seek assurance that areas of underperformance are identified and that appropriate quality improvements actions are taken in a timely manner to deliver the measurable improvements required

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

Review feedback and associated action plans from Quality Walks and Assurance visits.

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

## 4. Membership and attendance

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

- Three Non-Executive Directors one of whom will be the Committee Chair
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Chair of Patient Safety and Clinical Improvement Group
- Chair of Trust Infection Control Group – by invitation
- Company Secretary
- Head of Governance
- HR Representation
- Two associate medical directors
- Associate Director Knowledge Management – by invitation
- Ex-Officio Members, numbers to be determined by the Committee and to include patient representation.

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

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

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

## 5. Quorum

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

## 6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require.

## 7. Authority

The Committee is authorised by the Trust Board to review any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employers are directed to cooperate with any requests made by the Committee.

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

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

## 8. Reporting arrangements

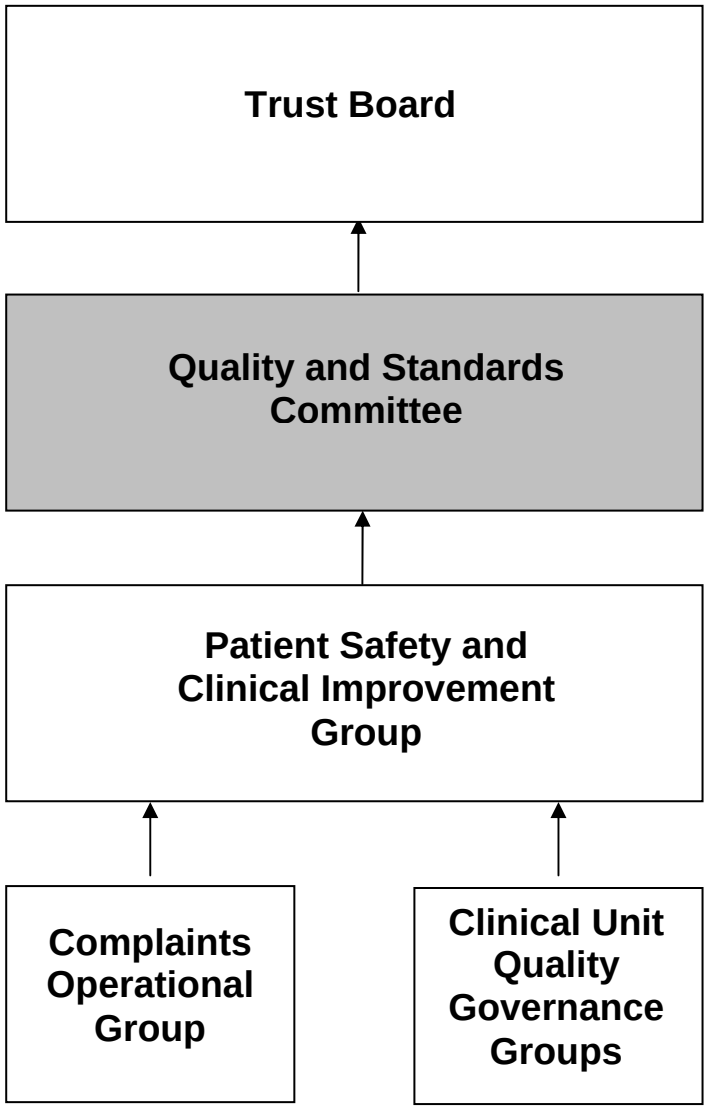
Minutes of the Committee meetings shall be formally recorded by the Secretary to the Committee and submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

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

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

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

9. Reporting structure



# East Sussex Healthcare NHS Trust (ESHT)

## Quality and Standards Committee

## Minutes of the Quality and Standards Committee /

## Monday, 10 November 2014 Committee Room, Conquest Hospital

Present: Mrs Sue Bernhauser, Non-Executive Director Designate (Chair)
Professor Jon Cohen, Non-Executive Director
Mrs Janet Colvert, Ex-Officio Committee Member
Dr David Hughes, Medical Director
Mrs Lindsey Stevens, Deputy Director of Nursing
Mr Richard Sunley, Chief Operating Officer
Mrs Moira Tenney, Deputy Director of HR
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary

In attendance: Mrs Susan Cambell, PA to Director of Nursing (minutes)
Dr Rebecca Coles-Gale, Senior Clinical and Health Psychologist

### 1.0 Welcome and Apologies for Absence

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

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

Mr Charles Ellis, Non-Executive Director
Miss Emily Keeble, Head of Assurance
Ms Tina Lloyd, Assistant Director of Nursing, Infection Prevention and Control
Ms Emma Tate, Head of Clinical Improvement
Mr Stuart Welling, Chairman
Dr James Wilkinson, Assistant Medical Director, Quality
Dr Jamal Zaidi, Assistant Medical Director, Workforce

### 2.0 Shared Learning in Practice (SLiP)

A presentation was made by a service user and Senior Clinical and Health Psychologist following treatment whilst under the care of the Trust. The case presented was summarised as a positive outcome with collaborative working between the organisation and Sussex Partnership Foundation Trust. It was noted that the temporary buildings, currently used by the Psychology service, required capital investment and Mrs Webster and Mr Sunley agreed to look **AW/RS**

into this.

## 3.0 Revised Terms of Reference (ToR) and Structure of Future Meetings

The Committee agreed to revise the Terms of Reference to include the Chair of Patient Safety and Clinical Improvement Group (PSCIG) and patient representation. It was noted that the Associate Director of Knowledge and Chair of Trust Infection Control Group would present reports by invitation. It was agreed that a visual chart be created to show groups reporting into the Committee. **SC**

The 2015 work programme was agreed by the Committee.

## 4.0 Minutes and Matters Arising

## 4.1 Minutes of the Previous Meeting

Minutes of the combined Quality and Standards Committee /PSCIG meeting held on 2 September 2014 were considered and agreed an accurate record.

## 4.2 Matters Arising

The updated action log from the Quality and Standards Committee meeting would be circulated with the minutes.

## 5.0 Compliance and Risk

## 5.1 Board Assurance Framework (BAF) High Level Risk Register

Mrs Wells presented the BAF report along with the latest version of the High Level Risk Register and the Committee noted the detail. Mrs Wells agreed to update the RAG rating regarding gaps in controls for 1.1.3, Review of Health Records and 3.5.1, Estates Strategy to be Developed. Mr Sunley agreed to present a deep-dive into the review of health records at the January 2015 meeting and the relevant front-line staff would be invited to attend. **LW /RS**

Mrs Wells assured the Committee that both the high and low level risks were scrutinized at both Clinical Management Executive (CME) and Trust Audit Committee meetings. Mrs Wells agreed to explore if the DatixWEB system allowed for changes to the risk rating be identified on the report. **LW**

Mrs Wells sought assurance around risk ID 1189, reporting on plain film backlog which had been escalated to Care Quality Commission (CQC). Mr Sunley explained that the backlog from September 2013 had been cleared, but prior to this date IT issues had meant a delay in the external review of the information. He further confirmed that no chest or abdomen x-rays had been

added to the backlog since April 2014. Mr Sunley agreed to present a report to the Committee at the next meeting. **RS**

5.2 **Care Quality Commission (CQC) update on Chief Inspector of Hospitals Visit and Project Group Actions**

Mrs Wells explained that there had been a delay to the expected timetable for the publication of the CQC report and the ESHT Quality Summit was now was now likely to take place in early January 2015.

5.3 **Legal and Claims**

**(i) Non Clinical Claims Report Quarter 1 2014/15**

Mrs Wells presented the updated position on behalf of the Head of Legal Services and it was noted that 10 new claims had been opened in the first quarter of the year. Mrs Wells stated that overall there were a comparatively small numbers of claims with no particular trending other than the relatively high number of slips, trips and falls claims.

**(ii) Clinical Negligence Claims Report Quarter 1 2014/15**

Mrs Wells explained that the team had changed the procedure whereby actual claims brought against the Trust, rather than speculative letters, were logged, thus reducing the workload.

Mrs Wells agreed to present an update to the Committee regarding the Sign up to Safety campaign and the possibility of a 10% reduction in premiums by the NHS Litigation Authority (NHS LA) to Trusts who evidenced that they had implemented learning from claims. She advised there would be a focus on high value claims. **LW**

6.0 **Quality**

6.1 **Integrated Quality Report**

The Committee noted receipt of the Integrated Quality report outlining the organisational position for Quarter 2 with triangulated data from agreed quality sources. Professor Cohen commented that the report was very informative and formed the core of the meeting. He requested a clarifying statement with regard to the ESHT commitments and Mrs Webster confirmed these are from the Patient Experience Strategy and agreed to ensure that these are included in future updates. **AW**

Mrs Webster reported that comparative data between Quarter 1 and 2 showed a slight decrease in the number of patient safety incidents and noted

that the number of patient falls, pressure ulcers and medication errors had reduced in line with this trend. Professor Cohen commented that the highest reporting issue remained pressure ulcers and Mrs Webster explained that the majority of these occurred in the community and patient choice was a factor. Mrs Webster confirmed that further work was being undertaken with public health to address this issue.

Mrs Webster summarised the emerging themes and trends from the quality walk programme and noted that changes to the organisational structure, VitalPAC and SystmOne had been positively embraced by staff. **LS**

Mrs Stevens assured the Committee that Patient Reported Outcome Measures (PROMs) would be included in future patient experience reports. Mrs Stevens further explained that she had met with Support Empower Advocate Promote (SEAP), an independent advocacy service who were keen to support the organisation with complaints that were complex, returning or had proven difficult to resolve.

Mrs Webster confirmed that the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report had been scrutinised at CME and timescales and compliance would be further monitored. Professor Cohen **AW /DH** expressed his concerns regarding non-compliance with the recommendations and suggested work should be undertaken to rank the recommendations in order, prioritizing those that are critical. Mrs Webster and Dr Hughes agreed to explore this further.

6.2 **Trust Infection Control Group – Self Assessment of Compliance Against Outcome 8 Regulation 12 'Cleanliness and Infection Control – Quarter 2, 2014-15.**

Mrs Webster presented the report on behalf of the Trust Infection Control Group (TICG) Chair which showed improvements made year to date and identified areas of concern for action and /or escalation. Mrs Wells stated that she had felt assured by the comprehensive reports shared with CQC and Mrs Webster confirmed that the team had exceptional links across the organisation.

7.0 **Human Resources**

7.1 **Mandatory Training and Appraisal Compliance Update**

The Committee noted receipt of the mandatory training and appraisal compliance update and Mrs Tenney stated that progress in mandatory training was expected, with a 90% compliance target set for March 2015. She reported that additional clinical and non-clinical updates had been arranged to assist with this. Mrs Tenney explained that work had been undertaken to

deliver a competency based assessment and this would be offered in 2015. Mrs Colvert sought assurance around work pressures and staff being released to attend training. Mrs Stevens said that in exceptional circumstances this might be an issue but it was noted that staff could only cancel a booked training session if the Head of Nursing or General Manager authorised it.

Mrs Tenney confirmed that currently there was a strong focus on appraisals with a message circulated to all staff from the Chief Executive for 100% compliance.

## 7.2 HR Incident Report

The Committee noted receipt of the HR Incident report and Mrs Tenney highlighted the significant reduction in the total number of formal incidents addressed under the organisation's workforce policies, compared with the same period in 2013. It was noted that a review of the data presented would be undertaken to identify specific areas and staff groups where a reduction had occurred.

Mrs Tenney highlighted the Dignity at Work Investigations and noted that the Trust had looked to develop a Learning into Action (LiA) approach to increase staff engagement in areas where poor working relationships had been identified.

Mrs Bernhauser sought clarity around the continued suspension of staff during lengthy police investigations which were not directly related to their employment and Mrs Tenney stated that she would be taking legal advice regarding this.

Mrs Tenney highlighted the work being undertaken around performance management issues and learning difficulties in an attempt to assist managers to consider signposting. Mrs Webster suggested that it might be helpful to know the number of referrals that had been made to professional bodies.

## 8.0 External Matters / Policy Requiring Consideration

## 8.1 Duty of Candour

Mrs Wells presented the report outlining the contractual requirement of the Duty of Candour which had become statutory on 1 October 2014. Mrs Wells cited the Being Open policy as evidence of the organisation being open and transparent. Mrs Wells stated that whilst robust systems were in place, the new regulations made clear that discussions with patients must be followed up with written confirmation. Mrs Wells confirmed that processes were being reviewed to incorporate this and would be submitted to the Trust Board for

approval. Mrs Wells agreed to present a report in May 2015 to assure the Committee that an audit trail was in place.

9.0 **For Information**

9.1 The following items were noted by the Committee;

Minutes from the Trust Health and Safety Steering Group meeting.
Minutes from the Consent and Clinical Ethics Committee meeting.

10.0 **Any Other Business**

None noted.

11.0 **Date of the Next Meeting**

Tuesday, 13 January 2015
2.30pm – 4.30pm
St Mary's Room, Eastbourne District General Hospital

# EAST SUSSEX HEALTHCARE NHS TRUST

**Notes of the Trust Board Seminar held on Wednesday, 5th November 2014, at 10.00 am in the St Mary's Board Room, Eastbourne DGH**

Present: Stuart Welling, Chairman
Sue Bernhauser, Non-Executive Director Designate
Professor Jon Cohen, Non-Executive Director
Barry Nealon, Non-Executive Director
Mike Stevens, Non-Executive Director
Darren Grayson, Chief Executive
Vanessa Harris, Director of Finance
Dr Amanda Harrison, Director of Strategic Development and Assurance
Dr David Hughes, Medical Director (Governance)
Richard Sunley, Deputy Chief Executive/Chief Operating Officer (from 11.00 am)
Lynette Wells, Company Secretary

In Attendance: Dr Tuhin Goswami, Clinical Lead – Organ Donation (item2)
Sarah Callaghan, Specialist Nurse – Organ Donation (item 2)
Lois Howells, Lay Chair – Organ Donation Committee (item 2)
Trish Richardson, Corporate Governance Manager (notes)

**ACTION**

## 1. Welcome and Apologies for Absence

a) Apologies for absence were received from:

Charles Ellis, Non-Executive Director
Monica Green, Director of Human Resources
Dr Andy Slater, Medical Director (Strategy)
Alice Webster, Director of Nursing

## b) Notes of the Seminar meeting held on 15th October 2014

The notes of the seminar held on 15th October 2014 were agreed as a correct record.

## c) Update on current issues

i) Finance Update

Mrs Harris reported that the month 7 financial position was not yet available but updated the Board on the recent notification that £18m of 2014/15 non-recurrent deficit funding would be issued to ESHT. She advised that the funding would provide cash and revenue support in year allowing the Trust to forecast a break even position at year end and this would result in the Trust's accumulated deficit not increasing.

Mrs Harris advised that any impact on future PDC payments was being assessed.

She reported that a formal letter was awaited setting out the conditions for the funding but she anticipated that they would be based on those set out in the recent publication, Secretary of State's Guidance under section 42A of the National Health Service Act 2006 - Procedures, criteria, terms and conditions for providing loans, public dividend capital or guarantees of payment to Foundation Trusts and NHS Trusts.

She commented that the Trust was already working towards the majority of the conditions.

Discussion took place on how the communications would be handled both internally and externally to focus on the Trust's underlying structural deficit being acknowledged but also that the Trust was continuing to make progress both financially and operationally.

She advised that the funding would be included in the M7 finance report to the Board at its meeting at the end of November and that the M6 financial report would be amended to show the revised forecast outturn of breakeven.

Mr Grayson updated the Board on his discussions with the TDA regarding the Trust's original capital Full Business Case (FBC) bid of £30 million and a subsequent reduced FBC for the highest priority schemes of £11.7 million.

He reported that the TDA had now requested the Trust to prepare a smaller capital bid of around £5 million to address high priority issues in relation to the Trust's infrastructure which could feature in the CQC report, eg health records, and this was being started.

ii) <u>CQC Update</u>

Mr Grayson reported that the draft report would be going to the CQC internal moderation meeting this week and he anticipated that the Trust would then receive the draft at the end of the following week and it would have 10 working days to check for factual accuracy but this would not be an opportunity to challenge on judgement and views. He anticipated that the report would then be published towards the end of this month or early next month.

Mr Grayson advised that the date for the Quality Summit had been set for 5th December and representatives from the TDA, the CCGs, East Sussex County Council, Healthwatch and HOSC would be present to hear the CQC present their report.

He advised that under the leadership of TDA the Trust and other stakeholders would then present their response.

Mr Grayson confirmed that he had not received any intelligence about the final judgement in the report.

iii) Referral To Treatment (RTT) Targets

Mr Grayson reported that good progress was being made with the admitted pathway and he was confident that sustainability would be achieved from December onwards

He advised that there was less confidence at present in relation to the non-admitted pathway due to capacity, administration and IT systems issues, particularly in relation to gastroenterology.

iv) Month 7 Performance

Mr Grayson reported that the Trust was likely to just miss the 95% A&E target in October due to increased activity and the impact of fewer beds although most of the winter capacity had been opened. He advised that the target was measured on a quarterly basis and therefore there was time to recover the position.

Mrs Harris reported that the winter and RTT funding amounts had been agreed with the commissioners and this would be reported in the financial position at the end of the month.

v) Challenged Health Economy

Mr Grayson updated on the challenged health economy work and discussions taking place with partners around opportunities for collaboration both in clinical and back office services.

Discussion took place on the recent review undertaken by PWC to identify the extent to which the Trust's financial problems were due to a structural underlying deficit and how this would be used in the next stages of the challenged health economy work.

2. **Organ Donation**

Mr Welling welcomed Dr Goswami, Ms Callaghan and Ms Howells to the meeting. All three provided a brief summary of their backgrounds and how they had come to be involved with organ donation.

Ms Howells explained that since taking on the role of chair of the committee its focus had changed to ensuring that the Trust was set up to maximise the potential for organs to be donated.

She explained that this entailed ensuring that the education, systems and processes within the Trust were in place to support this. She advised that a sub-committee led by Mr Gent, the previous committee chair, was concentrating on publicising organ donation externally.

Ms Howells highlighted that one organ donor could benefit 9 different people and 1 tissue donor could benefit 50 people and that 3 people a day died waiting for a transplant.

Dr Goswami highlighted that since the taskforce report in 2008 there had been a 49% increase in donors nationally and highlighted that everyone was more likely to receive a life-saving transplant than become a donor.

He outlined the process for organ donation in the Trust from identification of potential donors in accordance with NICE guidelines to the organ being removed and gave an example of two case studies.

He explained that there was an on-going audit of potential donors and, although the number of potential donors was small, the conversion rate still needed to be improved.

Dr Goswami stated that an audit of the organ donation policy had highlighted that staff still needed education on the optimum time to talk to families regarding potential donation and his view was that this could be addressed through organ donation training becoming mandatory for a selected group of staff. Ms Callaghan advised that there was funding available to backfill for staff released for organ donation training and it was agreed that Dr Hughes would discuss this further with Mrs Webster and Ms Green. **DH**

Dr Goswami confirmed that there was now a separate fund for organ donation within the Trust but requested some financial support to understand the budget statements and Mrs Harris confirmed that she would take this forward. **VH**

He commented that he had been very grateful for the support shown by Ms Kennett to the Committee and Mr Welling advised that he would be discussing with the non-executive directors who would take Ms Kennett's place on the Committee and advise Dr Goswami and Ms Howells in due course. **SW**

Mr Welling thanked Dr Goswami, Ms Callaghan and Ms Howells for their hard work and commitment to organ donation within the Trust.

## 3. HWLH Community Services Tender

Dr Harrison reported that the High Weald Lewes and Havens CCG had issued a PQQ in respect of a number of services which the Trust currently provided.

The subsequent discussion on this item was the subject of a private note in order to ensure that commercial confidentiality was maintained.

## 4. NHS England 5 Year Forward View

Mr Welling reported that the 5 Year Forward View articulated the agenda for the next five years across the health sector which linked to the Better Care Fund and the work on East Sussex Better Together would need to incorporate the view.

Professor Cohen suggested that the Trust should organise a conference for partners and collaborators to see how the 5 Year Forward View could be taken forward in the local health economy.

Mr Grayson noted that the Dalton review would also be published shortly reviewing management arrangements for improving services, eg chains, joint ventures, and Boards would be required to respond to the review and a conference, as suggested by Professor Cohen, could be a feature of that process.

It was agreed that this would be further considered following the publication of the Dalton review.

## 5. Board Assurance Framework and Board Workplan

Dr Harrison presented the revised format of the Board Assurance Framework (BAF) and confirmed that the content of the BAF had not changed in any way but the intention was to enable Board members to easier understand the gaps in controls or assurance, the actions being taken to address them and identify where Board reports and discussions provided assurance for inclusion on the BAF.

She proposed that there should be a minimum six month review of the BAF against all the reports the Board had received for the previous six months in order for the Board to assure itself that reports and discussions had covered the gaps in controls or assurance.

Professor Cohen commented that the format was very helpful and easy to read but suggested that as the Trust did not have an estates strategy at present it should be red on the BAF, rather than amber.

It was agreed that this would discussed at the Audit Committee meeting on 12th November. **MS**

## 5. Date and Time of Next Meeting

Wednesday, 10th December 2014, from 10.00 am to 2.00 pm, St Mary's Board Room, Eastbourne DGH.

# East Sussex Healthcare NHS Trust

| | |
|---|---|
| **Date of Meeting:** | 4th February 2015 |
| **Meeting:** | Trust Board |
| **Agenda item:** | 15 |
| **Subject:** | Chairman's Briefing |
| **Reporting Officer:** | Stuart Welling, Chairman |

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

**Purpose:**

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

**Introduction:**

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

**Key external meetings attended in October and November:**

- 25 November 2014 — Representatives of Campaign for Change
- 27 November 2014 — Health Overview and Scrutiny meeting
- 1 December 2014 — Chief Executive and Chairman of East Sussex County Council
- 3 December 2014 — Chairman of Brighton and Sussex University Hospitals NHS Trust
- 4 December 2014 — Conservative Parliamentary Candidate for Eastbourne
- 8 December 2014 — St Wilfrid's Hospice
- 15 December 2014 — Chief Executive and Chairman of Brighton and Sussex University Hospitals NHS Trust
- 22 January 2015 — Sussex Chairs meeting

Various Quality Walks

**Use of Trust Seal**

The Trust Seal has not been used since the last meeting:

**Proposals and/or Recommendations**

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

| **Name:** | **Contact details:** |
|---|---|
| Stuart Welling, Chairman | s.welling@nhs.net |