EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 5th August 2015, commencing at 10.00 am in the Ashdown Room, Uckfield Civic Centre, Bell Farm Lane, Uckfield TN22 1AE

AGENDA

			Lead:
1.	a) Chairman's opening remarks b) Apologies for absence c) Quality Walks		Chair
2.	Monthly award winner(s)		Chair
3.	Declarations of interests		Chair
4a.	Minutes of the meeting held on 2nd June 2015	Ai	Chair
4b.	Matters arising	Aii	Chair
5.	Board Assurance Framework	B	CSec

QUALITY, SAFETY AND PERFORMANCE

6.	a) Performance report month 2 (May) and Finance report month 3 (June) b) Safe Nurse Staffing Levels c) Staffing Establishment Review	Assurance	C	ALL DN DN DN
7.	Patient Experience Report Quarter 1	Assurance	D	DN
8.	Nursing Revalidation	Assurance	E	DN
9.	Medical Revalidation & Medical Appraisal Annual Report 2014-15	Assurance	F	MDCG

STRATEGY

10.	Annual Business Plan Quarter 1	Approval	G	DSA/ DF

GOVERNANCE & ASSURANCE

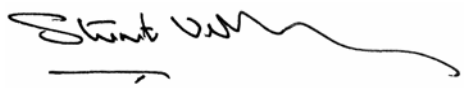
11.	Annual Reports: a) Health & Safety Annual Report b) Complaints Report Quarter 4 - End of Year Report	 Assurance Assurance	H	DN
12.	Workforce Race Equality Standard	Assurance	I	CSec

13.	Board sub-committees: a) Audit Committee Minutes 03.06.15 b) Finance and Investment Committee Minutes 29.04.15, 20.05.15 c) Quality and Standards Committee Report	Assurance	J	Comm Chairs

ITEMS FOR INFORMATION

14.	Chairman's Briefing	Assurance	K	Chair
15.	Questions from members of the public (15 minutes maximum)			Chair
16.	Date of Next Meeting: Wednesday, 30th September 2015 – Annual General Meeting at 10.00 am and public Trust Board meeting at 10.30 am, Lecture Theatre, Education Centre, Conquest			Chair

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



STUART WELLING
Chairman 10th July 2015

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
CSec	Company Secretary
DF	Director of Finance
DN	Director of Nursing
DSA	Director of Strategic Development and Assurance
HRD	Director of Human Resources
MDCG	Medical Director (Clinical Governance)

MDS	Medical Director (Strategy)
AC	Audit Committee
FIC	Finance and Investment Committee
QSC	Quality and Standards Committee

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	1c
Subject:	Quality Walks May/June 2015
Reporting Officer:	Amanda Harrison

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

Purpose:

This paper provides a summary of Quality Walks that have taken place during May and June 2015.

Introduction:

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

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

32 services/departments were visited as part of the Quality Walk programme during May and June as detailed below

Date	Time	Service	Site	Visit by
5.5.15	11am	Firwood	Hampden Park	Darren Grayson
5.5.15	10am	Coronary Care Unit/Cath lab	EDGH	Stuart Welling
6.5.15	10.3	Jubilee Eye Suite	EDGH	Darren Grayson
7.5.15	10am	Maternity Wards	Conquest	Stuart Welling
7.5.15	9am	Acute Admissions Unit	Conquest	Amanda Harrison
11.5.15	10am	Patient Advice Liaison Service (PALs)	Conquest	Sue Bernhauser
11.5.15	8.30am	Egerton Outpatients Clinical Administration Surgical Secretaries	Conquest	Monica Green
12.5.15	10am	Berwick Ward	EDGH	Stuart Welling
13.5.15	2.30pm	Theatres	Conquest	Jon Cohen
14.5.15	2pm	Community Paediatric Team	EDGH	Amanda Harrison
19.5.15	1pm	Kipling Ward	Conquest	Darren Grayson
20.5.15	1pm	Eye Department	Conquest	Darren Grayson
20.5.15	12pm	Wellington Ward	Conquest	Darren Grayson

20.5.15	1pm	Macdonald Ward	Conquest	Stuart Welling
20.5.15	2pm	Maxillo-facial department	Conquest	Stuart Welling
20.5.15	3.30pm	Benson Ward	Conquest	Stuart Welling
20.5.15	2pm	Clinical Administration	Conquest	Stuart Welling
29.5.15	10am	Surgical Secretaries	Conquest	Monica Green
27.5.15	9.30am	Radiology Department	Conquest	Sue Bernhauser
1.6.15	2pm	ENT (Outpatients)	Conquest	Vanessa Harris
3.6.15	1pm	Hailsham 3 Ward	EDGH	Stuart Welling
4.6.15	10am	Clinical Administration	Conquest	Stuart Welling
9.6.15	12 noon	Stroke Unit	EDGH	Stuart Welling
9.6.15	2.30pm	Maxillo facial/orthodontic outpatients	EDGH	Darren Grayson
11.6.15	2pm	Eastbourne Midwifery Unit	EDGH	Sue Bernhauser
12.6.15	9am	Health Records	Conquest	Monica Green
15.6.15	12pm	Jevington Ward	EDGH	Darren Grayson
16.6.15	1pm	Baird Ward	Conquest	Vanessa Harris
25.6.15	10am	Respiratory Team	Conquest	Amanda Harrison
30.6.15	6am	Cuckmere Ward	EDGH	Vanessa Harris

27 of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit. The remainder were carried out as ad hoc visits so staff may or may not have been notified to expect them. (NB other adhoc visits may have taken place, but reports have not yet been received).
At the time of writing the report feedback forms had been received relating to 24 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

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

Service Reconfiguration
Radiology at the Conquest reported that their volume of work remains high and that the department are working to cover 24 hours of service 7 days a week. This has been welcomed by radiographers who feel it offers a variety of experience for them and some working flexibility. Staff are rotated through several areas of practice to ensure they are part of a flexible workforce.
AAU at Conquest reported an increase in workload in the unit, and that patient flow does not always allow the unit to operate optimally.
The clinical administration teams feel that the current staffing arrangements are ineffective and inefficient with a loss of speciality experience which is detrimental to the service, they also reported that their working environment needs improvement as it is overcrowded and has poor ventilation

Information Technology (VitalPAC, SystmOne)
Staff continue to feedback positively about VitalPAC although there have been some recent connectivity issues.
The introduction of the EDM system which will allow all medical records to be electronically bar coded so their whereabouts can be tracked is due to be implemented in the next few weeks, it is acknowledged that this will be very challenging but it will have significant impact on the efficiency for clinic clerks, medical secretaries and all those seeing patients. It will also be hugely positive in terms of patient care and notes being available at clinics etc so clinicians have all relevant history and medical information
Management of coding was reported as an issue in one area but this has now been followed up.

Staff Survey/Feedback

Some administration staff feel they haven't been involved in decision making that impacts on their roles, and feel that the workload has increased and their numbers decreased. The raised issues too with having to constantly cancel patients' operations and the stress this causes them when patients are unhappy.

Other key issues

Various reports of good leadership and 'can do attitude' in teams were noted.
Berwick Ward has developed a positive innovative approach to HCA development which could be evaluated for wider application
Some areas reported that when other wards are under pressure it means staff are moved leading to concerns about overall delivery of care and time to spend with patients and relatives. Several areas reported that not all shifts are covered to the correct levels.
There have been significant issues reported with the fabric of some areas, and storage facilities, issues of medical records storage particularly at the Conquest continue.

Patient feedback

One person spoken to had been an inpatient for a month and stated that the care had been brilliant by nurses who are cheerful and that they saw the doctor every day. They stated that staff explain things to patients and treat them with compassion and that the food was good.
The PALs team reported that only 2% of their contacts result in formal complaints of which they are proud. The team are trying to be more proactive in engaging with patients and relatives and where possible will visit the outpatient department and waiting rooms to talk directly with patients and ask about their experiences.
Patients spoken to in Radiology were in general very positive about the service and the staff, but raised issues of the waiting time for their procedure to occur and the subsequent cost of car parking.

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 will be taking place in July and August with the following themes as agreed by the Board in June

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

Board Assurance Framework (please tick)

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

Strategic Objective 2 - Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences	
Strategic Objective 3 - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.	
Review by other Committees/Groups (please state name and date)**:**	
None	

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

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

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Tuesday, 2nd June 2015 at 10:00 am in the Lecture Theatre, Education Centre, Conquest Hospital

Present: Mr Stuart Welling, Chairman
Mrs Sue Bernhauser, Non-Executive Director
Prof. Jon Cohen, 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 David Hughes, Joint Medical Director - Clinical Governance
Dr Andy Slater, Joint Medical Director – Strategy
Mr Richard Sunley, Deputy Chief Executive/Chief Operating Officer
Mrs Alice Webster, Director of Nursing

In attendance:
Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Ms Jan Humber, Joint Staff Side Chairman
Mrs Lynette Wells, Company Secretary
Mr Mark Paice, General Manager, Estates (for item 053/2015)
Mr Peter Palmer, Assistant Company Secretary (minutes)

040/2015 **Welcome and Apologies for Absence**

a) Chairman's Opening Remarks

The Chairman welcomed everyone to the public part of the main Trust Board meeting and advised that the meeting was being recorded to ensure accuracy of records.

Before proceeding to the main agenda items Mr Welling made a formal statement in response to the no confidence vote by members of the Health Overview and Scrutiny Committee (HOSC) concerning leadership of the Trust. For accuracy the text of the statement is cut and pasted below:

"The Board fully recognises that, with its partner organisations, it is important to build confidence in the local NHS and its ability to provide patients with high quality care. As Board colleagues are aware my current term of office expires on the 10 July this year. However, I have accepted an invitation from the NHS Trust Development Authority to

extend my term of office to lead, with the Chief Executive, the implementation of our quality improvement plan. In due course I will support the process of appointing a new Chair by ensuring a smooth handover to my successor.

The TDA will support the Trust over the coming months to deliver the quality improvement plan that we have already started to implement. This plan includes requirements identified by the CQC in the reports published in March following the inspections last September and will be reviewed in the light of any findings from the CQC's further inspection in March."

b) Apologies for Absence

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

Mr Charles Ellis, Non-Executive Director

c) Feedback from Quality Walks

Dr Hughes reported that he had undertaken a visit to Bexhill Hospital. He explained that he had visited the Outpatient and the Ophthalmology departments as well as the Day Surgery and Stroke units during his visit. Dr Hughes outlined that during conversations with staff he had found them to be very positive about the recent changes made at Bexhill Hospital and that patients had also been complimentary about the recent improvements.

Dr Hughes said that staff in the Stroke Unit had raised concerns about the appropriateness of some of the patients who were being sent to them for rehabilitation, and explained that he would be holding conversations with his medical colleagues in order to understand and resolve this issue.

Prof. Cohen reported that he had visited the Pathology department at EDGH and Theatres and Critical Care at the Conquest Hospital.

He explained that two issues had come to light during his visit to the Pathology department. The first of these was that despite there being advanced processes in place for the re-provision of equipment, the speed at which this process took place caused frustration to the staff. Prof Cohen said that speeding up this service would allow for a more efficient pathology service. The second issue centred around the difficulty in recruitment and retention of trained pathology staff, which was a national problem.

Prof Cohen reported that on his visit to Theatres it had been clear that the space available was not sufficient. He explained that it was difficult to deliver the service within the current available space and facilities and that, although staff recognised that funding to make improvements

would be hard to attain, it was clear that changes would need to be made. Prof. Cohen praised the terrific work ethic of the staff and the pride with which they carried out their jobs. Mr Sunley said that Theatres was recognised as a high risk area, especially around issues relating to cooling. He reported that Theatres was high on the list for backlog maintenance as working practices and equipment had changed since the theatre complex had been constructed.

Prof. Cohen said that he had found Critical Care to be well staffed and well equipped. He explained that staff were very proud of the jobs they did and that he had been deeply impressed with their dedication. He said that concerns had been raised about out of hours medical staffing for the unit because, during the night, consultants were only available on call rather than being based in the unit. Dr Slater said that there was a Consultant Anaesthetist dedicated to Critical Care 24 hours a day, as well as a dedicated junior doctor based within the unit at all times. He explained that in comparison to national standards, the level of cover provided was excellent, but that he would speak to the Lead Clinician for Critical Care in order establish exactly what the issue was.

Mr Welling asked the Board to note the themes proposed for Quality Walks in 2015/16 and bear these in mind as walks were carried out.

The Board noted the report on quality walks and approved the themes for walks for 2015/16.

041/2015 **Monthly Award Winners**

Mr Welling reported that the Monthly Award Winner for April was Dee Honeysett who works as a Clinical Nurse Specialist for the Enys Road/Seaside Community Team. He explained the she had been nominated in recognition of her dedication to Community Nursing.

He reported that May's Monthly Award Winner was Jacquie Fuller, who worked as a Staff Child and Family Care Co-Ordinator in the HR department at EDGH. Jacquie was nominated for her work in ensuring that the Trust's Annual Awards ceremony had been a hugely successful event.

042/2015 **Declarations of Interest**

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

043/2015 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 25th March 2015 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

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

044/2015 **Chief Executive's Report**

Mr Grayson explained that he remained completely committed to securing the best quality services that were possible for ESHT and continuing to work with staff and stakeholders in order to achieve this. He said that since he had joined the Trust in 2011 sustainable improvements in performance, safety and clinical strategy had been achieved.

The Board noted the Chief Executive's report.

045/2015 **Board Assurance Framework**

Mrs Wells reported that every area within the Board Assurance Framework (BAF) that had been updated was shown in red, and that the document had been reviewed by the Quality and Standards Committee on 5th May 2015 where a deep dive had been undertaken into paediatrics. Further deep dives were planned for the next Quality and Standards meeting into Health Records, mandatory training and the NHS internet gateway. Mrs Harris reported that the issues around the NHS internet gateway had recently been resolved nationally, and no longer needed to be on the framework.

Prof. Cohen said that some of the items contained in the BAF had dates for completion that had already passed assigned to them, and asked how this situation was managed. Mrs Wells replied that the Trust's Clinical Units were responsible for maintaining any actions that fell within their remit, so if any went over their proposed date for completion then this would be followed up with them by the executive lead. Prof. Cohen said that clarity around the implications for failing was important in order to achieve success, and Mrs Wells said that she would review this process when the BAF was next updated. **LW**

Mr Sunley reported that new storage space for Health Records at the Conquest Hospital had been purchased and would arrive within the next five weeks. He said that staff were working hard to minimise the number of health records being stored incorrectly, and praised the work that they had undertaken to date. Mr Sunley reported that Radio

Frequency Identification of health records would commence on 27th September 2015.

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

QUALITY, SAFETY AND PERFORMANCE

046/2015 **Draft Quality Account**

Mrs Webster explained that the paper submitted to the Board was a summary of the draft Quality Account that had already been reviewed by the Board on 24th March 2015. She said that she had received very positive feedback about the document from both staff and the public , and that the Draft Quality Account had been shared with HoSC, the CCGs and Healthwatch for comment. She reported that the Draft Quality Account had been approved by CME and the Quality and Standards Committee, and was due to go before the Audit Committee on 3rd June 2015. The document would be published on 30 June 2015 and would be formally received by the Trust Board at the Annual General Meeting in September.

The Board formally approved the Draft Quality Account and the proposals set out within it.

047/2015 **Performance Reports**

a) Performance Report – March 2015 (Month 12)

i) Responsiveness

Mr Sunley reported that the key items contained within the responsiveness section of the report for March 2015 were:

- The year-end figure for A&E performance was 93.84% against a target of 95% of patients seen within 4 hours. The Trust continued to experience high demand in April and May 2015, and received a large number of out of hours GP referrals at EDGH. The Trust saw a 9% reduction in ambulances attending A&E at EDGH, despite the number of patient attendances to A&E at EDGH remaining constant, and a 13% increase in ambulances attending A&E at the Conquest.

- The Trust did not meet its targets for Referral To Treatment (RTT) in either admitted or non-admitted patients. It had very successfully reduced the 18 week wait backlog.

- A significant improvement had been made in community therapy services, and a lot of work was being undertaken in order to get

improved nursing data within the community.

- The Trust's non-admitted patient backlog numbers for 2014/15 were 1211, against a target of 900. The figure for 2013/14 was 1800. The backlog numbers for admitted patients were 294 against a target of 200, and 2013/14's figure was 500.

Dr Harrison explained that the reports would be updated for 2015/16 in line with TDA guidance with the inclusion of the Trust's performance set against national trajectories.

Prof. Cohen congratulated the Trust on the huge improvement in community waiting list times that had been made, and noted that it had been a big challenge to undertake this improvement. He explained that he felt that activity data was now good, and it was important to ensure that quality outlooks were also improved. He asked what plans were in place to improve the cancer waiting times.

Mr Sunley replied that issues still existed around two week cancer waits and that GPs would be informing their patients of the importance of attending their hospital appointments. He said that work was also being undertaken with the CCGs in order to try to resolve this problem, and that conversations would take place with other Trusts who were achieving the targets in order to gain greater insight into potential solutions.

Mr Sunley explained that the 62 day cancer target was a particular issues within urology and that work was being undertaken to enable a greater number of biopsies to be performed in order to reduce waiting times. He said that changes had also been made to the procedures around scanning and reporting of MRIs in order to speed up the patient pathway. Mr Sunley explained that if these issues within urology could be resolved then the Trust would be able to meet its targets.

He reported that the endoscopy service was utilised to almost 100% of its capacity, including weekend working. An increasing number of referrals were being received by the service and the Trust was considering different methods to enable it to cope with this increased demand. Mr Sunley said that the Trust was engaging with the CCG in order to try to understand the reasons behind the increase demands on the service.

Mr Grayson said that he had held a conversation with the CCG in connection with patient pathways into the endoscopy service and had suggested that obtaining an external review of the pathways would be useful. He said that the CCG had responded positively to this suggestion.

Mr Nealon said that A&E waiting times were increased by bed-blocking within the Trust and asked what actions were being taken in order to

resolve this issue. Mr Sunley reported that weekly meetings were being held with Social Services in order to maintain a focus on priority patients, and on length of patient stay within rehabilitation facilities. He explained that the provision of continuing care within the community at EDGH was due to be reviewed. Mr Sunley said that a 'Breaking the Cycle' initiative had been undertaken in April 2015 and that a daily manager was now identified to ensure that patients were put into the correct beds within the Trust.

Mr Grayson noted that the Trust's performance in managing the waiting times in community paediatrics had been outstanding, particularly in light of the increased number of referrals that were being received.

ii) Effectiveness

Dr Hughes explained that the Summary Hospital Level Mortality Indicator (SHMI) was now highlighted in red in the report due to a change in its reporting method. Mr Grayson commented that the SHMI was a helpful indicator of progress, but was more useful to Trusts who provided just acute services than it was for Trusts who provide both acute and community services. Dr Harrison explained that even though the SHMI was now red, it still fell within competence limits and was not considered to be problematic.

Mr Welling asked how confident Dr Hughes was that Mortality and Morbidity reviews were now sufficiently high on the agenda of the Clinical Units. Dr Hughes replied that some meetings had been missed in 2013/14 and that all of the Clinical Units had now participated in the Mortality Oversight Committee and been challenged about their performance in this area. He explained that he still felt that there was more work to do, but that the Clinical Units had a full understanding of the requirements and were being supported by his team.

iii) Safer Caring

Mrs Webster reported that there had only been two incidents of MRSA infection within the Trust during 2014/15, which was an improvement on the previous year. She explained that the figures included in the report for patient safety were not finalised, as some reports were still awaited. Mrs Webster said that six mixed sex beaches had occurred in March 2015, all as a result of the high activity levels. Dr Harrison said that the two never events which had been highlighted in the CQC's reports had both been confirmed as not meeting the never event criteria.

iv) Workforce

Ms Green reported that agency usage had been high during March 2015 due to increased activity within the Trust. She explained that recruitment remained a significant issue, although some success had been achieved in recruiting to areas that had previously been

problematic. She reported that overseas recruitment was being planned for nurses and midwives, along with greater support for career development for newly qualified nurses.

Ms Green reported a slight drop in sickness throughout the Trust for March 2015, and that work on improving this even further was ongoing, including the production of a new attendance management policy and increased support for staff at work. She also reported that appraisal rates had increased.

Dr Slater said that staff fully understood the need to employ extra staff, but he had found that they became frustrated when agency staff were employed when bank staff were willing to undertake the same shifts. Ms Green replied that the use of agency staff was always a last resort, and that staff should be offered overtime in the first instance, then bank staff would be used and finally agency staff would be engaged.

Prof Cohen asked how the Trust ensured that the English language skills of agency staff were appropriate, and Ms Green replied that the agencies were responsible for ensuring this standard was maintained. Mr Stevens asked whether the Trust used any agencies that were not approved and Ms Green assured him that the Trust only used agencies from the NHS framework except in emergency circumstances.

Mr Grayson said that he was pleased with the improvement in appraisal and mandatory training rates during March 2015 and that managers and staff should be supported to ensure the improvement continued into 2015/16.

The Board noted the performance report for March 2015.

b) Finance Report – April 2015 (month 1)

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

- The overall RAG rating for the Trust was red due to the Trust's proposed deficit plan. The Trust was within its deficit plan for April.

- The Trust was not quite on target with its Cost Improvement Plan, but the deviation was not a cause for concern.

- Pay costs for April were slightly above those predicted while non-pay costs were slightly below budget. Mrs Harris explained that this would have to be monitored, but that April had been a busy month in terms of staffing and patients.

Mr Nealon congratulated Mrs Harris and her team for meeting the Trust's budget for 2014/15 and successfully delivering the Trust's plans.

Mrs Harris said the entire organisation deserved praise for the successful delivery of the Trust's position..

The Board noted the finance report for April 2015.

048/2015 **Quality Improvement Plan**

Mrs Webster explained that the Quality Improvement Plan (QIP) had been produced in conjunction with the Clinical Units. Fortnightly meetings were being held to review and update the Plan. She said that it was important that any actions that came about as a result of the Plan became embedded into the Trust and were monitored. She advised that the Plan was available on both the Trust's internet and extranet so that staff and members of the public were able to view the Trust's progress in meeting the QIP.
Mr Welling asked whether the budget for the QIP had been finalised and Mrs Harris replied that the final budget was included in the Trust's financial plans for 2015/16. She explained that she attended the fortnightly review meetings in order to monitor any financial plans associated with the QIP. Mrs Webster explained that any financial plans would be subject to TDA and NHS England scrutiny.

Mr Stevens asked if any of the amber rated issues within the QIP would require further capital. Mrs Harris replied that some of the issues within the QIP would be subject to separate business cases, such as those in Theatres and A&E. Any business cases would be brought before the Board for approval as appropriate.

The Board noted the Quality Improvement Plan.

049/2015 **Patient Experience Report Quarter 4**

Mrs Webster reported that the Trust's Net Promoter Score for Quarter 4 was 61.2, an increase from 58 for the previous quarter. She explained that there was a national issue regarding levels of patient completion of Friends and Family Test feedback forms, and that the Trust was exploring alternate ways to encourage patients to do this.

Mrs Webster said that contacts with the Patient Advise and Liaison Service (PALS) had increased by 11% in Quarter 4, and that the biggest issue that patients had contacted PALS about was communication.

Mr Grayson asked that the next Patient Experience Report included trends for communications and complaints. He said that he had noticed an improvement in the depth and quality of responses to complaints that were produced by the Trust, but noted that producing better responses took more time. Mrs Webster said that she hoped that producing more detailed responses to complaints would reduce the number of complaints that would require reopening and therefore reduce the time spent on them in the long term. Mrs Bernhauser reported that she had **AW**

met with the member of staff who had been newly appointed to look at complaints and responses. She said that a new complaints procedure had been produced and considerable progress had been made in improving this process. Mrs Webster explained that learning outcomes and lessons learned from complaints would be audited, and a feedback centre had gone live which was being run in conjunction with Healthwatch.

Mr Welling said that the Parliamentary and Health Service Ombudsmen publish reports about key complaints to the Trust and asked if Mrs Webster was satisfied that any issues raised, and their solutions, became embedded within the Trust. Mrs Webster replied that the newly drafted complaints procedure included this process. Dr Harrison said that she felt that it would be useful to see any recommendations included within the Trust's QIP.

Mr Nealon said that he felt that communication in the clinical setting was generally excellent, but had concerns about the way that discharge information was sent to GPs. Mr Sunley explained that discharge summaries for inpatients were sent to GPs electronically 100% of the time, whereas this was not the case for A&E patients. He advised the Trust had a Clinical Correspondence Group which included GPs, and they are reviewing ways to improve these lines of communication.

Mr Grayson noted that the overall patient experience satisfaction score remained very close to, or at, 90 for the entire year. He praised this good performance, but iterated his desire to see the score increase even further. Mr Grayson said that he was very pleased to see the high scores for patients' satisfaction in the food the Trust provided, and that this emphasised that the investment made in patient catering had been very effective.

The Board noted the Patient Experience Report Quarter 4 report.

050/2015 **Research and Development Annual Report**

Dr Hughes thanked the Research and Development (R&D) team for their hard work over the previous year, especially in light of the team having undergone reorganisation. He explained that the second annual R&D meeting had taken place and that it had been very well supported.

Dr Hughes reported that the R&D team did not achieve their targets for recruiting patients for studies in 2014/15. He said that their recruitment target had been raised by 15% for 2015/16 and that funding had been lowered. He explained that in light of this the R&D team would aim to pursue more commercial studies in order to increase their cash flow.

Dr Hughes explained that the R&D team faced issues with the Trust's IT infrastructure and this impaired their ability to access National Institute for Health research data. He said that work was being undertaken in

order to resolve this problem.

Dr Hughes said that Dr Harry Walmsley was due to retire shortly and thanked him for all his hard work in leading the R&D team. He explained that the role of lead for the R&D team would be amalgamated into the Joint Medical Director – Clinical Governance role.

Dr Hughes noted that he would like to put some information about the Trust's work on research onto the Trust's letterheads and Mr Stevens asked why this had not yet been done. Mr Sunley said that he could see no reason why this could not be done and would look into the matter. **RS**

Prof. Cohen said that he thought the R&D report was excellent, but that he would like to see greater detail about the number of staff involved in the R&D process and what research they had published over the course of the year. He explained that he felt the R&D team should use their annual report in order to further promote their service. Dr Hughes said that he would ensure that the report contained more detail when it next came before the Board. **DH**

The Board noted the Research and Development report, and the appreciation for Dr Walmsley's work in leading the Research and Development team.

STRATEGY

051/2015 **Organisational Development Strategy**

Dr Harrison explained that the Organisational Development Strategy (OD Strategy) set out how the Trust planned to develop over the next five years, and reminded the Board that the strategy had previously been discussed at the Trust Board Seminar on 22nd April 2015.

Mr Nealon asked about how the OD Strategy related to the combined healthcare economy plan and Dr Harrison explained that East Sussex Better Together (ESBT) contained a workstream for provider impact assessment that the OD Strategy would feed into. Mr Grayson said that it remained the Trust's aspiration to have their plans as aligned as possible, and ESBT provided a platform for this to occur.

Mr Stevens asked how the Trust ensured that its published values were becoming embedded within the Trust. Mr Grayson replied that they were a core part of appraisal for staff as well as being included within recruitment and selection processes. Ms Green said that the values also influenced how all of the Trust's staff should behave, from the Trust Board downwards.

The Board approved the Organisational Development Strategy.

052/2015 **Workforce Strategy and Plan 2015**

Ms Green explained that the Workforce Strategy and Plan 2015 was part of the overall OD Strategy. She said that the key components of the strategy were:

- Improving and increasing workforce capacity
- Ensuring we have the right staff with the right skills
- Transforming services
- Ensuring the correct leadership is in place
- Improving workforce engagement

Mr Grayson asked how progress would be measured and reported and Ms Green explained that she was trying to align the Workforce Strategy with the Staff Survey in order to get clear indicators for each area. Mr Welling said that he felt that it was important for staff to be fully involved with the Workforce Strategy and asked to what extent staff realised that there was an engagement plan. Ms Green explained that there was an operational staff development plan which involved staff from all levels of the Trust. She said that a key challenge was ensuring that information was disseminated to all staff effectively and appropriately.

Prof. Cohen said that he felt that the process of staff engagement had begun positively and that staff were involved. Mrs Webster explained the importance of ensuring that staff were aware of any changes being made in response to issues that were raised. She said that it was very important to make sure that successful outcomes were published so that all staff could benefit.

Mrs Bernhauser asked how any ideas that staff may have about improving communication would be heard and considered, and Mrs Webster explained that changes to the theme of Quality Walks should enable this to take place.

Mr Stevens said that he felt that the Workforce Strategy Plan was good, but was concerned about the fact that no cost implications were included within the plan. Ms Green replied that the costs of the Plan were mostly covered within Human Resource's Budget so there was no additional cost implication involved. Individual business cases would be put together if necessary.

The Board approved the Workforce Strategy and Plan 2015.

053/2015 **Sustainable Development Management Plan**

Mr Paice presented the Trust's Sustainable Development Management Plan (SDMP) to the Trust Board. Mr Welling said he felt that the SDMP was clearly an important issue which should be high on the Board's priorities.

Mr Stevens asked whether the costs associated with the SDMP were linked to achievable savings. Mr Paice replied that the capital detailed in the SDMP was to enable the Trust to employ a transport co-ordinator who would be expected to submit a business case around improving travel plans within the Trust. He explained that this would realise savings in travel costs as well as energy savings.

Mr Grayson said that he felt that the template for reporting progress against the SDMP to the Trust Board was good and asked if the plan would also set out targets in the medium term. Mr Paice replied that further engagement would be needed in order to produce more accurate medium term targets, but the intention was for this to happen. Mr Grayson said that the Trust Board would need to formally accept any targets produced in the future.

Dr Slater asked how aspirational the SDMP was and Mr Paice replied that the savings detailed within the SDMP would need capital investment to be realised but were based on the Trust's current position.

Mr Welling thanked Mr Paice for his very clear report.

The Board approved the Sustainable Development Management Plan.

DELIVERY

054/2015 **Annual Business Plan 2015/16 & Financial Business Plan and Annual Budget 2015/16**

Dr Harrison said that the Annual Business Plan 2015/16 included in the papers was the same as the one that had been submitted to the TDA. She explained that it would be translated into a public facing document and a summary document. Mr Grayson explained that the plan was based on TDA guidance, commissioning intentions and clinical strategies and the planning session that had been held with the Trust Board and Clinical Units in March 2015 had also fed into the document.

Mrs Harris presented the Financial Business Plan and Annual Budget 2015/16. Mr Welling said that he felt that the Financial Business Plan underlined the importance of working alongside the ESBT programme.

Mr Grayson said that he felt that the Trust had achieved the correct balance with its plans between saving money and ensuring the safety and quality of the Trust's services were maintained. He explained that the Cost Improvement Plan (CIP) level had been set at a lower level than in previous years in order to maintain this balance. Mr Welling said that the Trust was not prepared to make any cuts that would put safety and quality at risk.

The Board approved the Annual Business Plan 2015/16 & Financial

Business Plan and Annual Budget 2015/16.

GOVERNANCE & ASSURANCE

055/2015 **Board Sub-Committee reports and Trust Board Seminar Notes**

a) Finance and Investment Committee
28th January 2015, 25th February 2015 and 18th March 2015

Mr Nealon presented the minutes from the previous three Finance and Investment Committee meetings, and noted that the business cases for Radiotherapy and Pevensey Ward had been supported.

The Board noted the minutes.

b) Quality and Standards Committee
2nd March 2015 and 5th May 2015

Mrs Webster presented the minutes from the meeting held on 2nd March 2015 and a summary report of the meeting held on 5th May 2015. She explained that a recent focus of the Quality and Standards Committee had been Schwartz Rounds, and that the first of these had been successfully held with over 65 staff attending.

The Board noted the minutes and report.

c) Trust Board Seminar
22nd April 2015

The Board noted the minutes.

056/2015 **Delegation of the approval of the Annual Report and Accounts for 2014/15**

Mr Welling asked the Trust Board to formally delegate authority for Mr Sunley and Mrs Harris to sign off the Trust's Annual Report and Accounts for 2014/15.

The Board gave approval for Mr Sunley to sign off the Trust's Annual Report for 2014/15 and for Mrs Harris to sign off the Trust's Accounts for 2014/15.

057/2015 **Themes for Quality Walks**

The Themes for Quality Walks were discussed, and approved, by the Trust Board under item 040/2015 c) of this meeting.

058/2015 **Chairman's Briefing**

Mr Welling presented the briefing which was self-explanatory.

059/2015 **Questions from Members of the Public**

Outsourcing Services

Mr Hardwick asked whether the Trust had any further plans to outsource their services in the future and Mr Grayson replied that the Trust had been looking closely at the potential for outsourcing services during the last 18-24 months. He explained that a discussion was due to take place in the Private Trust Board meeting which followed the public meeting, and that he hoped to make a public statement on the matter in due course.

Workforce Strategy

Mr Hardwick queried why the Workforce Strategy mentioned the viability of maintaining two large acute sites into the future and asked for a more detailed explanation. Mr Welling replied that single siting was mentioned within the Workforce Strategy as the Trust had to be aware of any potential issues around developing services. He said that it should not be taken as an indication that one of the sites would close.

Workforce Figures

Mr Campbell asked whether it would be possible to include the Trust's budget figure for their workforce within reports so that this was clearer. Mr Grayson said that the spend on workforce was already indicated on page 16 of the workforce report, and Mr Campbell explained that this did not give a precise budget figure and so was unsure whether the Trust was over or under their budget. Mr Grayson said that he would review whether this was possible. **DG**

Kingsgate

Mr Campbell said that the Trust had published Shaping Our Future, Cash Release Efficiency Schemes and Cost Improvement Plans over the last five years all centred around saving money. He asked if it was possible for the Trust to continue to realise savings. Mr Welling replied that the Trust had achieved in delivering significant savings whilst also improving services in 2014/15. He explained that the expected CIP savings for 2015/16 were set at a lower rate than in previous years which was reflected throughout the health economy. He said that bed capacity was now at a safe minimum, and the organisation needed a period of stability after undergoing a large amount of reconfiguration in recent years.

Mr Grayson explained that it was not possible for the Trust to continue to deliver savings at the level it had achieved in previous years, despite there being a requirement for the entire NHS to deliver savings. He said

that work now needed to be done on an NHS-wide basis to achieve further savings through system wide strategic changes.

Non-Executive Confidence

Mrs Walke expressed surprise that the contents of the CQC's reports on the Trust had not been discussed in more detail and asked whether the Non-Executive Directors retained their confidence in the Chairman and Chief Executive of the Trust. Mr Welling replied that he had made a statement, supported by the entire Trust Board, at the start of the meeting. He explained that a series of actions would be taken within the Trust in conjunction with the TDA, but that he would not go around the table in order to ask the Non-Executive Directors their opinions.

Births at the Crowborough Birthing Unit

Mr Ash asked about the time frame for the figure of 600 births at the Midwife Led Crowborough Birthing Unit. Mr Grayson replied that the births dated from May 2013, when the unit opened, to March 2015.

Organisational Development

Mr Campbell asked whether there was any viability in having a five year Organisational Development plan for the Trust or whether putting it together was a waste of money. Mr Grayson explained that the Trust Board needed to look at the future and that even if the form of the Trust should change in the future, the staff, patients and services would still remain and the OD strategy was an essential part of the Trust's plans.

Clinical Care Pathway

Mr Campbell asked whether, when reviewing the Clinical Care Pathway, the Trust's strategic plans were considered. Dr Harrison replied that elements of the services had been redesigned in order to improve safety and productivity, and Dr Slater confirmed that the Trust had anticipated seven day working in the NHS and that they had made a lot of progress towards achieving this aim.

060/2015 **Date of Next Meeting**

Wednesday 5th August 2015, at 10.00 am in the Ashdown Room, Uckfield Civic Centre

061/2015 **Closed Session Resolution**

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

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 02.06.15 Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
045/2015 a) i) Board Assurance Framework	Review of processes around missing deadlines set in BAF	Company Secretary	05.08.15	Company Secretary to provide update to Public Trust Board
049/2015 Patient Experience Report Quarter 4	Inclusion of trends for communications & complaints within report	Director of Nursing	05.08.15	Director of Nursing to include trends in report to Public Trust Board
050/2015 Research & Development Annual Report	Possibility of including information about research on Trust's letterheads	Chief Operating Officer	30.09.15	Chief Operating Officer to provide update to Public Trust Board
050/2015 Research & Development Annual Report	Greater detail about number of staff involved in research and publication of research to be included in report	Medical Director (Clinical Governance)	02.12.15	Medical Director (Clinical Governance) to greater detail in report to Public Trust Board

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	5
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 and reflects the revisions to risk descriptions made at the Board Seminar. The BAF clearly demonstrates whether the risk remains unchanged, has increased or decreased since the last iteration. There are clear actions against identified gaps in control and assurance and these are individually RAG rated.

There are two areas rated red 1.1.3 page 1 relating to health records and 1.3.1 on page 5 mandatory training and appraisals.

The gap in control 3.5.2 “Inability to use web based applications as the N3 Internet Gateway is running at capacity between 11:00 and 15:00 daily” has been removed as this has been resolved nationally.

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 6 July 2015 Audit Committee 3 August 2015

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

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

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

Board Assurance Framework - June 2015

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	C	There is a gap in control due to the number of policies that require review and updating.	Policy schedule produced and circulated. Process in place for reviewing and updating policies to achieve compliance. Apr-15 Number of out of date policies reduced, circa 26% trajectory set to achieve compliance. Jun-15 Focused work CU's being undertaken	end Aug 15	◄►	DN/COO	CME
1.1.2	A	CQC report issued for September 2014 inspection identifies a number of improvements that are required across the Organisation.	Project Group in place, action plan developed and delivery of actions being monitored. Monthly report to CME on progress. Monitored through Q&S. Inspection report for Mar-15 visit awaited.	end Sep 15	◄►	DN	Q&S 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.	Implementation of business case commencing to include storage and tracking of health records. Continued issues with record availability being monitored and actions developed. SOPs and necessary training being developed and delivered with use of external resources. Staff sessions taking place to manage staff concerns	end Sep-15	◄►	COO	Q&S CME

Board Assurance Framework - June 2015

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

Board Assurance Framework - June 2015

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.1	C	Gap in control in delivery of cancer metrics and ability to respond to demand and patient choice.	New monitoring tool developed by information department available to operations team. Trajectories for delivery identified and part of Trust Board performance report. IST review in July to supplement work with KSS Cancer network on pathway management.	end Jul-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. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA to support expansion; outcome awaited, planning permission being sought in advance.	end Jun-15	◄►	COO	CME
1.2.3	C	Effective controls are required to ensure achievement of referral to treatment timescales for incomplete pathways.	Performance against agreed trajectories monitored by Trust Board. Pressures on gastroenterology and orthopaedics, private sector and increased medical staffing required in these two areas.	end Jun-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. Cleaning controls in place and hand hygiene audited. Feb-15 Pevensey Ward separation of Day Unit from inpatients as interim measure until purpose built unit in place. Jun-15 Audit cleaning team has been strengthened. The infection control team is being restructured, to include increased management of the audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. Further assurance requested by the Quality and standards committee in July.	end Mar-16	◄►	DN	Q&S

Board Assurance Framework - June 2015

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

Board Assurance Framework - June 2015

Risk 1.3	**There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.**
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of CME involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.3.1	A	Assurance is required that the controls in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Mandatory training passport and developing e-assessments rolled out to support competency based local training. Additional mandatory sessions, temporary resource to help develop competency assessments. Apr 15 – Compliance figures continue to improve. CEO/HRD discussions with lowest compliance CUs. Competencies by role being developed to give clarity on mandatory requirements. June 15 – Appraisals: Focus on Clinical Admin staff where compliance levels are low. Additional training and support for line managers provided. Mandatory Training – Continuing to send out matrix about compliance levels in each area to advise Clinical Units who is out of date. Mandatory sessions for 15/16 have been planned	end Sep-15	◀▶	HRD	Q&S CME

Board Assurance Framework - June 2015

Strategic Objective 2:	**Play a leading role in local partnerships to meet the needs of our local population and improve and enhance patients' experiences**
Risk 2.1	**We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.**
Key controls	Develop effective relationships with CCGs and the TDA Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Participant in clinical senates

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls and engagement are required to ensure the Trust can model and respond to the potential loss of any services and reconfiguration following tender exercises.	Process in place for operational and financial management of transition to new community provider in HWLH CCG area	end Oct 15	◄►	COO/DF	F&I CME
			Working with prime provider to facilitate implementation of MSK model of care. Impact on current service configuration being determined. June 15 - Contract with MSK signed, long stop items to be agreed by end Sep 15.	end Sep 15	◄►	COO	CME

Board Assurance Framework - June 2015

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

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

Board Assurance Framework - June 2015

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB and CCG. Service spec being reviewed by commissioners; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. CCG reviewing. Jun-15 Service currently being tendered.	end Aug 15	◄►	COO	CME
2.3.3	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard.	end Jul-15	◄►	COO	CME Q&S

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

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

Strategic Objective 3:	**Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.**
Risk 3.2	**In running a significant deficit budget we are unable to invest in delivering and improving quality of care and patient outcomes. This could compromise our ability to invest in our ability to make investment in infrastructure and service improvement.**
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Monitoring by F&I Committee
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly.

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

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

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	Nursing establishment and skill mix review being undertaken again in Dec-14. To be signed off at Board in Jan-15 Apr 15 – Skill mix review now being widened to include original out of scope areas, to be completed by end June 2015.	end Jun 15	◄►	HRD	CME
			International Recruitment Programme for nurses to start in Jan-15 Feb 15 - European recruitment campaign started 4 new recruits to start. Apr 15 – Recruitment agencies appointed to supply 80 Phillipino nurses however recruitment cannot commence until Aug-15. Two cohorts expected to commence Dec-15 and Mar-16. International recruitment also initiated for middle grade A&E Doctors from India.	Mar-16	◄►	HRD	CME
			HCA local recruitment initiative commenced Jan with aim to achieve full establishment by June-15. Feb 15 - 23 new staff recruited. Apr-15 – Undertaken 3 generic recruitment events, planning HCA recruitment open day in May, objective to appoint 50 new starters. Jun 15 - 11 x bank HCAs recruited, 17 x substantive HCAs recruited and started, and 53 x substantive HCAs - recruitment process in progress. Further open days planned.	end Jun-15	▲	HRD	CME

3.3.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	TRAC recruitment tool implemented in March 2015. Will be rolled out to recruitment managers as required. Positive feedback received to date. Jun 15 – Management reporting tool now being developed to provide information on recruitment metrics.	end Sept-15	◄►	HRD	CME
			Value based recruitment to be incorporated into the recruitment process for all posts. Feb 15 - Implemented for newly qualified nurses. Apr 15 – Implemented for HCA's and plan being developed to extend to all staff groups as part of the R&R Strategy.	end Sept-15	◄►	HRD	CME

Board Assurance Framework - June 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	**If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.**
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and agreed by Board.
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.4.1	A	The CQC staff survey 2013 provided insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Listening into Action programme mainstreamed into wider engagement work. Values launched and being embedded. Staff Engagement Ops and Exec Groups established. Involved in national OD work on culture change - linked with Portsmouth for learning. Health & Wellbeing initiatives being developed. Leadership conversations programme. June 15 – Continuing to embed values and behaviours. Staff Engagement Plan developed based on Staff Survey, Staff FFT and CQC feedback. Meetings with CU management teams to discuss staff survey results and agree actions. OD Strategy and workstreams approved, workstreams led by Exec and NED, staff invited to participate. Leadership conversations in May focused on improving staff engagement.	end Dec 15	◄►	HRD	Q&S CME

Board Assurance Framework - June 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 3.5		**We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.**					
Key controls		Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee					
Positive assurances		Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee					
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.5.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post	end Jul-15	◄►	COO	F&I CME
	A	Also refer to 3.2.1					

Board Assurance Framework - June 2015

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

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

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	6a
Subject:	Integrated Performance Report – May 2015
Reporting Officers:	Director of Strategic Development & Assurance

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

Purpose:

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

Introduction:

The purpose of this paper is to inform the Trust Board of organisational compliance against national and local key performance metrics.

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

Overall Performance Score: 4 (from a possible 5)

Responsiveness Domain: 3

10 out of the 17 indicators for this domain were achieved this month. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were:

- RTT Non Admitted
- Diagnostic waiting times
- A&E performance
- Cancer 62 Day Standard
- Cancer 62 Day Standard for Screening
- Delayed Transfers of Care

Effectiveness Domain: 5

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

Safe Domain: 4

Due to there being one case of MRSA (high weighting within the domain) the Safe domain has remained at a score of 4.

Caring Domain: 4

The Caring domain achieved a score of 4 due to A&E Friends and Family scores remaining below the required standard.

Well Led Domain: 3

The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E response rates, turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3.

Finance Report:
The Trust performance in month 3 was a run rate deficit of £4.2m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stands at £10.2m which is £0.7m above plan.

Benefits:

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

The Board is aware of the Month 3 financial position.

Risks and Implications

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

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

Assurance Provided:

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

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

The forecast outturn is projected to be as per plan £37m deficit.

Proposals and/or Recommendations

To review the report in full and note Trust Performance against each domain.

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

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

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

Name:	**Contact details:**
Sarah Goldsack - Associate Director of Knowledge Management	sarah.goldsack@nhs.net
Garry East - Assistant Director of Delivery & Performance	garryeast@nhs.net

East Sussex Healthcare Trust
Integrated Performance Report

Month 2
May 2015

EAST SUSSEX HEALTHCARE NHS TRUST KNOWLEDGE MANAGEMENT

1.0 Executive Summary

Introduction:

The TDA have released a draft scorecard for Trust's based upon the 2015/16 Oversight and Escalation Framework. As acknowledged by the TDA's Business Intelligence team, the scorecard remains in development and requires a glossary section to clarify a number of items where the terminology isn't clear.

As such, this report will continue to be driven by the 2014/15 format until the TDA have completed work on the new document.

The layout of this report along with the information that is presented is currently being reviewed by both the Information and Performance teams. As part these changes the report will now show a rolling 12 month period throughout and there will be further improvements implemented over the coming months.

Performance Exceptions:

Referral to Treatment (RTT/18 Weeks) - the Trusts Admitted position for May was 83.93% against a recovery trajectory of 82.36% (National standard = 90%) and the Non-Admitted position was 93.27% against a recovery trajectory of 93.45% (National standard = 95%). Overall recovery plans require the Trust to achieve the Non-Admitted standard in September and Admitted in August. The Admitted plan is particularly challenging and is being monitored via the Trusts PTL meetings.
The Trust continues to achieve the 'Incomplete' standard of 92% with a May position of 94.79%.

Diagnostic Waiting Times - The Trust did not achieve the 6 week diagnostic waiting time standard for the month of May. The total number of breaches was 105 which resulted in an overall percentage of 2.44%.
As predicted in last month's report, Endoscopy continues to be a challenge with a high number of breaches that contributed to best part of the 2.44%.

- Significant increase in referrals due to "Be Clear on Cancer Campaign" and General Surgery waiting list initiative clinics
- Specifically 100% increase in upper GI referrals over the early months of the year.
- High volume of surveillance patients is also compromising our ability to meet DM01

Endoscopy will not meet the standard until August 2015 which is in line with the Trusts recovery plan. Part of this plan includes the usage of Medinet to provide short term capacity and activity for Endoscopy (July 15). The Trust has also invited the IMAS Intensive Support team to visit and carry out a review of its diagnostic activity processes in regards to Capacity and Demand and Administration (July & August 15).

A&E compliance – The Trust has shown considerable improvement in May with 92.41% of patients waiting less than 4 hours from arrival at A&E to admissions, transfer, or discharge, against a national standard of 95%.An action plan which supports the Trusts recovery and on-going achievement of the A&E 4 hour performance standard has been shared with the CCGs and the Trust expects to show further improvement in the June report.

Cancer - The preview Cancer report for May indicates that the trust will meet the Two Week Wait (urgent and breast symptoms) and 31 Day Surgery and Drug Standards. Early indications are that the trust did not see or treat the required number of patients against the 62 Day standard or screening targets.

2.0 Responsiveness Domain

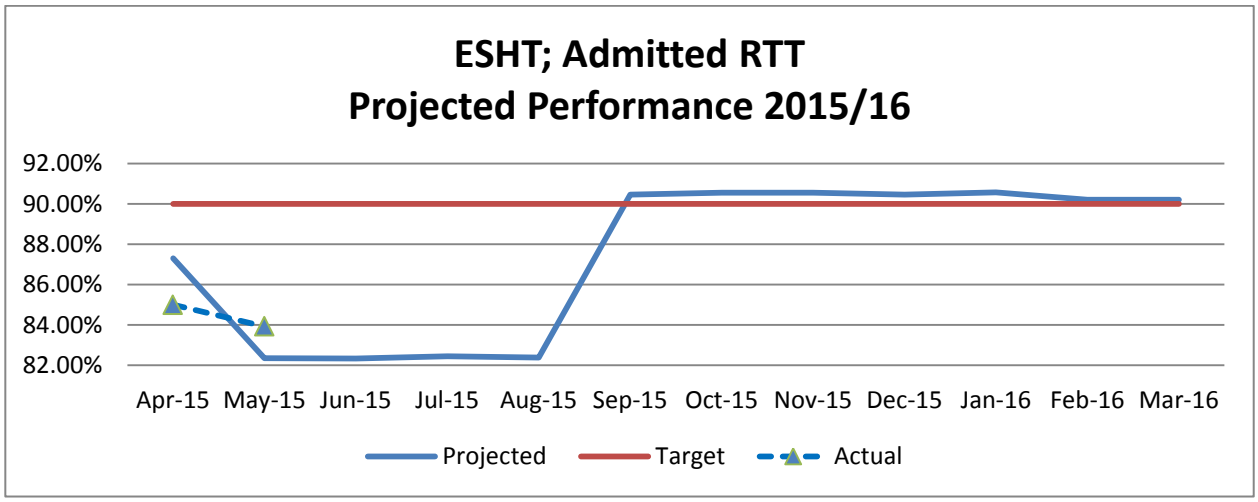
Responsiveness Domain		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
		DOMAIN SCORE											
Indicator	**Standard**	3	3	2	3	2	3	3	2	3	2	2	3
Referral to Treatment Admitted	90.00%	85.84%	80.88%	75.60%	82.74%	85.67%	78.26%	91.18%	74.76%	81.00%	84.75%	85.00%	83.93%
Referral to TreatmentNon Admitted	95.00%	91.81%	92.66%	91.16%	89.56%	91.42%	91.49%	90.55%	87.64%	89.74%	92.69%	93.65%	93.27%
Referral to Treatment Incomplete	92.00%	92.80%	92.35%	92.22%	93.39%	92.97%	92.04%	90.20%	92.35%	93.64%	94.24%	94.31%	94.79%
Referral to Treatment Incomplete 52+ Week Waiters	0	4	3	1	3	2	4	2	0	0	0	0	0
Diagnostic waiting times	1.00%	0.45%	0.70%	0.97%	0.18%	0.28%	1.29%	1.29%	1.79%	0.66%	1.13%	1.90%	2.44%
A&E All Types Monthly Performance	95.00%	95.08%	97.27%	94.07%	95.00%	93.44%	95.63%	89.00%	91.82%	92.86%	91.48%	88.88%	92.41%
12 hour Trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0
Two Week Wait Standard	93.00%	91.78%	89.69%	90.16%	93.41%	92.80%	92.22%	91.98%	90.20%	93.94%	92.47%	90.60%	93.63%
Breast Symptom Two Week Wait Standard	93.00%	85.00%	88.89%	93.58%	80.65%	95.89%	93.75%	92.73%	93.48%	91.15%	91.03%	94.85%	96.08%
31 Day Standard	96.00%	98.35%	99.34%	95.57%	94.87%	86.14%	90.74%	96.43%	90.20%	94.81%	96.20%	97.77%	98.10%
31 Day Subsequent Surgery Standard	94.00%	94.74%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Subsequent Drug Standard	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day Standard	85.00%	77.01%	75.11%	80.00%	79.15%	76.87%	75.00%	83.11%	83.68%	78.06%	74.60%	82.03%	72.22%
62 Day Screening Standard	90.00%	100.00%	83.33%	83.33%	68.75%	83.33%	83.33%	100.00%	76.47%	88.89%	75.00%	86.67%	87.50%
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	0	0	0	0	0	0	0	0	0
Proportion of patients not treated within 28 days of last minute cancellation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.00%	0.00%	0.00%	0.00%	0.00%
Delayed Transfers of Care	3.50%	4.23%	5.01%	3.95%	5.43%	4.63%	7.81%	12.15%	11.84%	11.25%	6.57%	5.50%	7.60%

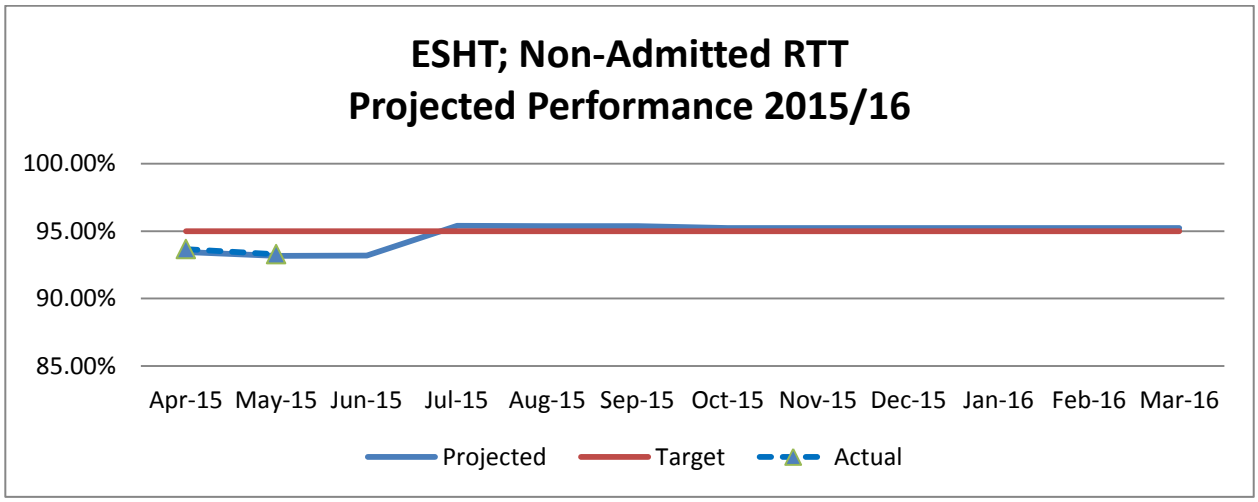
Performance in this domain has improved to a score of 3.

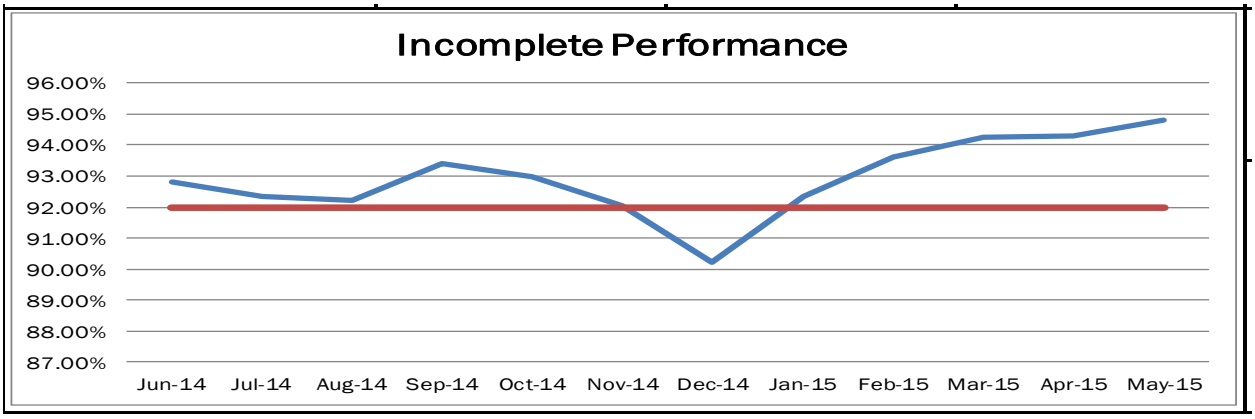
2.1 RTT Performance

The majority of RTT indicators are meeting agreed trajectories.

As detailed in recent communications, Admitted and Non-Admitted targets will be abolished from 24th June. From then on, Trusts will be held accountable to meeting the 92% incomplete target. ESHT has failed to meet this target only once in the previous 12 months.

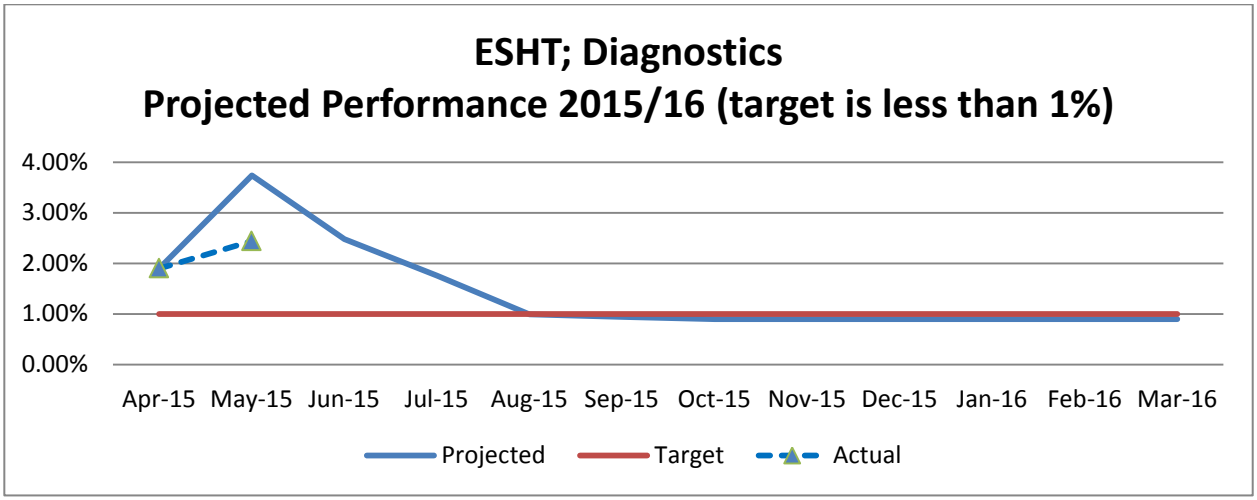






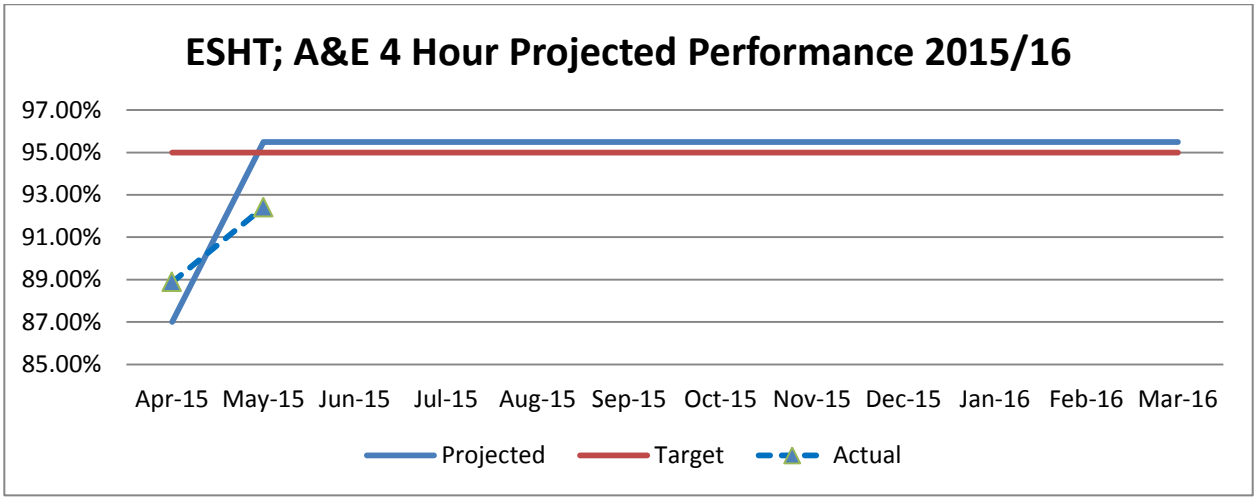
2.2 Diagnostics

Due to implementation of recent action plans, both Cardiology and Radiology positions improved during May and will continue to be monitored at weekly PTL meetings



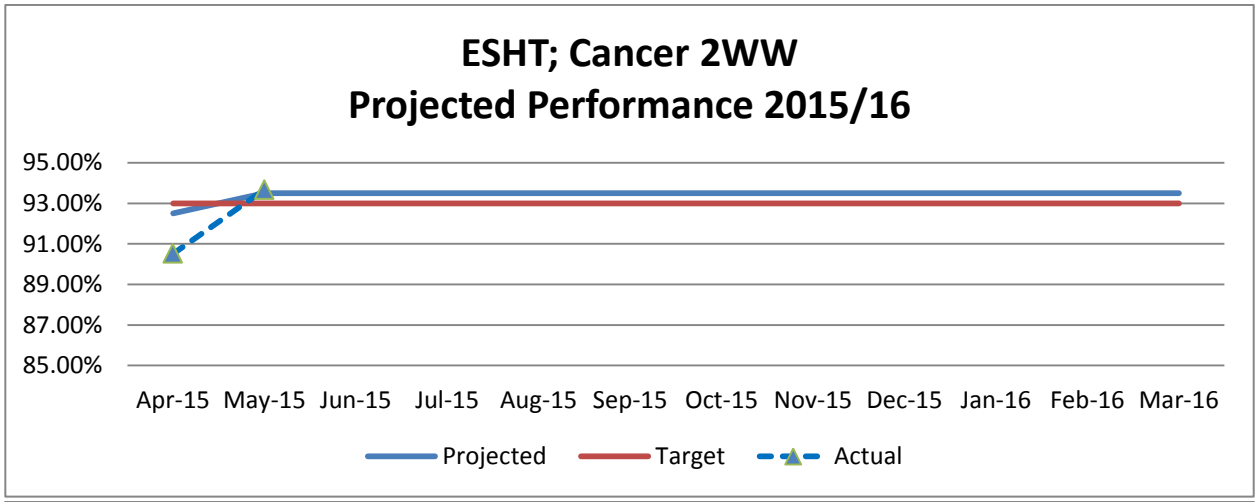
2.3 A&E Performance

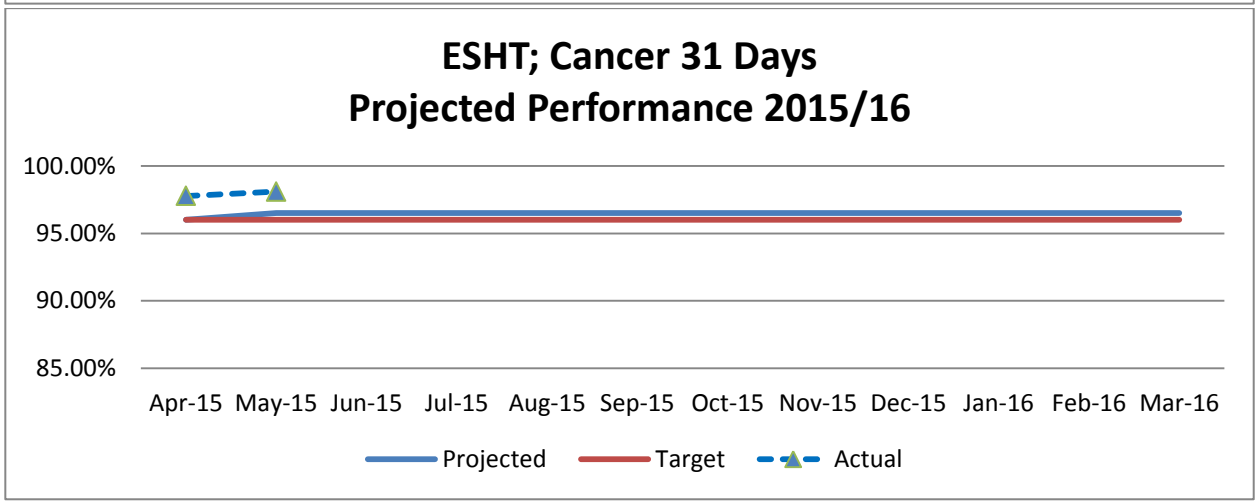
Performance against the 4 hour A&E waiting time standard in May was 92.41%.

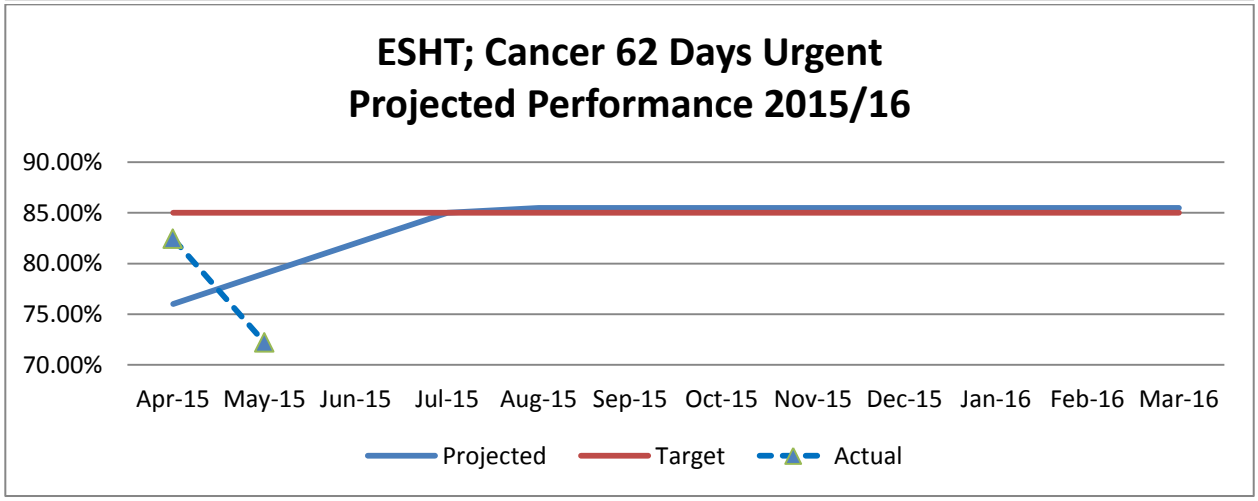


2.4 Cancer Performance

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







2.5 Cancellations

During May there were 11 cancellations of elective surgery for non-clinical reasons. At the time of writing this report, 10 have reached the 28 day threshold for re-booking. The status of the remaining 1 will be reported once the 28 day threshold has been reached.

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.

A breakdown is shown below.

Delayed Transfer of Care Breakdown	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Delayed Transfers of Care (Combined)	4.23%	5.01%	4.34%	6.67%	4.92%	7.81%	12.15%	11.84%	11.25%	6.51%	5.48%	7.60%
Delayed Transfers of Care (Acute Only)	3.28%	3.96%	3.27%	5.11%	3.96%	5.61%	10.73%	11.27%	11.39%	4.80%	4.67%	6.14%
Delayed Transfers of Care (Non-Acute Only)	9.82%	10.11%	9.12%	13.56%	8.98%	18.91%	18.28%	12.99%	8.77%	13.79%	9.50%	16.17%

The whole systems work with Adult Social Care and the CCGs is on-going and being reported into the System Resilience Group for East Sussex. A concentrated piece of work is starting in the community sites to ensure the DTC data is being recorded accurately in accordance with the guidance. This possible over reporting is thought to be contributing to the sharp rise in May from 9.5% to 16.17%. The shortage of nursing home and residential placements continues to delay discharges from both acute and community sites.

3.0 Effectiveness Domain

Effectiveness Domain		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
		DOMAIN SCORE											
Indicator	Standard	5	5	5	5	5	5	5	5	5	5	5	5
Hospital Standardised Mortality Ratio (DFI)	103.32	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08	103.08
Deaths in Low Risk Conditions	1.06	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
Hospital Standardised Mortality Ratio - Weekday	110.03	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49	104.49
Hospital Standardised Mortality Ratio - Weekend	117.35	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6	101.6
Summary Hospital Mortality Indicator (HSCIC)	1.066	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077	1.077
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	10%	6.38%	8.49%	7.64%	7.79%	7.94%	7.81%	7.81%	7.89%	7.14%	5.98%	6.15%	4.42%

3.1 Mortality

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

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

3.2 Emergency Re-Admissions

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

4.0 Safe Domain

Safe Domain		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
		DOMAIN SCORE											
Indicator	Standard	5	5	3	5	4	3	4	5	5	5	4	5
Clostridium Difficile - Variance from plan	4	4	2	6	2	7	6	6	3	2	3	1	3
MRSA bactaraemias	0	0	0	1	0	0	1	0	0	0	0	1	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient safety incidents that are harmful	0	3	1	1	0	1	3	0	1	5	4	7	3
Medication errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Overdue CAS alerts	0	0	9	0	0	12	6	17	7	0	10	6	4
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95.00%	98.29%	98.15%	98.10%	97.98%	98.67%	98.21%	96.04%	96.51%	97.03%	96.39%	95.33%	95.73%
Percentage of Harm Free Care	92.00%	94.29%	93.90%	97.53%	94.60%	94.97%	97.67%	97.83%	93.66%	93.45%	94.68%	93.67%	94.64%

4.1 Healthcare Acquired Infections

There were 3 reported cases of C-Difficile in May, which is below the trust trajectory for month 2.

Investigation is underway to determine if there were lapses in care

4.2 Patient Safety

Following the reporting for May, 3 harmful incidents were reported. Incidents recorded onto the system with a severity level of 4 or above, are included within this indicator but will be routinely reviewed to ensure that the severity has been appropriately assigned. In some cases this may reduce the severity of the incident and thus remove it from this line. As such, subsequent reports may show a different number.

5.0 Caring Domain

Caring Domain		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
		DOMAIN SCORE											
Indicator	Standard	4	4	5	5	4	4	4	4	4	4	4	4
Inpatient Scores from Friends and Family Test	60	68	68	65	70	64	68	68	64	70	71	71	77
A&E Scores from Friends and Family Test	46	37	45	54	48	45	38	38	42	45	39	38	40
Mixed Sex Accommodation Breaches	0	0	0	0	20	0	31	26	15	1	6	0	0
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9	7.9

5.1 Friends and Family Test (Patient Experience)

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

5.2 Mixed Sex Accommodation

There were no reported mixed sex accommodation breaches in May.

6.0 Well Led Domain

Well Led Domain		Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
		DOMAIN SCORE											
Indicator	Standard	4	4	4	4	4	4	3	3	3	3	3	3
Inpatients response rate from Friends and Family Test	30.00%	44.01%	46.84%	39.40%	46.21%	47.94%	48.62%	46.48%	38.55%	42.18%	41.52%	52.17%	47.22%
A&E response rate from Friends and Family Test	20.00%	35.03%	24.41%	28.75%	30.40%	25.10%	20.87%	16.66%	17.55%	21.99%	19.38%	14.99%	15.04%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40.70%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%	41.00%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	42.30%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%
Trust turnover rate	10.00%	12.72%	12.81%	13.19%	13.41%	13.32%	13.60%	14.09%	14.03%	13.95%	12.64%	13.03%	12.91%
Trust level total sickness rate	3.30%	4.26%	4.44%	4.59%	4.76%	5.50%	5.46%	5.74%	5.33%	5.02%	4.81%	4.67%	4.27%
Total Trust vacancy rate	10.00%	5.21%	5.61%	4.72%	5.47%	5.74%	7.60%	5.58%	6.66%	6.19%	6.24%	8.75%	8.85%
Temporary costs and overtime as % of total paybill	10.00%	8.72%	9.48%	9.58%	9.48%	9.73%	9.97%	10.16%	11.14%	12.41%	12.56%	13.44%	25.54%
Percentage of staff with annual appraisal	85.00%	63.74%	62.34%	67.02%	67.54%	68.34%	70.01%	68.28%	70.64%	71.71%	74.60%	75.17%	74.88%

6.1 Friends and Family Test (Response Rate)

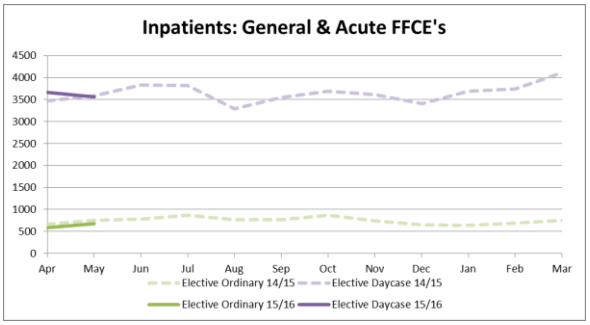
A&E response rates have fallen below the required standard for May.

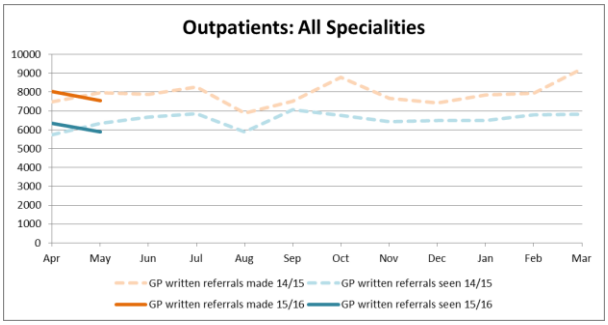
6.2 Workforce

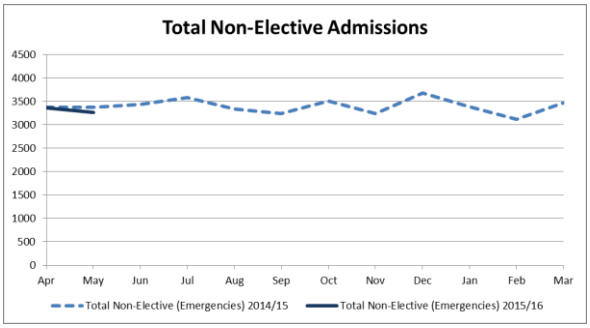
Sickness rates reduced for the fourth consecutive month. Temporary costs and overtime have further increased. Appraisal rates remain below the target figure of 85%. Further detail is given in section 8.

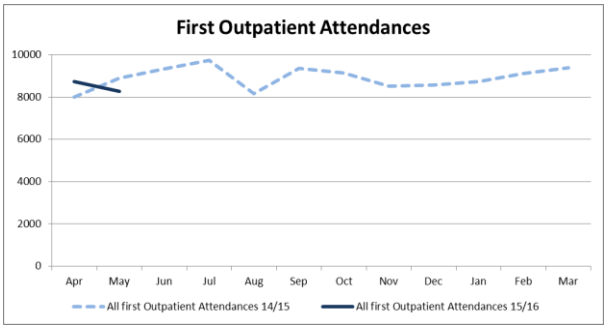
7.0 Activity

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









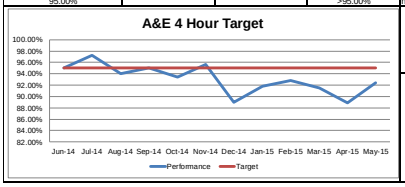
At month 2, elective activity within General and Acute specialties was in line with 2014/15.

Non-Elective activity is slightly lower than 2014/15, primarily due to reductions in NEL spells within the Surgical clinical unit on the EDGH site.

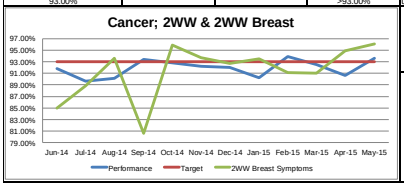
First outpatient attendances are lower than 2014/15 primarily due to reductions within Medical specialties.

Performance Profiles

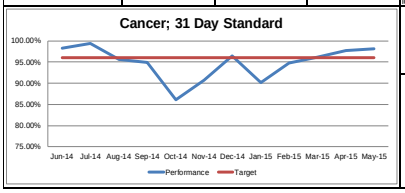
A&E 4-hour waiting time target				Description/Comments/Actions
Target	Month	YTD	Projected	To admit, transfer or discharge patients within 4 hours of arrival at A&E departments
95.00%			>95.00%	



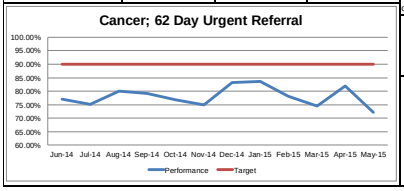
Cancer 2WW and 2WW Breast Symptoms				Description/Comments/Actions
Target	Month	YTD	Projected	To see patients within 2 weeks following an urgent GP referral for suspected cancer
93.00%			>93.00%	



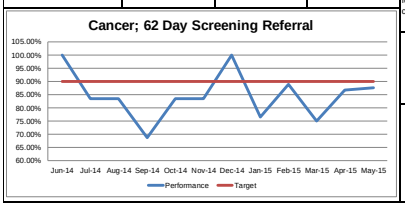
Cancer 31 Day				Description/Comments/Actions
Target	Month	YTD	Projected	A decision to treat is made within 31 days following urgent referral for suspected cancer



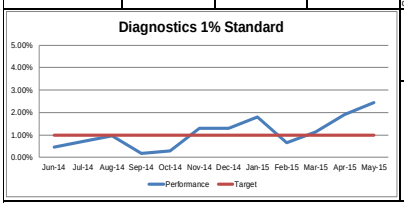
Cancer 62 Day Urgent				Description/Comments/Actions
Target	Month	YTD	Projected	To commence treatement within 62 days following and urgent referral for suspected cancer



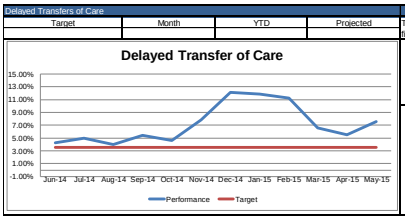
Cancer 62 Day Screening				Description/Comments/Actions
Target	Month	YTD	Projected	To commence treatement within 62 days following and urgent referral for suspected cancer



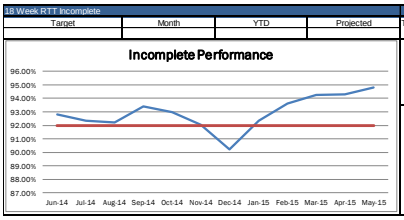
Diagnostic waiting times				Description/Comments/Actions
Target	Month	YTD	Projected	To undertake diagnostic testing within 6 weeks of referral



Delayed Transfers of Care				Description/Comments/Actions
Target	Month	YTD	Projected	To discharge or transfer patients when medically fit for dischrge



18 Week RTT Incomplete				Description/Comments/Actions
Target	Month	YTD	Projected	To treat patients within 18 weeks of referral



8.0 Community Services

8.1 Intermediate Care Beds

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

Occupancy Level	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	TBC	97.44%	91.53%	90.86%	99.26%	96.24%	99.58%	96.53%	96.99%	96.57%	91.76%	87.41%	96.95%
Irvine Unit	TBC	97.44%	91.53%	90.86%	99.26%	96.24%	99.58%	96.53%	96.99%	96.57%	83.06%	91.03%	82.20%
Crowborough Hospital	85.00%	91.90%	90.09%	87.79%	88.33%	92.63%	94.67%	94.80%	95.34%	96.43%	93.87%	89.33%	93.87%
Firwood House	TBC	91.11%	77.27%	77.27%	87.14%	87.71%	85.87%	88.94%	86.79%	71.09%	88.06%	74.83%	95.16%
Meadow Lodge	85.00%	79.23%	88.59%	92.93%	89.23%	85.36%	89.62%	89.33%	92.31%	93.41%	87.67%	84.64%	85.86%
Uckfield Hospital	85.00%	93.10%	90.78%	94.01%	86.90%	93.55%	87.86%	90.09%	95.39%	90.31%	84.79%	84.29%	94.70%
Rye Memorial Care Centre	TBC	80.24%	93.55%	90.55%	70.71%	93.78%	86.90%	81.11%	89.63%	84.18%	73.98%	84.67%	80.43%
Total Occupancy (excl BISU)	**TBC**	**89.82%**	**87.47%**	**85.40%**	**83.28%**	**89.71%**	**91.69%**	**91.99%**	**93.85%**	**90.46%**	**86.49%**	**85.26%**	**88.14%**

Total in Month Length of Stay (Days)	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	TBC	27.56	25.53	20.50	26.67	32.60	52.33	28.14	42.00	35.14	39.67	24.55	25.33
Irvine Unit	TBC	24.50	23.29	23.93	20.69	24.17	30.63	24.93	27.50	24.33	25.42	22.58	27.45
Crowborough Hospital	25.00	16.33	25.00	17.36	21.20	21.57	30.06	16.83	23.11	15.14	23.80	23.09	23.69
Firwood House	TBC	26.25	26.87	28.76	23.91	27.46	28.75	23.00	21.58	30.95	21.95	24.62	22.63
Meadow Lodge	25.00	29.66	39.19	30.00	25.20	27.67	23.84	30.60	28.38	27.76	30.64	16.93	16.44
Uckfield Hospital	25.00	23.41	25.32	13.33	29.00	23.27	22.33	19.44	25.18	16.09	11.65	19.38	21.00
Rye Memorial Care Centre	TBC	25.59	24.06	15.57	27.53	24.67	24.91	27.10	24.41	16.47	23.76	19.11	20.32
Total YTD ALOS (excl BISU)	**TBC**	**25.33**	**27.38**	**21.66**	**24.24**	**25.97**	**29.30**	**24.29**	**27.01**	**23.33**	**23.79**	**21.44**	**21.96**

Admissions	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	N/A	18	15	18	12	20	12	14	18	14	10	20	9
Irvine Unit	N/A	28	34	28	36	41	24	28	32	27	24	40	23
Crowborough Hospital	N/A	18	17	14	20	21	17	23	28	22	26	23	15
Firwood House	N/A	24	15	25	23	24	20	21	25	15	20	21	24
Meadow Lodge	N/A	35	26	15	20	30	25	30	21	25	26	29	28
Uckfield Hospital	N/A	17	19	24	18	11	18	25	11	22	28	21	12
Rye Memorial Care Centre	N/A	16	16	14	19	18	11	21	17	16	17	18	19
Total Admissions (excl BISU)	**N/A**	**138**	**127**	**120**	**136**	**145**	**115**	**148**	**134**	**127**	**141**	**152**	**121**

Step Up Admissions	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	N/A	0	0	0	0	1	0	0	0	0	1	0	0
Irvine Unit	N/A	0	2	0	0	1	1	0	1	1	0	0	2
Crowborough Hospital	N/A	9	5	7	10	5	11	4	11	13	5	8	6
Firwood House	N/A	0	1	3	2	3	1	0	2	0	1	0	2
Meadow Lodge	N/A	9	5	1	7	4	1	2	4	6	2	4	5
Uckfield Hospital	N/A	14	12	19	11	7	12	12	7	19	16	12	6
Rye Memorial Care Centre	N/A	3	5	3	2	6	2	3	5	3	6	1	2
Total Step Up Admissions (excl BISU)	**N/A**	**35**	**30**	**33**	**32**	**27**	**28**	**21**	**30**	**42**	**31**	**25**	**23**

Step Down Admissions	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	N/A	18	15	18	12	19	12	14	18	14	9	20	9
Irvine Unit	N/A	28	32	28	36	40	23	28	31	26	24	40	21
Crowborough Hospital	N/A	9	12	7	10	16	6	19	17	9	21	15	9
Firwood House	N/A	24	14	22	21	21	19	21	24	19	19	21	22
Meadow Lodge	N/A	26	21	14	13	26	24	28	17	19	24	25	23
Uckfield Hospital	N/A	3	7	5	7	4	6	13	4	3	11	9	6
Rye Memorial Care Centre	N/A	14	11	11	17	12	9	18	12	14	11	17	17
Total Step Down Admissions (excl BISU)	**N/A**	**122**	**112**	**105**	**116**	**138**	**99**	**141**	**123**	**104**	**119**	**147**	**107**

Available beddays	Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Irvine Stroke Unit	TBC	540	558	558	540	558	540	558	558	532	558	540	558
Irvine Unit	TBC	780	744	744	810	744	744	806	930	700	775	870	899
Crowborough Hospital	TBC	420	434	434	420	434	450	558	558	504	620	600	620
Firwood House	TBC	630	651	651	630	651	630	651	651	588	620	600	620
Meadow Lodge	TBC	780	806	806	780	806	780	26	806	728	868	840	806
Uckfield Hospital	TBC	420	434	434	420	434	420	420	434	392	434	420	434
Rye Memorial Care Centre	TBC	420	434	434	420	434	420	420	434	392	465	450	465
Total Available Beddays	**TBC**	**3990**	**4061**	**4061**	**4020**	**4061**	**3984**	**3439**	**4371**	**3836**	**4340**	**4320**	**4402**
Total Occupied Beddays	**TBC**	**3584**	**3552**	**3468**	**3348**	**3643**	**3631**	**3907**	**4102**	**3470**	**3834**	**3695**	**3929**

8.2 Community Nursing

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

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

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

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

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

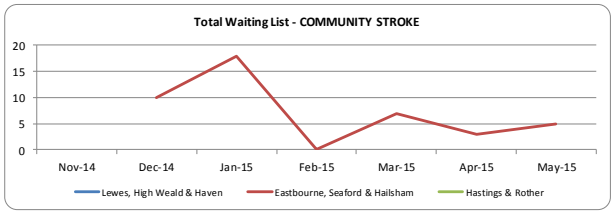
9.0 Community Therapy Referrals and Waiting List Trends

9.1 Referrals

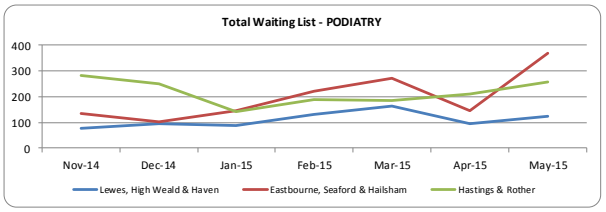
Number of Referrals Received							
Service	CCG	Jan	Feb	Mar	Apr	May	Trend
Podiatry	Lewes, High Weald & Haven	51	59	91	46	66	
	Eastbourne/Seaford/Hailsham	131	336	303	239	252	
	Hastings & Rother	159	176	211	209	180	
TOTAL		341	571	605	494	498	
SaLT	Lewes, High Weald & Haven	23	22	35	38	34	
	Eastbourne/Seaford/Hailsham	46	30	58	64	40	
	Hastings and Rother	32	46	49	34	39	
TOTAL		101	98	142	136	113	
Community Dietetics	Lewes, High Weald & Haven	163	104	112	91	87	
	Eastbourne/Seaford/Hailsham	157	161	181	152	164	
	Hastings & Rother	144	162	167	145	121	
TOTAL		464	427	460	388	372	
MSK	Lewes, High Weald & Haven	334	339	425	573	534	
	Eastbourne/Seaford/Hailsham	816	834	1058	813	627	
	Hastings & Rother	231	275	329	320	242	
TOTAL		1381	1448	1812	1706	1403	

9.2 Total Waiting List by Discipline

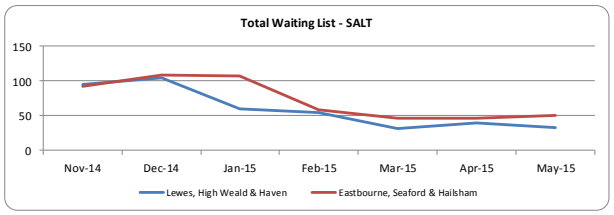
Community Stroke	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven		0	0	0	0	0	0
Eastbourne, Seaford & Hailsham		10	18	0	7	3	5
Hastings & Rother		0	0	0	0	0	0
Total	**0**	**10**	**18**	**0**	**7**	**3**	**5**



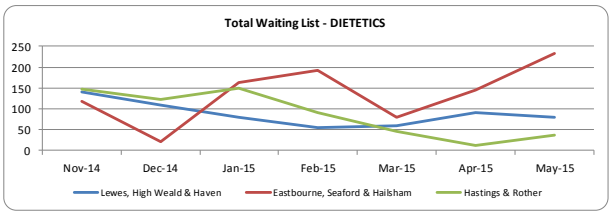
Podiatry	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	79	97	89	133	163	95	123
Eastbourne, Seaford & Hailsham	136	101	144	220	273	145	368
Hastings & Rother	281	250	142	189	184	211	258
Total	**496**	**448**	**375**	**542**	**620**	**451**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



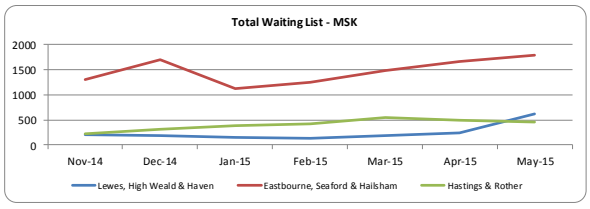
SALT	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	95	105	60	55	32	40	33
Eastbourne, Seaford & Hailsham	92	109	108	59	47	47	51
Hastings & Rother	86	44	32	19	33	27	33
Total	**273**	**258**	**200**	**133**	**112**	**114**	**117**



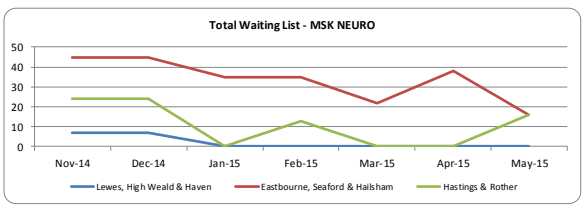
DIETETICS	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	140	109	80	55	60	91	79
Eastbourne, Seaford & Hailsham	117	22	164	193	80	145	232
Hastings & Rother	148	123	149	91	47	13	38
Total	**405**	**254**	**393**	**339**	**187**	**249**	**349**



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



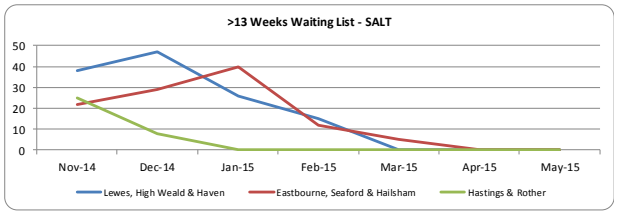
MSK Neuro	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	7	7	0	0	0	0	0
Eastbourne, Seaford & Hailsham	45	45	35	35	22	38	16
Hastings & Rother	24	24	0	13	0	0	16
Total	**76**	**76**	**35**	**48**	**22**	**38**	**32**

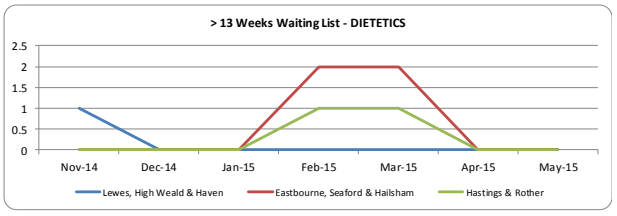


9.3 Total Patients waiting over 13 weeks by Discipline (Disciplines with no >13 waiters are not shown)

SALT	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	38	47	26	15	0	0	0
Eastbourne, Seaford & Hailsham	22	29	40	12	5	0	0
Hastings & Rother	25	8	0	0	0	0	0
Total	**85**	**84**	**66**	**27**	**5**	**0**	**0**

DIETETICS	Number of Patients Waiting						
Area	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Lewes, High Weald & Haven	1	0	0	0	0	0	0
Eastbourne, Seaford & Hailsham	0	0	0	2	2	0	0
Hastings & Rother	0	0	0	1	1	0	0
Total	**1**	**0**	**0**	**3**	**3**	**0**	**0**

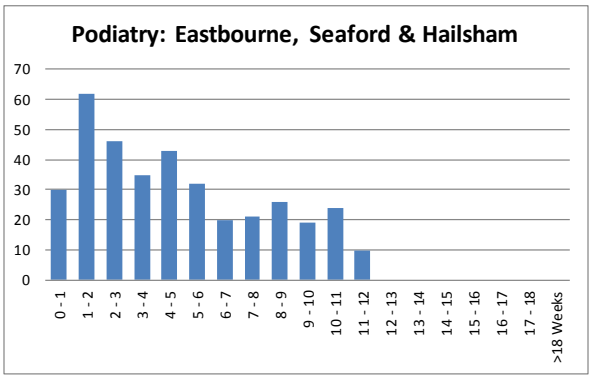




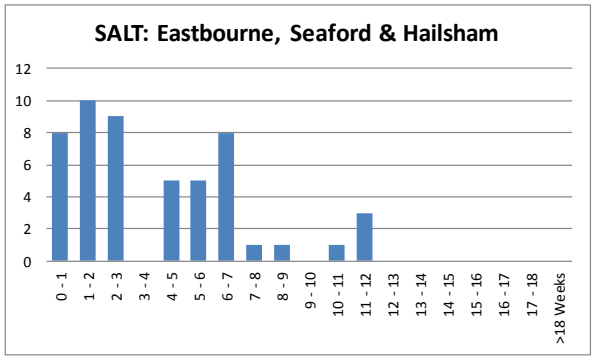
9.4 Community Therapy Waiting List Profiles

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

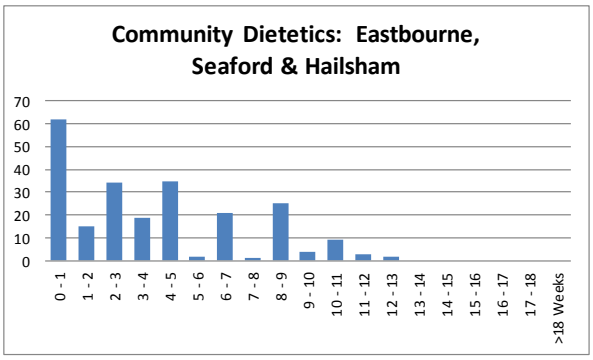
9.5 Eastbourne, Seaford and Hailsham



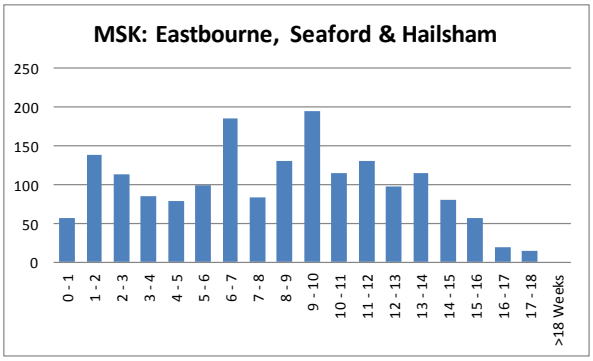
	May	April
Total Waiting List	368	145
% <13 Weeks	100%	100%



	May	April
Total Waiting List	51	47
% <13 Weeks	100%	100%

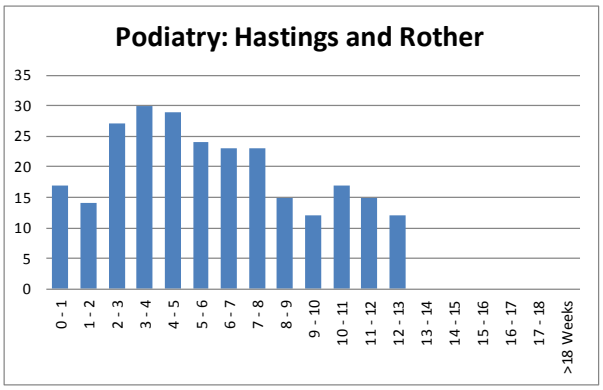


	May	April
Total Waiting List	232	157
% <13 Weeks	100%	92%

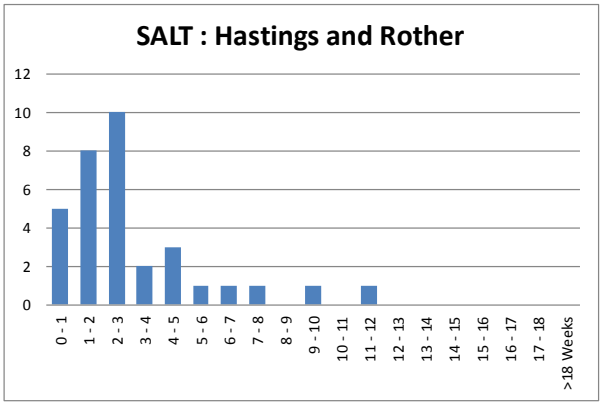


	May	April
Total Waiting List	1798	1669
% <13 Weeks	84%	86%

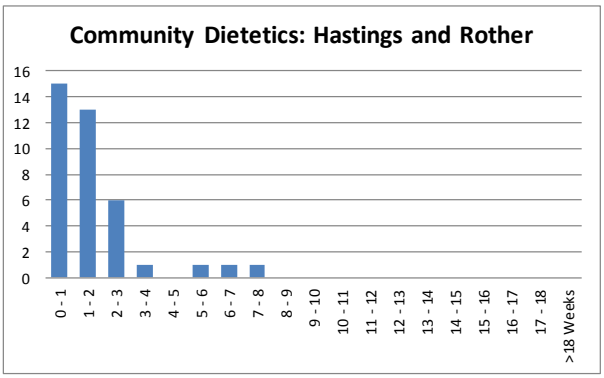
9.6 Hastings and Rother



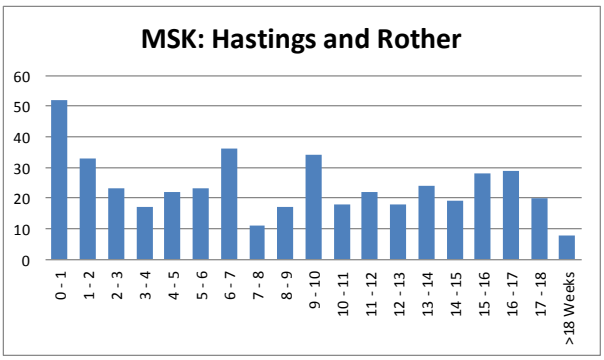
	May	April
Total Waiting List	258	211
% <13 Weeks	100%	100%



	May	April
Total Waiting List	33	27
% <13 Weeks	100%	100%

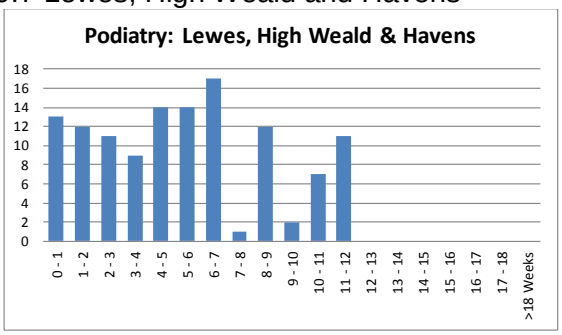


	May	April
Total Waiting List	38	58
% <13 Weeks	100%	100%

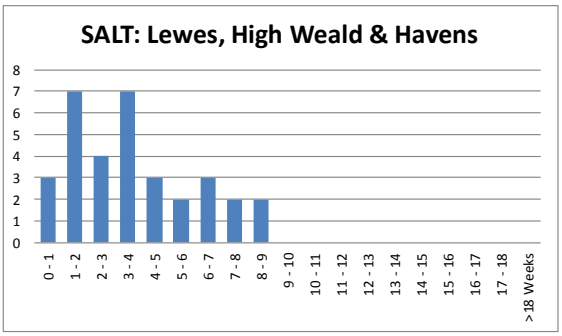


	May	April
Total Waiting List	454	497
% <13 Weeks	72%	71%

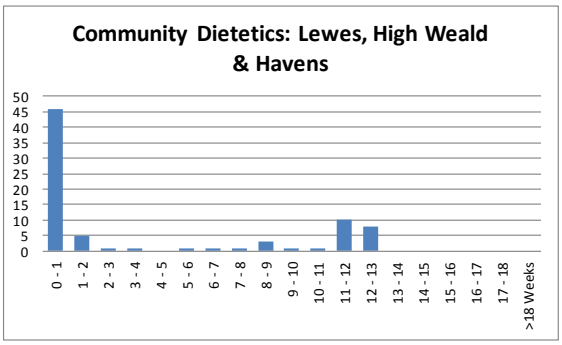
9.7 Lewes, High Weald and Havens



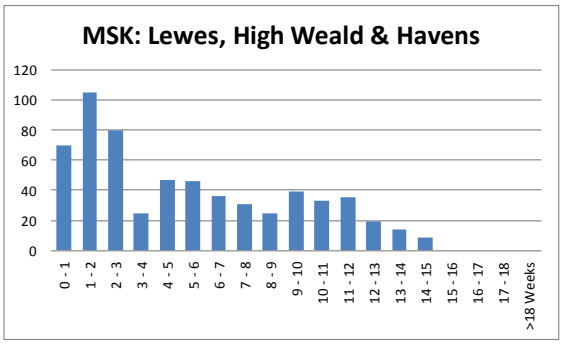
	May	April
Total Waiting List	123	95
% <13 Weeks	100%	100%



	May	April
Total Waiting List	33	40
% <13 Weeks	100%	100%



	May	April
Total Waiting List	79	91
% <13 Weeks	100%	100%



	May	April
Total Waiting List	614	241
% <13 Weeks	96%	100%

10 Community Paediatric Waiting Times

Community Paediatrics Waiting List Breakdown - as at 31st May 2015

1). From the original 614 identified, as at 31st May 2015, 17 patients remain unseen however all were seen in June. The 17 were due to a mixture of patient cancellations, clinical reasons and patient choice.
2). An additional new 352 referrals have been received since 1st January of which 135 have been seen.
3). The current waiting list, which includes all referrals received up to 31st May 2015, stands at 200. This includes the 17
4). Acceptable waiting times and size of waiting list to be agreed as per service specification.

Including new referrals - therefore would not be aiming for final WL of zero but a manageable WL with patients seen within agreed timescales

Month	Start PTL		Additions / referrals		*Patients seen by ESHT in consultant clinic*		*Patients transferred to SCT*		*Additional initiatives*		Revised PTL	
	F'cast	Actual	F	A	*F*	*A*	*F*	*A*	*F*	*A*	F	A
31st Jan 2015	614	614	40	53	40	40	43	43	64	61	507	523
28th Feb 2015	507	523	40	70	40	48	43	71	96	49	368	425
31st Mar 2015	368	425	40	65	40	53	43	9	96	103	229	325
30th Apr 2015	229	325	40	77	40	40	43	0	120	138	66	224
31st May 2015	66	224	40	87	40	32	43	0	120	79	0	200

11 Workforce

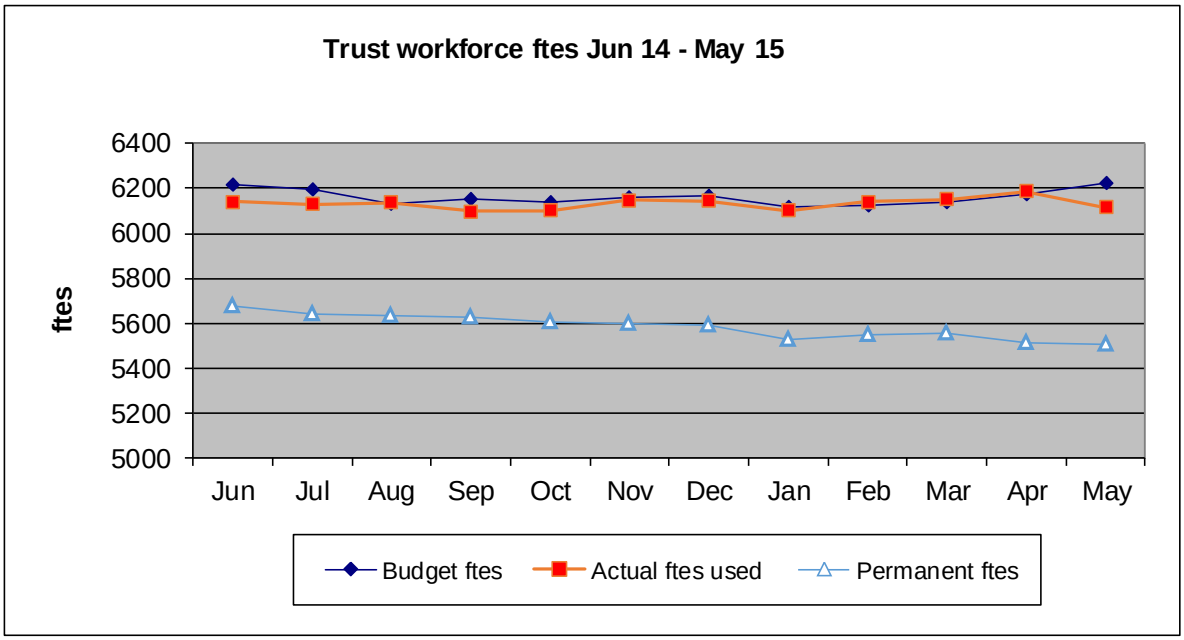
Summary

- Trust budgeted establishment has increased by 48.18 full time equivalents (ftes). Actual usage of staff in May was 6116.05 ftes, down by 69.01 ftes
- Temporary staff expenditure was £2,686K in May (12.82% of total pay expenditure). This comprises £1,087K bank expenditure, £1,567K agency expenditure and £32K overtime
- There are 536.35 fte vacancies (a vacancy factor of 8.85%)
- Monthly sickness was 4.24% a reduction of 0.41% from April
- Annual turnover was 12.91% which represents 704.74 fte leavers in the last year
- Mandatory training rates have increased, with the exception of Trust Induction and Infection Control which have fallen slightly
- Appraisal compliance fell marginally by 0.34% to 74.88%.

Trust & Clinical Unit Overview

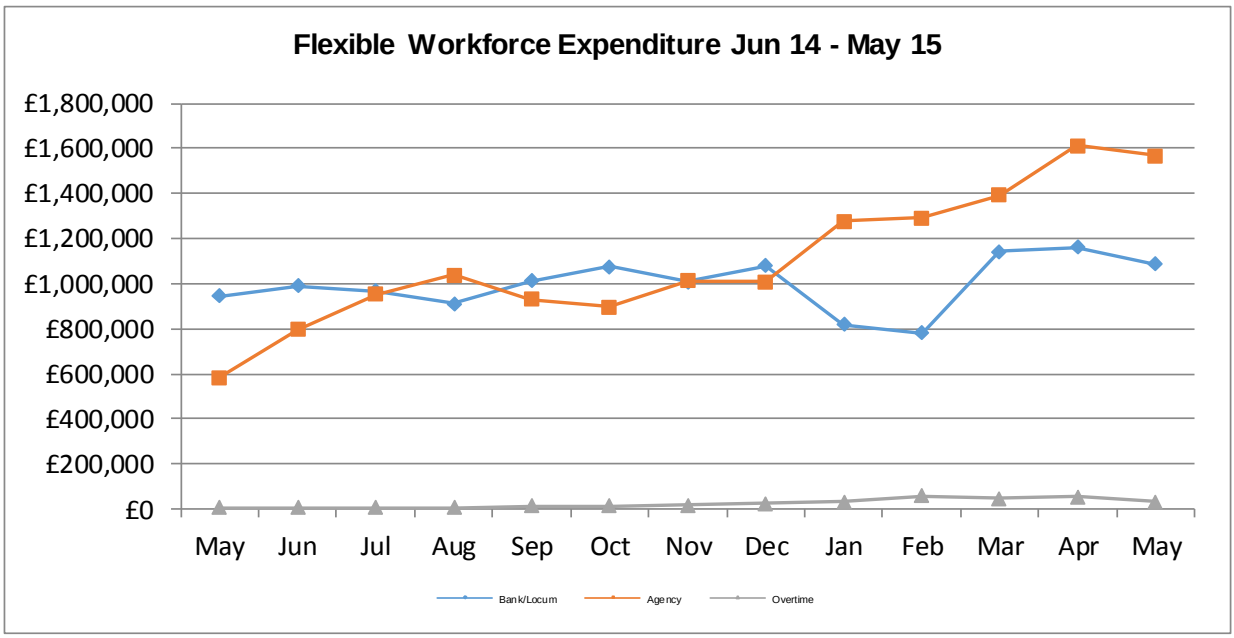
Apr-15	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised /exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,079.48	1,036.03	91.02	↓	91.40%	4.08%	5.12%	11.91%	£589,854	78.92%	↑
Cardiovascular Medicine	312.77	380.93	0.07	↓	99.98%	3.61%	4.11%	8.44%	£239,094	67.89%	↓
Urgent Care	543.07	513.20	91.49	↑	83.15%	4.76%	5.01%	13.42%	£448,448	71.85%	↓
Specialist Medicine	427.49	417.73	29.37	↑	93.13%	3.90%	5.11%	8.23%	£193,186	79.71%	↓
Out of Hospital Care	938.38	862.59	121.56	↓	87.04%	5.25%	5.85%	14.75%	£237,501	72.68%	↑
Surgery	687.26	713.93	47.43	↑	93.10%	2.82%	4.12%	12.81%	£527,963	94.44%	↑
Womens & Childrens	590.39	581.22	27.06	↑	95.41%	4.27%	4.74%	17.77%	£224,334	80.73%	↓
COO Operations	376.18	398.91	13.57	↓	96.39%	3.88%	5.05%	7.97%	£85,783	32.88%	↑
Estates & Facilities	712.81	734.99	47.89	↓	92.80%	5.82%	6.23%	11.84%	£164,710	67.22%	↓
Corporate	469.53	420.72	66.89	↑	85.62%	3.44%	3.97%	12.46%	£160,280	81.47%	↓
TRUST	6221.89	6116.05	536.35	↑	91.15%	4.24%	4.99%	12.91%	£2,685,936	74.88%	↓

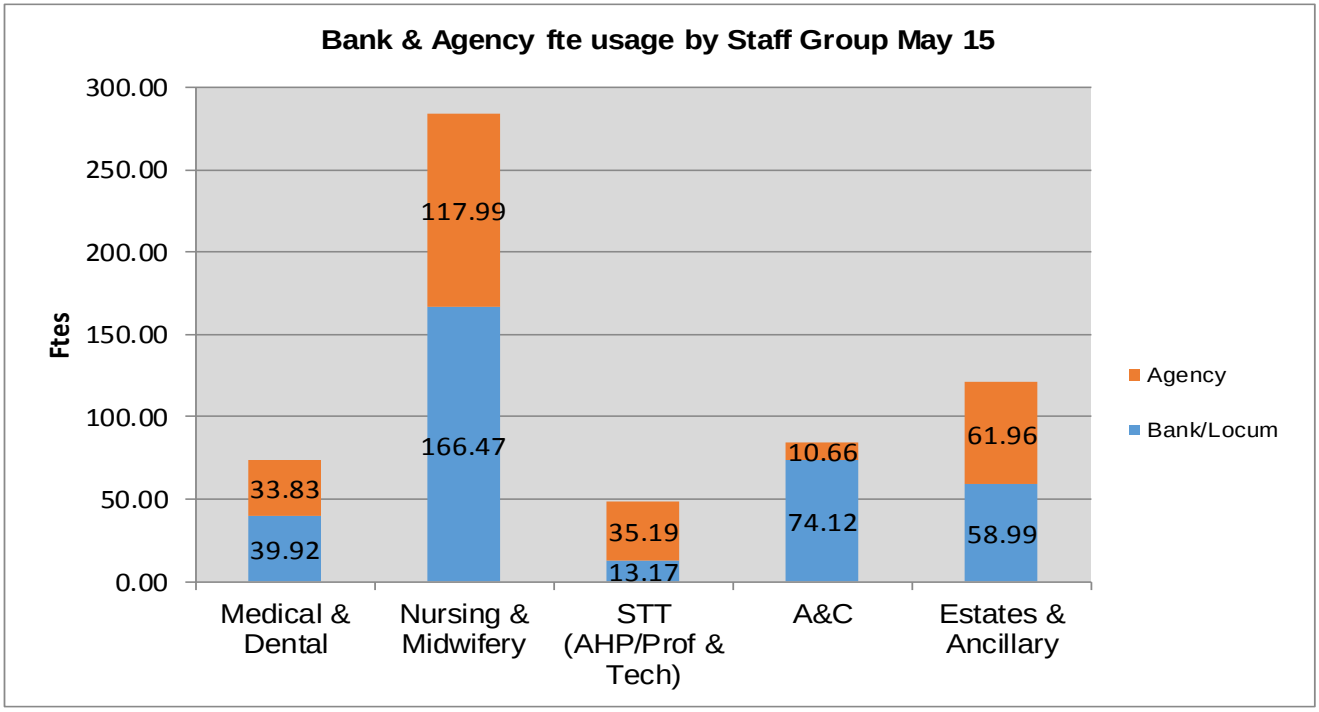
Workforce Usage



The actual full time equivalents (ftes) used this month is down by 69 ftes. This is due to a reduction in bank fte usage of 66 ftes. Agency fte usage was slightly up by 5 ftes, though agency expenditure was lower this month (see below). Budgeted establishment as a whole was up 48 ftes in May due to the addition of the budget for students for which the Trust is funded by Health Education England.

Flexible labour usage

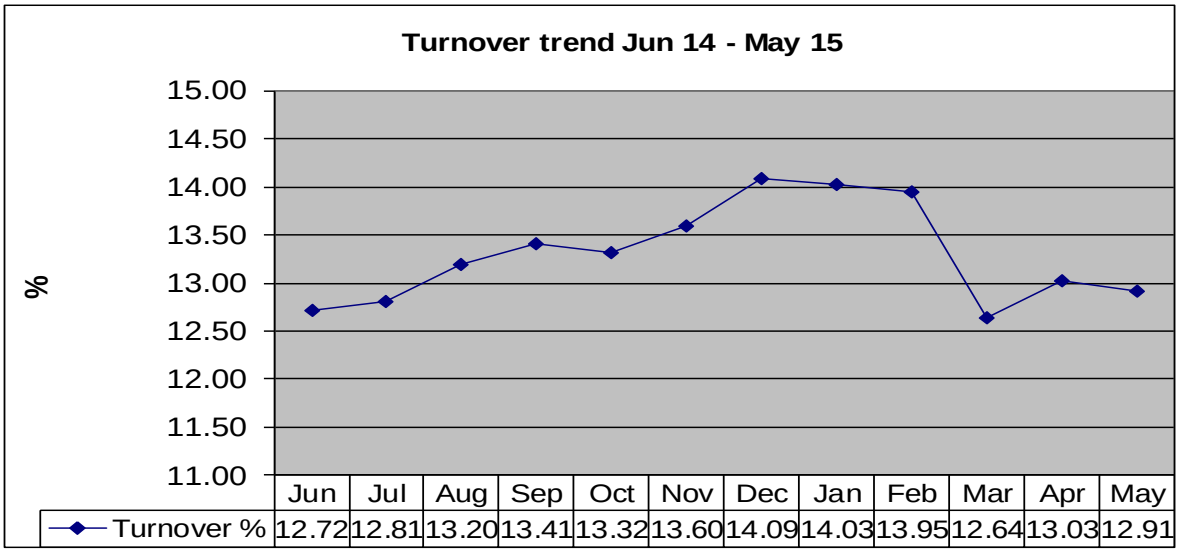




Temporary staff expenditure was £2,686K in May, a reduction of £143K compared to April. This total comprises £1087K bank expenditure (a reduction of £73K on last month) £1,567K agency expenditure (a reduction of £46K) and £32K overtime (a reduction of £24K).

Trust vacancies by Staff Group

STAFF GROUPS	Substantive budget ftes	Substantive actual ftes	Difference	Maternity ftes	Net vacancies	Vacancy trend since last month	Fill rate %
Medical & Dental	573.23	504.47	68.76	6.80	61.96	↑	89.19%
Registered Nursing & Midwifery	1,967.34	1,736.88	230.46	46.01	184.45	↑	90.62%
Unqualified Nurses	786.20	701.20	85.00	23.52	61.48	↓	92.18%
Sc. Therap & Techs (inc AHPs, Prof & Tech & Healthcare Scs.)	970.20	859.01	111.19	12.88	98.31	↓	89.87%
Administrative & Clerical	1141.19	1024.35	116.84	10.52	106.32	↓	90.68%
Estates & Ancillary	624.59	600.21	24.38	2.56	21.82	↑	96.51%
TRUST	6,062.75	5,426.12	636.63	100.28	536.35	↑	91.15%



STAFF GROUPS	FTE leavers in year	Annual Turnover %	Turnover trend since last month
MEDICAL & DENTAL	50.19	17.80%	↑
NURSING & MIDWIFERY REGISTERED	232.84	12.49%	↓
ALLIED HEALTH PROFESSIONALS	67.53	16.74%	↓
HEALTHCARE SCIENTISTS	21.40	16.28%	↓
PROF SCIENTIFIC & TECHNICAL	29.29	16.12%	↓
ADDITIONAL CLINICAL SERVICES	109.17	12.00%	↑
ADMINISTRATIVE & CLERICAL	116.35	11.15%	↑
ESTATES & ANCILLARY	72.34	11.47%	↓
STUDENTS	13.50	23.69%	↓
TRUST	**712.62**	**12.91%**	↓

**Additional Clinical Services comprises unqualified nurses, therapy helpers and other unqualified clinical support.*

The Trust's overall vacancy rate is 8.85% and 9.38% for registered nurses and midwives. This latter figure compares to a figure of 10% across Kent, Surrey and Sussex and 14% in London as outlined in the RCN Safe Staffing Report (December 2014) which describes a worsening national picture for nurse vacancies.

The Trust is undertaking a generic nurse recruitment in the nursing press, which will include the opportunity to undertake Return to Practice nurse training and an Overseas nurse Programme, for those overseas nurses who are currently in the country but haven't been able to secure the conversion training to gain their NMC registration. To date this has attracted 11 external applicants but the vacancy is open until 24th June 2015, so this number should increase.

Overseas recruitment for up to 100 nurses from the Philippines will take place in August and October. An issue with being able to obtain a sufficient Visa allowance has emerged, with pressure on the Restricted Certificate of Sponsorship allowance in June, with applications exceeding the monthly allowance. This will be monitored next month in conjunction with the recruitment agency, and representations will be made through NHS Employers to address this.

Recruitment to registered nurse vacancies continues to be a challenge and other recruitment methods are being explored, such as using social media (Facebook, Twitter, LinkedIn) with the help of the Communications Department.

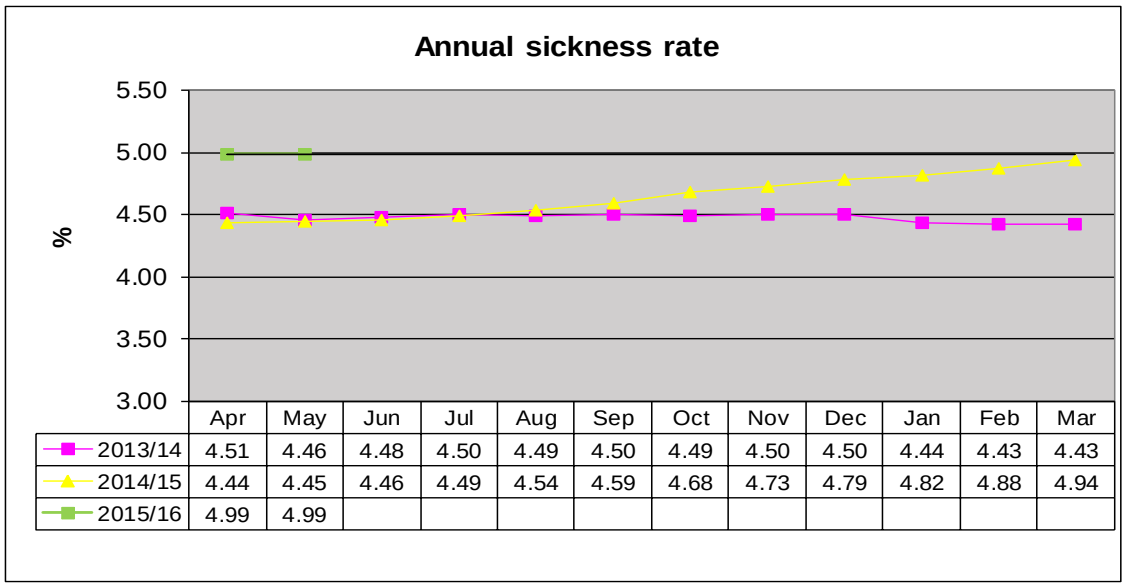
The Trust has signed up with a Recruitment Agency to interview overseas for doctors in the specialties that are hard to fill, such as Middle Grade doctors in Emergency Medicine and Radiology. The Trust is considering a proposal for a recruitment visit to India which would take place in July 2015.

An HCA recruitment open day took place on 18th May. Posts have been offered to 52 successful candidates into full time, part time and TWS vacancies. Start dates are planned in June, July and August. This exercise will be repeated in June, to maintain a rolling programme of new starters

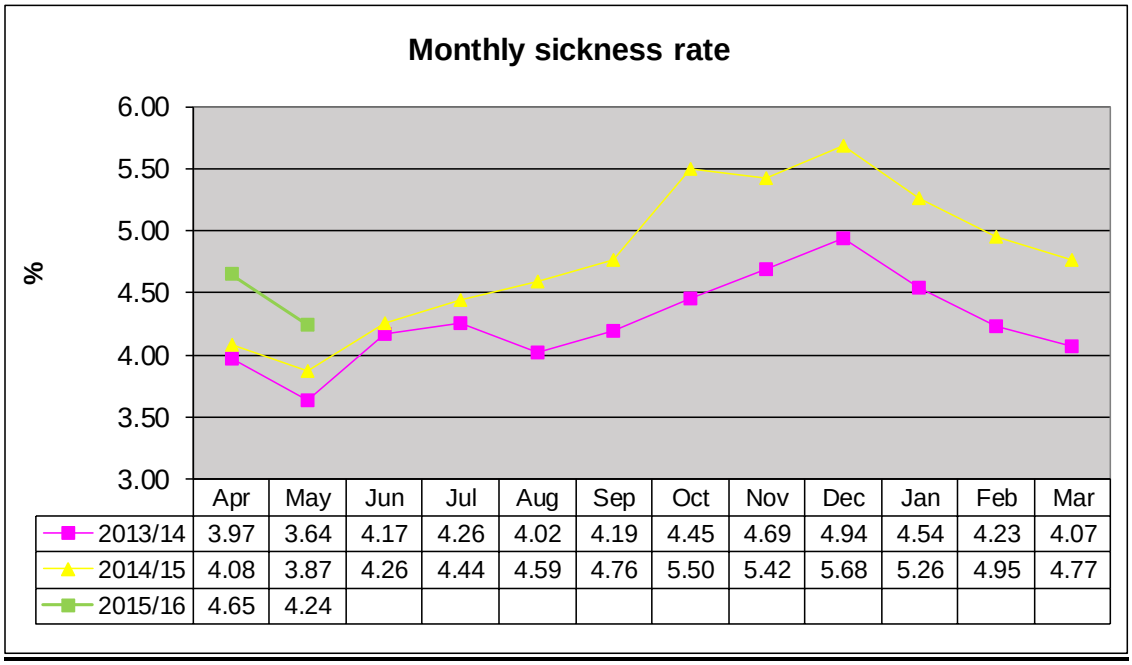
There is intense recruitment activity to support the Clinical Admin team, to recruit additional staff to support the bar-coding project, which is part of the Electronic Document Management project. They will start in post in June

Whilst training managers on TRAC, it is evident that there is a myth that they cannot start the recruitment process until a member of staff has left. 'Myth Busting' communications will be disseminated , to encourage a speedy start to the process if someone is leaving and to ask for feedback on any other 'myths' that are likely to be blockage points in the process

Sickness



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



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

Monthly sickness reduced by a further 0.41% compared to April whilst the annual rate remained static at 4.99%. The biggest monthly reductions in sickness were in Surgery (-181 fte days) and COO Operations (-123 fte days).

7412 full time equivalent (fte) days were lost to sickness in May 2015 (a reduction of 436 fte days compared to April). The top reasons for sickness remain anxiety/stress/depression at 1346 fte days and musculoskeletal (other than back injury) at 1237 fte days lost. The next highest identified reason is gastrointestinal problems at 470 fte days lost.

HR colleagues are continuing to support managers to undertake reviews under the new Attendance Management Policy. The new on line training programme, launched on 5th May, provides additional support to managers.

The first Schwartz Centre rounds to support staff with work pressures in clinical areas, have taken place.

Mandatory Training & Appraisals

Mandatory training – six month trend

Mandatory training course	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	6 month trend
Induction %	94.17	94.62	94.91	94.47	95.16	93.32	↓
Fire %	81.92	83.53	83.64	83.22	81.52	82.47	↑
Manual Handling %	78.95	80.33	80.80	81.08	79.84	82.97	↑
Infection Control %	86.00	86.55	86.94	86.41	86.32	86.27	↑
Info Gov %	78.49	81.03	78.82	77.06	75.99	77.26	↓
Health & Safety %	60.01	63.67	65.06	67.04	68.79	71.18	↑
Mental Capacity Act %	89.54	91.00	91.76	92.36	92.31	92.48	↑
Depriv of Liberties %	84.68	86.56	88.17	89.09	89.03	89.64	↑

(Green = 85%+, Amber= 80 – 85%, Red = <80%. Except for H&S Green = 85%+, Amber= 67 – 85%, Red = <67%)

Clinical Unit mandatory training & appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Appraisal compliance
Theatres & Clinical Support	88.47%	86.77%	95.65%	87.62%	84.88%	72.40%	92.87%	90.03%	78.92%
Cardiovascular Medicine	78.46%	77.23%	86.21%	80.00%	68.00%	56.00%	90.25%	86.24%	67.89%
Urgent Care	77.73%	74.85%	94.20%	76.70%	62.47%	57.73%	85.40%	83.01%	71.85%
Specialist Medicine	87.98%	88.66%	97.62%	87.07%	78.00%	70.29%	95.28%	89.31%	79.71%
Out of Hospital Care	83.86%	87.98%	95.71%	88.08%	77.18%	72.97%	96.41%	97.41%	72.68%
Surgery	84.40%	86.18%	92.37%	84.54%	78.80%	75.10%	92.32%	89.40%	94.44%
Womens & Childrens	87.17%	82.30%	94.44%	88.79%	81.56%	68.58%	91.07%	85.82%	80.73%
COO Operations	62.02%	78.42%	92.86%	79.78%	55.74%	46.72%	n/a	n/a	32.88%
Estates & Facilities	73.34%	68.51%	92.86%	89.36%	77.76%	83.98%	66.67%	100.00%	67.22%
Corporate	88.55%	92.43%	78.26%	92.02%	88.14%	86.30%	93.83%	92.65%	81.47%
TRUST	**82.47%**	**82.97%**	**93.32%**	**86.27%**	**77.26%**	**71.18%**	**92.48%**	**89.64%**	**74.88%**

(Green = 85%+, Amber= 80 – 85%, Red = <80%. Except for H&S Green = 85%+, Amber= 67 – 85%, Red = <67%)

Mandatory training percentages have improved in most areas this month, despite the Trust being in “Black” status early in May. Trust induction compliance was down which may partly reflect the fact that due to unexpected long term sickness in Learning & Development administration , the team were not able to follow up the non attendees as quickly as usual.

Appraisal compliance registered a marginal fall of 0.34%, the first drop for five months, as appraisal renewals did not quite keep pace with numbers expiring. Another 305 will need renewal in June if the rate is not to fall further.

East Sussex Healthcare NHS
NHS Trust

FINANCE REPORT – June 2015

Vanessa Harris – July 2015

East Sussex Healthcare NHS
NHS Trust

Financial Summary – June 2015

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 3.	R
Continuity of Service Risk Ratings	Current rating of 2.	A
Financial Summary	The Trust performance in month 3 was a run rate deficit of £4.2m with an adverse variance against plan of £0.5m. Year to date the run rate deficit stands at £10.2m which is £0.7m worse than plan.	R
Activity & Income	Total income received during June was £0.2m below planned levels increasing the year to date variance to £1.0m below plan. £0.9m of this YTD shortfall is due to Tariff-Excluded Drugs and Devices (TEDDs) income underperformance. There is however, a corresponding underspend of £0.9m on TEDDs expenditure so therefore, this has a zero effect on the bottom line.	G
Expenditure	Direct Pay costs are above plan by £0.7m in month and are cumulatively £1.2m above plan, this is mainly due to high agency spend covering escalation beds and clinical vacancies. Direct Non Pay costs are £0.2m below plan in month and are cumulatively £1.4m below plan. £0.9m of this underspend is due to reduced expenditure on TEDDs as detailed above. Total costs, including the donated asset adjustment, are now £0.3m underspent year to date	G
CIP plans	The CIP achievement year to date was £1.6m which was below the plan of £1.9m.	A
Forecast Outturn	The forecast outturn is projected to be as per plan at £37m deficit.	G
Balance Sheet	DH loans have increased by £4.0m in month as a result of the draw down of the revolving working capital facility.	G
Cash Flow	The cash balance shows an overall increase in the month of £0.7m to £7.2m. An interim revolving working capital support facility agreement is currently in place and an application for re-financing is planned later in the financial year which if approved will allow the repayment of the revolving working capital support.	G
Capital Programme	Capital expenditure after 3 months was £3.6m which is slightly ahead of plan.	G

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Income & Expenditure – June 2015

Headlines

• Total income in the month was £29.2m against a plan of £29.4m, an adverse variance of £0.2m and brings the YTD position to £1.0m below plan.

• Total costs in the month were £33.5m, this was £0.5m above plan. The YTD position is now £0.2m below plan.

• The YTD run rate deficit against plan was a was an adverse variance of £0.7m.

• Cost improvement Plans of £11.4m have been developed for 2015/16 with a year to date achievement of £1.6m versus plan of £1.9m.

• Direct Pay costs in the month, including Ad hoc costs, were £0.7m above plan and are now £1.2m above plan YTD.

• Direct Non Pay costs, including 3rd party costs, were £0.2m below plan in the month and are £1.4m below plan YTD.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	26,296	26,167	-129	80,323	79,586	-737	319,325
Private Patient/ ICR	324	317	-7	971	780	-191	4,284
Trading Income	436	528	92	1,306	1,475	169	5,220
Other Non Clinical Income	2,295	2,170	-125	6,886	6,605	-281	27,180
Total Income	**29,351**	**29,182**	**-169**	**89,486**	**88,446**	**-1,040**	**356,009**
Pay Costs	-20,746	-21,357	-611	-62,223	-63,299	-1,076	-247,766
Ad hoc Costs	0	-49	-49	0	-127	-127	0
Non Pay Costs	-10,575	-10,314	261	-31,631	-30,055	1,576	-124,877
3rd Party Costs	-3	-59	-56	-13	-148	-135	-42
Other	125	125	0	375	375	0	1,500
Total Direct Costs	**-31,199**	**-31,654**	**-455**	**-93,492**	**-93,254**	**238**	**-371,185**
Surplus/- Deficit from Operations	**-1,848**	**-2,472**	**-624**	**-4,006**	**-4,808**	**-802**	**-15,176**
P/L on Asset Disposal	0	0	0	0	6	6	0
Depreciation	-1,090	-1,108	-18	-3,269	-3,298	-29	-13,075
Impairment	0	0	0	0	0	0	0
PDC Dividend	-647	-647	0	-1,941	-1,941	0	-7,763
Interest	-82	-79	3	-245	-236	9	-978
Total Indirect Costs	**-1,819**	**-1,834**	**-15**	**-5,455**	**-5,469**	**-14**	**-21,816**
Total Costs	**-33,018**	**-33,488**	**-470**	**-98,947**	**-98,723**	**224**	**-393,001**
Net Surplus/-Deficit	**-3,667**	**-4,306**	**-639**	**-9,461**	**-10,277**	**-816**	**-36,992**
Donated Asset/Impairment Adjustment	0	93	93	0	84	84	0
Adjusted Net Surplus/-Deficit	**-3,667**	**-4,213**	**-546**	**-9,461**	**-10,193**	**-732**	**-36,992**

Cash Flow – June 2015

Headlines

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

Cash Flow Statement April 2015 to March 2016

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-2,181	-2,346	-3,580	-500	-2,596	-1,771	-3,425	-2,874	-3,048	-1,452	-3,412	-109
Depreciation and Amortisation	1,095	1,095	1,108	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,090	1,057
Impairments												
Interest Paid	-81	-81	-81	-84	-83	-84	-83	-84	-83	-84	-83	-91
Dividend (Paid)/Refunded	0					-3,882						-4,531
(Increase)/Decrease in Inventories	136	168	-68									68
(Increase)/Decrease in Trade and Other Receivables	-637	-371	-6	1,063	0	402	0	0	402	0	0	-2,535
Increase/(Decrease) in Trade and Other Payables	2,859	1,725	434	-6,862	1,691	1,000	6,864	4,764	4,617	210	198	-18,345
Provisions Utilised	-59	-10	0	-107	0	-121	0	-121	0	-111	0	-23
Net Cash Inflow/(Outflow) from Operating Activities	**1,132**	**180**	**-2,193**	**-5,400**	**102**	**-3,366**	**4,446**	**2,775**	**2,978**	**-347**	**-2,207**	**-24,509**
Cash Flows from Investing Activities:												
Interest Received	3	3	2	2	2	2	2	2	2	2	2	1
(Payments) for Property, Plant and Equipment	-1,817	-2,232	-1,567	-932	-1,797	-1,357	-4,697	-4,697	-4,700	-2,976	-515	-193
(Payments) for Intangible Assets	-42	-32	-40									
Net Cash Inflow/(Outflow) from Investing Activities	**-1,856**	**-2,261**	**-1,605**	**-930**	**-1,795**	**-1,355**	**-4,695**	**-4,695**	**-4,698**	**-2,974**	**-513**	**-192**
Net Cash Inflow/(Outflow) before Financing	**-724**	**-2,081**	**-3,798**	**-6,330**	**-1,693**	**-4,721**	**-249**	**-1,920**	**-1,720**	**-3,321**	**-2,720**	**-24,701**
New Temporary PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	-36,992
Revenue Support Loans	7,440	936	4,039	3,000	2,000	3,000	2,000	2,000	2,000	3,000	2,000	6,577
New Permanent PDC	0	0	0	0	0	0	0	0	0	0	0	36,992
New Capital Loan	0	0	441	0	0	0	0	0	0	0	0	17,400
Loans and Finance Lease repaid	-40	-16	-28	-40	-40	-253	-13	-13	-13	-13	-13	-281
Net Cash Inflow/(Outflow) from Financing Activities	**7,400**	**920**	**4,452**	**2,960**	**1,960**	**2,747**	**1,987**	**1,987**	**1,987**	**2,987**	**1,987**	**23,696**
Net Increase/(Decrease) in Cash	**6,676**	**-1,161**	**654**	**-3,370**	**267**	**-1,974**	**1,738**	**67**	**267**	**-334**	**-733**	**-1,005**
Opening balance	1,008	7,684	6,523	5,141	3,807	4,074	2,100	3,838	3,905	4,172	3,838	3,105
Closing balance	7,684	6,523	7,177	1,771	4,074	2,100	3,838	3,905	4,172	3,838	3,105	2,100

Balance Sheet – June 2015

Headlines

• The value of property, plant & equipment is forecast to rise due the indexation of assets and the planned clinical strategy investment. The clinical strategy full business case is yet to be considered by the Trust Development Authority (TDA).

• The year to date increase in non current DoH loans is in respect of the planned interim revolving working capital support facility of £31.3m which is being accessed on a monthly basis. An application for re-financing is planned later in the financial year which if approved will allow the repayment of the revolving working capital support.

•The remaining forecast increase in DoH loans is in respect of the anticipated clinical strategy interest bearing capital loan of £17.4m.

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

• The projected increase in property, plant and equipment indexation has the effect of increasing the revaluation reserve. The forecast increase in the income & expenditure reserve is due to the in year budgeted I&E deficit.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Forecast March 2016
Non Current Assets			
Property plant and equipment	271,373	271,754	299,100
Intangilble Assets	1,293	1,407	547
Trade and other Receivables	1,184	1,184	680
	273,850	**274,345**	**300,327**
Current Assets			
Inventories	6,599	6,363	6,511
Trade receivables	12,637	7,595	13,527
Other receivables	6,800	11,564	7,279
Other current assets	0	0	0
Cash and cash equivalents	1,008	7,177	2,100
	27,044	**32,699**	**29,417**
Current Liabilities			
Trade payables	-6,972	-9,340	-9,274
Other payables	-20,535	-21,893	-21,620
DH Capital Investment Loan	-383	-383	-1,297
Other Financial Liabilities	-335	-335	-263
Provisions	-591	-485	-773
	-28,816	**-32,436**	**-33,227**
Non Current Liabilities			
DH Capital Investment Loan	-3,583	-4,024	-20,083
Borrowings - Revenue Support Facility	0	-12,415	0
Other Financial Liabilities	-263	-179	0
Provisions	-2,588	-2,623	-2,345
	-6,434	**-19,241**	**-22,428**
Total Assets Employed	**265,644**	**255,367**	**274,089**
Financed by:			
Public Dividend Capital (PDC)	-153,530	-153,530	-190,522
Revaluation Reserve	-119,711	-119,711	-128,150
Retained Earnings Reserve	7,597	17,874	44,583
Total Tax Payers Equity	**-265,644**	**-255,367**	**-274,089**

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- By value, year to date 95% of trade invoices has been achieved and 93% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- As at month 3, the Aged Debt KPI stood at 37%, down from 52% in month 2.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	1,000	1,150	3,179	2,121
31 - 60 Days	451	400	1,163	874
61 -90 Days	167	278	475	705
91 - 120 Days	187	114	442	1,572
> 120 Days	902	945	2,336	2,371
Total	2,707	2,887	7,595	7,643

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	5,805	3,990	6,112	4,260
31 - 60 Days	1,061	1,519	2,028	2,184
61 -90 Days	493	444	598	1,173
91 - 120 Days	184	162	358	180
> 120 Days	488	412	244	271
Total	8,031	6,527	9,340	8,068

Better Payments Practice Code	Month Number of Invoices	Month By Value	YTD Number of Invoices	YTD By Value
Trade invoices paid within contract or 30 days of receipt	93.48%	92.43%	93.86%	94.81%
NHS invoices paid within contract or 30 days of receipt	94.00%	91.56%	93.79%	93.11%

Key Performance Indicators – June 2015

TDA Finance Risk Assessment Criteria

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

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

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

Monitor Continuity of Service Risk Rating

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

Better Payments Practice Code (BPPC)

• Year to date performance is in line with the BPPC target for Trade invoices. However, NHS invoices paid by value were marginally below target.

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

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

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	95	95
BPPC – NHS Invoices by value (%)	93	95

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Activity & Contract Income – June 2015

Headlines

•Re-admission fines have been accrued based on planning assumptions.

•CQUIN performance is based on ESHT achieving 100%.

•Activity plans are subject to finalisation with commissioners.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,435	4,208	773	10,301	11,188	887
Elective Inpatients	1,630	699	-931	2,504	1,956	-548
Emergency Inpatients	3,843	4,279	436	10,829	11,225	396
Total Inpatients	**8,908**	**9,186**	**278**	**23,634**	**24,369**	**735**
Excess Bed Days	2,141	3,322	1,181	6,496	5,393	-1,103
Total Excess Bed Days	**2,141**	**3,322**	**1,181**	**6,496**	**5,393**	**-1,103**
Consultant First Attendances	7,989	7,916	-73	22,552	22,857	305
Consultant Follow Ups	11,599	12,489	890	34,085	35,853	1,768
OP Procedures	4,529	4,298	-231	13,342	12,217	-1,125
Other Outpatients inc WA & Nurse Led	12,523	12,968	445	37,152	36,269	-883
Community Specialist	136	194	58	618	415	-203
Total Outpatients	**36,776**	**37,865**	**1,089**	**107,749**	**107,611**	**-138**
Chemotherapy Unbundled HRGs	564	1,016	452	1,623	1,580	-43
Antenatal Pathways	336	315	-21	965	874	-91
Post-natal Pathways	240	318	78	818	900	82
A&E Attendances (excluding type 2's)	9,061	8,937	-124	26,805	26,806	1
ITU Bed Days	469	484	15	1,397	1,485	88
SCBU Bed Days	279	446	167	837	1,051	214
Cardiology - Direct Access	43	62	19	186	122	-64
Radiology - Direct Access	4,953	5,480	527	14,315	15,501	1,186
Pathology - Direct Access	271,054	289,557	18,503	798,238	811,619	13,381
Therapies - Direct Access	1,754	4,556	2,802	4,974	8,406	3,432
Audiology	1,754	1,858	104	3,051	3,670	619
Midwifery	8	16	8	34	38	4

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,284	2,303	-1,981	13,836	9,761	-4,075
Inpatients - Emergency	6,112	6,793	681	18,541	18,957	416
Excess Bed Days	469	711	242	1,421	1,167	-254
Outpatients	3,899	3,155	-744	11,340	10,469	-871
Other Acute based Activity	2,270	2,778	508	7,564	7,832	268
Direct Access	720	856	136	2,100	2,272	172
Block Contract	5,372	5,448	76	15,982	16,115	133
Re-admissions	0	60	60	0	-142	-142
Other	0	1,095	1,095	0	4,509	4,509
CQUIN	548	548	0	1,675	1,675	0
Subtotal	23,674	23,747	73	72,459	72,615	156
Exclusions	2,622	2,420	-202	7,864	6,971	-893
GRAND TOTAL	**26,296**	**26,167**	**-129**	**80,323**	**79,586**	**-737**

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

Headlines

Trust wide

Total Pay reported £0.7m overspend against the TDA plan in the month. Cumulatively pay was £1.2m overspent.

Clinical Units (CUs)

The overall clinical unit performance was £0.9m overspend in June against plan, mainly due to continued agency usage across medical and nursing vacancies, and continued use of escalation beds. The contingency (central items) is being phased in but this only partly offsets this pressure.

Tariff-excluded drugs and devices reported £0.2m underspend in the month against plan, which was offset by under achievement on Contract Income so overall has a neutral impact.

Estates and Facilities Directorate

June reported a marginal overspend in month due to increased agency usage in housekeeping.

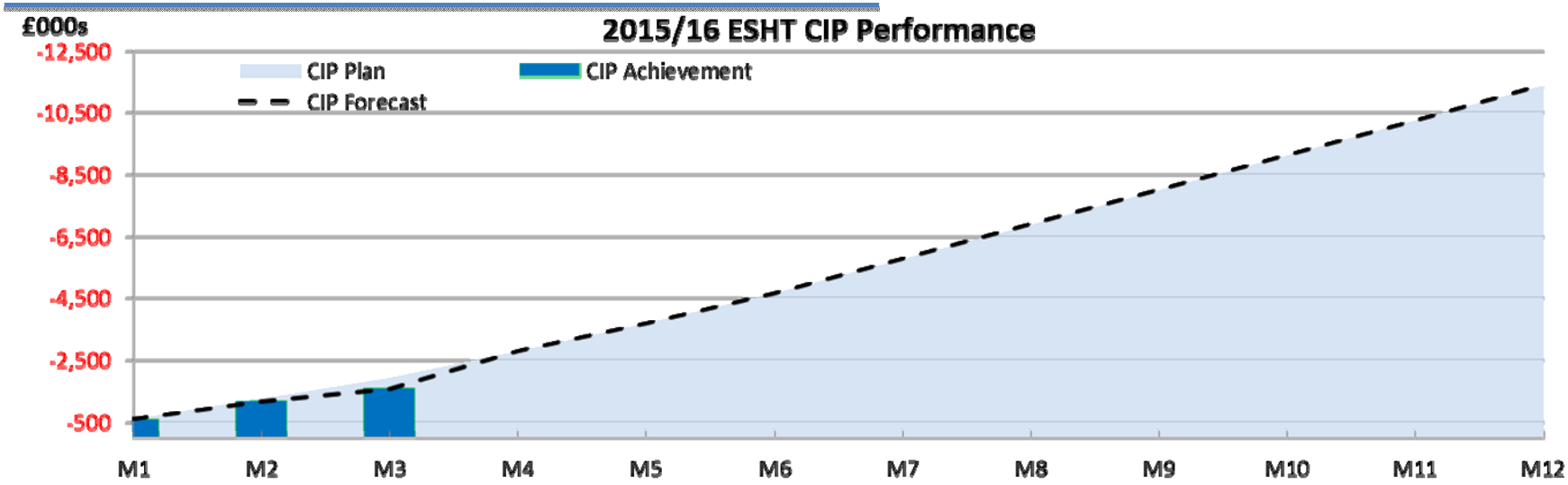
Corporate Services

Corporate Services was on plan as at month 3.

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	-2,024	-2,064	-40	-6,090	-6,188	-98
Specialist Medicine	-1,615	-1,726	-111	-4,916	-5,151	-235
Cardiovascular	-1,234	-1,518	-284	-3,701	-4,574	-873
Surgery	-3,196	-3,378	-182	-9,602	-9,960	-358
Women & Children	-2,571	-2,667	-96	-7,729	-7,874	-145
Out of Hospital Care	-2,897	-3,027	-130	-8,692	-8,780	-88
Clinical Support	-6,328	-6,547	-219	-18,918	-19,562	-644
Tariff-Excluded Drugs & Devices	-2,621	-2,398	223	-7,863	-6,960	903
COO Operations	-968	-1,075	-107	-2,854	-3,096	-242
Total Clinical Units	**-23,454**	**-24,400**	**-946**	**-70,365**	**-72,145**	**-1,780**
Estates & Facilities	-2,209	-2,256	-47	-6,646	-6,739	-93
Corporate Services	-2,212	-2,183	29	-6,682	-6,625	57
Central Items	-2,368	-1,769	599	-6,927	-4,939	1,988
Total Central Areas	**-6,789**	**-6,208**	**581**	**-20,255**	**-18,303**	**1,952**
Contract Income	26,296	26,167	-129	80,323	79,586	-737
Income	280	135	-145	836	585	-251
Donated Asset/Impairment Adjustment	0	93	93	0	84	84
Adjusted Net Surplus/- Deficit	**-3,667**	**-4,213**	**-546**	**-9,461**	**-10,193**	**-732**

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
543	517	Urgent Care	-1,933	-1,963	-30	-5,800	-5,871	-71
429	422	Specialist Medicine	-1,515	-1,577	-62	-4,590	-4,746	-156
313	377	Cardiovascular	-1,085	-1,397	-312	-3,256	-4,127	-871
691	714	Surgery	-2,864	-2,988	-124	-8,566	-8,964	-398
591	581	Women & Children	-2,286	-2,355	-69	-6,858	-6,997	-139
940	881	Out of Hospital Care	-2,528	-2,637	-109	-7,583	-7,730	-147
1,086	1,044	Clinical Support	-4,142	-4,278	-136	-12,349	-12,821	-472
371	402	COO Operations	-893	-956	-63	-2,673	-2,832	-159
4,963	**4,939**	**Total Clinical Units**	**-17,246**	**-18,151**	**-905**	**-51,675**	**-54,088**	**-2,413**
715	723	Estates & Facilities	-1,444	-1,489	-45	-4,345	-4,410	-65
519	519	Corporate Services	-1,558	-1,706	-148	-4,931	-5,028	-97
1,234	**1,243**	**Total Non-Clinical Divisions**	**-3,002**	**-3,195**	**-193**	**-9,276**	**-9,438**	**-162**
0	**0**	Central Items	-498	-60	438	-1,272	100	1,372
6,197	**6,182**	**Total Pay Analysis**	**-20,746**	**-21,406**	**-660**	**-62,223**	**-63,426**	**-1,203**

2015/16 ESHT CIP Performance to date – Month 3



	In Month			Year to Date			Forecast		
Clinical Unit	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Cardiovascular Medicine	-66	-30	37	-179	-94	85	-1,123	-1,123	-
Estates and Facilities	-93	-31	61	-278	-185	93	-1,585	-1,585	-
Corporate	-149	-197	-48	-438	-444	-6	-2,281	-2,281	-
Specialist Medicine	-30	-59	-29	-89	-97	-8	-403	-403	-
Surgery	-73	41	114	-217	-161	56	-1,154	-1,154	-
Trustwide	-15	-	15	-7	-120	-113	-329	-329	-
Urgent Care	-2	-10	-7	-6	-42	-36	-320	-320	-
Womens Health & Childrens Services	-35	-56	-21	-105	-156	-51	-660	-660	-
Contract Income	-42	-	42	-125	-	125	-500	-500	-
Out of Hospital Care	-53	16	69	-158	-45	113	-633	-633	-
Clinical Support	-117	-76	41	-322	-212	110	-2,386	-2,386	-
Total	**-674**	**-401**	**273**	**-1,925**	**-1,556**	**369**	**-11,375**	**-11,375**	**0**

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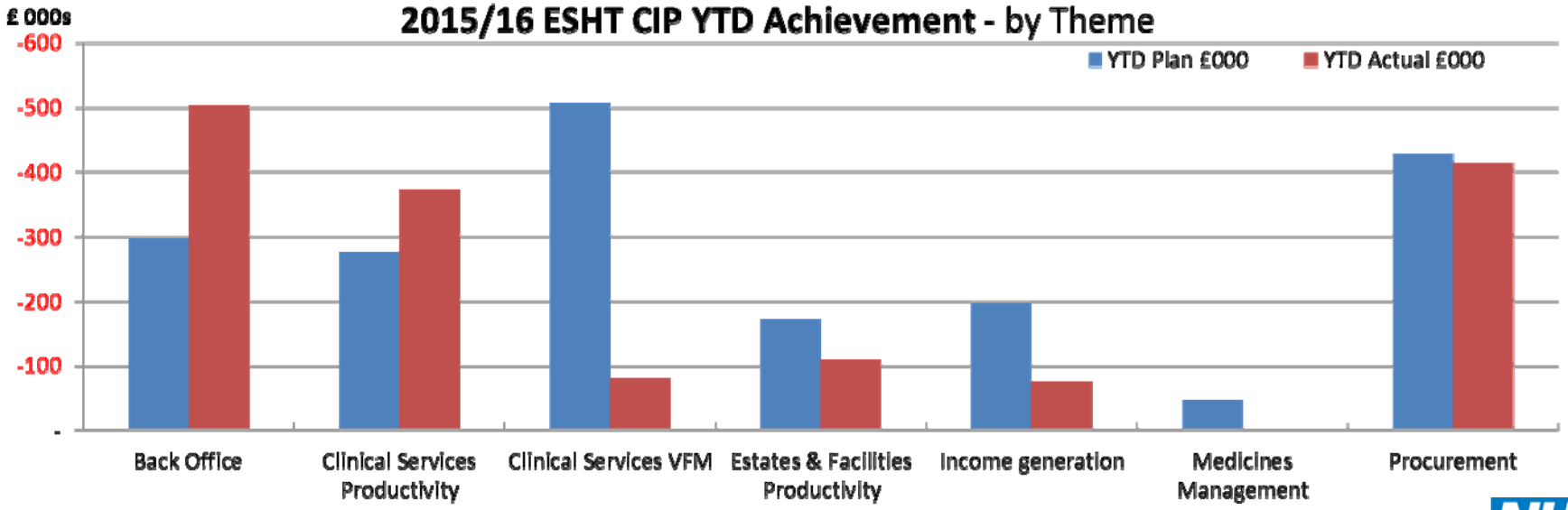
2015/16 ESHT CIP Performance by Theme – Month 3

	In Month			Year to Date			Forecast		
TDA Theme	Plan £000	Actual £000	Var £000	YTD Plan £000	YTD Actual £000	YTD Var £000	Annual Plan £000	Forecast £000	Variance FOT £000
Back Office	-103	-175	-72	-298	-503	-205	-1,547	-1,547	-
Clinical Services Productivity	-104	-165	-61	-276	-372	-96	-2,319	-2,319	-
Clinical Services VFM	-183	12	195	-508	-81	427	-2,805	-2,805	-
Estates & Facilities Productivity	-57	-36	21	-171	-110	61	-1,105	-1,105	-
Income generation	-67	-21	46	-197	-76	121	-800	-800	-
Medicines Management	-16	-	16	-46	-	46	-293	-293	-
Procurement	-144	-17	127	-429	-414	15	-2,506	-2,506	-
Total	**-674**	**-401**	**273**	**-1,925**	**-1,556**	**369**	**-11,375**	**-11,375**	**0**



East Sussex Healthcare NHS
NHS Trust

Year on Year Comparisons – June 2015

Headlines

- Total Inpatients activity was 3.0% higher than last year's activity level.
- Total outpatients were 0.6% lower than last year.
- Total A&E attendances were marginally below last year.

Activity	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	11,188	10,750	438	4.1%
Elective Inpatients	1,956	2208	-252	-11.4%
Emergency Inpatients	11,225	10,710	515	4.8%
Total Inpatients	**24,369**	**23,668**	**701**	**3.0%**
Elective Excess Bed Days	364	483	-119	-24.6%
Non elective Excess Bed Days	5,029	5,859	-830	-14.2%
Total Excess Bed Days	**5,393**	**6,342**	**-949**	**-15.0%**
Consultant First Attendances	22,857	22,513	344	1.5%
Consultant Follow Ups	35,853	34,544	1,309	3.8%
OP Procedures	12,217	13,825	-1,608	-11.6%
Other Outpatients (WA & Nurse Led)	36,269	36,738	-469	-1.3%
Community Specialist	415	672	-257	-38.2%
Total Outpatients	**107,611**	**108,292**	**-681**	**-0.6%**
Chemotherapy Unbundled HRGs	1,580	1,010	570	56.4%
Antenatal Pathways	874	952	-78	-8.2%
Post-natal Pathways	900	802	98	12.2%
A&E Attendances (excluding type 2's)	26,806	26,808	-2	0.0%
ITU Bed Days	1,485	1,457	28	1.9%
SCBU Bed Days	1,051	638	413	64.7%
Cardiology - Direct Access	122	181	-59	-32.6%
Radiology - Direct Access	15,501	14,603	898	6.1%
Pathology - Direct Access	811,619	798,070	13,549	1.7%
Therapies - Direct Access	8,406	9,505	-1,099	-11.6%
Audiology	3,670	3,575	95	2.7%
Midwifery	38	34	4	11.8%

£000s	2015/16 YTD Actual	2014/15 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	79,586	80,326	-740	-0.9%
Private Patient/ RTA	780	585	195	33.3%
Trading Income	1,475	1,210	265	21.9%
Other Non Clinical Income	6,605	6,033	572	9.5%
Total Income	**88,446**	**88,154**	**292**	**0.3%**
Pay Costs	-63,426	-61,249	-2,177	-3.6%
Non Pay Costs	-30,203	-29,414	-789	-2.7%
Other	375	550	-175	31.8%
Total Direct Costs	-93,254	-90,113	-3,141	-3.5%
Surplus/-Deficit from Operations	**-4,808**	**-1,959**	**-2,849**	**-145.4%**
Profit/Loss on Asset Disposal	6	0	6	
Depreciation	-3,298	-3,093	-205	-6.6%
Impairment	0	0	0	
PDC Dividend	-1,941	-2,067	126	6.1%
Interest	-236	-82	-154	-187.8%
Total Indirect Costs	-5,469	-5,242	-227	-4.3%
Total Costs	**-98,723**	**-95,355**	**-3,368**	**-3.5%**
Net Surplus/-Deficit	**-10,277**	**-7,201**	**-3,076**	**-42.7%**
Donated Asset / Other Adjustment	84	257	-173	67.3%
Normalised Net Surplus/-Deficit	**-10,193**	**-6,944**	**-3,249**	**-46.8%**

Capital Programme – June 2015

Headlines

Year to Date Performance:-
After three months of the financial year capital expenditure amounts to £3.6m slightly ahead of plan.

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

The overall Trust's capital programme resource of £29.2m includes an assumed clinical strategy interest bearing capital loan of £17.4m. However, the clinical strategy full business case has yet to be considered by the Trust Development Authority (TDA).

The current over planning margin has increased slightly to £81k but is considered quite manageable and the CAG will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital.

Capital Investment Programme £000s	2015/16 Capital Programme	Expenditure at Month 3
Capital Resources		
Depreciation	11,820	
Clinical Strategy exceptional additional PDC	17,400	
Additional Capital Loan - Health Records Storage	441	
League of Friends Support	1,255	
Cap Investment Loan Principal Repayment	-427	
Gross Capital Resource	30,489	
Less Donated Income	-1,255	
Capital Resource Limit (CRL)	**29,234**	**-**
Capital Investment		
Clinical Strategy Reconfiguration	17,400	0
Medical Equipment	1,529	828
IT Systems	1,126	358
Electronic Document Management	1,010	172
Child Health Information System	673	93
PAS Upgrade	523	41
Backlog Maintenance	871	60
Infrastructure Improvements - Modernisation of Inpatient Environment and Facilities	700	22
Pevensey Ward	2,055	1,028
Minor Capital Schemes	1,500	375
Health Records	597	443
Other various	1,331	170
Sub Total	**29,315**	**3,590**
Donated Asset Purchases	1,255	221
Donated Asset Funding	-1,255	-221
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**29,315**	**3,590**
Overplanning Margin (-) Underplanning (+)	-81	0
Net Capital Charge against the CRL	**29,234**	**3,590**

Continuity of Service Risk Ratings – June 2015

Headlines

Continuity of Service Risk Ratings (COS):-

- Liquidity (days)
  - Days of operating costs held in cash or cash equivalent forms.
- Capital service capacity ratio (times)
  - The degree to which the organisation's generated income covers its financial obligations.
- Monitor assigns ratings between 1 and 4 to each component of the continuity of service risk ratings with 1 being the worst rating and 4 the best. The overall rating is the average of the two.
- The Trust has a liquidity ratio of -6 days, a rating of 3.
- The capital servicing ratio of -2.21 results in a rating of 1.
- As a result the overall Trust rating is 2.

Liquidity Ratio (days) £000s	2014/15 Outturn	2015/16 YTD
Opening Current Assets	27,044	32,699
Opening Current Liabilities	-28,815	-32,436
Net Current Assets/Liabilities	-1,771	263
Inventories	-6,599	-6,363
Adj Net Current Assets/Liabilities	**-8,370**	**-6,100**
Divided by:		
Total costs in year	364,471	93,254
Multiply by (days)	360	90
Liquidity Ratio	**-8**	**-6**

Capital Servicing Capacity (times) £000s	2014/15 Outturn Actual	2015/16 YTD Plan	2015/16 YTD Actual
Net Surplus / Deficit (-) After Tax	473	-9,461	-10,277
Less:			
Donated Asset Income Adjustment	-1,107	-314	-221
Interest Expense	235	251	243
Profit/Loss on Sale of Assets	-29	0	-6
Depreciation & Amortisation	12,265	3,269	3,298
Impairments	-629	0	0
PDC Dividend	8,073	1,941	1,941
Revenue Available for Debt Service	**19,281**	**-4,314**	**-5,022**
Interest Expense	235	251	243
PDC Dividend	8,073	1,941	1,941
Temporary PDC repayment			
Working capital loan repayment	18,171	0	0
Capital loan repayment	320	121	84
	26,799	2,313	2,268
Capital Serving Capacity	**0.72**	**-1.87**	**-2.21**

Financial Risks & Mitigating Actions – June 2015

Summary	
RISKS:-	
The following areas of risk have been identified in achieving the projected year end £37.0m deficit.	
1) Application of fines and penalties.	
2) Activity levels exceed baseline amounts in contracts and are not paid for / paid at marginal rate only.	
3) Stranded costs arising from the outcome of competitive tendering.	
4) Activity and capacity pressures.	
5) Unplanned operational cost pressures (e.g. continued high use of agency staff and escalation wards).	
6) Non delivery of CIPs.	
7) Revenue cost implications of re-financing.	
MITIGATING ACTIONS:-	
Potential mitigating actions include joint management of demand and continued improvement in productivity.	

East Sussex Healthcare NHS Trust

Date of Meeting:	5 August 2015
Meeting:	Trust Board
Agenda item:	6b
Subject:	Safe Nurse & Midwifery Staffing Levels
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

- Appropriate Nurse staffing levels are critical to patient safety
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- The variations that have occurred are managed appropriately
- Where there is concern regarding quality metrics that full investigation is undertaken to understand contributory factors

Benefits:

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

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/

Assurance Provided:

The Trust has responded to the expectations of the NQB and NHS England and can demonstrate that all inpatient areas are assessed and monitored with regard to nurse staffing levels and related quality indicators.

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

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

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

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

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

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

2. Background

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

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

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

3. May 2015

3.1 The dashboard in Appendix 1 has been prepared for May 2015, reflecting the above requirements.

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

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

3.3 There has been a slight reduction in recorded pressure ulcers and greater reduction in the number of falls reported. The number of medication errors is not available due to a technical difficulty. All these measures are closely monitored within the patient safety and quality forums.

4. Conclusion/Recommendation

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

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

This overview provides assurance that the systems and processes in place allow the Trust to provide safe care in our inpatient wards.

Alice Webster
Director of Nursing

Elizabeth Fellows
Assistant Director of Operations

Appendix 1

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

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

East Sussex Healthcare NHS Trust

Date of Meeting:	5 August 2015
Meeting:	Trust Board
Agenda item:	6c
Subject:	Staffing Establishment Review
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

- To provide a report to the board on safe staffing levels: Nursing on acute inpatient wards.
- To provide information to support the consideration of the nursing, midwifery and care staff workforce capacity from ward to Board
- To assure the board of the work plan for 2015/2016 re: Safer staffing nursing establishments for ESHT.
- To recommend staffing levels for inpatient areas

Introduction:

This report has been prepared in response to the requirements of the National Quality Board (November 2013) and the published NICE guidance, "Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals" (July 2014). There is an expectation that reviews of inpatient staffing establishments are undertaken twice a year. The last establishment review was carried out in March 2015

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

- Proposal of inpatients staffing levels for 2015/2016.
- How the staffing establishment review was undertaken.
- Recommendations and findings of the staffing establishment review.
- Moving forward 2015/2016 the staffing establishment review work plan.
- Introduction to the Safer staffing: A guide to care contact time work stream.

Benefits:

- There is a robust staffing establishment review process in place for all inpatient and clinical areas.
- Opportunity to discuss staffing establishments in relation to service changes and ward reconfigurations.
- Safer staffing: care contact time will provide evidence to review the skill mixing of clinical areas and the proposal of new posts to support the registered nursing staff during the national challenge in recruitment.

Risks and Implications

- It is acknowledged that these figures are based on the month of March 2015 audit data and that there will be local variation depending on the requirements of the ward that are unpredictable. For example patients requiring special observations, additional beds open

for escalation above establishment i.e. stroke, change in speciality i.e. EDGH orthopedic ward H3 to medicine to support admissions and requirement for additional medical beds.

- Currently there is no published guidance on data collection for other areas that don't fall within the inpatient safer staffing toolkit. NICE has only published guidance on data collection/recommendation of staffing levels for acute inpatient and maternity.

- At the time of the staffing establishment review there was an expectation that there would be further guidance from NICE re: A&E staffing. However, in June an announcement was made by NHS England to NICE asking for a suspension on the safe staffing programme for A&E. There is an expectation that this work will be taken forward as part of NHS England's wider programme of work dealing with challenges faced over the next few years. At the time of this report we are waiting to hear how this will be taken forward.

- Although there has been a decrease in beds footprint this does not automatically mean a reduction in staffing levels due to the minimum staffing levels required as recommended by professional bodies.

- Having completed the inpatient review of staffing levels it tells us that in total we need an increase of **16.56 WTE Registered Nurses** and **10.02 WTE Health Care Assistants**

- The next step; Clinical Units General Managers/ Heads of Nursing to consider how they will fund the additional posts required for their areas.

Assurance Provided:
The Trust has responded to the expectations of the NQB and NHS England and can demonstrate that all inpatient areas are assessed and monitored with regard to nurse staffing levels

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

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

For further information or for any enquiries relating to this report please contact:	
Name:	**Contact details:**
Alice Webster, Director of Nursing Lucy Scragg Assistant Director of Nursing (WEST)	01323 417400 ext 5855 01323 417400 ext 3095

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

Nurse Establishment Review

April 2015

1. Background

Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE (National Institute of Central Excellence) was asked by the Department of Health and NHS England to produce guidelines on safe staffing in the NHS. The focus of work is on nursing and midwifery staffing, including nursing support staff, to ensure an appropriate balance of skill-mix across the whole team on the wards and in other settings. In July 2014 Nice published it guidance Safe staffing for nursing in adult inpatients wards in acute hospital setting

Following the staff establishment review reported to the Trust Board in April 2014 in response to the NICE guidance the senior nursing team has undertaken the third, twice yearly review. This took place in March 2015, with the input of Ward Matrons and Heads of Nursing in all inpatient areas.

As recommended the review team used the NICE validated Shelford Safer Nursing Care Tool (SNCT) alongside triangulation with:

- Existing budgeted establishments
- Professional Judgement (Kingsgate Establishment calculator) on which existing establishments were generated in 14/15
- Patient experience feedback, quality and safety metrics
- Local intelligence i.e. ward geography, shifts required, speciality.

1.1 Of the areas that were in scope for this establishment review (Appendix 1) it is recognised that the SNCT tool is not designed for use in all acute inpatient areas. These include the following:

- Paediatrics inpatients.
- Medical and surgical assessment units.
- Special care.

Therefore alternative professional recognised tools and professional judgement have been used in these areas.

1.2 Moving forward to achieve a full review of all nursing establishments in 2015 a work plan has been developed. Areas that were out of scope and did not fall within the

SNCT will be reviewed. The proposed tools for these areas are currently in draft form or are in the process of data being collected. (Appendix 2)

- Intensive care/HDU
- Cath lab EDGH and CQ
- Accident and emergency
- Maternity
- Outpatients
- Community nursing
- Theatres

Since the staffing establishment review in March 2015 an announcement was made in June 2015 that NHS England have asked NICE to suspend the safe staffing programme for A&E. There is an expectation that this work will be taken forward as part of NHS England's wider programme of work to help the NHS deal with the challenges it is facing over the next few years. At the time of this report we are waiting to hear how this will be taken forward.

2. Methodology

2.1 All ward matrons and heads of nursing were advised of the plan to undertake data collection, using the SNCT. As per the SCNT the data collection took place for 4 weeks (Mon – Fri only) in March 2015. The SNCT records the acuity of patients, staffing levels and other influencing factors e.g. number of admissions/discharges.

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 Each area also recalculated using 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.

2.4 Following completion of the data collection a spread sheet was developed to compare the results of the SNCT and Kingsgate/professional model with the existing establishment for each area. (appendix 1) 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.

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

50% supervisory time for ward matrons.

18 % local uplift for annual leave, training and absence.

3% central uplift fund for exceptional circumstances e.g. maternity leave or long term absence as this cannot be consistently applied across all areas.

2.6 The results of this exercise are available in Appendix 1.

3. Findings/Recommendations

3.1 The establishment reviews demonstrate a robust method of determining the required establishment for each area and allow consideration of all key factors.

3.2: 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 or individual patient safety. As a result there is a 'Safe Staffing' escalation policy that is used on a daily basis within the Trust.

3.3 It is also recognised that even though there have been bed reductions there are minimum staffing levels that are recommended from professional bodies that need to be acknowledged. i.e. Royal College of Nursing.

3.4: During March 2015 there were a number of areas that opened beds above budgeted nursing establishment these were as follows'

- Hailsham 4 EDGH between 2-6 beds
- Hailsham 3 EDGH between 2-6 beds
- Irvine unit generic beds additional 7 beds
- ESHT Stroke unit additional 6 beds
- Crowborough Intermediate care unit additional 2-6 beds

This had an impact on the results of the safer staffing results seen in appendix 1

Using the data available for the inpatient review of staffing levels it provides information that there is the need to increase the current funded establishment. This is as outlined in appendix 1 but for the Trust totals:- 16.56 WTE Registered Nurses and 10.02 WTE Health Care Assistants; however each of the clinical units is reviewing this in light of changes to bed configurations and activity. Once this data is available the CU's will develop the necessary business cases.

4. Enhanced observation shifts (special shifts)

In the course of this review a number of enhanced observation or 'special shifts' were required and have therefore been considered. These shifts are commonly used to provide one to one care for patients who may be confused and wandering, therefore at risk of absconding or falling and sustaining injury or have special care requirements such as airway management. As these shifts are in addition to the current ward establishments they are frequently filled by agency workers who are not permanent staff and come at a premium cost to the Trust. The Trust has seen a considerable increase in the use of such shifts over the last year and further work is required to ensure a robust process for obtaining staff to cover these shifts. Furthermore, a reduction in the use of temporary staff with an increase in establishment and employment of substantive staff will reduce clinical risk.

5. Safer staffing: Care contact time

Following on from the safer staffing establishment review in November 2014 NHS England published 'A Guide to Assessing Care Contact Hours' As part of the drive to deliver safe and effective care, it was decided to develop a guide for providers identifying 'care contact time'. The guide published sits alongside the National Quality Board (NQB) guidance; NICE guidelines and NICE endorsed safe staffing toolkits, to give providers a suite of toolkits to support them in making decisions to secure safe staffing for their patients and service users.

In undertaking their duties, it is acknowledged that a range of elements make up the role of the nurse or midwife. All of these are important in ensuring that the patient receives the best possible quality of care. It is important to note that whilst a significant element of nursing and midwifery staff time should be spent providing direct care, such as patient hygiene, this needs to be balanced with indirect patient care. For example, attendance at multi-disciplinary ward rounds or liaising with families to plan discharge, as well as other activities, such as supporting and mentoring students and newly qualified nurses or midwives.

There is an expectation that a baseline assessment will be completed by the end of autumn 2015. The Senior Nursing team is currently working on a tool for data collection along with those activities to be measured.

6. Finance

The potential increase to staffing establishment would represent an investment in nursing establishments. Evidently, whilst this is a significant requirement for investment proposed at a time of financial challenge, the recommendations of this would be that this is a sustainable method of providing safe staffing levels and reducing temporary staff and agency costs.

7. Conclusions/Recommendations

The triangulation of 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.

Each clinical area is compliant with NICE guidance of actual versus planned staffing levels. All areas are reviewed daily to assess their safety, and appropriate actions taken, as required. Further work will be completed to ensure that current practice compares to best practice.

The clinical units identified as where more staff are indicated are reviewing further the data sets to ensure that any necessary workforce actions are taken based on more data than was available from one collection and business plans will then be developed

The Board is asked to note the content of the paper and Appendix 1 and 2 to support safe and effective care of inpatients within the Trust.

Lucy Scragg
Assistant Director of Nursing

Proposed Staffing for Inpatient Wards

Site	CU	Ward/Area	Budgeted Established Beds	FTE Budget 15/16 BWP	Average Staff Req	Prof Judgement Tool	Proposed Staffing FTE	Diff Bet Budget & Proposed Staff	Uplift RN's	Uplift HCA's
CONQ	Urgent Care	AAU	19	36.94		40.80	40.80	-3.86	3.86	
CONQ	Urgent Care	Baird MAU	28	39.09	42.22	40.80	40.09	-1.00	1.00	
CONQ	Surgery	Benson Trauma	28	33.43	39.42	32.20	33.43	0.00		
CONQ	Surgery	Egerton Trauma	28	33.70	36.86	32.20	33.70	0.00		
EDGH	Cardiovascular Clinical Ur	Berwick	28	35.60	40.88	28.21	35.60	0.00		
CONQ	Surgery	Cookson Attenborough Surgical Short Stay	12	14.68	15.80	0.00	14.68	0.00		
CONQ	Surgery	Cookson Devas Elective	20	24.25	16.64	22.87	24.25	0.00		
CROW	Out of Hospital	Crowborough Intermediate Care Beds	18	20.77	25.36	25.69	20.77	0.00		
EDGH	Specialist Medicine	Cuckmere	21	30.24	29.21	35.77	35.77	-5.53	1.89	3.64
CONQ	Surgery	De Cham	28	32.53	39.56	31.45	32.53	0.00		
CONQ	Surgery	Gardner	28	32.53	36.88	31.45	32.53	0.00		
EDGH	Cardiovascular Clinical Ur	EDGH CCU	11	27.13	17.11	18.13	27.13	0.00		
FIRW	Out of Hospital	Firwood beds	21	10.45	19.16	15.61	10.45	0.00		
EDGH	Surgery	Hailsham 3	17	22.18	32.97	20.72	22.18	0.00		
EDGH	Surgery	Hailsham 4	28	30.01	38.69	33.60	30.01	0.00		
BEX	Out of Hospital	Irvine Generic	24	26.07	28.56	50.88	26.07	0.00		
BEX	Out of Hospital	Irvine Stroke	18	26.07	30.62	0.00	26.07	0.00		
CONQ	Cardiovascular Clinical Ur	James/CCU	22	28.75	35.94	30.73	31.75	-3.00	3.00	
EDGH	Specialist Medicine	Jevington	27	38.23	40.15	40.80	38.23	0.00		
ML	Out of Hospital	Lewes Intermediate Care	28	35.77	36.05	35.77	35.77	0.00		
CONQ	Urgent Care	MacDonald Complex Elderly	28	35.76	44.64	43.32	42.49	-6.73	2.98	3.75
CONQ	Women and Children	Mirrlees	8	14.76	5.35	10.73	14.76	0.00		
CONQ	Urgent Care	Newington	28	36.83	47.80	36.49	39.67	-2.84	0.21	2.63
EDGH	Specialist Medicine	Pevensey Unit	17	30.77	18.69	19.93	30.77	0.00		
CONQ	Surgery	Richard Ticehurst SAU	26	38.28	33.69	37.89	38.28	0.00		
RMCC	Out of Hospital	Rye Intermediate Care Beds	15	18.90	16.92	18.13	18.90	0.00		
EDGH	Surgery	Seaford 3 MSSU/Frailty	29	38.13	38.25	38.28	38.13	0.00		
EDGH	Surgery	Seaford 4 - Urology	27	35.27	33.02	33.60	35.27	0.00		
EDGH	Cardiovascular Clinical Ur	Sovereign Ward	36	58.58	52.55	53.40	58.58	0.00		
UCK	Out of Hospital	Uckfield Harlands Intermediate Care Medical	14	18.14	14.11	18.13	18.14	0.00		
CONQ	Specialist Medicine	Wellington	20	32.15	31.10	35.77	35.77	-3.62	3.62	
		Grand Total	702.00	935.99	938.23	913.35	962.57	-26.58	16.56	10.02

Appendix 2

Establishment Review programme of work 2015

Clinical area	Tool	Date of review	Completion of review	Involved	Comments	Who to action	Update July 2015
Inpatient areas	SCNT and PJ	March 15	April 2015	ADN / BI and HONS/Matrons	Areas in scope identified in appendix 1		*Completed and recommendations to board in August*
Scubu	Badger/British association of Perinatal medicine	March 15	April 2015	AND/BI/Matron			*Update required ADN to action*
Paediatrics	Professional judgement	March 2015	April 2015		No changes to overall numbers of establishment however proposed changes between sites and skill mix. HON taking forward.	HON	*HON revised skill mix and working with GM re: costings*
Cath lab EDGH	Professional judgement	April 2015	June 2015		Number of sessions and minimal staffing levels considered: establishment integrated with CCU staffing. HON taking forward	HON	*Delayed due to HON leaving to be picked up by interim HON*
Cath lab Conquest	Professional judgement	April 2015	June 2015		Number of sessions and minimal staffing levels considered.	HON	*Delayed due to HON leaving to be picked up by interim HON*
Theatres	Professional judgement	April 2015	June 2015		Number of sessions and minimal staffing levels considered.	DHON	*Awaiting detail of review*

Clinical area	Tool	Date of review	Completion of review	Involved	Comments	Who to action	Update July 2015
ITU	Core standards for intensive care	May 2015	June 2015		Potential increase in staffing to meeting core standards and the shift leader/supervisory role.	DHON and CSM	*Awaiting detail of review*
OPD	Professional judgement	July 2015	Sept 2015		Clinic templates and admin review impact to be considered.	To be discussed	*On track*
Maternity	Birth-rate plus	June 2015	Sept 2015	LM and JC to lead	Awaiting tool. The tool will review both community and acute birth rate numbers and case mix. The results will present an overall configuration of WTE's.	HON	*On track*
A&E EDGH	Professional judgement and NICE draft tool	June 2015	August 2015		Very detailed amount of data collection required , Meeting set up in May 2015 to set up working group and support to carry out. Meeting arranged with meridian to review possibility of tool to collect data electronically	HON	*NICE guidance suspended June 2015.*
A&E Conquest	Professional judgement and NICE draft tool	June 2015	August 2015		Very detailed amount of data collection required , Meeting set up in May 2015 to set up working group and support to carry out Meeting arranged with meridian to review possibility of tool to collect data electronically	HON	*NICE guidance suspended June 2015.*
Community Nursing	Hurst model /NICE	July 2015	Sept 2015		HON attending, Master class in June 2015 with Keith Hurst to review proposed model for data collection	HON	*NICE guidance suspended June 2015. Await*

Clinical area	Tool	Date of review	Completion of review	Involved	Comments	Who to action	Update July 2015
AAU Conquest	No recognised tool	April 2015	May 2015 2015		No recognised tool recommendations of staffing increase based on professional judgement as per appendix 1		*Completed*
MAU SF1 EDGH	No recognised tool	tbc	tbc		No recognised tool		*tbc*
SAU Conquest	No recognised tool	tbc	tbc		Carried out SCNT however tool not designed for assessment ward will need reviewing with appropriate tool		*tbc*

East Sussex Healthcare NHS Trust

Date of Meeting:	5 August 2015
Meeting:	Trust Board
Agenda item:	7
Subject:	Patient experience Q1 2015/16
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

To inform the Trust Board about Q1 feedback from patient's about their experience when using services provided by the organisation.

Introduction:

Patient Experience provides feedback from patients and the public on their experience of the Trust. The information in this report outlines the Trusts position in Quarter 1 in the following areas:

- Friends and Family Test (FFT)
- NHS Choices
- Patient Advice and Liaison Service (PALs)
- Complaints including Parliamentary and Health Service Ombudsman (PHSO)

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

Friends and Family Test (FFT) Patient feedback

Inpatient areas achieved an overall satisfaction rating of 89.78%
The Emergency departments achieved an overall satisfaction rating of 85.71%
The Labour and Birth departments achieved an overall satisfaction rating of 85.47%
The overall satisfaction score of all patients surveyed during Q1 was 89.85%

NHS Choices

Of the 35 narratives posted 23 comments gave three stars or above with positive comments and 12 comments gave three stars or below with negative comments

Patient Advice and Liaison Service (PALS)

The total number of PALs contacts for Q1 2015/16 is 1959 this is a 12% increase compared to Q1 2014/15
The majority of concerns raised through PALs are related to communication and patient pathways.

Complaints Summary

In Q1 the Trust received 172 complaints compared to 190 in Q4 2014/15; this is a reduction of 9.5%.
Top 5 themes of the complaints received in Q1 remain unchanged on the previous quarter; patient pathway, provision of service, communication, standard of care and attitude
During Q1 a total of 2 PHSO enquiries were received both are being progressed to formal investigation

Benefits:

Triangulation at department, service and ward level with regular review of their patient feedback data arising from FFT, complaints, NHS choices, PALS and compliments is used to help improve services; patient pathways and front line care. Regular meetings will be held between the Patient Experience Lead, Complaints and PALs Manager and the Patient Experience Manager to triangulate further this information and create work plans.

Risks and Implications

Q1 highlighted little change in the 'themes' around patient experience. It is clear that further work needs to be done to improve the number of complaints about staff communication and attitude particularly within certain professional groups. The Learning and Development team are reviewing the provision of Communication Skills training. In addition, Duty of Candour training is being commissioned from an external training provider which will support staff to have open and honest conversation with patients and their family.

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. Further developments for example 'Patient Experience Champion' sessions are to be developed to feed into the Patient Experience Steering Group. This will allow further exploration into how positive changes can be made. In turn this can then be fed back to the Patient Experience Steering Group and learning can then be shared across the wider organisation.

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; CME; Trust Nursing and Midwifery Advisory Group

Proposals and/or Recommendations

The use of FFT has proven to be very helpful in monitoring patient experience. The collection of FFT data is soon to be refined as the Trust has committed to purchasing an upgrade to the Meridian system. Optimum the company will provide better support to enable improved data analysis and training to staff so that they can access this data themselves.

Re-establishment of the Patient Experience Steering Group will enable better reviewing and triangulation of data at a higher level across the trust. This group will review all feedback including information from National CQC surveys. The groups will monitor action plans with clinical units where appropriate.

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. Patient Experience Champions support this process and are made aware of the different sources of feedback data. They underpin the Patient Experience Strategy by raising awareness within their teams and encouraging continuous service improvement. All Information is to be reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing.

Finally, Datix (the provider of the Complaints and PALS reporting system) is to review the system set-up and make recommendations as to how improvement to the reporting can be made for example by adding appropriate sub categories. This will enable greater analysis to be undertaken and appropriate actions set accordingly.

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

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

East Sussex Healthcare NHS
NHS Trust

Patient Experience Report

Quarter 1 2015/16

1.0 Introduction

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

The information in this report outlines the Trusts position in Quarter 1 (Q1) in the following areas:

- Friends and Family Test (FFT)
- NHS Choices
- Patient Advice and Liaison Service (PALs)
- Complaints including Parliamentary and Health Service Ombudsman (PHSO)

2.0 Friends and Family Test (FFT) Patient feedback

2.1 Previously this report has presented a benchmark figure; the Net Promoter Score (NPS). A review of the FFT was published in July 2014 and made a number of recommendations. The FFT Review suggested that the presentation of the data should move away from using the Net Promoter Score (NPS) as a headline score and use an alternative measure. In line with this recommendation this report will move to using the percentage of respondents that would recommend/wouldn't recommend the service in place of the NPS.

2.2 Inpatient areas achieved an overall satisfaction rating of **89.78%** (based on 2790 responses in Q1) compared to **89.13%** in Q4 2014/15 (based on 2507 responses). The overall satisfaction has remained the same but the total number of responses has increased by 10% during Q1.

2.3 The Emergency departments achieved an overall satisfaction rating of **85.71%** (based on 4278 responses in Q1) compared **to 85.5%** in Q4 2014/15 (based on 4321 responses) which is static. Although the overall satisfaction has remained the same, the total number of responses has decreased by 1%, this is a further decrease as Q3-Q4 2014/15 had decrease by 8%.

2.4 The Labour and Birth departments achieved an overall satisfaction rating of **85.47%** (based on 357 responses in Q1) compared to **85.53%** in Q4 2014/15 (based on 213 responses). The overall satisfaction has remained the same, the total number of responses has increased by 40%.

2.5 The overall satisfaction score of all patients surveyed during Q1 was **89.85%** of all patients who used the Trusts services were satisfied (15399 responses). This overall satisfaction score has remained the same from Q4 2014/15 (which had an overall satisfaction score of 89.8%), the number of responders has increased by 6% (Q4 2014/15 total responses received14476).

2.6 The collection of FFT data is soon to be refined as the Trust has committed to purchasing an upgrade to the Meridian system. Optimum the company will provide better support to enable improved data analysis and training to staff so that they can access this data themselves.

2.7 Sample Patient Feedback from Family and Friends Free Text

Thank you to all the nurses and doctors. You are amazing!

I did not always understand the purpose of all my medication but, perhaps that was not required.

Every single member of staff could not have been more helpful and kind to the patients

Every member of staff has been incredibly friendly and helpful. No one makes you feel like you're in the way.

.
Would appreciate if I had been told what had actually been done in the operation without having to ask.

2.7 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. It has been identified that these boards are sometimes out of date, a bi weekly review of the boards will take place with the support of Patient Experience Volunteers (under the guidance of the Patient Experience Lead) to ensure that these are updated appropriately and regularly. The following tables provide some extracts of these Boards taken from Q1:

Littlington

You said	We did
1. Staff were friendly efficient and caring in all aspects of their admission and discharge. 2. Food could be improved. 3. Long time waiting for operation. 4. Car parking charges were high.	1. Continue to ensure all clients/patients were kept informed and up to date with all information regarding their admission. 2. Spoke to kitchen regarding some sandwiches being a little dry and they would pass information on to suppliers. 3. Have spoken to both Surgeons and administration staff to try to improve admission times to avoid long waits for patients. i.e. only am admissions coming in at 7.30. 4. Informed management regarding car parking fees.

Gardner Ward

You said	We Did
Best feedback: That our patients felt they were given enough privacy when being examined or treated. Worst feedback: That our patients felt they were occasionally bothered at night by noise from hospital staff	Whilst we always try to promote a restful environment for patients we hope that you understand that because we offer a 24 hour service we are often as busy at night as we are in the day time. We rely heavily on communication to allow us to keep you safe and for you to receive the appropriate treatment. We offer free ear plugs for patients and where appropriate we try to use the doors on the bays if it is safe to do so.

Seaford 4 MAU

You said	We did
You said that at times you feel the ward environment isn't clean enough stressing that dust gathers quickly. You said the length of time waiting for prescriptions could be improved and whether it is possible to give a patient a prescription to take themselves to the chemist at the hospital on their way home.	We have introduced cleaning assistants who help with the cleaning routine freeing our regular housekeepers to focus on their routine and nursing staff to focus on patient care. The results are a much cleaner ward and happier staff and patients. Our Pharmacy supplies medication to the hospital as well as the community and works as quickly as possible once they receive the prescription. Because of the extensive amount of medication our pharmacy department dispatches to different areas and an extra charge that would apply for individual prescriptions it is presently not possible for patients to collect their own medications from our in-house pharmacy.

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 rate the service using 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 35 narratives were posted on NHS choices during Quarter 1, this is a decrease 36% in posts compared to 55 in Q4 2014/15. It was noted that during Q4 there was an increase due to comments relating to the CQC report.

Of the 35 narratives posted 23 gave three stars or above with positive comments and 12 gave three stars or below with negative comments.

3.3 The following table shows the themes from the 35 narratives received in Q1.

For excellent ratings:	**For low ratings**
Staff kindness, efficiency and caring attitude. **Good communication.** **Many staff praised for their standards of care.**	***Accident and Emergency** **Staff attitude.** **Communication.** **Staffing levels (nursing and medical)**

** Please note this is a new theme this quarter*

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 all been raised during Q1 via NHS Choices. This route of patient feedback allows the Trust to comment, thank and sign post our service users.

3.5 NHS Choices information is disseminated to all Patient Experience Champions for distribution amongst their teams. If there is a specific positive or negative experience posted then the relevant Head of Nursing or Manager will be notified.

3.6 Some examples of the comments received and the feedback provided are shown below.

Examples of comments received and responses provided

Comments received	Our replies
Very pleased! I attend the Thoracic dept and am very very satisfied with my treatment there. My doctor is excellent and also their staff. Also a member of staff where I have my Breathing Tests. Also the staff at the check in are very efficient and nice. I have been attending a few years now and am very satisfied. Also in November 2014 attended A.E.D. by Ambulance with breathing problems and was also satisfied. Visited in June 2015. Posted on 20 June 2015	Thank you for expressing your appreciation of the service you received from staff in Respiratory Medicine at Eastbourne DGH. They will be pleased to hear that you are satisfied with the care and treatment they provided. They work very hard to ensure that all patients receive high quality care, and postings such as yours confirm that they are achieving this. It was very kind of you to take the time to provide feedback. We will ensure that your posting is shared with staff.

Still Awaiting biopsy results I was referred to the DGH by my GP to undergo a biopsy on the 3rd of March following a small lump that had formed on my forehead. The staff at the hospital were great, friendly and very polite and made me feel comfortable. The procedure itself was quick and straight forward and I was totally satisfied with the service. The nurse told me on my departure that if I hadn't heard from them within 3 to 4 weeks I should contact them. After 5 weeks of waiting I still had heard nothing so took it upon myself to call the hospital back. This is where my concern and disapointment with the service lay, I spoke to a member of staff, who was very pleasant and charming, who set out to find my file and inform me with what was happening. To my dismay I was told that the Consultant was on holiday and that a possibility for the delay in my results could be due to the fact that they were being sent from India!! I was shocked that this was the case and wasn't made any happier when the receptionist explained that results have been known to get lost and miss translated	We're concerned to read that there has been a mis-communication about the process of informing you about your biopsy results and that this has, not surprisingly, caused you alarm. If you are still not in receipt of your results, we urge you to contact the Patient Advice & Liaison Service (PALS) who will look into your individual concern. PALS assist patients by liaising with Trust staff on their behalf. They can be contacted on 01323 435886 or by email at esh-tr.PALSE@nhs.net. Please accept our apologies for the fact that your experience could have been better. We hope to resolve your concern as quickly as possible once you provide further details.

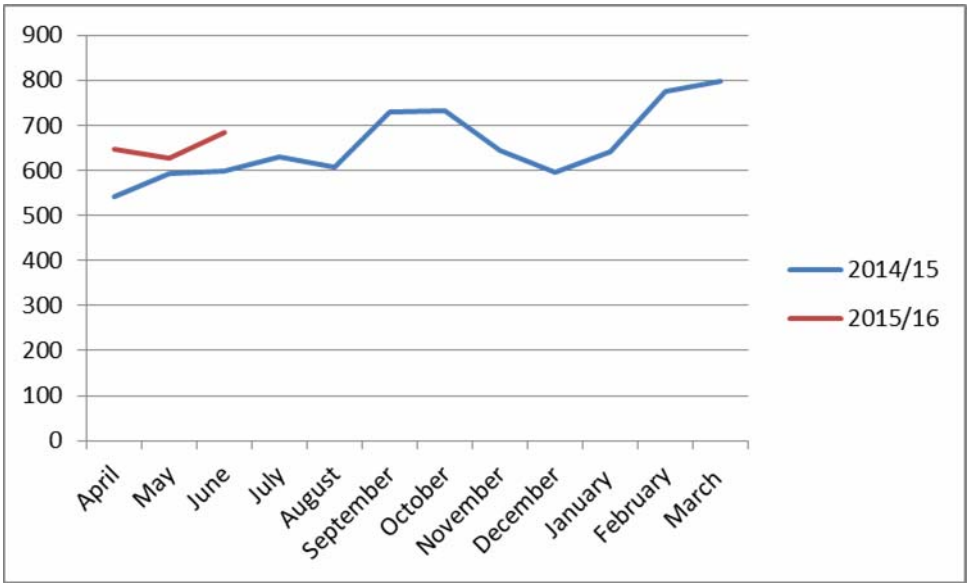
during this procedure. If anyone could shed any light on this or has had any similar situations I would be interested to hear as I am still waiting	

3.7 The Patient Experience Champion sessions are being developed to feed into the Patient Experience Steering Group, this will happen through monitoring of patient experience regarding the Champions specific area (trends and themes via NHS Choices, PALs contacts, complaints, plaudits, surveys completed). This will allow further exploration into how they can make changes which can then be fed back to the Patient Experience Steering Group, which can then be shared across the wider organisation. Initial analysis identifies that discharge planning will be one of the first priorities.

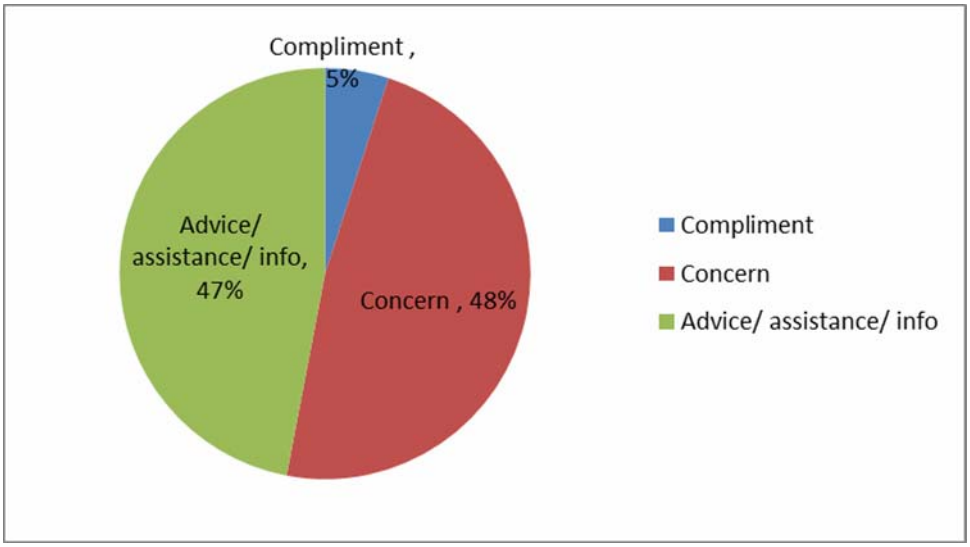
4.0 Patient Advice and Liaison Service (PALS)

4.1 The graph below shows the number of PALs contacts by month for 2014/15 and 2015/16. The total number of PALs contacts for Q1 2015/16 is 1959 this is a 12% increase compared to Q1 2014/15.

PALs contacts in Q1 2015/16 compared to 2014/15



4.2 The chart below shows the type of contacts which PALs received in Q1.



In Q1 48% of PALs contacts were concerns (total number of concerns 935) although the percentage remains the same as Q4 2014/15 the total number of contacts relating to concerns has reduced by 12% (Q4 2014/15 total concern raised 1066).

4.3 PALS are continuing to provide a rapid access point of contact for patient's and the public with 90% of concerns being responded to within 2 working days. The response rate has decreased from 92% in Q4 2014/15.

4.4 The table below shows the site in which the PALs contacts relate to:

Site	**Number of contacts in Q1**
Eastbourne DGH	1019
Conquest Hospital	899
Bexhill Hospital	16
Community (not Hospital)	14
Other	5
Uckfield Hospital	2
Crowborough Birthing Unit	2
Lewes Victoria Hospital	1
Crowborough War Memorial	1
Total	1959

4.5 The Q1 PALS concerns have the following outcomes recorded on Datix:

61% Completed with no further action

26% Provided with information

8% Work pending

2% Emotional support

1.5% Lost contact with PALS

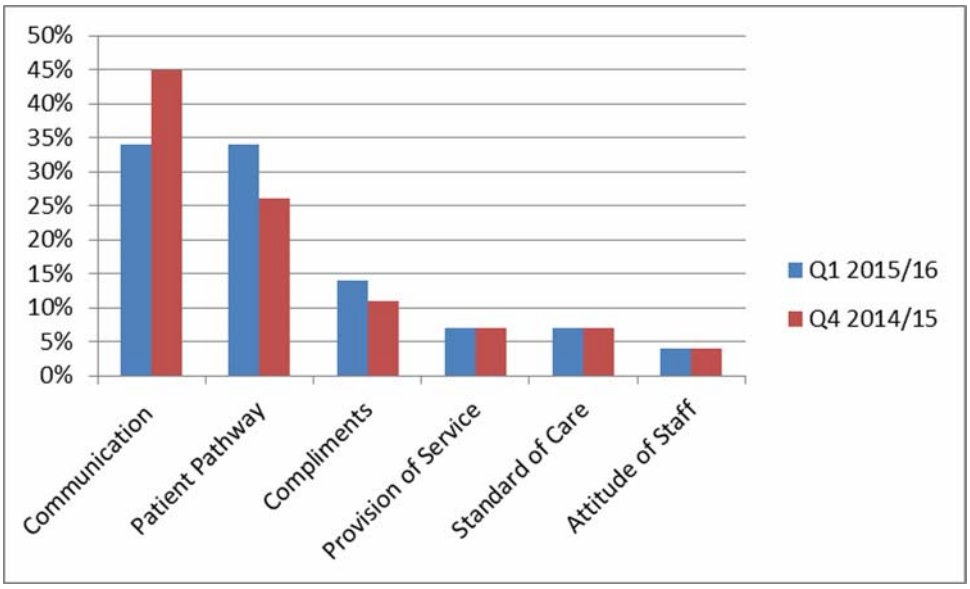
1% Referred to complaints

0.5 % Referred to another agency

1% of concerns raised were referred to complaints for investigation, this is reduction compared to Q4 2014/15 which was 2% and Q3 2014/15 was 3%.

4.6 The graph below shows the breakdown of PALS concerns by category as recorded on Datix.

Top PALs Themes in Q1 2015/16 compared to Q4 2014/15

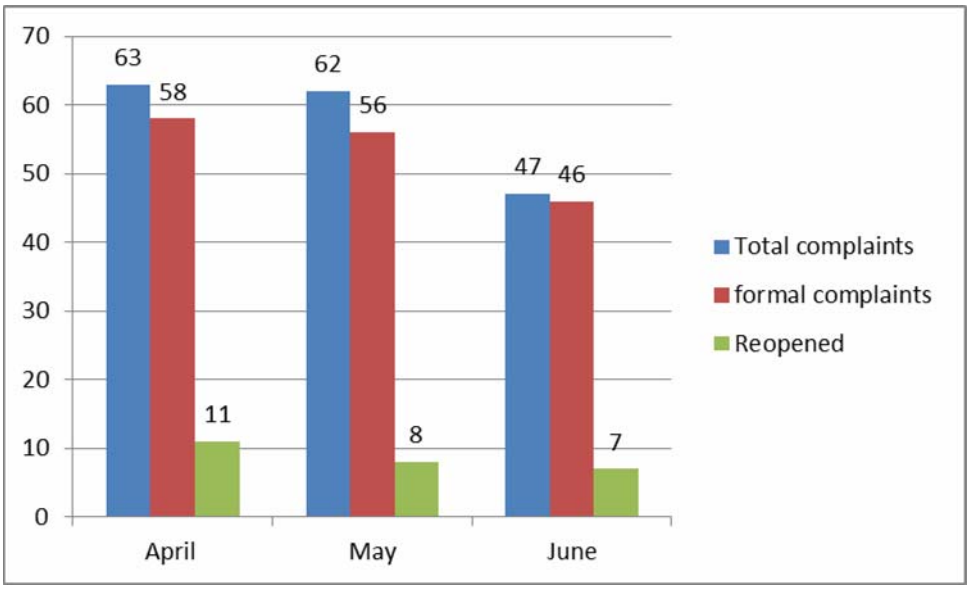


4.7 In response to this finding a number of actions are being taken. The Learning and Development team are reviewing the provision of Communication Skills training, with particular emphasis for Doctors (see 5.5 and 5.7). In addition, Duty of Candour training is being commissioned from an external training provider which will support staff to have open and honest conversation with patients and their family. Finally, Datix (the provider of the Complaints and PALS reporting system) is to review the system set-up and make recommendations as to how improvement to the reporting can be made for example by adding appropriate sub categories. This will enable greater analysis to be undertaken and appropriate actions set accordingly.

5.0 Complaints Summary (including Parliamentary and Health Service Ombudsman)

5.1 In Q1 the Trust received 172 complaints compared to 190 in Q4 2014/15, this is a reduction of 9.5%. The following chart shows the total number of complaints, formal complaints and reopened received per month:

New Complaints received in Q1



5.2 94% of complaints were acknowledged within three working days. Those complaints which were not acknowledged within the regulated time scale were complex in nature. It is recognise these should be acknowledged and action is being taken to rectify this. 94% is a slight decrease compared to Q4 2014/15 which was 96.4% complaints were acknowledged within three working days.

5.3 The number of complaints closed during Q1 was 172, this is a decrease compared to 188 in Q4 2014/15. 76% of complaints closed were responded to outside of timeframes (overdue).

5.4 Our position at the end of Q1 regarding overdue complaints was a total of 51 overdue cases.

Of the 51 cases which were overdue at the end of Q1, 27% of these were out of the Trusts control, 53% with Clinical Units and 20% were with the complaints team.

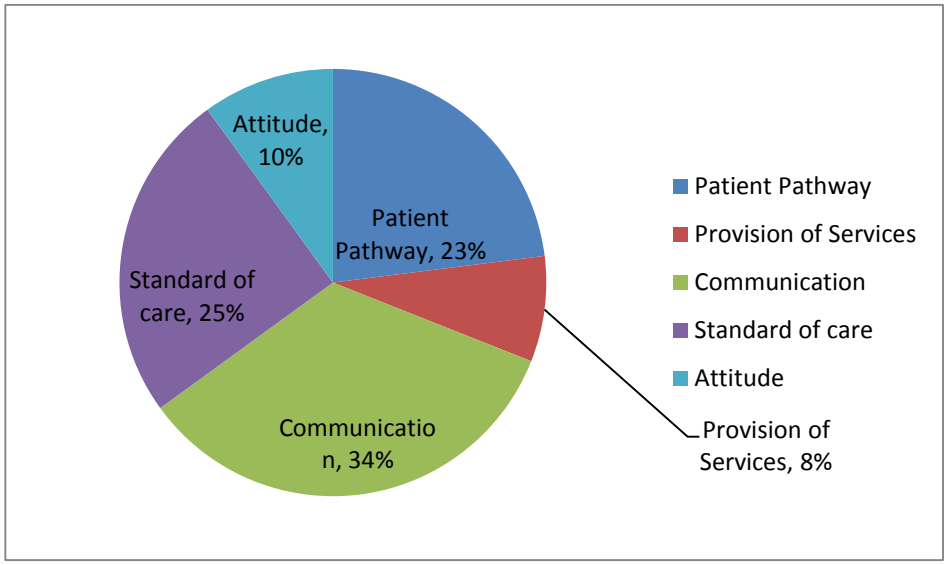
The Quality Assurance checks have continued in the absence of the Interim Complaints Manager, during Q1 the number of reopened complaints has decreased from 11 (April) to 7 (June). Initial findings would suggest that the Quality Assurance process is enabling the complaints team to ensure we are proving an adequate response which meets the needs of the complainant.

Shortcomings which continue to be identified through the quality assurance process (to date) include:

- Failure to provide dates and times of when events occurred
- Acceptance that an error occurred with no investigation as to how it happened – lack of root cause analysis and therefore learning
- No learning identified even when errors acknowledged
- No identification of the evidence that has been reviewed (e.g. medical records, specific policy or guidance)
- Failure to respond to complainant's specific concerns
- Incomplete responses sent to the Complaints team

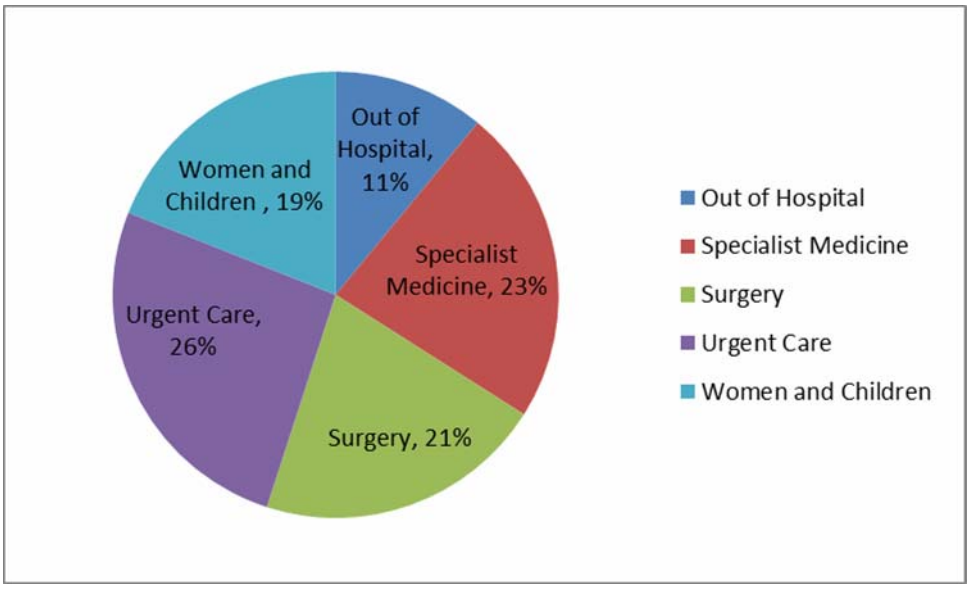
5.5 The chart below shows the top 5 themes of the complaints received in Q1 as recorded on Datix.

Top 5 Complaint Themes in Q1



5.6 The chart below shows the top 5 Clinical Units whose complaints had "communication" recorded on Datix as a subject:

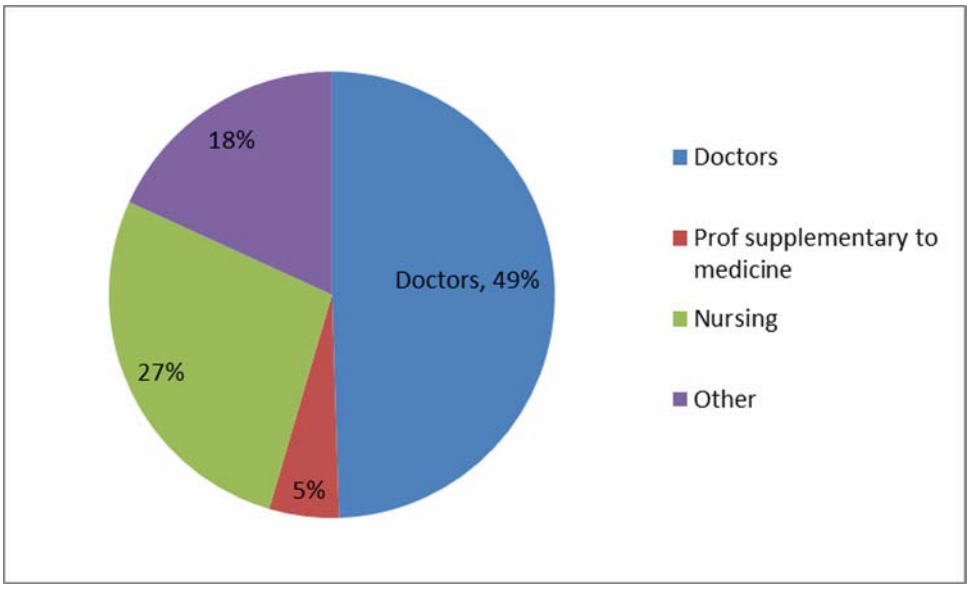
Top 5 Clinical Units with reference to communication Q1



5.7 In response to this action is being taken. With regards to the themes, further analysis is required to understand this and the work that Datix has been commissioned to undertake will support this (Datix will be reviewing our system in July and delivering training in September). The communication theme has been picked up with the PALS thematic analysis (4.7) and is being addressed with the review and provision of Communication Skills and Duty of Candour training.

5.8 The chart below shows the professions where a complaint has been raised against them (please note: “other” includes administrators).

Complaints against professions in Q4



5.8 The Learning and Development team are currently reviewing and considering the provision of Communication Skills training with particular emphasis for doctors. Concerns about doctors communication was also a theme that was fed back to the Trust from patients and family / carers during the Dignity Day hosted by the Trust in March 2015. The Complaints Manager will be delivering complaints handling training to all staff who may be asked to investigate a complaint. Consideration is also being given to a form of “customer care” training to all staff.

5.9 Outcomes/ lessons learnt themes from complaints closed in Q4.

Clinical Unit	**Lessons learnt**
Urgent Care	• Portacath training to be provided to all A&E staff.
Surgery	• Opthalmology to consider available capacity to reduce outpatient waiting times.
Specialist Medicine	• Central admin team to be given training for coding appointments.

5.10 As noted at 5.4 the quality assurance check process has identified that there has been a failure to identify the questions raised by the complainant at the start of the process, resulting in cases being reopened. A system is in place where new complaints are reviewed (triaged) and if the questions are not clear then the complaints team make contact with the complainant preferable by telephone to seek clarification of the questions raised within the complaint.

5.11 In order that we gain assurance that lessons from complaints have been learnt and actions implemented, from Q2 there will be a meeting with all Clinical Units to review the progress made. This format replicates the approach used to follow up actions from Serious Incidents and will be undertaken on a quarterly basis.

5.12 Parliamentary and Health Service Ombudsman Enquiries (PHSO)

During Q1 a total of 2 PHSO enquiries were received. Of these enquiries, the PHSO is currently progressing formal investigation on both cases.

During Q1 one PHSO case was closed with no further action and two were closed not upheld and one was partially upheld. All had undergone full investigation by the Ombudsman.

The actions required to address the case which was partially upheld:

- To give an apology to provide information on the falls policy.

6.0 Analysis and conclusion

6.1 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.

6.2 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.

6.3 It has been identified that the records of information on Datix has been incomplete. Datix training and review of our modules has been requested to ensure our reports are thorough and meet the needs and expectations of the Trust. Also to consider the addition of fields so greater understanding can be obtained around the issues of patient pathway and communication.

6.4 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. Once the Complaints and PALs Manager is in post regular meetings will be held between the Patient Experience Lead, Complaints and PALs Manager and the Patient Experience Manager to triangulate this information and create work plans.

6.5 Patient Experience work plan has been devised for 2015/2016 and is shared and monitored at the Patient Experience Steering Group. Clinical Units are required to have a representative at each meeting who is responsible for taking back the lessons learnt. All Information is triangulated and reviewed at quality review meetings chaired by the Director (and Assistant Directors) of Nursing.

6.6 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 categories.

7.0 Recommendations and Actions from the Report

Activity	Action	Timescale
Responding to patient complaints.	Significantly improve on the number of out of time complaints.	**Ongoing-** The quality assurance process has impacted on the time delay to complainants. Revised time scale July 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.	**June 2015-** Healthwatch feedback centre goes live 28th May 2015, ESHT is waiting for HW to provide ESHT with a subscription package which we would be able to buy into.
Recruit to Complaints and PALs Manager post	Advertise and recruit to Manager post	**Completed-** manager appointed, start date 3rd August 2015.
Implement post complaint survey	Survey to be sent to complainants	**July 2015-** revised time scale **September 2015**
Review of the 4C Policy	Review of 4C policy in line with national guidance	**Completed**
Meet with Clinical Units to review process for completing actions arising from complaints.	Meet Quarterly with Clinical Units to review the progress towards completing the actions.	**From May 2015-** meeting to take place during Q2
Consider specific patient survey relating to patient pathway, to identify areas of improvement.	Compile a survey; include patient's participation in the set up to ensure we are covering areas of concerns.	**August 2015**
Seek to find a greater understanding of the communication issues raised.	Further analysis into the data recorded on Datix by commissioning the delivery of a health check of our systems by Datix followed by training to the complaints and PALs teams.	**August 2015** This has been authorised, date to be agreed with Datix
Patient Experience Manager to work with clinical areas to improve the number of responses received FFT	Patient Experience Manager to work with Matrons to increase the response rate of FFT	**September 2015**

Patient Experience Manager
April 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	August 2015
Meeting:	Trust Board
Agenda item:	8
Subject:	Nursing revalidation – progress in ESHT
Reporting Officer:	Alice Webster, Director of Nursing

Action: This paper is for **(please tick)**					
Assurance	X	**Approval**		**Decision**	
Purpose:					
To provide assurance regarding the development of a nursing revalidation system in ESHT.					

Introduction:

Nursing and Midwifery revalidation will replace the current post-registration education and practice (PREP) standards i.e. the existing three-year renewal cycle and the 'notification of practice' form. The revalidation process supports the four main principles of the new Nursing and Midwifery Council (NMC) Code introduced in April 2015; revalidation will be implemented from 1st April 2016.

There are currently approximately 2200 nurses in ESHT, 160 nurses of whom are expected to revalidate by submitting the relevant documentation to the NMC between 1st February 2016 and 30th April 2016.

The four main principles of the new NMC code are to:

1. Prioritise people
2. Practise effectively
3. Preserve safety
4. Promote professionalism and trust

The process of revalidation will enable nurses and midwives to provide fuller and richer evidence of their continued ability to practise safely and effectively at the time they renew their registration. East Sussex Healthcare Trust (ESHT), as the employer of a large number of nurses and midwives, has a responsibility to ensure that they are supported to prepare for, and meet, the requirements of revalidation, alongside existing monitoring arrangements.

As a result, a business case was presented to the Business Planning Steering Group on 11.5.15 and the Clinical Management Executive team on 8.6.15 to request additional resources; 1 x wte Band 4 revalidation administrator post and 1 x wte Band 3 governance administrator post were approved. The Band 4 post will join the revalidation team; the Band 3 post will join the governance team to provide Appraisal Governance Reports (complaints and incidents) from DatixWeb.

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

This report provides assurance about the progress being made in ESHT to develop a nursing revalidation system in ESHT.

Benefits:

The overall aims of revalidation are to:

- Improve public protection
- Increase public confidence in nurses and midwives by allowing them to demonstrate that they are always fit to do their work.
- Ensure nurses and midwives on the register continue to meet NMC standards.
- Enable nurses and midwives to be accountable for demonstrating their continuing fitness to practise.
- Promote a culture of professionalism and accountability through on-going reflection on the Code and standards.

Opportunities presented by nursing revalidation

Nursing revalidation offers an increased opportunity to embed Trust values within nursing appraisals and medical appraisals; combined training and support for medical and nursing appraisers offers the opportunity for synergy and a unique and innovative opportunity for doctors and nurses to work closely together towards quality improvement.

As appraisers share their experiences and learning, they will be able to offer high quality appraisals to their appraisees and focus on key issues such as managing the Duty of Candour, managing complaints, managing patient and colleague feedback, issues of equality and diversity, Dignity at Work etc. in a consistent manner that aligns with Trust values.

Risks and Implications

The key risks for nursing revalidation, identified to date, are:

- Lack of awareness of nursing registrants of the change in requirements for registration
- Lack of awareness of Heads of Nursing & Governance, nursing appraisers and line managers in the change or requirements and their essential role
- The further need for increased resources within ESHT to provide a robust revalidation process
- The absence of the above may result in a large number of lapsed registrants who are unable to practise

Assurance Provided:

ESHT is developing and implementing support for nurses' revalidation.

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

Clinical Management Executive 8.6.15

Proposals and/or Recommendations

Members of the Trust Board are invited to receive this report as assurance of progress being made for the support of nurses' revalidation in ESHT.

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: Alice Webster or Debbie McGreevy	**Contact details** Alice Webster: 01323 435855 or 07825197426 Debbie McGreevy: 01323 413802 or 07554 439098

East Sussex Healthcare NHS
NHS Trust

NURSING REVALIDATION IMPLEMENTATION IN ESHT

1.0 Introduction

This report provides information on how the nursing revalidation system and processes are being developed and implemented in ESHT.

2.0 Background

Unlike medical revalidation, which requires a Responsible Officer, nurses are required by the Nursing & Midwifery Council (NMC) to meet a range of revalidation requirements designed to show that they are keeping up to date and actively maintaining their fitness to practise. Nurses are expected to demonstrate evidence of:

- Practising a minimum number of hours
- Undertaking continuing professional development (CPD)
- Obtaining feedback about their practice
- Reflecting on the Code, their CPD and feedback about their practice
- Providing a health and character declaration
- Having appropriate cover under an indemnity arrangement

Once nurses have met these requirements, they will need to discuss their revalidation with a third party confirmer and they will need to be able to provide them with evidence of meeting these requirements. Every three years each registered nurse will be asked to apply to the NMC for revalidation using NMC Online. It is the NMC that decides ultimately whether a nurse is fit to practise and not the confirmer. The confirmer is usually the nurse's line manager but it can be another health care professional such as a doctor, dentist or pharmacist in cases where there is not another registered nurse available to provide confirmation.

3.0 Nursing revalidation in ESHT

Of approximately 2200 nurses in the Trust, there are approximately 160 nurses due for revalidation between 1st April 2016 and 30 June 2016. These nurses can submit their confirmations to the NMC two months before their revalidation date (all confirmations must be sent by the end of the same month of their revalidation date) which means that confirmations and revalidations can take place from 1st February 2016.

These nurses in particular will need to be provided with targeted support as soon as is practicable so that they understand what they need to do. Equally, nursing appraisers need to be advised on how to undertake nursing appraisals that comply with NMC guidance. All nurses will benefit from guidance as nursing revalidation progresses. It is anticipated that progress on developing and implementing nursing revalidation will be restricted until recruitment to the administrator posts is successfully completed. The interim work will focus on developing training for nursing appraisers and the introduction of appraisal templates that align NMC requirements and the Trust values. The Trust will rely on an internal database for nursing appraisal and revalidation monitoring purposes; the implementation of this will also be delayed until further administrative support is available.

4.0 Revalidation team reformation

The medical revalidation team will now be known as the 'revalidation team'. Two revalidation administrators will have similar job descriptions for business continuity purposes and they will each support both doctors and nurses with medical and nursing revalidation.

5.0 Incident and complaints reporting

An administrator will also be based in the governance team and this person will provide Appraisal Governance (incidents and complaints) reports for all nurses and doctors on an annual basis for their appraisals and on request; these reports will also inform Clinical Units by providing a clinical governance monitoring tool that identifies issues and trends in complaints and incidents concerning individual healthcare workers.

6.0 Governance & Quality Assurance arrangements

6.1 Revalidation team

The Assistant Director – Revalidation will continue to be managerially accountable to the Medical Director/Responsible Officer and to her line manager, Assistant Medical Director – Workforce for medical revalidation and job planning. The Assistant Director - Revalidation will also be accountable to the Director of Nursing for nursing revalidation.

6.2 Heads of Nursing & Governance

The Heads of Nursing and Governance (HoNs) will be accountable for nursing appraisal compliance within their Clinical Units. Training will be offered to the HoN with regard to nursing appraisal requirements by the Assistant Director - Revalidation and the Head of Learning & Development. Ongoing support will be provided by the revalidation team.

Training will also be offered to other nurses who will become confirmers and/or nursing appraisers, with specific regard to appraisals, their roles and responsibilities, the process and how to provide support to nurses.

6.3 Quality Assurance and Performance reports – nursing appraisal compliance

Nursing appraisal performance reports will be provided at regular intervals for Trust Board from April 2016; an annual report will be developed for Trust Board in the summer of 2016; support for a Trust Board seminar can be provided on request by the revalidation team.

6.4 Nursing Revalidation Advisory Panel

A Nursing Revalidation Advisory Panel (NRAP) will be developed with full terms of reference and the suggested following objectives, for example, to:

a. Provide oversight and scrutiny of nursing appraisal outputs and relevant documentation in order to provide assurance to the Director of Nursing that these comply with NMC guidance; the inclusion of patient and public representatives on this panel is highly recommended;

b. Provide clinical governance assurance to the Director of Nursing in the process of identifying trends in complaints and incidents for individual nurses with data provided by the governance team; the Heads of Nursing & Governance will have the responsibility of monitoring this data within their Clinical Unit;

c. Provide robust quality assurance of the nursing appraisal process and the nursing appraisers

There is the potential to merge the Medical Revalidation Advisory Panel with a new Nursing Revalidation Advisory Panel in the future.

6.5. Nursing Revalidation & Appraisal Policy

A nursing revalidation and appraisal policy will be developed and monitored by Assistant Director - Revalidation. All policies will be submitted for ratification by the appropriate committee.

7.0 Training

Following the initial nursing appraisal training in the autumn of 2015, the Assistant Director - Revalidation will offer training to new nursing appraisers and those likely to be confirmers. Brief revision training may also be offered and extranet support etc will also be available to all nurses and nursing appraisers via the revalidation team.

In the medium to longer term, synergy and economies of scale between medical and nursing appraisals will be promoted by the use of combined regular medical and nursing appraiser update training; there are many common elements such as the Trust values, quality assurance, information governance, equality and diversity, public and patient involvement, quality improvement, clinical governance etc.,

8.0 Appraisal and Portfolio Documentation Management

Nursing appraisal and template revalidation portfolios will be supported by appraisal documentation developed by the Assistant Director – Revalidation in collaboration with the Head of Learning & Development in order that appraisal also accommodate the Trust Values, the Chief Nursing Officer's 6 Cs in nursing (care, compassion, competence, communication, courage and commitment) and the NMC's new Code.

Appraisal documentation will align with real time NMC guidance and it will be amended immediately if and when it is updated by the NMC, with support offered to nurses and nursing appraisers via email, extranet and by their contacting the revalidation team. It has been agreed and arranged with our IT team that there is sufficient space on our server to provide an 'Appraisal folder' for each of the nursing appraisers if required.

A folder can also be set up for each of the nurses - if they wish any of their appraisal or portfolio documentation to be centrally saved so that it is backed up in a secure setting. Arrangements have been made that these documents can be stored (and therefore accessed via the revalidation team) for at least ten years, free of charge to the nurse. Nurses will need to manage their portfolio independently of the web but will be provided with a template and guidance to assist them. Nurses will be able to take their portfolio with them if they leave the Trust without any third party intervention.

9.0 Summary

Nurses will be supported through nursing appraisals and nursing revalidation in ESHT although this will be restricted in its scope as resources are limited.

10.0 Recommendation

The Trust Board is asked to receive this report as assurance that systems and processes in ESHT are in progress to support nurses through nursing revalidation.

Alice Webster, Director of Nursing, August 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	5 August 2015
Meeting:	Trust Board
Agenda item:	9
Subject:	Medical Revalidation Annual report 2014 - 2105
Reporting Officer:	Dr David Hughes, Medical Director & Responsible Officer

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

Purpose:

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

The Chief Executive and/or the Chair of the Trust Board will be asked to sign a statement of compliance following presentation of this report that will be submitted to NHS England before 30.9.15

Introduction:

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

This paper provides information about medical revalidation and medical appraisals in ESHT from 1st April 2014 to 31st March 2015.

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

The paper provides data and information for the year 2014 - 2015 about:

1. Governance and assurance
2. Appraisal benchmark data
3. Appraisal compliance
4. Revalidation data
5. Audit findings for missed appraisals
6. Public and patient involvement in appraisals
7. Quality assurance of appraisal outputs and process
8. Challenges for medical revalidation

The paper also provides information about the NHS England Independent Verification Visit that took place in December 2014. ESHT scored EXCELLENT for its core standards relating to responsibilities of the Designated Body and Appraisals. The Trust also scored 'COMPLIANT' for performance monitoring and HR processes.

Benefits:

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

Risks and Implications

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

1. The RO (and therefore ESHT) will be in contravention of the Medical Professions (Responsible Officers Regulations) 2010 and 2013;
2. The RO will be unable to make recommendations to the GMC about the fitness to practise of doctors employed in the Trust;
3. The doctors in the Trust are at risk of operating without a licence to practise;
4. The Trust would be unable to offer assurance to regulators, patients or public about the fitness to practise of the doctors employed in ESHT and there would be a loss of confidence in the Trust and damage to its reputation;
5. Doctors may not receive quality assured medical appraisals with all the benefits they confer for their personal development;
6. Timeliness of remediation would be affected with likely consequences for patient safety;
7. ESHT would be exposed to increased risk for clinical negligence claims, poor practice and reduced quality of patient care and patient safety;
8. ESHT may lose its CQC registration and NHSLA cover.

Assurance Provided:

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

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

Medical Revalidation Advisory Panel 15 May 2015
Clinical Management Executive 8 June 2015

Proposals and/or Recommendations

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

The Chief Executive and/or the Chair of the Board is/are asked to sign off the attached compliance statement so that it can be submitted to NHS England before the deadline of 31st August 2015.

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

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

Medical Revalidation and medical appraisals apply to all trained doctors with a prescribed

connection to the Responsible Officer therefore no risk to Equality & Human Rights has been identified.

For further information or for any enquiries relating to this report please contact:	
Name: Dr David Hughes or Dr Debbie McGreevy	**Contact details: EDGH Ext (13) 6253 or 6285**

East Sussex Healthcare NHS
NHS Trust

MEDICAL REVALIDATION ANNUAL REPORT 2014 - 2015

1. Introduction

This report provides information about the medical appraisal and revalidation system and processes over the year 2014 – 2015, highlighting key issues and actions being taken to respond to them.

On 31st March 2015 there were 317 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director – Governance.

The Trust has again achieved a very high medical appraisal compliance status for 2014 – 2015 with almost 99% (313) of all doctors having their medical appraisal within the required timescales. Of the remaining four doctors at 31 March 2015, three are presently in the process of undertaking their 2014 – 2015 appraisal and one is formally authorised to defer their appraisal.

2. Background

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

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the Trust Board of ESHT will oversee compliance by:

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

3. Governance and Quality Assurance

NHS England provides a Framework of Quality Assurance for Responsible Officers (FQA) and this has been published by the Department of Health. The framework details the combined approaches to achieving quality assurance so that the Responsible Officer has confidence that the doctors working in ESHT are up to date and fit to practise. It comprises of the following elements:

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Core standards:

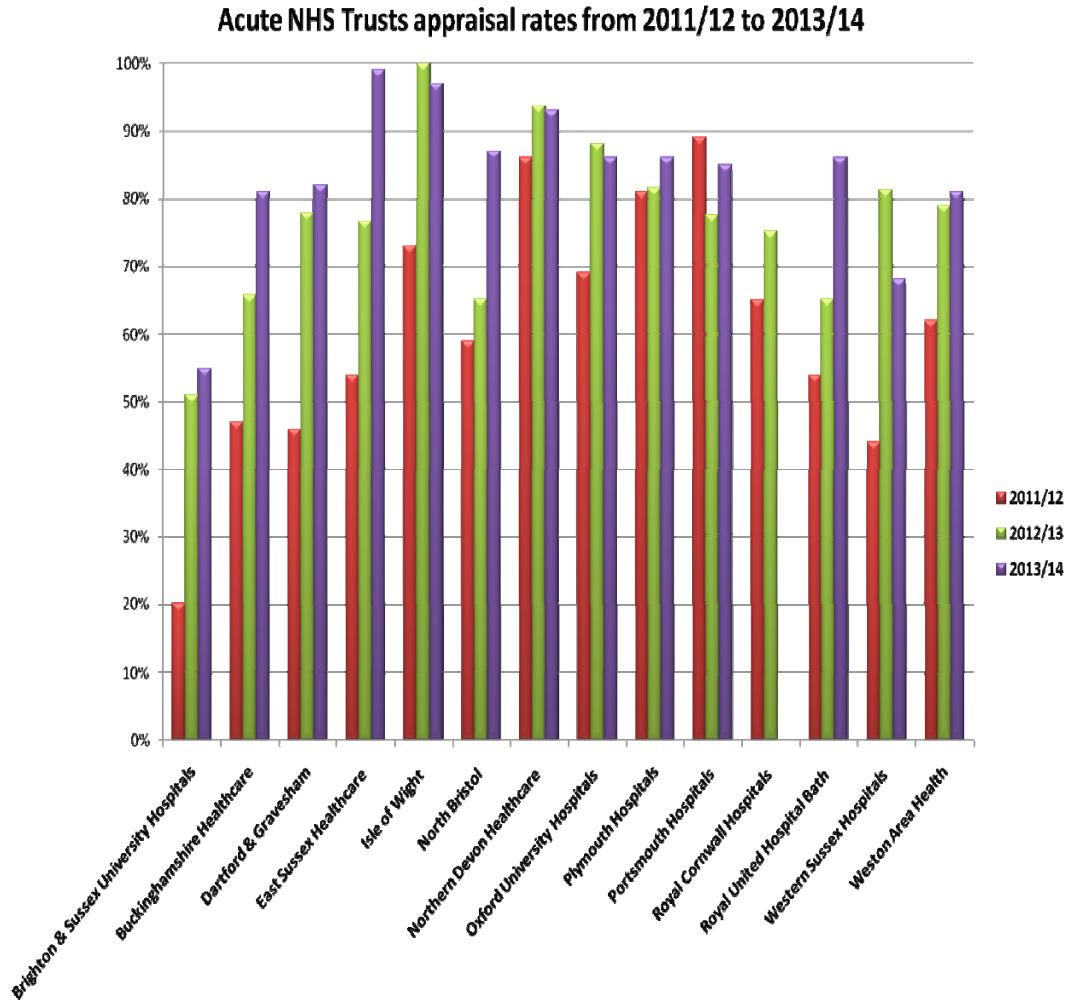
Core standards are a comprehensive overview of the requirements of the Responsible Officer regulations and associated mandatory guidance within a single document. ESHT is compliant with 97 of the 107 core standards; actions have been identified to address those relevant to ESHT, with which we are not yet fully compliant. These actions are monitored through the Quality and Standards Committee.

Quarterly information template:

This reporting process maintains quarterly communications between Responsible Officers at local level and their higher level Responsible Officers, to whom they are linked. This information provides ESHT appraisal rate data to be shared with NHS England regularly. A monthly performance report/dashboard with narrative is also provided to the Trust Board so that assurance is given that the medical appraisal compliance status is steadily increasing during the year.

Annual Organisational Audit (AOA):

The AOA is a mandatory audit that all Responsible Officers are required to complete. This is a standardised return to the higher level Responsible Officer and ultimately to Ministers and the public on the status of the implementation of revalidation across England. This information forms the benchmark across the NHS region and the chart below, provided by NHS England, shows that ESHT has consistently improved its medical appraisal rates, achieving the highest compliance in the region last year for an acute hospital trust.



Trust Board Annual Report:

Trust Boards are responsible for monitoring the organisation's progress in implementing the Responsible Officer regulations. The Trust Board annual report is one method of informing the Board of the achievements, challenges and compliance status in ESHT with regard to medical appraisals and medical revalidation

Statement of Compliance:

The Responsible Officer Regulations include the requirement of Designated Bodies such as ESHT to provide adequate support to the Responsible Officer. The Chair of the Trust Board or the Chief Executive is asked to sign a statement of the organisation's compliance with the RO Regulations. This is submitted to the higher level Responsible Officer. The statement of compliance accompanies this Trust Board annual report.

Independent Verification:

All Designated Bodies undergo a process to validate their system at least once in each 5 year revalidation cycle. An extensive audit is conducted of evidence that provides assurance to the higher level Responsible Officer. An Independent Verification visit was made to ESHT in December 2014 by NHS England. The report declares that ESHT achieved a rating of 'EXCELLENT' for core standards relating to responsibilities of the Designated Body and Appraisals. The Trust scored 'COMPLIANT' for performance monitoring and HR processes.

Examples of good practice in ESHT, as identified by NHS England representatives, included: Trust Board engagement in medical revalidation by holding an informative seminar; collaborative working with local hospices and the Appraisal Lead's advice to them with regard to their relevant clinical governance processes; Medical Appraisers feel valued and praised the support they received from the Medical Revalidation team; the Trust extranet site for medical revalidation; the use of external case investigators when relevant.

4. Policy and Guidance

The Medical Revalidation and Medical Appraisal Policy and the Remediation Policy have been revised to reflect recent changes required in process and procedures and they are in the process of being ratified formally.

5. Medical Revalidation and Medical Appraisals

5.1 Appraisal and Revalidation Performance Data

The GMC provides web based access to ESHT revalidation data via GMC Connect. The revalidation status of all doctors who claim a prescribed connection to the Responsible Officer and ESHT as their Designated Body features on this site. The list of doctors with a prescribed connection is cross checked each month against a list provided by the Medical Recruitment team and when doctors leave or join the Trust.

5.2 Revalidation Recommendations in ESHT between 1 April 2014 – 31 March 2015

Table 1. Revalidation Recommendations in ESHT 1.4.14 – 31.3.15

Positive recommendations	99
Non engagement notifications	0
Recommendations completed on time	108
Recommendations completed not on time	0
Deferrals requests	9
Reasons for all missed or late recommendations	n/a

ESHT has not missed any of the deadlines for recommendation for revalidation. There are 121 revalidation recommendations due between 1st April 2015 and 31st March 2016.

The reasons for deferrals are as follows:

- Four deferrals were requested to allow time for doctors to provide sufficient supporting information in the form of multisource feedback ('360 report')
- Four deferrals were requested for new starters to provide them with sufficient time to have their appraisals and to prepare supporting information for their medical revalidation recommendation
- One deferral was requested as the doctor had been on long term sick leave and needed more time to prepare for their medical appraisal

5.3 Table 2: Medical Appraisals in ESHT between 1 April 2014 – 31 March 2015

ESHT reporting process:	Total	Green	%	Amber	%	Red	%
Consultants	212	210	99.1%	0	0.0%	2	0.9%
SAS/Trust Grade	85	83	97.6%	0	0.0%	2	2.4%
LAS	20	20	100.0%	0	0.0%	0	0.0%
Total Number of Doctors with Prescribed Connection	317	313	98.7%	0	0.0%	4	1.3%

KEY:

98.74%	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
0%	Doctors who have NOT had an appraisal since 1st April 2014 but who are expected to have an appraisal before the end of April 2015
1.3%	Doctors who have NOT had an appraisal since 1st April 2014 and are now undergoing the non-engagement process

On 31st March 2015 there were 317 doctors in the Trust claiming a prescribed connection to the Responsible Officer, the Medical Director – Governance.

The Trust can boast a very high medical appraisal compliance status for 2014 – 2015 with almost 99% (313) of all doctors having their medical appraisal within the required timescales.

5.4 Methods of reporting appraisal compliance

5.4.1 NHS England/GMC method of reporting:

There are two methods of reporting compliance with medical appraisals i.e. the method prescribed by NHS England/GMC and the other is the ESHT method which has a smaller timescale to define compliance.

The method of reporting medical appraisal compliance is prescribed by NHS England/GMC as follows:

1a is a completed annual medical appraisal whereby the appraisal meeting has taken place between 9 and 15 months of the date of the last appraisal, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.

1b is a completed annual medical appraisal whereby the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- a period of time of less than 9 months or greater than 15 months from the last appraisal has elapsed;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;
- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.

However, in the judgement of the responsible officer, the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

Where the organisational systems of the designated body do not permit the parameters of a '*Category 1a* completed annual medical appraisal' to be confirmed with confidence, the appraisal should be counted as a '*Category 1b'.* For example, new starters in the Trust have recently been confirmed as belonging to Category 1b, by NHS England.

5.4.2 ESHT method of reporting:

In ESHT, the medical appraisal cycle runs from April to December each year. If it is agreed by the Responsible Officer that, due to exceptional circumstances, an appraisal may take place between January and March, an additional appraisal must be undertaken by the end of December in the same year. Every doctor should have an appraisal in the anniversary month, or before, of their previous appraisal. Doctors who conform to this and/or have their appraisal within 365 days of their last appraisal are reported as being compliant.

ESHT's medical revalidation team contacts all doctors joining the Trust and provides them with supporting information including the expected month of appraisal; this is particularly significant in situations where their previous appraisal took place between January and March or if they have not had an appraisal within the twelve months before joining ESHT. Doctors are expected to have an appraisal within six months of joining ESHT if they have not had an appraisal within the previous 12 months.

If doctors have had a medical appraisal within the last 12 months, and it was not conducted between January and March, the doctor will be expected to inform the Medical Revalidation team, who will then make every effort to provide a medical appraisal no later than their annual appraisal anniversary month. Therefore, doctors are reported as being compliant until they have been in the Trust for six months. After this time, if the doctor has not had an appraisal, they are reported as being non-compliant.

5.4.3. Summary of reporting methods:

The two methods of reporting compliance status with medical appraisals currently requires two different sets of data as supplied to the Trust Board and to NHS England.

NHS England has recently indicated that it is considering aligning its reporting criteria to those similar to ESHT and that the 15 month timescale, currently permitted by the GMC, may be reduced in the future.

ESHT will continue to expect doctors to have their medical appraisal on or before their appraisal anniversary month each year.

5.5 Appraisals completed by 31 March 2015 by Clinical Unit

Table 3. Appraisals completed by 31 March 2015 by Clinical Unit

Clinical Unit	**Number of doctors**	**Number of completed appraisals**	**Number of doctors who have not had an appraisal for the year 2014 - 2015**	**Number of new starters not due an appraisal until next cycle***
Cardio Vascular	20	18	0	2
Clinical Support	35	33	1	1
Specialist Medicine	31	28	0	3
Surgery	89	80	2	7
Theatres	53	51	1	1
Urgent care	39	36	0	3
Women & Children	50	46	0	4
Totals	**317**	**292**	**4**	**21***

* These doctors are compliant with ESHT Medical Revalidation and Medical Appraisal Policy.

5.6 Missed appraisal audit

It is felt that one of the contributing factors in the high medical appraisal compliance status in ESHT is that doctors are reminded of their annual appraisal on at least two occasions. However, some doctors do miss their appraisals and an audit is conducted for all missed appraisals, whether approved or otherwise, and the reasons for these are provided here in Table 4.

A missed appraisal is defined as either approved or unapproved. Approved missed appraisals are where the Responsible Officer has authorised a postponed or cancelled appraisal. Three of the four doctors who missed the 2014 – 2015 timescales are in progress of having their annual medical appraisal and one doctor has been officially deferred.

Table 4. Reasons for missed or incomplete appraisals 2014 - 2015

Doctor factors (total) **N.B. These doctors have either since undertaken their annual appraisal, or are in progress, with the exception of one doctor.**	**Number**
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	4
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter not due to have appraisal in current year but due within six months of joining (authorised)	21
Postponed due to incomplete portfolio/insufficient supporting information (authorised)	3
Appraisal outputs not signed off by doctor within 28 days	3
Lack of time of doctor	7

Lack of engagement of doctor (unauthorised)	4
Other doctor factors (describe) • Doctor thought the appraiser would contact her and so missed her appraisal date • Conflict of interest with allocated appraiser – another appraiser was allocated • Two doctors had a break in employment at time appraisal was due – appraisal undertaken upon return for both doctors • Doctor only works at weekends and does not have Trust email – he only contacted us once he realised his revalidation recommendation was due • Doctor was late having his 2013-14 appraisal and he believed that it covered him for the year 2014-15; an appraisal was arranged but both doctor and appraiser were later named in the same complaint so it needed to be rearranged.	7
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors	0

5.6 Public and Patient Involvement

Doctors are supported in obtaining patient and public feedback, an essential component of their supporting information in preparation for their medical revalidation recommendation to the GMC by the Responsible Officer. The Trust provides this support through the Allocate Software system in order for each doctor to gather patient feedback.

In the last year, 95 doctors received patient and colleague feedback in a report that was discussed during their appraisal with their medical appraiser. This is one of the most important elements of the appraisal and revalidation process as it provides assurances about many facets of individual character and performance and includes colleagues' and patients' views about the fitness to practise of each doctor. Occasionally, the report indicates that one or more areas of feedback warrant support to the doctor, in the form of further personal development or training. In this case, the medical appraiser and doctor being appraised are encouraged to add relevant actions to the doctor's Personal Development Plan. All 360 reports are read prior to submission to the Responsible Officer recommendation to the GMC for medical revalidation.

A Public and Patient Representative has this year joined the Medical Revalidation Advisory Panel to provide oversight and scrutiny of medical revalidation processes. Work is in progress to increase the level of public and patient involvement in medical and nursing revalidation processes.

5.7 Medical Appraisers

NHS England requires that the Responsible Officer ensures that the Designated Body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection. Doctors from a variety of backgrounds should be considered for the role of appraiser. This includes associate specialist doctors in secondary care settings. An appropriate specialty mix is important and it is not possible for every doctor to have an appraiser from the same specialty. The recommendation for the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. ESHT attempts to have approximately 40 trained medical appraisers available each year so that each appraiser has an average of 8 – 10 appraisals to conduct in that time scale. This offers a ratio of approximately 1:9 appraisers to doctors in ESHT, taking into account locum doctors and doctors who leave and join the organisation each year.

ESHT currently has 35 trained medical appraisers with 5 new appraisers being trained during the early summer of 2015. Medical appraisers are provided with regular update training at least twice per year, when appraisers also have the opportunity to calibrate their professional judgements for medical appraisals. This means that medical appraisers are able to compare their appraisal decisions and outputs with other medical appraisers and align them with the NHS England and GMC requirements. Two training sessions were conducted during the medical appraisal year 2014 – 2015. At least two group sessions of medical appraiser training is planned during 2015 for all medical appraisers.

As part of the training process for medical appraisers, training needs are identified by the following methods:

1. auditing of the appraisal outputs by the medical revalidation team, particularly for new Medical appraisers who receive constructive feedback by the Medical Appraisal Lead on at least their first three appraisals and doctors who are due to be reviewed for revalidation;
2. Medical appraisers adding learning objectives about their medical appraiser role to their own Personal Development Plans (PDPs); and
3. Medical appraisers identifying learning needs during update training sessions so that they can be addressed within the group setting.

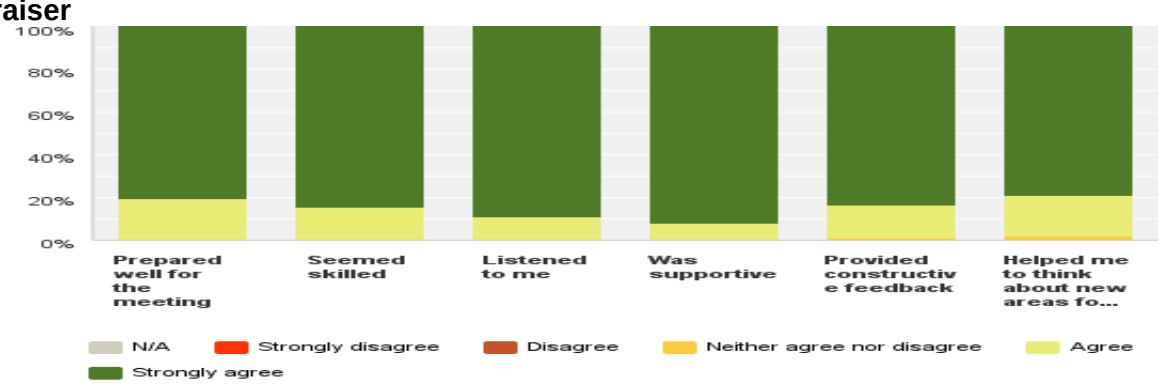
An Appraiser Review Summary provides details of the self identified learning needs of medical appraisers to the Medical Appraisal Lead; a thematic analysis of the learning needs is undertaken; this allows these learning needs to be formally incorporated into subsequent Medical Appraiser update training sessions.

The update sessions are also an opportunity to discuss any challenges that are posed by being a medical appraiser and these are addressed in an open forum when possible so that all appraisers can share their experiences and work together. Where certain issues are raised that can be addressed, such as appraisals being ‘bunched together’, the revalidation team can work with appraisers to ensure that appraisals are spaced out over the appraisal year. The medical appraisers and the medical revalidation team work well together in a spirit of co-operation and most issues are fully resolved with mutual respect and support.

The medical revalidation team offers advice and support to medical appraisers and both the team and medical appraisers receive very positive feedback. Tables 5 and 6 display a summary of this feedback for the year 2014 – 2015 and some free form comments are provided here.

Table 5. Feedback on medical appraiser performance by 243 ESHT doctors 2014 - 2015

My appraiser



	N/A	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
Prepared well for the meeting	0.00% 0	0.00% 0	0.00% 0	0.41% 1	18.93% 46	80.66% 196	243
Seemed skilled	0.00% 0	0.00% 0	0.00% 0	0.41% 1	15.23% 37	84.36% 205	243
Listened to me	0.00% 0	0.00% 0	0.00% 0	0.41% 1	10.70% 26	88.89% 216	243
Was supportive	0.00% 0	0.00% 0	0.00% 0	0.00% 0	8.23% 20	91.77% 223	243
Provided constructive feedback	0.00% 0	0.00% 0	0.41% 1	0.41% 1	15.64% 38	83.54% 203	243
Helped me to think about new areas for development	0.00% 0	0.00% 0	0.41% 1	1.65% 4	18.93% 46	79.01% 192	243

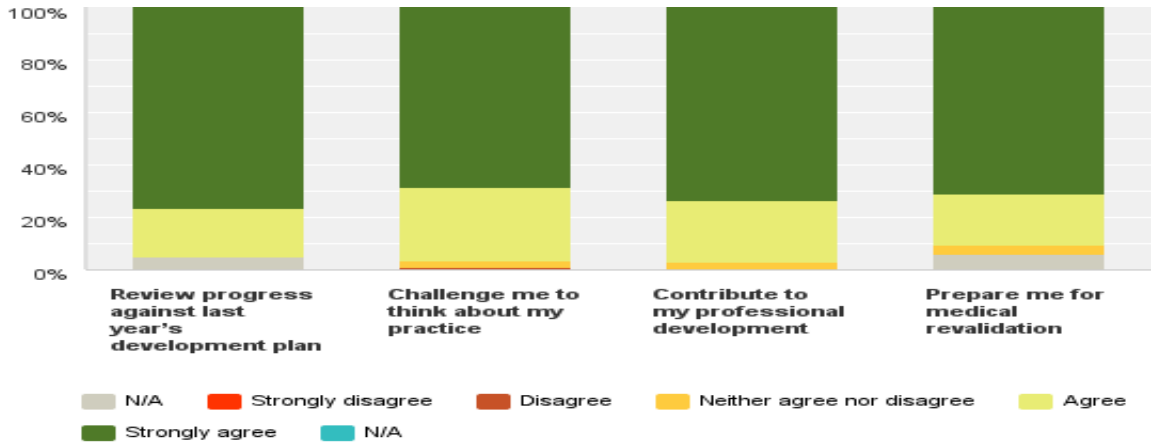
In each feedback questionnaire there is an opportunity for doctors to write comments about their appraiser. Some of these comments are included here, with many doctors seemingly making the shift from being cynical and reluctant to participate in medical appraisals, to now viewing them as a being a positive and constructive dialogue:

> “My appraiser was extremely supportive and for the first time, I saw the true purpose of appraisals. “

> “I felt that my appraiser provided a very professional assessment of my work and was supportive where I have failed to meet my targets.”

> “My appraiser had clearly taken time to review my MAG and other forms and was keen to learn and discuss my role in the Trust and to give constructive advice for career development. I found it a very helpful meeting. “

My appraiser was able to:



	N/A	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A	Total
Review progress against last year's development plan	4.94% 12	0.00% 0	0.00% 0	0.00% 0	18.52% 45	76.54% 186	0.00% 0	243
Challenge me to think about my practice	0.00% 0	0.00% 0	0.82% 2	2.88% 7	27.98% 68	68.31% 166	0.00% 0	243
Contribute to my professional development	0.00% 0	0.00% 0	0.41% 1	2.47% 6	23.46% 57	73.66% 179	0.00% 0	243
Prepare me for medical revalidation	6.17% 15	0.00% 0	0.00% 0	3.29% 8	19.75% 48	70.78% 172	0.00% 0	243

Medical appraisers receive regular training on core appraisal skills but also of any GMC updates and ESHT processes. This leads appraisers to become excellent sources of knowledge and champions for medical appraisals, one of the many reasons that the appraisal compliance in ESHT is so high, particularly compared with other Trusts. Our medical appraisers are highly valued and were this year nominated for a Trust Staff Award. Here are some further comments from doctors being appraised about their medical appraiser:

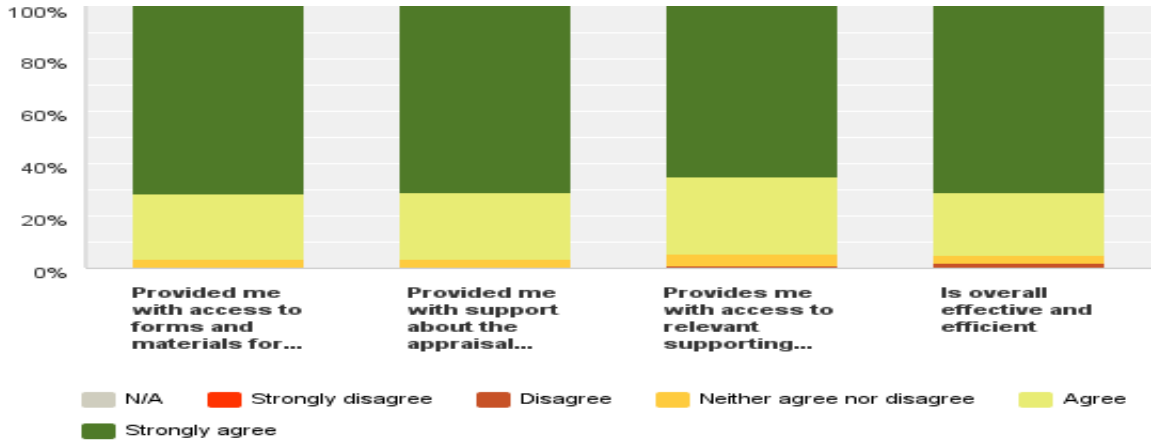
> "My appraiser gave me extremely good information on the appraisal and revalidation process. Last year's development plan and appraisal were reviewed prior to the meeting and preparation to discuss key areas had obviously been done thoroughly prior to the meeting, The Trust, hospital and department work was discussed at length and was incredibly valuable to me, especially at this early stage in my consultant career. I had been in continued contact with my appraiser prior to my appraisal and he was very helpful regarding the process. The actual appraisal was very professional, insightful and an overall enjoyable process that, thanks to the obvious experience and expertise in this area that my appraiser has, I feel I have gained much from."

> "My appraiser is an excellent, enthusiastic appraiser. He has taken the time to make me understand the process of medical revalidation, He has a very good understanding of the process and he has inspired me. "

> "It surpassed my expectations as a useful process, making me reflect on my work and goals, largely due to the skills, insight and help of my appraiser. "

"My appraiser was able to understand the departmental needs and my personal PDP needs; he guided me to achieve those in the future. My appraiser is an excellent appraiser as I was given new direction in my future plans. He is very supportive and helpful. "

Table 6.Feedback on medical revalidation team performance by doctors



	N/A	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
Provided me with access to forms and materials for appraisal	**0.00%** 0	**0.41%** 1	**0.00%** 0	**2.88%** 7	**25.10%** 61	**71.60%** 174	243
Provided me with support about the appraisal process	**0.00%** 0	**0.00%** 0	**0.41%** 1	**3.29%** 8	**25.10%** 61	**71.19%** 173	243
Provides me with access to relevant supporting information	**0.00%** 0	**0.00%** 0	**1.23%** 3	**4.12%** 10	**29.63%** 72	**65.02%** 158	243
Is overall effective and efficient	**0.00%** 0	**0.41%** 1	**1.65%** 4	**2.88%** 7	**23.87%** 58	**71.19%** 173	243

The medical revalidation team organise all the associated administration for medical appraisals and medical revalidation and deal directly with all enquiries from the medical staff. Table 6 indicates that the vast majority of doctors are satisfied with the support received by the administration team:

"Excellent department and very supportive of the appraisal process."

"Very effective process and easy to follow"

"The process for collecting documents and data for appraisal enabled me to review my previous work and gave me the chance to be well organised. "

"Very efficient, prompt, and easy to contact."

"Nice and friendly, supportive but firm, recommended."

"We are blessed at ESHT with the most supportive team. Invaluable."

Despite the very positive feedback received by the medical revalidation team for medical appraisers and the organisation of medical appraisals, it is evident that some cynicism remains about the appraisal process itself for a few doctors. There is further work to do to engage all doctors willingly in the medical appraisal process:

> "A shame, but possibly not surprising, that you do not ask for feedback on how valuable we find the appraisal process."

> "I regret that I am not sure that the appraisal process is genuinely a good use of our time, but in the circumstances, the administrative support has been first class. "

One of the criticisms of "too much bureaucracy" has been addressed by group discussions with doctors and listening to their feedback. As a result of these discussions, some appraisal forms have been discontinued and the Responsible Officer now relies on the content of the Medical Appraisal Guide (MAG) form to receive declarations on probity, health, incidents and complaints, alongside a more comprehensive appraisal summary supplied by the medical appraiser. Training is continuing for medical appraisers on writing an effective appraisal summary; this has reduced the number of documents required post appraisal without compromising the Responsible Officer's requirements for review of supporting information.

5.7 Quality Assurance

The Medical Revalidation Advisory Panel regularly undertakes quality assurance exercises and 99 portfolios have been scrutinised by Panel Members over the appraisal year 2014 - 2015 to provide assurance regarding the following appraisal inputs:

- the pre-appraisal declarations and supporting information provided is available and appropriate - by whom and sign offs
- review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard, by whom and sign offs
- review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal summary - by whom and sign offs

During 2014 – 2015, over 20% of all Personal Development Plans (PDPs) that were audited were subsequently returned to the appraiser and to the doctor being appraised, with advice on how to amend and improve this provided by the Appraisal Lead, thus ensuring that quality assurance standards are met and to provide learning for the future.

Continuous improvement of the quality of appraisal outputs is a common theme within all medical appraiser update training. The move away from 'tick box' appraisals is reinforced by the attention placed on the quality of the outputs and the consequent support of the individual doctor in their personal and professional development. Although the Trust was praised for its high quality of appraisal outputs by NHS England during its recent Independent Verification visit, the medical revalidation team strive for continued excellence.

Within some local Acute Trusts, there is a formal panel who review all appraisal outputs, rather than a randomised selection, or for those who are submitting their supporting information for review in preparation for their medical revalidation recommendation to the GMC. Capacity does not permit this in ESHT and this may become more of a challenge to the Trust in the future when seeking assurance of quality of appraisal outputs.

For the individual appraiser, quality assurance is achieved by holding a review of:

- the annual record of the appraiser's reflection on appropriate continuing professional development
- the annual record of the appraiser's participation in appraisal calibration events such as update training sessions
- 360 feedback from doctors for each individual appraiser; this is collected through 'Survey Monkey' and it is reviewed by the Medical Revalidation Panel on at least an annual basis. Findings are presented to the medical appraisers individually, where possible, and collectively in their update training sessions. Some Trusts have capacity to meet or discuss this feedback regularly on an individual basis. Capacity does not permit this in ESHT but medical appraisers are always welcome to request a confidential meeting if they wish.

  Feedback on medical appraisers is reviewed by the Trust's Appraisal Lead and individual support is provided to each medical appraiser, where appropriate and collectively all learning needs are addressed through the action learning update sessions
- Appraisal outputs and the quality of the Personal Development Plan and appraisal summary in particular.

5.8 Information Governance

There have been no breaches of information governance this year for medical appraisal documentation. Doctors are made fully aware through the medical revalidation and medical appraisal policy, and personal advice, that no patient identifiable data can be used in their portfolio of supporting information. Any appraisal governance report that identifies patients, and is used for the discussion within the appraisal for learning from complaints and incidents, is kept confidential. It is forbidden to forward any patient identifiable information outside the Trust. This applies also to the Transfer of Information forms that are requested by other employers for doctors who work in other organisations or who are leaving ESHT and must supply references that include their appraisal and revalidation status.

In the year 2014 – 2015, the medical revalidation team handled in excess of 30 requests for Transfer of Information forms for other Responsible Officers. This requires gathering information on the doctor's appraisal status and any involvement in incidents, complaints, investigations and undertakings.

One of the key challenges for the medical revalidation team is obtaining Transfer of Information forms for doctors who join the Trust. Some doctors join the Trust from other organisations or countries where Responsible Officers do not exist, or the doctor has not had appraisals previously. This is addressed by contacting all new doctors and supporting them through the appraisal and revalidation process as quickly as possible. All new doctors are expected to have an appraisal which includes the development of a personal development plan, within six months of joining ESHT.

Locum doctors, who might be new to the organisation, are always contacted and offered support with medical appraisals which enhances patient safety. Work is continuing to provide further information within an induction process and an enhanced policy for locum doctors. This work is being led by the Human Resources Department.

5.9 Clinical Governance

Every doctor is required to supply an Appraisal Governance Report to their medical appraiser at least two weeks ahead of their annual appraisal; this report is obtained through the governance team and doctors are guided through this process by the medical revalidation team. An Appraisal Governance Report allows doctors a formal opportunity to review and reflect upon all incidents and complaints in which they were named or involved during the previous year.

In excess of 350 Appraisal Governance Reports were generated in the year 2014 – 2015. These reports are also generated immediately prior to the medical revalidation recommendation to the GMC so that the Responsible Officer is able to make an informed recommendation of the doctor's fitness to practise.

6 Challenges and Next Steps

- Further support for doctors who hold honorary or locum contracts is being implemented through the development of an enhanced induction policy and process on their recruitment; this is being addressed through an action plan monitored by the Quality and Standards Committee.

- Quality and service improvement initiatives are to be encouraged through the medical appraisal process and the development of professional objectives in the Personal Development Plan.

- As nursing revalidation will be introduced in early 2016, (the first nurses can apply for revalidation from February 2016) this offers many opportunities for the revalidation team. It is intended that integrated medical and nursing appraiser training will be implemented as the potential benefits are immense. Joint working may promote effective quality and service improvement initiatives that can be guided by nursing and medical appraisers through the development of PDPs. Additionally, patient and public involvement and engagement may be widened through effective feedback initiatives and the involvement of patients in the scrutiny of the process and outputs of appraisals. Nurses and doctors can also benefit by learning from the others' knowledge, skills and experience. This activity will thoroughly support all the Trust Values.

7 Recommendations

1. The Trust Board is asked to approve this annual report, noting it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.
2. The Trust Board is also asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with the regulations. The CEO and/or Chair of the Trust Board are asked to sign the statement.

Dr David Hughes

Medical Director – Governance & Responsible Officer – Medical Revalidation

August 2015

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	10
Subject:	Annual Business Plan 2015-16 Quarter 1 update
Reporting Officer:	Dr Amanda Harrison, Director of Strategic Development and Assurance

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

Purpose:

The attached high level report outlines progress against the objectives of the Annual Business Plan for 2015/16 which was approved by the Board at its meeting on 2 June 2015. Each Director has an underpinning plan which provides milestones for delivery to achieve the corporate objectives and demonstrates progress against these milestones. Updates are provided in red font.

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:

- There have been no change in the ratings for the first quarter for the year
- Rating 6.1 – RTT compliance - this is changing to a focus on 'Incomplete' pathways as per NHS England TDA instruction so the definition of RTT compliance may have to change. Patient Access Policy - it is going to take longer than originally expected to complete due to RTT compliance and review of the draft policy by the Intensive Support Team. It is not anticipated that this will impact on the CQUIN targets as staff can still be trained on the policy.

Benefits:

There is clarity about the organisational priorities and targets for 2015/16 and the risks attached.

Risks and Implications

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

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

Review by other Committees/Groups (please state name and date)**:**
Business Planning Steering Group 16.09.14

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

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

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

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 Assessment against the Monitor Well Led Framework

Outcome Measures	**Risks**
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	Several new non-executives who may have insufficient knowledge to form an evidence based view on some areas of the framework. The Board has insufficient time and focus to undertake what is a significant piece of work. Additional investment required

Actions:	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Assessment against the Well Led Framework deferred until completion of Capstick's Governance Review.	End Sep15	**A** ↔	**DSA**	Board

1.2 Respond to national plans for the revalidation of nursing staff

Outcome Measures	**Risks**
Plan in place to ensure that the Trust is compliant with the agreed national requirement	System is complex with large numbers of staff requiring revalidation Additional investment required Staff fail to register with Nursing & Midwifery Council

Actions:	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Medical revalidation team to assume responsibility for nursing revalidation	Apr15	**A** ↔	**DN**	CME
Process for nursing revalidation agreed resource requirements assessed	May15			
Business case for additional resources approved by CME	Jun15			
N&M Revalidation Advisory Panel set up and will monitor project plan led by Assistant Director - Revalidation				
Staff roadshows being arranged and generic e-mail set up for communications	end Aug/beg Sep			

1.3	Further strengthen Clinical Audit reporting to the Board and its Committees				
Outcome Measures Clear process in place for Clinical Audit to ensure national and local requirements are met		**Risks** Medical staff are not engaged in the process			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Central Clinical Governance team in place. The Clinical Effectivness Outcomes core group, chaired by Assistant Medical Director - Quality, held first meeting on 11th June. Draft ToRs were discussed by the core group and amended, final, version to be signed off at next meeting of the full group (23rd July) The full group (incorporating the CU management team representatives) will meet bi-monthly. The core group will meet monthly to review data and track progress against forward plans.		Jun15 Jul15	**A** ↔	**MDG**	PSCIG
ABP Objective 2:	**Ensure the organisation takes action to improve quality and outcomes for patients**				
2.1	**Implementation of the Quality Improvement Programme including QUIPP and CQUIN plans**				
Outcome Measures Quality Improvement Programme developed as a result of CQC visits in Sep14 and Mar16 and other Trust quality improvements Quality Improvement programme includes QUIPP and CQUIN programmes for areas of most clinical quality concern, with a quality impact assessment completed on them with measurable performance indicators. Organisation reporting framework to ensure annual plan met by Mar16 with regular forecasts to confirm plan on target. Impact on 2016/17 and beyond understood. Cash impact understood and managed		**Risks** Programmes are not meeting the clinical quality requirements and do not have an appropriate purposefulness that improves patient safety, experience and outcomes QUIPP and CQUIN programmes are developed without clinician involvement QUIPP and CQUIN lead sits within the COO structure and needs to be linked to the governance team In year cost pressures not covered off by contingencies or other savings plans Savings schemes slip in year Stakeholders challenge Trust's plans Lack of CU engagement			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Annual plan approved by Board and submitted to TDA - monitored through the monthly Integrated Delivery Meeting with TDA Budget completed and signed off by Trust Board Fortnight quality monitoring of Quality Improvement Programme in place QUIP and CQUIN plans developed and leads identified, monitoring group in place and monthly reports provided to CME - on track for quarter 1		May15 May15 Jun15 On-going	**A** ↔	**DN/ MDG/ DF/ COO**	CME

2.2	Rehabilitation Strategy for Trauma, Vascular and Acquired Brain Injury Patients				
Outcome Measures Strategy in place to provide specialist multidisciplinary rehabilitation closer to home for our patients		**Risks** Difficulty in recruiting Rehabilitation Medical consultant Additional investment required			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Case for change being developed by Associate Director - Strategic Service Development and Out of Hospital Clinical Unit		Nov-15	**A** ↔	**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**				
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	**Development and implementation of a marketing and engagement strategy**				
Outcome Measures Strategy agreed by the Board leading to: · clarity about key stakeholders; · roles and responsibilities within the Trust; · improved relationships with key stakeholders		**Risks** Insufficient resources for relationship management actions identified in the strategy and action plan			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Marketing and Engagement Strategy to be further developed in line with on-going work on communciations and engagement Strategy to go to August Board for approval		On-going Aug15	**A** ↔	**DSA**	CME

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	Risks
ESHT active participant in further work 5 year plan aligned to commissioning intentions Full alignment between ESBT and Challenged Health Economy (CHE) work	Failure to draw together ESBT and CHE work leads to misalignment of ESHT 5 year plan and plan for sustainability not achieved Proposed developments are not funded

Actions:	Date/ milestone	RAG	Lead	Monitoring Group
Engagement ongoing - CCGs have 150 week implementation plan - discussions underway to ensure full Trust engagement.	Apr-16	A ↔	DSA	CME

4.2	Engage in the programme of work to support the re-design of community services

Outcome Measures	Risks
Clarity on which community services support Trust strategy and	Staff engagement

Actions:	Date/ milestone	RAG	Lead	Monitoring Group
Trust engaged in community service redesign through ESBT focusing on streamlined point of access, locality working redesign and urgent care redesign -	Apr16	A ↔	MDS/ COO/ DSA	CME
business cases for crisis response service and community geriatricians going to Business Planning Steering Group for approval on 21.07.15	Jul15			
Trust unsuccessful in bid to run community services in HWLH	May15			
Review of community paediatric services taking place jointly with CCG -				
service specification agreed with CCGs	Jun15			
Business case for two community paediatric consultants going to Business Planning Steering Group on 21.07.15 for approval	Jul15			

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 efficiency and effectiveness are improved through the implementation of the Cost Improvement Programme**				
5.1	**Development and implementation of a revised medical model across the Trust**				
Outcome Measures New model implemented on both acute sites		**Risks** Unable to recruit senior clinicians to fill the rota			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Case for change for new frailty model being developed led by Associate Director - Strategic Service Development and will compliment the work being through ESBT in relation to frail patients		Nov-15	**A ↔**	**COO/ MDS**	CME
ABP Objective 6:	**Implement plans for the delivery of key operational requirements**				
6.1	**RTT compliance plan**				
Outcome Measures All specialities to be RTT compliant		**Risks** Insufficient capacity available to achieve compliance in all specialities			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Majority of services will be RTT compliant with the exception of gastroenterology and orthopaedics by Apr15 Gastroenterology to be compliant by Aug15 Orthopaedics to be compliant by Sep15 Patient access policy to be agreed by end of 2nd quarter		Apr15 Aug15 Sep15 Sep15	**A ↔**	**COO**	CME

6.2	7 Day Working				
Outcome Measures Costed strategy for delivery of 7 day working in urgent and emergency care Safe service provision		**Risks** Insufficient funding available from commissioners Unable to recruit staff sufficiently skilled to provide a safe service			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Registration for NHS IQ Self assessment against 10 clinical standards to inform gap analysis Revised Hospital at Night provision at EDGH to be incorporated into 7 day working project Costed plan to address		Mar15 Sep15 Sep15 Mar16	**R** ↔	**MDS**	
ABP Objective 7:	**Develop and implement enabling strategies and programmes to ensure efficiency and effectiveness of the Trust**				
7.1	**Organisation Development Strategy**				
Outcome Measures A culture and behaviours based on our values and focused on the improvement of quality, safety and patient experience Clarity of organisational purpose that is aligned to a direction of travel for services that will ensure we are able to deliver our vision Leadership capability to meet our organisational aims and objectives Performance focused way of working that ensures individual accountability is clear and that the organisation recognises and values the contribution made by individuals and teams		**Risks** Unable to develop the organisational capacity and capability to ensure it is able to successfully deliver its strategic aims and objectives.			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Strategy approved by the Board Steering group met 15.06.15 and workstreams established, satisfactory progress being made		Jun-15	**A** ↔	**CEO/ DSA**	Board

7.2	**Development of an estates strategy that supports the Trust's agreed clinical services model**				
Outcome Measures New estates strategy in place		**Risks** Re-organisation of estates and operational structures that would not give sufficient time for development			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Interim Head of Estates presented outline estates strategy to April Board Seminar Further presentation to Board seminar in Jul15 Draft development control plans Estates strategy for approval		Apr15 Jul15 Sep15 Dec15	**A** ↔	**COO**	CME
7.3	**Implementation of IT Strategy delivery plan**				
Outcome Measures Internal transformational plan implemented		**Risks** Delays in implementation Key roles not recruited to Impact of market testing TDA approval			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Transformation plan developed - project underway Review of market testing possibilities and report to Board		Sep15 Dec15	**A** ↔	**DF**	IM&T Steering Group

7.4	Workforce Strategy/Plan

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

Actions:	Date/ milestone	RAG	Lead	Monitoring Group
Workforce strategy/plan aligned with 2015/16 Business Plans - specific workforce risks are detailed on CU Department Risk Registers. WFP contains a summary of key risks and mitigating actions Workforce Strategy/Plan approved by Board in 3rd June 2015. Feedback included request for outcome measures (which were included), and a twice yearly update report - first one due December 2015.	May15 Jun15 Dec15	A ↔	HRD	CME

7.5	Conclude implementation of the Health Roster programme

Outcome Measures	Risks
Right staff in right place at right time Reduced agency and bank usage Real time reporting of staffing numbers and absence	System support resource not agreed System use deteriorates due to lack of support Inability to provide actual nursing numbers from Healthroster

Actions:	Date/ milestone	RAG	Lead	Monitoring Group
Roll-out of Healthroster across Facilities - commenced May15 project on track. Roll-out of Healthroster across corporate areas - now started and on-going Temporary Nursing support to Healthroster Team also agreed, will focus on ensuring wards are using Healthroster appropriately. Discussions are ongoing with senior nursing colleagues re nursing support into the Healthroster team.	May15 May15 Jul15	A ↔	HRD	CME

7.6	Implement key IM&T programmes including PAS upgrade, SystmOne, Windows 7, EDM and Clinical Portal				
Outcome Measures IT systems implemented successful with minimal disruption		**Risks** Delays in implementation Impact of market testing Lack of investment identified TDA approval			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Capital investment identified Implementation plans complete and understood		On-going	**A** ↔	**DF**	CME
7.7	**Development of GS1 Plan**				
Outcome Measures GS1 Strategic Outline Plan in place		**Risks** Lack of resources			
Actions:		**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
Gap analysis completed Strategic outline plan in place - project group to be set up		May15 Jul15	**A** ↔	**MDS**	CME

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	11a
Subject:	Health and Safety Annual Report 2014/15
Reporting Officer:	Alice Webster

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

Purpose:

The Health and Safety (H&S) Annual Report 2014-15 demonstrates that the H&S team continue to ensure the organisation has robust systems, processes and the ability to embed the learning in practice which supports all staff and patients.
It also highlights how and what the Trust H&S team will be taking forward for 2015/16.

Introduction:

East Sussex Healthcare NHS Trust (ESHT) recognises that the effective management of health, safety and welfare supports the Trust in meeting its vision of being 'the healthcare provider of first choice for the peoples of East Sussex' and the main values of the Trust are:

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

The H&S Team for ESHT has strived to develop, build and embed systems and processes that support staff to embrace the Health and Safety Executive (HSE) strategy for Great Britain, June 2009 mission statement:

> *"The prevention of death, injury and ill-health to those at work and those affected by work activities"*

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

The analysis of the data for H&S incidents and audits can be found on pages 8-18 of this report. The H&S team are not surprised to see an increase in reporting from Trust services and are aware that this is due to the increase of training being delivered and as a consequence an improvement in staff awareness. Training being delivered includes; face to face team training within the clinical and non- clinical settings delivered by managers who have successfully passed their IOSH training for healthcare (cascade training) and by the Trust H&S team trainers; face to face training at

mandatory update training days by the health and safety team trainers and through to electronic e-learning. Managers and supervisors who manage staff are still able to access IOSH training; the H&S team are supporting another executive and senior managers IOSH update in October 2015.

The 3.7% increase in H&S incidents in 2014/15 on the number reported in 2013/14 is not seen as problematic. The Trust is now seeing more minor to negligible injuries being reported, which (as above) demonstrates that staff have more awareness of H&S issues. Lessons are being learnt and shared across services.

Moving and handling staff related incidents (Fig 17.2 page 29) that looks at the category breakdown and this shows a specific reduction in all areas, except the category "Moving a patient". This increase can be aligned to the management of plus size patients (formerly referred to as bariatric patients) as there has been a steady rise in the admissions and length of stay. A working group has been reinstated with the aim of putting in place a robust process resulting in a multidisciplinary approved pathway.

Fig 17.3 page 30 - staff incidents show an overall downward trend when categorised by severity with Major and Negligible reporting remaining static.

In contrast, patient incidents categorised by severity, there were no incidents recorded as Major or Moderate. 3 incidents were recorded as being Minor, the remaining were categorised as Negligible or None. It may be the case that near miss incidents are not being sufficiently reported and this will be encouraged during 2015/16 through staff training.

Fig 17.4 page 30 – demonstrates that the total Moving and Handling patient incidents shows a 65% reduction between 2013 and 2014. The M&H team are aware and are working to support staff with the availability of appropriate equipment and training.

Benefits:

The Trust will see what and how we have made our various proposals a reality each year within an annual report.

Risks and Implications

ESHT has specific responsibilities as an employer under various sections of the Health & Safety at Work etc. Act 1974:

- Section 2 – duties of employers to employees;
- Section 3 – duties to protect people who are not its employees from being exposed to the risks of its activities, e.g. patients, members of the public;
- Section 4 – duties as a landlord by being in control of premises.

The Management of Health and Safety at Work Regulations 1999 extends the provisions of the Health and Safety at Work etc Act 1974 and in particular the requirement to undertake suitable and sufficient risk assessments and provide adequate training and supervision.

Assurance Provided:

This annual report is presented to show the progress made over the year 2014 / 15. It is well recognised that health and safety is central in the delivery of safer services for staff, patients, contractors visiting our site/s, carers and visitors.

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

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

Health and Safety Steering Group 17th July 2015
Clinical Management Executive (CME) 13th July 2015

Proposals and/or Recommendations

The Health and Safety team inclusive of the Moving and Handling team will continue to build on what is now established to ensure that:

- Our health and safety structure activity is measured and monitored regularly
- Development of a business case for the purchase of a centralised H&S risk management system that will capture all risk assessments and H&S audits and this in turn can be scrutinised and issues highlighted are flagged quickly and dealt with efficiently and effectively
- Working collaboratively with the named Non-Executive Director (NED) and the Director of Nursing who is the named executive lead to ensure that H&S issues, lessons learnt and good practice are shared with all staff group both clinical and non-clinical within the Trust
- The organisation can demonstrate a positive health and safety culture aligned to the safe behaviour and attitude of all staff
- Revitalising health and safety targets have been met and a culture of continuous improvement is measured and celebrated within our services
- The contribution to health and safety is better understood at all levels of staff within the organisation
- All levels of the organisation are regularly informed of our progress against the local and national health and safety targets
- Bench mark audit tool will become the principal tool to monitor performance and address deficiencies and this element is being developed on a South East Sector.

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

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

N/A

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

Name:	**Contact details:**
Nicky Creasey	Ext 6545

East Sussex Healthcare NHS
NHS Trust

Health and Safety

Annual Report

April 2014 – March 2015

Complied and completed by Trust Health and Safety Team

Nicky Creasey, Trust Lead Health and Safety

Jennifer Newbury, Deputy Trust Lead Health and Safety

Susanna Marsden, Specialist Practitioner Moving and Handling Lead Advisor

FINAL NC 14/07/2015

Contents

This annual report is presented to show the progress made over the year 2014 / 15. It is well recognised that health and safety is central in the delivery of safer services for staff, patients, carers and visitors.

The Health & Safety Steering Group has been established to plan, organise and monitor organisational compliance with its statutory health & safety obligations and duties. The role of the health & safety group is to ensure compliance with external body requirements such as the Health and Safety Executive, NHSLA, Department of Health, CQC etc. This annual report reflects that work over the period 2014 /15

The nature of our activities means that a wide range of risks exist, but through the implementation of related policies, directors, managers and workers continue to ensure that all significant risks to health are reduced so as far as is reasonable and practicable. In the coming year the newly reconfigured health and safety team will continue to progress its overall management of health and safety across the Trust.

This report demonstrates the progress made, acknowledges areas of development and this report is intended to assure the Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Director of Nursing and Governance – Trust Executive Lead for Health and Safety

1. Introduction

East Sussex Health care NHS Trust (ESHT) ethos and values are at the heart of how we within the organisation behave and act and they cover:

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

The organisation health and safety department fully embraces the organisation values and this annual report demonstrates the work completed over the preceding year and how the department will move forward. The health and safety department as stated in the Overarching Trust Health and Safety at Work Policy will:

- Conduct all of our undertakings so as to avoid, or control to an acceptable level, risks to the health and / or safety of all of our employees, all users of our services, all members of the general public who are exposed to our activities and all other people who work on, or visit, our premises;
- Create and maintain a positive health and safety culture within all areas of our organisation, so that there is a continuous, improvement in our health and safety performance;
- These aims will be pursued regardless of whether the particular services which form part of the organisations' undertakings are performed by our employees, or by outside contractors acting on our behalf;
- These aims will be borne in mind in all policy and operational decisions made by the organisation, especially in relation to the adequate provision of resources. It is recognised that managers could render themselves liable under criminal health and safety law should they place requirements upon staff that are contrary to this policy.

2. Working together with Trade Unions

Staff-side is made up from members of East-Sussex HealthCare NHS Trust Staff (ESHT) who are members of a Trade Union or Society, recognised by the Trust. The Staff-side members have been elected and / or appointed into their role of Health & Safety Representatives, through their Trust recognised organisations.

These staff members undergo training by their own organisations in Health & Safety, and also may have undertaken further training via the Trade Union Confederation (TUC) which runs more in-depth courses which are College/University accredited. They also attend seminars & workshops in Health & Safety subjects, such as; stress, COSHH (Controls of Substances Hazardous to Health,) and RSI (Repetitive Strain Injury.)

- Staff-side Health & Safety representatives are governed by "The Safety Representatives and Safety Committees Regulations 1977".
- Staff-Side Health & Safety representatives are part of the consultation process into Health & Safety policies written by the management side of the Trust.
- Staff-side Health & Safety representatives support & represent staff, patients & visitors to the Trust.

The union members hold their own staff-side Health & Safety Committee, to which The Chair & Deputy are elected yearly into the role. They attend the main Trust Health & Safety Steering Group (HSSG) and report hazards and findings to the management side. These meetings are every other month and minutes are taken during meetings and agreed correct at the next meeting date.

The staff side chair also completes a report to the Staff-side Forum/Joint Staff Committee (JSC), so that Union & Society members elected into the role of workplace stewards are made aware of any issues which have arisen from meetings. Policies approved by staff side Health & Safety representatives are forwarded to the JSC for information.

2.1 Context

ESHT has a head count of staff (excluding bank) at 31st March 2015 of 6566 (source: ESHT Workforce Department); operating over 120 sites and covers 770 square miles.

The Trust Health and Safety Steering Group (HSSG) is chaired by the Director of Nursing & Governance who is the executive named. The Group receives reports from Trust wide services, for example, Clinical Units, Fire, Security, Waste and so forth, see Appendix 1 for the H&S reporting structure within the Trust.

2.2 Legal background

The key pieces of legislation and guidance are:

The Health and Safety at Work etc 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular it requires organisations to:

- Provide a health and safety policy
- Provide safe and secure working environment
- Provide safe suitable work equipment
- Provide information, instruction, training and supervision
- Provide adequate welfare facilities.

Management of Health and Safety at Work Regulations 1999 which extends the provisions of the Health and safety at Work etc 1974 in particular the requirement to undertake suitable and sufficient risk assessments.

Management for health and safety (HSG65) 2013 guidance explains the Plan, Do, Check, Act approach and shows how it can help an organisation to achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Leading health and safety at work (INDG 417) guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes. Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board. Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety. By following this guidance, it would help the organisation find the best ways to lead and promote health and safety, and therefore meet its legal obligations.

3. Key achievements 2014/15

A full copy of the action plan is available on request from the H&S team as well as the HSG 65 plan, do, check, act service gap analysis.

- The action plan for 2014/15 was based on a detailed gap analysis utilising the HSSG 65 standards on plan; do; check; act principals. The health and safety team reviewed the standards against our current systems and processes that also encapsulates demonstrable evidence that showed full compliance, partial or none. The action plan covered 12 key aspects for the organisation from a health and safety perspective. Some of the actions were achieved within the financial year and those areas still progressing or not started are reflected in the 2015/16 action plan

- Health and safety audits of services both clinical and non-clinical continue and the detail of which can be found on pages 8-16 of this report.

- Health and safety team from April 2014 the service increased with the interim redeployment of a Health and Safety Officer 0.43 wte from the 'old' Urgent Care Division. The changes to the organisation from divisions to clinical units with the centralisation of governance meant that the Clinical Facilitators were given a unique opportunity to work with in any of the governance departments as an interim measure and allow staff to experiences other services and ways of working whilst the governance team was going through a consultation phase. Health and Safety team besides the manager, deputy and a 0.41 H&S officer the team increased to three staff members 0.91; 0.60 and 0.60 (respectively). The completion of the governance consultation is expected to be completed June 2015.
- Health and safety policies are all up to date – the main policy list is available on request.

4. Annual Incident Report and Audit Findings

4.1 Summary

This annual review highlight trends and key areas of risk in terms of health and safety through the identification and reporting of incidents and audit results. Key risks were identified;

1. Failure to achieve KPI's set for Occupational Health and Safety Managements Systems (OHSMS) audits
2. Inability of the organisation to report incidents leading to 3 or more days absence from work as previously required by the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2005 as amended
3. Dermatitis

4.2 Introduction

This section gives the number of health and safety related incidents and also describes the nature of Health & Safety related incidents that occurred in East Sussex Healthcare NHS Trust between 1st April 2014 and March 31st 2015 to staff and others. Full reports are given by departments responsible for leading on the implementation of their subject matter; Moving and Handling, Occupational Health, Security, Waste, Infection Control (Sharps incidents) and Fire.

Patient Safety incidents are reported to the Patient Safety and Clinical Improvement Group however, where patient incidents are defined as reportable to the Health and Safety Executive within the context of RIDDOR; these are reported to this Steering Group as well. Patient related RIDDOR's are identified in section 3. In addition, patient falls are reported to the Falls Steering Group.

From 1st April 2015, the report for the Health and Safety Steering Group will include health and safety related incidents affecting patients including a summary of patient falls.

This section also includes findings from the Occupational Health and Safety Management Systems (OHSMS) audit conducted by the Health and Safety department throughout the fiscal year and reports on activities of the Health and Safety department.
2013/14 was the first year where full information was able to be extracted from Datix enabling a benchmark to be set due to the implementation of Datix web part way through the financial year 2012/13 and this year enables full comparisons to be made against that benchmark. An exercise enabling benchmarking of comparable Trust data external to the organisation has also been undertaken on RIDDOR events.

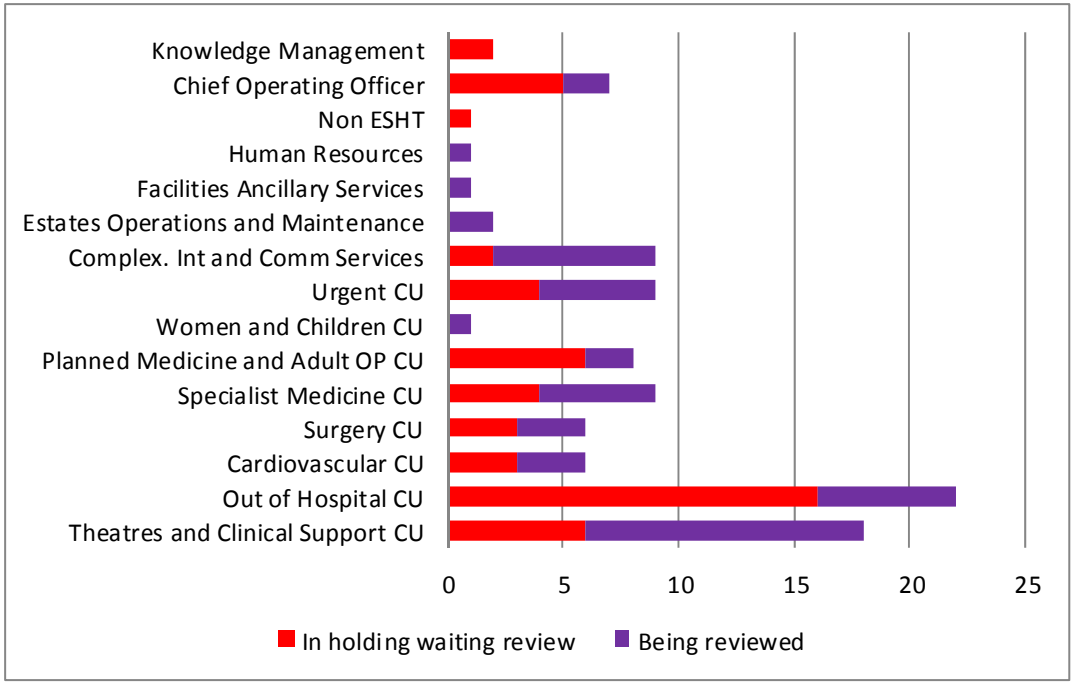
4.3 Incidents

Information for the purposes of this area was extracted from Datixweb on 9th June 2015 and is based on the date of incident to enable trends analysis.

4.3.1 Incident Review and Closure

The framework for using Datixweb efficiently includes the requirement to review incidents within a specified timeframe, in line with training received and then assign or undertake investigations according to the level of incident. Handlers are automatically sent an email by the Datix programme at the time of the person reporting the incident as well as specialists.

There are a total of 50 incidents yet to be reviewed by the handler and 52 incidents are still in the process of being reviewed.



The graph represents the cumulative incidents that are still outstanding for the previous year the results of which will affect the accuracy of this report. Therefore whilst every effort has been made to ensure the accuracy of the data presented in the following report, the information presented is as accurate as that which is taken from Datix at the time and relies on both timely review of the incident, the accuracy and interpretation of the trained handler.

The benefits of moving to an online reporting system are clear, including:

- Greater ownership of incidents in real time by local managers Feedback can be sent to reporters of an incident
- Instant notification to be sent to specialists
- Reinforcement of a strong incident reporting culture
- Full audit history on every incident and subsequent investigation.

4.3.2 Classification of Severity and Categories

This report includes the following categories of incident as reported;
Health and Safety
Animal bites
Burns and Scalds – dry or wet

Cuts and Lacerations
Trapped by the collapse or an overturn of an object
Impact with static object – walking in to/ standing up
Impact with moving, falling or flying object
Road traffic collision
Exposure to Hazardous Substances or clinical waste – biological, dust, chemicals, spores
Environment - Infestation, noise, temperature, ventilation, surfaces and walkways
Slips, Trips and Falls
Moving and Handling
Needlestick and other Sharps
Security, Violence and Aggression. Theft and loss has been excluded for the purposes of this review.

In accordance with the National Patient Safety Agency (NPSA) matrix an extract of which is below; and in line with the requirements of the National Reporting and Learning System (NRLS), the report identifies those incidents according to the initial severity. It is essential that the matrix is used consistently within the organisation for both the reporting and grading of incidents and risk. Whilst there have been difficulties reported with staff using the NPSA risk matrix, the difficulty is identified as a training issue rather than the matrix itself.

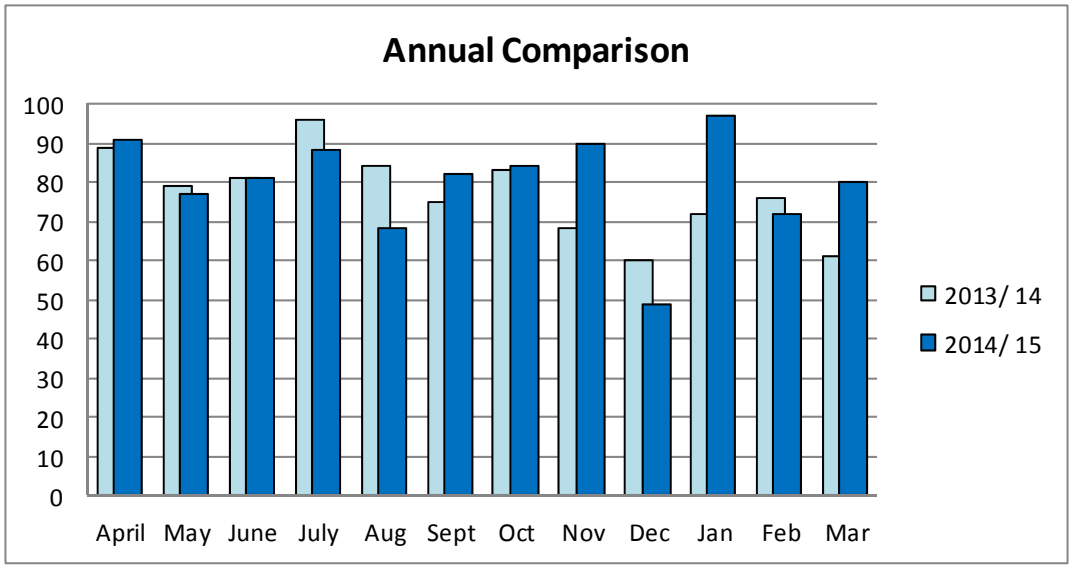
NPSA matrix	**Consequence score (severity levels) and examples of descriptors**				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects

Source; www.npsa.nhs.uk

4.3.3 Incidents reported

The graph represents the incidents reported by month for the full calendar year. There has been a 3.7% increase in incidents reported over the last year and the NHS Staff Survey indicates the same percentage of staff witnessing potentially harmful errors, near misses or incidents as in

2013 which is 29%. The actual figure of staff reporting incidents or errors within the last month (key finding 13) is stated to have decreased marginally and may affect the reliability of some of the figures in the report. The survey is sent to staff in September 2014 and the results published in February 2015



The graph to the left indicates a month on month trend compared with the previous year. The average monthly incident figure for 2013/ 14 was 77.00 which has increased for 2014/15 to 79.92 an increase of almost 3 incidents per month. There was a marked increase in January and March 2015. The incidents that account for the increase were;

Health and Safety

These appear to be either process related involving collisions with objects or maintenance such as faulty shelving.

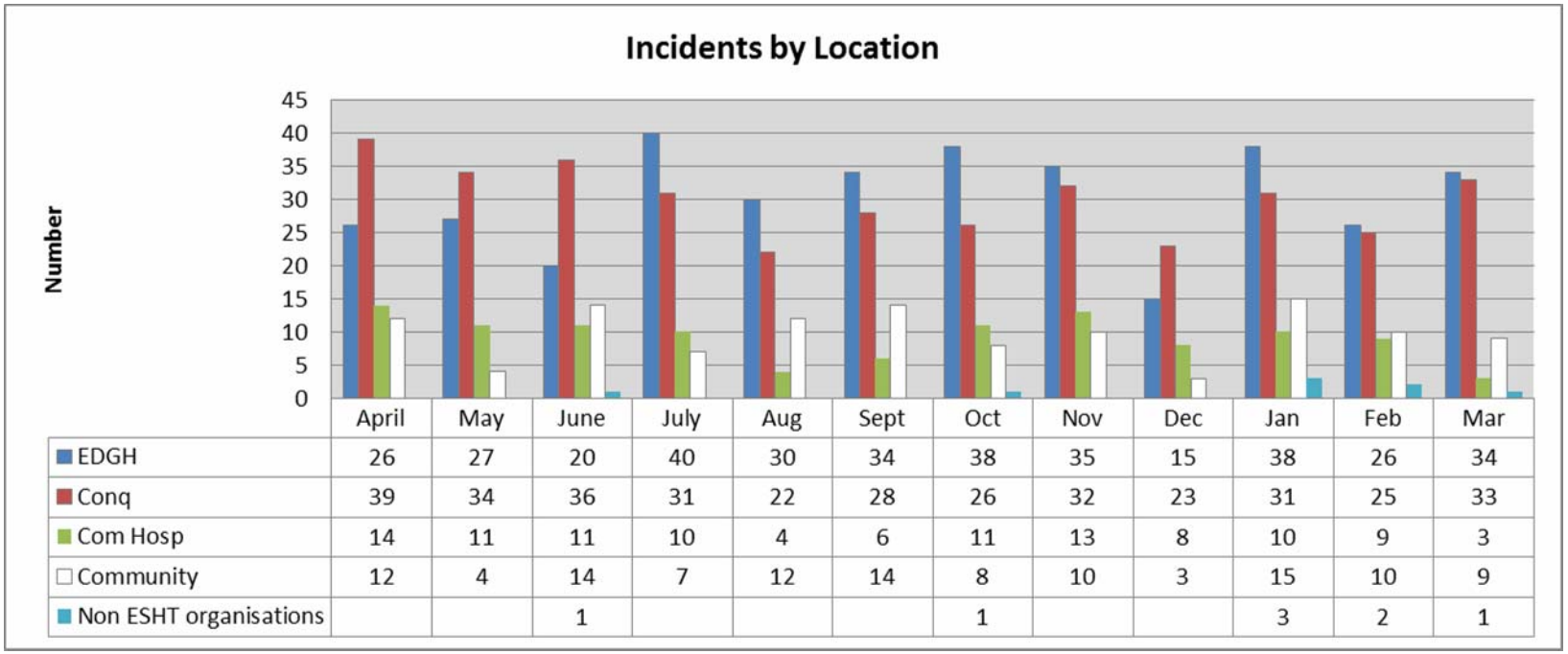
Sharps - These are generally low however January saw a very marked increase almost all of which were 'dirty' injuries. (9)

Violence and Aggression

These increased by 29% and 42% respectively and although data indicates verbal abuse and harassment is responsible there have more serious incidents of intentional physical assault by patients. There no incidents reported of staff causing physical or verbal abuse to colleagues in quarter 4

New Incidents	2013/14	2014/15
Quarter 1	263	249
Quarter 2	255	238
Quarter 3	211	223
Quarter 4	209	249
TOTAL	924	959

4.3.4 Incidents by Location



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH	26	27	20	40	30	34	38	35	15	38	26	34
Conq	39	34	36	31	22	28	26	32	23	31	25	33
Com Hosp	14	11	11	10	4	6	11	13	8	10	9	3
Community	12	4	14	7	12	14	8	10	3	15	10	9
Non ESHT organisations			1				1			3	2	1

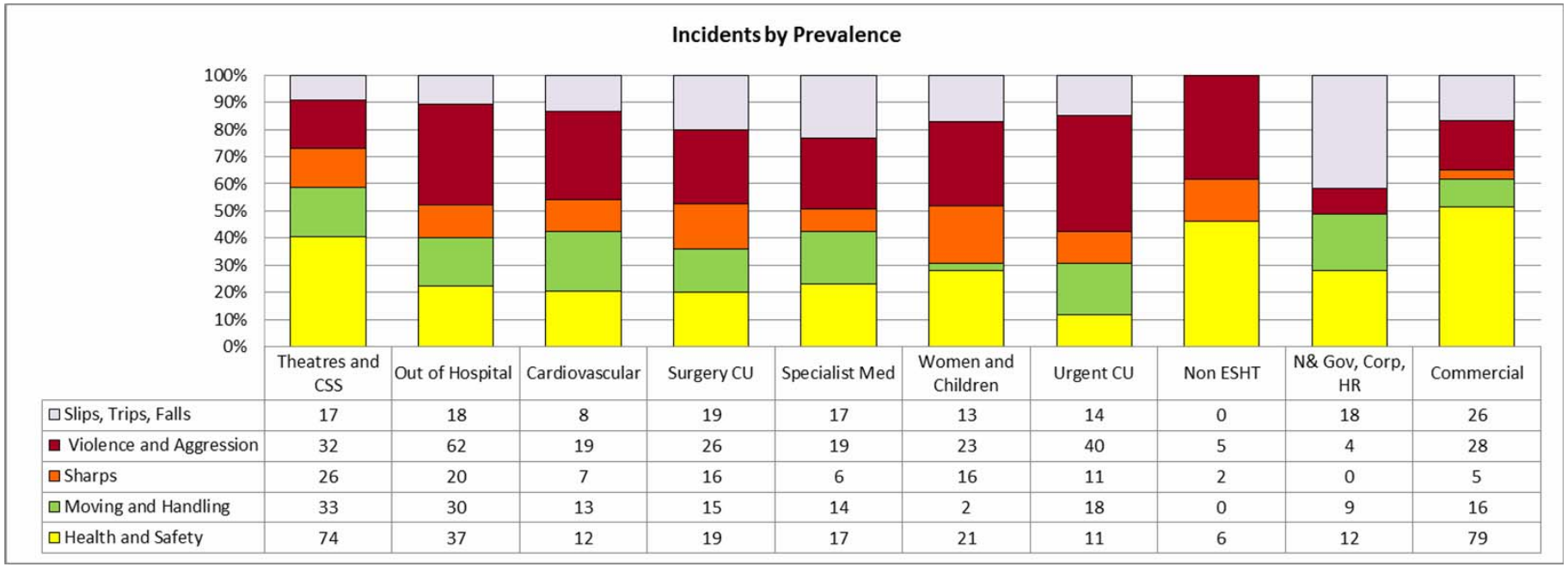
Incidents by location have been included in the annual report to enable potential identification of trends across sites and areas where services are to be located to enable preventative measures to be put in place. As 2013/14 annual report indicated, incidents that occur in community and domiciliary tend to be higher generally higher coinciding with school term dates whereas community hospitals tend to be lower during this period

	Quarter 1				Quarter 2			
	April	**May**	**June**	**Total**	**July**	**Aug**	**Sept**	**Total**
EDGH	26	27	20	73	40	30	34	104
Conq	39	34	36	109	31	22	28	81

Also of note is the difference between quarter 1 and quarter 2 in the acute sites indicated left with Conquest site spiking on all months in quarter 1 a trend that was mirrored by EDGH in quarter 2. Incidents for the full year are comparable and both sites have increased by around 7% Community hospitals decreased by 17% and community and domiciliary related incidents indicate a small increase of 4%. Q2 figures are completely reversed with trends almost the same - an exception of several incidents around excess of temperature including ill-health effects on staff

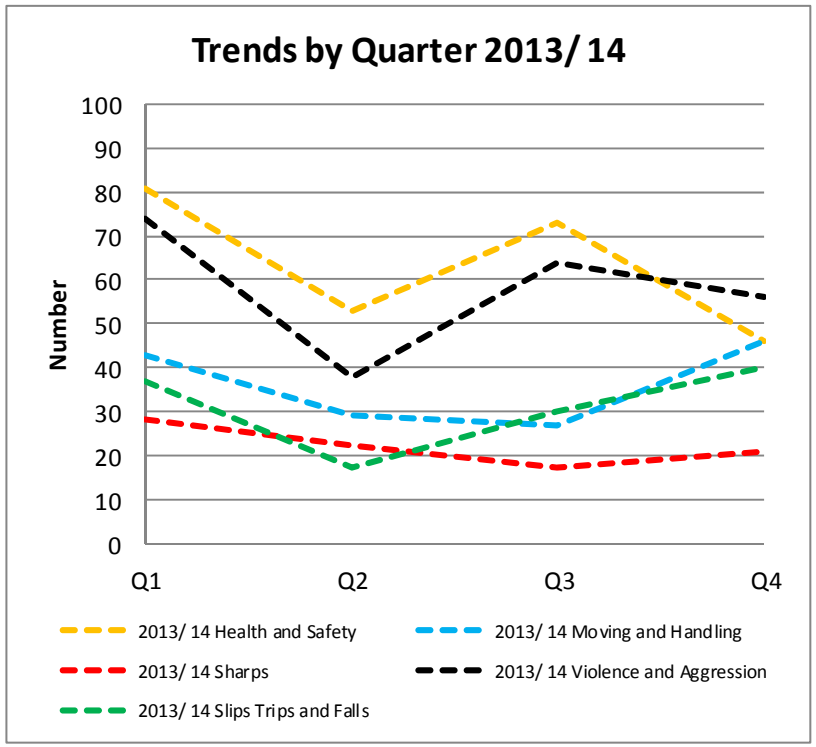
4.3.5 Incidents by Prevalence and Clinical Unit/ Division

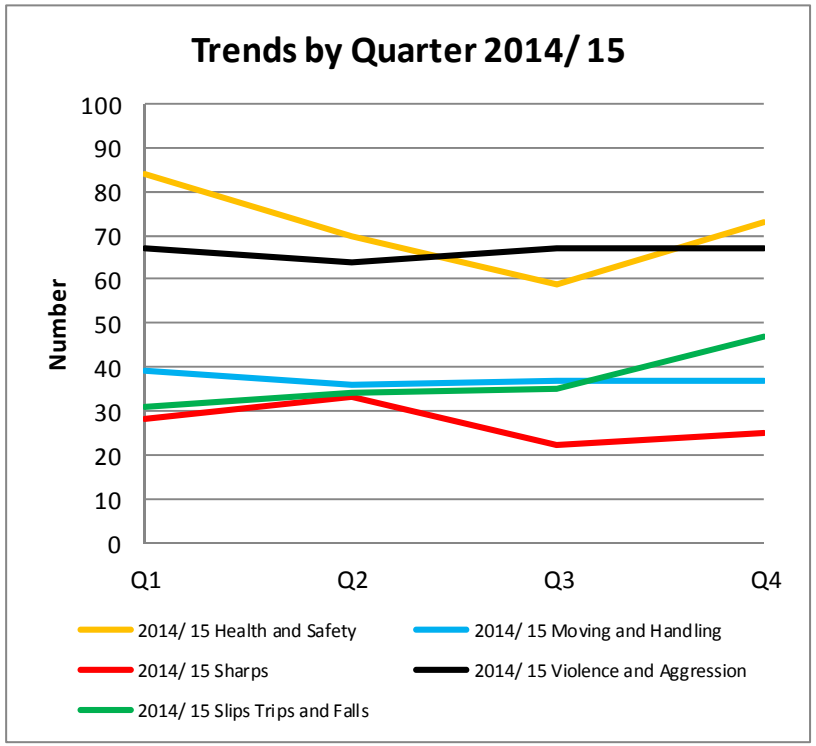
The graph summarises all incidents to staff by severity for the full year. Each Clinical Unit and Directorate reports on those incidents quarterly to the Health and Safety Steering Group.
Violence and aggression to staff are an ongoing concern in the community and domiciliary environment and Out of Hospital clinical unit reported the second highest number with 39 of those incidents being intentional physical or verbal abuse and discrimination. 17 were domiciliary and 22 were community site based. Sharps continue to be a problem in Theatres and clinical support; decontamination services and analysis of these indicate two themes; inappropriate placement of needles when finishing procedures and problems with catches on safety needles.



	Theatres and CSS	Out of Hospital	Cardiovascular	Surgery CU	Specialist Med	Women and Children	Urgent CU	Non ESHT	N& Gov, Corp, HR	Commercial
Slips, Trips, Falls	17	18	8	19	17	13	14	0	18	26
Violence and Aggression	32	62	19	26	19	23	40	5	4	28
Sharps	26	20	7	16	6	16	11	2	0	5
Moving and Handling	33	30	13	15	14	2	18	0	9	16
Health and Safety	74	37	12	19	17	21	11	6	12	79

4.3.6 Incident trends by Quarter





- Health and Safety Incidents

20% increase from 2013/ 14

Incidents involving collision with static or moving objects have increase over the year from 71 to 122, 111 were site based 5 of those resulted in a RIDDOR event. Analysis of those incidents indicates potential space constraints however there are also more minor and negligible incidents being reported.

- Moving and Handling

1.4% increase from 2013/ 14

An analysis of the Moving and Handling incidents is provided in a separate section of this annual report on pages 29-30

- Sharps

22.7% increase from 2013/ 14

Whilst an analysis of these incidents is provided in a separate report it must be noted that 79 of 88 incidents involved a 'dirty' sharp occurring through a clinical process or where an injury was caused through poor disposal of dirty sharps.

- Violence and Aggression

14.2% increase from 2013/ 14

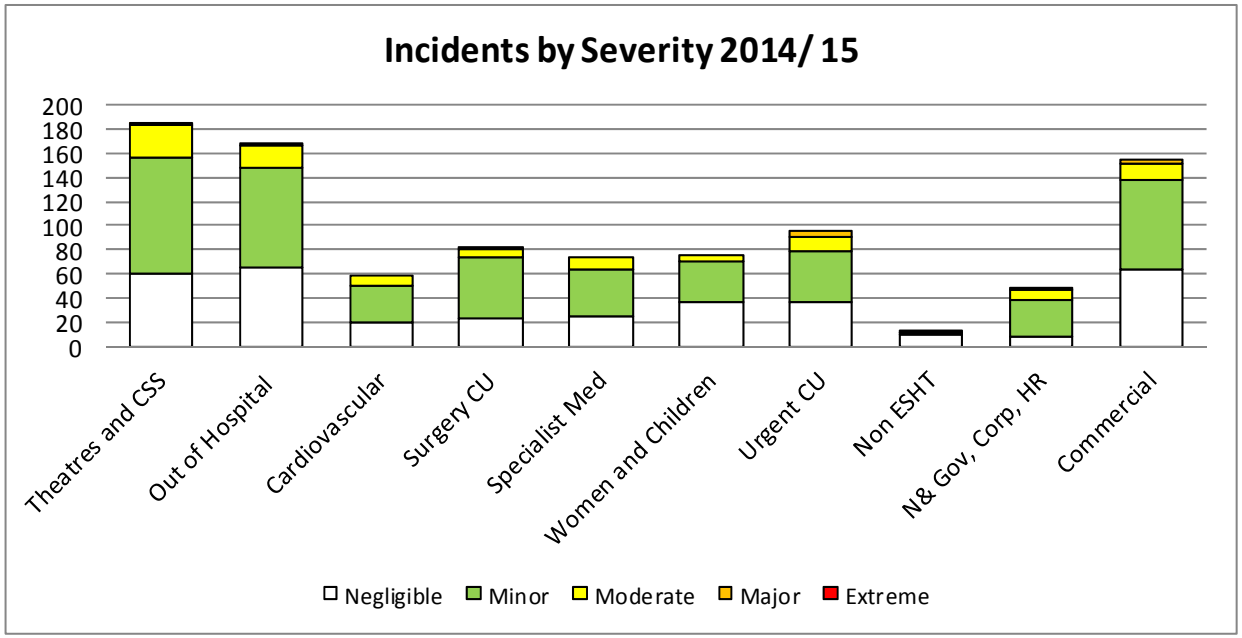
63 were categorised as intentional physical assault, 2 incidents resulted in a RIDDOR event. A further analysis of incidents of these incidents is provided in a separate report by the Security department

- Slips, Trips and Falls

18.5% increase from 2013/ 14

7 RIDDOR events including 1'specified injury' although more minor and negligible incidents are being reported. Incidents involving slips and falls escalate through quarters 3 and 4 in almost all years in line with seasonal weather.

4.3.7 Incidents by Severity



5.0 RIDDOR events

The Reporting of Incidents Disease and Dangerous Occurrences Regulations (as amended) 2013 requires the Trust to report certain categories of incidents to the Health and Safety Executive (HSE). The update to the Regulations amended the requirement for incidents involving an absence of 3 days or more to 7 days or more however, the Regulations stipulate that those incidents falling into the category of 'over 3 days' must be formally recorded by all organisations.

Across the full year, a total of a total of 46 incidents defined within the RIDDOR Regulations were reported to the Health and Safety Executive: staff and others (40) patients (6)

		Health and Safety	Moving and Handling	Sharps	Violence/ Aggression	Slips Trips and Falls	Total
	Over 7 day	7	16	0	3	7	33
	Specified Injury	2	1	0	0	7	10
	Fatality	0	0	0	0	0	0
	Dangerous Occurrence	2	0	0	0	0	2
	Disease	1	0	0	0	0	1

5.1 Over 7 day Incidents

Moving and handling incidents remain the same as last year as do slip trip and fall incidents. Cause of trips were staff falling over objects on floors, trailing wires resulting in falls on floors, down steps or stairways. There was 1 slip on a wet floor. Health and Safety related incidents were as a result of staff colliding with static or moving objects and 2 road traffic accidents caused staff to be absent for more than 7 days.

5.2 Specified Injuries

Slips, Trips and Falls resulted in 6 fractures to patients and 1 fracture to staff (5 in 2013/14) it must be noted that serious injuries to staff as a result of slips trips and falls have decreased dramatically. The single incident involved a member of staff slipping on a wooden board in the car park assumed to have been left by contractors.

Three patients were found on the floor suspected of falling and two further incidents involved a trip on a mat and over a kerb stone. I patient was involved in an incident with bed rails causing a fall on the floor. Patient falls which result in a specified injury or a fatality are reported to the

Health and Safety Executive however, as a result of the Memorandum of Understanding between the external agencies any report involving a patient is copied by the HSE to the CQC who now have similar powers under the Memorandum.

There was one Moving and Handling incident and 2 Health and Safety related incidents. One of the latter incidents involved a waste porter and this incident was rated as a 'Serious Incident' and a full root cause-analysis was completed. One member of staff collapsed in Theatres with a suspected reaction to Latex and involved the member of staff being suspended from work as a necessity. Investigation involved both the consultant involved with care, extensive allergen testing and Occupational Health.

5.3 Fatalities

There have been no fatalities reported to the HSE in 2014/15

5.4 Dangerous Occurrences

There was one ocular exposure to bodily fluids in Theatres and a further incident involved a member of staff removing curtains for cleaning. The curtain rail pulled from the wall releasing a small amount of asbestos where a rawl plug fitting had been fastened to a wall.

5.5 Disease

There has been a single instance of work related Dermatitis diagnosed by a General Practitioner (GP).

6.0 Policies

Health and Safety Policies continue to be reviewed and during review a summary sheet is now embedded within the policy which will enable staff to briefly note and recognise the objectives, purpose and contents of the policy. The summary sheet will not absolve managers and staff of the need to read the policy in full where required.

7.0 Health and Safety Links

The database of health and safety link persons is progressing and those staff registered on the database having had suitable training receive information directly from the health and safety department to ensure that there is no miscommunication or delay of information and that information is disseminated at an operational level quickly.

8.0 Health and Safety Intranet

The intranet is continually updated with all aspects of health and safety information including links and newsletters from associated departments and regulatory bodies including the Medicines and Healthcare Regulatory Agency (MHRA). Plans identified in 2013/14 to ensure that a Trust wide database of commonly used substances exists as well as the associated COSHH assessments and up to date safety data sheets is progressing. All departments that have responsibility for trialling and approving substances for use Trust wide also have a responsibility for ensuring a COSHH assessment is completed. Departments; Infection Control, Waste, Pathology, Facilities and Occupational Health are currently working with the Health and Safety department to ensure these assessments. Access to the public folders via the intranet will avoid duplication of work however all department must adapt these to their department.

9.0 Training

There are 4 levels of Health and Safety training all of which require refresher training at 3 yearly intervals.

- IOSH for Senior Executives
- IOSH Managing Safely for Healthcare Professionals for
- Full day Health and Safety training for team leaders, supervisors and managers
- E-Learning or Cascade training for staff who do not have supervisory or management responsibilities

Learning and Development provide a monthly report that identifies training compliance by clinical unit. This information is collated by HR and used to populate the scorecard that is sent to senior managers. Levels of health and safety training compliance are also now reported to Board. Work has been undertaken by both the Health and Safety department and Learning and Development to ensure that courses are aligned with the National Passport System which the Trust has signed up to.

With the implementation of Cascade training throughout the Trust, provisional figures indicate at total of 4203 staff in date with health and safety training – an improvement on 2013/ 14 of 35.8%.

10.0 Dermatitis

A gap analysis has been conducted by the Health and Safety department on the adequacy of arrangements for the avoidance and control of work related Dermatitis using the Topic Inspection Pack used as an Enforcement Management Model by the HSE to identify any potential improvements necessary. Work is currently underway with Infection Control, Dermatology and Occupational Health to ensure the Trust has adequate arrangements in place. As part of the forward planning for 2015/ 16 a specific event will be arranged in September as part of staff awareness.

11.0 Health and Safety Executive

The Health and Safety Executive visited the Trust on January 19th 2015 in response to an incident that occurred in November 2014 involving a piece of Laundry process equipment, A Visiting Officer (VO) and an Inspector of HSE were present. During the visit the equipment was investigated thoroughly by the HSE Inspector. Emergency stop devices, interlock systems, conveyor gaps were included in the examination. The HSE Inspector and Visiting Officer made multiple attempts to recreate the circumstances leading to the injury and in line with statements without success. They concluded that the HSE were satisfied from a visual inspection the equipment was safe, well maintained and operated fully with the intrinsic safety mechanisms. The visit was centred around Laundry operations although also included vehicle loading bays.

In addition to the visit, there have been telephone and email queries from the HSE to the Trust Leads for Health and Safety regarding:

- A complaint received by the HSE for Theatres in relation to failure to control the risks from Formalin
- Minor concerns raised by the HSE after a scheduled visit to Pathology targeted specifically at Containment Laboratories.

The HSE was satisfied on all points that the Control of Substances Hazardous to Health Regulations 2002 (as amended) was adhered to and no formal notices were received.

12.0 Audits

12.1 Process

Elements of the OHSMS relevant to the service are objectively scored against compliance criteria – legislation and Trust policy.
Evidence is required at the time of audit to support any statements;

1. Visible evidence obtained by the auditor e.g. presence of legal notices and posters, storage of PPE
2. Questions of both staff and managers
3. Records e.g. training records, risk assessments, minutes of meetings, fire inspection records

All areas audited are subject to a further audit the frequency of which is currently dependent on risk rating of the preceding audit as indicated below.

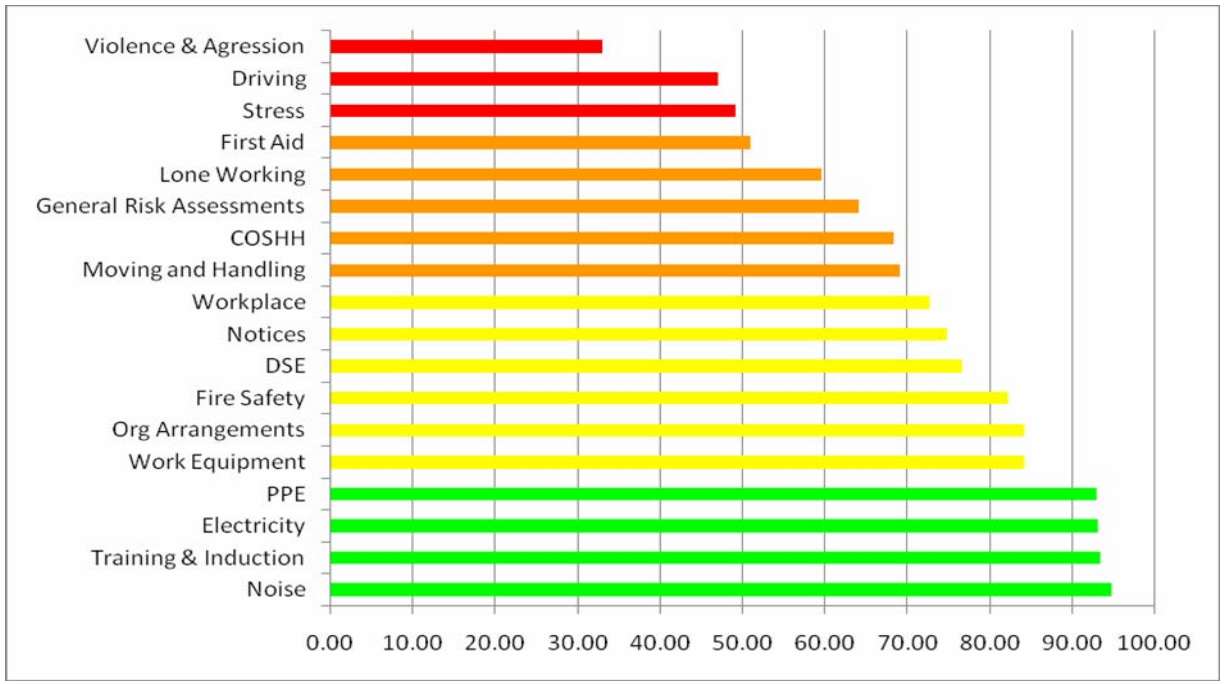
% Compliance	RISK RATING	Re audit
0-50	Very High	6 months
51-70	High	6 – 12 months
71-90	Medium	12 - 18 months
91-100	Low	18 - 24 months

The results of audit have remained largely static since inception of the audit both in the individual standards across the Trust and also in those audits conducted in departments. It is therefore proposed that the frequency of audits is changed where risks and incidents remain low. See **Appendix 2;** Original Methodology and **Appendix 3**; 2015/ 16 Proposed Audit Methodology

The initial benchmark audit takes approximately 2 – 3 hours and at the end of audit and as part of the process of continual improvement in the OHSMS, the auditor will state actions necessary for areas where a need for improvement has been identified. The local manager will retain a copy of the audit and action plan. This will be further distributed to the Clinical Unit or Directorate Health and Safety Governance lead.

12.2 Audit Findings

12.2.1 Benchmark 2012/ 13



Audits for Occupational Health and Safety Management Systems (OHSMS) began in June 2012, quarter 2 and have been conducted since in order to both benchmark the systems in place to support health and safety and measure improvements made. The audit tool comprises 18 standards which are designed to examine;

Structure and Roles/ Responsibilities

- Consultation, Communication and Reporting
- Documentation
- Hazard Identification, Risk Assessment and Control of Risks for routine and non-routine activities
- Hazardous Substances, Infectious Materials and control of waste.

Initial results indicated;

- Lack of assessment where the risk was significant
- Failure to check documents such as driving documentation
- Low level of awareness for the process of escalating risk

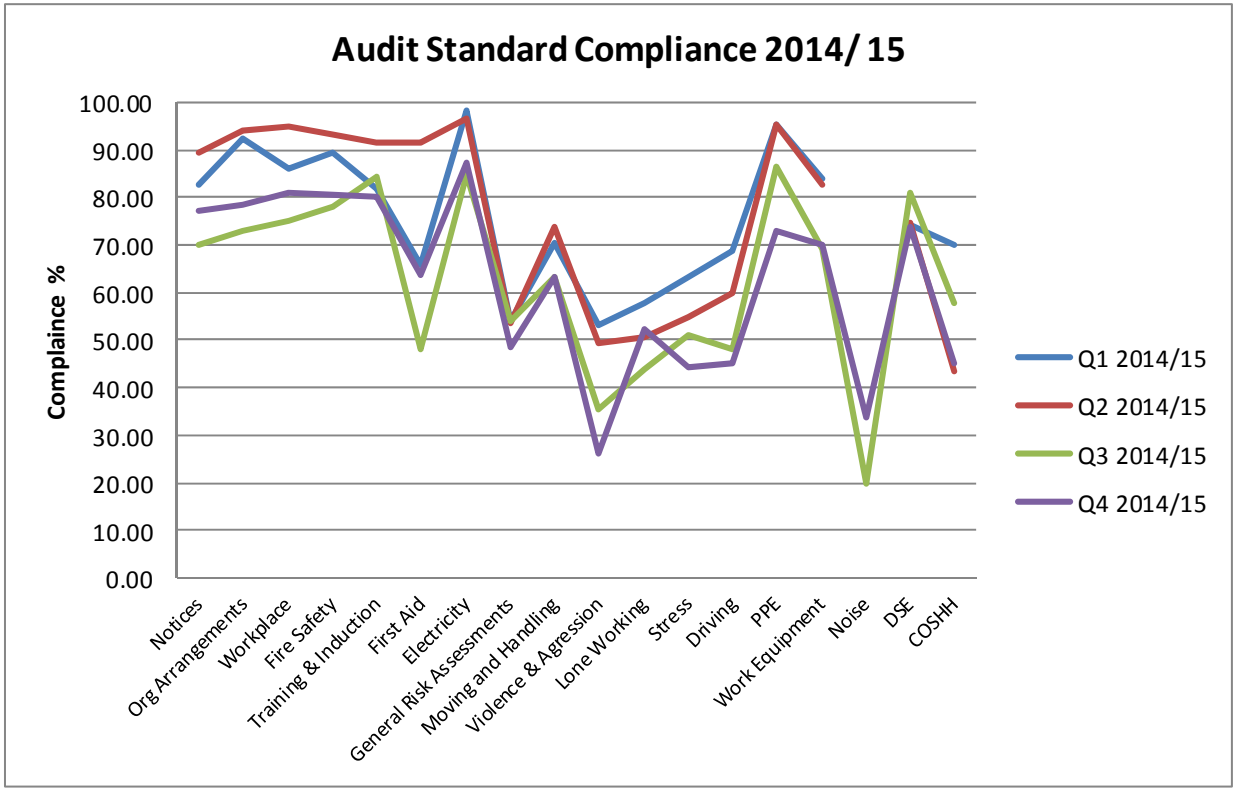
Subject specific leads were then able to identify which areas needed and improvement targets were set for 2013/14;

30% improvement for Very High risk
20% High risk and
10% Medium risk

The majority of those targets were achieved during that year with the greatest improvements made in assessment for Violence and Aggression, Lone Working and risk mitigation for Driving although improvements were still needed for Stress.

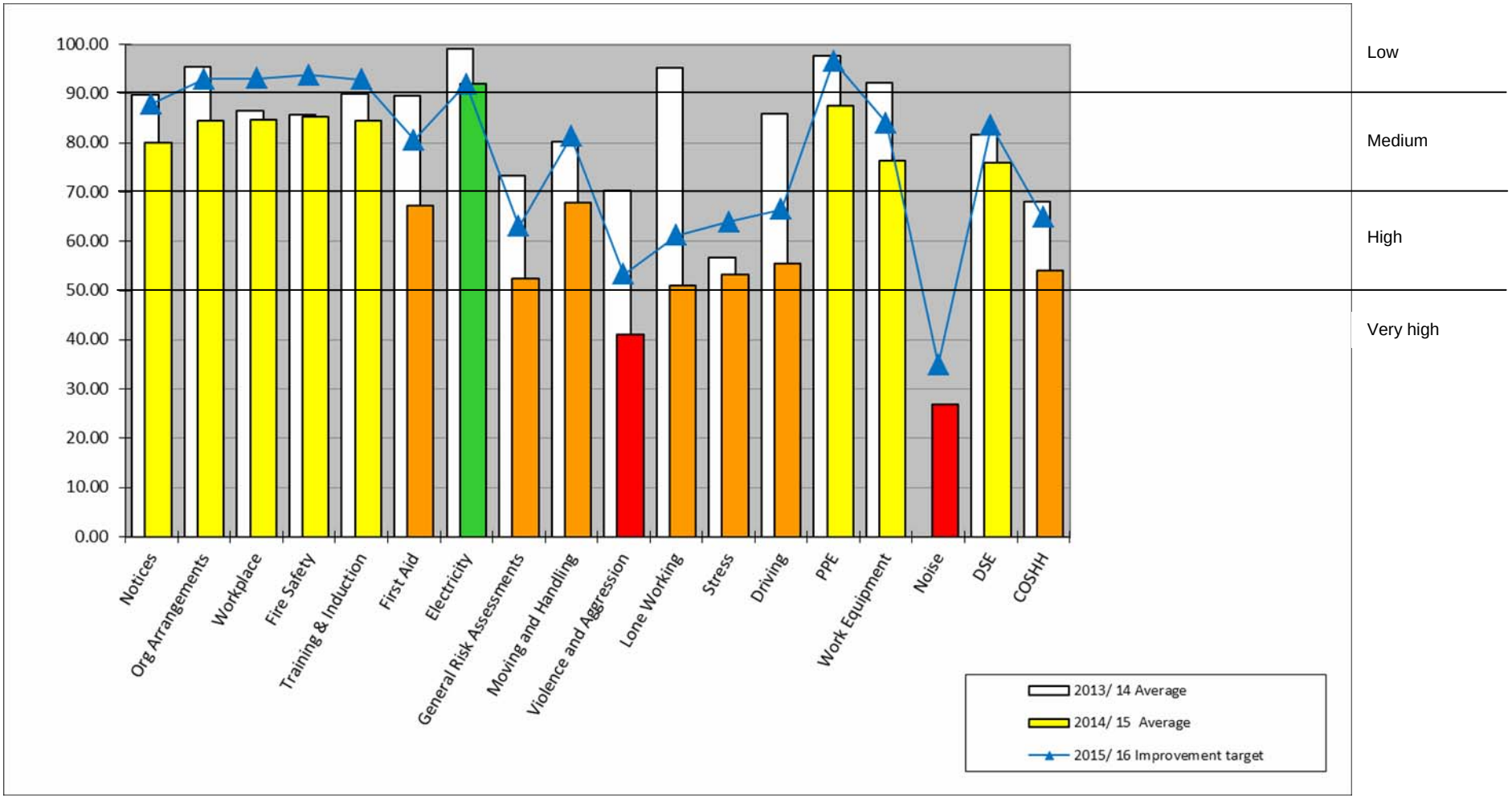
12.2.2 Audit Compliance 2014/ 15

109 Audits took place in 2013/ 14 and 113 throughout 2014/ 15. The majority of those audits conducted were to measure improvements on benchmarks; the graph left indicates the collated results of each specific standard;



Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Lowest audit score	39.44	Lowest audit score	38.21	Lowest audit score	41.36	Lowest audit score	29.18
Highest audit score	100.00	Highest audit score	98.64	Highest audit score	100.00	Highest audit score	100.00

12.2.3 Annual Improvement Targets



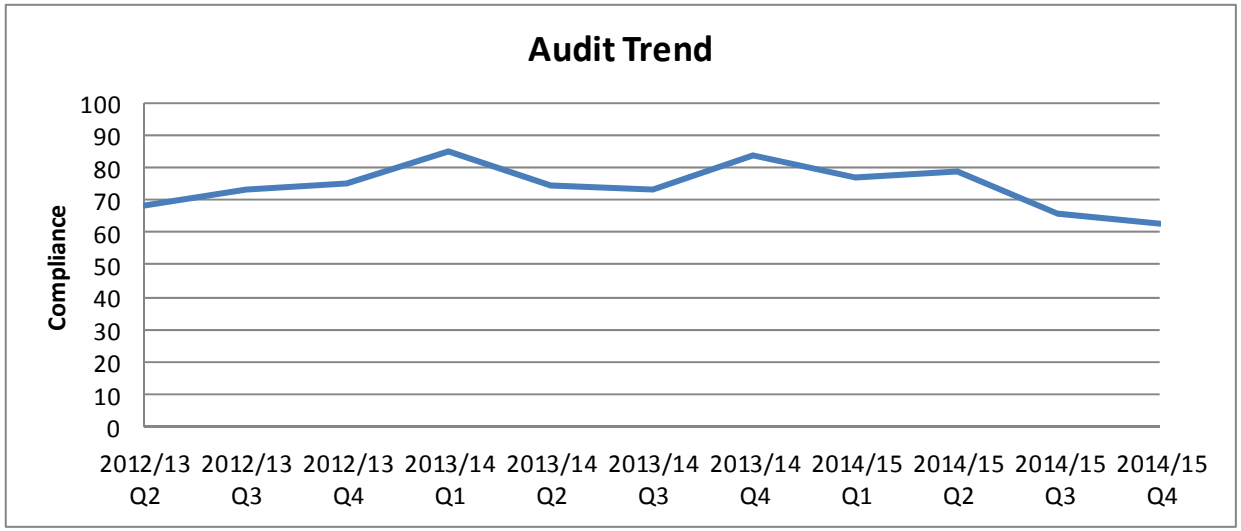
The graph on the previous page indicates both the audit findings from the previous year in clear bars. Coloured bars indicate actual audit results 2014/ 15 with the respective percentages set as a target to achieve by the end of 2015/ 16. As in previous years, those improvement targets are set at 30% for Very High risk, 20% for High risk and 10% for Medium risk.

Whilst both Violence and Aggression and Driving for Work improved and exceeded target for 2013/ 14 those department with 2012/ 13 poor compliance have been reviewed and improvements have not been made. Stress compliance is still very poor. Findings for this standard indicate that team based stress assessments are not being undertaken in some areas, staff are not aware of the individual perceived work related stress assessment or there is a lack of information on health and wellbeing in the local area.

Findings in general are still the lack of comprehensive general assessments that address the scope of risk that is presented by the work activity, specifically;

- Limiting assessments to those that are accessed on the health and safety intranet
- Failing to score risk or adapt the assessment to the activities of the department
- Not completing COSHH assessments for hazardous substances
- Lack of documented training including self-verification of competencies

Plans to address this include the COSHH database for common substances in use Trust wide, revision of risk assessment and health and safety training, implementation of health and safety link days and further health and safety 'surgeries'.



Trust wide, the trend graph indicates the overall movement since the start of OHSMS audits implemented in June 2012. Whilst there appears to be a decline in compliance standards it must .be noted that this does depend on the departments audited during the year as part of the current two year cycle

13.0 Conclusion

Audits will continue across the Trust in 2015/ 16 and the Health and Safety Steering Group is asked to note the contents of Appendix 2 and Appendix 3 to this report

14.0 Moving and Handling Team Structure

The Executive Lead for Moving and Handling is the Director of Nursing & Governance.

During the first part of 2014/15 the Moving and Handling team reported into Learning and Development. Following a restructure in October 2014 the Moving and Handling team was moved across to the health and safety team within Nursing and Governance directorate reporting the Trust Lead for Health & Safety.

Clinical Matrons, managers and supervisors / team leaders have the responsibility for ensuring staff are compliant with completing Moving and Handling mandatory training, and for the purchase of suitable equipment and risk assessments that demonstrate best practice and fitness for purpose.

14.1 Staffing

At the beginning of 2014/15 the team consisted of 3 M&H Advisors (one of which was also the team leader) was reduced to 1 as 2 Advisors made the decision to leave the NHS and relocate overseas. The remaining Lead Advisor felt it was time to retire, with a planned last workings day of 31st March 2015.

With multiple changes and analysis required for the redevelopment of the team, as an interim measure external competent agencies provided full support in terms of delivering mandatory moving and handling training. In February 2015 x 2 wte secondments were filled, with the appointments becoming permanent in the latter part of March 2015.

14.2 Vacancies

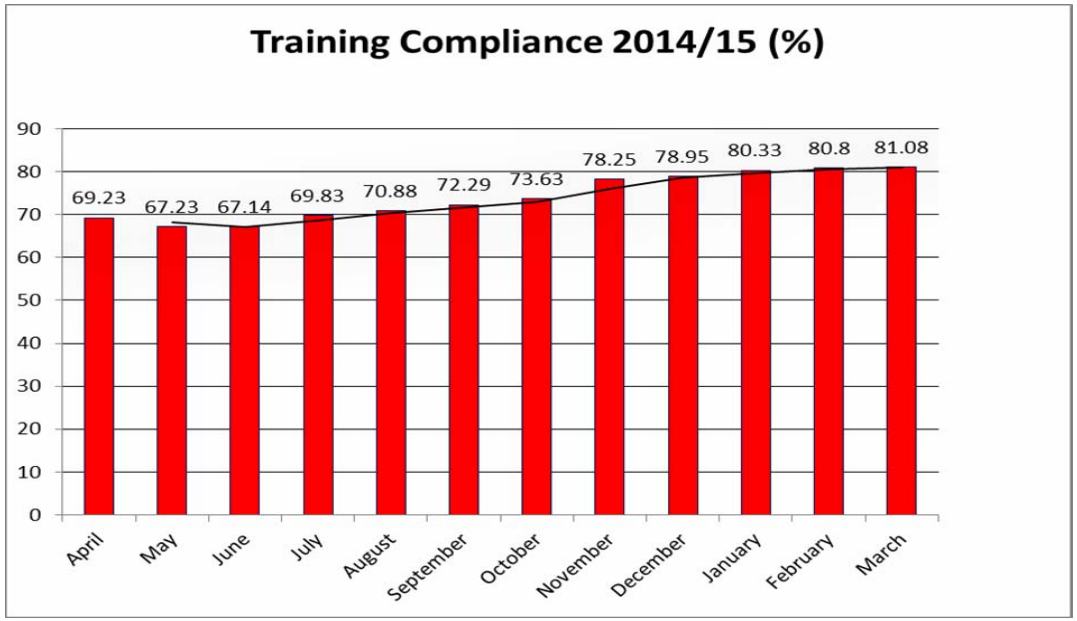
There remains currently 1 x wte vacant Specialist Practitioner Moving and Handling Advisor post, which it is anticipated to filled July/August 2015/16.

15.0 Moving and Handling - Training and Education

The Moving and Handling Team provide a comprehensive training programme for all Trust staff and volunteers in the acute and community, this includes:

- Mandatory training on induction for Clinical, Non-Clinical staff, and volunteers
- Mandatory eLearning Induction for Doctors and Dental staff
- Annual refresher training for clinical staff and targeted non-clinical staff teams
- 3 yearly refresher training for non-clinical staff
- Supporting other multi-disciplinary training events e.g. Tissue Viability (SSKIN)
- Train the Trainer sessions for new equipment roll out
- Internal Moving and handling Train the Trainer pilot

15.1 Training Compliance Mandatory training compliance is monitored by the Trust with measures taken when required attendance is trending below required standards; the target has been set as 85%. Manual Handling training compliance figures for 2014/2015 were:



In September 2014 the Learning and Development team presented plans for a 6 month update Mandatory Training programme to respond to falling compliance figures across all service areas. The Trust requested that the Moving and Handling team deliver a shortened presentation with no practical element with the strong recommendation that staff who attended a none practical session have to book a practical refresher training session at the earliest opportunity in 2015/16.

16.0 Professional Development

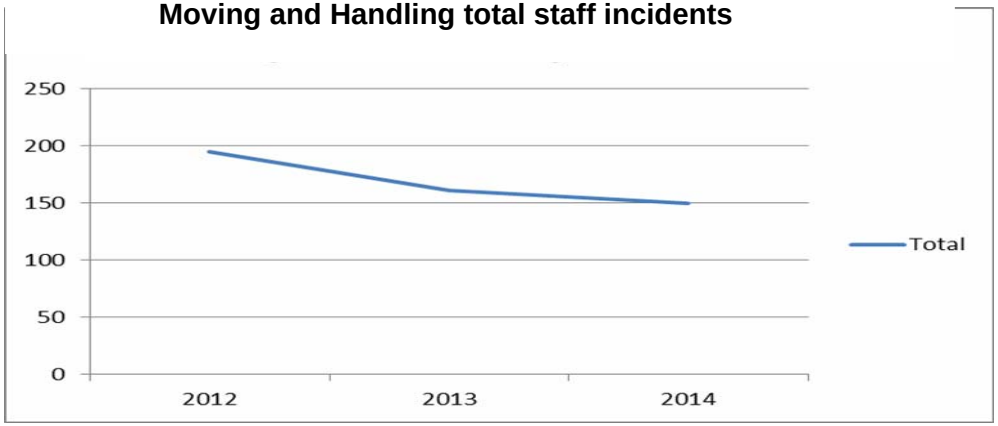
It is recommended that the Moving and Handling Team hold membership for the Back Care Exchange and maintain professional competence. Attendance of targeted and relevant training, conferences and study are a basic requirement for the team. Networking with other Advisors should also be supported facilitating attendance at regional group meeting enabling shared learning, innovation and reflective practice.

Due to the sudden reduction of the Team, from 3 members of staff to 1, and the 3rd retiring there was not the opportunity to support professional development until February 2015. With the Q4 x2 secondments being appointed training programmes and networking opportunities at recognised forums were established and will be developed during 2015/16.

17.0 Incident reporting

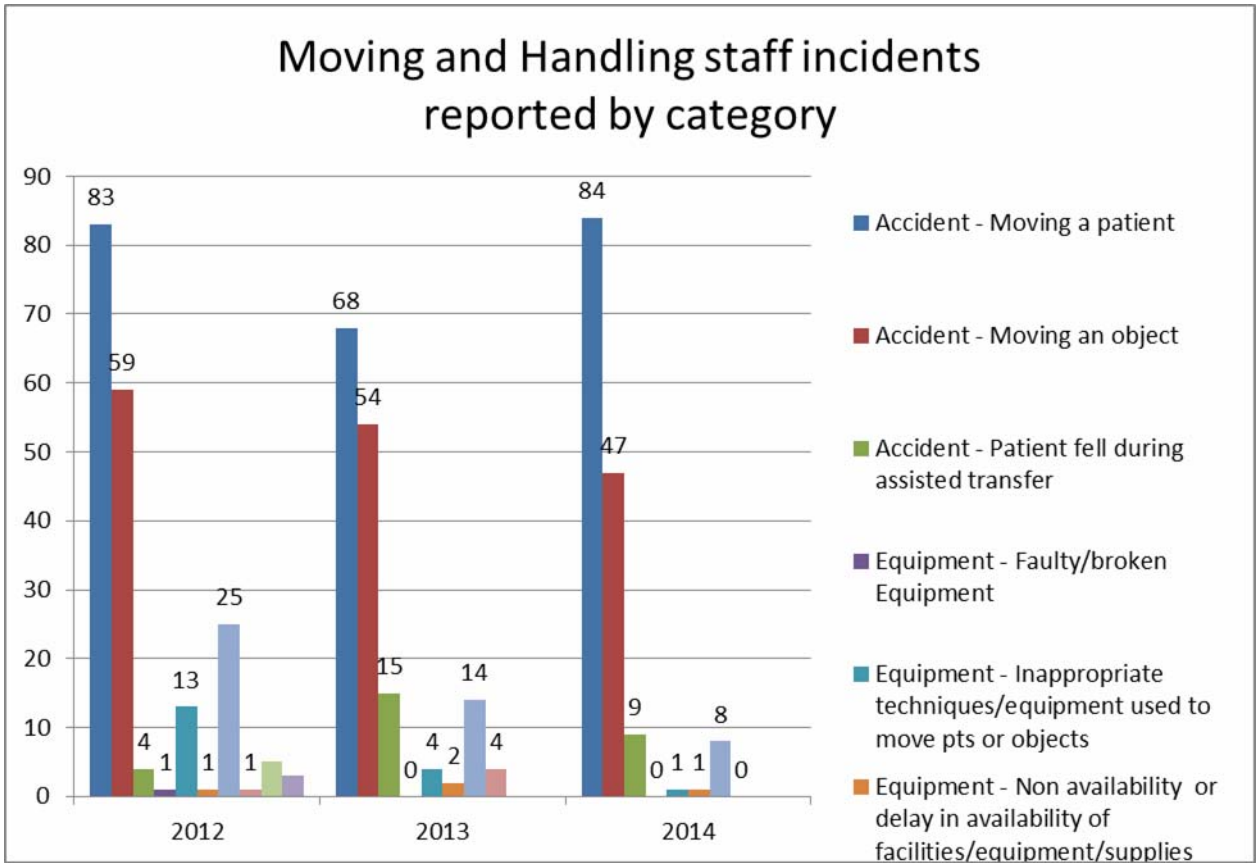
Datixweb is the system introduced to the Trust mid-2011, and is the database for all incident reporting therefore figures below reflect reporting from 2012/13.

Fig 17.1



Year on year there has been a positive downward trend in total number of staff incidents being reported; during 2014 this figure was 150.

Fig 17.2



17.2 Looking at the staff incident category breakdown there is a reduction in all areas, except the category “Moving a patient”. This increase can be aligned to the management of plus size patients (formerly referred to as bariatric patients) as there has been a steady rise in the admissions and length of stay. A working group has been reinstated with the aim of putting in place a robust process resulting in a multidisciplinary approved pathway.

Fig 17.3

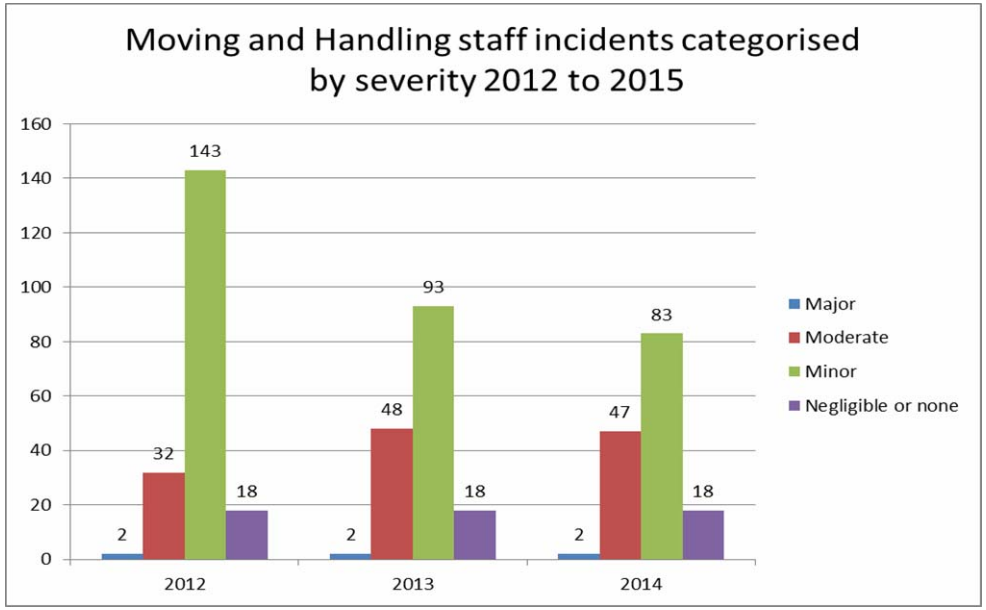
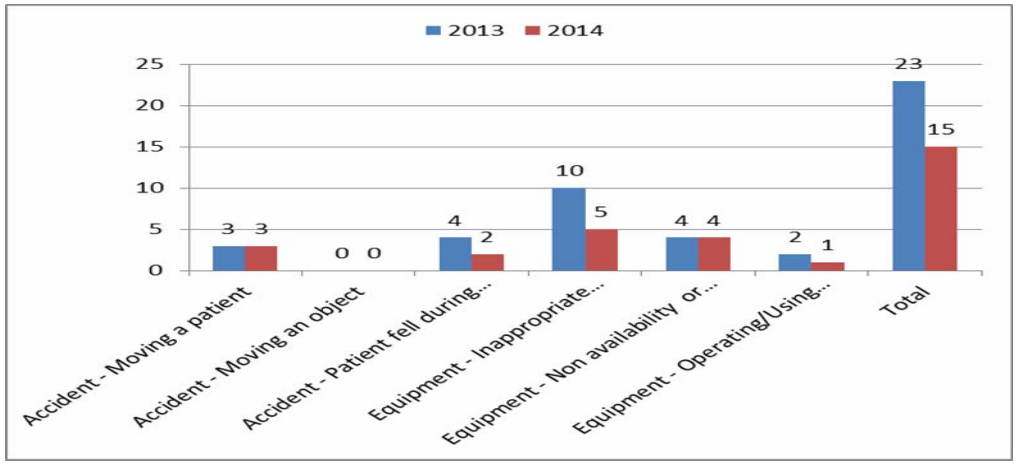


Fig 17.3 Staff incidents show an overall downward trend when categorised by severity with Major and Negligible reporting remaining static. In contrast, with the Patient incidents categorised by severity there were no incidents recorded as Major or Moderate, just 3 incidents were recorded as being Minor, the remaining were categorised as Negligible or None. It may be the case that near miss incidents are not being sufficiently reported and this should be encouraged.

Moving and Handling patient incidents

Fig 17.4



Total Moving and Handling patient incidents shows a 65% reduction between 2013 and 2014.
Additional work is required to support staff with availability of appropriate equipment and sufficient training.

18.0 Moving and handling team - Future Development:

18.1 Service Development

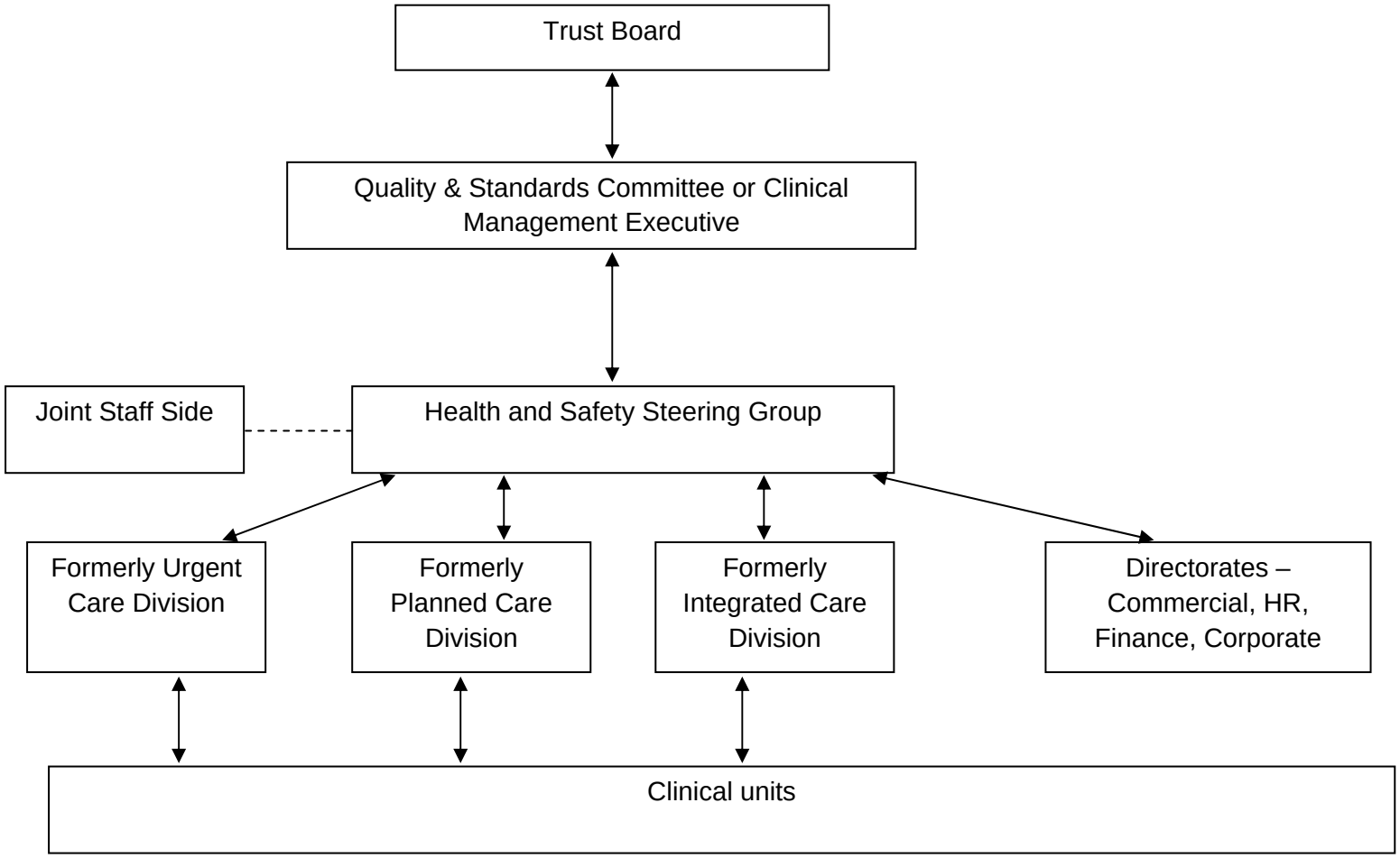
Manual Handling training helps reduce Musculoskeletal (MSDs), which are the most common cause of workplace injuries in the workplace, an estimated 11.6 million days a year are lost to MSDs in the UK.

Historically the Moving and Handling Team have focused on the delivery of training, which has been classroom based. It is widely recognised that training has to be fully comprehensible to everyone so that the knowledge can be put into practice.

In the next 12 months the Manual Handling Team will aim to:

- Achieve training compliance of 85%
- Respond to the needs of the Trust
- Recruit to establish a full complement of 3 full time staff
- Develop roles and functions to reflect recent job description changes, from Trainers to Specialist and Associate Practitioners
- Plan and continue to develop effective training, to include a training needs analysis
- Trial simulation training in the department/ ward environment
- Support and develop a Plus Size (formerly known as bariatric) pathway
- Increase visibility within the Trust through face to face contact, working groups and IT services
- Establish clear and workable processes for the management of Moving and Handling equipment, including stock management
- Work closely with procurement to ensure that products purchased are best practice, fit for purpose and value for money
- Review and update policies and documentation , ensuring they are readable, usable and reflect current guidelines and practices
- Produce meaningful reports
- Respond to Datixweb incidents and support managers in a timely fashion to reduce potential hazards and risks
- Promote healthy posture, by running a dedicated study day focussed on Backcare Awareness
- Trial new equipment for clinical and non-clinical staff , as appropriate
- Launch a Moving and Handling Trust webpage , part of a 2 year project to centralise resources and publish
- Launch “Back on-line” a bimonthly newsletter
- Develop better working relationships with key stakeholders
- Be accessible by all staff

Appendix 1 Health and Safety reporting structure



Appendix 2

East Sussex Healthcare NHS Trust – OHSMS 2012-2013
Internal Audit Methodology

1.0 Auditor Competencies

Auditors for management systems will be a member of the Health and Safety department.
Auditors should be suitably qualified Health and Safety professionals with a minimum of one year experience in a recent occupational health and safety related post and familiar with prevailing OHS legislation.

Auditors must be independent of the service or area to be audited and not have worked within that department for a minimum of 3 years. Suitable arrangements such as an alternative auditor will be available in the event of a potential conflict of interest

2.0 Audit Frequency

All services will be audited within the first 24 month cycle and audit priority given to areas deemed to be high risk indicated by either incident history or risk potential.

% Compliance	RISK RATING	Re audit
0-50	Very High	6 months
51-70	High	6 – 12 months
71-90	Medium	12 – 18 months
91-100	Low	18 – 24 months

3.0 Scope

Elements of the OHSMS relevant to the service will be objectively scored against compliance criteria – legislation and Trust policy;

- Structure and Responsibility
  Resources
  Responsibility and Accountability
  Training and Competency

- Consultation, Communication and Reporting
  Consultation
  Communication
  Reporting

- Documentation
  SOP's SSW's
  Work plans
  Inspection Records
  Training records

- Hazard Identification, Risk Assessment and Control of Risks

- Risk Management and Control

- Hazardous Substances, Infectious Materials and control of waste.

4.0 Action Planning

As part of the process of continual improvement in OH&S management, the auditor will agree an action plan with local manager with actions that are SMART for areas where a need for improvement has been identified.

5.0 Audit Distribution

The local manager will receive the audit prior to reporting and be able to comment on both the findings and the actions. After agreement, they will receive the final electronic copy of the audit and action plan, it is for the manager to allocate responsibility to specific individuals. Where actions cannot be undertaken due to resource issues including staffing and finance, this will be included in the overarching risk assessment and escalated in accordance with the risk assessment and risk management policy.
The audit will be further distributed to the Divisional Clinical Governance lead.

6.0 Audit Reporting

Results of audits are reported on a quarterly basis as part of divisional/ directorate H&S KPI's to the HSSG by the CG divisional/ directorate leads. Audit collation and benchmarking of standards will be summarised by the H&S department as part of the quarterly incident report from 2013/14.
Full year audit reports will be available on an annual basis to CME and Trust Board

Appendix 3

East Sussex Healthcare NHS Trust

Occupational Health and Safety Management Systems
Internal Audit Methodology 2015/16 proposed

Document	Change proposal
Department	Health and Safety
Unit	Nursing and Governance
Reporter	Jennifer Newbury
Role	Deputy Trust Lead – Health and Safety
Information or Approval	Approval
Detail	Change to the time frame of audit reviews

Background

Audits have been conducted by the Health and Safety department as an objective measurement of the Trusts delegated Health and Safety System at departmental level since June 2012.

The audit is focussed on risk assessments and also the management of health and safety at a local level including the management and communication of risks, incidents and lessons learned. The audit is comprised of 18 standards the structure of which enables the addition of sub-standards within sections to include potential risks to the organisation for example; Medical Devices manuals and requirements of Medicines and Healthcare Regulatory Agency (MHRA) alert notices.

Audits take 2 -3 hours to complete and must have the input of the manager or senior clinician responsible for health and safety. Larger or more complex departments may take 2 days to complete. Audit reviews are conducted on the basis of risk previously agreed by the Health and Safety Steering Group.

% Compliance	RISK RATING	Re audit
0-50	Very High	6 months
51-70	High	6 – 12 months
71-90	Medium	12 – 18 months
91-100	Low	18 – 24 months

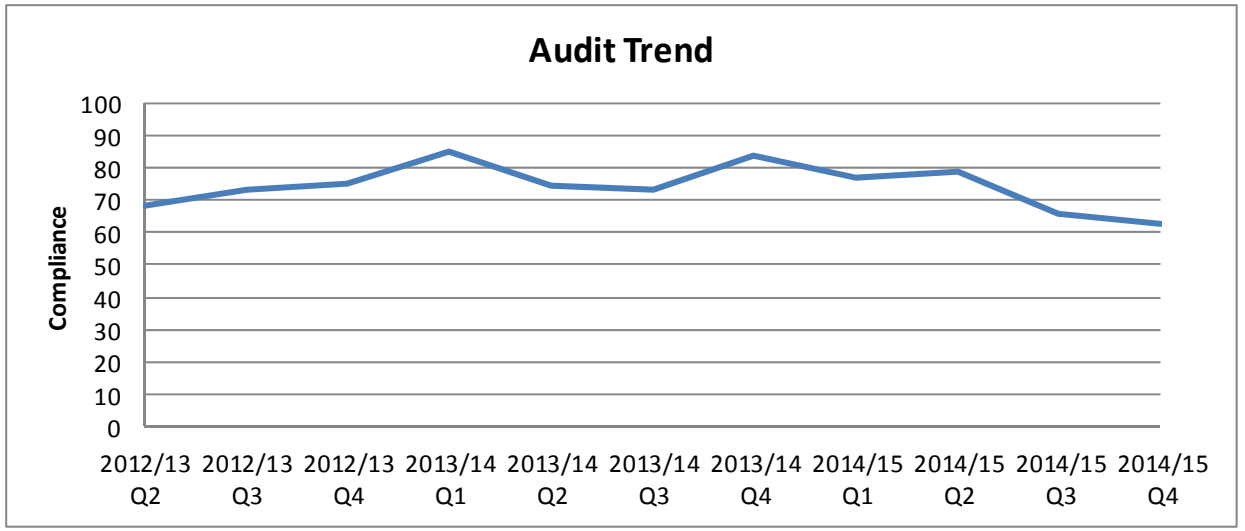
Audit Findings

Over the past year 113 audits have taken place;

- 36 audits demonstrated good compliance of over 80% and were either rated high compliance/ low risk with evidence of systems in place that were effective at managing health and safety. 27 of these were conducted as a first or second review
- 42 audits were graded as 'Very High' risk (10) or 'High' risk (32)
- 26 audits rated as 'Very High' or 'High' risk were conducted on a first or second review basis within the same reporting year.

This has resulted in a static audit trend with departments failing to implement health and safety. Reasons for this lack of conformity are discussed with the manager at the time as part of the audit however, auditors are consistently finding;

- Lack of assessment where the risk was significant
- Failure to scope hazards adequately
- Documentation including operating procedures and evidencing discussion of incidents, risks and lessons learned
- Low level of awareness for the process of escalating risk
- Limiting assessments to those that are accessed on the health and safety intranet
- Failing to score risk or adapt the assessment to the activities of the department
- Not completing COSHH assessments for hazardous substances
- Lack of documented training including self-verification of competencies



OHSMS Audit Trend

Rationale for Change

To continue undertaking audits within the current timeframe is not of benefit for the Trust, its staff or patients and may present the following risks if continued;

- Focus is on measurement rather than solutions and continual improvement, there is also potential for regulatory bodies to criticise,
- Departments known and evidenced during audit as having effective health and safety management continue to be measured with no evidence of change and must allocate time away from management of the department
- Potential for departments presenting a high risk to not have access to competent health and safety advice and assistance due to time commitments of audit

It is proposed that the time frame for reviewing audits is amended to take into account the above factors so that the Health and Safety department can focus a greater proportion of time to those departments presenting higher risks or specific problems at audit.

% Compliance	RISK RATING	Re audit	Proposal
0-50	Very High	6 months	6 months
51-70	High	6 – 12 months	6 – 12 months
71-90	Medium	12 – 18 months	12 – 24 months
91-100	Low	18 – 24 months	24 – 36 months

It is also proposed that for this change to occur, The Health and Safety department will meet with the Governance leads for each clinical unit and directorate to identify departments and decide on the most appropriate actions required.

The time frame for review will remain a risk based decision but will allow for more effective management of health and safety both strategically and operationally for the Trust.

East Sussex Healthcare NHS Trust

Date of Meeting:	5 August 2015
Meeting:	Trust Board
Agenda item:	11b
Subject:	Annual Complaints Report 2014/15
Reporting Officer:	Alice Webster, Director of Nursing

Action: This paper is for **(please tick)**

Assurance	✓	**Approval**		**Decision**	

Purpose:

To inform the Trust Board on the number of complaints received over the year in comparison to the previous year; about the themes of the complaints; the number of complaints where PHSO ombudsman enquires have been made and finally to present recommendations from this report

Introduction:

Patient complaints are extremely important in helping the Trust to identify patient concerns; needs and suggestions. Collation of data around patient complaints can have a very positive impact on patient experience as this information can be used improve services.

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

Formal complaints in this year have increased by 20%
Informal complaints have decreased by 15%
Complaints are grouped into themes; the top 5 themes for formal complaints include;
Patient Pathway
Attitude of staff
Clinical care
Communication
Provision of service
Further analysis in respect of the above is provided within this report.

Complaints about staff have been reviewed and the following noted
54% are about doctors
26% about nurses/midwives
6% about other staff the vast majority of which were related to the appointments system
Referrals to the PHSO has decreased on the previous year from 19 to 17 in this year

Benefits:

Listening to patients, relatives and carers can have significant benefit to the organisation; helping staff to see and understand were improvements to a services; pathway; policy or individual behaviour can be made.

The recent appointment of an interim complaints manager has led to some improvements within

the quality assurance of responses to patients. This is essential in reducing the number of re-opened complaints. (Q1 2015-16) complaints report would indicate that the number of re-opened complaints are falling.

Risks and Implications

Increase in patient concerns may lead to a lack in service user confidence in the hospitals and community services. It is therefore essential that the trust uses patient feedback in a positive manner to improve services.

Assurance Provided:

There have been significant changes within the complaints handling process and although this has led to an increase in the number of 'out of time' complaints because of the more robust mechanisms for quality checking this has improved the quality of the responses. The new complaints manager will be starting in the next month and further improvements will be made to the whole complaints pathway.

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 – 6 July 2015

Proposals and/or Recommendations

Continue to triangulate data received from all avenues of complaints i.e. formal and informal to further improve services.

An update in September on Datix provision with a "Health Check" on the complaints module will provide any updates as required. Training will also be delivered regarding the use of Datix to the complaints team. This will allow better data extraction and analysis of complaints.

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: Lindsey Morgan	**Contact details: 07554553138**

East Sussex Healthcare NHS
NHS Trust

Complaints Report

Quarter 1-4 (Annual) Report 2014/15

1.0 Introduction

1.1 Each quarter, a report of Patient Experience activity which includes complaints is produced and presented to the Trust Board. This report builds on those earlier reports to provide the complaints data for all four quarters for the year of 2014/15.

1.2 The information in this report outlines:

- Number of complaints received
- Identified themes of complaints
- Position at the end of Q4 regarding overdue complaints
- Complaints referred to the Parliamentary and Health Services Ombudsman (PHSO)
- Recommendations and actions

2.0 Number of complaints received

2.1 The table below shows the total number of complaints received, formal and informal and then upheld formal complaints.

Year	Total number received	Formal	Informal	Upheld (formal)
2013/14	639	521	118	303
2014/15	746	645	101	379

During 2014/15 the Trust received a total of 645 written formal complaints compared to 521 in 2013/14, an increase of 20%.

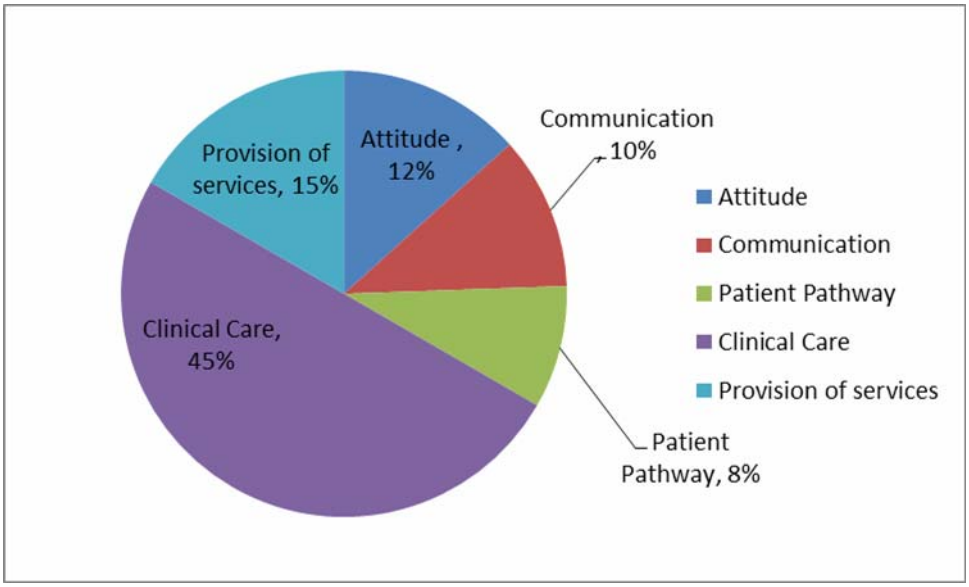
During 2014/15 the Trust has received a total of 101 informal complaints compared to 118 in 2013/14, a decrease of 15%.

59% (379) of formal complaints were upheld in 2014/15 compared to 58% (303) of upheld in 2013/14; an increase of 1%.

3.0 Identified themes of complaints

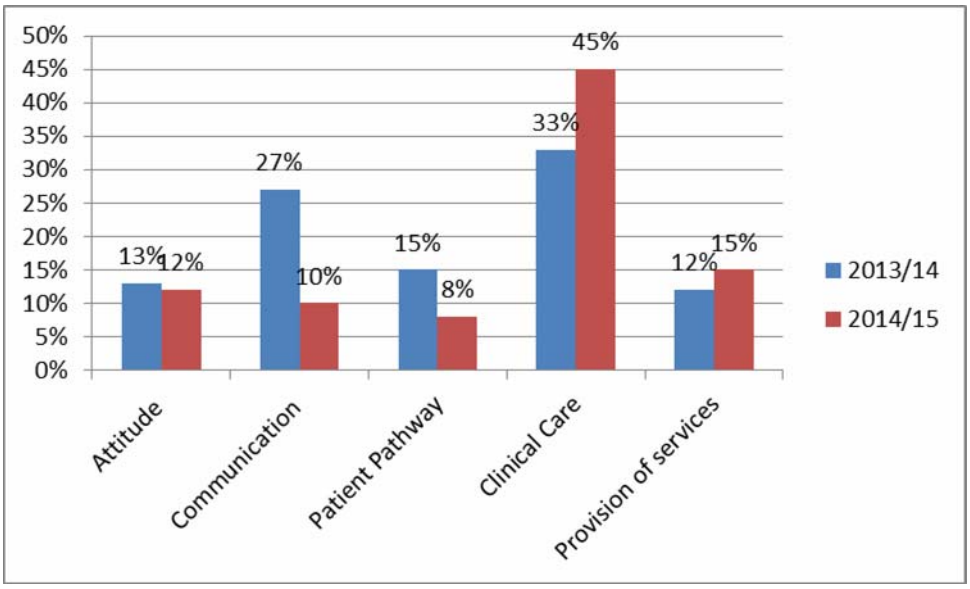
3.1 The following chart shows the top 5 themes of formal complaints by subject as recorded on Datix:

Top 5 Formal Complaint Themes 2014/15



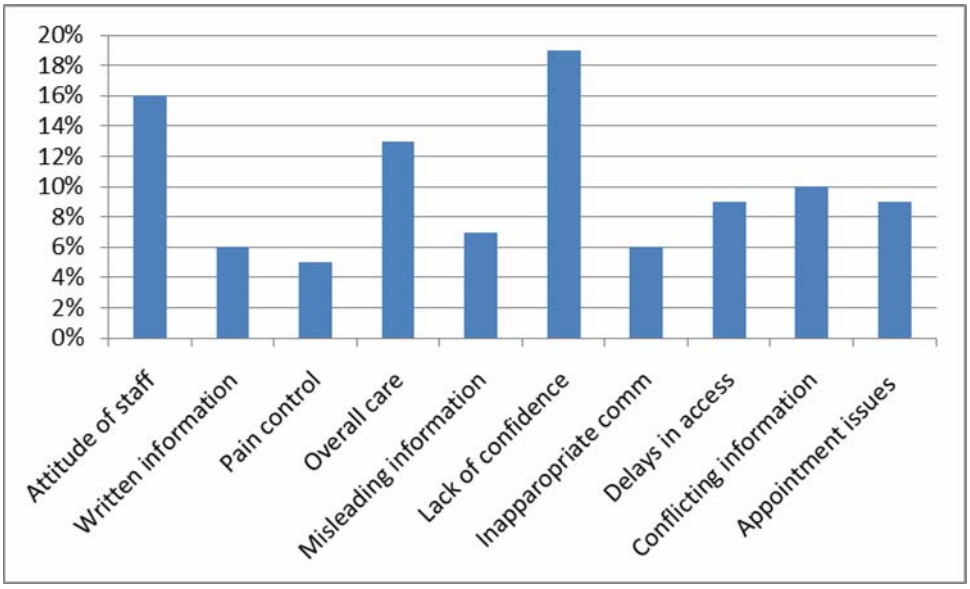
3.2 The following chart compares the top 5 themes of formal complaints by subject for the years 2013/14 and 2014/15 as recorded on Datix:

Top 5 Formal Complaints Themes 2013/14 and 2014/15



3.3 Further analysis into communication themes identifies that lack of confidence in staff and attitude of staff is amongst the biggest concern for patients. The table below identifies the top 10 themes for the sub-subject (as recorded on Datix) within communication complaints.

Breakdown of Communication Complaints 2014/15

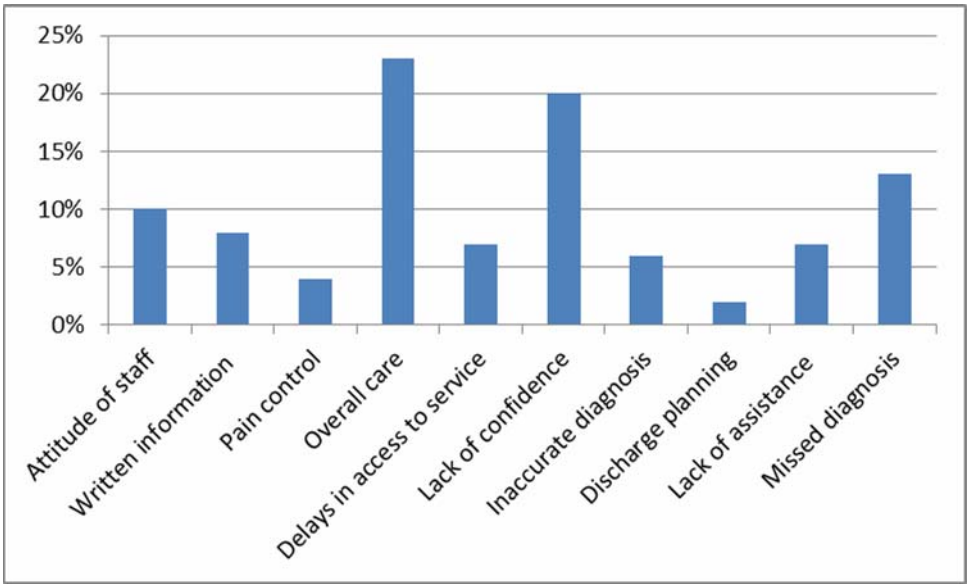


Communication is being addressed with the review and provision of 'Communication Skills' training and Duty of Candour training with particular emphasis on Doctors (see 3.8 complaints relating to profession). Communication was also an identified area requiring improvement that was fed back to the Trust from patients and family / carers during the Dignity Day hosted by the Trust in March 2015. Communication is also a commitment within the Quality Account.

Written information is being addressed through the Quality Account; two specialities per quarter will review all written patient information through the existing Patient Information Group.

3.4 Further analysis into the clinical care theme identifies overall care and lack of confidence as the main issue for complainants. The table below identifies the top 10 themes for the sub-subject (as recorded on Datix) within clinical care complaints.

Breakdown of Clinical Care Complaints 2014/15



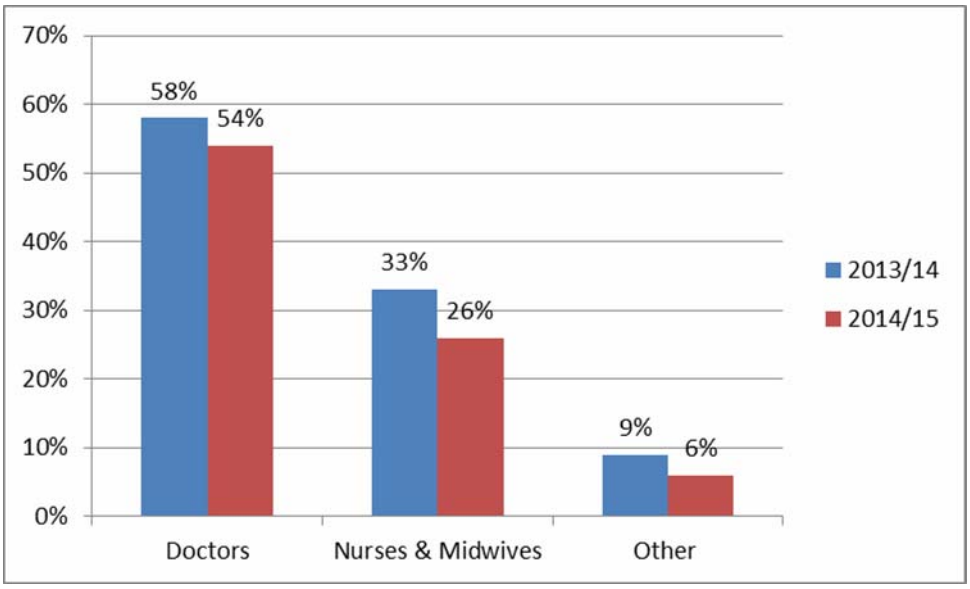
3.5 Attitude of staff – this is being addressed through personal development reviews, training and supervision of staff. Consideration is being given to request that any staff member in receipt of a complaint regarding their attitude to attend the communication skills training. This is likely to be in place once all staff are undertaking revalidation.

3.6 Patient Pathway - Initial investigation indicates that this is related to changes made to the out patients administration service which is being reviewed.

3.7 Provision of service - Initial investigation identifies this relates to where services have become single sited and lack of service provided where there are Consultant vacancies (mainly Neurology).

3.8 The following chart shows the professions where a complaint has been raised (please note: “other” includes administrators: review of the data shows that these complaints predominately relate to the appointments system).

Formal Complaints against professions 2013/14 and 2014/15



Where communication and clinical care relating to a member of staff is identified through a complaint, this is dealt with through personal development reviews and/or supervision where identified learning opportunities are put into place.

4.0 Position at the end of Q4 regarding overdue complaints

4.1 Overdue complaints at the end of this year totalled 37 cases (position on 1 January 2015 was 24, 1 February 2015 28, 1 March 2015 25 cases).

The Interim Complaints Manager initiated quality assurance checks on all responses from the middle of March 2015. This increased the overdue numbers as the quality assurance checks added time to the process. Shortcomings in the investigations are identified and draft responses returned to the Clinical Units for further or more in depth investigation and clarification. The Interim Complaints Manager also met with all Clinical Units mangers in order to challenge inadequate responses and offer support. Until the investigations and draft response improve, this process will have to continue. It is hoped that this process, will in the longer term, significantly reduce the number of cases that have to be re-opened or investigated by the Parliamentary and Health Services Ombudsman (PHSO).

The shortcomings that have been identified through the quality assurance process (to date) include:

- Failure to provide dates and times of when events occurred
- Acceptance that an error occurred with no investigation as to how it happened – lack of root cause analysis and therefore learning
- No learning identified even when errors acknowledged
- No identification of the evidence that has been reviewed (e.g. medical records, specific policy or guidance)
- Failure to respond to complainant's specific concerns
- Medical terminology not explained
- Incomplete responses sent to the complaints team

The quality assurance checking process has also identified that there has been a failure to identify the questions raised by the complainant at the start of the process, resulting in cases being reopened. A system is now in place where new complaints are reviewed (triaged) and if the questions are not clear then the complaints team make contact with the complainant preferable by telephone to seek clarification of the questions raised within the complaint

Weekly overdue complaints reports are provided to the Director of Nursing which demonstrates where the issues are regarding overdue complaints (i.e. out of the Trusts control, with Clinical Units or with complaints team).

5.0 Parliamentary and Health Service Ombudsman Enquiries (PHSO)

5.1 The table below shows the total referrals received via the PHSO for 2013/14 and 2014/15.

During 2014/15 a total of 17 PHSO referrals were received and 17 cases closed. 8 cases were upheld, 4 cases partially upheld, 3 cases not upheld and 2 cases no further action.

This is compared to PHSO referrals received in 2013/14 which were: 19 referrals received and 7 cases closed. 1 case upheld and 1 not upheld and 5 no further action.

Year	Total referrals received	Total cases closed	Upheld	Partially upheld	Not upheld	No further action
2013/14	19	7	1	0	1	5
2014/15	17	17	8	4	3	2

5.2 The actions required to address the root cause of the complaints referred to the PHSO are:

- Provide training regarding documentation and End of Life Care.
- Cardiology booking clerks to have additional training regarding booking patients onto the correct pathway.
- Provide Junior Doctors education on assessing abdominal pain.
- Accident and Emergency escalation process to be adhered to.
- Improve the triage process within Accident and Emergency.

6.0 Recommendations and Actions from the Report

- The complaints team will continue to work closely with the Clinical Units to ensure responses are completed to meet the complainant's needs and within the time agreed.
- To implement a post complaint survey (to ask complainants their opinion about the complaints handling process) to be sent to all complainants following receipt of their response.
- Consider the use of a specific survey post complaint for those relating to specific themes (i.e. patient pathway) to identify areas of improvement.
- Consider holding a Listening in Action group to improve the handling of complaints following the feedback of complainants and the complaints team.
- Work with Learning and Development team to review the provision of Communication Skills and Duty of Candour training.
- Meet quarterly with Clinical Units to review the process of their complaints handling and any agreed actions that have emerged from complaints.
- Better understanding of the concerns raised by patients within the categories "lack of confidence" and "discharge planning" is essential to be able to improve this both within the pathway and with individual staff.
- Datix will be completing a "Health Check" on the Complaints module to review and provide any updates as required. Training will also be delivered regarding the use of Datix in September to the complaints team. This will allow better data extraction and analysis of complaints.
- To continue the Quality Assurance process and weekly complaints reports to inform Clinical Units of the complaints they currently have.
- To provide a full and supported induction to the new Complaints Manager (starting August 2015).
- Written patient information to be reviewed as part of the commitment set within the Quality Account.

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	12
Subject:	Workforce Race Equality Standard (WRES)
Reporting Officer:	Lynette Wells, Company Secretary

Action: This paper is for **(please tick)**

Assurance	x	**Approval**		**Decision**	

Purpose:

This paper provides a high level overview of the requirements of the Workforce Race Equality Standards and the key metrics. This area, along with Equality and Diversity, will be considered at the September Board Seminar where discussion will take place to outline the Trust's processes to support compliance with this standard.

Introduction:

WRES is a new standard from April 2015 and is a requirement of the NHS contract.

The aim of the 2014 -2015 report is to collect baseline figures for the 9 metrics that make up the standard. Using the baseline figures, the Trust must identify and address, during 2015-16, any inequalities that have been identified. The Trust must also improve on areas where data collection is incomplete or unavailable.

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

The baseline figures demonstrate that the Trust is representative of the population it serves. A steering group will devise an action plan and monitor the 9 metrics.

Benefits:

The WRES will assist the Trust in meeting its legal obligations as an equal opportunities employer and to comply with the Public Sector Equality Duty. The standard will also assist the Trust in identifying and addressing any racial inequalities and thus providing a more inclusive workforce.

Risks and Implications

There are incompleteness of data sets due to how access to non-mandatory training is captured. Workforce development will look at ways to capture this data more accurately in time for 2015-16 reporting.

Disciplinary figures cannot be published as it risks breaching staff confidentiality. Figures are extremely small that the relative likelihood is not a true representation. This is unlikely to change in 2015-16.

Non-compliance with WRES would be a breach of the NHS standard contract.

Assurance Provided:
The paper provides assurance of the process in place to support implementation and monitoring of WRES.

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

Proposals and/or Recommendations
The Board is asked to review the Workforce Race Equality Standard and initial mapping against the metrics and note the proposals to improve data collection and monitoring.

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: Kim Novis **Equality Diversity and Human Rights Lead**	**Contact details:** Kim.novis@nhs.net ext (14)2620

East Sussex Healthcare NHS
NHS Trust

The Workforce Race Equality Standard

1. Introduction

The Workforce Race Equality Standard (WRES) was introduced by NHS England to all NHS organisations from April 2015. WRES consists of nine metrics that can be used to help NHS organisation identify and address race inequality. East Sussex Healthcare NHS Trust (ESHT) has welcomed the new standard which provides an opportunity to demonstrate our commitment to advancing equality of opportunity for the diverse workforce it employs. The metrics will be used as a tool to help identify and close gaps between BME and White staff within the organisation. The new standard will assist the Trust in meeting its legal obligations as an equal opportunities employer. It will also assist in ensuring the Trust is fulfilling its legal duties to comply with the Public Sector Equality Duty.

Robert Francis's 2010 report into the Mid Staffordshire hospital scandal along with Research Fellow Roger Kline's 2014 The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England, has demonstrated there is a strong link between patient care and staff experience. Such research highlights the many areas which many NHS organisations need to address.

The Trust is committed to equality of opportunity, treatment and behaviour, employment, promotion and development. We will actively seek to eliminate unlawful discrimination and foster good relations between those who share a protected characteristic (age, race religion, gender, gender reassignment, sexual orientation, marriage and civil partnership, pregnancy and maternity and disability – including carers) and those who do not.

Along with the implementation of the Refreshed Equality Delivery System (EDS2), WRES will assist the Trust in ensuring our workforce can be confident that the Trust is giving due regard to using the indicators (below) contained in the WRES to help ensure any inequalities are identified and addressed.

2. Data Collection and Monitoring

In order to demonstrate progress against the nine WRES indicators, it is important that the Trust records data to support benchmarking and improvement. There will be a focus on improving processes for data collection.

2014-15 is ESHT first report of the WRES and baseline data will be used to develop an action plan for 2015-16. A joint EDS2 & WRES steering group will meet twice annually commencing in September/October 2015. The group will engage with others such as the BME network and will aim to devise a robust system to monitor the WRES metrics and actively seek to remove any barriers wherever possible. An action plan will be published following the steering group meeting.

3. Workforce Race Equality Standard Metrics

Workforce metrics For each of these four workforce indicators, the Standard compares the metrics for white and BME staff.	
1.	**Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce**
	At the time of reporting, ESHT employs 6566 members of staff. ❖ 11.8 % Identified as BME ❖ 81.6% Identified as White British or White Other ❖ 6.7% Unknown 6.7% of the workforce were employed in positions 8 – 9 and VSM. ❖ 17.1% of Bands 8 - 9 and VSM identified as BME compared to 11.8% BME in the overall workforce. ❖ 78.4% in Bands 8 - 9 and VSM identified as White British or White Other. ❖ 4.6% of staff in Bands 8 - 9 and VSM, ethnicity was unknown
2.	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	4584 applicants were shortlisted. . ❖ 3576 applicants identified as White British or White Other ❖ 916 applicants identified as BME ❖ 92 applicants ethnic origin was unknown 730 applicants were appointed ❖ 620 appointees identified as White British or White Other ❖ 84 appointees identified as BME ❖ 26 appointees ethnic origin was unknown The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 1.88 times greater.
3.	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**
	Staff identified as White British or White Other were 2.2 times more likely to enter the formal disciplinary process compared to staff identified as BME. These figures for reporting of staff entering into the disciplinary process over a 2 year period were extremely small. Only a relative likelihood figure is included due to the risk of breaching staff confidentiality. This is unlikely to change in 2015-16.

4.	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**
	Available figures demonstrate BME staff were 1.13 times more likely to access non-mandatory training compared to white staff. Note: Collection of data on those accessing non-mandatory training is incomplete due to how this data is captured. Line managers often block book places on conferences and university workshops, the booking forms require a line manager's name plus the number of attendees and not necessarily individual names. Therefore identifying members of staff who have attended these non-mandatory training events has proved challenging. Where staff have been identified this has been reported.
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff	
5.	**KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	31% of ESHT staff said they had experienced harassment, bullying or abuse from patients, relatives or the public in last 12 month. This is an increase of 2% from the previous year. The national average for acute Trusts in 2014 was 29% and the best score was 20%. ❖ 31% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. ❖ 26% of BME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6.	**KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	27% of ESHT staff said they had experienced harassment, bullying or abuse from staff in last 12 months. This was an increase of 1% from the previous year. The national average for acute Trusts in 2014 was 23% and the best score was 17%. ❖ 26% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. ❖ 25% BME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months.
7.	**KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion**
	83% of ESHT staff believed they were provided with equal opportunities for career progression or promotion. This is a decrease of 1% compared to the previous year. The national average for acute Trusts in 2014 was 87% with the best score of 96% ❖ 85% White respondents believed they were provided with equal opportunities for career progression or promotion. ❖ 70% BME respondents believed they were provided with equal opportunities for career progression or promotion.
8.	**Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	8% of respondents felt they had experienced discrimination at work from their

	manager or team leader. The national average was 8% ❖ 4% reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. The national average was 4%.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Boards are expected to be broadly representative of the population they serve**
	ESHT Board is broadly representative of the population it serves. Although no members identify as BME they do identify with other protected characteristics which also have a high prevalence in East Sussex. Advertisement of current Board vacancies include BME networks/forums and other wider advertising such as The Telegraph.

4. Timetable for implementation

April 2015

- Identify Board Level Lead
- Identify WRES Lead for reporting

April – June 2015

- Collection of baseline data for WRES
- Set up joint steering group for EDS2, WRES & Equality Objectives Progress Agree members. To meet to annually in September & May

July 2015

- Report containing baseline figures for WRES submitted to Board

August 2015

- Publish reports

September 2015

- Steering Group Meet
- Devise plan to address highlights / implications from WRES baseline data
- Identify / confirm Leads for EDS2 Outcomes (some link with WRES) and some WRES metrics
- Identify data monitoring and collection methods for EDS2 & WRES.
- Confirm data collection dates / deadlines (likely to be April / May).
- Agree engagement
- Implement engagement plans / activities for EDS2 & WRES

April - May 2016

- Steering Group meet
- Presentation by Leads on data, progress, implications
- Progress update on Equality Objectives

June - July 2016

- Draft reports sent out (EDS2, WRES, Equality Objectives update)

August 2016

- Publish Reports

This Report is available in alternative formats upon request. Alternative formats include (but not limited to) Large Print, Braille, Audio, Alternative Community Languages. Please contact the Equality, Diversity & Human Rights Team by emailing esh-tr.equality@nhs.net or Telephone 01424 755255.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 3rd June 2015 at 10.00am in the Committee Room, Conquest Hospital

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

In attendance Mrs Vanessa Harris, Director of Finance
Dr David Hughes, Medical Director – Clinical Governance
Mr Richard Sunley, Chief Operating Officer and Deputy CEO
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Mr Jody Etherington, BDO
Mr Robert Grant, BDO
Mr Mike Townsend, Regional Managing Director, Tiaa
Mr Bertram Green, Project Consultant, Year-End Accounts
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

1. Welcome and Apologies for Absence

Mr Stevens opened the meeting and noted that a quorum was present.

Apologies for absence had been received from:

Mr Charles Ellis, Non-Executive Director
Mr Darren Grayson, CEO
Mr Steffan Wilkinson, Counter Fraud Manager, TiAA
Dr Amanda Harrison, Director of Strategic Development & Assurance

2. Minutes

i) The minutes of the meeting held on 4th March 2015 were reviewed and agreed as a correct record.

ii) Matters Arising

Any matters arising were deferred to the next Audit meeting scheduled for Wednesday 8th July 2015.

3. Quality Account 2014/15

Mrs Webster presented a paper on the Quality Account 2014/15 to the Committee, stating that the Trust had complied with mandatory guidance. This document was due to be submitted to the Secretary of State by 30th June 2015. Mr Grant advised that BDO would complete an audit on the Annual Report prior to submission and an audit report would be presented to the next Audit Committee meeting

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

4. Annual Accounts & Report 2014/15

a) ISA260 BDO Annual Governance Report on the Annual Accounts 2014/15

Mrs Harris noted that the version of the report circulated to the committee would undergo further non-material updates prior to finalisation.

Mr Grant presented the report and noted that the Annual Accounts were due to be submitted on Friday 5th June. He explained that none of the additions that were due to be made to the report were considered material and that in respect of the financial statements no material misstatements had been identified.

Mr Grant advised the Committee that appendix 3 of the report highlighted identified misstatements that were considered to be immaterial in the context of the financial statements when taken as a whole. The overall effect of these misstatements if corrected would be an increase In the Trust's surplus for 2014/15.

Mr Grant advised the Committee of six unadjusted audit differences, of which two related to errors identified in previous years. Subject to satisfactory completion of outstanding work, he anticipated issuing an unqualified true and fair opinion on the financial statements for the year end 31 March 2014.

He highlighted the following areas:

Control Environment
Audits to assess the accuracy of clinical coding had been carried out on a reduced basis during 2014/15 and the results of audits had not been systematically reported to Trust management. It was recommended that the Audit Committee oversee the clinical coding audit programme during 2015/16 in order to obtain an appropriate level of assurance.

Use of resources
The small surplus achieved by the Trust in 2014/15 was noted, along

with the Trust's deficit position for 2014/15 and future budgeted deficit position. The audit report would therefore include an adverse value for money conclusion due to the cumulative deficit reported by the Trust as at March 2015 and because of the further deficit planned for 2015/16.

Key Trust Strategies
A review of the Trust's framework of key strategies was undertaken and it was found that the various strategies were soundly based on comprehensive data and benchmarking.

Management Override of Controls
Mr Stevens queried the conclusion that there was significant risk associated with the management override of controlssince this would require collusion between at least 2 members of staff.. Mr Grant agreed with that but explained that BDO were required to review this, and had recognised that there were circumstances in all entities where management controls could be overridden.

Revenue Recognition
Mr Stevens asked about the significant audit risk reported in the accounts around revenue recognition, given that the Trust's revenue was agreed with the CCGs in advance. Mrs Harris explained that the issue related to work in progress at year end. She reported that this was a very specific issue associated with year-end and that the Trust believed it had been reflected accurately within the accounts.

Impairment of non-NHS Receivables
Mr Stevens explained that while he would generally agree with the statement that non-NHS receivables amounting to £179,000 which were more than six months old should be subject to a provision, he felt that the NHS often worked differently from the private sector however, and that many of the debtors would take longer than six months to pay but would still do so. Mr Grant explained that BDO had taken a technical view on the recoverability of the debtors and had felt it was important to highlight the fact that they felt that insufficient debt chasing was being undertaken by the Trust.

Mrs Harris said that she would look at improving policies around non-NHS debtors. She also noted that work would need to be undertaken to look at the review process around the Trust's fixed assets.

Mr Stevens said that the external auditor's report had highlighted different areas where improvements could be made and that these would be incorporated into the Annual Accounts process for 2015/16.

The Audit Committee noted the external auditor's Annual Governance Report for 2014/15, the unqualified opinion on the

financial accounts and the qualified conclusion on the use of resources.

b) Annual Report including Annual Governance Statement for 2014/15

Mrs Wells confirmed that the document followed national guidance and revisions had been made in line with auditors' recommendations. It was noted that a minor change had been made to the Remuneration Report for the final version of the document.

Mr Nealon asked that the two paragraphs on page 9 of the Annual Report relating to the CQC's visits to the Trust be reworded as the reports from the CQC's visit to the Trust in March 2015 were not yet known. It was agreed that Mrs Wells would amend these paragraphs prior to the report's final submission.

LW

The Audit Committee approved the Annual Report and Annual Governance Statement for 2014/15 subject to the amendments to be carried out by the Company Secretary.

c) Annual Account & Associated Certificates & Summary Financial Statements 2014/15

Mr Green gave a detailed breakdown of the key information in the Trust accounts.

Mrs Harris explained that Mr Sunley had been given delegated authority to sign off the certificates associated with the Annual Accounts and that he would also be signing off the audit report and letter of representation.

The Audit Committee approved the Annual Accounts and associated certificates for 2014/15 and noted that they would be signed by Mr Sunley on behalf of the Chief Executive.

d) Internal Audit Annual Report & Head of Internal Audit Opinion for 2014/15

Mr Townsend reported that he had provided a reasonable assurance opinion for the Trust in respect of the internal controls that had been reviewed during the year.

He explained that six final audit reports had been issued, one giving limited assurance, three giving reasonable assurance and two giving substantial assurance. The five remaining reviews were all nearing completion with four at the draft report stage. Mr Townsend reported that all of the audits for 2014/15 should be finalised by the end of June 2015.

He noted that the report provided a summary of the audits

undertaken during the year and the assurance opinions provided. Individual reports were considered in detail at each Audit Committee.

The Committee noted the Internal Audit Annual Report and the Head of Internal Audit's Opinion of Reasonable Assurance for 2014/15

e) Auditor's report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998

A Section 19 letter was issued by auditors to the Secretary of State for Health on 29th May 2015 reporting the Trust's deficit position.

Mr Stevens asked whether there was any scope within the letter sent to the Secretary of State to show that the Trust had achieved £60million in Cost Improvement Plan savings over the last 3 years. Mr Grant replied that the letter was a factual statement about the Trust's financial position and that there was no scope for including further context within it. He explained that there were other avenues through which the Trust's achievements could be highlighted.

The Committee noted the Auditor's report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998

5. **LCFS Annual Report 2014/15**

Mr Townsend asked the Committee to note that the self review toolkit criteria for assessing Local Counter Fraud Specialist provision at the Trust for 2014/15 was only released in May 2015, but that it was expected that the Trust's ratings would remain green in all areas under the new criteria.

Mr Stevens asked about the extent to which staff within the Trust were aware of counter fraud processes and prevention. Mrs Harris replied that counter fraud referrals during 2014/15 had come from a wider array of sources within the Trust than in previous years, which suggested a broad knowledge of counter fraud amongst staff. She explained that continued efforts were made to promote the service to staff.

The Committee noted the LCFS Annual Report 2014/15.

6. Audit Committee Annual Report 2014/15

Mrs Wells presented the Audit Committee Annual Report and explained that it was timetabled for consideration by the Board at its August meeting. Mr Stevens explained that he wanted the Audit Committee to have a focus on clinical audit during 2015/16 and that **MS/LW/**

he would speak with Mrs Wells and Dr Hughes about achieving this. **DH**

The Committee approved the Audit Committee Annual Report 2014/15 for submission to the Trust Board.

7. Internal Audit Plan 2015/16

Mr Townsend presented the Internal Audit Plan for 2015/16. He explained that a schedule had been added to the Internal Audit Plan to show what audit work had been undertaken since 2008/09 at the Trust, and what work was planned for the future.

Mrs Webster queried whether an audit of Data Security Measures and Data Loss, which had been given an audit opinion of no assurance in 2011/12, had ever been followed up as the schedule did not indicate that this had occurred. Mr Townsend explained that actions taken following recommendations made in the audit would have been reviewed. He agreed to look into the matter and discuss it at his next 1:1 meeting with Mrs Harris. **VH/MT**

The Committee approved the Internal Audit Plan for 2015/16.

Date of Next Meeting

Wednesday, 8th July 2015, at 10:00am in the Committee Room, Conquest Hospital. Subsequently changed to 3 August 2015.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 29 April 2015 at 9am – 11am in St Mary's Board Room Eastbourne DGH

Present	Mr Barry Nealon, Non-Executive Director/Chair Mr Michael Stevens, Non-Executive Director Professor Jon Cohen, Non-Executive Director Mr Darren Grayson, Chief Executive Mr Richard Sunley, Chief Operating Officer/Deputy CEO Mr Vanessa Harris, Director of Finance Mr Philip Astell, Deputy Director of Finance
In attendance	Dr Nik Patel, Clinical Lead – Cardiovascular (for item 8) Mrs Paula Smith, General Manager - Cardiovascular (for item 8) Mr Andy Horne, Programme Director (for item 13) Mr Stephen Hoaen, Head of Financial Management (for item 15) Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the meeting. Apologies were received from Dr David Hughes.	**Action**
2.	**Minutes of Meeting of 18 March 2015** The minutes of 18 March 2015 were agreed as an accurate record.	
3.	**Matters Arising** <u>(i) Abridged Minutes of meeting of 25 February 2015</u> The Committee agreed that for commercial reasons an abridged version of the minutes would be shared with the Board. <u>(ii) Radiotherapy Business Case</u> It was noted that the Radiotherapy Full Business Case has been presented to Part 2 of the ESHT Board on 25 March 2015.	

4(i)	**Performance Report – Month 11** Mr Sunley presented the month 11 Performance Report which had been discussed at a recent Board Seminar. This detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Overall Performance Score: 4 (from a possible 5) Responsiveness Domain: 2 9 out of the 17 indicators for this domain were achieved this month. The score increased to a 3 predominantly due to the achievement of the diagnostic wait times. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were: • RTT Non Admitted • A&E performance • Breast Symptom Two Week Wait Standard • 31 Day Standard • 62 Day Standard • 62 Day Standard for Screening • Delayed Transfers of Care Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 5 The Safe domain remains at 5, achieving in all indicators with the exception of CDifficile and harmful incidents. There were 2 reported cases of C-Difficile during this month. Caring Domain: 4 The Caring domain remains at 4. A&E Friends and Family scores remain below the required standard. There was 1 Mixed sex accommodation breach. Well Led Domain: 3 The score for the Well Led domain remains at a 3 with achievement of 5 of the 9 indicators. Turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3. It was noted that work was ongoing on producing RTT, Cancer and A&E trajectories. These would be available for all future meetings.	**RS**

	Action **The Committee noted the Performance Report for month 11 and noted the Trust Performance against each domain and the Workforce update.**	
4(ii)	**Finance Update – Year End 31 March 2015** Mrs Harris updated the Committee on the year end financial position as at 31 March 2015. Following receipt of non-recurrent deficit funding of £18m which had been recognised in the year end position, the trust performance at year end was a surplus of £88k (subject to audit). This was a favourable variance against original deficit plan of £18,600k. The cost improvement programme achievement was £21,010k which was above original plan by £593k. **Action** **The Committee noted the year end unaudited financial position.**	
5.	**Transformation Update** Mrs Harris presented the Committee with the final Kingsgate Report which set out a summary of the Kingsgate project covering the following areas: • The summary of the original deliverables and what has been completed • The summary of the workstreams and the EHST lead for continuation • The areas that Kingsgate consider needs to be developed by the Trust to ensure ongoing delivery A progress update was given against each of the development areas. The Committee asked that this be summarised and brought back to the next meeting for review. **Action** **The Committee noted the Kingsgate Report.**	**VH**
6.	**Financial Planning Update 2015/16** Mrs Harris updated the Committee on the Plan submission made to the TDA on 7 April 2015. It was noted that this latest submission was based on the Board planning paper approved on 25 March 2015. The draft Plan showed a significant deficit. The Committee reviewed the bridge chart that compared the original £14m deficit with the Plan deficit.	

	It was noted that expenditure was set at the level agreed by the Board at its last meeting save for two changes highlighted in para 1.3. Income was made up of: 1) estimated NHS patient income based on the latest position with Commissioner contract negotiations and 2) other income as per the Board approved provisional budget agreed in March. It was noted that a final Plan is due to be submitted to the TDA on 14 May 2015. Mrs Harris gave an update on progress against the main Commissioner contracts – East Sussex CCGs and NHSE and also the MSK partnership. The Committee noted the proposed and most up to date contract values. **Action:** **The Committee noted the latest plan submission and progress against the main Commissioner contracts including latest proposed contract values.**	
7.	**5 Year Plan** No further update. This item to be rescheduled for a future meeting.	
8.	**Cardiology – Progress against action plan** Dr Patel and Mrs Smith provided the Committee with an update on the subsequent actions following the presentation of the Cardiology Service Review to the Committee in November 2015. Recommendations were made following this review and Cardiology has been asked to present an update on the progress made to date. It was noted that the Cardiology EBITDA position had improved by 1.7% between Q1 to Q3 2014-15. The Clinical Unit gave an update on the following: • Readmission rates • EDGH medical model vs Conquest nurse practitioner model of care • A comparison of acuity levels and patient pathways for EDGH vs Conquest • Length of stay patient audit • Causes of agency spend on Berwick ward • Audit of Cardiology patients going through A&E • ESHT tertiary work	

	• Cath lab capacity issues It was noted that the average length of stay for patients with complex conditions was sometimes longer than clinically necessary because of delays in transfer of care packages. Discussion took place about reviewing the policy for use of "specialing". It was agreed that the Director of Nursing, Alice Webster would be asked to review the policy and assure the Finance & Investment Committee that the Policy and its application is in line with best practice. Professor Cohen asked if high risk patients could be identified via a risk score and their pathway managed appropriately to avoid long lengths of stay. Dr Patel agreed this was something that could be investigated. **Action** **The Committee noted the actions that Cardiology had put into place to improve its EBITDA statement position, at the same time improving quality. It was noted that Cardiology would continue to work on the next steps highlighted in the Cardiology Service Review paper.**	**AW**
9.	**2013-14 Reference Costs Submission** Mrs Harris presented an update on the arrangements for the 2014-15 Reference Cost submission. As was the case last financial year the Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission that it is satisfied with the Trust's costing processes and systems, and that the Trust will submit its reference cost return in accordance with guidance. Specifically, Boards or their appropriate sub-committees are required to confirm that: (a) costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance* (b) appropriate costing and information capture systems are in operation (c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance (d) procedures are in place such that the self-assessment quality	

	checklist will be completed at the time of the reference costs return. It was noted that confirmation should be obtained in advance of the reference costs submission. Workbooks are released in May with validation and open submission between 22nd June – 28th July. The Finance and Investment Committee, reporting directly to the Board was considered the most appropriate Committee to carry out this review. The Committee noted that TiAA (internal auditors) had undertaken an audit of the 2013-14 reference cost submission process in October 2014 and a substantial assurance assessment was given. The review provided assurance that processes and systems were in place to ensure accuracy and completeness of the Reference cost submission This same resource and process was in place for 2014-15 so the Finance and Investment Committee could assume the same level of assurance around the arrangements for reference cost submission. **Action** **The Finance and Investment Committee confirmed that it was satisfied that the costing process, supported the 2014-15 reference costs submission and that the trust will submit its reference cost return in accordance with guidance.** **Minutes of this meeting will be taken to the Board and this will provide documentary evidence should the Trust be subject to external review.**	
10.	**Capital Programme – Review of Outcomes** The Committee received an update on the capital business cases which had been considered by the Capital Approvals Group (CAG) and the by Finance & Investment Committee during 2014/15. These included: • Conquest Clinical Decisions Unit • Anaesthetic machines replacement • Surgical Operating Tables • Conquest X Ray Room 7 • Conquest Fluoroscopy Room 9 • Health Records • Electronic Expense Claims • Electronic Document Management • C Diff Action Plan • Pevensey Development • Windows 7 Office 2010 Migration • Nurse Technology Fund – Automated storage of medicines	

	Action **The Committee noted the outturn position on capital business cases approved during 2014/15.**	
11.	**Capital Programme Report** Mrs Harris provided the Committee with an update on the provisional capital outturn for 2014/15. At the end of the financial year the capital expenditure amounted to £11,770k an underspend against the capital resource limit of £3k. It was noted that the capital pressures the Trust is facing was very significant with back log pressures on maintenance, medical equipment and IT at a time when it is also under pressure on its revenue performance. The Trust continues to face risks in relation to the total value of capital resource available to meet the capital needs of the Trust. In summary the risks are in respect of:- • Backlog maintenance of the Trust's estate • Backlog medical equipment replacement • Costs arising from IM&T backlog and infrastructure pressures **Action** **The Committee noted the provisional year end outturn of the Capital Programme and the capital risks facing the Trust.**	
12.	**Making Better Use of Government Resource Services Procurement & Service Delivery Platforms and the Lord Carter Review – Update Report** Mrs Harris gave an update on progress with the DH (Department of Health) invitation to take part in 1) a review of Government support services and delivery platforms and 2) the Lord Carter review of efficiency and productivity metrics. It was noted an early draft business case was being prepared which considers the use of SBS and would be reviewed by the Project Steering Group at its meeting on 6 May. If and when a final version business case is ready it will be brought to the Committee for decision. It was noted that the Lord Carter review was also progressing. A meeting with each Trust (CEO and Chairman) had been arranged. The ESHT meeting was set for 10 June 2015. In addition and as reported through the market testing update at a previous Committee meeting, the DH had provided some soft FM	

	expertise to ESHT with a view to looking at any potential efficiency in this area. The DH had reported very good progress in this area. The Committee received draft minutes of the Project Steering Group meetings held on 23 February and 24 March 2015. **Action** **The Committee noted the progress on these two projects to date and noted that under the Terms of Reference any recommendations would be brought to this Committee where any formal decisions would be taken.**	
13.	**Market Testing Programme Update** Mr Horne updated the Committee on progress on the market testing of Occupational Health and Nursery Services and provided an update on the soft FM service evaluation with the Department of Health. For Occupational Health the closing date for tender receipt and the moderation meeting and interviews are scheduled for May after which a recommendation will be made for consideration by CLT, the Finance & Investment Committee and the Board. For Nursery Services, tenders were due back on 13 April 2015 but none were received. The Committee noted the position and it was agreed that the Board would need to look at the various options and make a decision at a future Board Seminar. For soft FM, it was noted that the team had worked very hard to apply the private sector principles to our services and had been well supported by Finance. The DH contact was impressed by the local team and believe they have the capacity to deliver significant savings. For Laundry Services a business case was being developed by Commercial Services which would include market testing as an option. It was agreed that details would be requested of when the Laundry Service business case will be available. It was noted that the service evaluation panels had proved to be a good process to enable discussion and agreement between service users and support departments. Whether or not the services were outsourced, the business cases being developed should incorporate contract managers who would facilitate discussion at all levels to ensure the service specification and KPIs are being delivered and to intervene as necessary. **Action** **The Committee noted market testing update.**	**DG** **IH**
14.	**Tender & Service Development Schedule**	

	The Committee received a schedule which provided an update on current tenders and service developments. It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings. The Committee noted the position of the following PQQ/tenders in the pipeline: • High Weald Lewes and Havens community services – the final CDD was submitted on 15 April. The commissioners have also contracted PWC to undertake a provider impact assessment on ESHT should it not be successful in winning the tender and they are due to report to the commissioners in May. • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs – the Trust has submitted a PQQ as the prime provider • Cancer Quality Improvement Service – Hastings & Rother CCG intend to commission a service to liaise closely with General Practice in their area. The Trust submitted a completed request for information (RFI) as the first stage in the process **Action** **The Committee noted the update on tenders and service developments.**	
15.	**Technical Benefits Programme Salary Sacrifice Scheme** Mr Hoaen presented the benefits of introducing a salary sacrifice scheme for IT/electrical equipment. The Committee was asked to consider and agree implementing a Technical Benefits (Salary Sacrifice) Programme offering tablets, laptops, smart TVs and mobile phones programmes as additional staff Benefit schemes that can be offered to employees of the Trust. The Committee noted the benefits for offering the programme for staff. They would have access to the very latest in technology which would make a positive contribution to their technology skill and be of benefit to home and working lives. The scheme would generate some savings through employer National Insurance and Pension Contributions and there were no direct costs to the Trust The Committee supported the Technical Benefits Programme Salary Sacrifice scheme subject to discussion with and the support of staff side and the FAQs being made more user friendly.	

	Action **The Committee recommended the approval of the Technical Benefits Programme Salary Sacrifice Scheme to the Board and recommended the self-financing of the scheme subject to discussion with staff side.**	
16.	**2015 Work Programme** The revised 2015 work programme was reviewed. It was noted that the 5 Year Financial Plan would not be available for the May meeting. This would be scheduled in for later in the year. **Action** **The Committee noted the revised work programme.**	
17.	**Date of Next Meeting** The next meeting will take place on Wednesday 20 May 2015 at 9.30am – 11.30 am in the Committee Room, Conquest hospital.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 20 May 2015 at 9.30am – 11.30am in the Committee Room, Conquest Hospital

Present
Mr Barry Nealon, Non-Executive Director/Chair
Mr Michael Stevens, Non-Executive Director
Mr Vanessa Harris, Director of Finance
Mr Philip Astell, Deputy Director of Finance
Dr David Hughes, Medical Director
Mr Darren Grayson, Chief Executive (from item 5)
Mr Stuart Welling, Chairman (from item 5)

In attendance
Mrs Alice Webster, Director of Nursing (for item 3)
Ms Angela Alletson, Interim Senior Category Manager for Procurement (for item 10)
Ms Shinal Amin, Principal biomedical Scientist, Pathology (for item 13L)
Mrs Wendy Mills, Finance Business Partner CSS & Cardiology (for item 13)
Mr Mark Paice, General Manager for Estates (for item 13)
Mr Steve Bance, Acting Finance Business Partner, Commercial & Out of Hospital Care (for item 13)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the meeting. Apologies were received from Professor Jon Cohen and Mr Richard Sunley.	**Action**
2.	**Minutes of Meeting of 29 April 2015** The minutes of 29 April 2015 were agreed as an accurate record.	
3.	**Matters Arising** (i) Performance Report M11 At its last meeting the Committee had requested information on RTT, Cancer and A&E trajectories. This had been received at a very high level, however the Committee wished to see more detailed information at the June meeting on how the Trust was performing	**RS**

	against these trajectories. <u>(ii) Transformation Update</u> See agenda item 5. <u>(iii) Specialing</u> Following a query at the last meeting over the numbers of specials used across the Trust and the costs associated with this, Mrs Webster attended to give a brief update to the Committee on the appropriateness of the application of the specialing policy. It was noted that the policy was reviewed regularly and was in line with national policy for both mental health and safeguarding policy. Mrs Webster provided assurance to the Committee that the policy was being applied appropriately. <u>(iv) Market Testing Update</u> Mr Nealon queried whether a date had been set for the Board to look at the options for nursery services. In the absence of the Chairman and Chief Executive, Mrs Harris undertook to look into this. With regard to the Laundry Business Case, Mrs Harris reported that she had received an email from Ms Clements indicating that the Outline Business Case was being finalised and would be presented to the June Finance & Investment Committee.	**VH** **MC/CH**
4(i)	**Performance Report – Month 12** The Committee received the month 12 Performance Report which detailed the Trust's in month performance against key trust metrics as well as activity and workforce indicators. The report included all indicators contained within the Trust Development Authority's Accountability Framework for 2014/15. Overall Performance Score: 4 (from a possible 5) Responsiveness Domain: 2 8 out of the 17 indicators for this domain were achieved this month. The Trust remains below the higher scores predominately as a result of not achieving the RTT admitted standard of 90%. This indicator has a high weighting within the domain. The other indicators which were not achieved this month were: • RTT Non Admitted • A&E performance	

	• Breast Symptom Two Week Wait Standard • 31 Day Standard • 62 Day Standard • 62 Day Standard for Screening • Delayed Transfers of Care Effectiveness Domain: 5 The domain remained at a 5, achieving in all indicators. Safe Domain: 5 The Safe domain remains at 5, achieving in all indicators with the exception of CDifficile and harmful incidents. There were 2 reported cases of C-Difficile during this month. Caring Domain: 4 The Caring domain achieved a score of 4 due to A&E Friends and Family scores remaining below the required standard. There were 6 Mixed sex accommodation breaches. Well Led Domain: 3 The score for the Well Led domain remains at a 3 with achievement of 4 of the 9 indicators. A&E response rates, turnover, sickness, temporary costs and appraisal rates remain below the required standard, keeping the domain score to 3. Mr Nealon raised an issue over waiting times for Podiatry and for MSK which he will ask Mr Sunley for clarification outside the meeting. **Action** **The Committee noted the Performance Report for month 12 and noted the Trust Performance against each domain and the Workforce update.**	**BN**
4(ii)	**Finance Update – Month 1 Flash Report** Mrs Harris updated the Committee on the financial position as at Month 1. It was noted that the April deficit was £2.9m in month v. plan of £3.0m deficit which was marginally better than plan. Pay costs were in excess of plan principally because winter escalation areas remained open during the period. However, in compensation non-pay costs had been less than plan. Pay costs to be kept under review. **Action** **The Committee noted the financial position as at Month 1.**	

5.	**Transformation Update** Mrs Harris presented a report on progress made against the recommendations in the final Kingsgate Report which had been considered at the April Committee meeting. The progress report, which showed the position as at 30 April 2015, had been discussed with the Executive Team on 19 May 2015. Mrs Harris drew the attention of the Committee to recommendation 7 and discussion took place on the difficulty in maintaining the accountability review routine when the hospital is under operational pressure so that an appropriate balance is maintained between quality, safety and finance. Mr Grayson explained that there was an escalation policy, which he would be happy to share. Mr Grayson said this policy may need to be reviewed in this respect. **Action** **The Committee noted the position at 30 April 2015.**	**DG**
6.	**2015-16 Budget including Capital Programme: Update** Mrs Harris updated the Committee on the Plan submission made to the TDA on 14 May 2015. The latest submission was based on the Board paper approved on 13 May 2015 incorporating the amendments suggested at that meeting. The Plan showed a deficit of £37m and was the same document circulated to the Board at its seminar on 13 May 2015 with minor amendments from that meeting. The Committee also received the bridge chart that compared the original £14m deficit with the Plan deficit of £37m. Mrs Harris reported that the Trust was receiving good feedback from the TDA and the auditors about the provision of Financial Information. Expenditure was set at the level agreed by the Board. With regard to Income, the Trust now had a signed Heads of Agreement with the CCGs. This was the same value that was presented to the Board at its meeting of 13 May 2015 Mr Stevens requested information on reconciliation from one year to the next. Mrs Harris reported that there was a bridge chart which she would forward to Mr Stevens for information. **Action:** **The Committee noted the latest Plan submission made on 14 May 2015.**	**VH**

7.	**HWLH Community Services** The Committee noted an impact assessment draft report commissioned by the CCG on the potential loss of the HWLH community services. **Action** **The Committee noted the draft report.**	
8.	**PMO Projects Update** The Committee received a summary report which provided an update on the following core system developments and projects for 2015/16: 1. Acute Oasis PAS upgrade 2. Euroking maternity system upgrade 3. MSK ESHT 4. Community and Child Health system 5. Pathology Managed Equipment and Rationalisation 6. Clinical correspondence 7. Digital Medical Record Tracking (IfIT) 8. Health Records Storage Rationalisation 9. JAG Accreditation 10. Windows 7 / Office 2010 migration 11. Pathology Managed Equipment and Rationalisation 12. Electronic Document Management and Clinical Portal 13. VitalPac patient bedside monitoring 14. Enterprise printing Mr Nealon requested a more detailed update on the PAS upgrade project and Health Records Storage Rationalisation and it was agreed to invite the SRO and Project Lead to the next two meetings as follows: 24 June 2015 Acute Oasis PAS upgrade – Dr Andy Slater & Mrs Sarah Goldsack 29 July 2015 Health Records Storage Rationalisation –Meeting Mr Richard Sunley and Mrs Liz Fellows **Action** **The Committee noted the progress with projects and asked for a further update on specific projects at the next two meetings.**	**AS** **RS**
9.	**Job Planning** Dr Hughes reported that a lot of work was going on with regard to job planning.	

	Work was progressing through the Clinical Unit Management teams and in order to provide support and oversight on compliance and quality, he would be attending the accountability review meetings. A further detailed update on job planning would be presented to the June Committee meeting. **Action** **Job planning update deferred to the June meeting.**	**DH**
10.	**Procurement Update** Mrs Alletson presented a report highlighting the Procurement achievements to date against the CIP target, and gave assurance that a robust 3 year Procurement Strategy was under development. It was noted that the Strategy focuses on opportunities for the Trust to make significant cost savings and efficiency improvements through harnessing and developing the skills and expertise within the Procurement team and more integrated work with key stakeholders. It was reported that the Procurement team had delivered its target CIP for 2014/15 and had started the process to deliver a comprehensive Procurement Efficiency Programme in 2015/16 to release further savings. The target savings for 2014/15 CIP were £2.5m combined cash releasing and procurement savings. The total cash releasing savings were £2.51m with non-cash procurement savings of £847k giving total savings of £3.3m. Mrs Alletson reported that a recent opportunity analysis by an external consultancy identified key areas of focus for the Trust in 2015/16 and this will form part of the Procurement Efficiency Programme going forward. An experienced interim had been recruited and had started on some major activities and was engaging with key stakeholders. It was confirmed that where applicable a clinical evaluation of products was always carried out. Mr Nealon passed on his thanks to the Procurement team for their hard work and congratulated the Team on the good progress that was being made. **Action** **The Committee noted the progress made against the target and the key metrics.**	

11.	**Making Better Use of Government Resource Services Procurement & Service Delivery Platforms and the Lord Carter Review – Update Report** Mrs Harris gave an update on progress with the DH (Department of Health) invitation to take part in 1) a review of Government support services and delivery platforms and 2) the Lord Carter review of efficiency and productivity metrics. A meeting with Lord Carter had been arranged with each Trust. Mr Grayson and Mr Welling would be attending on behalf of the Trust. It was noted that Mr Astell would provide a briefing prior to this meeting. The Committee received the draft minutes of the Project Steering Group meeting held on 6 May 2015 for information. Mr Nealon queried the communication to staff on Soft FM services. Mr Grayson reported that a paper would be presented to the June Board and following this a communication would be sent to all staff. **Action** **The Committee noted the progress on these two projects to date and noted that under the Terms of Reference any recommendations would be brought to this Committee where any formal decisions would be taken.**	**PA**
12.	**Tender & Service Development Schedule** The Committee received a schedule which provided an update on current tenders and service developments as at 12 May 2015. It was noted that the tender and service development schedule was updated on a weekly basis and monitored by the Business Planning Steering Group (BPSG) at its weekly meetings. The Committee noted the position of the following PQQ/tenders in the pipeline: • High Weald Lewes and Havens community services – the final CDD was submitted on 15 April 2015 and an announcement on the outcome of the tender was scheduled for end May 2015 • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs – the Trust had submitted a PQQ and a decision was awaited on who will be invited to tender. **Action** **The Committee noted the update on tenders and service developments.**	

13(i)	**Pathology Reconfiguration and Re-equipping under a Managed Service Contract** Ms Amin presented the draft Full Business Case (FBC) for the redevelopment of Clinical Laboratory Diagnostics (CLD). The Outline Business Case had been previously presented to the Finance Committee, Trust Board and TDA in August 2014. The OBC had been formally approved by the TDA, however there were a number of areas which needed to be addressed. The revised FBC presented included the elements requested in the TDA response letter (a copy of which had been circulated to the Committee). It was noted that there were two areas which need to be finalised before submission to the TDA: Written confirmation of the Trusts assumed VAT treatment from the Trust's VAT advisors and Agreement on the accounting treatment for the scheme, including written confirmation from the Trusts auditors regarding the Trusts assumed treatment of existing assets that are to be novated into the new contract. Mr Astell would ensure these confirmations were obtained. The FBC was still in draft due to the time constraints to update the case for the equipment list, the revised contract and the capital purchase figures which had been supplied. This would be completed in time for the submission to the TDA Mr Stevens queried what the impact was on costs in the current year and whether the budget had provided for this contract being awarded. It was confirmed that the capital and revenue costs were in the plan. Mr Stevens asked if there would be any double running in the first six months that would result in higher costs. Ms Amin advised that there will be running of both services during the evaluation process to ensure that this was of the right quality and Mrs Mills said they were still working through the costs of this. It was noted that final elements of the contract were currently being negotiated. Mr Astell made some suggestions, associated with risk, which he felt should be included and it was agreed that he would forward his comments on for inclusion. These would include reference to business continuity arrangements. The Business case will be presented to the June Board and to the TDA for final approval. It is anticipated that contract signature and implementation can commence in September 2015. **Action** **The Committee approved the continuation of the work with the chosen managed service provider and to recommend approval of the FBC to the Board. Signature of the contract will follow**	**PA** **WM** **PA**

	Trust and TDA approval. Implementation will commence shortly after contract signature.	
13(ii)	**Energy Performance Contract** Mr Paice presented the Outline Business Case (OBC) for the development of an Energy Performance Contract (EPC) to guarantee reductions in energy costs to the Trust for a period of 7 years. Committee discussions on this matter are considered to be commercially confidential and have therefore been removed from the publically available minutes.	
16.	**2015 Work Programme** The updated work programme was reviewed. **Action** **The Committee noted the revised work programme.**	
17.	**Date of Next Meeting** The next meeting will take place on Wednesday 24 June 2015 at 9.30am – 11.30 am in St Mary's Board Room, EDGH.	

East Sussex Healthcare NHS Trust

QUALITY AND STANDARDS COMMITTEE

1. Introduction

1.1 Since the last Board meeting a Quality and Standards Committee meeting has been held on 6 July 2015. A summary of the issues discussed at the meeting is provided below.

1.2 The minutes of the meeting held on 5 May 2015 are included at Appendix 1. Further discussion was had regarding item 4.1. This was identified a concern to the Committee and clarification was sought that this would be presented at the next meeting due to staff sickness and annual leave from the presenters.

2. Issues discussed at 6 July 2015 Meeting

2.1 Patient Story

A presentation was made by a service user on behalf of a family member. The case highlighted the need for further learning around communication and empathy. The service user had agreed to be filmed so that their experiences could be shared with staff at induction and development sessions. They had also met with the Learning and Development Manager to influence future staff training programmes.

2.2 Mandatory Training and Appraisal Compliance

The Committee noted that mandatory training compliance percentages had improved in most areas, despite the operational pressures the organisation had experienced. It was however noted that appraisal compliance had registered a marginal fall of 0.34% with specific work being undertaken with the Chief Operating Officer Operations clinical unit due to having the lowest compliance. The Chair requested that a deep dive into compliance with appraisal and training by the Cardiovascular Unit be undertaken at the next meeting.

2.3 Board Assurance Framework and High Level Risk Register

The organisational Board Assurance Framework (BAF) and High Level Risk Register were considered by the Committee and areas of concern noted which related to health records, mandatory training and appraisals. The Company Secretary informed the Committee that the gap control around the inability to use web based applications due to the internet gateway running at capacity between 11am and 3pm daily had been removed, as this had been resolved nationally.

2.4 Legal and Claims Annual Report

The Committee was provided with the Legal Services Annual Report 2014/15 for East Sussex Healthcare NHS Trust (ESHT). The purpose of the report was to feed the data provided back into the organisation and provide information on

lessons to be learned from claims, litigation and HM Coroner's inquests. The Committee sought assurance around Duty of Candour training and competency for staff, and requested a report related to this be submitted at the next meeting.

2.5 **Changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Fundamental Standards of Care**

The Director of Nursing described important changes to the health and social care standards which are regulated by the Care Quality Commission. It was noted that the 12 Fundamental Standards of Care represented one of the main ways in which the Government had responded to the Francis Inquiry and these replaced the previous 16 Essential Standards of Quality and Safety. The Director of Nursing highlighted the guidance for staff to help them relate to the standards in their day to day roles had been widely communicated and made available on the extranet.

2.6 **Quality Improvement Plan (CQC Recommendations)**

The Director of Nursing tabled an update on the progress in achieving the recommendations made by the Care Quality Commission (CQC) following their visit in September 2014. The report explained that the organisation worked within the themes identified in the CQC's overarching Trust report and an action plan ensured that all the 'must do' recommendations were being addressed. It was noted that following review by the Project Improvement Working Group currently there were 112 actions of which 9% were overdue, 48% were on track and 43% had been completed.

2.7 **Deep Dive – Health Records Report**

The Deputy Chief Operating Office provided an update and overview of the progress and actions within the Health Records Service to address known risks and concerns. The primary risks for the organisation were described as the impact on clinical care and not being able to robustly demonstrate compliance with Department of Health Code of Practice for Records Retention and Disposal Scheme. The iFIT Health Records tracking implementation, which had successfully revolutionised the service in other NHS Trusts, was highlighted. The Chairman sought assurance around rebuilding staff confidence in the teams that had been affected and requested this was fed back to the Assistant Director of Operations.

3 Conclusion

3.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 6 July 2015 and the minutes of the meeting held on 5 May 2015.

Charles Ellis
Quality and Standards Committee
7 July 2015

Appendix 1

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee

Minutes of the Quality and Standards Committee /

Tuesday, 5 May 2015
St Mary's Room, Eastbourne General Hospital

Present:
Mrs Sue Bernhauser, Non-Executive Director
Professor Jon Cohen, Non-Executive Director
Mr Charles Ellis, Non-Executive Director (Chair)
Dr David Hughes, Medical Director
Miss Lindsey Morgan, Deputy Director of Nursing
Ms Emma Tate, Head of Clinical Improvement
Mrs Moira Tenney, Deputy Director of Human Resources
Mrs Alice Webster, Director of Nursing
Mrs Lynette Wells, Company Secretary
Dr James Wilkinson, Assistant Medical Director, Quality

In attendance:
Dr Rachel Atkinson, Community Paediatrician for item 7 only
Ms Catherine Ashton, Associate Director Development and Transformation for item 7 only
Mrs Pauline Butterworth, Deputy Chief Operating Officer obo Mr Sunley
Ms Florence Mpofu, Senior Infection Control Nurse obo Ms Lloyd for item 4.1 only

Mrs Susan Cambell, PA to Director of Nursing (minutes)

1.0 Welcome and Apologies for Absence

Mr Ellis welcomed participants to the Quality and Standards Committee meeting and confirmed that the Committee was quorate.

Mr Ellis noted that apologies for absence had been received from :

Mrs Janet Colvert, Ex-Officio Committee Member
Miss Emily Keeble, Head of Assurance
Ms Tina Lloyd, Assistant Director of Nursing Infection Prevention and Control
Mr Richard Sunley, Chief Operating Officer
Mr Stuart Welling, Chairman
Dr Jamal Zaidi, Assistant Medical Director, Workforce

2.0 Patient Story – A Human Connection to Patient Care

A video was presented to the Committee showing the human connection to patient care and how empathy with both patients and staff should be fundamental to the organisation. Mrs Tenney suggested that this video or an East Sussex Healthcare NHS Trust (ESHT) specific one should be shown at

all staff inductions. Mrs Webster agreed to investigate the possibility of developing this with local involvement. **AW**

3.0 **Minutes and Matters Arising**

4.1 **Minutes of the Previous Meeting**

Minutes of the Quality and Standards Committee meeting held on 2 March 2015 were considered and agreed an accurate record.

4.2 **Matters Arising**

The action log was reviewed and updated.

4.0 **Compliance and Risk**

4.1 **Update on Compliance Against Outcome 8 Regulation 12 'Cleanliness and Infection Control' Quarter 3, 2014-15.**

Ms Mpofu was welcomed to the meeting and she presented the compliance update on behalf of the Trust Infection Control Group (TICG). The Committee was informed that the overall compliance by the Trust against Outcome 8 had decreased slightly from 88.31% at the end of quarter 3, to 88.20% at the end of quarter 4. It was noted that of the 10 criterion the Trust was judged against, the organisation was compliant with 5. Mrs Webster requested that criterion 6 and 9 were discussed at the next TICG meeting and an improvement plan to achieve compliance formulated. She further requested that the lack of staff to update policies be noted on the Trust Risk Register. **TL**

Ms Mpofu highlighted the key risks identified in each of the CU reports and Mrs Bernhauser noted that the Urgent Care clinical unit had not provided a report to TICG. It was confirmed that there was a trend of low compliance with the National Cleaning Standard (NSC) audit within the Accident and Emergency (A&E) departments and staff were being supported with this. It was acknowledged that environmental issues were a contributory factor and Mrs Butterworth stated that a business case had been submitted to the Trust Development Agency (TDA) relating to this.

Professor Cohen sought clarity around the National Cleaning Standard (NSC) data and requested that performance metrics to show trends, demonstrate assurance and contextualize findings were presented at the next Quality and Standards Committee meeting. **TL**

Ms Mpofu stated that clarity was being sought from the TDA with regard to A&E being graded as a very high risk area where the standard of cleanliness expected would be equivalent to that of an ITU.

Mrs Webster assured the Committee that the housekeeping service review was currently being undertaken and had Senior Nurse input.

4.2 Care Quality Commission (CQC) Improvement Plan

Mrs Webster provided the Committee with a summary of the overarching Improvement Plan that had been developed following the Care Quality Commission (CQC) inspection. It was noted that the plan, produced in collaboration with the Clinical Commissioning Groups (CCGs), TDA and NHS England (NHSE) detailed those recommendations that CQC had identified in their reports as 'must do's'. Mrs Webster confirmed that a Project Improvement Working Group was in place to oversee progress of the delivery of the plan and the plan could be found on the Trust extranet. It was confirmed that the group met every two weeks and was attended by identified executive leads for the relevant work streams. Professor Cohen sought assurance around staff engagement with the development of the plan and Mrs Webster explained that key people in each clinical unit had been involved; actions had been developed and disseminated. Mrs Webster confirmed that localised plans had been produced and Mrs Hilary White, Head of Compliance provided representation at the executive working group for this. Mrs Wells stated that several actions had been identified prior to the inspection and work by staff had already commenced.

Mrs Webster confirmed that outcomes from the plan would only show as completed when evidence had been presented and the group were confident it had been embedded into the organisation.

Mrs Webster informed the Committee that she had initiated contact with another Trust who had been in a similar situation but had had a different project management approach.

4.3 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 highlighted the areas on the framework where it was felt there was insufficient assurance.

Mrs Butterworth agreed to provide an update regarding the reduction in the backlog of plain film reporting and the delay in reporting non-urgent radiological investigations. **PB**

Mrs Butterworth updated the Committee regarding improvement in the patient transport for discharges with the introduction of the Elite service, however she confirmed that risk around long waits for outpatients transportation remained.

Mr Ellis sought assurance around improvement in the Health Records service and the impact this had on patients from a quality and safety perspective. Following discussion it was agreed that this would be a deep dive agenda item at the next meeting. **RS**

4.4 **Risk Management Strategy / Assurance of Duty of Candour / Being Open Policy**

Mrs Wells presented a suite of reports linked to compliance with the statutory duty of candour which had been introduced for NHS bodies from November 2014.

Mrs Wells highlighted the revised Never Events Policy and Framework, and the Serious Incident Framework and described the actions that had been taken to ensure that local policies and procedures remained in line with these national policy frameworks. The Committee noted and approved the Risk Management Strategy, Incident Reporting and Management policy, and the Being Open policy. Mrs Wells agreed to update the Committee at the November 2015 meeting with an audit trail showing that the Trust was compliant with the requirement of the regulations. **LW**

Mrs Webster assured the Committee that a revised incident training programme had been initiated with particular emphasis on matrons and therapists to ensure that staff fully understood the implications of the changes.

4.5 **CQC Intelligent Monitoring**

Mrs Wells informed the Committee that the CQC had issued in draft form its latest Intelligent Monitoring Reports (IMR). It was explained that the IMR was used to monitor a range of key indicators about NHS acute and specialist hospitals. It was noted that the Trust had been assessed against 96 applicable key indicators, of which, 11 showed evidence of risk or elevated risk. Mrs Wells confirmed that three of the elevated risks noted related to the staff survey and a new indicator related to the number of complaints going to the Parliamentary and Health Service Ombudsman (PHSO). Miss Morgan agreed to include PHSO information in future Integrated Quality Reports. **EK**

5.0 **Quality**

5.1 **Review of Draft Quality Account**

Ms Tate provided the Committee with the draft Quality Account for 2014 /15 and explained that some year-end data and information still needed to be added once it was available. Ms Tate confirmed that the draft document had been circulated internally and externally to Healthwatch East Sussex, Health Overview Scrutiny Committee (HOSC) and the CCGs for formal feedback. Mrs Tenney requested that the wording noted in Priority 4: Patient Safety, around nursing vacancy ‘fill rates’, be more specific. **ET**

5.2 **Integrated Quality Report**

Miss Morgan presented the quarter 4 Integrated Quality report and highlighted three key areas of Trust activity; Patient Safety; Patient Experience and Clinical Effectiveness.

Miss Morgan informed the group that the interim Complaints Manager had initiated quality assurance checks on all complaint responses from March 2015 and it was expected that there would be improvement in the complaints handling process over the next few months. Miss Morgan further explained that the team had undertaken a root cause analysis of overdue complaints and had found that issues lay predominantly with the clinical units. Miss Morgan confirmed that work was ongoing to address any communication issues with staff.

Mrs Bernhauser requested an update report from the interim Complaints Manager be shared at the next Committee meeting. **LM**

6.0 Human Resources (HR)

6.1 HR Incidents Report

Mrs Tenney presented the HR Incident report which provided information on the number of formal staff complaints and conduct issues raised from 1 October 2014 to 31 March 2015. Mrs Tenney commented that there was a significant amount of work still to be done in response to the staff survey results and CQC inspection report. She explained there was a staff perception of harassment and bullying within the organisation and staff felt unable to raise these issues. Mrs Tenney informed the Committee that actions had been developed using Listening into Action (LiA) processes to engage with staff to help understand the reasons why they felt unable to raise concerns. Mrs Bernhauser suggested that an increase the number of complaints around harassment and bullying in the next quarter might show this was having an effect.

Mrs Tenney confirmed that there had been a reduction in the number of formal complaints addressed under the Trust's workforce policies in 2014 /15 compared to 2013/14 which she felt was linked to the significant organisation change that had taken place.

Mrs Tenney explained that there had been no formal issues raised under the Raising Concerns Procedure, formally known as Whistle Blowing. It was noted that following the CQC inspection, staff had retrospectively requested that grievances be looked at again.

Mrs Webster requested that the number of referrals to regulatory bodies be included in future reports. **MT**

7.0 Deep Dive

7.1 Community Paediatrics

The Committee welcomed Ms Catherine Ashton, Associate Director of Development and Transformation and Dr Rachel Atkinson, Community Paediatrician who outlined the initiatives put in place to significantly reduce the 600 plus patients waiting for appointments with Community Paediatrics

services. The Committee were informed that the services provided by the Trust had been the subject of a number of reviews which had highlighted areas where the services were felt to be failing to meet all the required standards of quality and safety. It was noted that the CCG had expressed concern at the number of patients waiting for assessments and had issued formal contract query notices. Ms Ashton confirmed that there was evidence that ESHT had alerted commissioners to the demand and capacity issues over 12 months ago.

Ms Ashton and Dr Atkinson described how ESHT managers and clinicians had worked hard to develop and implement an action plan, and with significant extra resources and drive, this had meant that the trajectory set by the CCGs had been met.

In order to ensure a safe and sustainable service in the long term, Ms Ashton highlighted the need for a review of the current specification, which it was noted had been in place since 1992. The Committee was assured that a working group had been set up to review the specification with input from the commissioners, GPs, community paediatricians and East Sussex County Council (ESCC) Public Health department.

Mrs Webster sought assurance that of the 600 plus patients on the waiting list, no adverse outcomes had been reported. Dr Atkinson stated that whilst there had been instances of annoyed parents due to length of time it took to be seen, no adverse outcomes had been identified.

Mr Ellis thanked both Ms Ashton and Dr Atkinson for all their hard work and requested that this was shared with the team.

9.0 **Sub Committee Minutes**

The following items were noted by the Committee;

9.1 Minutes from the Trust Health and Safety Steering Group meeting held on 23 March 2015.

9.2 Minutes from the Patient Safety and Clinical Improvement /Essential Compliance Group meeting held on 30 March 2015.

10.0 **Any Other Business**

10.1 **Healthwatch East Sussex**

Mrs Webster requested agreement from the Committee for a nominated representative from Healthwatch East Sussex to join future meetings. It was agreed that this would be piloted.

11.0 **For Information**

11.1 None noted.

12.0 **Date of the Next Meeting**

Monday, 6 July 2015
2.30pm – 4.30pm
Committee Room, Conquest Hospital

East Sussex Healthcare NHS Trust

Date of Meeting:	5th August 2015
Meeting:	Trust Board
Agenda item:	14
Subject:	Chairman's Briefing
Reporting Officer:	Stuart Welling, Chairman

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

Purpose:

To keep the Board informed of the activities undertaken by the Chairman since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of activities undertaken and relevant correspondence received or sent by the Chairman since the last Board meeting.

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

Key external meetings attended in April and May:

- 10th June 2015 — Meeting with Lord Carter re NHS procurement & efficiency
- 1st July — Meeting with Anne Eden, NHS TDA
- 9th July — Project Search Graduation Awards
- 17th July — Healthwatch Annual Event
- 22nd July — Meeting with Huw Merriman, MP for Bexhill & Battle

Use of Trust Seal

No documents have been sealed since the last Board meeting:

Proposals and/or Recommendations

The Board is asked to note the activities undertaken by the Chairman since the last Board meeting.

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

Name:	**Contact details:**
Stuart Welling, Chairman	s.welling@nhs.net