East Sussex Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

Wednesday, 8th June 2016

at 12:30 am

in the St. Mary's Boardroom, EDGH

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday, 8th June 2016, commencing at 1230 in the St Mary's Boardroom, EDGH

	AGENDA		**Lead:**	**Time:**
1.	a) Chair's opening remarks b) Apologies for absence c) Monthly award winner(s) d) Annual Staff Awards (presentations to staff who couldn't attend award night)		Chair	1230 – 1315
2.	Quality Walks	A	Chair	
3.	Declarations of interests		Chair	
4a.	Minutes of the Trust Board Meeting in public held on 13th April 2016	B	Chair	
4b.	Matters arising	C		
5.	Chief Executive's report	D	CEO	
6.	Board Assurance Framework	E	CSec	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Quality Improvement Programme	Assurance	F	CEO/DN	1315 - 1420
8.	Draft Quality Account 2015/16	Information	G	DN	
9.	Integrated Performance Report Month 1 (April) 1. Performance 2. Finance 3. Workforce	Assurance	H	DN/MD COO HRD DF	
10.	Safe Nurse Staffing Levels report	Assurance	I	DN	
11.	Patient Experience Report (Quarter 4)	Assurance	J	DN	

STRATEGY

					Time:
12.	End of Life Care Strategy	Approval	K	MD	1420 - 1450
13.	ESHT 2020	Approval	L	CEO	

GOVERNANCE AND ASSURANCE

					Time:
14.	Staff Survey	Assurance	M	HRD	1450 - 1510
15.	Board sub-committees: a) Audit Committee (including Annual Report) b) Finance and Investment Committee c) Quality & Standards Committee	Assurance	N	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
16.	Use of Trust Seal	O	Chair	1510 - 1530
17.	Questions from members of the public (15 minutes maximum)		Chair	
18.	Date of Next Meeting: Wednesday 3rd August, Uckfield Civic Centre		Chair	
	To adopt the following motion: *That representatives of the press and other members of the public will be excluded from Part 2 of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest* *(Section1(2) Public Bodies (Admission to Meetings) Act 1960)*		Chair	

David Clayton-Smith

David Clayton-Smith
Chairman

5th May 2016

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

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	2.
Subject:	Quality Walks March - April 2016
Reporting Officer:	Alice Webster

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

Purpose:

This paper provides a summary of the Quality Walks that have taken place during March and April 2016.

Introduction:

Quality Walks are currently carried out by Board members and are either planned or carried out on an ad hoc basis. They are intended to provide an opportunity to observe and review care being delivered, listen to feedback from patient's, visitors and staff and enable quality improvement actions to be identified and addressed from a variety of sources in order to provide assurance to the Board of the quality of care across the services and locations throughout the Trust.

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

- 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

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

18 services/departments were visited as part of the Quality Walk programme by the Board during March and April as detailed below. In addition the Chief Executive visited the Health Records Department at the Conquest, and the Emergency Departments on both acute sites.

Date	Time	Service	Site	Visit by
2.3.16	10am	Michelham Ward (Private Unit) Out Patients Radiology	EDGH EDGH EDGH	Miranda Kavanagh
3.3.15	3pm	Sexual Health - Avenue House	Eastbourne	Jackie Churchward-Cardiff
7.3.16	12.30pm	Special Care Baby Unit (SCBU)	Conquest	Jackie Churchwood-Cardiff
11.3.16	11am	Egerton Ward	Conquest	Pauline Butterworth
14.3.16	2pm	Occupational Therapy	Conquest	Andy Slater
22.3.15	12.30pm	Emergency Department	EDGH	David Meikle
22.3.16	8.30pm	Hospital at Night Team	Conquest	Jackie Churchward-Cardiff
5.4.16	2pm	Housekeeping Services	EDGH	David Clayton-Smith
7.4.16	1pm	Electrical Medical Equipment (EME)	EDGH	David Hughes
12.4.16	2.00pm	Infection Control	EDGH	Jackie Churchwood-Cardiff

14.4.16	2.00pm	Frank Shaw and Delivery Suite	Conquest	Jackie Churchwood-Cardiff
20.4.16	10am	Richard Ticehurst Unit	Conquest	Pauline Butterworth
20.4.16	2.00pm	Pathology	EDGH	Monica Green
21.4.16	2pm	Irvine Unit	Bexhill	Alice Webster
26.4.16	2pm	Judy Beard Unit	Conquest	Andrew Slater

17 of these visits were pre-arranged and the Ward or Unit Manager notified in advance to expect the visit, 1 was carried out as an ad hoc visit so staff may or may not have been previously notified. (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 11 of the visits to individual services or departments, copies of which have been passed on to the relevant managers for information.

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

How communication and engagement can be strengthened
It was noted at the Hospital at Night handover meeting that attendance was 'patchy' as it is dependent on workload and the staff available; however the presence of the anaesthetic consultant provided much needed organisation and guidance.
The Sexual Health service has identified communication links necessary for improved patient care across services and is working on improvements with relevant specialties and developing pathway connections for HIV patients to identify and mitigate risk.
In the Pathology department there has been good involvement of staff and communication about the changes of moving to a managed service contract within the department of which the staff are very positive.
It was reported that communication and documentation processes in Maternity seemed fragile with over reliance on verbal and informal systems.

Reporting, action and learning from incidents and risks
Staff in SCBU highlighted that since the unit was moved to a single site as part of the rationalisation of services in 2013 there has been no physical expansion of the unit and that a lack of space is a key issue for staff. Although the unit can accommodate up to 12 cots the associated space for parents, equipment and staff is severely constrained leading to operational pressures. A number of schemes have been proposed to expand the unit but not completed and the staff were feeling frustrated over a lack of progress.
It was reported that in the Infection Control and Prevention service that the documentation associated with mandatory RCAs, reviews, risk assessments, contracting as well as service audits and surveillance is considerable and impacts on the time available for practice development.

Fundamental safety issues – cleanliness, drug security, records management
Ward staff appear well supported by the critical outreach team which helps maintain patient safety and alert senior staff to physiological risk, however medical cover at night appeared lean and an embedded governance framework for the Hospital at Night team to underpin processes would be beneficial to enhance safety.
It was noted that staff working in the sexual health department have good counselling/supervision sessions and support mechanisms.
In maternity there is a daily meeting with consultants and the risk lead, which provides a valuable opportunity for learning, and publication of learning points are supported and encouraged to promote a safety culture and joint working.
It was observed that in maternity unit some of the delivery rooms require some environmental improvements which required escalation to the Estates department to resolve.

Other Issues
It was observed that Michelham Ward was very peaceful and quiet, however it was noted that the inpatient capacity is not being fully utilised.

Patient transport for the Outpatient department at Eastbourne was reported as an area of concern due to the time people are kept waiting by external transport services, however the department has developed a toolkit for staff - '10 Steps for supporting the patient awaiting transport', which is proving beneficial. It was noted that the proliferation of staff wearing scrubs in various areas can make it difficult to recognise if clothing is appropriate to the area and differentiate between job roles.

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.
Review by other Committees/Groups (please state name and date)**:**
None

Proposals and/or Recommendations
The Board are asked to note the report and agree if any changes to the current themes of: Communication and engagement; learning from incidents and risks and fundamental safety issues is required.

Outcome of the Equality & Human Rights Impact Assessment (EHRIA)
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
Not applicable. However, if there any E&D issues identified during the quality walks these will be shared with the Head of E&D.

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Wednesday, 13th April 2016 at 09:30 am in the Lecture Theatre, Conquest Hospital.

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

In attendance:
Mrs Pauline Butterworth, Acting Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mrs Lynette Wells, Company Secretary
Ms Jan Humber, Joint Staff Side Chair
Mr Pete Palmer, Assistant Company Secretary (minutes)

022/2016 **Welcome and Apologies for Absence**

a) Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He noted that this was Dr Bull's first public Board meeting, on only his third day with the Trust. He thanked Richard Sunley for all his hard work during his time as Acting Chief Executive, and explained that he had taken a position working for NHS Improvement closer to his home.

Mr Clayton-Smith also welcomed Mr Astell to the Board, explaining that he had taken the role of Acting Director of Finance for the Trust. He explained that while David Meikle still worked for ESHT, he could only be the Trust's accountable officer on an interim basis for six months.

b) Apologies for Absence

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

Ms Sally Herne, Improvement Director
Dr Andrew Slater, Director of Clinical Information & Strategy

c) Monthly Award Winners

Mr Clayton-Smith reported that the monthly awards winners for February were staff nurses Marta Cunha, Marisa Ferreira and Vera Quintes. He explained that they had won the awards after using their annual leave to travel to Calais in order to offer first aid to refugees living in the refugee camp. He thanked them for the personal generosity they had shown through their actions.

He reported that the cross-site Clinical Preparation teams had received March's award for the work they had carried out on the availability of health records for medical appointments. Mr Clayton-Smith outlined that there had been a large increase in the availability of notes following this work, and thanked members of the team for all their hard work.

023/2016 Feedback from Quality Walks

Ms Kavanagh reported that she had undertaken a number of quality walks, including visits to outpatients, radiology, DeCham Ward and with hospital porters. She advised that she had found the Trust's staff to be fantastic and caring.

She explained that the recent refurbishments had been undertaken in the outpatients department, but that the major issues highlighted during her visit related to patient transport and the transfer to a new provider.

Ms Kavanagh reported that issues had been identified within the radiology department with storage and that the department were looking at ways to address this. She explained that the waiting area within the department was split between two different areas and that this meant that staff found patient supervision to be challenging.

Mr Stevens reported that he had visited Folkington Ward, a newly established dementia ward, which he had found to be a pleasant, well organised ward. He observed that the ward had insufficient low beds, increasing the risk of falls amongst dementia patients.

He reported that the ward had a day-room for use by patients, but that they did not currently have a television. He explained that the matron planned to create a staff room by moving her office to another room within the ward.

Mrs Butterworth noted that Folkington had been established as a winter escalation ward. She explained that plans had already been proposed to improve the waiting areas within the Radiology department, and that the issues around patient transport existed due to a recent change in provider.

Mrs Webster reported that the provision of patient transport had recently

changed from South East Coast Ambulance Service to Coperforma, and that a large number of issues had arisen following the change of provider. She explained that Coperforma had formally apologised for their service on two occasions during the previous week, and that a meeting had been called with them to discuss the serious concerns that existed. She noted that patient transport had been raised as a serious incident with the CCG and that similar issues had occurred throughout the southeast. Mrs Webster reported that the Trust had used private ambulances and taxis in order to ensure that patients had received appropriate transportation.

The Board noted the report on quality walks.

024/2016 **Declarations of Interest**

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

025/2016 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 10th February 2016 were considered and were agreed as an accurate account of the discussions held.

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

b) Matters Arising

012/2016 – Greater detail to be provided to the Board within the Complaints Report
This item was on the agenda as item 10.

013/2016 – Revised End of Life Care strategy to be presented to the Board
Dr Hughes explained that he would be presenting a revised End of Life Care (EoLC) strategy to the Board in June. He explained that work was being undertaken by the EoLC team to respond to the recommendations made by the CQC, and to recommendations made within a recent EoLC audit. **DH**

Mrs Bernhauser noted that that Trust only had one opportunity to ensure that EoLC was carried out correctly, and that the Quality and Standards Committee would be looking at EoLC in depth.

026/2016 **Acting Chief Executive's Report (verbal)**

Dr Bull explained that each of the Executive Directors had provided him with a brief overview of the key issues within their remit. He reported that he corresponded with his new colleagues prior to starting with the Trust, and that it was clear that high pressures associated with the Trust regularly being under 'black' status were problematic, and that he would look at how to resolve these issues as a priority.

He said that ESHT had been in denial about the issues that it faced in the past, and that he was determined that this would no longer be the case. He explained that many actions were already in place to improve the Trust and that he would be working hard to ensure that this improvement was sustained in the long term.

It was noted that future CEO reports would be written.

027/2016 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had been considered by the Quality and Standards Committee and by the Audit Committee and that the changes noted were self-explanatory. She highlighted that two areas within the BAF – health records and mandatory training - had increased levels of assurance and that infection control had a reduced level of assurance.

She asked for approval to remove three items from the BAF where gaps in control were no longer reported:

- Clinical laboratory diagnostics
- Plain film reporting
- MSK modelling

Mrs Wells noted that there were three areas rated as red within the report:

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

Mrs Webster reported that the Trust had appointed Dr Anne Wilson as Director of Infection Control, and that she would be undertaking the role from 18th April. She updated that the infection control team had undergone restructuring, and that it would be maintaining a greater clinical focus moving forwards.

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

The Board approved the removal of the three areas no longer reported as having significant gaps in control.

QUALITY, SAFETY AND PERFORMANCE

028/2016 **Quality Improvement Plan**

Mrs Webster presented a highlight report outlining progress made on the Trust's Quality Improvement Plan (QIP) since the last meeting, noting that multiple internal monitoring processes were in place within the organisation to provide assurance about what was being reported. She advised that the Trust had a dedicated Project Management Office in place, and that while the QIP included actions raised by the CQC it also encompassed other areas for improvement that had been identified within the organisation.

Mrs Webster explained that ESHT would not be able to meet the deadline for compliance CQC's A&E workforce warning notice in respect of compliance with Royal College guidance on staffing numbers. This had been discussed with both the CQC and NHS Improvement (NHSI) and mechanisms were in place to ensure the department was safely staffed. She reported that actions from the remainder of the CQC's warning notices had been completed, as had the CQC's 'should do' actions.

Mr Nealon asked if a additional informtaion could be included within the report to show the progress that was being made by the Trust against actions, and Mrs Webster agreed to include this in the next QIP report. **AW**

Mrs Churchward-Cardiff enquired about the progress that was being made in defining a vision for maternity services. Mrs Butterworth replied that the service had undergone an external review, and that additional support for leadership within the area had been put in place. She explained that a programme for transformational change would be implemented.

Mrs Churchward-Cardiff asked when the proposed review of A&E by the Royal College of Medicine (RCM) was due to be undertaken. Mrs Butterworth explained that a review of A&E was currently being undertaken by the Academic Health Science Network (AHSN), and that the results of this review would be used to consider the scope of a review by RCM. Dr Bull noted that if the results of the AHSN review did not support further review by RCM then the secondary review may not be required.

Ms Kavanagh expressed concern about the number of actions that were rated as amber within the report. Mrs Webster explained that actions that had been completed and were rated amber until it was clear that they were both effective and had become embedded within the Trust.

She advised that every action had a different timescale for when it could be moved to green, and that this trajectory was included within the more detailed internal action plan.

Mr Clayton-Smith asked whether recent improvements in relationships with the Trust's stakeholders were helping with completion of the QIP. Mrs Webster explained that Healthwatch had undertaken a number of reviews within the Trust on a 'Critical Friend' basis and that these had been extremely useful in providing a knowledgeable outside perspective.

029/2016 **Integrated Performance Reports – February 2016 (Month 11)**

i) Patient Safety & Clinical Effectiveness

Ms Kavanagh asked why the increase in incidents being reported was viewed as being a positive by the Trust, and Mrs Webster replied that this showed that staff were confident that they should report incidents and that learning would be gained from doing this. Whilst the number of incidents reported had risen, the number of severe incidents reported had not increased. Dr Bull agreed that the increase in reporting was an encouraging sign and explained that staff were encouraged to proactively report any incidents.

ii) Performance, Access and Responsiveness

Mrs Butterworth reported that 1,000 additional patients had attended the Trust's A&E departments compared to the previous year, and that these additional patients, combined with the issues being faced with discharging patients from the Trust were leading to difficulties in meeting the 95% A&E standard.

She reported that the 18 week Referral to Treatment (RTT) standard had been achieved, but that recent industrial action had created an increase in the number of patients awaiting appointments. Mrs Butterworth reported that 2 week and 31 day cancer targets were being met, and that during February the targets for 62 day cancer pathways had also been achieved.

Mrs Butterworth reported that the number of delayed transfers of care had increased, and that work was being undertaken with the CCGs and with social care in order to try to resolve what was a national issue. She explained that the discharge of some patients was being delayed due to a lack of care packages and beds being made available by private providers.

Mr Stevens asked if the Trust was looking at solutions other Trusts had found to the issues being faced, and Dr Bull explained that he had spoken to the Chairman of NHS Providers about ways in which learning could be shared across the entire system.

iii) Finance

Mr Astell reported that the Trust's deficit in February was £3.9 million, an adverse variance of £259kto plan. He said that the total yearly deficit was £44.5million, £11.4million greater than had been projected at the start of the year. He explained that the forecast outturn for the year was expected to be £48million.

Mr Nealon noted that at the start of the year the CCG had assumed that A&E attendances would reduce due to work being carried out in the community. He said that figures showed that attendances had increased during the year, and asked what plans had been made for 2016/17 in order to manage the increase in patients. Mrs Butterworth replied that business planning for 2015/16 had included detailed capacity work, and that the CCG had agreed that the trajectory for the coming year would show increased A&E attendance.

iv) Workforce

Ms Green reported during February the fill rate across Clinical Units was above 90% for the first time. She outlined that the fill rate for medical staff was 88%, and that HCAs had been recruited to 100%. She explained that the Trust was looking overseas to try to recruit more nurses, and that this initiative had led to a number of staff already starting with the Trust. Ms Green reported that sickness had risen slightly during February. She reported that mandatory training levels had increased, and that appraisals levels across the Trust were now above 85%.

Mr Clayton-Smith explained that the Trust was encouraging staff to work on the Bank by paying them on a weekly basis and at their substantive pay point in order to reduce agency spending. Ms Green advised that weekly pay for staff working on the Bank would commence in June, and that work was being undertaken in order to ensure that staff were aware of the improvements to Bank pay. Mrs Webster explained that nurses received additional benefits from the Trust in the form of annual leave accrual, and support for their revalidation when they worked on the Bank.

Mr Clayton-Smith asked what actions were being taken to improve Safeguarding training compliance, and Ms Green explained that work was being undertaken with Clinical Units to further improve rates of mandatory training.

The Board noted the Performance, Workforce and Finance Reports for December 2015.

030/2016 **Safe Nurse & Midwifery Staffing Levels**

Mrs Webster presented a report detailing nursing and midwifery levels across the Trust, noting that staffing numbers were checked four times every day to ensure that wards were safely staffed. Dr Bull asked whether figures for district nurses were included within the report, and Mrs Webster replied that the staffing levels for district nurses was carried out on a different basis, as not every out of hospital patient needed to be seen on daily. Dr Bull noted that, if feasible, he would like to see the staffing numbers for district nurses included within the report in the future. **AW**

Mrs Churchward-Cardiff asked why there had been increased falls reported on the Stroke Unit at EDGH and Mrs Webster replied that the Unit was appropriately equipped, and that work was being undertaken to ensure that patient pathways minimised the risk of patient falls.

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

031/2016 **Patient Experience Report**

Mrs Webster presented the report and noted that there had been a reduction in the number of Friends and Family Tests (FFT) received by maternity. She explained that a lot of work was being undertaken across the Trust to increase FFT response rates, and that the use of text messages to encourage patients to complete the tests was being considered.

Mrs Webster explained that the way in which patient complaints were managed within the Trust had been altered. She explained that the change would allow more detailed information to be provided to Clinical Units and would make it easier to identify any trends that emerged. She reported that Healthwatch had undertaken a review of the Trust's complaint procedures and that their report was expected before the end of April.

Mrs Webster noted that one of the Never Events reported as having taken place during 2015/16 within the Patient Experience Report had actually occurred in August 2014. She explained that the Never Events had been thoroughly investigated and also were scrutinized by the CCGs She reported that new processes had been introduced by the Trust following the investigations.

Mrs Webster reported that following Duty of Candour training, staff were reporting that they were becoming more confident about holding conversations with patients to inform them of any adverse incidents.

Mrs Churchward-Cardiff asked whether any themes had been identified from patient complaints and Mrs Webster replied that complaints were often about communication from the Trust and that work was being

undertaken to improve the way in which staff communicated.

Ms Kavanagh noted that it would be useful for the Board to see long term trend figures in order to establish emerging patterns, and Mrs Bernhauser explained that annual complaint trends and data were presented to the Quality & Standards Committee.

The Board noted the Patient Experience Report

032/2016 **Mortality**

Dr Hughes reported that a review of a large variety of data was being undertaken in order to better understand the reasons for the recent rise in mortality rates within the Trust. He explained that NHS organisations received delayed mortality data and that the data currently being reported was from the winter period. He explained that the Trust's Mortality Review Group reviewed all of the data received by the Trust before feeding this into the Mortality Overview Group. Clinical Units also undertook monthly reviews of all deaths within their areas.

Dr Hughes reported that two consultants had taken on the task of reviewing all deaths within the Trust, with help from the coding and bereavement teams. He explained that a meeting had taken place with the TDA to discuss the issue in greater depth, and that the TDA had made a presentation to the Board and Clinical Units on mortality in March. Dr Hughes noted that a Clinical Summit on mortality was being convened by the Trust.

Dr Bull explained the imperative for resolving issues that existed around coding of co-morbidities, and Dr Hughes noted that this work was already underway. He advised that completion rates of mortality reviews had recently dropped as a result of a requirement for consultant sign off on all reviews. He explained that the two consultants who were reviewing all deaths within the Trust would ensure that the completion rate increased as the new system became embedded. He explained that the intention was that within six months, consultant review of all deaths within the Trust would take place within one month.

Ms Kavanagh asked how many of the reported deaths were classified as avoidable. Dr Hughes explained that mortality reviews scored all deaths on a scale of avoidable harm from 1-5, and that those receiving a score of greater than four underwent a more detailed review. He reported that seven deaths within the Trust during 2015/16 had been classified as avoidable. Dr Bull noted that a validated method for assessing whether a death was avoidable was available and should be being utilised.

Mr Clayton-Smith asked that Dr Hughes provided a further update on mortality at a future Board meeting, including greater detail about variations between nationally published and internally monitored mortality metrics. **DH**

The Board took assurance on the increasing robustness of the Trust's mortality review systems, whilst noting the urgent need to remap on Pas of clinical specialities and consultants to relevant CUs. The Board noted the variations in nationally published and internally monitored mortality metrics.

GOVERNANCE AND ASSURANCE

033/2016 **Delivering Same Sex Accommodation Annual Declaration of Compliance**

Mrs Butterworth noted that the declaration being presented would need to be amended prior to being published on the Trust's website due to a number of breaches in same sex accommodation in recent months. She explained that these had taken place due to the high level of attendances to the Trust in recent months and that a new policy had been introduced as a result.

Mr Clayton-Smith asked what had been learnt from the recent breaches and Mrs Butterworth explained that changes to the layout of wards within the Trust had been recommended in order to be able to flexibly assign areas as demand changed. She noted that accommodation was reviewed four times a day, and that heads of nursing were focussed on eliminating any same sex breaches within the Trust.

The Board asked for the revised declaration to be circulated for approval prior to publication on the Trust's website.

033/2016 **Board Sub-Committee Reports**

a) <u>People and Organisational Development Committee</u>

Ms Kavanagh reported that the People and Organisational Development (POD) Committee had met for the first time and that the meeting had been well attended. She advised that the Committee's Terms of Reference had been agreed, that the results of the staff survey had been reviewed and that recruitment and retention and staff engagement within the Trust had been discussed. She explained that the POD Committee would try to engage proactively with national measures, including junior doctors' contracts and changes to pensions.

The Board noted the report and agreed the Terms of Reference.

b) <u>Audit Committee</u>

Mr Stevens advised that the Trust was not currently managing to complete all of its internal clinical audits to a good level, and that the Audit Committee had asked that less internal audits were undertaken in

2016/17 in order to ensure that they were completed properly and in a timely fashion.

Mr Clayton-Smith reported that he had asked Capsticks to undertake a review of the Trust's clinical governance processes, and that the findings of this review would be brought to the Board for discussion following its conclusion at the end of May.

The Board noted the Audit Committee report.

c) Finance and Investment Committee

Mr Nealon reported that the Trust had had been one of 22 Trusts who had provided data to Lord Carter's Review of Productivity within NHS Trusts, and that the findings of this review had been received. He explained that the report suggested that £37million of savings could be found within the Trust, although noted that some of the assumptions of savings within the report were very ambitious. He reported that Clinical Units' business plans for 2016/17 incorporated elements of the Lord Carter Review.

The Board noted the Finance and Investment Committee report.

ITEMS FOR INFORMATION

034/2016 **Use of Trust Seal**

The Board noted the use of the Trust Seal on 11th March 2016 on the agreement between ESHT and Roche Diagnostics Ltd. to provide pathology managed services for a seven year period.

035/2016 **Questions from Members of the Public**

a) ESHT

Mrs Walke commented that she had found the atmosphere of the Trust's Board meetings to have changed to one that was far more open than had previously been the case. She said that she hoped that this would mark a new start for the Trust, and that staff would also feel the same.

Mrs Walke reported that she, and other members of the Save the DGH campaign, would be meeting with Dr Bull on Friday 15th April. She said that she was pleased that the patient transport issues being faced by the Trust had been discussed during the Board meeting, and explained that she had received an increase in patient feedback about good levels of cleanliness on maternity wards.

b) Infection Control

Mrs Walke asked how the Trust monitored infections following the discharge of patients, and Mrs Webster replied that the CCG had an

infection control team who would report any issues to the Trust so that they could be discussed. She explained that both the CCG and Trust would complete a Root Cause Analysis to establish where the issue had occurred, and whether anything could be learnt from it.

c) Mortality

Mrs Walke asked whether deaths that were classified as avoidable could be identified within the mortality reports, and also explained that including the age of patients who had died would provide greater context to the report. Mr Clayton-Smith noted that the risk adjusted mortality figures being presented already took into account the age of patients.

d) Overtime Payments to Staff

Mr Hardwick asked how staff were paid for any overtime they worked. Mr Clayton-Smith replied that staff were paid at their substantive grade and pay point when working at the same grade on the nurse Bank. He noted that if staff worked at a lower grade than their substantive grade, then they were paid at the top pay point of the lower grade.

e) Acorn House

Mr Hardwick asked whether the Trust was responsible for Acorn House in Eastbourne. Mrs Wells replied that she was not aware of the Trust being responsible for the property, and would find out who was responsible for the building. **LW**

f) Agency Pay Rates vs. Bank Pay Rates

Mrs Hardwick asked how the Bank rates paid to staff compared to the rates that they could earn working for an agency. Mrs Webster replied that staff working on the Bank accrued annual leave, had access to Trust training and development and received help in completing their revalidation. She noted that agency staff did not receive these benefits and said that the difference between Bank and agency pay rates did not take these additional factors into account.

g) Patient Discharge Plans

Mr Campbell asked which staff were responsible for completing patient discharge plans and ensuring that external agencies were contacted when necessary. Mrs Webster replied that the Integrated Patient Document used for all inpatients included patient discharge plans and nurses, working alongside clinicians, were responsible for ensuring that these were completed.

h) Patient Transport

Mr Campbell noted that some patients had had to travel to London to receive treatment at their own expense. He asked whether it would be possible for appropriately costed transport to be provided for patients. Mrs Butterworth said that this could be raised with transport providers, and that she hoped they would be able to recommend reasonably priced transport for patients who were not eligible for free transport to appointments.

i) CCG Representation

Mr Campbell asked why there was not a representative for the CCG at the Board meeting, and Mrs Wells explained that there was no legal reason why they could not attend although any potential conflicts of interest would have to be managed as the CCG were the Trust's commissioners. Mr Clayton-Smith said that it was clear that greater levels of communication between the Trust Board, and those of the CCG and East Sussex Better Together would be vital in moving forward.

036/2016 **Date of Next Meeting**

Wednesday, 8th June 2016, at 1100 in the St Mary's Boardroom, EDGH.

033/2016 **Closed Session Resolution**

The Chair 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 13th April 2016 Trust Board Meeting

Agenda item	Action	Lead	Progress
025/2016 b)	Revised End of Life Care Strategy to be presented to Board	Medical Director	On Agenda
028/2016	Additional information to be included within Quality Improvement Plan report to show Trust progress against actions	Head of Nursing	Included within report
030/2016	Head of nursing to investigate whether district nursing figures can be included within Safe Nurse Staffing report	Head of Nursing	Will be included from September 2016 – methodology currently being tested.
032/2016	Update on mortality to be provided at a future Board meeting	Medical Director	On agenda for August's meeting
035/2016 e)	Update on ownership of Acorn House to be given	Company Secretary	Undertook some research and unable to ascertain membership; we do not believe this is an NHS property.

21153

Chief Executive's Update

1. Introduction

As the Board will see from the papers on the agenda we have made good progress in establishing the organisation's strategic agenda for the coming year. These are being translated into early action and incorporated into Directors' personal objectives. We have set out our clear priorities and identification of key risks in the five areas of Safety & Quality, Leadership & Culture, Access & Delivery, Clinical Strategy, Finance & Capital.

Our single biggest risk remains weakness in recruitment to establishment across the organisation. This has recently been successfully addressed in nursing and radiography. A programme is being put in place to replicate this success with a significant corporate initiative for senior medical staff. A parallel initiative will ensure continued success in local recruitment. Retention of staff remains an imperative as part of this and it is good to see the rate of turnover reducing.

A key current operational issue is the impact of a seriously substandard patient transport service (see below).

This month's reviews with NHSI were well received. We must now make rapid progress in defining the month by month plans we have to maintain and accelerate the improvement that we have begun to see in patient flows through the organisation.

Plans are in hand for the mock CQC inspection which we have arranged for late June. The actual inspection will take place week commencing 3rd October.

Key points in specific areas are as follows:

2. Safety and Patient Experience

2.1 Quality and Safety

Patient transport issues remain a major concern. They are causing significant patient dissatisfaction and pose a safety risk to many patients. There is no evidence of improvement. Many patients are not attending appointments and there are significant delays in discharge. Discharged patients are having to stay an additional night and in one area even an outpatient stayed overnight!

On an internal note we have also paid approx. £40,000 on additional vehicles in April. Whilst we are cross charging this that rate of expenditure across all the Trusts will exceed any cost benefits that may have been achieved in the tender. The matter has been escalated across the system. All providers are experiencing problems. The problem may be particularly acute in Eastbourne. Further reviews are being held with the CCG who hold the contract. They have given assurance of improved performance over the coming weeks.

A successful summit meeting was held to discuss the issue of mortality. Over 50 consultants were in attendance with senior nursing staff and managers also participating. The underlying drivers have now been described and drawn up into a plan of action which will be brought to the next Board seminar. There are a number of good and successful quality initiatives underway including reductions in complications of colitis and bowel surgery, and recovery of the deteriorating patient.

2.2 Patient Experience

Hand Hygiene Day on 5th May 2015 was actively supported by the Trust.

International Nurses Day in May was celebrated across the Trust.

A new service has started aimed at supporting frail people to live independent and healthy lives out of hospital. Eight Frailty Practitioners will coordinate the care of frail people so they can be supported to live independently at home. Using their advanced clinical skills, a comprehensive geriatric assessment will be undertaken to assess frail people's needs and establish a plan of care to support them. In some instances this will include anticipatory future care planning. Medically, this work will be overseen by Dr Elena Mucci, Consultant Geriatrician with the team led by Sue Lyne, Nurse Consultant for Frailty & Older People/Frailty Practitioner

3 Workforce

3.1 Operational HR

Recruitment

36 Overseas and EU nurses have started; there are 103 applicants pending starting of which 45 will be starting in May and June.
Medical recruitment continues to be of concern and we are developing specific Action Plans for each Specialty as well as overall plans to recruitment generally including improving the marketing of the Trust.

Temporary Workforce

We are participating in a project led by NHS professionals to review and identify best practise in the engagement of Agency and Bank staff.

A workshop will be held on 22nd June for Trusts across Sussex.

Employee Relations Training

To improve the quality and responsiveness of investigations 3 training programmes have been delivered in conjunction with ACAS to train line managers and HR staff in best practice for Investigations. We now have a cohort of 45 Investigators across the Trust. In partnership with Capsticks solicitors, panel member training has also been delivered to Senior Line Managers to ensure that we have robust governance and decision making in place for cases that require a formal hearing.

Junior Doctors - New contract

We have 36 FY1 Junior Doctors that will be appointed on the new contract in August.
The new contract has been accepted by negotiators but remains subject to a ballot of BMA members.
The post of Guardian of Safe Working has been advertised.

3.2 Staff Engagement & Wellbeing

Two of our current 15/16 Project Search interns have already secured permanent substantive posts with ESHT before they even finish their programme – Sam who will be on Reception in the Michelham unit, and Luke who will be a Porter.

Cultural review now completed – the report will be presented back to the Board in June 2016 which will identify areas we do well and areas we need to improve.

Developing our Health and Wellbeing service - now recruiting to a Health and Wellbeing Manager post and a physiotherapist to support our staff with MSK injuries.

Dates planned for next year for emotional resilience workshops. Schwartz Rounds continue to run every month, Take a Break campaign launched on the 23rd May 2016.

Trust Annual Awards took place with over 200 staff attending recognising the achievements of some of our staff who have made a real difference to the lives of the people of East Sussex. It was an inspirational evening and congratulations to all the nominees and prize winners.

We have welcomed a number of both European and Filipino staff following a successful overseas recruitment programme.

64 FTE Registered Nurses have started in the last two months. The origins of these nurses are: 16 EU and 13 Overseas, 15 United Kingdom, 20 newly qualified nurses. The overseas and EU nurses will undertake orientation programmes within the Trust. Further recruitment trips are planned in April and May.
80 FTE Health Care Assistants have started since January 16 and the Trust is now above establishment against budget for this staff group.
20 radiographers have been appointed from the Philippines and are expected to start in July 2016; this recruitment will enable the Trust to move towards a 7 day service.

4 Operations

The Junior Doctor's Industrial action on the 26th/27th April was successfully managed with good clinical engagement from all clinical units.

Urgent Care and patient flow improvement programme is ongoing. This has driven improvements in recent A&E performance and the ability to reduce our escalation beds on the Eastbourne site.

With support from NHS Improvement we are now delivering improvements in our cancer standards and expect to sustain this moving forward.

5 Governance

We have been advised that our CQC inspection will take place at the beginning of October. The inspection will cover eight core areas including urgent and emergency services, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care and outpatients.

One of our Consultant Speech and Language Therapists, Anita Smith, organised the first national Swallowing Awareness Day in May on behalf of the Royal College of Speech and Language Therapists. Events took place in our Trust and across the country which was a real credit to Anita and her team. We were able to launch a new service called Fibreoptic Endoscopic Evaluation of Swallowing to help assess patients with a swallowing disorder thanks to the generosity of the Conquest League of Friends.

6 Strategy

Work has commenced with stakeholders internally and externally to develop a robust clinical strategy whereby ESHT can achieve its vision of the integrated care provider of choice for the population of East Sussex. Priority clinical services have been identified.

We continue to engage fully with the STP and ESBT programmes. We believe it important that the STP is built on the principles of the place based care strategy for the East Sussex population that is contained in ESBT.

Work on 7 day services will establish a baseline of current position and develop a roadmap of how to meet the national standards for timeliness of consultant review, diagnostic availability, and MDT working.

7 Clinical Information

Key areas of current development include continued review and revitalisation of System 1, Electronic Document Management (launch of which is delayed from September), PAS hardware upgrade, GS1 and electronic discharge summaries.

8 Finance and Contracting

In the first month of the new financial year the Trust made a deficit of £5.2m, which was £0.5m worse than plan. While income and pay costs were broadly in line with plan, the income position was balanced by higher than expected urgent admissions but lost activity because of the Junior Doctors' strike. Non-pay budgets were overspent by £0.5m. The main factor was third party support to deliver endoscopy backlog and RTT compliance in orthopaedics. These costs were not budgeted and, although both will have delivered additional activity, this was not sufficient to generate an overall compensating income variance. There is a CCG commitment to support these additional costs which will be followed up. A fine (circa £230k) was also levied by the CCGs for non-achievement of targets; this money will be reinvested in Trust services.

There has been a significant reduction in agency costs, in line with plan.

The Trust's draft final accounts will be presented for approval to the Audit Committee on 1 June ahead of the submission date to NHSI on 2 June. No major issues have so far been highlighted from the audit.

The Trust has submitted its third request for a cash drawdown against its £31.3m Revolving Working Capital Facility. The request for June is for £3.9m, bringing the total drawdown to date to £16.2m, more than half of the facility currently available for the year. The contract for 16/17 has not yet been signed pending final reconciliation of minor issues and agreement on forecast activities.

The CEO of NHSI has sent a letter to all organisations clarifying the position on tendering for services by CCGs. Effectively the letter requires that competitive tendering for the provision of care is used only after all options with existing NHS providers have been fully tested. The letter contains the following paragraphs:

"In order to secure the best deal for patients, we expect CCGs to have fair and transparent processes and engage with existing providers. If CCGs are not happy with the service being provided under an existing contract, they need to give their current providers the opportunity to address concerns under the terms of their contract before considering other options. In those cases where CCGs can roll over or extend contracts, this should not happen when the provider has failed to respond appropriately to such concerns.

For the avoidance of doubt, tendering is not the automatic solution in every case. But there is definitely a requirement for CCGs to have good processes to ensure that chosen providers are best placed to deliver what patients need locally."

9 Recommendations

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

Dr Adrian Bull
Chief Executive

East Sussex Healthcare NHS Trust

Date of Meeting:	8 June 2016
Meeting:	Board Meeting
Agenda item:	6
Subject:	Board Assurance Framework
Reporting Officer:	Lynette Wells, Company Secretary

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

Purpose:

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

Introduction:

The Assurance Framework has been reviewed and updated since the last meeting of the Board. Objectives have been revised following agreement at the last Board meeting and this has included the addition of the objective relating to workforce.

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

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. There have been no additional gaps in control or assurance added to this iteration of the BAF. Key revisions include:

Assurance has reduced in two areas:
Page 7 - 2.3.1 Amber to Red - Patient transport
As a result of the transfer of the service to the new provider and the impact this has had on the service and patient experience.

Page 12 - 3.4.1 Green to Amber – Tenders/AQP
Need to review resource and mechanisms to respond to tenders/AQP.

Removal of gap in control:
Page 16 – 4.2.2 Board vacancies
It is proposed to remove “Transition in executive team and inability to successfully recruit to Chief Executive and Chairman posts could impact on Board effectiveness” as key posts are now filled.

Four areas are rated red:
1.2.2 Relating to reconfiguration of emergency department and capital required
1.2.4 Mortality indices
2.3.1 Patient transport
3.1.1 Financial position

Benefits:

Identifying the principal strategic risks and gaps in control and assurance provides assurance to the Trust Board that there are effective controls and mitigation in place to support the Trust in achieving its strategic aims and objectives.

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

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

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

Consideration by other Committees
Quality and Standards Committee 2 June 2016

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

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

Board Assurance Framework - May 2016

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes	
Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies	
Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM contract signed and implementation plan being developed
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	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement (QIP) plan reviewed and revised and submitted to CQC and TDA. Improvement Director working with the Trust. Internal quality summits in progress. Jan-15 Comprehensive action plan in place with forward trajectory of progress against actions. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection.	end Oct-16	◄►	DN	Q&S SLF
1.1.2	C	In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.	Oct-15 iFIT starting to embed with some good results; rolling improvement programme. Mitigating actions continue and extended to provide daily information re availability of notes. New escalation procedure for missing notes. Project to centralise Health Records underway. Health records management structure reviewed. Dec-15 Ongoing programme of work to support effective delivery of health records service monitored by SLF. Consultation taking place re health records structure. Mar 16 - iFIT and on-going review of processes in Health Records have significantly reduced missing notes, positive feedback from clinicians.. Storage remains challenging but is being addressed through the development of an off-site facility. Repairs continue but ultimate solution is the EDM programme. May-16 Marked improvement in the availabilty of records. Progressing offsite storage of records.	end Dec-16	◄►	COO	Q&S SLF

Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes	
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 Cleaning controls in place and hand hygiene audited Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	IST review to supplement work with KSS Cancer network on pathway management. Oct-15 – Poor performance of targets in Aug and Sept. Cancer Recovery merged with Trusts 8 high impact cancer priority plan. Focused piece of work taking pace to initially cover 2ww performance position. Dec-15 – Challenges in meeting 2WW standard continue although performance is improving on a monthly basis. Alterations to the set-up of the 2WW booking team and their processes are being implemented in order to improve performance. Mar-16 - Acheived 2WW breast symptomatic in Jan and both standards in Feb. In addition, TDA support provided 2 days per week to focus on sustainability and 62 day achievement. May-16 Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb and Mar, breast symtomatic not achieved Mar, 62 days improving.	end Oct-16	◄►	COO	SLF

Board Assurance Framework - May 2016

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.2.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans.	end Dec-16	◄►	COO	SLF
1.2.3	A	Assurance is required that there are effective systems in place to minimise infection control incidents and share learning throughout the organisation.	Jun-15 Audit cleaning team strengthened. Infection control team being restructured, to increase management of audit / assurance process. Weekly walks round both sites with facilities and IC to review areas highlighted by the auditors as 'areas of risk'. Further assurance requested by Quality & Standards Committee. Aug-15 NSC Audit Group meeting and reviewing reporting of metrics. NSC audits scrutinised at Accountability Reviews. Oct 15 Reporting to Q&S Nov. Increased numbers of auditors recruited Meeting / Governance structure to be reviewed Nov-15 Dec-15 Continued review and shared learning. Infection control deep dive at Jan Q&S committee. Mar-16 External assurance visits via CCG, TDA and External DIPC, Head of Estates and IC Lead. Awaiting report immediate action required in 2 out of 6 areas following one visit. Nothing further identified in remaining assurance visits form the CCG.Control dashboard being developed and planned to be part of the accountability review meetings. Single comprehensive action plan and annual programme of work being developed for April 2016. Assurance moved from Green to Amber. May-16 Bare below the elbows policy implemented in all clinical and ward areas. Increased compliance with national cleaning specification standards	end Aug-16	◄►	DN	Q&S

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Strategic Objective 1: We will ensure safe patient care is our highest priority by delivering high quality services and clinical outcomes							
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**
1.2.4	A	Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Mar-16 Focussed action plan being developed. Identified top 10 drivers for elevated indices and reviewing pathways for cause in these groups. Internal mortality summit planned April 2016. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. May-16 Mortality meeting held with clinicans 20 May. Weekly review of deaths undertaken by consultant and senior coder. Work underway to understand further co-morbidity profile of our patients. A number of clinical pathway reviews in place to reduce risks eg colitis, deteriorating patient, gastroenterology.	end Jul-16	◄►	MD	Q&S
1.2.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed and activity beign monitored. i Dec-15 Business Case (BC) and PTL considered Dec. Further updates to the BC and PTL will be reviewed at Jan meeting. Mar-16 CCG reviewed community paediatric business case, negotiations taking place. Following approval of business case substantive recruitment will take place to reduce the reliance on locums. Date moved to Sept to recognise recruitment timeframe. May-16 – Implementation timeframe of the recruitment plan is currently worked up. This will allow the service to build a recovery trajectory to reduce the waiting time and list size. This continues to be monitored at Contract Performance meetings with the CCGs.	end Sept-16	◄►	COO	SLF Q&S
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
1.2.6	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMHS for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients Dec-15 Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people. Mar-16 Continued working with CAMHS and SPT to develop pathway. May-16 A& E Liaison Nurse appointed to Conquest, equivalent being recruited toDGH. HoN requested in-reach pathway from CAMHS for these pts and daily ward visit. HoN attending urgent help/crisis meeting care and attending CAMHS transformation board to raise profile of young people in crisis with commissioners and gain adequate investment for this cohort.	end Jul-16	◄►	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
1.3.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Oct 15 – Dec 15 Compliance for mandatory training and appraisal is improving month on month and is a continuing upward trend. Specific actions to be taken over the next few months to support areas include: Tailoring mandatory courses to meet the needs of clinical units/departments. Continued review of mandatory training and appraisal compliance at Clinical Unit Accountability meetings and facilitated drop in/team sessions. Mar 16 - As at 31/1/16 Mandatory compliance is 86.6% and Appraisal compliance is 83.34%. This is the highest level of compliance in the Trust for some time. The Appraisal process and paperwork has been redesigned and we are aiming to launch this from 1st April 2016 along with a development programme for Appraisers. A new L&D manager started in February and one of her objectives to review all that we are doing with mandatory training, move forward the competency work and identify any further efficiences we can make. Rating moved from amber to green. May-16. Compliance trend for mandatory training and appraisals continues to rise towards the 90% target. To support appraisal, Engaging for Development Masterclasses have been planned to run in June and July. Revised paperwork for Appraisal is currently being ratified and will be launched in July 2016.	end Sep-16	◄► Mar-16	HRD	Q&S SLF

Strategic Objective 2: We will enhance patients' experiences by working with local partnerships to meet the needs of our local population	
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.	
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 effective relationships with commissionrs and regulators Proactive engagement in STP and ESBT Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders Develop and embed key strategies that underpin the Integrated Business Plan (IBP) Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Two year integrated business plan in place Stakeholder engagement in developing plans Service delivery model in place Refreshing clinical strategy to ensure continued sustainable model of care in place

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust 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 Dec-15 ESBT work continues. Board to Board meeting with Eastbourne, Hastings and Rother CCG took place Dec15. Mar-16 SPT footprint agreed. Trust to work with stakeholders to develop strategic plans. Board Seminar planned April 16. May-16 Trust fully engaged with SPT and East Sussex Better Together programmes. Trust strategy being developed and “stakes in the ground” identified. Priority specialities for clinical strategy development identified and specific work commenced	end Dec 16	◄►	MD(S)	F&I SLF

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.3.1	A	Assurance is required that patient transport services will be improved to minimise any detrimental impact on patient care and experience.	Incidents logged, issues escalated to SECAMB /CCG. Service spec reviewed by commissioner; Trust engaging with process. Apr-15 Inpatients - Trust has access to additional vehicles via Elite. Issue remains with outpatients. . Oct-15 Tender for service to be awarded end Oct with April implementation date. Will work with CCG and new provider to support improvement. Mar-16 New provider in place, managed service contract. Working with provider to ensure effective transition from SECAMB. Effectiveness of service will be monitored. May-16 Following handover to new provider there have been significant service problems impacting on patient care and experience. In addition there has been an increase in DNA rates and loss of procedure time due to failure to collect patients and late arrivals. There is an operational group in place, monitoring of incidents and this has been escalated both internally and externally. All Trust in Sussex are experiencing the same issues and there is a CEO summit w/c 31.5.16	end Jul-16	▼	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.3.2	C	A number of concerns have been identified following the centralisation of reception and outpatient services on the two acute sites. Shortage of staff in appointment and admissions booking teams Further controls are required to support delivery of an efficient service and good patient experience.	Review instigated to support implementation of focussed actions. Feb-15 Central team in place and systems being monitored. Considering developing specialist teams to support areas with complex processes. Apr-15 -Dec15 Close liaison between service managers and booking team. Increased working space/ essential equipment. Monitoring of performance via dashboard. Reviewed processes to minimise short notice clinic cancellation and ensure appropriate clinical assessment of affected patients. New call management system iintroduced to address technical and resource issues in the appointments centre/provide enhanced service Review of 700+ letter templates underway to improve patient communication. SOPs and specialty booking rules agreed and implemented. Following review of call reminder system significant improvement in DNA rates, more scope within the programme. March 16 – 80% referrals registered within 48hrs of receipt, scanned on to e searcher to minimise risk of paper referrals going missing. First specialty about to go live with e referral system, continued roll out through 16/17. Scheduled to undertake review of the standard operating procedures implemented in Sept 15 at end of March. Staff capacity/demand remains an issue and is being addressed through business planning. Planning to develop some self- service check in facilities in 16/17 May-16 Business Case for Clinic Manager and Self-Serve check in underway with PMO and IT. New structure with additional resources for OP booking to support retention of staff due for implementation by end of July 16. Informal staff engagement underway.	end May-16	◄►	COO	SLF Q&S

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	Require evidence to ensure achievement of the 2016/17 Financial Plan and prevent crystallisation of risks as follows: activity and income targets are not achieved; contractual fines and penalties are levied; activity, capacity and unplanned cost pressures arise; the CIP plan is not delivered;	PBR contract in place. Activity and delivery of CIPs regularly managed and monitored. Monthly accountability reviews in place and remedial action undertaken where necessary. Timely reporting of finance/activity/workforce performance in place. Regular reviews by BPSG, CLT, SLF, Finance & Investment Committee and Board. May-16 – Month 1 performance £0.5m adverse to plan. CIP plan for the month achieved. Income broadly in line with plan with non-elective over performance offsetting elective shortfall arising from doctors' strike. Fines and penalties incurred – Trust will discuss with commissioners reinvestment of these. Pay costs in line with plan with a significant reduction in agency costs. Capacity cost pressures incurred – Trust will recover some of these through Tariff while premium cost of delivery to be discussed with commissioners. Integrated performance meetings in place, chaired by the CEO; continuing oversight by Finance & Investment Committee; Efficiency Improvement Group driving financial improvement, including opportunities from Lord Carter review.	Commenced and on-going review and monitoring to end Mar-17	◄►	DF	F&I

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. The Board approved a capital programme at its meeting on 2 June 2015. Delivery of this capital plan will be reported regularly to the Finance & Investment Committee and Board. Oct 15 – At the end of Q2 capital expenditure was £5.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. Dec 15 – At the end of Nov 15 capital expenditure was £6.5m (marginally behind plan). The planning margin was being maintained, however as the programme is over committed, any new capital schemes will mean a re-prioritisation of the existing projects. An application is being submitted to the ITFF for additional capital investment to support the Quality Improvement Plan. Mar 16 – the 2015/16 plan is on track and expected to achieve the Trusts CRL. May-16 – the Trust achieved its CRL in 2015/16 A capital programme has been submitted to NHSI as part of the 2016/17 business planning submission. The Trust Board will undertake a further review the capital programme with a view to ensuring that priorities for spend are correct within the limited funds available, including any urgent elements from the Estates Strategy. The Board will also look at medium term priorities to help shape a business case to the Department of Health for a capital loan to support requirements over and above 'core' capital funding.	On-going review and monitoring to end Mar-17	◄►	DF	F&I

Strategic Objective 3: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable.							
Risk 3.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.							
Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital Approvals Group and Finance and Investment Committee						
Positive assurances	Essential work prioritised with Estates, IT and medical equipment plans Capital approvals group meet monthly to review capital requirements and allocate resource accordingly Monitoring by Finance and Investment Committee						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	There is a gap in control as a result of the Trust not having an aligned estates strategy in place.	Estates Strategy being developed. Progress updated presented to Board seminar in April. Substantive Head of Estates in post Aug-15 Presentation on progress to date at Board seminar in Jul-15 on track for submission to December Board. Dec-15 Estates strategy reviewed by Board, further engagement session planned. Mar-16 Estates strategy will be considered at May Board seminar. May-16 Producing clear statement of agreed capital programme for 16/17 and a forward five year plan for capital and estates development projects to support clinical strategy. This will be the basis of the bid for additional (PDC) funding	end Sep-16	◄►	COO	F&I SLF

Risk 3.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.4.1	A	In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners.	Oct-15 Portfolio moved to DF and being reviewed. Dec 15 - additional external resource has been commissioned by the Trust for a limited period with a specific objective of knowledge transfer. Mar-16 as above Trust successful in Sexual Health Tender. May-16 Business planning team dispersed to support other projects, support required for tendering exercises will form part of portfoliio of Director of Strategy. Assurance level moved from Green to Amber.	end Jun-16	▼ May-16	DF	SLF

Strategic Objective 4: We will show that we value our staff by developing them and engaging with them to ensure they have the right skills and knowledge to deliver effective patient care and are involved in decision making	
Risk 4.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	
Key controls	Workforce strategy approved Jun-15 - aligns workforce plans with strategic direction and other delivery plans; - ensures a link between workforce planning and quality measures Recruitment and Retention Strategy approved Jun-15 with planned ongoing monitoring Workforce metrics reviewed as part of the Integrated scorecard and alongside quality and performance data (plans to include vacancies) Rolling recruitment programme Monthly vacancy report and weekly recruitment report to CLT Nursing establishment and skill mix review undertaken and monitored by Board TRAC recruitment tool in place
Positive assurances	Training and resources for staff development Workforce planning aligned to strategic development and support Workforce assurance quarterly meetings with CCGs Implementing Values Based Recruitment and supported training programme Success with some 'hard to recruit to' posts Well functioning Temporary Workforce Service. Full participation in HEKSS Education commissioning process.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	May-16 Recruitment hotspots are Medical Consultants, A&E, Histopathology, Stroke, Gastroenterology, Other areas of focus are Dermatology, Obstetrics, Neurology, Haematology Paediatrics Middle Grades – A&E, Geriatrics, followed by Gastro and Orthodontics. Task and finish groups with CUs to develop a recruitment and retention strategy which includes skill mix review, international recruitment. Use of head hunters to identify suitable candidates. Registered Nurses – there has been an increase in establishment which has resulted in the vacancy rate increasing for registered nurses for this staff group. This will continue to be addressed through a combination of on-going international and overseas recruitment and newly qualified and UK recruitment. It is anticipated that a fill rate for Registered Nurses will be 93% by April 2017, and 97% by April 2018 Reviewing current recruitment marketing strategy and developing new literature and addition to the corporate website to promote ESHT as a place to work.	end Dec-16	◄►	HRD	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.1.2	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties e.g. cardiac physiologists, ODPs and anaesthetic staff.	May-16 Values Based recruitment has been introduced for all newly qualified Nursing Staff. As part of the Recruitment and Retention Strategy, Values and Behaviours based selection process is being developed and will be introduced for all posts	end Mar-17	◄►	HRD	SLF
4.1.3	C	Assurance is required that the Trust has effective controls in place to maintain sufficient staffing levels in A&E; recruitment difficulties in consultant, middle grade and nursing. Deanery short falls in fill rate for junior positions.	Aug-15 Business continuity plans in place to cover short term difficulties. Overseas recruitment taking place. Longer term review of staff model planned. Dec-15 Discussion taking place with commissioners as part of East Sussex Better Together. Mar-16 Recruitment taking place however short falls in staffing remains. Mitigating actions such as use of long term locums	end Sep-16	◄►	COO	SLF

Strategic Objective 4: We will show that we value our staff by developing them and engaging with them to ensure they have the right skills and knowledge to deliver effective patient care and are involved in decision making.

Risk 4.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

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

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.2	C	Transition in executive team and inability to successfully recruit to Chief Executive and Chairman posts could impact on Board effectiveness.	Aug-15 Chief Executive left July, Director of Strategy and Director of Finance leave the Trust at the end of September. Interim CEO and Director of Finance in place. Portfolio of Director of Strategy being redistributed. Jan-16 Substantive CEO in place Mar-16 CEO appointed commences Apr-16. DoF appointed commences Jun-16. Board will then be up to full complement and development programme will commence. May-16 DoF joining June. Adverts prepared for Director of Strategy and substantive Director of Operations. [To be removed from next iteration of BAF]	end Jun-16	▲	CEO/ Chair	Rem Comm/ Board

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	7
Subject:	Quality Improvement Programme
Reporting Officer:	Alice Webster Director of Nursing

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

Purpose:

To provide a highlight report of the Quality Improvement Programme initially developed from the recommendations made by the CQC in their reports published in March and September 2015 following the Chief Inspector of Hospitals visits in September 2014 and March 2015

Introduction:

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

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

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

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

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

2. Project Summary Dashboard - exceptions only
   For each objective this shows the current delivery and sustainability RAG status

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including KPIs where appropriate.

3. Key activities over the next 2 months and Significant Risks
   Risks that potentially seriously threaten the progress of the Improvement Plan

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

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

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

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

Review by other Committees/Groups (please state name and date)**:**
Senior Leaders Forum May 2016 Quality and Standards Committee May 2016

Proposals and/or Recommendations
The Board is asked to review and note the progress in implementing the ESHT 2020 quality improvement programme.

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: Lesley Walton Alice Webster Director of Nursing	**Contact details:** alice.webster@nhs.net

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Quality Improvement Programme Update

1. Introduction

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

2. Quality Improvement Programme Status

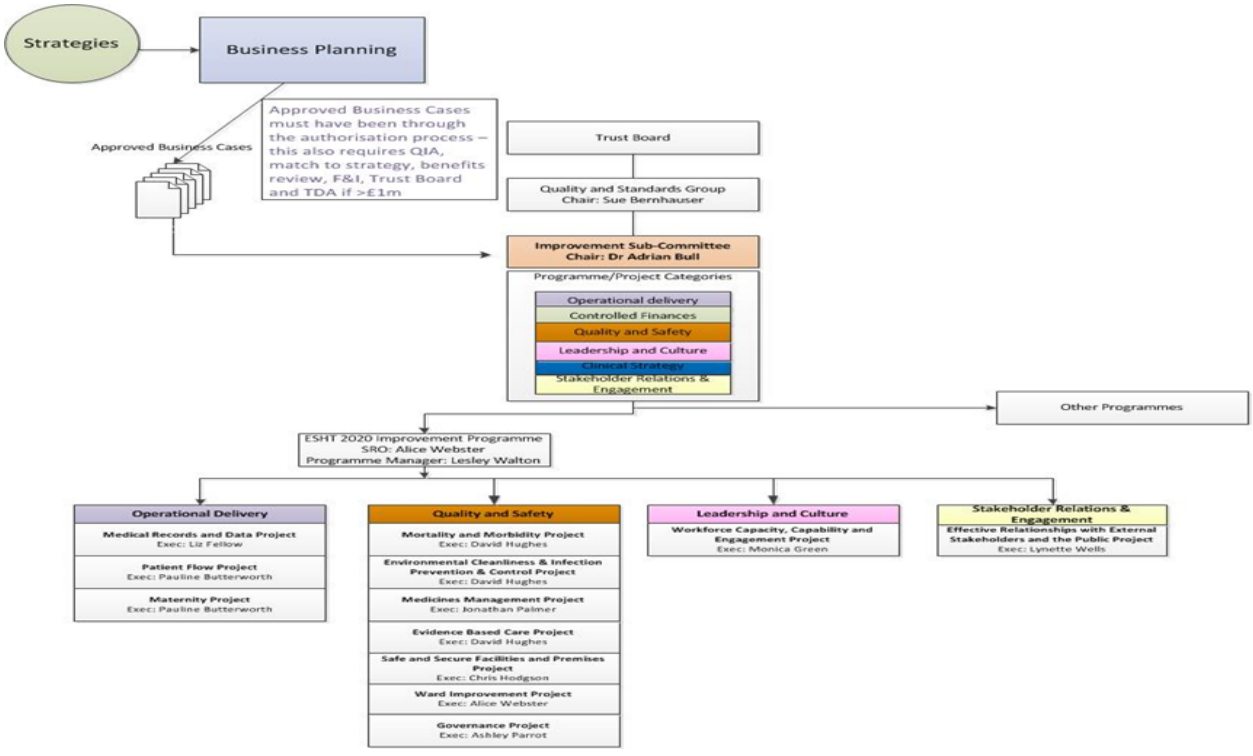
This report provides an update on the following aspects from the last two months:

- Highlights and Milestones
- Project Summary Dashboard by exception only
- Key activities over the next 2 months and Significant Risks
- Improvements

3. Programme Highlights

The main focus since the last report to the Board has been to migrate to a new governance framework and gain momentum on progressing improvements. The key activities have been:

- Improvement Sub-Committee and governance established. First meeting held on 9th May chaired by Dr. Adrian Bull.



- Transition from weekly QIP meetings to monthly Improvement Project Reviews. First Project reviews held for all the projects and future meetings booked for the remainder of the year
- Draft ESHT 2020 Improvement Plan for publication under review
- Project Improvements progressed – see later slides. Further development of KPIs and expanded scope for projects
- Communications Plan for ESHT 2020 for approval
- Programme progress reports to IDM TDA, Trust Board, Quality & Standards Committee, Quality Monitoring Group, and Ministerial Briefing.
- CQC Workshop to help define readiness plan for October inspection.
- Surgical and Mortality Deep Dive

3.1 Mortality and Morbidity Project - Project Executive: David Hughes

R	MORTALITY AND MORBIDITY PROJECT	Due Date	Latest Metric	Six-Month Trend
	Improve the Governance of Mortality and Morbidity (IP 53)			
	Increase percentage of Mortality Cases reviewed within three months of death	30-Jun-16	66%	
	Increase percentage of Mortality Meetings held to review deaths across the Trust	30-Jun-16	35%	

Project still developing scope, objectives and KPIs. Mortality summit on Friday 20th May to establish final scope and priority improvements. Objectives will include timely review of deaths and learning clearly evidenced. Root cause and reasons for unexpected deaths to inform changes in practice. Sepsis and AKI potentially the initial focus.

3.2 Secure Premises and Facilities Project - Project Executive: Chris Hodgson

R	SECURE PREMISES AND FACILITIES PROJECT	Due Date	Latest Metric	Six-Month Trend
	Separate Areas / Cubicles in Conquest CDU and A&E (IP 31)			
	Complete Estates Work to Allow Separate Areas / Cubicles	31-Apr-17	0%	n/a
	Privacy and Dignity in Radiology and OPD (IP 32)			
	Complete Estates Work to Facilitate Privacy and Dignity in Radiology	31-Apr-17	0%	n/a
	Complete estate work to ensure safety and security for Paediatric Assessment/ Mental health in ED's 3	31-Apr-17	0%	n/a
	complete estates work to facilitate privacy and dignity in urology 32d	31-Apr-17	0%	n/a
	Secure Oxygen Cylinders (IP 40)			
	Secure All Oxygen Cyclinders	31-Mar-16	100%	n/a
	A&E department isolation in the event of lock down being required (IP 47)			
	Fit Electronic Lock to A&E Department Door at Conquest Hospital	31-Mar-16	100%	n/a

This project has delivered improvements e.g. secured oxygen cylinders, A&E lockdown however, there is no identified capital to undertake the improvements to ensure privacy and dignity in A&E, CDU, Urology and Radiology, interim measures are being revie2wed. Awaiting outcome of bid for capital.

3.3 Evidence Based Care Project - Project Executive: David Hughes

R	EVIDENCE BASED CARE PROJECT	Due Date	Latest Metric	Six-Month Trend
	MDT Working at Conquest Hospital - Morning Board Rounds (IP 3a)			
	Implement Morning Board Rounds at Conquest Hospital	30-Nov-17	100%	n/a
	MDT Working at Conquest Hospital - Shift Handover (IP 3b)			
	Increase frequency of Shift Handovers (?)	30-Nov-17		
	Trust Consent to Treat Policy (IP 34)			
	Increase Percentage of Consent Forms being Confirmed by the Patient	30-Nov-17	58%	n/a
	Increase Percentage of Consent Forms where Written Information has been provided to the Patient	30-Nov-17	40%	n/a
	Increase use of Formal Capacity Assessment when using Form 4 of Mental Capacity Act	30-Nov-17	71%	n/a
	Audit compliance with VTE Guidance (IP 37)			
	Increase Rate of VTE Assessments undertaken within 24h of admission	30-Nov-17	95%	
	Percentage of Fatal VTE Root Cause Analyses undertaken on 100% of cases	30-Nov-17	40%	n/a
	Percentage of Non-Fatal Post-Operative VTE Root Cause Analyses	30-Nov-17	0%	n/a
	Audit compliance with National Nil-By-Mouth Guidance (IP 36b)			
	Undertake Nil-By-Mouth Audit	30-Nov-17	0%	n/a
	Audit compliance with National End of Life Care Guidance (IP 36c)			
	Complete End of Life Care Audits	31-Aug-16	10%	n/a
	Review and re-launch EoLC Policies	01-Oct-16	10%	n/a
	EoLC Strategy Approved	31-Jul-16	0%	n/a
	Increase EoLC Training for Clinical Staff	01-Oct-16	10%	
	Effective Pain Relief - Emergency Department			
	Undertake Pain Relief Audit (?)	30-Nov-17		
	Pain Assessment Strategy for Dementia Patients			
	Implement audit of Patients with Dementia to ensure Correct Pain Assessment Used	30-Nov-17	0%	n/a
	Pain Assessment Strategy for Learning Disability Patients			
	Implement audit of Patients with Learning Disabilities to ensure Correct Pain Assessment Used	30-Nov-17	0%	n/a

Project is addressing a number of quality concerns raised by the CQC. VTE assessments are now completed within 24 hours following changes in February and remain above target. Further development required of pain assessment objectives and KPIs. Other areas of improvement remain in the early stages and hospital at night will be added to the scope of this project.

3.4 Patient Flow Project - Project Executive: Pauline Butterworth

R	PATIENT FLOW PROJECT	Due Date	Latest Metric	Six-Month Trend
	Outpatient Department Flow (IP 10a, 10b, 10c and 11)			
	Reduction in DNAs for New Appointments	31-May-16	8.48%	
	Reduction in DNAs for Follow-Up Appointments	31-May-16	8.35%	
	Reduce Outpatient Complaints received via PALS regarding patient experience during appointment	30-Nov-16	43	
	Reduce Formal Outpatient Complaints regarding patient experience during appointment	30-Nov-16	4	
	Percentage of GP letters completed within 5 working days	28-Feb-17	55.00%	n/a
	Percentage of outpatient clinic cancellations with less than 6 weeks notice	31-Aug-16	37%	
	Number of New and Follow Up Appointments Cancelled as overall % of average outpatients bookings	31-Aug-16	25%	n/a
	Rates of Same Sex Breaches in Conquest CDU and A&E (IP 30)			
	Reduce Number of Same Sex Accommodation Breaches	31-Mar-16	0	
	Referral to Treat (RTT) Times (IP 35)			
	Meet Four Hour Standard	30-Sep-16	79.00%	
	Consistently Achieve the Two-Week Wait Targets	30-Jun-16	94.90%	
	Meet 62 day Cancer Target	31-Mar-17	70.50%	
	Meet 92% RTT Target	30-Jun-16	90.50%	
	Reduce Diagnostic Breaches to <1%	30-Jun-16	6.67%	
	Ward Moves (IP 38)			
	Reduce Number of Unneccessary Ward Moves Out-of-Hours (2200-0600)	30-Jun-16	165	
	Discharge Process (IP 39)			
	Reduce Number of Discharges Out-of-Hours (2200-0600)	30-Jun-16	518	
	Reduce Number of Complaints relating to Poor Discharge Process	30-Jun-16		
	Surgical Assessment Unit Waiting Times (IP57)			
	Process in place to monitor the length of stay and outcomes for SAU patients			
	Urology Unit Patient Flow at EDGH (IP58)			
	Unit reconfigured to enable it to cope with the current service demand and address patient flow			
	Theatre Planning (IP59)			
	Increase in the utilisation of theatres			
	Day Surgery Patient Flow at EDGH (IP60)			
	INSERT OUTPUTS			
	Theatres Recovery Patient Flow at EDGH (IP61)			
	INSERT OUTPUTS			

This project is progressing well and is still expanding the scope.

Improvement KPIs will be developed to measure progression against the recent RTT cancer report recommendations e.g. diagnostic and referral to booking KPIs. The RTT cancer 2ww target was achieved in February which is the first time we have achieved this since recording started in July 2015.

Significant improvement in mixed sex breaches with 0 recorded in March. Ward Moves trending upwards and the KPIs need to be further developed to measure in hours. Discharges out of hours trending upwards and complaints KPIs relating to discharges still being developed and scoped.

Outpatient DNA KPIs recently trending upwards currently which is thought to be due to patient transport issues and Junior Doctors Strike.

Diagnostic breaches is trending upwards due to Radiology staffing and equipment failure also Endoscopy capacity. PALS patient complaints relating to outpatients have significantly reduced due to the new telephone system.

GP letters sent within 5 working days achieved 55% (target 75%).

Improvements made in clinic cancellations have been affected by the doctors strike however trends show trends by specialty that will allow more targeted improvements e.g. annual Leave and sickness still high in some areas as reasons for cancellations.

4. Activities next 2 months

- Publish new ESHT 2020 Programme Plan on ESHT along with case studies of improvement
- Finalise scope of projects
- Initiate Ward Improvement Project
- Mortality Summit will inform finalised scope for M&M project to progress actions
- Prepare and run the Mock Inspection at the end of June; holding communications events ensuring our staff are informed and prepared; developing ambassadors of improvement; conducting internal audits to assess progress on improvements to inform further work in readiness for the inspection; progressing improvements that related to our Inadequate rating

5. Significant Risks:

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

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

6. Programme Recent Key Improvements

- Addressed privacy and dignity issues in Urology at Eastbourne DGH, with the move to a new ward area and creation of a Urology Assessment Unit. Pain practitioner employed to support acute pain service.
- 2 x band 1 Theatre Orderlies have been employed to maintain waste management throughout the theatre complex.
- Continued our nurse recruitment 28 nurses who have started work in the last two months. A further 75 nurses are due to join us by the end of June.
- Improved the availability of Health Records for outpatient appointments so clinicians have all the information they need prior to an appointment and the number of temporary records being created has reduced

- Press coverage has been mainly positive over the last 2 months

- Run the first of a series of surveys to understand staff issues and improve the working environment. The first survey on staff engagement received over 600 responses.
- Mandatory training rates have increased to 87.36%, an increase of almost 2.5% from October last year
- Comfort packs available for End of Life Carers
- Continued to increase the number of National Standards of Cleanliness (NSC) audits undertaken and the percentage of these audits that find the required standards have been met

- Robust governance arrangements now in place in Surgery CU. 61% increase in reporting of incidents over the last 6 months. Learning from incidents and complaints presented at key meetings to share learning and enable changes in practice

East Sussex Healthcare NHS Trust

Date of Meeting:	8 June 2016
Meeting:	Trust Board
Agenda item:	8
Subject:	Draft Quality Account 2015/16
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

The purpose of this report is for the Board to formally note the draft Quality Account 2015/6, previously circulated to Board members on 29th April, and delegate authority for the final document be signed off by Chair's action for submission by the 30th June deadline.

The final Quality Account will be received by the Board at the August AGM.

Introduction:

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

Our Quality Account for 2015/16 includes the identified and agreed priorities for quality improvement in 2016/17, whilst additionally reflecting on organisational achievement against last year's priorities.

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

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

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

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

The quality improvement priorities for 2016/17 have been divided into three main categories, allowing the Trust to clearly focus on identified specific areas of concern in the year ahead.
The three quality improvement categories are**:** Patient Safety**;** Clinical Effectiveness**;** Patient Experience

and improvement areas are:

Patient Safety

- Improve medicine management
- Reduce the transfer of patients for non-clinical reasons between wards

Clinical Effectiveness

- Improve the recognition and treatment of Sepsis

Patient Experience

- Improve the availability and timeliness of outpatient appointments
- Improve end of life care
- Understand the scale of the transport issues between sites experienced by our patients and staff

Benefits:

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

Risks and Implications:

Failure to submit a set of Quality Accounts by the 30th June 2016 to the Secretary of State would result in non-compliance with legislation.

Assurance Provided:

Assurance can be given to the Trust Board that the content of the draft Quality Account 2015/16 accurately reflects statutory requirements. The document is subject to review by auditors.

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

Quality and Standards Committee 2nd June 2016
Audit Committee 1st June 2016

Proposals and/or Recommendations

The Board is asked to note the draft 2015/16 Quality Account and compliance with statutory requirements and delegate authority for sign off by Chair's action.

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

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

The Quality Improvement Priorities have been reviewed to ensure that the Trust meets its obligations in respect of the public sector equality duty and no risks have been identified.

For further information or for any enquiries relating to this report please contact:	
Name: Emma Tate Head of Clinical Improvement	**Contact details:** emmatate@nhs.net

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board Meeting
Agenda item:	9
Subject:	Integrated Performance Reports – April 2016 (Month 1)
Reporting Officers:	Acting Finance Director Director of Human Resources Acting Chief Operating Officer

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

Purpose:

The attached document(s) provide information on the Trust's performance for the month of April 2016 (month 1).

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:

There were some key improvements this month:

- Cancer performance; performance continued to improve in the Two Week Wait standard and the 31 Day Standard.
- No Mixed Sex Accommodation breaches.

Performance deteriorated in:

- A Never Event was reported in Clinical Support and Theatres.
- RTT incompletes did not meet the 92% standard with a final figure of 90.5%.
- Diagnostic performance did not meet the < 1% target in March.
- A&E performance remains challenged and under the target.

In the first month of the new financial year the Trust made a deficit of £5.2m, which was £0.5m worse than plan. While income and pay costs were broadly in line with plan, non-pay budgets were overspent by £0.5m. The main factor was third party support to deliver endoscopy backlog and RTT compliance. These costs were not budgeted and, although both will have delivered additional activity, this was not sufficient to generate an overall compensating income variance.

The full year projection at this early point in the year is in line with the £48m planned deficit

Monthly sickness has continued to reduce, whilst both mandatory training and appraisal compliance have increased.

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

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

Assurance Provided:
This report includes all indicators contained within the NHS Improvement Accountability Framework along with additional key, quality and performance information. The information contained within this report has been extracted from the Trust Data Warehouse in line with guidance supplied by NHS Improvement.

Review by other Committees/Groups (please state name and date)**:**
Finance and Investment 25th May 2016 Executive Director Meeting 31st May 2016 Trust Board 8th June 2016

Proposals and/or Recommendations
To review the report in full and note Trust Performance.

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

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 Direct of Delivery & Performance	garryeast@nhs.net

East Sussex Healthcare NHS
NHS Trust

Month 01 - April 2016

Integrated Performance Report

East Sussex Healthcare NHS
NHS Trust

Contents

1.0 Performance – APRIL 2016

Key Issues

- Accident and Emergency
- RTT
- Diagnostics
- Never Events
- Trajectories

Key Risks

- Failure to deliver national and local targets and trajectories for improvement
- Financial position

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

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

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

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

1.1 Patient Safety – APRIL 2016

Indicator Description	Target	Jan-16	Feb-16	Mar-16	Current Month Apr-16	Current Month Apr-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Never events - incidence rate	0	0	0	0	1	0	1	1	0		
Serious Incidents rate (new Sis per 1000 beddays)	Monitoring	0.40	0.23	0.40	0.47	0.61	-23.7%	0.47			
Medication errors causing serious harm - incidence rate	0	0	0	0	0	0	0	0.00	0		
% of Patient safety incidentscausing severe harm/death	0.50%	0.0%	0.0%	0.0%	0.0%	0.7%	-100.0%	0.0%	0.7%	-100.0%	
Patient Safety Incident Rate (Incidents/1000 Beddays)	37	33	37	35	41	36	13.6%	41	36	14%	
Patient safety incidents resulting in death or severe harm	0	0	0	0	0	6	-100.0%	0	6	-100.0%	

Commentary

There was one Never Event recorded in April, within Theatres and Clinical Support. This related to medication being administered via an incorrect route. No harm was caused to the patient.

There continued to be no patient safety incidents causing severe harm, though the rate of all reported patient safety incidents did rise slightly higher than the national average (37). Whilst this does indicate a greater number of actual incidents it is also an indication of improved reporting practice.

1.2 Patient Safety – APRIL 2016

Indicator Description	Target	Jan-16	Feb-16	Mar-16	Current Month Apr-16	Current Month Apr-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Clostridium Difficile - Variance from plan	4	4	3	5	2	2	0	2	2	0	
MRSA bactaraemias rate	0	0	0	0	0	1	-1	0	1	-1	
VTE Risk Assessment	95%	96.5%	95.8%	94.8%	95.2%	96.6%	-1.4%	95.2%	96.6%	-1.4%	
Number of Grade 3 or 4 Pressure Ulcers	Reducing	6	4	4	4	0	4	4	0		
Number of Falls: no harm/near miss	105 p/m (1260 OT)	118	122	118	99	107	-7.5%	99	107	-7.5%	
Number of Falls: Minor/Moderate	48 p/m (581 OT)	65	56	51	56	85	-34%	56	85	-34%	
Number of Falls: Major/Catastrophic	0	0	0	0	0	1	-1	0	1	-100.0%	

Commentary

There were 2 reported cases of C-Difficile in April. This is within the Trust trajectory.

During March 2016 there was a reduction in the VTE assessment rate. This was as a result of the implementation of an improved data collection mechanism. Subsequently the rate has increased in April and is now above the 95% target.

There were 4 hospital acquired pressure ulcers of grade 3 or 4 in April. This is stable for the previous 3 months, following a step change in January 2015. In April 93.90% of eligible admissions received an accurate Waterlow score on admission or within 2 hours. The Waterlow score is a risk screening tool identifying patients at risk of developing pressure ulcers.

Reported falls causing no harm (or near misses) remain on a downward trend following a significant increase in 2015. As outlined in the previous section, whilst increased and decreases will be an indication of increasing prevalence, these trends will also support improving or declining reporting practice.

Falls causing moderate harm also saw an increase in 2015, though it was more gradual and now appears to be stabilising.

During April, 95.30% of eligible admissions were risk screened for falls within 6 hours of admission.

1.3 Patient Experience – APRIL 2016

Indicator Description	Target	Jan-16	Feb-16	Mar-16	Current Month Apr-16	Current Month Apr-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Inpatient Scores from Friends and Family Test % positive	96.00%	97.9%	98.0%	97.8%	98.9%	96.6%	2.3%	98.9%	96.6%	2.3%	
A&E Scores from Friends and Family Test % positive	88.00%	92.9%	91.0%	88.3%	93.5%	88.1%	6.1%	93.5%	88.1%	6.1%	
Maternity Scores from Friends and Family Test % positive	96.00%	95.9%	90.4%	95.2%	92.1%	94.8%	-2.8%	92.1%	94.8%	-2.8%	
Inpatients response rate from Friends and Family Test	45.00%	11.5%	13.1%	13.3%	14.0%	45.5%	-69.2%	14.0%	45.5%	-69.2%	
A&E response rate from Friends and Family Test	25.00%	8.2%	8.0%	6.5%	9.0%	15.0%	-40.2%	9.0%	15.0%	-40.2%	
Written Complaints - Rate	Monitoring	1.61	2.14	1.98	2.96	2.78	6.6%	2.96	2.65	11.8%	
Percentage of complaints respond to (within mandatory or agreed timescales)	95.00%	96.2%	93.1%	98.4%	100.0%	93.3%	7.1%	100.0%	93.3%	7.1%	
Mixed Sex Accommodation Breaches	0	27	29	0	0	0		0	0		

Commentary

The Trust reported no mixed sex accommodation breaches during April. This is the second consecutive month of no breaches, indicating the steps put in place earlier this year are showing some sustainability.

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

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

1.4 Clinical Effectiveness – APRIL 2016

Indicator Description	Target	Jan-16	Feb-16	Mar-16	Current Month Apr-16	Current Month Apr-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Crude Mortality Rate	1.36%	2.09%	1.85%	2.32%	2.03%	1.87%	8.4%	2.03%	1.87%	8.4%	
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	Monitoring	7.30%	7.41%	8.07%	7.54%	7.8%	-2.8%				

Commentary:

Crude mortality reduced in April. There were a total of 176 deaths recorded across the Trust in April.

The top 4 recorded causes of death in April (making up 25% of the total) are:
Bronchopneumonia (8.52% / 15)
Pnuemonia (5.68% / 10)
Aspiration pneumonia (5.68% / 9)
Community acquired pneumonia (5.11% / 8)

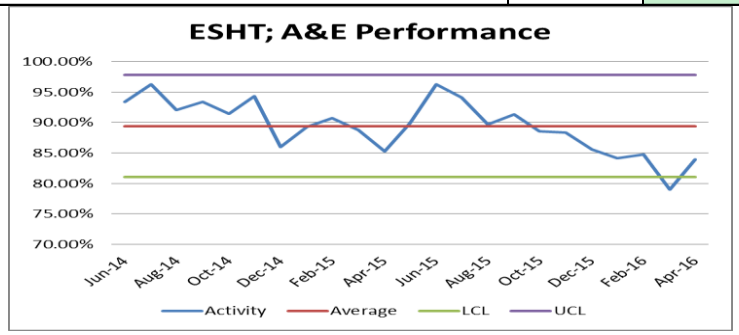
The remaining 132 deaths were spread across 84 different causes.

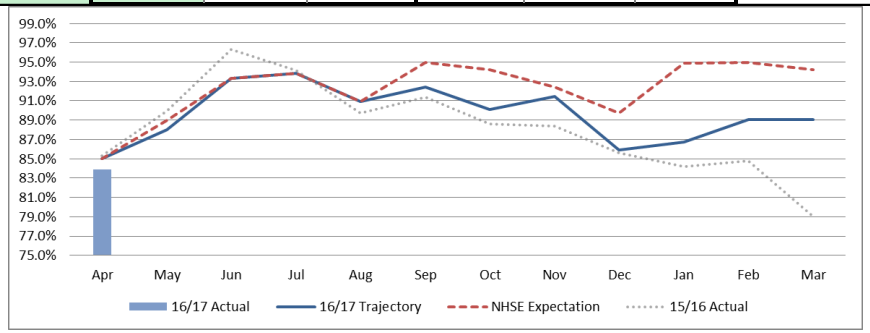
Deaths reviewed by consultant within 3 months:

2015 deaths	Oct-15	Nov-15	Dec-15	Jan-16
No of deaths	155	159	173	175
Reviewed within 3 months	79	86	93	116
% Reviewed within 3 months	**51%**	**54%**	**54%**	**66%**

1.5 Access and Responsiveness – APRIL 2016

Indicator Description	Target				Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	Apr-15	Var	Curr Yr	Last Yr	Var	
A&E Monthly Performance (4Hr Wait)-Type 1 Only	95%	84.2%	84.8%	79.0%	83.9%	85.3%	-1.3%	83.9%	85.29%	-1.6%	
Emergency A&E >12hr to Admission	0	0	0	0	0	1	-1	0	1	-1	





Commentary

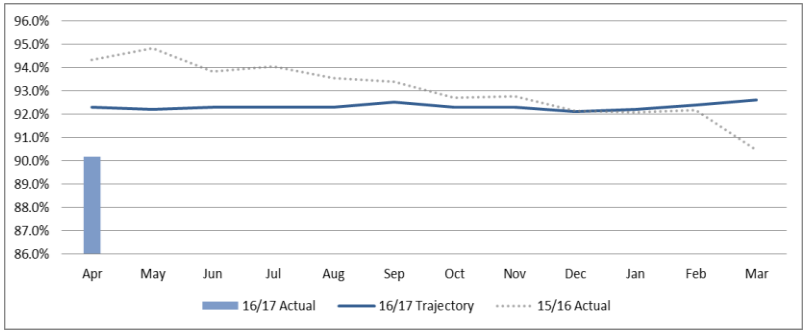
The declining trend seen since the beginning of last financial year showed some improvement in April, however the Trust was short of the trajectory target agreed with NHS Improvement.

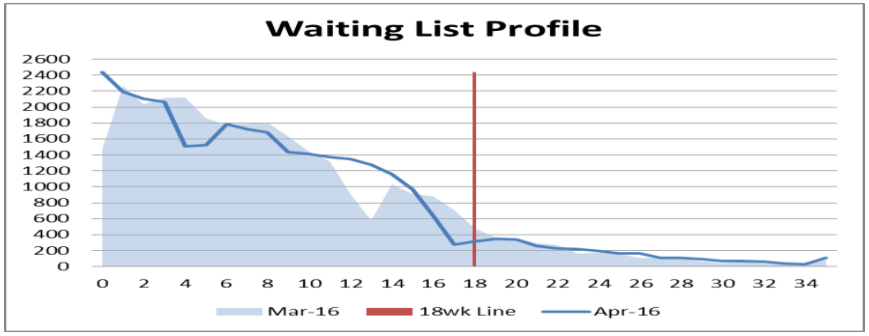
A number of actions have been undertaken to improve the position, including:

- A revised site meeting process focussing on earlier discharge procedures to improve patient flow out of the department.
- Enhanced recruitment for clinicians is underway to reduce medical vacancies
- The Academic Health Science Network have undertaken an initial analysis. Clinical triangulation for the Conquest site is complete with the EDGH site visit to be completed by the end of May
- There is a joint ESHT and CCG action plan to be developed from this work by the start of June

1.6 Access and Responsiveness – APRIL 2016

Indicator Description	Target				Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	Apr-15	Var	Curr Yr	Last Yr	Var	
Referral to Treatment Incomplete	92%	92.06%	92.16%	90.5%	90.2%	94.33%	-4.2%	90.2%	94.33%	-4.4%	
Referral to Treatment Incomplete 52+ Week Waiters	0	0	0	0	0	0		0	0		
Diagnostic waiting times	1.0%	3.81%	2.44%	6.67%	2.93%	1.90%	54.2%	2.93%	1.90%	54.2%	





Commentary

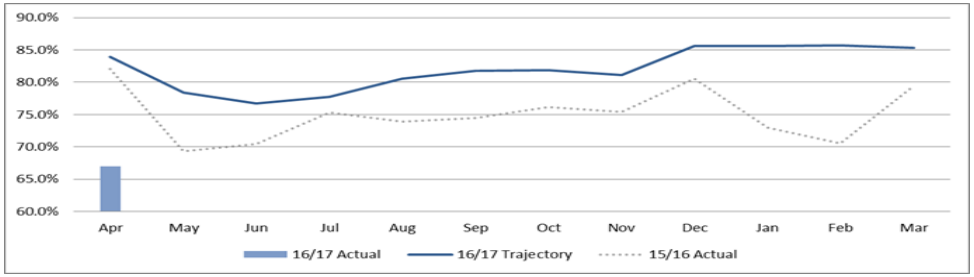
For the second consecutive month the RTT Incomplete standard has been severely impacted by both industrial action and patient flow. Since December, 218 elective inpatients and 1700 outpatients have been cancelled as a result of the industrial action. The following actions are in place to recover performance and bring back in line with the trajectory shown above.

- Any pathways greater than 18 weeks are fully validated.
- Any patient waiting over 40 weeks is reviewed by the Clinical Outcomes Review group.
- Enhanced PTLs are now in place to manage the recovery of the RTT position.
- The Elective Care Programme Board will begin in June to oversee the detailed planning and implementation of operational recovery and clinical strategy to ensure RTT sustainability
- The Trust is working with the STP to deliver regional recovery for elective care.
- An NHS Elect site visit has been arranged for early June in order to scope possible support of our RTT processes.

There remains an ongoing difficulty in achieving the diagnostic standard due to breaches in Endoscopy. April's radiology position has recovered by securing a longer term workforce along with the purchase of 8 new Ultra-sound machines which come online in May and June. The Trust has also secured increased Endoscopy capacity by continuing to use Medinet through April.

1.7 Access and Responsiveness – March 2016 * Cancer data is always reported 1 month in arrears

Indicator Description	Target	Dec-15	Jan-16	Feb-16	Current Month Mar-16	Current Month Mar-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Two Week Wait Standard	93.0%	91.9%	92.5%	94.9%	96.9%	92.40%	4.5%				
Breast Symptom Two Week Wait Standard	93.00%	90.0%	99.1%	93.0%	90.0%	91.03%	-1.0%				
31 Day Standard	96.0%	98.3%	96.9%	98.8%	99.3%	96.52%	2.8%				
31 Day Subsequent Drug Standard	98.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%				
31 Day Subsequent Surgery Standard	94.0%	100.0%	100.0%	100.0%	100.0%	100.00%	0.0%				
62 Day Standard	85.0%	80.6%	73.0%	70.5%	79.4%	75.17%	4.3%				
62 Day Screening Standard	90.0%	60.0%	33.3%	100.0%	42.9%	75.00%	-32.1%				
104 Day Waits	Monitoring	12.0	8.0	14.5	3.5	18.0	-14.5				



Commentary

Both February and March's Cancer 2 Week Wait performance shows achievement. The Trust did not achieve the 2 Week Wait Breast Symptomatic standard due to a high number of patients unable to attend around the Easter period.

The 62 day standard has continued to show improvement in March. The Trust has undertaken a 'Deep Dive' of 20 patients which identified areas of delay. The areas highlighted are now being worked through with the tumour sites. All 104 Day Waits are reviewed at MDTs and the Clinical Outcome Review meeting. There were 3.5 breaches in March.

Trust is continuing to work with NHS Improvement as part of its cancer recovery plan. This includes increased focus on achievement of the 62 day standard by December 2016.

1.8 Access and Responsiveness – APRIL 2016

Indicator Description	Target	Jan-16	Feb-16	Mar-16	Current Month Apr-16	Current Month Apr-15	Current Month Var	YTD Curr Yr	YTD Last Yr	YTD Var	Trend
Urgent Ops Cancelled for 2nd time (Number)	0	1	2	1	0	0	0.0%	0	0		
Proportion of patients not treated within 28 days of last minute cancellation	0.0%	0.0%	5.7%	6.6%				0	22		
Delayed Transfers of Care	3.5%	7.5%	10.8%	9.4%	5.3%	5.5%	-0.2%				

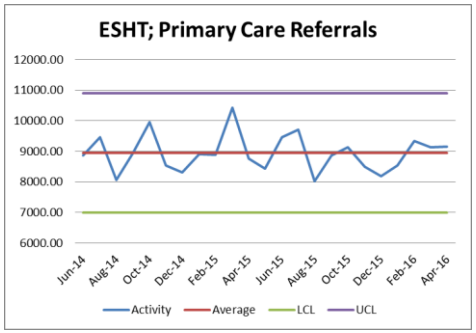
Commentary

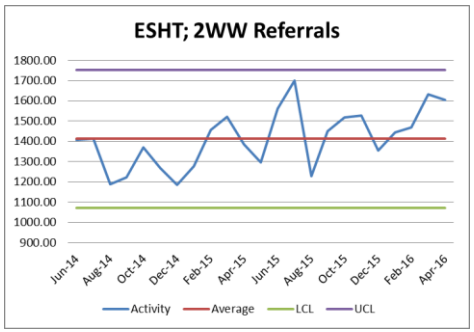
There were no 'Urgent Operations' cancelled for a second time in April.

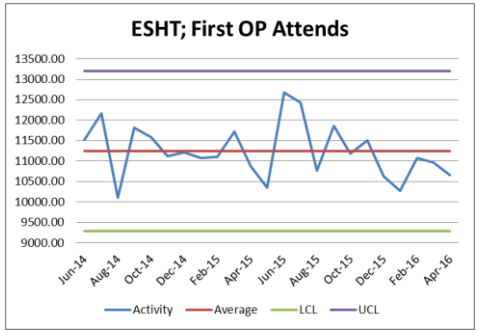
Recent collaborative work across the system appears to be improving the Trust's Delayed Transfer of Care position, with a drop below 6% for the first time.

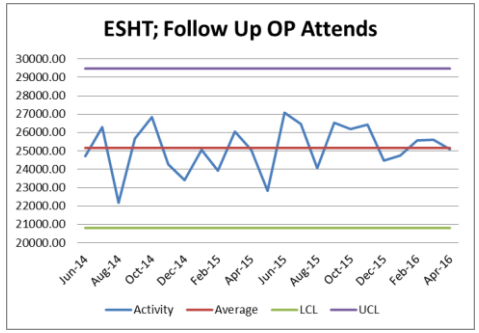
1.9 Activity/Effectiveness – APRIL 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	Apr-15	Var	Curr Yr	Last Yr	Var	
Primary Referrals	Previous Yr	8,545	9,352	9,136	9,157	8,767	4.4%	9,157	8,767	4.4%	
Cons to Cons Referrals	Previous Yr	1,273	1,273	1,280	1,384	1,661	-16.7%	1,384	1,661	-16.7%	
First OP Activity	Previous Yr	10,275	11,081	10,966	10,653	10,882	-2.1%	10,653	10,882	-2.1%	
Subsequent OP Activity	Previous Yr	24,736	25,575	25,609	25,104	25,054	0.2%	25,104	25,054	0.2%	









Commentary

Referrals are relatively stable overall though there are pathways and specialties sustaining significant increases. This is particularly notable in Cardiology, receiving 655 referrals in April, compared to 508 in May last year.It should be noted that ENT and Urology referrals have been increasing over the last few months.

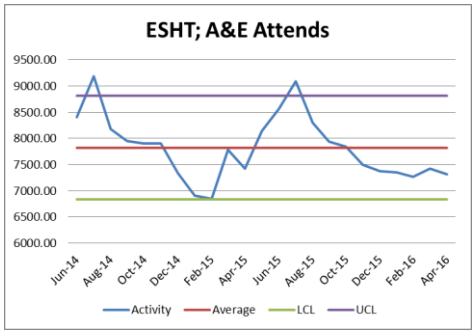
Overall 2 Week Wait referrals are increasing exponentially since August 2015. This demand can be seen predominantly in Women & Children (Gynaecology), where in referrals breached the upper control limit in April, indicating special cause. This is currently under investigation.

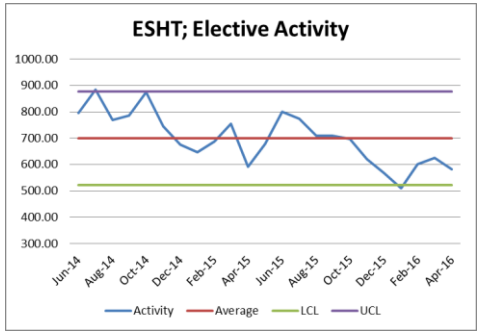
Whilst demand has been stable and in some cases increased (as indicated above), out patient activity is decreasing. This trend is prevalent across all clinical units except for Theatres & Clinical support where clinical oncology clinics have seen increased attendance. Follow up activity is rising causing a shift in new to follow up ratio. Cardiovascular and Medicine are driving this change, with specific increases within Cardiology, Endocrinology, Gastroenterology and Rheumatology clinics.

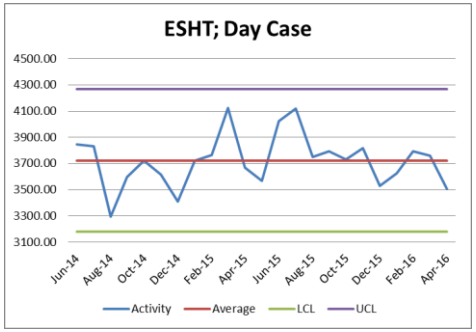
There are some notable variances in Women and Children however; whilst overall attendances for this CU are stable, there are significant increases in follow up attendances at Obstetrics and Paediatric clinics.

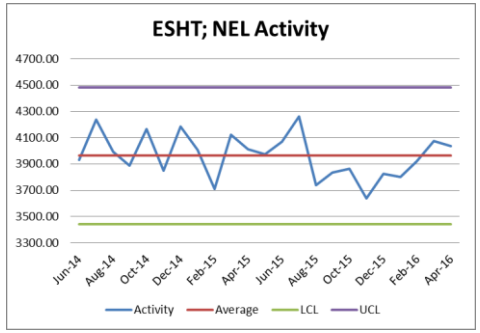
1.10 Activity/Effectiveness – APRIL 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	Apr-15	Var	Curr Yr	Last Yr	Var	
Elective IP Activity	Previous Yr	511	601	626	583	591	-1.4%	583	591	-1.4%	
Elective DC Activity	Previous Yr	3,628	3,795	3,761	3,504	3,667	-4.4%	3,504	3,667	-4.4%	
Non-Elective Activity	Previous Yr	3,800	3,921	4,073	4,037	4,011	0.6%	4,037	4,011	0.6%	
A&E Attendances	Previous Yr	8,731	8,571	9,398	8,715	8,709	0.1%	8,715	8,709	0.1%	
Average LOS Elective	3.0	2.7	3.0	3.0	2.7	3.1	-11.4%	3.2	3.1	4.5%	
Average LOS Non-Elective	4.6	5.7	6.0	6.0	6.1	5.7	6.9%	6.1	5.7	6.3%	









Commentary

Elective activity continues remains on an overall downward trend despite an increase over the last two months. This appears to be driven by Surgery, Medicine, Cardiovascular and Women & Children:

-T&O
-Breast Surgery
-Thoracic Medicine
-General Medicine (though this may be due to better recording of specialty)
-Cardiology

-Gynaecology
Junior doctors strikes earlier in the year caused a number of cancellations which dropped CUs close to or beyond lower control limits.

Day case activity has risen over the past two years and appears now to be leveling off following an upward trend to July last year. Part of this increase will be a shift from elective procedures.

Day case activity for Surgery has reduced significantly over the last 6 months due to a proportion of T&O procedures being undertaken by the MSK partnership.

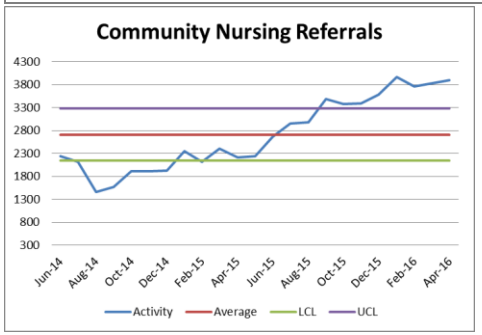
Cardiovascular and Medicine have increased activity which has counteracted this decrease in the overall numbers. These increases are predominantly seen in Clinical Oncology, Dermatology and Gastroenterology, and have contributed to performance against RTT, Cancer and diagnostic performance standards.

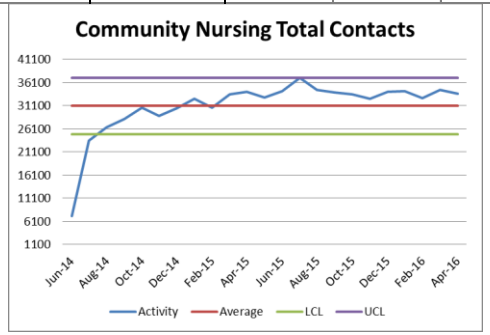
Overall non-elective activity has picked up over the past 5 months having been on the decline since June 2015.
Whilst non-elective activity in Surgery and Urgent care have continued to reduce, significant increases in Medicine (Gastroenterology, General Medicine) have meant an overall upward trend is developing.

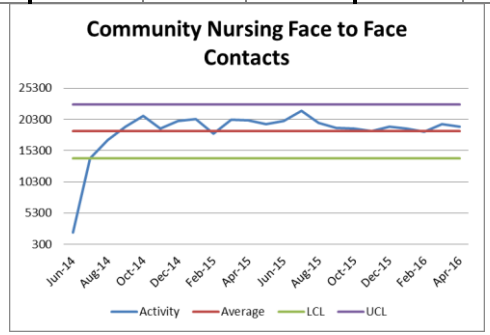
Further investigation will be required into the increase in General Medicine to ascertain if these are spells that do legitimately fall within General Medicine or if they have been assigned to a specific specialty (which would support improved reporting). The Trust continues to work to improve the recording of discharging specialties to reduce generalisation.

1.11 Community Services – APRIL 2016

Indicator Description	Target	Previous Months			Current Month			YTD			Trend
		Jan-16	Feb-16	Mar-16	Apr-16	Apr-15	Var	Curr Yr	Last Yr	Var	
Community Nursing Referrals	Monitoring	3,971	3,764	3,836	3,894	2,219	75.5%	3,894	2,219	75.5%	
Community Nursing Total Contacts	Monitoring	34,210	32,702	34,510	33,637	34,116	-1.4%	33,637	34,116	-1.4%	
Community Nursing Face to Face Contacts	Monitoring	18,849	18,385	19,529	19,114	20,159	-5.2%	19,114	20,159	-5.2%	
% Patient Facing Time	60.00%	55.1%	56.2%	56.6%	56.8%	59.09%	-3.8%	56.8%	59.09%	-3.8%	
Community Nursing ALOS	42.00	37.4	33.6	37.6	30.7	61.72	-50.3%	33.4	61.72	-46.0%	







Commentary

The above SPC charts run from the go live month of SystmOne and thus the first several months should be treated with caution as data input processes were developed and new services were brought online over time. It would be recommended to use August 2014 as the “effective” go live date.

Referrals have continued to increase into the service over time. Whilst this will in part be due to better recording and end-users getting to grips with the input process, there has undoubtedly been an increase in demand, as reported by many of the community nursing teams.

2.0 Financial Summary – April 2016

Key Issue	Summary	YTD
Overall RAG Rating	The Trust Development Authority (TDA) finance risk assessment criteria are shown in full on page 6. The Trust's overall RAG rating under the revised TDA criteria is red in month 1.	R
Financial Sustainability Risk Ratings	The Continuity of Services Risk Rating has been enhanced and is now referred to as the Financial Sustainability Risk Rating (FSRR). The FSRR builds on the previous ratings by retaining the Liquidity Ratio and Capital Servicing Capacity, but with additional risk ratings for I&E Margin and I&E Margin Variance from Plan (see page 13). The current rating for the Trust is red.	R
Financial Summary	The Trust performance in month 1 was a run rate deficit of £5.2m with an adverse variance against plan of £0.5m.	R
Activity & Income	Total income received during April was in line with planned levels	G
Expenditure	Operating Pay costs are marginally above plan in month. Agency expenditure was £1.9m. Operating Non Pay costs are £0.5m above plan in month and this equates to the adverse variance on total costs.	A
CIP plans	The CIP achievement in month was £0.2m which was below the plan of £0.3m.	A
Forecast Outturn	The forecast outturn position is anticipated to be in line with the £48.0m deficit plan.	G
Balance Sheet	DH loans have increased by £7.3m in month as a result of the draw down of the revolving working capital facility.	G
Cash Flow	The cash position of the Trust remains extremely challenging as a result of the revenue financial deficit. This continues to result in increasing creditor values and poor performance against the Better Payments Practice Code.	A
Capital Programme	The charge against the Capital Resource Limit (CRL) was £0.6m in the month.	G

2.1 Income & Expenditure – April 2016

Headlines

• Total income in the month was £29.2m in line with plan.

• Total costs in the month were £34.4m; this was £0.5m above plan.

• The £5.2m year to date deficit against plan was an adverse variance of £0.5m.

• Cost improvement plans of £10.8m have been developed for 2016/17 with a month 1 achievement of £0.2m against this target.

• Operating pay costs in the month, including ad hoc costs, were marginally above plan.

• Operating Non Pay costs, including third party costs, were £0.5m above plan in the month. The main reason was use of third parties to reduce the endoscopy and RTT backlogs.

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	23,477	23,525	48	23,477	23,525	48	284,487
Tariff-Excluded Drugs & Devices	2,608	2,656	48	2,608	2,656	48	31,300
Private Patient/ ICR	243	161	-82	243	161	-82	2,919
Trading Income	483	421	-62	483	421	-62	3,631
Other Non Clinical Income	2,373	2,428	55	2,373	2,428	55	29,148
Total Income	**29,184**	**29,191**	**7**	**29,184**	**29,191**	**7**	**351,485**
Pay Costs	-21,964	-21,957	7	-21,964	-21,957	7	-256,266
Ad hoc Costs	-34	-52	-18	-34	-52	-18	-450
Non Pay Costs	-7,655	-7,954	-299	-7,655	-7,954	-299	-92,991
Tariff-Excluded Drugs & Devices	-2,608	-2,656	-48	-2,608	-2,656	-48	-31,300
3rd Party Costs	-41	-272	-231	-41	-272	-231	0
Other	83	123	40	83	123	40	1,000
Total Operating Costs	**-32,219**	**-32,768**	**-549**	**-32,219**	**-32,768**	**-549**	**-380,007**
Surplus/- Deficit from Operations	**-3,035**	**-3,577**	**-542**	**-3,035**	**-3,577**	**-542**	**-28,522**
P/L on Asset Disposal	0	0	0	0	0	0	0
Depreciation	-1,043	-1,039	4	-1,043	-1,039	4	-12,519
Impairment	0	0	0	0	0	0	0
PDC Dividend	-406	-406	0	-406	-406	0	-4,869
Interest	-177	-175	2	-177	-175	2	-2,090
Total Non Operating Costs	**-1,626**	**-1,620**	**6**	**-1,626**	**-1,620**	**6**	**-19,478**
Total Costs	**-33,845**	**-34,388**	**-543**	**-33,845**	**-34,388**	**-543**	**-399,485**
Net Surplus/-Deficit	**-4,661**	**-5,197**	**-536**	**-4,661**	**-5,197**	**-536**	**-48,000**
Donated Asset/Impairment Adjustment	0	41	41	0	41	41	0
Adjusted Net Surplus/-Deficit	**-4,661**	**-5,156**	**-495**	**-4,661**	**-5,156**	**-495**	**-48,000**

2.2 Cash Flow – April 2016

Headlines

- The cash balance at the financial year end was £2.1m as required by the Department of Health.
- The Trust has in place a revolving working capital facility (RWCF) draw down of £31.4m against which £7.29m was drawn down in April.
- This new loan is repayable in April 2020.
- However, the cash flow assumes that the trust will be successful later in the financial year with an application for an increase in the RWCF to finance the full planned deficit of £48m.
- If this should not be the case, the level of trade & other payables would increase to a level that risks non-delivery of goods and services.

Cash Flow Statement April 2016 to March 2017

£000s	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2017	Feb	Mar
Cash Flow from Operations												
Operating Surplus/(Deficit)	-4,616	-4,081	-4,402	-3,350	-3,583	-2,878	-3,002	-3,403	-2,887	-3,861	-3,361	-1,617
Depreciation and Amortisation	1,039	1,043	1,043	1,043	1,043	1,043	1,043	1,043	1,043	1,044	1,044	1,048
Impairments	-3,577	-3,038	-3,359	-2,307	-2,540	-1,835	-1,959	-2,360	-1,844	-2,817	-2,317	-569
Interest Paid	-177	-406	-406	-406	-406	-406	-406	-406	-406	-406	-406	-632
Dividend (Paid)/Refunded						-2,434						-2,435
(Increase)/Decrease in Inventories	-90											90
(Increase)/Decrease in Trade and Other Receivables	-2,003	902	-140	127	360	-151	99	0	-974	500	500	1,378
Increase/(Decrease) in Trade and Other Payables	1,574	929	1,251	-1,500	205	500	0	16	-500	500	-54	-990
Provisions Utilised	11	-40	-40	-40	-40	-40	-40	-40	-40	-40	-40	-83
Net Cash Inflow/(Outflow) from Operating Activities	**-4,262**	**-1,653**	**-2,694**	**-4,126**	**-2,421**	**-4,366**	**-2,306**	**-2,790**	**-3,764**	**-2,263**	**-2,317**	**-3,241**
Cash Flows from Investing Activities:												
Interest Received	2	2	3	2	2	3	2	2	3	2	2	3
(Payments) for Property, Plant and Equipment	-978	-250	-500	-500	-1,000	-1,000	-2,000	-2,000	-2,000	-3,000	-2,000	-690
(Payments) for Intangible Assets	-35	-40	-40	-40	-40	-40	-40	-40	-40	-40	-40	-45
Net Cash Inflow/(Outflow) from Investing Activities	**-1,011**	**-288**	**-537**	**-538**	**-1,038**	**-1,037**	**-2,038**	**-2,038**	**-2,037**	**-3,038**	**-2,038**	**-732**
Net Cash Inflow/(Outflow) before Financing	**-5,273**	**-1,941**	**-3,231**	**-4,664**	**-3,459**	**-5,403**	**-4,344**	**-4,828**	**-5,801**	**-5,301**	**-4,355**	**-3,973**
New Capital PDC	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Revenue Support Loan	7,290	1,725	1,725	1,725	1,725	1,725	1,725	1,725	1,345	0	0	0
Revenue Support Loan	0	0	0	0	0	0	0	0	0	0	0	0
New interim revenue support facility	0	3,275	2,275	2,275	2,275	1,775	1,775	1,775	2,155	3,500	3,500	2,710
New Capital Loan	0	0	0	0	0	0	5,000	0	0	0	0	0
Loans and Finance Lease repaid	0	0	0	0	0	-126	0	0	0	0	0	-301
Net Cash Inflow/(Outflow) from Financing Activities	**7,290**	**5,000**	**4,000**	**4,000**	**4,000**	**3,374**	**8,500**	**3,500**	**3,500**	**3,500**	**3,500**	**2,409**
Net Increase/(Decrease) in Cash	**2,017**	**3,059**	**769**	**-664**	**541**	**-2,029**	**4,156**	**-1,328**	**-2,301**	**-1,801**	**-855**	**-1,564**
Opening balance	2,100	4,117	7,176	7,945	7,281	7,822	5,793	9,949	8,621	6,320	4,519	3,664
Closing balance	4,117	7,176	7,945	7,281	7,822	5,793	9,949	8,621	6,320	4,519	3,664	2,100

2.3 Balance Sheet – April 2016

Headlines

- The forecast increase in non current borrowings is in respect of the interim revolving working capital support facility (RWCF) required to finance the planned £48m revenue deficit.
- The reduction in the forecast retained earnings reserve is also a result of the planned deficit.

BALANCE SHEET £000s	Opening B/Sheet	YTD Actual	Plan March 2017
Non Current Assets			
Property plant and equipment	231,172	230,706	244,661
Intangilble Assets	1,650	1,685	2,130
Trade and other Receivables	1,193	1,193	1,193
	234,015	**233,584**	**247,984**
Current Assets			
Inventories	6,472	6,562	6,341
Trade receivables	8,397	8,397	5,773
Other receivables	8,146	10,149	5,601
Other current assets	0	0	0
Cash and cash equivalents	2,100	4,116	2,100
	25,115	**29,224**	**19,815**
Current Liabilities			
Trade payables	-13,571	-13,571	-12,639
Other payables	-25,618	-27,192	-23,861
DH Capital Investment Loan	-427	-427	-427
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-253	-265	-503
	-39,869	**-41,455**	**-37,430**
Non Current Liabilities			
DH Capital Investment Loan	-3,767	-3,767	-7,876
Borrow ings - Revenue Support Facility	-35,004	-42,294	-83,218
DH Working Capital Loan	0	0	0
Other Financial Liabilities	0	0	0
Provisions	-2,709	-2,708	-2,902
	-41,480	**-48,769**	**-93,996**
Total Assets Employed	**177,781**	**172,584**	**136,373**
Financed by:			
Public Dividend Capital (PDC)	153,562	153,562	153,562
Revaluation Reserve	98,247	98,247	104,746
Retained Earnings Reserve	-74,028	-79,225	-121,935
Total Taxpayers' Equity	**177,781**	**172,584**	**136,373**

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

Headlines

- The Better Payment Practice Code (BPPC) requires all NHS organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services.
- The target achievement of BPPC is 95%.
- By value, in month 73% of trade invoices has been achieved and 83% of NHS invoices.
- The Aged Debt (over 90 days) KPI is measured as a percentage of the total level of debt. The target is for this to be no more than 5%.
- The current Aged Debt KPI is 16% at 30th April 2016.

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	890	998	5,909	6,034
31 - 60 Days	256	470	1,839	1,413
61 -90 Days	218	157	280	(326)
91 - 120 Days	120	140	347	295
> 120 Days	817	744	1,180	981
Total	2,301	2,509	9,555	8,397

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	6,597	7,222	6,520	6,838
31 - 60 Days	4,235	2,433	6,889	3,221
61 -90 Days	992	709	1,644	460
91 - 120 Days	449	300	(49)	593
> 120 Days	1,042	959	2,498	2,459
Total	13,315	11,623	17,502	13,571

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	70.24%	72.52%	70.24%	72.52%
NHS invoices paid within contract or 30 days of receipt	24.13%	82.64%	24.13%	82.64%

2.5 Key Performance Indicators – April 2016

TDA Finance Risk Assessment Criteria

- The TDA has set out its reporting requirements in the latest accountability framework.
- The finance metrics have been revised by the TDA to ensure that they focus on in year delivery against plan and the individual indicators are set out in the adjacent table.
- Although the majority of risk criteria are green in the plan, the bottom-line I&E assessment (1a) has an overriding effect on the overall Trust rating. As the Trust has set a deficit plan this rating is red and under the revised TDA criteria, the overall Trust rating is red.

Monitor Financial Sustainability Risk Ratings

- The Trust has a liquidity ratio rating of 1, a capital servicing capacity ratio of 1, an I&E margin of 1 and a variance in I&E margin of 2. This results in an overall rating of 1.

Better Payments Practice Code (BPPC)

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

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

Monitor Financial Sustainability Risk Ratings	YTD Actual	YTD Plan
Liquidity Ratio Rating	1	2
Capital Servicing Capacity Rating	1	1
I&E margin rating	1	1
Variance in I&E margin rating	2	4
Overall Monitor Risk Rating	1	2

Local Measures	YTD Actual	YTD Plan
BPPC – Trade invoices by value (%)	73	95
BPPC – NHS Invoices by value (%)	83	95

2.6 Activity & Contract Income – April 2016

Headlines

- The Trust is on a PbR Contract with the 3 local CCGs for 2016/17. This is a change to the 'Cap & Collar' Risk share contract in 2015/16.
- The planned activity in the table on the right represents the TDA plan and not contracted activity.
- NHS Patient Income in month 1 was £96k above the TDA internal plan. Clinical Unit income was £97k below plan, Surgery £467k below plan (approx. £300k associated to Junior Doctors' strike & a reduction in expected T&O activity), Out of Hospital Care was £148k below plan (linked to ESBT). These adverse variances are partially offset by over performances in Urgent Care £279k above plan (Non-Elective activity in General Medicine) and Specialist Medicine £209k (Non-Elective activity in Gastroenterology).
- A provision for Fines & Penalties has been made of £234k. This relates to A&E breaches £116k (shown in Urgent Care position) and £118k shown centrally for C Diff, 18 weeks and Readmissions.

Activity	Current Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Day Cases	3,589	3,061	-528	3,589	3,061	-528
Elective Inpatients	655	601	-54	655	601	-54
Emergency Inpatients	3,547	3,485	-62	3,547	3,485	-62
Total Inpatients	**7,791**	**7,147**	**-644**	**7,791**	**7,147**	**-644**
Excess Bed Days	2,162	2,293	131	2,162	2,293	131
Total Excess Bed Days	**2,162**	**2,293**	**131**	**2,162**	**2,293**	**131**
Consultant First Attendances	7,901	7,475	-426	7,901	7,475	-426
Consultant Follow Ups	12,346	12,094	-252	12,346	12,094	-252
OP Procedures	4,504	4,493	-11	4,504	4,493	-11
Other Outpatients inc WA & Nurse Led	12,124	12,223	99	12,124	12,223	99
Community Specialist	172	196	24	172	196	24
Total Outpatients	**37,047**	**36,481**	**-566**	**37,047**	**36,481**	**-566**
Chemotherapy Unbundled HRGs	616	874	258	616	874	258
Antenatal Pathways	310	281	-29	310	281	-29
Post-natal Pathways	285	258	-27	285	258	-27
A&E Attendances (excluding type 2's)	9,170	8,903	-267	9,170	8,903	-267
ITU Bed Days	501	518	17	501	518	17
SCBU Bed Days	299	331	32	299	331	32
Cardiology - Direct Access	68	71	3	68	71	3
Radiology - Direct Access	5,103	5,780	677	5,103	5,780	677
Pathology - Direct Access	276,562	288,610	12,048	276,562	288,610	12,048
Therapies - Direct Access	2,541	2,590	49	2,541	2,590	49
Audiology	1,014	775	-239	1,014	775	-239
Midwifery	13	9	-4	13	9	-4

Income £000's	Current Month			YTD		
	Contract	Actual	Variance	Contract	Actual	Variance
Inpatients - Electives	4,093	3,900	-193	4,093	3,900	-193
Inpatients - Emergency	6,106	6,960	854	6,106	6,960	854
Excess Bed Days	477	498	21	477	498	21
Outpatients	3,994	3,966	-28	3,994	3,966	-28
Other Acute based Activity	2,738	2,697	-41	2,738	2,697	-41
Direct Access	772	821	49	772	821	49
Block Contract / Other	4,817	4,437	-380	4,817	4,437	-380
Re-admissions	0	-234	-234	0	-234	-234
CQUIN	480	480	0	480	480	0
Subtotal	23,477	23,525	48	23,477	23,525	48
Exclusions	2,608	2,656	48	2,608	2,656	48
GRAND TOTAL	**26,085**	**26,181**	**96**	**26,085**	**26,181**	**96**

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

Headlines

Pay

Total Pay reported a marginal overspend against plan in the month.

Total agency spend in April was £1.9m compared to £2.7m in March. This reflects recruitment to substantive posts and negotiation to April capped rates. Agency costs were less than 9% of total pay bill in the month compared to more than 12% in March. Continued use of escalation beds in April caused an overspend of £0.2m in the month.

Medical pay was overspent by £0.4m in month 1 due to continued agency spend covering vacancies in Urgent Care and Surgery. This was offset by vacancies and reduction in agency spend in other staff groups.

Non pay

Total non pay recorded a £0.5m overspend. Surgery and Specialist Medicine have outsourced activity to third party providers in April at a cost of £0.2m, Pathology non pay overspent by £0.1m and non pay CIP schemes did not deliver in full. Tariff Exclusions were £0.1m overspent offset by over delivery on income.

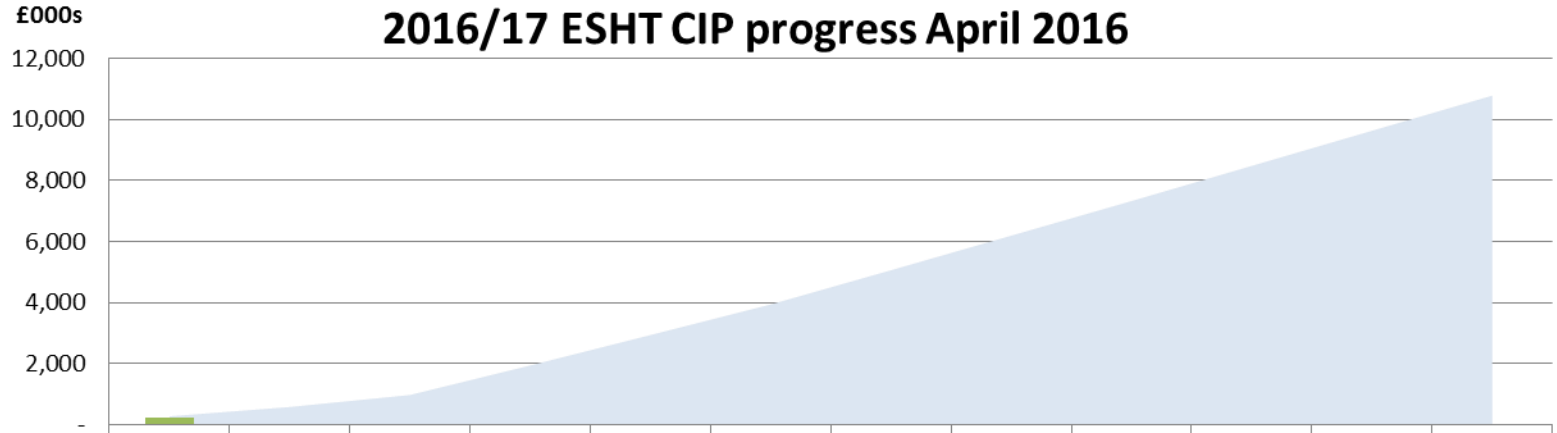
Income

Non contract Income reported £0.1m under delivered, mainly on Injury Cost Recovery and Private Patient income.

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	-2,451	-2,769	-318	-2,451	-2,769	-318
Specialist Medicine	-1,895	-1,992	-97	-1,895	-1,992	-97
Cardiovascular	-1,428	-1,491	-63	-1,428	-1,491	-63
Surgery	-3,295	-3,680	-385	-3,295	-3,680	-385
Women & Children	-2,510	-2,492	18	-2,510	-2,492	18
Out of Hospital Care	-2,335	-2,337	-2	-2,335	-2,337	-2
Clinical Support	-6,712	-7,052	-340	-6,712	-7,052	-340
Tariff-Excluded Drugs & Devices	-2,608	-2,656	-48	-2,608	-2,656	-48
COO Operations	-1,065	-1,107	-42	-1,065	-1,107	-42
Total Clinical Units	**-24,299**	**-25,576**	**-1,277**	**-24,299**	**-25,576**	**-1,277**
Estates & Facilities	-1,991	-2,041	-50	-1,991	-2,041	-50
Corporate Services	-2,449	-2,571	-122	-2,449	-2,571	-122
Central Items	-2,223	-1,313	910	-2,223	-1,313	910
Total Central Areas	**-6,663**	**-5,925**	**738**	**-6,663**	**-5,925**	**738**
Contract Income	26,085	26,181	96	26,085	26,181	96
Non-contract Income	216	123	-93	216	123	-93
Donated Asset/Impairment Adjustment	0	41	41	0	41	41
Adjusted Net Surplus/- Deficit	**-4,661**	**-5,156**	**-495**	**-4,661**	**-5,156**	**-495**

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
629	711	Urgent Care	-2,325	-2,616	-291	-2,325	-2,616	-291
478	451	Specialist Medicine	-1,743	-1,719	24	-1,743	-1,719	24
290	297	Cardiovascular	-1,148	-1,183	-35	-1,148	-1,183	-35
786	771	Surgery	-3,068	-3,262	-194	-3,068	-3,262	-194
601	560	Women & Children	-2,325	-2,295	30	-2,325	-2,295	30
773	725	Out of Hospital Care	-2,143	-2,186	-43	-2,143	-2,186	-43
1,105	1,101	Clinical Support	-4,330	-4,458	-128	-4,330	-4,458	-128
395	419	COO Operations	-979	-1,027	-48	-979	-1,027	-48
5,057	**5,036**	**Total Clinical Units**	**-18,061**	**-18,746**	**-685**	**-18,061**	**-18,746**	**-685**
706	731	Estates & Facilities	-1,451	-1,526	-75	-1,451	-1,526	-75
607	554	Corporate Services	-1,807	-1,771	36	-1,807	-1,771	36
1,312	**1,285**	**Total Non-Clinical Divisions**	**-3,258**	**-3,297**	**-39**	**-3,258**	**-3,297**	**-39**
0	**0**	Central Items	-679	34	713	-679	34	713
6,369	**6,321**	**Total Pay Analysis**	**-21,998**	**-22,009**	**-11**	**-21,998**	**-22,009**	**-11**

2.8 2015/16 ESHT CIP Performance to date – April 2016



	M1 Apr-16	M2 May-16	M3 Jun-16	M4 Jul-16	M5 Aug-16	M6 Sep-16	M7 Oct-16	M8 Nov-16	M9 Dec-16	M10 Jan-17	M11 Feb-17	M12 Mar-17
Plan	278	581	974	1,944	2,940	3,942	5,062	6,196	7,330	8,481	9,633	10,785
Actual	241											

Theme	In Month Plan £000	Actual £000	Var £000
Clinical services productivity	37	28	9
Corporate, admininstrative estates	79	29	50
Direct engagement	23	34	-11
IM&T schemes	-	-	-
Income generation	-	-	-
Lord Carter	13	69	-56
Medicines Management	120	71	49
Procurement	6	10	-4
Redesign	-	-	
Total	**278**	**241**	**37**

Clinical Unit	In Month Plan £000	Actual £000	Var £000
Cardiovascular	-	-	-
Estates & Facilities	62	40	23
Operational COO	-	-	-
Corporate	57	34	23
Specialist Medicine	-	-	-
Surgery	64	56	8
Urgent	7	7	-
Women's & Children's	46	36	10
Out of Hospital	-	-	-
Clinical Support	13	69	-55
Trustwide	29	-	29
Total	**278**	**241**	**37**

2.9 Year on Year Comparisons – April 2016

Headlines

- Total Inpatient activity to date is 5.9% lower than last year's level.
- Total outpatients are 0.1% lower than last year.
- Total A&E attendances are 1.6% higher than last year.
- Total income is £0.7m (2.4%) down on the same period last year.
- Total expenditure is £1.6m (4.8%) up on the same period last year.

Activity	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Day Cases	3,061	3,484	-423	-12.1%
Elective Inpatients	601	598	3	0.5%
Emergency Inpatients	3,485	3,514	-29	-0.8%
Total Inpatients	**7,147**	**7,596**	**-449**	**-5.9%**
Elective Excess Bed Days	140	60	80	133.3%
Non elective Excess Bed Days	2,153	1,476	677	45.9%
Total Excess Bed Days	**2,293**	**1,536**	**757**	**49.3%**
Consultant First Attendances	7,475	6,381	1,094	17.1%
Consultant Follow Ups	12,094	15,535	-3,441	-22.1%
OP Procedures	4,493	3,370	1,123	33.3%
Other Outpatients (WA & Nurse Led)	12,223	10,983	1,240	11.3%
Community Specialist	196	249	-53	-21.3%
Total Outpatients	**36,481**	**36,518**	**-37**	**-0.1%**
Chemotherapy Unbundled HRGs	874	257	617	240.1%
Antenatal Pathways	281	301	-20	-6.6%
Post-natal Pathways	258	289	-31	-10.7%
A&E Attendances (excluding type 2's)	8,903	8,766	137	1.6%
ITU Bed Days	518	463	55	11.9%
SCBU Bed Days	331	489	-158	-32.3%
Cardiology - Direct Access	71	55	16	29.1%
Radiology - Direct Access	5,780	4,810	970	20.2%
Pathology - Direct Access	288,610	263,252	25,358	9.6%
Therapies - Direct Access	2,590	2,636	-46	-1.7%
Audiology	775	922	-147	-15.9%
Midwifery	9	16	-7	-43.8%

Income £000s	2016/17 YTD Actual	2015/16 YTD Actual	Increase / Decrease Yr on Yr	% Increase / Decrease Yr on Yr
NHS Patient Income	26,181	26,912	-731	-2.7%
Private Patient/ RTA	161	302	-141	-46.7%
Trading Income	421	447	-26	-5.8%
Other Non Clinical Income	2,428	2,242	186	8.3%
Total Income	**29,191**	**29,903**	**-712**	**-2.4%**
Pay Costs	-22,009	-21,062	-947	-4.5%
Non Pay Costs	-10,882	-10,052	-830	-8.3%
Other	123	125	-2	
Total Direct Costs	-32,768	-30,989	-1,779	-5.7%
Surplus/-Deficit from Operations	**-3,577**	**-1,086**	**-2,491**	**-229.4%**
Profit/Loss on Asset Disposal	0	0	0	
Depreciation	-1,039	-1,089	50	4.6%
Impairment	0	0	0	
PDC Dividend	-406	-647	241	37.2%
Interest	-175	-78	-97	-124.4%
Total Indirect Costs	-1,620	-1,814	194	10.7%
Total Costs	**-34,388**	**-32,803**	**-1,585**	**-4.8%**
Net Surplus/-Deficit	**-5,197**	**-2,900**	**-2,297**	**-79.2%**
Donated Asset / Other Adjustment	41	37	4	-10.8%
Normalised Net Surplus/-Deficit	**-5,156**	**-2,863**	**-2,293**	**-80.1%**

2.10 Capital Programme – April 2016

Headlines

The Trust's capital programme is planned on the following basis:-

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

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

The limited level of capital funds available to the Trust in recent years has constrained spending on backlog maintenance, medical equipment and IT infrastructure. This has resulted in delays in the replacement of essential equipment and a consequent increase in maintenance expenditure.

Year To Date Performance:-
After one month, capital expenditure amounted to £571k, principally on brought forward commitments, minor capital schemes and electronic document management.

Capital Investment Programme £000s	2016/17 Capital Programme	Expenditure at Month 1
Capital Resources		
Depreciation	11,519	
Interest Bearing Capital Loan Application. (Not currently approved by the TDA.)	0	
League of Friends Support	1,000	
Cap Investment Loan Principal Repayment	-552	
Gross Capital Resource	11,967	
Less Donated Income	-1,000	
Capital Resource Limit (CRL)	**10,967**	-
Capital Investment		
Medical Equipment *	0	0
IT Systems	2,738	50
Electronic Document Management	1,112	112
Estates Strategy	2,750	0
Backlog Maintenance	2,000	0
Minor Capital Schemes	1,000	123
Pathology CLD	727	63
Vital Pac	338	2
Project Management	106	7
Brought Forward Commitments - Various	1,096	214
Sub Total	**11,867**	**571**
Donated Asset Purchases	1,000	23
Donated Asset Funding	-1,000	-23
Net Donated Assets	**0**	0
Sub Total Capital Schemes	**11,867**	**571**
Overplanning Margin (-) Underplanning (+)	-900	0
Net Capital Charge against the CRL	**10,967**	**571**

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

2.11 Financial Sustainability Risk Ratings – April 2016

Headlines

Financial Sustainability Risk Ratings (FSRR):-

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

- Monitor assigns ratings between 1 and 4 to each component of the FSRR with 1 being the worst rating and 4 the best. The overall rating is the average of the four.
  - The liquidity ratio of -17 days, a rating of 1.
  - The capital servicing capacity ratio of -6.19 results in a rating of 1.
  - The I&E margin of -17.8% results in a rating of 1.
  - The variance in I&E margin is -1.8%, a rating of 2.
  - As a result the overall Trust rating is 1.

Liquidity Ratio (days) £000s	2015/16 Outturn	2016/17 YTD
Opening Current Assets	25,115	29,224
Opening Current Liabilities	-39,869	-41,455
Net Current Assets/Liabilities	-14,754	-12,231
Inventories	-6,472	-6,562
Adj Net Current Assets/Liabilities	**-21,226**	**-18,793**
Divided by:		
Total costs in year	383,768	32,606
Multiply by (days)	360	30
Liquidity Ratio	**-20**	**-17**

Capital Servicing Capacity (times) £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual
Net Surplus / Deficit (-) After Tax	-47,759	-4,661	-5,197
Less:			
Donated Asset Income Adjustment	-947	-83	-36
Interest Expense	846	179	177
Profit/Loss on Sale of Assets	-29	0	0
Depreciation & Amortisation	12,664	1,043	1,039
Impairments	-411	0	0
PDC Dividend	6,940	406	406
Revenue Available for Debt Service	**-28,696**	**-3,116**	**-3,611**
Interest Expense	846	179	177
PDC Dividend	6,940	406	406
Temporary PDC repayment			
Working capital loan repayment	31,842		
Capital loan repayment	335		
	39,963	585	583
Capital Serving Capacity	**-0.72**	**-5.33**	**-6.19**

Financial Efficiency £000s	2015/16 Outturn Actual	2016/17 YTD Plan	2016/17 YTD Actual	2016/17 YTD Variance
Normalised Net surplus/ deficit	-47,759	-4,661	-5,197	
Less fixed asset impairments/disposals	-440	0	0	
	-48,199	-4,661	-5,197	
Divided by:				
Total Income (excl donated assets)	-355,205	-29,101	-29,155	
I&E Margin	**13.6%**	**-16.0%**	**-17.8%**	**-1.8%**

2.12 Financial Risks & Mitigating Actions – April 2016

Summary	
RISKS:-	
The following areas of risk have been identified in achieving the projected year end £48.0m deficit.	
1) Increased activity and capacity cost pressures, e.g. Junior Doctors' strike, RTT pressures, Escalation Wards, Radiology capacity and scoping.	
2) Unplanned operational cost pressures, e.g. recruitment delays and continued high use of agency staff.	
3) Shortfall on delivery of CIPs.	
4) Fines and penalties.	
5) Under delivery of activity and income plans.	
MITIGATING ACTIONS:-	
The following mitigations have been identified to offset the risks identified above.	
1) Continuation of 'grip and control'.	
2) Reduction in expenditure through discretionary spend controls and additional cost improvement schemes.	
3) Tighter controls on authorisation of agency expenditure, success in international recruitment and negotiation of agency rates within prescribed caps.	

3.0 Workforce Executive Summary – Key Points – APRIL 2016

Headlines
• Actual workforce usage of staff in April was 6320.64 full time equivalents (ftes), 48.29 below the revised budgeted establishment of 6368.93 ftes. • Temporary staff expenditure was £3,310K in April (15.04% of total pay expenditure). This comprises £1,316K bank expenditure, £1,906K agency expenditure and £88K overtime. This is a decrease of £820K overall compared to March. • There were 606.76 fte vacancies (a vacancy factor of 9.83%). This increase is due to an addition to the budgeted staffing establishment of 312 ftes • Annual turnover was 10.25% which represents 543.29 fte leavers in the last year. This is a decrease of 0.37% compared to last month. • Monthly sickness was 4.18%, a decrease of 0.61% from March. The annual sickness rate was 4.50%, a decrease of 0.03%. • Mandatory training rates have all increased, with the exception of Induction and Information Governance which were slightly lower. The overall mandatory training rate was 87.16% • Appraisal compliance increased by 1.21% to 88.47%

3.1 Trust Overview – APRIL 2016

TRUST	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Trend line
WORKFORCE CAPACITY													
Budgeted fte	6221.89	6197.01	6233.56	6239.90	6244.41	6240.44	6028.97	6059.16	6057.38	6057.36	6057.39	6368.93	
Total fte usage	6116.05	6181.61	6216.76	6243.02	6237.90	6281.08	6236.91	6226.53	6282.89	6334.88	6492.33	6320.64	
Variance	105.84	15.4	16.8	-3.12	6.51	-40.64	-207.94	-167.37	-225.51	-277.52	-434.94	48.29	
Permanent vacancies	536.35	520.61	556.18	542.99	542.14	514.02	479.35	479.90	464.71	422.43	342.18	606.76	
Fill rate	91.15%	91.43%	90.84%	91.07%	91.09%	91.55%	91.83%	91.87%	92.12%	92.84%	94.20%	90.17%	
Bank fte usage (as % total fte usage)	5.77%	6.07%	6.15%	6.42%	6.34%	6.34%	6.75%	6.68%	6.27%	6.65%	6.58%	6.97%	
Agency fte usage (as % total fte usage)	4.25%	4.53%	5.64%	5.33%	5.08%	5.30%	6.94%	6.45%	7.35%	7.06%	8.09%	5.29%	
WORKFORCE EFFICIENCY													
Annual sickness rate	4.99%	4.97%	4.94%	4.91%	4.86%	4.77%	4.72%	4.61%	4.54%	4.53%	4.53%	4.50%	
Monthly sickness rate (%)	4.24%	4.30%	4.21%	4.26%	4.36%	4.51%	4.60%	4.48%	4.45%	5.10%	4.79%	4.18%	
Turnover rate	12.30%	12.12%	12.26%	12.20%	11.77%	12.24%	12.07%	11.97%	11.79%	11.28%	10.62%	10.25%	
TRAINING & APPRAISALS													
Appraisal rate	74.88%	74.54%	75.03%	73.69%	77.60%	77.93%	81.83%	81.85%	83.34%	85.29%	87.26%	88.47%	
Fire	82.47%	82.82%	83.78%	83.03%	82.90%	82.77%	84.49%	83.49%	83.96%	85.07%	85.31%	86.25%	
Moving & Handling	82.97%	84.59%	85.44%	84.21%	85.24%	85.02%	85.81%	85.76%	86.93%	88.09%	88.25%	89.43%	
Induction	93.32%	93.64%	94.62%	90.95%	92.53%	91.89%	93.66%	90.95%	91.97%	92.79%	93.83%	93.67%	
Infec Control	86.27%	84.85%	85.78%	84.58%	85.82%	85.81%	86.83%	86.53%	86.99%	87.86%	87.37%	87.92%	
Info Gov	77.26%	81.89%	82.57%	82.38%	82.25%	83.41%	87.40%	86.42%	86.81%	86.23%	85.49%	84.78%	
Health & Safety	71.18%	73.36%	74.80%	75.47%	78.16%	80.03%	82.88%	83.67%	84.42%	85.35%	85.94%	86.74%	
MCA	92.48%	92.63%	93.02%	92.80%	93.18%	92.84%	93.39%	93.36%	93.10%	93.40%	93.10%	93.92%	
DoLs	89.64%	90.11%	90.88%	90.82%	91.44%	91.31%	91.81%	92.29%	92.78%	93.29%	93.81%	94.06%	
Safeguarding Vulnerable Adults	73.24%	74.38%	75.08%	74.62%	76.05%	76.05%	77.64%	78.06%	78.28%	79.06%	79.71%	81.54%	
Safeguarding Children Level 2	79.61%	79.87%	80.13%	79.19%	80.59%	80.40%	81.42%	80.75%	81.45%	82.46%	82.12%	83.25%	

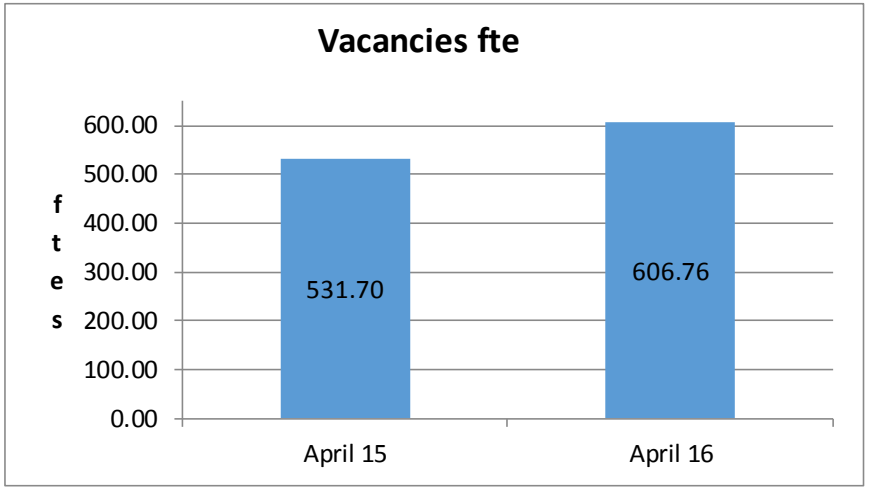
3.2 Trust Overview – Clinical Units – APRIL 2016

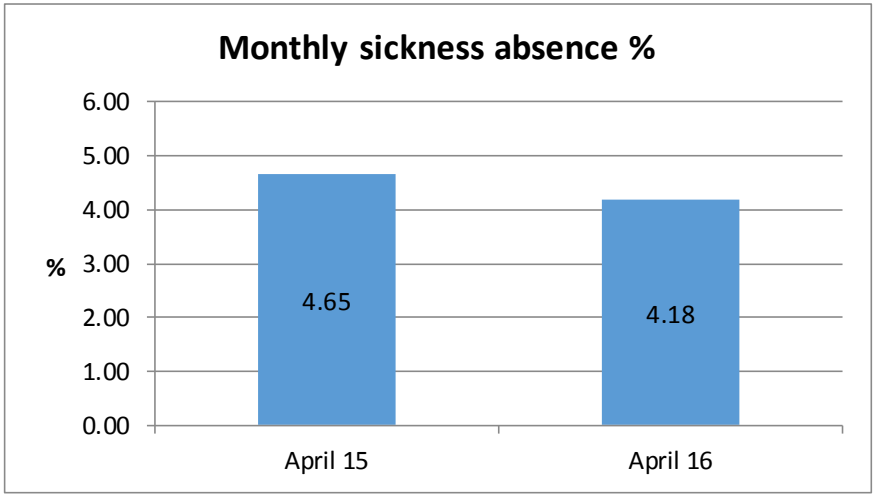
Apr-16	Budg estab fte	Actual worked fte	Vacancies fte	Vacancy trend since last month	Fill rate %	Monthly sickness %	Annual sickness %	Turnover	Temp staff expenditure	Appraised/ exempt in last yr	Appraisal trend since last month
Theatres & Clinical Support	1,104.82	1,101.27	62.93	↑	94.20%	4.63%	4.52%	8.25%	£631,032	90.73%	↑
Cardiovascular Medicine	290.16	297.45	30.58	↑	89.46%	4.55%	3.76%	7.23%	£192,843	91.32%	↓
Urgent Care	629.05	711.19	79.81	↑	87.31%	4.19%	5.08%	10.00%	£841,419	86.94%	↑
Specialist Medicine	477.59	451.10	62.90	↑	86.80%	4.62%	4.33%	9.70%	£245,297	91.05%	↑
Out of Hospital Care	772.67	724.53	76.17	↑	90.11%	5.45%	5.07%	14.67%	£207,905	86.88%	↓
Surgery	786.37	771.38	105.34	↑	86.44%	2.98%	3.53%	9.24%	£535,092	90.21%	↑
Womens & Childrens	601.32	560.08	47.94	↑	91.99%	4.01%	4.80%	11.56%	£167,672	78.54%	↓
COO Operations	394.71	418.94	13.39	↑	96.39%	2.87%	3.99%	10.13%	£129,501	86.50%	↓
Estates & Facilities	705.57	731.00	52.09	↓	91.95%	5.53%	5.95%	8.66%	£248,752	88.47%	↓
Corporate	498.78	489.62	75.61	↑	85.60%	2.38%	3.61%	11.07%	£110,516	93.65%	↑
TRUST	6368.93	6320.64	606.76	↑	90.17%	4.18%	4.50%	10.25%	£3,310,029	88.47%	↑

3.3 Trust Overview – Staff Groups – APRIL 2016

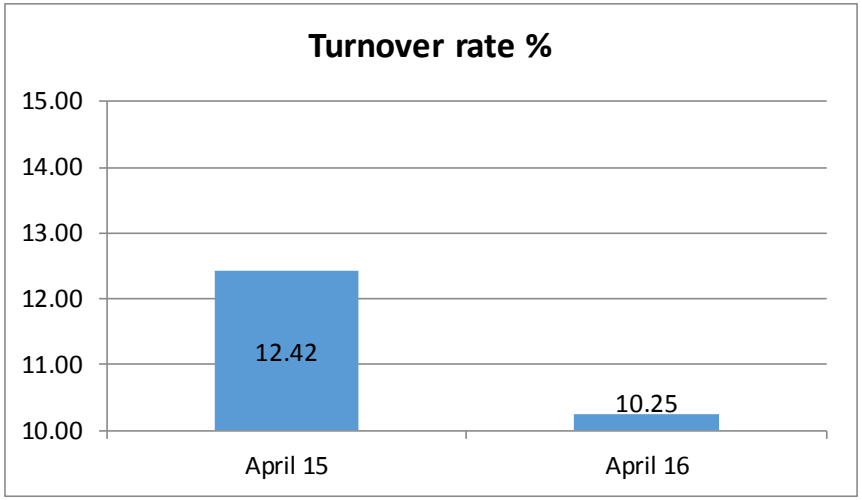
STAFF GROUPS	Budg estab fte	Actual worked fte	Vacancies fte	Fill rate %	Monthly pay budget (£000s)	Monthly pay expend. (£000s)	Monthly sickness %	Turnover %	Appraised/ exempt in last yr
MEDICAL & DENTAL	598.36	583.40	68.12	88.00%	£4,858,543	£5,209,469	1.69%	10.98%	92.64%
NURSING & MIDWIFERY REGISTERED	1993.41	1968.18	243.88	87.57%	£7,076,560	£7,202,443	4.82%	9.25%	85.33%
SCIENTIFIC, THERAP & TECH	938.55	877.46	81.35	91.33%	£2,976,496	£2,941,255	3.51%	12.35%	91.94%
ADDITIONAL CLINICAL SERVICES	831.57	932.88	23.98	97.03%	£1,820,101	£1,986,971	5.36%	11.86%	89.64%
ADMINISTRATIVE & CLERICAL	1262.62	1205.75	122.77	89.89%	£3,320,511	£3,164,239	3.29%	9.99%	88.61%
ESTATES & ANCILLARY	744.42	752.97	66.66	90.19%	£1,945,843	£1,505,022	5.27%	8.42%	88.75%
TRUST	6368.93	6320.64	606.76	90.17%	£21,998,054	£22,009,399	4.18%	10.25%	88.42%

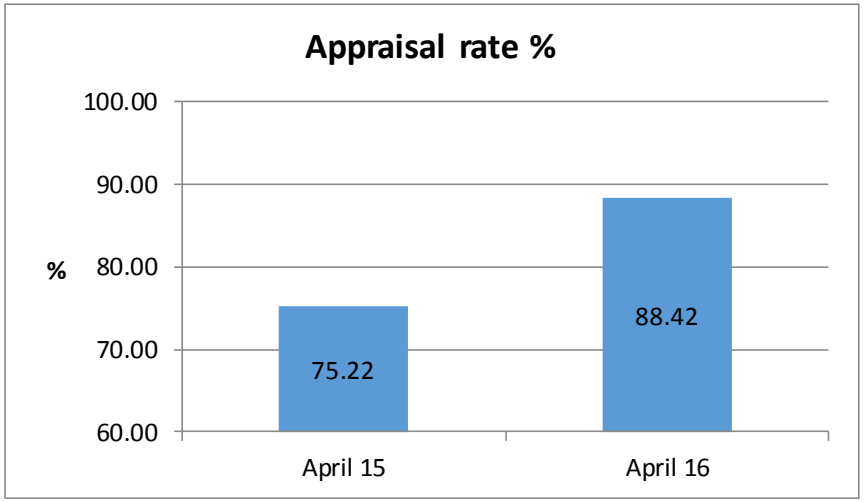
3.4 12 Month Comparisons – APRIL 2016



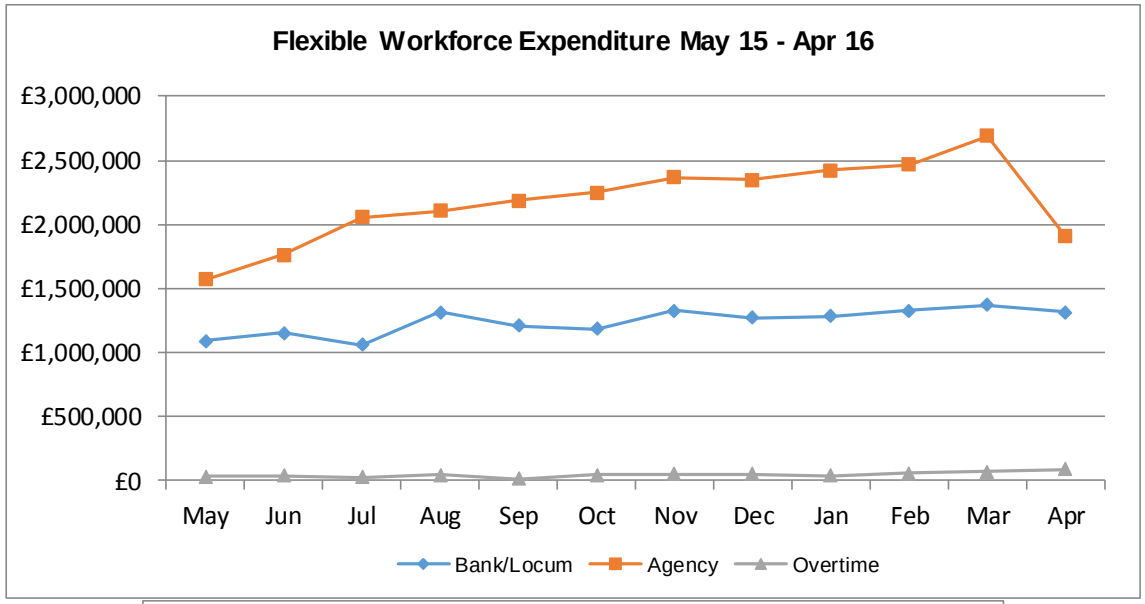


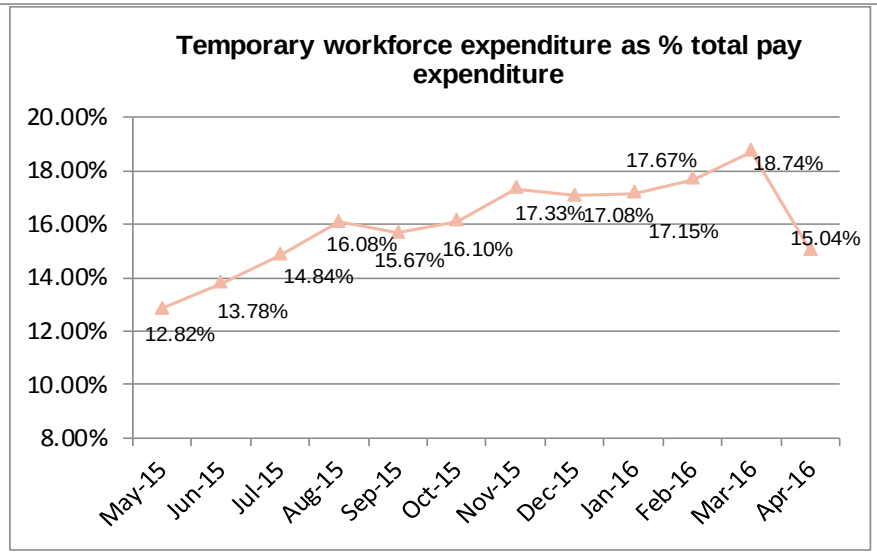
(April 16 vacancies increase due to rise in budgeted establishment for 2016/17 of 312 ftes)

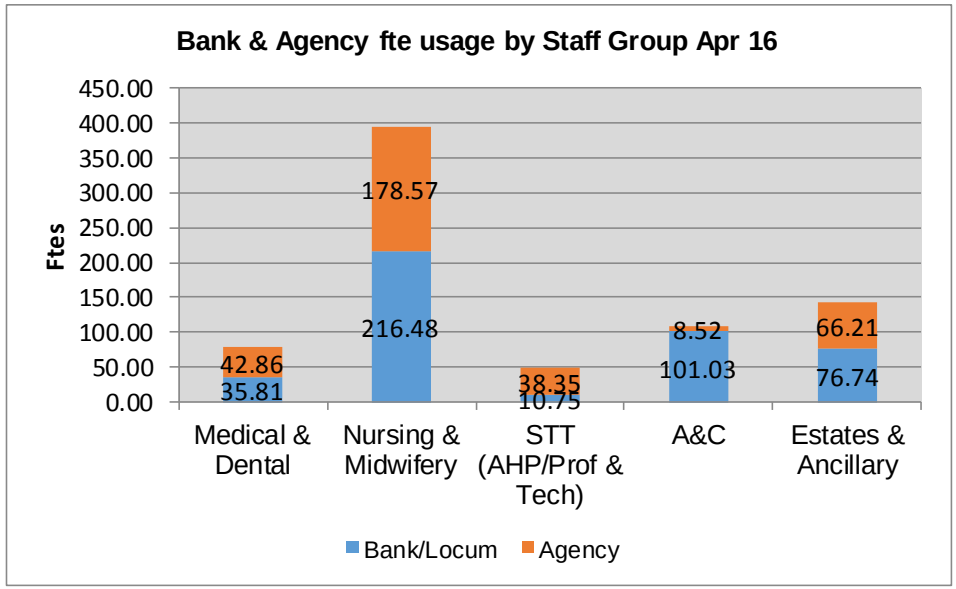


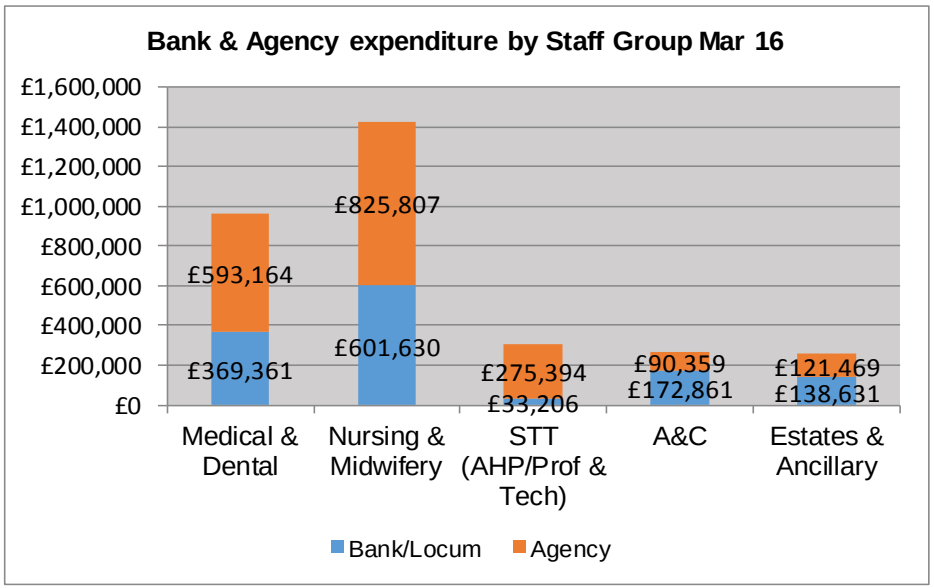


3.5 Workforce Usage – APRIL 2016





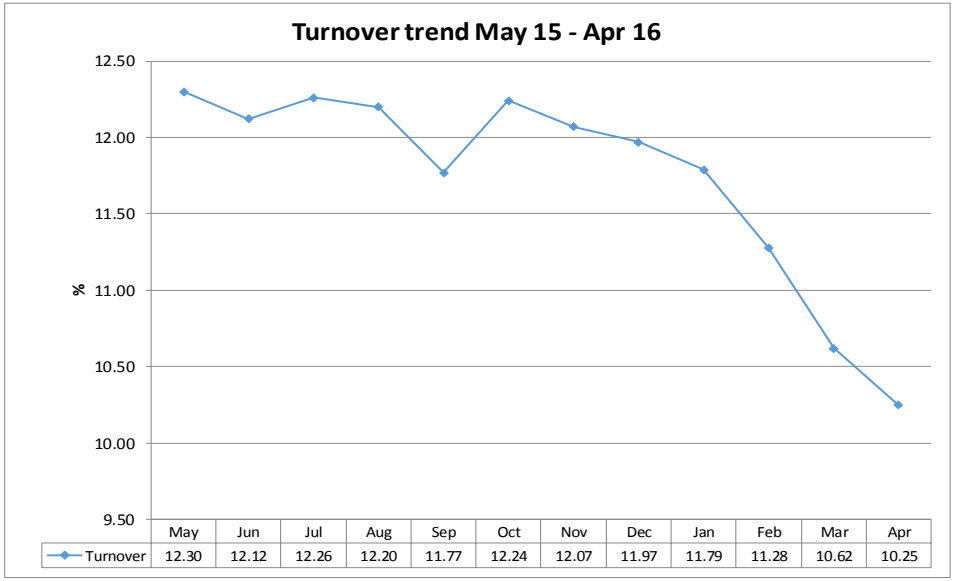


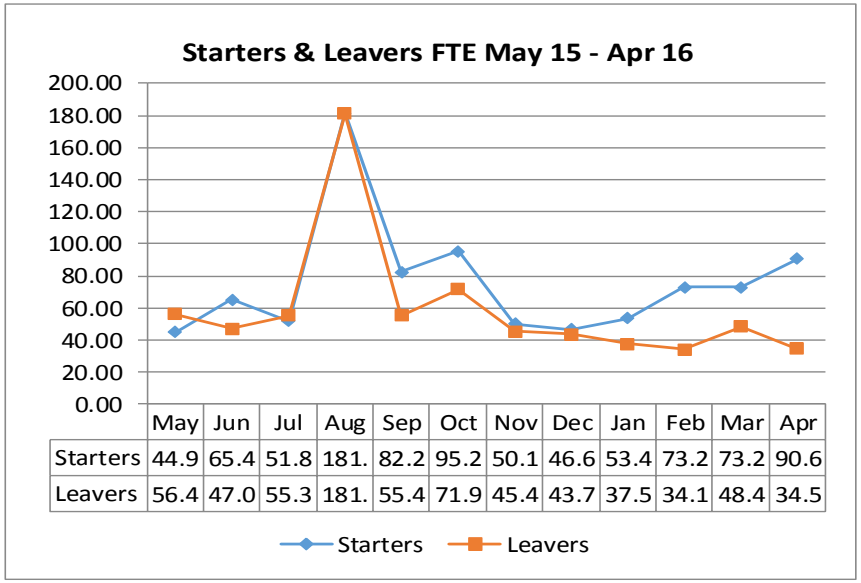


The budgeted establishment has increased by 312 ftes in April following budget setting for 2016/17. Reasons for this increase include over 100 additional ftes following review of ward establishments, comprising additional nursing staff from the safer nursing review and new clinical orderly posts, 37 ftes from East Sussex Better Together funding, staffing of additional low acuity beds on Folkington, additional radiographer posts to improve capacity, funding for Laundry agency staff, additional Emergency Nurse Practitioner posts, funding for the full complement of Stroke beds and a number of other approved business cases. The number of substantive staff has actually slightly increased since March but the increase in budgeted establishment does mean that the Trust vacancy factor has significantly increased, as mentioned below.

Agency usage has dropped significantly this month, by 190 ftes (£784K reduction). Partly this is due to the fact that there were accruals and late invoices last month but there is evidence of a shift from agency to bank usage. All the Clinical Units reduced their agency usage and expenditure this month and agency expenditure for nursing staff, scientific, technical & therapeutic staff and estates & ancillary staff has all fallen. Medical agency expenditure has increased this month, however, though this is partly due to accounting adjustments in March producing lower than normal expenditure on medical agency, but there is further work to be done to reduce this expenditure to enable the Trust to meet the annual control total for agency expenditure in 2016/17 of £15,743K.

3.6 Turnover & Vacancies – APRIL 2016





Starters & Leavers (not inc Employee Transfers)	May-15		Jun-15		Jul-15		Aug-15		Sep-15		Oct-15		Nov-15		Dec-15		Jan-16		Feb-16		Mar-16		Apr-15	
STAFF GROUP	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr	Start	Lvr
Add Prof Scientific and Technic	0.00	1.00	0.64	2.80	0.73	1.20	0.00	1.40	3.60	1.00	0.00	2.00	0.20	1.00	3.00	0.00	5.43	2.40	1.40	0.00	2.00	0.00	0.00	0.00
Additional Clinical Services	9.82	12.33	16.28	7.24	17.75	9.77	11.01	18.02	19.67	9.30	5.01	8.43	19.50	9.02	17.67	8.17	20.51	8.45	36.38	6.61	16.89	9.39	49.38	3.66
Administrative and Clerical	14.31	11.44	22.41	8.09	13.31	4.79	5.40	11.75	8.12	12.55	10.56	10.03	8.40	10.44	1.49	6.53	12.05	7.15	12.44	8.12	13.76	6.92	13.24	7.22
Allied Health Professionals	3.60	2.00	5.00	7.00	4.40	9.00	11.10	6.50	4.79	5.48	5.77	3.67	4.00	2.00	0.00	3.91	4.00	0.69	0.85	2.00	3.00	2.00	3.00	2.00
Estates and Ancillary	0.00	4.76	2.07	2.07	4.00	3.76	4.00	3.00	4.00	2.11	3.27	5.08	2.00	6.85	5.04	2.36	0.43	3.87	1.00	3.10	13.20	6.40	6.07	2.60
Scientists	3.00	1.00	4.00	0.00	2.00	4.00	2.00	3.00	4.00	1.00	0.00	0.00	0.85	4.00	2.00	1.00	2.00	1.00	0.00	0.00	1.00	1.40	2.00	0.00
Medical and Dental	5.60	9.00	4.00	5.60	3.50	5.49	139.93	116.33	19.90	14.55	37.20	27.10	6.30	1.60	10.80	7.80	2.00	1.60	6.80	6.70	11.00	10.55	5.60	13.30
Nursing and Midwifery Registered	8.59	14.88	11.03	14.27	6.16	16.36	8.17	19.26	13.72	9.43	33.48	15.60	8.93	10.51	6.61	13.02	7.00	12.40	14.35	7.63	12.38	11.73	11.28	5.75
Students	0.00	0.00	0.00	0.00	0.00	1.00	0.00	2.00	4.50	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	**44.92**	**56.41**	**65.43**	**47.06**	**51.85**	**55.37**	**181.61**	**181.26**	**82.29**	**55.42**	**95.29**	**71.91**	**50.19**	**45.42**	**46.61**	**43.79**	**53.42**	**37.56**	**73.22**	**34.16**	**73.23**	**48.39**	**90.57**	**34.54**

As a result of the increase in budgeted establishment for 2016/17 by 312 ftes, Trust fte vacancies have increased to 606.76 ftes at the end of April, a vacancy rate of 9.83%. The medical vacancy rate was 12.00% (68.12 fte vacancies), for registered nursing & midwives, it was 12.43% (243.88 ftes) whilst for unqualified nurses it was 2.97% (23.98 ftes).

The next cohort of 7 Philippine nurses arrives on 17th June to commence work in the Trust. There are a further 15 pending from the offers made in November 2015. A second trip to the Philippines took place in May 2016 with offers made to 27 nurses. Many UK Trusts are now recruiting from overseas and so the pool of suitable registered nurses is smaller than 12 months ago, however, the interviewers were very pleased with the calibre of nurses offered. There is an anticipated lead time of about 4 – 5 months, with expected start dates in October 2016 for this cohort. 22 EU nurses are scheduled to start in May, 16 in June and a further 16 with a provisional start date in July & August. Skype interviews have been set up for May and there are 17 nurses on the list for interviewing. There are also 42 UK nurses with offers or pending a start date. An assessment will be done on the timing of further EU recruitment as the wards are at a point currently where they need to integrate those EU/Overseas nurses already on the wards before they can support any further cohorts**.**

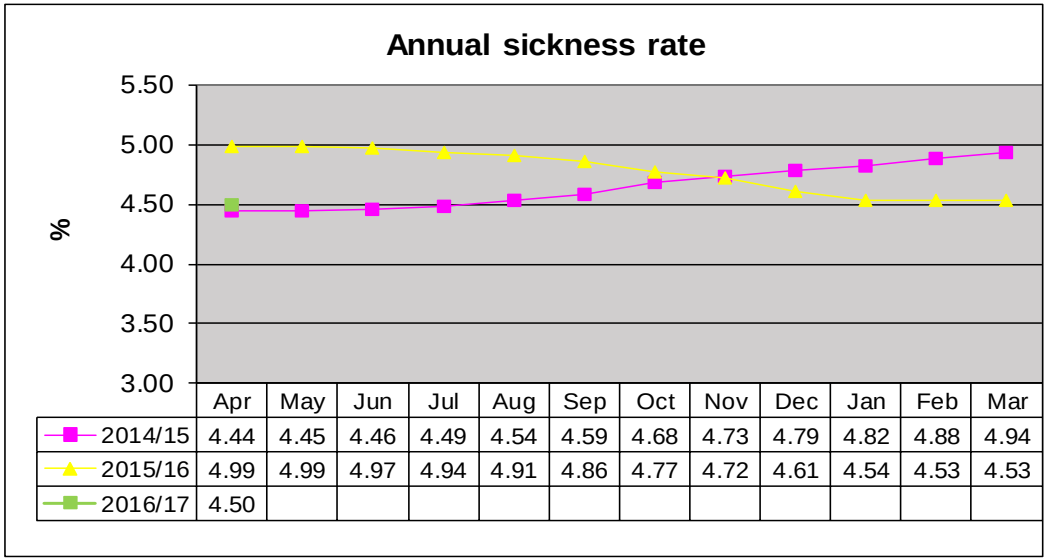
The next cohort of newly qualified nurses will join the Trust in October 2016 and recruitment for this group will begin in June. There are 40 nurses in the group.

Consultants in Radiology, Obstetrics & Gynaecology and Paediatrics will be joining the Trust in May, plus locum Consultants in ENT and Paediatrics. In addition, Specialty Doctors in Ophthalmology, Obstetrics & Gynaecology and Anaesthetics will start that month. There are interviews in place for Consultants in Ophthalmology, Neurology and Community Paediatrics and a Specialty Doctor in Paediatrics.

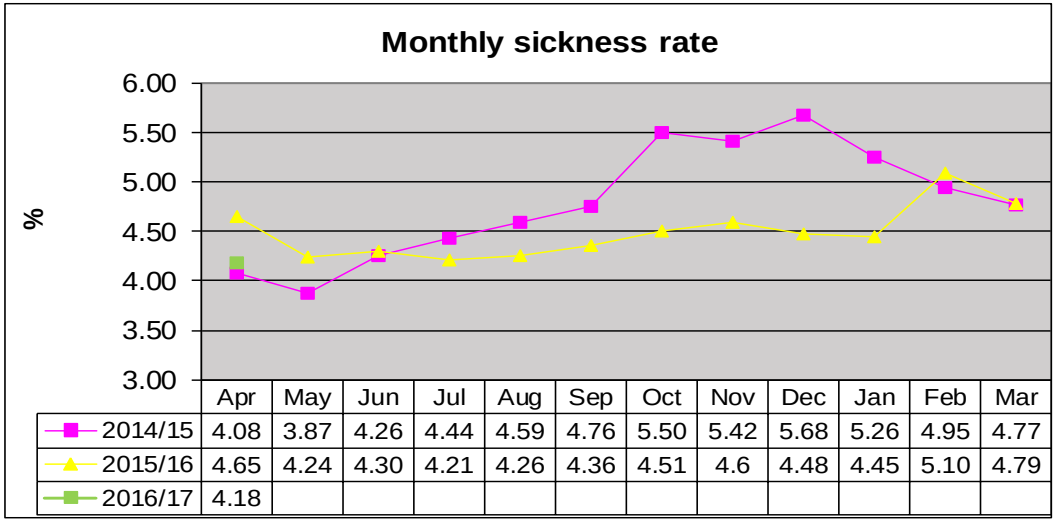
There are 48 unqualified nurses in the recruitment pipeline. Some generic recruitment is being undertaken, to ensure that vacancies are covered going forward and to plan for winter pressures.

A Recruitment strategy for the Trust is being developed and material is being collated to promote the overall Trust Recruitment campaign, including “unique selling points” and better use of social media. By 20th May the Trust will be using Facebook, Twitter and LinkedIn to promote vacancies and recruitment activity. The Recruitment manager will also be meeting with all General Managers, and henceforth on a regular basis, to discuss current and future vacancies as well as any “hidden vacancies” covered by agency. Individual campaigns, for areas, will then be produced including activity such as targeted email campaigns.

3.7 Sickness – APRIL 2016



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



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

Monthly sickness has reduced this month by 0.61% to 4.18%. The annual sickness rate is down by 0.03% to 4.50%.

Sickness amongst Additional Clinical Services staff (mostly unqualified nurses, therapy helpers) is down by 1.33% this month, for Estates & Ancillary staff it is down by 0.79% and for Registered Nurses and Midwives it is down by 0.52%

The latest available comparative figures from the Health & Social Care Information Centre show the monthly sickness rates for NHS Trusts, in January 16, at 4.63%, at a time when our rate was 4.45%. The rate for large Acute Trusts was also 4.66% and for Community Trusts it was 5.03%.

3.8 Training & Appraisals – APRIL 2016

Mandatory Training – Six Month Trend

Mandatory training course	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	6 month trend
Induction %	93.66	90.95	91.97	92.79	93.83	93.67	
Fire %	84.49	83.49	83.96	85.07	85.31	86.25	
Manual Handling %	85.81	85.76	86.93	88.09	88.25	89.43	
Infection Control %	86.83	86.53	86.99	87.86	87.37	87.92	
Info Gov %	87.40	86.42	86.81	86.23	85.49	84.78	
Health & Safety %	82.88	83.67	84.42	85.35	85.94	86.74	
Mental Capacity Act %	93.39	93.36	93.10	93.40	93.10	93.92	
Depriv of Liberties %	91.81	92.29	92.78	93.29	93.81	94.06	
Safeguard Vuln Adults	77.64	78.06	78.28	79.06	79.71	81.54	
Safeguard Child Level 2	81.42	80.75	81.45	82.46	82.12	83.25	

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Appraisal compliance
Theatres & Clinical Support	85.77%	88.48%	96.00%	87.17%	84.93%	88.86%	94.15%	92.41%	81.60%	83.96%	90.73%
Cardiovascular Medicine	84.42%	89.13%	90.00%	84.78%	83.70%	80.43%	93.00%	95.24%	79.01%	77.37%	91.32%
Urgent Care	78.00%	82.73%	90.52%	80.18%	72.18%	79.82%	87.45%	87.43%	72.11%	76.10%	86.94%
Specialist Medicine	89.37%	91.76%	95.59%	88.07%	82.21%	86.77%	93.77%	93.90%	84.79%	83.75%	91.05%
Out of Hospital Care	89.85%	93.02%	96.59%	92.77%	84.39%	86.80%	96.97%	98.68%	86.62%	84.00%	86.88%
Surgery	85.36%	87.47%	90.00%	85.36%	82.59%	90.24%	94.76%	93.81%	83.08%	80.39%	90.21%
Womens & Childrens	85.00%	88.06%	94.74%	86.94%	80.81%	83.71%	94.85%	93.22%	78.97%	92.03%	78.54%
COO Operations	85.20%	91.06%	93.55%	82.68%	95.25%	69.83%	n/a	n/a	n/a	n/a	86.50%
Estates & Facilities	85.15%	88.50%	94.59%	92.14%	91.12%	92.87%	100.00%	100.00%	100.00%	100.00%	88.47%
Corporate	93.65%	95.77%	96.88%	94.81%	93.65%	95.00%	96.00%	98.46%	90.67%	93.26%	93.65%
TRUST	**86.25%**	**89.43%**	**93.67%**	**87.92%**	**84.78%**	**86.74%**	**93.92%**	**94.06%**	**81.54%**	**83.25%**	**88.47%**

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

Compliance rates have generally improved but Information Governance training has dropped slightly from last month despite continued promotion of the workbooks. The workbooks (covering Information Governance, Safeguarding Adults and Safeguarding Children) are sent out every month together with the Training Matrix for the CU Leads to cascade to their teams so that they can tackle areas or individuals who are not compliant with the mandatory training requirements.

Learning & Development are planning to directly target wards/service areas with low compliance rates to offer further support where needed. They are also working closely with colleagues in HR to explore ways to further improve compliance with the Induction requirements.

The appraisal rate continues to improve, up by a further 1.21%.

3.9 Staff Engagement – APRIL 2016

The first Pulse survey on Staff Engagement was open for six weeks from Friday 18th March – Friday 29th April. The survey could be completed online and paper copies were sent to Estates & Facilities and Out of Hospital Care. A total of 612 responses were received.

The total Staff Engagement score was 3.46 out of 5. Scores are further broken down into categories of Advocacy (would staff speak well of the organisation), Involvement (how involved staff feel in the development of their service) and Motivation (how motivated staff are to do their job) based on answers to relevant questions. This categorisation is used by NHS Employers and in the Staff Survey. The overall indicator score for staff engagement in the 2015 staff survey was 3.56.

Clinical Unit/Department	Number of responses	Overall Staff Engagement score	Advocacy score	Involvement score	Motivation score
TRUST TOTAL	**612**	**3.46**	**3.39**	**3.36**	**3.64**
Out of Hospital Care	129	3.71	3.53	3.77	3.98
Corporate	114	3.66	3.51	3.65	3.81
Surgery	46	3.59	3.43	3.49	3.84
Specialist Medicine	35	3.41	3.34	3.16	3.72
Cardiovascular	9	3.36	3.34	3.18	3.56
Theatres & Clinical Support	78	3.34	3.39	3.23	3.39
Women & Children's	45	3.31	3.14	3.24	3.56
Estates & Facilities	35	3.27	3.28	3.06	3.47
Urgent Care	35	3.23	3.24	3.03	3.43
Clinical Administration	70	3.1	3.27	2.89	3.14

It is encouraging that those areas that those areas who have been actively trying to improve their staff engagement with staff are the top three highest scorers which suggests that dedicated support & effort and sharing best practice is helpful to the Clinical Units. These results will be shared with each Clinical unit and they will be encouraged to share them with their teams and develop joint actions which would improve the overall staff engagement within their Unit. Line managers will also be contacted to ensure they are clear about expectations of engaging with staff and ensuring that all new staff have appropriate local induction, one to ones and team meetings and undertake timely and worthwhile appraisals.

East Sussex Healthcare NHS Trust

Date of Meeting:	30th April 2016
Meeting:	Trust Board
Agenda item:	10
Subject:	Safe Nurse & Midwifery Staffing Levels, March – April 2016
Reporting Officer:	Alice Webster, Director of Nursing

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

Purpose:

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

Introduction:

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

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

- Appropriate Nurse staffing levels are critical to patient safety
- The Trust has systems in place to address and manage variations with support from senior nursing staff
- Quality metrics and contributory factors are fully explored within the N&M Quality Review Group

Benefits:

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

Risks and Implications

- It is acknowledged that these figures are an average across the month but the breakdown of this information is available at http://www.esht.nhs.uk/nursing/staffing-levels/
- The quality figures cannot be considered as a measure of performance without significant validation and correlation with other dashboards and measures.
- This report does not negate the challenges of recruiting and maintaining a workforce that is robust and sustainable, without resorting to agency support.

Assurance Provided:

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

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

TNMAG

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

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

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

East Sussex Healthcare NHS Trust

SAFE NURSE & MIDWIFERY STAFFING LEVELS

1. Introduction

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

The current mandated reporting requirements also include the following inpatient areas: Paediatrics, Midwifery and Community Hospitals. The guidance does not require escalation areas to be included however given the recent decision to retain an escalation area on each main site within ESHT they are included from February 2016.

2. Background

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

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

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

3. Current Report – March 2016 –April 2016

3.1 The dashboards in Appendix 1 have been prepared to reflect the above requirements for March 2016.

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

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

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

3.6 It is not possible to make a monthly comparison of the data due to changes in the report e.g. the community sites that transferred to Sussex Community Trust.

3.8 All these quality areas are monitored through respective steering groups, the safety thermometer and the trust nursing and midwifery reviews. The reviews utilises data from the nursing dashboard.

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

This overview provides assurance that the systems and processes in place allow the Trust to monitor the provision of safe care in our inpatient wards, responding to changes in activity and demand. It does not however negate the challenges of recruiting and maintaining a workforce that is robust and sustainable.

Alice Webster
Director of Nursing

Lucy Scragg
Assistant Director of Nursing (west)

Appendix 1

Mar-16	CCU	Average fill day rate - registered nurses/midwives (%)	Average fill day rate - care staff (%)	Average fill night rate - registered nurses/midwives (%)	Average fill night rate - care staff (%)	PU's	Falls	Medication Errors
Berwick Ward	Cardiovascular	98.18%	122.38%	95.70%	124.54%	1	3	1
CCU - Eastbourne DGH	Cardiovascular	92.61%	-	101.24%	80.65%	2		1
James/CCU Ward	Cardiovascular	97.04%	91.82%	92.53%	106.97%		5	
Michelham	Cardiovascular	112.30%	103.86%	99.65%	106.45%	1		3
Stroke Unit EDGH	Cardiovascular	96.80%	118.94%	95.40%	105.56%		7	2
	Cardiovascular Clinical Unit Total					4	15	7
Irvine Unit	Out of Hospital Care	101.90%	97.57%	92.90%	95.79%	3	8	1
Rye Intermediate Care Beds	Out of Hospital Care	115.39%	100.81%	83.91%	98.28%	1	2	
	Out of Hospital Total					4	10	1
Cuckmere Ward	Specialist Medicine (Loc)	108.35%	105.77%	98.39%	123.18%	1	8	
Folkington	Specialist Medicine (Loc)	105.28%	102.57%	95.89%	94.19%	1	5	
Jevington Ward	Specialist Medicine (Loc)	102.24%	106.50%	93.34%	112.44%	3	2	
Wellington Ward	Specialist Medicine (Loc)	95.63%	91.18%	81.38%	151.19%	1		1
Pevensey Unit	Specialist Medicine (Loc)	105.55%	100.00%	100.00%	103.23%	1	3	3
	Specialist Medicine Total					7	18	4
Benson Trauma Ward	Surgery	93.76%	119.85%	95.44%	125.11%	4	8	
Cookson Devas Elective Ward	Surgery	94.39%	99.38%	93.55%	100.00%	1	2	
De Cham	Surgery	93.53%	115.32%	97.76%	113.28%	1	4	
Egerton Trauma Ward	Surgery	86.12%	94.27%	100.00%	94.20%	4	6	2
Gardner	Surgery	102.62%	98.98%	91.54%	101.92%	1	5	2
Hailsham 3 Ward	Surgery	109.28%	105.98%	89.97%	96.97%	2	2	1
Hailsham 4 - Urology Ward	Surgery	103.08%	91.46%	99.72%	85.73%	3	4	1
Richard Ticehurst SAU	Surgery	97.18%	117.27%	89.63%	105.35%		2	1
Seaford 2 Escalation	Surgery					1		
Seaford 4 - Mixed Surgery ward	Surgery	94.10%	97.35%	101.56%	111.73%	1	6	1
	Surgery Total					18	39	8
Cookson Attenborough Surgical short Stay	Theatres and Clinical Support	99.02%	89.88%	92.43%	87.82%	1	2	3
ITU / HDU (Conq)	Theatres and Clinical Support	89.17%	93.41%	85.08%	93.83%	1		
ITU / HDU (EDGH)	Theatres and Clinical Support	102.00%	95.16%	88.61%	-	2		4
	Theatres and Clinical Support					4	2	7

Acute Admissions Unit (AAU) Conquest	Urgent Care	86.94%	94.57%	95.85%	100.00%	2	5	3
Baird MAU Ward	Urgent Care	96.60%	95.56%	95.79%	99.86%	2	9	
Newington Ward	Urgent Care	99.84%	93.08%	91.37%	100.68%	4	6	1
MacDonald Ward	Urgent Care	103.23%	91.60%	81.29%	112.02%	1	2	
Seaford 1 (Medical Assessment) Unit	Urgent Care	90.74%	98.12%	95.04%	98.37%	1	3	4
Tressell Ward	Urgent Care					1	6	1
	Urgent Care Total					11	31	9
Crowborough Birthing Unit	Women and Children	111.69%	100.00%	98.53%	95.91%			
Eastbourne Midwifery Unit (EMU)	Women and Children	105.33%	100.00%	90.32%	100.00%			
Frank Shaw	Women and Children	93.65%	96.15%	90.14%	89.78%			1
Kipling Ward	Women and Children	98.78%	98.50%	94.57%	110.76%			3
Mirrlees	Women and Children	105.53%	100.33%	91.73%	97.48%		1	
Special Care Baby Unit (SCBU) Conquest	Women and Children	81.21%	100.00%	89.06%	80.65%			
	Women and Children Total					0	1	4
	Grand Total					48	116	40

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	11
Subject:	Patient Experience Report
Reporting Officer:	Alice Webster

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

Purpose:

To provide a summary of Patient Experience feedback during April 2016.

Introduction:

Patient Experience provides useful feedback from patients and the public on their experience of the Trust and should be used effectively to drive improvements. The Patient Experience Steering Group delivers the forum to discuss findings and develop clear work plans. The Quality and Standards Committee receives a comprehensive report to provide assurance on behalf of the Board. This Board report provides a broad overview of the governance processes and findings from Complaints, Patient Advice and Liaison Service (PALs), Friends and Family Test (FFT) and NHS Choices

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

- Complaints backlog is gradually reducing and 100% of all new complaints have been acknowledged within 3 days during April.
- The number of complaints reported during April (67) has increased to the highest level in 7 months (Sept 2015)
- Further work required and in progress to ensure actions following complaints are tracked for progress
- PALS enquiries increased in April due to transport issues with new PTS provider
- FFT response rate continues to remain low but work underway to identify causes
- NHS Choices feedback during April was overall very positive

Benefits:

Responding effectively to patient feedback will support the delivery of improvements in service provision.

Risks and Implications

Failure to collect patient feedback data and analyse the information will prevent the trust from learning and responding to concerns.

Assurance Provided:

Systems in place to collect feedback with work underway to increase responses and conduct further in depth analysis and triangulate with other data such as incidents. Although areas for improvement there are positive comments on NHS Choices and PALS enquiries demonstrating evidence of good care and experience.

Review by other Committees/Groups (please state name and date)**:**
Quality and Standards will review Patient Experience information within the Quality Report Patient Experience Steering Group

Proposals and/or Recommendations
To note the report and actions underway to increase patient feedback and analysis.

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

For further information or for any enquiries relating to this report please contact:	
Name: Ashley Parrott	**Contact details:** 07972244079

East Sussex Healthcare NHS Trust

Patient Experience Report – April 2016

1. Introduction

1.1 Patient Experience provides useful feedback from patients and the public on their experience of the Trust and should be used effectively to drive improvements. The Patient Experience Steering Group delivers the forum to discuss findings and develop clear work plans. The Quality and Standards Committee receives a comprehensive report to provide assurance on behalf of the Board. This report provides a broad overview of the governance processes and findings from the following sources:

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

2. Complaints and Patient Advice and Liaison Service

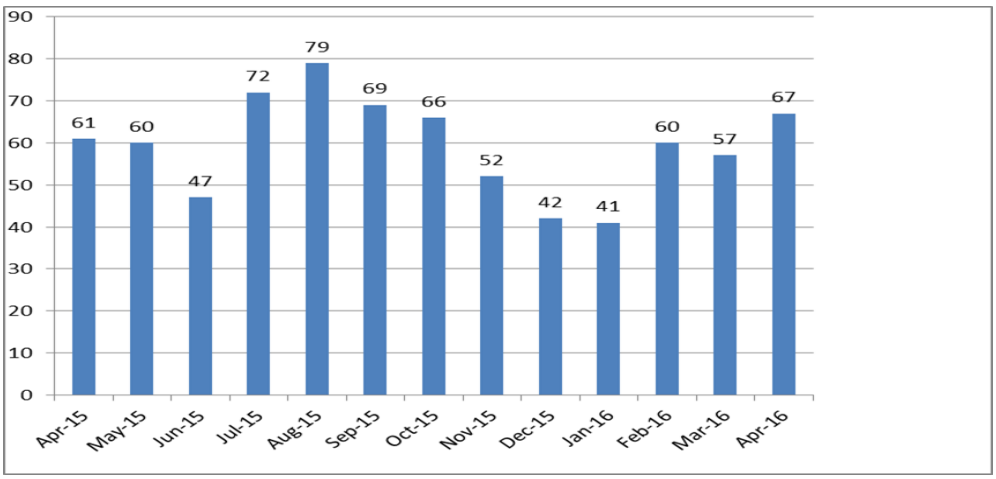
2.1 Complaints Process

The complaints backlog has started to reduce on a weekly basis with the number overdue now at 44 (69 in March 2016), and 139 open complaints compared to (153 in March 2015). 100% of all complaints reported in April were acknowledged within 3 working days. There were 5 re-opened cases by the Complaints Team during the month where the complainant did not feel all original concerns were answered. During April there were no cases referred to the Parliamentary and Health Service Ombudsman Enquiries (PHSO) and a total of 2 in 2016 have been referred to the PHSO with no final decision confirmed on outcome to date.

The Complaints team has increased their face to face support with the Clinical Units to manage the responses. The actions identified once the final report has been approved are now being recorded on the Datix system. The next step is to track these to ensure completed. Although the majority are the responsibility of the Clinical Units the Governance Team need to manage a central assurance process to document compliance.

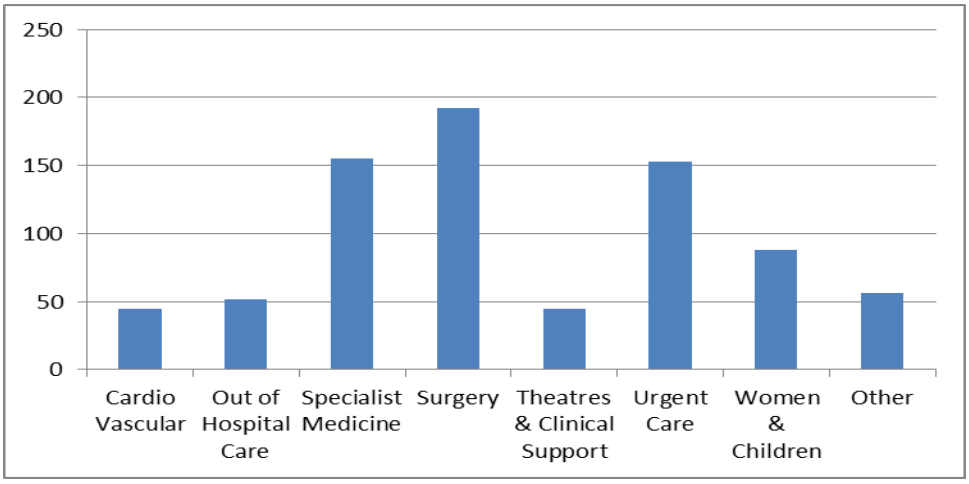
2.2 Complaints data

The following chart shows the number of complaints reported per month.



The highest complaints categories have consistently been patient pathway, standard of care and communication. We are undertaking a deep dive into these areas to determine if there is a specific theme, trend or location.

The highest number of complaints recorded occurs in Surgery and Urgent Care Clinical Units. The chart below is a 12 month total of all complaints by clinical Unit.



2.3 Patient Advice Liaison Service (PALS)

The number of PALS contacts made during April was 742, the highest since July 2015. This is mainly due to calls about transport arrangements following the change in Patient Transport Service from the 1st April to Coperforma.

General themes identified in April are patients unable to contact the appointment centre (line busy), cancelled appointments and transport related issues.

Further work is required and underway on the recording and subsequent reporting of PALS information to ensure the data is used to its full potential.

3. Friends and Family Test (FFT) Data

The current data for April is as follows:

Collection Unit	Mean Response Rate (from previous 12 months)	Response Rate (April 2016)	% Recommended (April)	Key Themes
Urgent Care (A&E)	9%	9%	91%	Waiting times and staff attitude.
Inpatient care	19%	14%	98%	Noise at night, staff shortages, waiting time for discharge and communication.
Maternity	29%	29%	90%	More staff required, Improve communication on care plan
Outpatient care	2%	1%	95%	Informing patients about delays.

The FFT response rate continues to remain low with a downward trend from the previous 12 months to April with the exception of maternity where it has been fairly consistent. This was discussed at the Patient Experience Steering Group. The plan for April and May is to conduct a deep dive into each area (Urgent Care, Out-patients, Inpatient services and Maternity) to understand from staff their collection issues, ask patients how they would prefer to give feedback (format such as paper, electronic) and seek new ideas on how the responses could be increased. The Meridian system can record the information collected because the FFT questions are embedded within the satisfaction surveys. Once these findings are confirmed the group will establish a clear plan to improve response rates.

4. NHS Choices

The following table and information is based on the “NHS Choices” feedback provided from patients using the trust services. The overall response rate is for all responses to date (Conquest/EDGH).

	Overall rating (172/176)	Cleanliness (172/173)	Staff co-operation (174/171)	Dignity and respect (173/174)	Involvement in decisions (169/170)	Same-sex accommodation (146/130)
Conquest						
EDGH						

The actual feedback submitted by patients in April is as follows:

Conquest Hospital - Four comments posted. Three of which gave 5 stars stating excellent care provided and one 3 star rating stating good care on the ward but concerns about a specialist service unavailable at the weekend. The PALs team have requested the patient to contact them to follow up on concerns.

Eastbourne District General Hospital (EDGH) -
Five comments posted. Three gave a 5 star rating, one did not provide a rating but gave extremely positive comments and one gave a rating of 1 star raising a concern over care in the Obstetrics specialty. This patient was asked to contact the trust to discuss concerns in care.

5. **Recommendation**

This report demonstrates slight improvements in the complaints process and in most cases positive experiences reported through the NHS Choices website. There is however work required (in progress) to undertake greater analysis of the PALs and complaints information and triangulate with incidents. The Patient Experience Steering Group has revised its terms of reference to strengthen membership and leadership (including more patient representatives). The priorities for the group confirmed at the last meeting in April are;

- Increase/improve the volunteer presence at each hospital site main entrance;
- Increase FFT response rates;
- Establish a complaints feedback process (satisfaction on the complaint process);
- Undertake in depth analysis of inpatient survey, complaints, PALS and FFT to identify 3 main work streams;
- Review patient information for admission (admission booklet/pack) and discharge information to determine quality and standardisation across the Trust.

Although work is required on increasing and communicating patient feedback the majority of feedback that is provided appears to be positive when reviewing FFT, PALs responses and NHS Choices.

Ashley Parrott
Associate Director of Governance

June 16

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	12
Subject:	End of Life Care Strategy 2016/2019
Reporting Officer:	Dr David Hughes

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

Purpose:

The purpose of this paper is to present the first draft of an ESHT End of Life Care Strategy 2016/2019

Introduction:

ESHT have made many improvements since the CQC report rated end of life care across ESHT as "requiring improvement". In the absence of a specific regional and multi-agency wide strategy ESHT now require a local strategy to take forward improvements through to 2019. This paper introduces that strategy which uses the national document; *Ambitions for Palliative and End of Life Care*, as a framework for identifying areas still requiring improvement.

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

The End of Life Care Strategy contains the results of a joint needs analysis and uses them along with the recommendations by the CQC and the National Audit of Palliative and End of Life Care to formulate a strategy using the Ambitions for Palliative and End of Life Care as a framework.

Benefits:

The benefits of excellent end of life care are vast but some examples include:

- Recognition that people are at the end of life stage (death may occur within 12 months) and also the recognition that people have entered the last days/hours of life.
- People dying in their preferred place of death which is normally their usual place of residence.
- Emotional well-being for family members and carers through holistic assessment of their needs, adequate support and effective communication.
- Symptom management, comfort and well-being for the patient.
- Assessment and care planning co-ordinated by a senior clinician.
- Excellence in care after death.
- Reduction in unnecessary admission to acute hospitals.

Risks and Implications
There is a risk that there will not be the financial resource to implement the changes required to fulfil the strategy e.g. extra staffing will be required to extend Specialist Palliative Care to provide a seven day a week service. There is a risk that this local ESHT End of Life Care Strategy has not been formulated with the involvement of all stakeholders due to the need for improvement in a timely manner. The strategy will therefore remain as a draft until the Board are assured that all relevant agencies have been consulted with.

Assurance Provided:
This strategy will be closely monitored in terms of performance and delivery to ensure that improvements are implemented at pace.

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

Proposals and/or Recommendations
That this strategy will be accepted as a draft until all agencies have been consulted with but that assurance is taken that implementation in its current format will continue.

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, all members of the community should have equal access to End of Life Care Services.

For further information or for any enquiries relating to this report please contact:	
Name: Angela Colosi Assistant Director of Nursing	**Contact details:** angela.colosi@nhs.net

East Sussex Healthcare NHS Trust

DRAFT END OF LIFE CARE STRATEGY 2016 - 2019

1. Introduction

1.1 Death and dying are inevitable. Palliative and end of life care must be a priority. The quality and accessibility of this care will affect all of us and it must be consistently improved. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

1.2 There have been an abundance of recent national and local drivers supporting the end of life care agenda and the purpose of this strategy is to bring them together into one plan that will drive improvement in this area of care delivery by ESHT services.

1.3 Since April 2014 improvement has been made locally but there is still much more to do if we are to improve choice and experience at end of life for our community. This will be achieved by utilising national frameworks and local recommendations and by engaging and training our workforce to deliver compassionate and knowledgable care. It is also essential that we continue to improve our services by actively listening and responding to the feedback of people receiving care and those most important to them.

2. Background

2.1 East Sussex Healthcare Trust (ESHT) is responsible for the delivery of healthcare services to a population of over half a million people, with a 7% greater number of people over the age of 65 than the national average.

2.2 East Sussex has an ageing demographic and higher levels of people aged 65, 75 and over 85 years than the England averages as shown in table x below, with a corresponding lower number of people aged 20-44 years. This impacts on health needs and demands as older people are more likely to have a range of conditions that require them to access health services.

Table x Older population comparisons (JSNA [1.] using 2013 figures)

Averages	% population aged over 65 years	% male population aged over 65 years	% female population aged over 65 years	% population aged over 85 years	% male population aged over 85 years	% female population aged over 85 years
England	17	16	19	2.3	1.6	3
East Sussex	24	22	26	3.9	2.7	4.9
ESH	26	24	28	4.5	3.2	5.7
HR	24	22	26	3.9	2.7	5
HWLH	22	20	24	3.1	2.1	4.1

CCG Area	[1]Population Total (2013 data) = 534,202
ESH	183,482
HR	181,482
HWLH	166,329

2.3 The East Sussex population is projected to increase by 1.6 % by 2026 mainly due to net migration. Within this growth the working age population is projected to decline by 10%. The growth is projected to be in the older age groups with a significant growth of those aged 65 years and over by 31%, and those aged 75 and over by 17%.

2.4 The care for people and those most important to them at the end stage of life need to be considered in these population figures. Whilst ESHT have progressed in this area there is still much improvement to be made. The CQC in their most recent inspection of End of Life Care rated ESHT as "requiring improvement".

2.5 National publications that have influenced the ESHT strategy include:

Transforming end of life care in acute hospitals: The route to success 'how to' guide (Revised: NHS England 2015).
Building on the Best (Macmillan Cancer Support, the National Council for Palliative Care, NHS England and the Trust Development Authority 2015).
Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020 (National Palliative and End of Life Care Partnership 2015).
NHS Five Year Forward View (NHS England 2014).
One Chance to get it Right (Leadership Alliance for the Care of the Dying Person 2014)
NICE guidance NG31: Care of adults in the last days of life (NICE 2015).
House of Commons Health Committee, End of Life Care, Fifth Report of Session (2015)

Dying Without Dignity (Parliamentary and Health Service Ombudsman 2015)
NHS Outcomes Framework 2016-2017

2.6 Local drivers for improvement include:

Local commissioning plans through East Sussex Better Together (ESBT) e.g. Vulnerable Patients LCS and Rapid Discharge Service H&R.
End of Life Care Strategic Clinical Reference Group
South East Coast Strategic Clinical Network
Healthy Lives, Healthy People (East Sussex Health and Wellbeing Strategy 2013-2016)
JSNA End of Life Care (ESCC), 1.
CQC Recommendations
Feedback from complaints, incidents and plaudits

3. ESHT End of Life Care Vision

1. East Sussex County Council (2015) Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) Joint Strategic Needs Assessment (JNSA) 2015 Needs and Assets Profile; East Sussex County Council (2015) Hastings and Rother CCG JNSA 2015 Needs and Assets Profile; East Sussex County Council (2015) High Weald, Lewes and Haven CCG JNSA 2015 Needs and Assets Profile

3.1 Our vision for end of life supports the overall trust vision; to be the healthcare provider of first choice for the people of East Sussex. It also supports our trust mission statement which is to *deliver better health outcomes and an excellent experience for everyone we provide with healthcare services.*

3.2 Specifically our End of Life Care Vision is that:

ESHT will promote and deliver high quality care for all people in East Sussex at the end of life, through supported decision making and availability of responsive services equipped to meet needs.

ESHT's vision is built on the same foundations as the *Ambitions for Palliative and End of Life Care*:

- Personalised care planning
- Shared records
- Evidence and information
- Involving, supporting and caring for those important to the dying person
- Education and training
- 24/7 access
- Co-design
- Leadership

3.3 ESHT End of Life Care Mission Statement
ESHT will improve access to care that meets agreed national standards for all adults, children and young people approaching the end of their life. We will achieve this by contributing to the commissioning plans that will enable services that provide people with genuine choice about where they are cared for and where they die. We will also work collaboratively with partner organisations and the public in the continued development of end of life care services across East Sussex through education and training.

3.4 Short term objectives mean that by the end of 2016, ESHT will have:

Completed a range of end of life care audits
Reviewed and launched all trust policies and guidelines relating to end of life care.
Increased end of life care training compliance to 80% (currently at 35.39%).

All recent recommendations from the CQC report and the National Audit for Palliative and End of Life Care have been incorporated into this local strategy. There is also a need to link end of life care developments with mortality in order to triangulate data which will provide a more complete picture of our local need.

3.5 Given our population profile a long term goal for ESHT is to become an exemplar centre for care of the older person and end of life care by 2020.

4. National Context

Following on from ESHT's commitment to the NHS Improving Quality work stream; Transforming End of Life Care in Acute Hospitals, Macmillan Cancer Support, the National Council for Palliative Care, NHS England and the Trust Development Authority have come together to form an improvement programme called Building on the Best. The programme recognises the 5 key enablers (Advance Care Planning, AMBER care bundle for patients whose recovery is uncertain, Electronic Palliative Care Co-ordination Systems (EPaCCs), Rapid Discharge and Priorities for Care in the last days of life). It has also identified 4 key priority areas which were felt to have the potential and biggest impact for quality improvement. They are:

- Outpatient Departments (large footfall and opportunities for Advance Care Planning).
- Improving pain and symptom management.
- Enabling shared decision making between the patient, family and clinician.
- Improving handover from acute to primary/community care.

ESHT are committed to making these 4 areas a priority but other local and national audit results also highlight other areas for improvement such as the timely recognition of the dying patient.

Other national drivers for change include engagement with Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020 (National Palliative and End of Life Care Partnership 2015). The approach taken in the Ambitions Framework is aligned to the NHS Five Year Forward View and recognises that the emphasis in today's health and social care system is on local decision-making and delivery. The Ambitions Framework sets out six ambitions to bring about that overarching vision:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Comfort and wellbeing is maximised
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help.

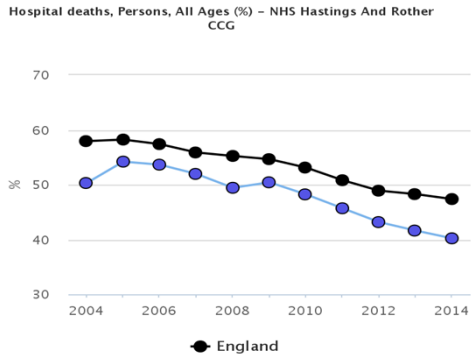
5. The Case for Change

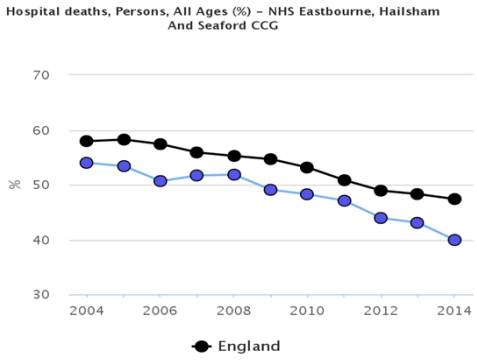
5.1 A Joint Strategic Needs and Assets Assessment by East Sussex County Council has utilised Public Health England's End of Life Care Profiles (2014) to highlight areas required for improvement. This assessment provides information in a number of areas:

5.2 Place of Death

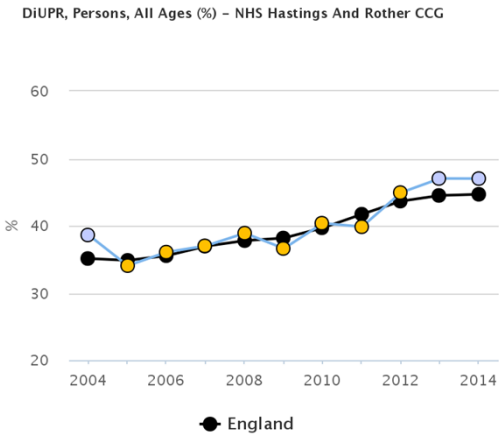
The information provided shows that the South East Coast (SEC) has a lower than average number of hospital deaths (all ages). This is benchmarked against an England and regional average. Whilst place of death is a significant indictor the more important factor is that choice is achieved. In considering this it must be remembered that whilst most may choose to die at home, there are a proportion that will choses to die in other settings including hospital. There are a number of

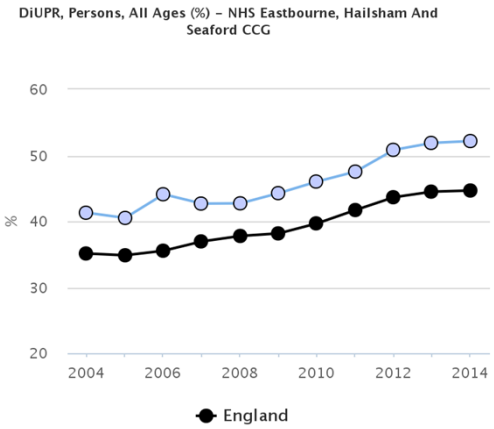
reasons for this such as their social circumstances or the nature of care they may need. This was illustrated in a national survey undertaken in 2013[2].





5.3 The SEC also has a lower than average number of home deaths and an average number of deaths in hospices and care homes, indicating that there is room for improvement to facilitate care in the home setting, although SEC have a higher than average number of deaths in the person's usual place of residence.





ONS 2011-2013

Place of death	EHS	H&R	HWLH	England
Hospital	44.63	43.48	41.13	49.31
Home	19.15	18.35	23.14	22.16
Care Home	30.2	25.33	25.35	20.74
Hospice	4.17	10.7	6.81	5.65
Other places	1.84	2.66	3.52	2.14

5.4 **Underlying Cause of Death**
Life expectancy for East Sussex as a county tends to be above the England averages of 78.9 years for males and 82.7 years for females[3]. However within

[2] NATIONAL END OF LIFE CARE INTELLIGENCE NETWORK , (2013) *What we know now* . New information collated by the National End of Life Care Intelligence Network

[3] Office for National Statistics (2014) National Life Tables UK 2011-2013

different areas this varies significantly with levels of deprivation. The data shows that SEC has a higher number of deaths in the following groups of people:
Circulatory disease (all ages)
Cancer (under 65)

	Cancer under 65	Circulatory all ages
England	38.0%	27.1%
H&R CCG	38.8%	34.6%
EHS CCG	40.6%	31.3%

5.5 **Mortality Rates**
The data shows that our rates of death are lower than the average in all ages except the over 85s where it is higher.

	Over 85s
England	39.1%
H&R CCG	45.1%
EHS CCG	49.4%

For under 74s:

EHS Mortality Causes - 2013 - For those aged under 74 years - Cancer 45%, Circulatory diseases 22%, Digestive diseases 9%, Respiratory diseases 8.7 %, (and then in order of deceasing incidence) death not by disease, nervous system diseases, endocrine diseases, mental illness, musculoskeletal system diseases, infectious diseases.

H&R Mortality Causes - 2013 - For those aged under 74 years - Cancer 43%, Circulatory diseases 21%, Respiratory diseases 10 %, Digestive diseases 7%, (and then in order of deceasing incidence) death not by disease, nervous system diseases, endocrine diseases, other , musculoskeletal system diseases, Congenital disorders, and infants.

6. **ESHT's Strengths in Relation to End of Life Care**
Strength's and areas for improvement have been identified by the National Audit for Palliative and End of Life Care.

6.1 We are an integrated trust which gives us the opportunity to develop seamless and rapid pathways for patients at the end of life.

6.2 The CQC rating for caring within ESHT was "Good". This is a solid foundation to build upon in order that care is delivered in an individualised and compassionate way.

6.3 We have a workforce who values the importance of excellent end of life care. This value extends from "Ward to Board".

6.4 ESHT have already made many improvements in end of life care:

- The introduction of a universal syringe driver to be used in all settings thus preventing an interruption in symptom control delivery.

- A review of syringe driver documentation and policies.
- Shared documentation and access to electronic systems between organisations.
- Incident and complaint data are now regularly collated and analysed. Lessons are then shared across the organisation.
- End of Life Care is now a regular Trust Board agenda item.
- A process to collect feedback from the deceased family and carers is now in place across EDGH and the Conquest Hospitals.
- End of Life Care resource boxes are in all clinical areas.
- Refurbishment of accommodation blocks for family/carers in both acute hospitals.
- Funding obtained for "comfort packs".
- Proactive Elderly persons Advisory CarE planning tool (PEACE) fully embedded in practice in the H&R CCG region.
- Collaborative working with St Michael's Hospice to begin a Rapid Discharge Service in May 2016 that is preventing unnecessary hospital admissions.

6.5 Joint working with our local hospices to improve end of life care.

6.6 Care after death is delivered well by our front line staff, bereavement officers and mortuary staff.

7. ESHT Areas for Improvement

7.1 There is a need for a robust process to hear the views of others regarding the care received by the deceased person.

7.2 Formal in-house training does not include/cover communication skills training for care in the last hours or days of life for medical staff, nursing staff (registered and non-registered) and allied health professionals.

7.3 There is not 7 day access to ESHT specialist palliative care services.

7.4 There is not always documented evidence that a discussion regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a senior doctor with the patient that was relevant to the last episode of care.

8. Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020

8.1 This is the National Framework that ESHT have used to strategically plan required improvements. Required outcomes yet to be realised are listed below each ambition. These outcomes will be short, medium and long term and will culminate in excellent delivery of end of life care by 2019. Timescales and outcome measures will be detailed in the Trust End of Life Care Action Plan.

Ambition One. Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

- Training for senior clinicians in communication and having difficult conversations.
- A process in place to ensure timely conversations and documentation of management plans e.g. Amber Care Bundle, PEACE etc.
- Visiting times in the acute setting that are conducive to conversations with senior clinicians.
- Rapid Discharge Service for patients in hospital.

Ambition Two. Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

- Gathering and analysis of local data.
- The generation of more data to answer questions.
- Partnership working with other organisations to understand need.
- Scope and develop a useful dataset that can tell us what we need to know in relation to patient outcomes.
- Development of end of life care key performance indicators that can be monitored and analysed regularly both in the acute and community setting.
- Evidence that established audit programmes have been implemented and results acted upon.

Ambition Three. Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

- Training for all appropriate staff in the recognition of signs of distress and how to address the causes. This will be delivered by continuation of the 5 year training programme that commenced in 2014 and delivered through induction training, e-learning, ward-based learning and Grand Rounds.
- Training for all appropriate staff in assessment and management of physical symptom control.
- Seven day access to specialist palliative care.
- All staff trained in the 5 priorities of care for the dying person.

- An understanding of rehabilitative palliative care in order that people can achieve their wishes.

Ambition Four. Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

- Patients' wishes, with their consent, to be documented and shared with relevant agencies.
- That there are clear roles and responsibilities particularly in relation to the new Frailty and Crisis Response services.
- That there is out of hours support available.
- That there is an easily identifiable individualised plan of care available in the health record.
- The quality of documentation should be improved upon and monitored.

Ambition Five. All staff are equipped and supported to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

- All ESHT employees will demonstrate a professional ethos in regards to end of life care and will strive to create an environment conducive to excellent care through Trust Board support and governance.
- Staff will be educated in the use of technology and legislative awareness and knowledge so that they can deliver care which will protect the individual.
- Staff will have emotional resilience through the provision of supportive and safe workplace processes such as Schwartz Rounds and access to resilience training.
- There will be a clear method of ensuring that learning from incidents is cascaded and that good practice is shared locally, nationally and internationally.
- Continuation of the 5 year training programme commenced in April 2014.

Ambition Six: Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

- ESHT will continue to support efforts to inform the public on End of Life Care developments and initiatives e.g. Dying Matters week.
- ESHT will work with our volunteer workforce to ensure that they have access to training and support.
- ESHT will promote and support opportunities for advance care planning in the community and primary care setting. This will ensure that patients' wishes are known e.g. DNACPR forms are completed at an appropriate time.

- ESHT will develop a process to hear the views of others regarding the care received by the deceased person. These views can then be used to develop and improve services.
- ESHT will continue to work in partnership with our local hospices to ensure access to specialist services.

9. Implementation and Monitoring Arrangements

9.1 The implementation and monitoring of the strategy will be governed by the newly formed End of Life Care Steering Group. The Steering Group will report directly to the Trust Board.

9.2 The initial implementation plan formulated to capture the CQC recommendations has been extended to include the National Audit of Palliative and End of Life Care recommendations and the recommendations of the Ambitions for Palliative and End of Life Care Framework. This will be agreed by the Steering Group who will monitor implementation to ensure that the strategy is shaping services in the way intended.

9.3 The End of Life Care Steering Group will also have a lead role in the development of a communication and engagement plan that will set out:

- how implementation of the strategy will be communicated to key stakeholders and members of the public; and

- how stakeholders will be engaged throughout the implementation.

9.4 Integrated performance against agreed key performance indicators will also be monitored through the Improvement Programme Group. Regular progress reports on implementation of the strategy will be produced to the Trust Board.

9.5 A large proportion of end of life care improvement is dependent upon education of staff. A separate educational trajectory will be formed to ensure regular progress is made against the plan.

10. Conclusion/Recommendation

10.1 The implementation of the ESHT End of Life Care Strategy will ensure that the people of East Sussex and those most important to them are cared for in a co-ordinated, compassionate, dignified and knowledgeable way so that the person if at all possible can fulfil their needs and wishes before their death. There is only one chance to “get it right” and ESHT are committed to listen, involve and educate in order to achieve continual improvement.

Angela Colosi
Assistant Director of Nursing

14th May 2016

Strategic End of Life Care Implementation Plan; Priorities for 2016/2017

This high level implementation plan shows key priorities for 2016. They will be co-ordinated by the End of Life Care Facilitators and progress monitored by the End of Life Care Steering Group.

Ambition	Outcome Measure	By When
1. Each person is seen as an individual	ESHT staff will know which patients who are in the last days or hours of life in both the community and acute settings.	March 2017
2. Each person gets fair access to care	Following a baseline audit an end of life care strategy that has been developed in consultation with other agencies and the public will be approved.	July 2016
3. Maximising comfort and wellbeing	80% of ESHT staff will have received End of Life Care Education.	March 2017
4. Care is coordinated	100% of people who are in the last days or hours of life will have a clearly identifiable individualised plan of care.	September 2016
5. All staff are equipped and supported to Care	All ESHT end of life care policies and guidelines will be reviewed and up to date in line with recommendations and national guidelines.	October 2016
6. Each community is prepared to help	A process will be in place to hear the views of others regarding the care received by the deceased person. These views can then be used to develop and improve services.	October 2016

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	13
Subject:	2020 – Strategic Priorities for Improvement
Reporting Officer:	Dr Adrian Bull

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

Purpose:

This document sets the framework of objectives and actions that we must undertake to make ESHT into the high-performance organisation that we want it to be by 2020.

Introduction:

It has taken the vision and strategic objectives that were published in 2015 and has brought these up to date. This framework will be adopted across the organisation and translated into the individual work programmes in clinical units, corporate services, and cross-organisation initiatives. It will be the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders.

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

Safe patient care is our highest priority.

We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.

All Trust employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles

We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services

We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health

We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable

Benefits:

The framework provides organisational focus on the key priorities, actions and risks to enable the Trust to become a high performing organisation.

Risks and Implications

Risks are outlined in the document.

Assurance Provided:

The organisation has a clearly articulated framework to effectively support improvement.

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

Proposals and/or Recommendations
The Board are asked to agree and adopt the framework of objectives.

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: Dr Adrian Bull, Chief Executive	**Contact details:** (13) 5653

ESHT 2020

Strategic Priorities for Improvement

Introduction

This document sets the framework of objectives and actions that we must undertake to make ESHT into the high-performance organisation that we want it to be by 2020. It has taken the vision and strategic objectives that were published in 2015 and has brought these up to date. This framework will be adopted across the organisation and translated into the individual work programmes in clinical units, corporate services, and cross-organisation initiatives. It will be the reference document for personal objectives, internal communications, and external communication with partner organisations and other stakeholders.

The document will be adopted by the Trust Board and will be revised annually as part of the routine business planning cycle

Vision Statement

‘ESHT combines community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex’

Framing our work

Our strategic objectives cover five areas:

- Quality and Safety
- Leadership and culture
- Clinical Strategy
- Access and operational delivery
- Financial control and capital development

Strategic Objectives

- Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
- All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles
- We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services
- We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health
- We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable

Our Values

People across the organisation were involved in the identification of the values which we wish to characterise the way we work. These are:

- Respect and compassion *(for each other and our patients)*
- Working together
- Engagement and involvement
- Improvement and development

Underlying Principles

We will adopt the following principles as the basis for our work:

- We are ambitious and aspire to excellence
- We work closely with commissioners and social services in planning and delivering health and care
- We state clearly what we do and achieve high standards in delivering it
- Services are provided seamlessly across hospital and community settings
- We have robust operational and financial systems.

BY 2020 WE WILL HAVE ACHIEVED THE FOLLOWING:

QUALITY AND SAFETY

What we will have achieved	What it will feel like	Our next steps
Quality & Safety We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.	• Across the organisation we are committed to safe care as our first priority • We monitor and publish our clinical outcomes which benchmark well with peer organisations • We fully comply with evidence based national standards of care and prevention • Patients regularly choose our services and recommend us to family and friends • We listen to patients and carers; we continually learn to improve • Patients and the public have full confidence in our services • The environment is clean, uncluttered and welcoming •Patient dignity and privacy is protected • Patients are cared for with minimum handovers and transfers of care. In hospital they are cared for on the correct ward from admission	•We will implement a comprehensive safety strategy under which: • we continually learn from past events • we fully adopt evidenced standards and policies of safe practice • we ensure operational resilience for the future • We will establish clear governance structures and business intelligence support to ensure safety • Senior medical staff will fully observe standards of safe practice through multi disciplinary ward rounds and early review of patients; standards of practice for hospital at night and 7 day working will be established. • Mortality and morbidity reviews will be regularly undertaken and clinical pathways adjusted according to lessons learned • We will ensure that we are staffed to full complement and reduce short notice staff transfers and short term agency working • End of life care standards will be defined & adopted • The use of wards and theatres will be reviewed to ensure sufficient capacity to ensure the treatment of all patients in the correct environment from the start of their treatment

CLINICAL STRATEGY

What we will have achieved	What it will feel like	Our next steps
Clinical Strategy: We will work closely with commissioners, local authority, and other partners to plan and deliver services that meet the needs of our local population in conjunction with other care services	We will have a clear strategy for the organisation to fulfil its role as the lead provider of hospital and community healthcare services in East Sussex. The strategy will be fully aligned with the joint strategy for the local health and care economy 'East Sussex Better Together'. Each clinical service will have a clear and settled view of its planned development over the next five years.	• We will participate fully in the development of the Sustainability and Transformation Plan (STP) for Sussex and East Surrey. • We will play our full role in the development and implementation of the plans for the local health economy 'East Sussex Better Together' (ESBT). • Each of our clinical units and clinical specialities will be supported to develop clinical strategies and business plans in the context of the STP and ESBT. • We will establish a joint clinical strategy group with primary care, local CCGs, and social services. • Our clinical and care strategies will encompass end to end patient care pathways focusing on maintaining health, preventing deterioration, and providing rapid acute response when required • We will develop joint cross-organisation plans for the efficient and appropriate discharge from hospital of medically fit patients

LEADERSHIP AND CULTURE

What we will have achieved	What it will feel like	Our next steps
Leadership and Culture: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles	• There is recognisably good leadership at all levels in the organisation which role models our values and motivates their teams • There is a healthy, open culture in which people feel able to raise their concerns, confident that they will be heard and addressed as appropriate • People across the organisation feel pride and satisfaction in their work and recommend the Trust as a place for care and a place to work • Our values are reflected in our behaviours in all parts of the organisation – respect, collaboration, involvement, development • People have the opportunity to develop their skills and the opportunity to progress through the organisation	•ESHT's vision, mission and values will re-launched with the implementation of the communications & engagement strategy •Behaviours based on values will be made explicit; everyone will be held accountable for their behaviour, irrespective of their seniority or professional group • The programme of staff engagement will ensure the adoption of the core elements of team leadership and communication at all levels • A strategy for leadership development and talent management will be produced and implemented • The quality of appraisals and team communication will be enhanced through training • Recruitment will be given a high priority and will be explicitly linked to Trust values • A robust framework for medical leadership will be developed and adopted • Governance and operational management structures will be reviewed and developed to ensure clarity and reinforce local ownership and accountability

ACCESS AND DELIVERY

What we will have achieved	What it will feel like	Our next steps
Access and Delivery We will operate efficiently and effectively, diagnosing and treating patients in timely fashion and expediting their return to health	•Clinical areas are calm and well controlled •There is systematic analysis and knowledge of waiting list and waiting time profiles. The hospital is meeting all access targets. •Elective care is protected from urgent demand. •Patients are transferred directly to the right wards and are looked after in the most appropriate settings •Discharge planning starts at admission, includes community based teams and is implemented efficiently. •Community services are fully aligned with primary and social care colleagues • Hospital and community based services are fully linked and providing seamless care.	• The hospital will establish an Elective Care Delivery Board, a Cancer Care Delivery Board, an Urgent Care Delivery Board, and a Maternity Care Delivery Board. These will oversee the operational arrangements to ensure the efficient achievement of operational standards for these areas of care. Each will be supported by a dedicate improvement/transformation programme. •Hospital in-patient and day-case capacity will be reviewed and re-aligned to meet urgent and elective care demands. This includes a review of theatre utilisation. •A joint review with social services and primary care to establish the efficient discharge of medically fit patients to appropriate community based settings •Endoscopy and radiology services will be re-equipped and brought to required capacity • The review of the administration service will be completed and the services brought up to full complement and effectiveness • The Clinical Unit structures and accountabilities will be streamlined, leadership and local accountability for delivery of safe, effective, and efficient care will be reinforced

FINANCE AND CAPITAL

What we will have achieved	What it will feel like	Our next steps
Finance and Capital We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable	•Revenues and costs are managed to ensure financial balance while providing safe and effective services. •Contracts will have the appropriate balance of risk and opportunity •There is a culture of continuous efficiency improvement and achievement of low reference costs •Priorities will be clarified in annual plans; spending will be accurately budgeted and fully controlled by departments and clinical units. • Contract and CQUIN targets will be achieved consistently and well •There will be a systematic forward looking capital programme driven by clinical strategies with clear identification of equipment, estates and IM&T priorities •There is a robust procurement strategy and well managed comprehensive procurement programme ensuring optimum cost efficiency with appropriate governance	• Operational and Financial accountability of clinical units will be strengthened with enhanced information and reporting to support the achievement of plans • We will develop an improved system of budgetary control and reporting • A zero-based review of all spending budgets will be undertaken • The recommendations from the Carter review will be prioritised and implemented • A package of measures will be launched to increase bank working and reduce dependency on agency staff. This will be extended to medical and AHP staff. Agency cap targets will be delivered • The procurement functions will be streamlined and product lines will be rationalised. • The cost improvement programme will be delivered and will include staff ideas about how to make clinical practice more efficient • Contract requirements and CQUINs will be tracked and met • The coding centre will brought to full complement and expertise to ensure comprehensive and timely coding of activity • The capital programme will be prioritised according to clinical need. The bid for additional capital funding from PDC will be made successfully. • The budgeted workforce plan will be developed commensurate with operational plans

METRICS

The following pages provide the high level metrics which will be used to assess our progress against these strategic objectives. They are not intended to be comprehensive. The performance of the organisation will be tracked in more detail by a pyramid of metrics below each of these.

Safety & Quality metrics

- Reduced Trust's standardised mortality ratios
- Reduction in patient complaints
- All wards accredited as providing consistently high standards
- Reduction in Trust acquired infections or complications e.g. Sepsis, Acute Kidney Infection, pressure sores, VTE
- Increased incident reporting and reduced serious incidents
- Evidence of changes to practice due to learning from serious incidents
- No mixed sex breaches or privacy and dignity complaints
- Trust wide compliance with controlled drug checks and medication reviews
- Minimised number of patients transferred from ward to ward
- Full compliance with 7 day care standards & consultant led clinical reviews
- Routine publication by clinical units/specialities of clinical outcomes

Leadership & Culture metrics

- Increase the percentage of staff employed compared to how many are planned (the fill-rate) for each of the key staff groups
- Improve staff wellbeing and commitment reflected by improved staff survey results
- Reduce sickness absence & staff turnover levels
- Increase rates and quality of mandatory training and appraisal
- Reduce the number of short notice staff moves
- Reduce the use of agency staff as proportion of the workforce

Access & Delivery metrics

- Reduce the number of Outpatient appointment cancellations
- Reduce the number of elective procedure cancellations (<3 days)
- Achieve all relevant access targets – cancer, urgent care, elective care, diagnostics.
- Achieve all waiting time targets for community services
- Reduce unplanned re-attendance in 7 days (ED)
- Reduce unplanned re-admission in 30 days (Wards)
- Eliminate bed days for delayed discharges
- Increased rate of ambulatory care
- Reduced total of non-elective bed days

Finance & Capital metrics

- Deliver annual financial plan
- Secure ESHT cash position
- Establish and achieve 5 year financial trajectory
- Achieve Monitor rating of 3 by March 2018 and 4 by March 2021
- Achieve reference costs of 100 by end March 2018
- Achieve financial balance as a local health economy by end March 2021
- Establish and deliver 5 year capital programme IT/Maintenance/Equipment/Estates
- Complete improvement of contracting and business intelligence by end March 2017

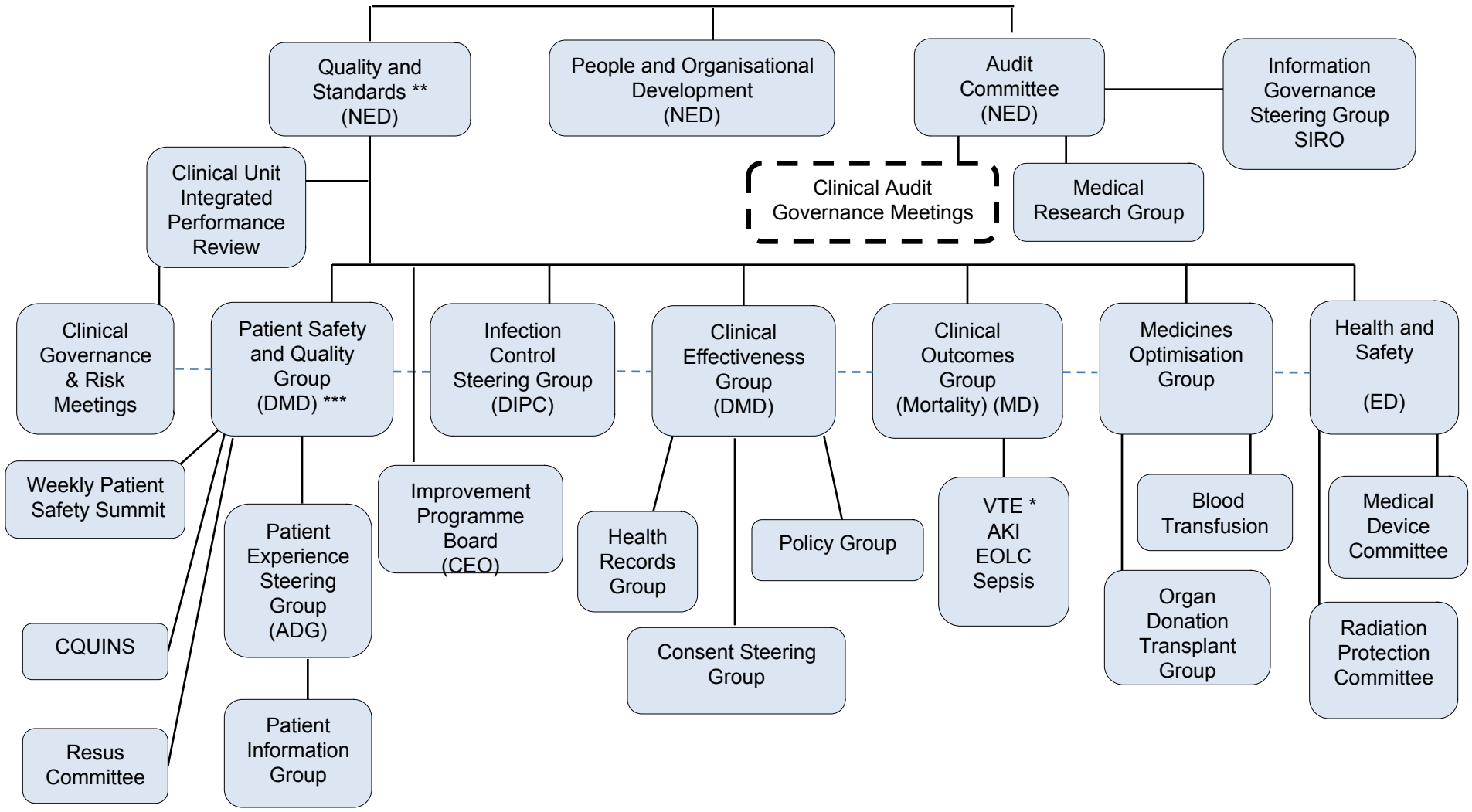
Clinical Strategy metrics

- The Trust's strategy will be understood across the organisation
- The Trust's strategy will be endorsed by external stakeholders
- The Trust's strategy will be incorporated into East Sussex Better Together
- Clinical strategies will be known and understood in each clinical area

Governance structures

We have restructured our governance arrangements to ensure clear accountability and reporting for the initiatives and programmes of work to deliver these strategic objectives as follows.

Quality Structure

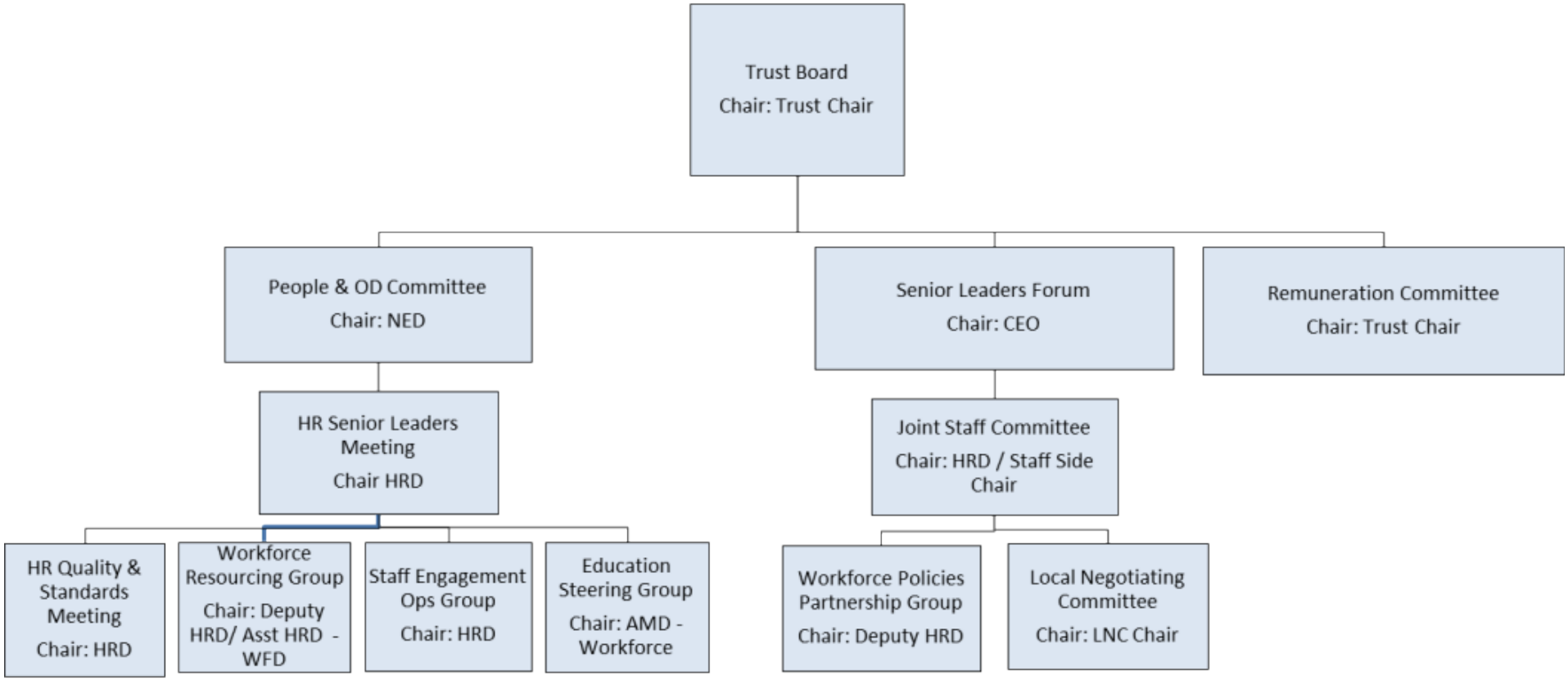


*** This group will manage trends, themes and learning actions to ensure embedded on the following: all incidents; Sis; complaints and PALS; claims and deaths

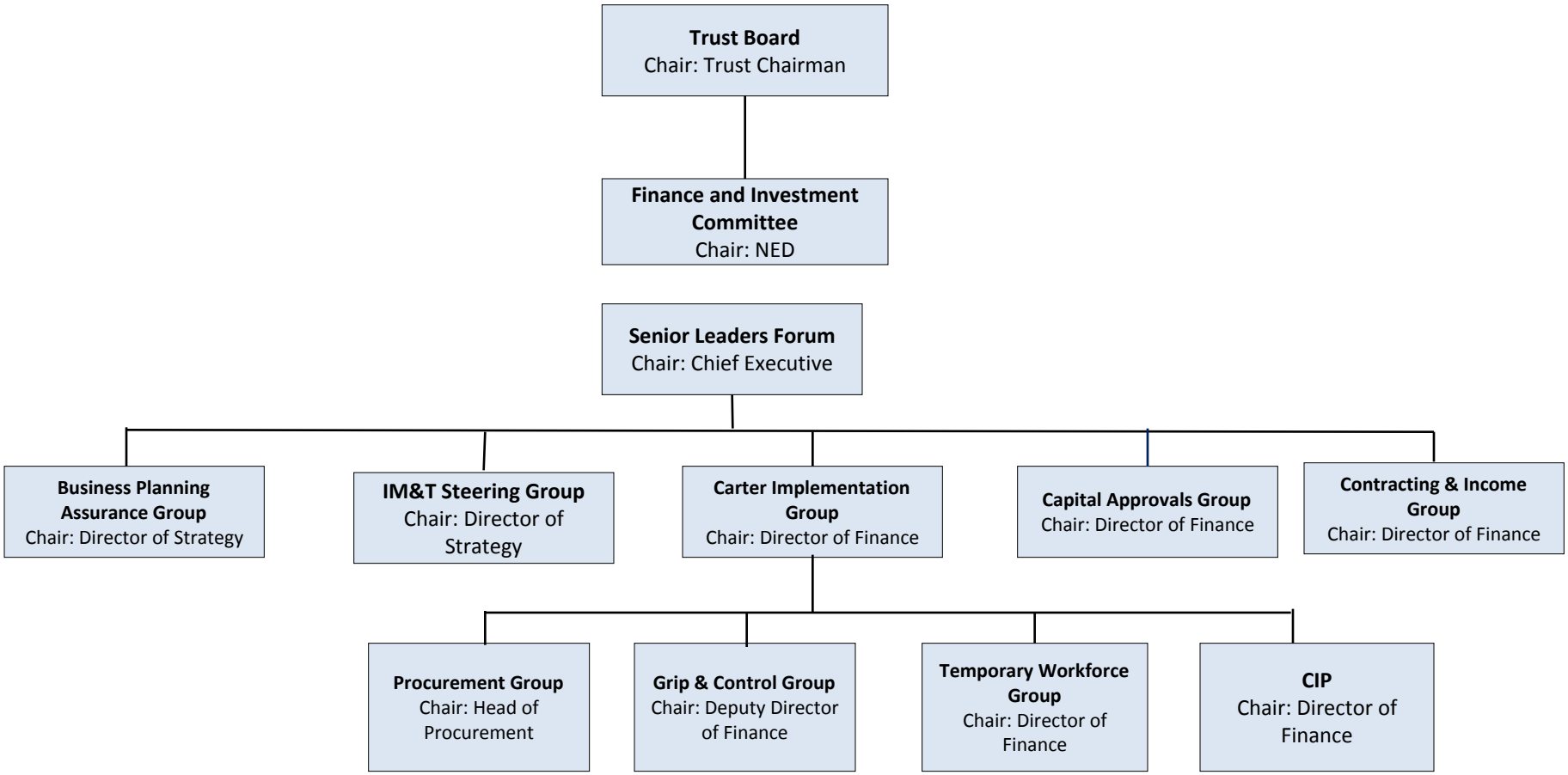
* These are included: - the Clinical Outcomes Group alongside Mortality

** The Q&S Committee will only receive progress/exception reports from the groups directly reporting in. The groups will manage and deal with the detailed analysis

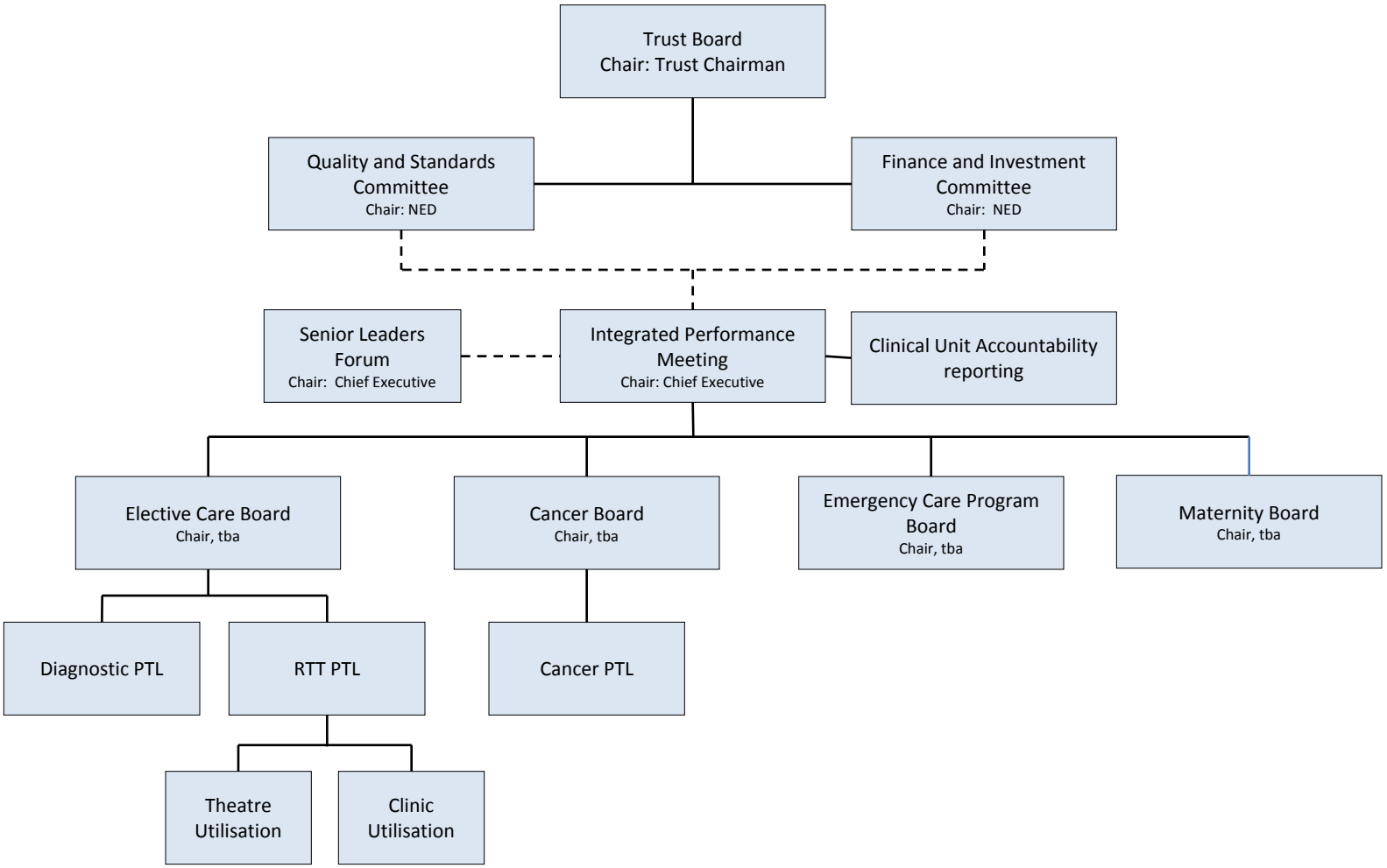
LEADERSHIP & CULTURE

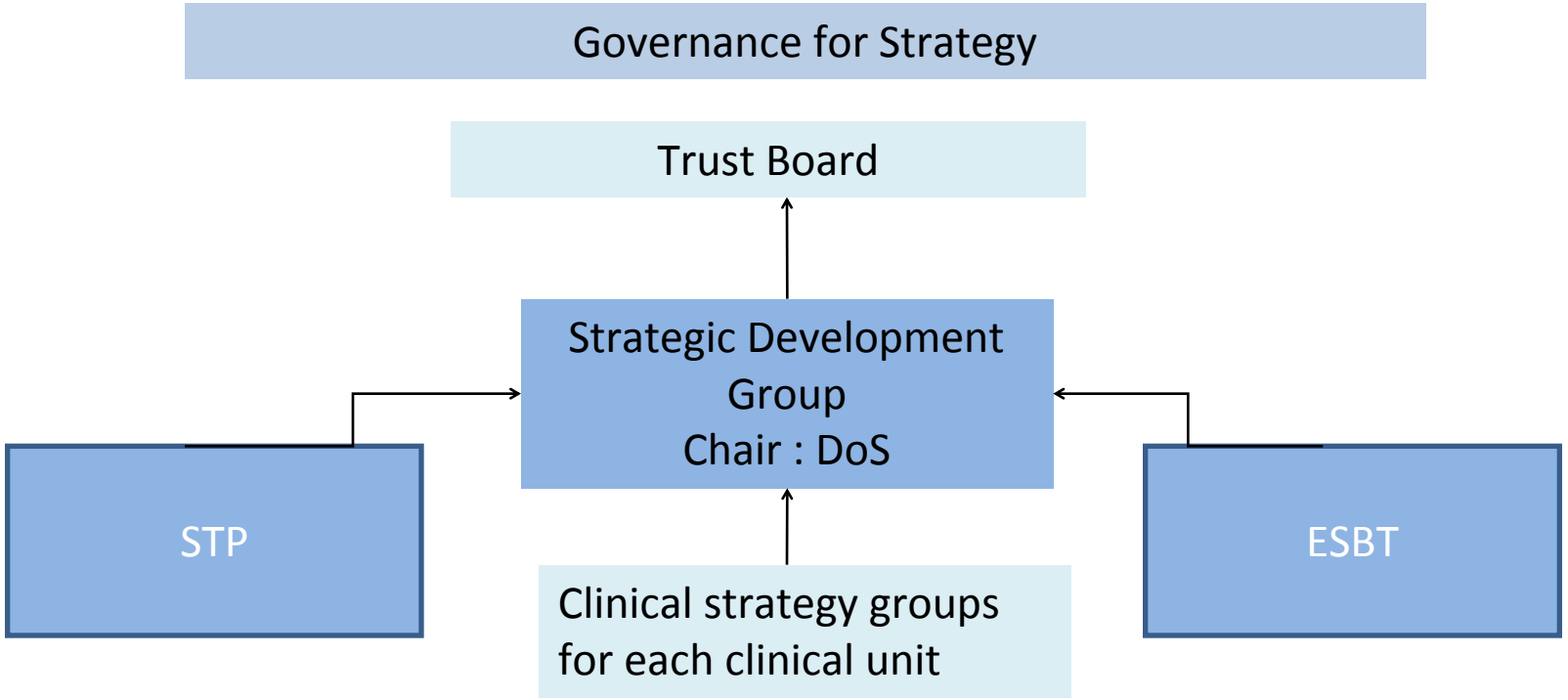


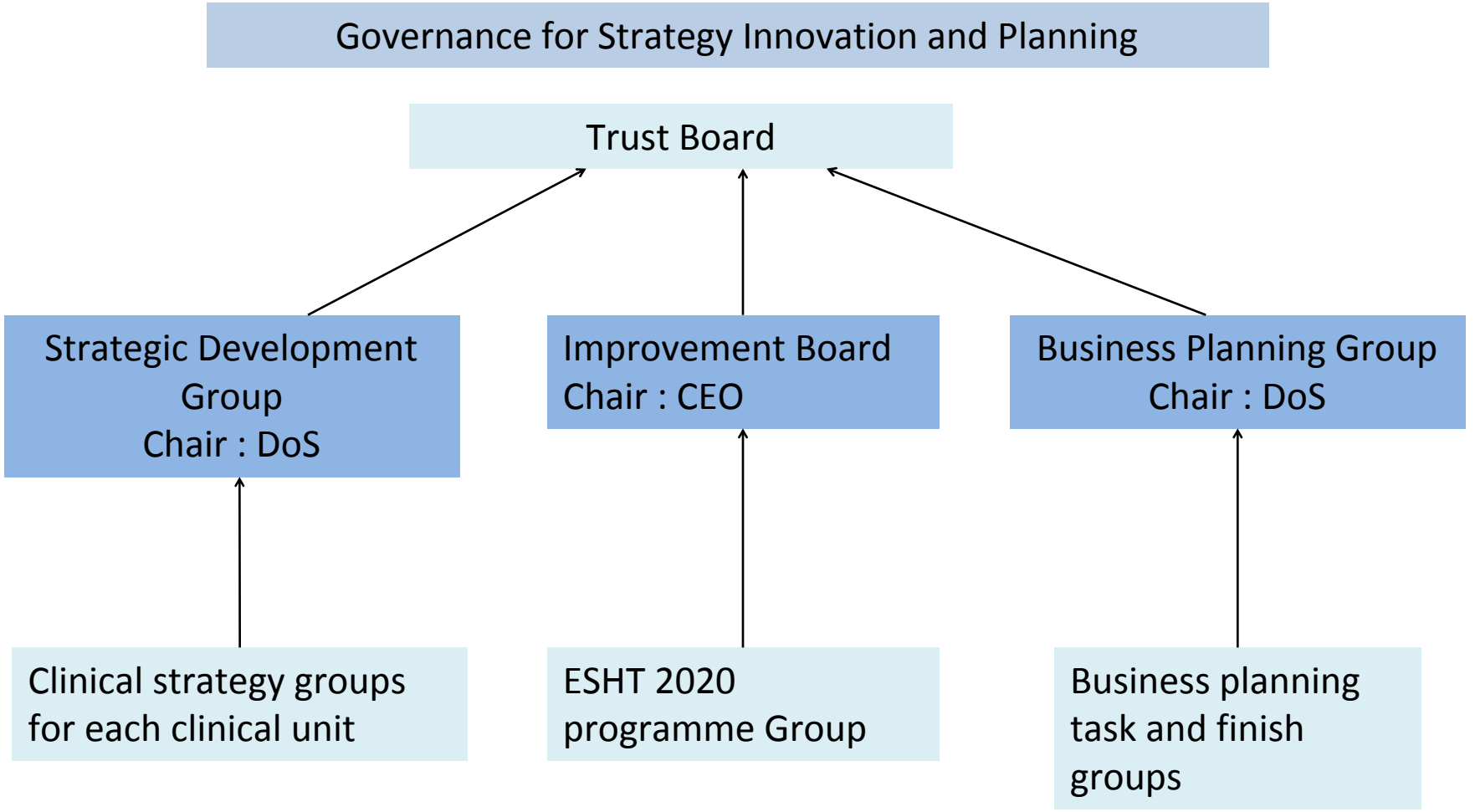
FINANCE


Trust Board
Chair: Trust Chairman
Finance and Investment Committee
Chair: NED
Senior Leaders Forum
Chair: Chief Executive
Business Planning Assurance Group
Chair: Director of Strategy
IM&T Steering Group
Chair: Director of Strategy
Carter Implementation Group
Chair: Director of Finance
Capital Approvals Group
Chair: Director of Finance
Contracting & Income Group
Chair: Director of Finance
Procurement Group
Chair: Head of Procurement
Grip & Control Group
Chair: Deputy Director of Finance
Temporary Workforce Group
Chair: Director of Finance
CIP
Chair: Director of Finance

ACCESS & DELIVERY




Governance for Strategy
Trust Board
Strategic Development Group
Chair : DoS
STP
ESBT
Clinical strategy groups for each clinical unit


Governance for Strategy Innovation and Planning
Trust Board
Strategic Development Group
Chair : DoS
Improvement Board
Chair : CEO
Business Planning Group
Chair : DoS
Clinical strategy groups for each clinical unit
ESHT 2020 programme Group
Business planning task and finish groups

RISK ASSESSMENT

We have identified the most significant risks that the organisation faces in meeting its strategic objectives and have set out the actions we are taking to mitigate these

Risks

Quality and Safety – key risks

There is a risk that we are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impair the quality of our clinical care and affect our registration and compliance with regulatory bodies

QUALITY & SAFETY

Gaps	Mitigations
<u>Recruitment</u> Difficulty in appointing to a number of areas particularly "hard to recruit specialties" and effectively manage vacancies. e.g. stroke physicians, emergency care consultants, cardiac physiologists, ODPs, radiologists and anaesthetic staff.	Active recruitment programme in place including international and European recruitment and use of specialist agencies Head of recruitment appointed and comprehensive strategy being developed including monitoring of department and team fill rates Review of staffing models and development of staff in-house. Exploring opportunities for joint posts eg with Brighton Medical School.
<u>Compliance with Fundamental Standards</u> Trust in special measures. Inability to demonstrate compliance with CQC fundamental standards and warning notices could lead to enforcement action.	Quality Improvement Governance programme in place led by the CEO. Introduced Clinical Governance Group and rationalised quality and safety work programmes under this overall governance Comprehensive quality improvement action plan developed and monitored Regular quality meetings with external stakeholders. Number of external reviews in place to provide support and assurance.
<u>Infection Control</u> Assurance is required that there are effective systems in place to minimise infection control incidents and share learning throughout the organisation.	Single comprehensive action plan and annual programme of work developed for infection control. Control dashboard being developed and planned to be part of the accountability review meetings. Bare below the elbows policy implemented in all clinical and ward areas. Audits and monitoring of compliance against national cleaning specification standards

QUALITY & SAFETY

Gaps	Mitigations
<u>Mortality</u> Mortality levels above expected range and assurance is required that there are robust mechanisms in place to understand the metrics and implement best practice.	Focussed action plan being developed on specific care pathways and admission of complex cases to in patient beds. Mortality Overview Group in place and additional governance review of deaths using data from the Bereavement Office. Peer review and support being accessed. Programme to achieve full audit of all deaths in hospital Internal mortality summit May 2016.
<u>Children and Young People</u> Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self-harm diagnoses are assessed and treated appropriately.	Joint working with SPT and CAMHS recruiting to develop appropriate pathway for these young people. Recruitment of assessor and mental health nurse located in emergency department.

Access and Delivery – key risks

There is a risk that 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.

ACCESS & DELIVERY

Gaps	Mitigation
Demand and Capacity **Insufficient capacity and resources to meet increasing demand in a number of specialities (eg ophthalmology, diagnostics, community nursing and community paediatrics) has an adverse impact on delivery of access targets and patient experience and outcomes**	Development of strategy and exploring partnership working in specialities such as ophthalmology Recruitment initiatives to attract and retain high calibre staff. Discussions with commissioners to rebase community block contract to reflect demand. Excess capacity review Effective job planning Theatre utilisation project
Emergency Departments **Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.**	AHSN supporting Trust with patient flow in A&E areas, which will have a positive impact on patient experience and privacy and dignity. Redesign of patient flow through EDs and assessment units. Finance application being developed for submission to ITFF to support capital plans.
Health Records **In order to deliver an effective service, there is a requirement to improve controls in Health Records; to encompass systems and processes, storage capacity and quality of case note folders.**	Health records management structure revised Electronic records tracking iFit introduced and on-going review of processes in Health Records have made significant reduction in missing notes, positive feedback from clinicians and reduced incidents. Off-site storage for health records. Consultation and engagement with affected staff. Some records are in poor state of repair being address but ultimate solution is the EDM programme
Clinical Administration **The appointment and admissions booking teams cannot adequately deal with demand and fail to deliver the required appointments for patients.**	Achievement of full staffing levels on permanent staff basis Training and support for staff to improve retention.

Leadership and Culture – key risks

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

There is a risk that we are unable to effectively recruit our workforce and to positively engage with staff at all levels.

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

LEADERSHIP & CULTURE

Gaps	Mitigation
<u>Culture</u> Staff surveys indicate some staff are not satisfied or engaged and would not recommend the organisation to others. Concerns regarding culture of bullying and harassment.	Programme of staff engagement and well-being in place Ensure significant improvement in team leadership and people management across the organisation Cultural diagnostic being undertaking Leadership and development courses taking place Speak up Guardian in post

Clinical Strategy – key risks

There is a risk that 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.

There is a risk that we are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.

There is a risk that 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.

There is a risk that we are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.

CLINICAL STRATEGY

Gaps	Mitigation
<u>Clinical Strategy</u> Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the wider Health Economy	Trust fully engaged with SPT and East Sussex Better Together programmes. Trust strategy being developed and "stakes in the ground" identified. Priority specialities for clinical strategy development identified and specific work commenced
<u>Retention of services</u> In order to retain and develop services the trust requires the capacity and capability to effectively respond to tenders. Specialist skills are required to support Any Qualified Provider and tendering exercises by commissioners	Successfully awarded Sexual Health Tender External resource being used to support current Elective Care Services AQP but limited capacity in-house.

Finance and Capital – key risks

In running a significant deficit budget there is a risk that 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.

There is a risk that we are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.

FINANCE & CAPITAL

Gaps	Mitigation
Capital **Limited availability of capital resources. As a result there is a overplanning and a risk that essential significant works may not be affordable. Potential impact on estate infrastructure, IT and medical equipment**	Essential work prioritised within Estates, IT and medical equipment plans. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly Application being developed for submission to the ITFF for additional capital investment to support the Quality Improvement Plan.
Finance **Trust set deficit budget of £48million for 2016/17 and robust controls required to ensure plans achieved and to manage unplanned cost pressures and delivery of CIP plan**	Timely reporting of finance/activity/workforce performance. Regular reviews by BPSG, SLF, Finance & Investment Committee and Board. Agency controls in place. Activity and delivery of CIPs managed and monitored. Monthly accountability reviews in place chaired by CEO.

CAPACITY & CAPABILITY FOR IMPROVEMENT

ESHT 2020 sets out a broad, ambitious programme of change. In order to make it a reality ESHT needs to be able to master both - improvement (refining the way existing services are run) *and* transformation, including introducing new services and new models of care. ESHT has reviewed the learning from Trusts that have successfully implemented and sustained programmes which deliver both these approaches. We have identified that they tend to have 4 key things in place

- They use a defined service improvement method to understand current state, develop their improvement aims, design and test ideas
- They actively engage staff and stakeholders at each stage of the process e.g. through experience based design techniques
- They don't assume competence – they coach and train people to acquire improvement skills
- They measure well and can therefore demonstrate their achievement

Over the last 3 months ESHT has worked with its key internal and external stakeholders to apply the learning and describe the method and infrastructure needed to deliver the local improvement agenda. The improvement and transformation methodology and the team to support both forms of change will be implemented incrementally over the course of 2016/17.

Implementing Improvement capability

- Adoption of ‘Community First’ QI methods
- Establish an improvement hub by end 2016
- Hub to include information/statistics, clinical leadership, programme management
- Training & development through coaching, placements, rotations, and fellowships

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board Meeting
Agenda item:	14
Subject:	Staff Survey 2015
Reporting Officer:	Monica Green , HR Director

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

Purpose:

To update the Trust Board on the 2015 Staff Survey results, to reaffirm the key corporate priorities for 2016/17, and to identify how progress will be measured.

Introduction:

This paper outlines a summary of ESHT Staff Survey results for 2015, outlines the three corporate priorities for improvement for 2016/17 and the approach to identifying local priorities and actions at Clinical Unit/Directorate level.

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

- The trust has identified three corporate priorities for action linked to the Staff Survey. Each Clinical Unit/Directorate is beginning to make progress in identifying areas for improvement. The action plans will be reviewed at future Clinical Unit Integrated Performance Review meetings.
- Rather than wait until Staff Survey results are published once a year, regular pulse checks, linked to the three corporate priorities have been introduced. The information from the pulse surveys will be fed back into the Clinical Unit action plans.
- The significance of the Staff Survey and Staff Family and Friends Test should not be underestimated with regard to the Trust's reputation.
- Closer links need to be made between good staff engagement and patient outcomes and patient experience, and this is currently being explored further.

Benefits:

The implementation of the corporate priorities and work of Clinical Units will improve staff engagement, help to recruit and retain high quality staff and deliver better patient outcomes/patient experience.

Risks and Implications

There are some Clinical Units who, for various reasons, are less engaged in the process than others and this is being addressed with the acting Chief Operating Officer.

Assurance Provided:

Plans are in place to address the three corporate priorities linked to the Staff Survey and the Clinical Units are developing action plans supported by Staff Engagement and Wellbeing Team.

Review by other Committees/Groups (please state name and date)**:**
People and Organisational Development Committee Staff Engagement Operational Group

Proposals and/or Recommendations
The Board is asked to review and note the 2015 staff survey results, identified priorities and actions that are being implemented.

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: Lorraine Mason Head of Staff Engagement & Wellbeing	**Contact details** **Tel: (13) 6615** Email: lorraine.mason1@nhs.net

East Sussex Healthcare NHS Trust

Staff Survey 2015

1. Introduction

1.1 This paper provides a summary of the ESHT Staff Survey results for 2015, outlines the three corporate priorities for improvement for 2016/17, and the Trust's approach to identifying local priorities and actions at Clinical Unit/Directorate level.

1.2 The Board are asked to support this approach.

2. Background

2.1 The NHS National Staff Survey has been running since 2003. It is used alongside the NHS Staff Family and Friends Test by NHS England and by the Care Quality Commission (CQC) to judge and assess Trust performance.

2.2 The 2015 survey was run between September and December 2015. During this time Clinical Units and Directorates were asked to encourage staff to complete the survey by explaining its relevance to how the trust is judged and by giving protected time in team meetings. The Trust also offered all staff who completed the survey the opportunity to be entered in a prize draw. The Trust response rate was 40% compared to the national average of 42%. Those Clinical Units and Directorates that did give protected time typically saw a response rate of 50%.

2.3 The survey results were published on the 23rd February 2016 and presented to Board members at a Board Seminar the next day by Quality Health who run the survey for the Trust.

3. Summary of Results

3.1 For the first time, ESHT results were compared with the national average for other combined acute and community trusts, rather than just with all acute Trusts.

3.2 The survey asked 30 multi-part questions which are grouped into 32 Key Findings (KFs).

3.3 Results:

3.3.1 ESHT result highlights

Overall Staff Engagement (1 to 5 with 5 being highly engaged) had an overall score of 3.56 (3.46 in 2014), which is below average when compared with other combined acute and community Trusts.
Questions 21a, 21c and 21d feed into Key Finding 1 "Staff recommendation of the organisation as a place to work or receive treatment".

Question	**ESHT in 2015**	**Average (median) for combined acute and community trusts**	**ESHT in 2014**
Q21a "Care of patients / service users is my organisation's top priority"	58%	73%	51%
Q21b "My organisation acts on concerns raised by patients / service users"	52%	72%	52%

Q21c "I would recommend my organisation as a place to work"	40%	58%	39%
Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	54%	68%	52%
KF1. Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.36	3.71	3.26

3.3.2 Top scores

- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months – 13% (lower score is better, national average 14%)
- Percentage of staff experiencing physical violence from staff in last 12 months – 2% (lower score is better, national average 2%)
- Percentage of staff working extra hours – 72% (lower score is better, national average 72%)
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month – 29% (lower score is better, national average 29%)

3.3.3 Bottom scores

- Effective use of patient / service user feedback – 3.41 (higher score is better, national average 3.65)
- Fairness and effectiveness of procedures for reporting errors, near misses and
- Incidents – 3.41 (higher score is better, national average 3.71)
- Staff confidence and security in reporting unsafe clinical practice – 3.31 (higher score is better, national average 3.65)
- Percentage of staff reporting good communication between senior management and staff– 19% (higher score is better, national average 30%)
- Support from immediate managers – 3.53 (higher score better, national average 3.72)

3.3.4 Largest improvements since 2014

- Staff motivation at work– 3.77 (higher score is better, 2014 score 3.65)
- Staff satisfaction with level of responsibility and involvement– 3.79 (higher score is better, 2014 score 3.70)
- Support from immediate managers– 3.53 (higher score is better , 2014 score 3.45)
- Percentage of staff appraised in last 12 months– 82% (higher score is better, 2014 score 78%)
- Staff recommendation of the organisation as a place to work or receive treatment– 3.36 (higher score is better , 2014 score 3.26)

3.3.5 Largest deteriorations since 2014

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – 32% (lower score is better, 2014 score 27%)
- Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell – 66% (lower score is better, 2014 score 62%)
- Percentage of staff working extra hours– 72% (lower score is better, 2014 score 69%)

3.3.6 In summary:

- 5 KFs had a statistically significant positive change since the 2014 survey
- 3 KFs had a statistically significant negative change since the 2014 survey
- 24 KFs had no statistically significant change since the 2014 survey

3.3.7 When compared to other combined acute and community Trusts:

- No KFs were better than average
- 28 KFs were worse than average
- 4 KFs were average

3.4 Staff Survey 2015 by Staff Group

Staff Group	Better results	Worse results
Nursing & Midwifery	• Staff feeling that they made a difference • Contributing to improvements • Numbers of appraisals • Reporting of incidents	• Staff working extra hours. • Pressure to attend work when unwell. • Physical violence and harassment or bullying from patients, relatives or the public • Witnessing potentially harmful errors
Allied Health Professionals	• Staff contributing to improvements • Appraisal quality • Perception of equal opportunities • Levels of violence from patients, relatives or the public	• Staff working extra hours • Pressure to attend work when unwell • Reporting of violence and harassment/bullying • Witnessing potentially harmful errors
Additional Professional Scientific & Technical	• Satisfaction with work and care • Levels of stress • Discrimination • Incidents of violence and harassment from the public	• Numbers of appraisals • Perception of equal opportunities Harassment/bullying from staff • Reporting of harassment • Witnessing potentially harmful errors
Clinical Scientists	• Satisfaction with quality of work Working extra hours • Equal opportunities • Reporting harassment • Witnessing potentially harmful errors	• Ability to contribute to improvements • Violence and/or harassment from patients, relatives or the public Reporting violence • Reporting errors
Medical & Dental	• Feeling pressure to work when unwell • Perception of equal opportunities • Violence from patients, relatives or the public • Violence from staff • Reporting of errors	• Satisfaction with flexible working • Staff working extra hours • Harassment from patients, relatives or the public • Reporting of harassment • Witnessing potentially harmful errors
Admin & Clerical	• Good communication by senior management • Satisfaction with flexible working • Working extra hours • Discrimination at work • Witnessing errors	• Agreeing their role makes a difference • Numbers having been appraised • Reporting of violence • Harassment/bullying • Reporting errors/incidents

Estates & Ancillary	• Working extra hours • pressure to come to work when unwell • Harassment from the public • Reporting harassment • Witnessing errors	• Agreeing their role makes a difference • Ability to contribute to improvements • Satisfaction with flexible working • Equal opportunities • Reporting violence

3.5 Staff Survey 2015 by Clinical Unit/Directorate – key findings

- Staff motivation at work – improved across all Clinical Units
- Able to contribute towards improvements at work – improved in all except Theatres and Clinical Support. No change in Corporate
- Equal opportunities for career progression / promotion – improved in Estates and Facilities, OOH, Specialist Medicine, W&C
- Experiencing harassment, bullying or abuse from staff in last 12 months – improved in Cardiovascular only
- Reporting errors, near misses or incidents witnessed in last month – improved in and Facilities, Specialist Medicine, Surgery and Theatres

4. Key priorities

4.1 There were a number of recommendations made by Quality Health in relation to the staff survey which were discussed at the Board Seminar, and these and the approach to setting local priorities were agreed at the People and Organisational Development Committee.

4.2 Trust priorities

The priority areas agreed are around communications, stress felt by staff and bullying & harassment, specifically to:

- Review and develop the **communication skills** of managers to ensure that key messages, both upwards and downwards, are communicated more effectively and to ensure that staff are aware that the Trust seeks **feedback** on a regular and ongoing basis.
- Prioritise the issue of reported **physical deterioration and stress at work** and analyse ways in which the Trust can address legitimate problems.
- Identify issues of **harassment, bullying and abuse** by drilling down the data.

4.3 Work being undertaken to address these priorities:

4.3.1 Communication and feedback skills of managers

A programme is being developed for line managers to embed excellent communication and engagement skills. This will include the requirement for good local induction processes, regular 1-1's and team meetings, effective 15 minute coaching conversations and appraisals training. This training will also see the launch of the Trust's engagement and communication toolkit which outlines the expectations of managers as well as acting as a resource. The intention is that all managers will undertake this programme.

4.3.2 Health and wellbeing of staff

The Trust's Occupational Health and Wellbeing Services are being transformed to support the physical and emotional needs of staff. For the first time the Trust will employ a physiotherapist in the Occupational Health Department to address issues linked to MSK

injuries in staff. Staff MOTS are being introduced and staff will be supported to make lifestyle adjustments. Further roll-out of the Emotional Resilience training and Schwartz Rounds will be undertaken to support the emotional wellbeing of staff. A number of Health and Wellbeing listening conversations have been held with staff and one of the outcomes this has resulted in is a "Take a Break campaign" which was launched on the 23rd May, whereby all staff are encouraged to take a break and each area has been given a basket containing advice and guidance about making the most of a break.

4.3.3 Bullying & Harassment

The results of the cultural review into the Trust will be published in June which will provide valuable information on what staff feel about this issue. Using the results from the review there will be a refreshment of our existing policies linked to bullying and harassment to ensure they are clear and fit for purpose. The feedback will also inform the development of a programme related to professionalism which will be underpinned by the Trust Values.

4.4 Local priorities linked to the Clinical Units and Directorates

Each Clinical Unit/Directorate has received their staff survey results and additional information about their top five highest scoring areas and five lowest scoring areas. They have shared their results with staff and have begun to develop action plans. The staff engagement and wellbeing team are working with each area to share best practice and support the development of key actions.

4.5 Pulse Surveys – seeking regular feedback

It is important to seek regular feedback from staff and not only rely on the annual National Staff Survey. This will be done via the Staff Family and Friends Test and the introduction of regular pulse checks. The pulse checks will include a range of questions linked to Trust priorities. The first pulse survey has just been undertaken and focused on staff engagement. A total of 612 responses were received.

Below are the results by Clinical Unit. It is encouraging to see that those Clinical Units who have scored above the Trust average are those areas that have demonstrated a real commitment to wanting to improve staff engagement. These results will be shared with the Clinical Units which are using them to further enhance their action plans. The scores are measured on a scale of 1-5, with 5 being high, 1 being low.

5. Further Work

The Staff Survey is key to how external bodies judge the Trust and also to how staff feel about working for the Trust. There is a growing amount of evidence that those trusts who have high levels of staff engagement also have better patient outcomes and retain staff. Although there has been a slight improvement in the last Staff Survey in relation to the percentage of staff who would recommend ESHT to a family or friend for care (58%), the Trust is considerably below the national average (73%). There is a need to increase the response rate to the Staff Survey, Staff Family and Friends Test and Pulse Surveys by demonstrating to staff that their feedback is acted on. Ways of making links between the Staff Survey and Staff Family and Friends Test results, and patient outcomes and experience are currently being developed

Lorraine Mason
Head of Staff Engagement and Wellbeing
June 2016

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Wednesday 23rd March 2016 at 10.00am in the St Mary's Boardroom, EDGH

Present: Mr Mike Stevens, Non-Executive Director (Chair)
Mrs Sue Bernhauser, Non-Executive Director

In attendance

Jenny Crowe, Head of Midwifery (for item 4 only)
Mr Stephen Hoaen, Head of Financial Services
Mr John Kirk, Facilities Manager (for item 5 only)
Mr David Meikle, Director of Finance
Mr Adrian Mills, Audit Manager, TIAA
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Company Secretary
Mr Steffan Wilkinson, Counter Fraud Manager, TIAA
Mr Keith Wilshire, Interim Clinical Effectiveness Lead
Sally Herne, Improvement Director
Jody Etherington, Audit Manager, BDO
Mr Pete Palmer, Assistant Company Secretary (minutes)

Observing: Mrs Danielle Clarke, EDHR Assistant

Action

014/16 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mr Barry Nealon, Non-Executive Director
Mr David Hughes, Medical Director
Mrs Alice Webster, Director of Nursing

015/16 Minutes of the meeting held on 20th January 2016

i) The minutes of the meeting held on 20th January 2016 were reviewed and were agreed as an accurate record.

ii) Matters Arising

The following verbal updates were provided:

Trust IT Strategy
It has been arranged for the Head of IT to present the Trust's IT strategy to the Audit Committee on 20th July 2016.

Out of Date Trust Policies
Mrs Wells reported that she had emailed a list of out of date Trust policies and procedures to Mr Stevens.

Clinical Audit Strategy
This was discussed as item 6E c) on the agenda of the meeting.

Losses and Special Payments Review
Mr Hoaen reported that processes were in place to ensure that insurance excesses for vehicle accidents were passed on to the driver of the vehicle.

016/16 Board Assurance Framework and High Level Risk Register

Mrs Wells presented the Board Assurance Framework (BAF) and High Level Risk Register.

She noted that a new red rated risk had been added to the BAF due to the issues being faced by the Trust around mortality.

Mrs Wells explained that the gap in control concerning health records had moved from red to amber as there was now a greater level of assurance that revised processes were becoming embedded within the Trust. She reported that the Trust had introduced the IFIT health records tracking project and that a decreasing number of clinics were now reporting missing health records.

Mrs Wells reported that infection control assurance had moved from green to amber, and that mandatory training assurance had moved from amber to green.

She noted that a number of gaps in control were due to be removed from the BAF:

- A managed service contract had been signed for the provision of pathology equipment.
- The backlog for reporting plain films had been significantly reduced, and effective controls had been introduced to ensure the timely reporting of films
- MSK modelling had been undertaken and was now part of business as usual for the Trust.

Mrs Wells reported that the BAF included three areas rated as red, relating to the reconfiguration of the emergency department, mortality indices and the Trust's financial position.

Risk Register

Mrs Wells noted that a number of new risks concerning the Trust's estates had been added to the register. She explained that the descriptions and ratings of a number of the new inclusions had been challenged and a review would be undertaken to ensure that they were accurate.

She reported that pharmacy risks had also been added to the register, and that these would also be reviewed to ensure that they were accurate. Mrs Wells explained that members of the Trust's governance team would be meeting with risk leads to ensure that risk reporting and scoring was applied consistently throughout the organisation.

Mr Stevens asked whether the scale of the Trust's risk register was comparable to that of other similar sized Trusts. Mr Townsend replied that he felt that ESHT's risk register was comparable. Mrs Wells explained that, while the risk register had been greatly improved over recent years, more work needed to be undertaken to further improve the register.

The Committee reviewed and noted the revised High Level Risk Register and Board Assurance Framework and were of the view that the main inherent/residual risks had been identified and that actions were appropriate to manage the risks.

017/16 Women & Children Clinical Unit Clinical Audit & Risk Register Review

Ms Crowe presented the Women & Children Clinical Unit's (CU) Audit and Risk Register review to the Committee.

Risks

She reported that the CU had 22 risks on its register, and that two new risks had been added in 2016. The first of these concerned out-of hours paediatric consultant at EDGH. The second risk was associated with a reduction in the number of midwifery supervisors available following the transfer of some midwifery services to Maidstone and Tunbridge Wells NHS Trust in April. She explained that the CU planned to recruit a full time midwifery supervisor in order to resolve this issue.

Ms Crowe noted a number of key risks for the CU. She explained

that the CU had a number of out of date policies and that these had now undergone revision and were scheduled to be posted onto the Trust's intranet.

Ms Crowe reported that external locum paediatric clinicians were currently responsible for covering 40% of the acute paediatric service. She explained that job planning for permanent clinicians had been completed and that she anticipated that by September there would only be one paediatric consultant within the Trust who would not be included on the consultant on call rota.

Ms Crowe reported that a Psychiatric Liaison Nurse had been recruited for EDGH, and that they should start with the Trust in April. She explained that the nurse had been recruited in response to an increase in admissions to the acute paediatric ward of young people with mental health and deliberate self-harm diagnoses.

Ms Crowe explained that partial funding had been received from the avoidable harm fund for four new resuscitaires, one at EDGH and three at the Conquest. She noted that the CU still needed further resuscitaires which cost £9k each, but it was possible that some existing units would be able to be converted for £1k each. Mr Stevens suggested that Ms Crowe contact the Friends at EDGH and the Conquest to see if they would be willing to help to fund purchase or adaptation of units, or alternatively to explore whether charitable funds could be used to purchase the resuscitaires.

Mrs Bernhauser asked about the number of maternity policies that needed to be updated. Ms Crowe replied that the CU had 102 maternity policies that required annual review and revision, and of those twenty were outstanding and plans were in place to update these..

In response to a question from Mrs Bernhauser it was noted that SIs were due to be discussed in greater detail at the Trust's Board meeting on 13th April.

018/16 Estates Risk Register Review

Mr Kirk presented the Estates Risk Register review to the Committee. He explained that forty one risks had been added to the register during the previous two months, mainly as a result of the Trust's backlog maintenance legacy which now stood at almost £30million. He noted that other risks had been added as a result of the pressures on capital funding within the Trust.

He reported that the Trust's full estates strategy included plans to address many of the risks on the register and that this was scheduled to be presented to the Trust Board in May 2016.

Mr Kirk noted that there were a number of significant issues on the register, and that these included:

- The need to provide dedicated areas to decant discharging patients in order to improve patient flow.
- The potential for failure of obsolete equipment still in use in the Trust.
- Planned Preventative Maintenance (PPM) frequencies have been increased, but there is a lack of appropriate resource in place to support this increased activity.

Mr Kirk explained that Estates' risk register was reviewed at monthly senior estates team meetings as well as at monthly governance meetings. He reported that meetings were held with the identified mangers of the risks in order to review actions that had taken place and to ensure that the register remained up-to-date.

Mr Stevens noted that the register contained a mix of risks; some that would require a lot of money to resolve, and others that would be relatively cheap to resolve. Mr Kirk explained that the majority of the risks required financial investment to resolve, and that these were included in the estates strategy.

Mr Stevens asked if the risk register could highlight issues that could be resolved without investment and those that would require investment to resolve. Mr Kirk agreed to speak to the identified managers of the risks about whether this could be done.

Mrs Wells explained that she felt that some of the risks had been incorrectly scored, and that it would be useful for the risk register to undergo independent review to ensure that scores were consistent. The Risk Management team would be asked to review this with the team.

Mr Townsend asked what actions were being taken to resolve the risks highlighted within the risk register. Mr Kirk explained that the risks on the register were reviewed on a monthly basis by senior management in Estates. They were then presented to the Health and Safety steering group who oversaw the main risks included on the register, and that the register had been presented at the Senior Leaders' Forum. Mr Stevens explained that it was imperative that items placed onto the risk register underwent regular review by both the Estates team and by Executives.

Mr Wilkinson noted that theft of linen from the Trust's laundry service had been mentioned at the previous Audit Committee meeting in January and asked whether this was included on the risk register. Mr Kirk replied that this was not on the register as it had been considered as a theft and fraud issue, and not as a risk. He

explained that the tagging linen had been considered, but that the cost of any tagging system was prohibitive.

019/16 Clinical Audit Forward Plan 2015/16 Report

a) Mr Wilshire presented the clinical audit update to the Committee and reported that CUs and Specialities had been asked to provide details of their clinical audit priorities for the forthcoming year. He explained that the update included prospective national audits and that the plan was being amended to make it a rolling plan rather than a year-on-year plan, as some national studies would take place over 3-5 years.

Mr Wilshire reported that his team had begun to provide greater levels of challenge to proposals for new audits, to ensure that they were of sufficient quality, relevance and included acceptable levels of detail. The audit team were working hard to ensure that proposed timescales for audits were met and to identify which audits would not be completed. He noted that this had led to a rise in the number of abandoned audits being reported.

Mr Wilshire explained that the number of outstanding audits from the previous three years had been reduced, but that in some cases his team were having difficulty in getting definitive responses to their queries as members of staff with named responsibility for audits had left the organisation.

Mr Wilshire reported that nationally mandated audits were included within the report and that the only audit with a risk rating of red had been added to the Trust's Risk Register.

He noted that there were two audits rated as orange. The first was a National Emergency Laparotomy Audit (NELA) where no clinical lead had been identified. The second was the UK Parkinson's Audit, where clinicians at the Conquest had not had sufficient time to collect data from health records.

Mrs Wells commented that the number of nationally mandated clinical audits had greatly increased in comparison to the previous year. Mr Wilshire explained that this number was likely to increase further in forthcoming years, as "must consider" audits were likely to be nationally mandated in the future.

Ms Herne commented that audits concerning conditions of elevated mortality within patient pathways in the Trust should be prioritised to help to identify and resolve the issues that the Trust faced with mortality. Mr Stevens asked if it was possible for Mr Wilshire to elevate the priority of these audits, and Mr Wilshire replied that if clear links to mortality could be identified then he could do this. He noted that data collection for audits could take up to a year, and

production of reports could take a further six months and that this would not be a short term solution.

b) National Audits – Risk register Entries and Internal Governance Process

Mr Stevens explained that he would like to have sight of the process that was in used to evaluate whether the Trust undertook local audits. He felt that every proposal should be evaluated to ensure that necessary resources were available to complete it to a high standard, and that every audit should be approved by Mr Wilshire and Dr Hughes. Mr Wilshire noted that approval process had recently been revised to make it more challenging and to receive greater assurance that the Trust would receive value for money from the audit.

Mrs Bernhauser explained that she had found the report to be very useful but that she was concerned about the possibility of reputational risk if nationally mandated audits were not completed. She noted that data from national audits should be used to influence decisions made at a local level.

c) Proposed Trust Strategic Clinical Audit Priorities 2016-2019

Mr Wilshire presented the recommended strategic priorities for the development of clinical audit between 2016-19. He explained that, once agreed, they would allow the Quality and Standards Committee and the Trust Board to easily identify the Trust's top 10 audit priorities. He noted that items rated grey within the proposal showed the Trust's current position, and that the yellow rating illustrated the position the Trust hoped to achieve. Mr Wilshire explained that the Trust's audit ambitions were aligned with the Trust's revised Quality Strategy and that some of the work detailed within the plan had already been undertaken.

Mr Stevens noted that he was very impressed with proposal. Mr Wilshire explained that he was leaving the Trust at the end of March 2016 as his temporary contract was ending. Mr Stevens thanked him for the excellent work he had done while he had been at the Trust.

The Audit Committee noted the contents of the Clinical Audit Reports.

020/16 Internal Audit

a) <u>Progress Report</u>

Mr Mills explained that that the progress report provided an update to the Committee on work that had been undertaken since January. He noted that the final report on the Cost Improvement Plan audit had been issued, but that it only included partial management responses as Trust Executives had not responded to repeated requests for feedback. Mrs Bernhauser said that she felt that providing responses to external auditors was a fundamental part of Trust business and Mr Hoaen agreed to follow up on responses that had not been received. Mr Stevens asked for this matter to be raised at the Audit Committee meeting in July as a separate item, to enable it to be discussed in full.

SH

PP

Mr Mills reported that limited assurance had been given in respect of complaints and claims and that two priority one recommendations had been made. He noted that substantial assurance had been given in respect of risk management and reasonable assurance given in respect of the IG toolkit.

He reported that three draft reports, concerning the Trust's child health system, the data warehouse and nursing rosters had been issued. He noted that all external audit fieldwork for 2015/16 had been completed and that all reviews were at the reporting stage.

Ms Herne noted that Trust appraisal and mandatory training rates had seen a significant improvement, and asked what measures had being taken to ensure that appraisal quality had remained high during the increase. Mr Mills explained that the remit of a recent audit had been to review training processes, and that the quality of the training and appraisal being given to staff had not been reviewed.

Ms Herne asked which aspects of Infection Control had been externally audited. Mr Mills reported that the audit had looked at national cleanliness standards. He explained that external auditors received guidance from executives about areas where there were concerns, and that they then choose other areas to review at random.

The Committee noted the Internal Audit Progress Report.

Internal Audit Plan for 2016/17

b) Mr Townsend reported that the first draft of the Internal Audit Plan had been discussed with Mr Meikle and Mr Hoaen, and that they had provided him with feedback which was reflected in the plan presented to the Audit Committee. He noted that he was happy that the plan reflected a variety of areas across the Trust and included audits of emerging risks, data quality, serious incidents, cost improvement plans, estates maintenance and clinical audit. He explained that the proposed reduction in the number of days spent auditing the Trust from 415 to 390 for the coming year which

reflected the fact that the Trust now provided fewer services than it had in 2015/16.

Mr Stevens asked whether there were any links between the proposed audits for 2016/17 and the actions required following the CQC's inspection. Mr Townsend explained that where clear links were shown they would be highlighted. Mr Mills explained that among the proposals were audits of End of Life Care, serious incidents and complaints and that the plan of work for 2015/16 had already looked at many areas covered within the CQC's reports.

Mr Stevens explained that he would like to see the effectiveness of appraisals being audited to receive assurance that they continued to be carried out appropriately and effectively. Mr Townsend agreed to speak to the HR department about undertaking this audit, and noted that this would fall within the five days' contingency for additional work that was built into plan. **MT**

Ms Herne asked whether medicines management could be audited during the upcoming year and Mr Townsend replied that this was in the schedule for 2017/18 and that he would hold discussions to ascertain if this should be brought forward to 2016/17.

Mr Stevens asked about how the Trust's audit coverage compared to that of other Trusts and Mr Townsend explained that ESHT was in top quartile of audit plans among comparable Trusts. He noted that the Trust's plans had both breadth and depth and that the Trust could be assured that their audit plans were good.

c) Audit Recommendations Tracker

Mr Townsend reported that a number of audit actions were being presented to the Committee for closure, and that a major exercise was being undertaken to follow up on all the outstanding recommendations.

Mr Stevens said that he would like the audit tracker to include the name of the member of staff in the Trust who had responsibility for each action, and Mrs Bernhauser agreed that this would be a useful addition.

The Committee approved the closure of the recommended audit actions.

021/16 Local Counter Fraud Service

a) Progress Report

Mr Wilkinson presented an update on the Local Counterfraud

Service (LCFS) to the Committee, and reported no major areas of concern that represented a large risk to the Trust.

He reported that a counterfraud staff awareness survey had been completed, and that of the 500 people asked to respond, around 20% had done so. He noted that a full report on the staff survey including benchmarking against other Trusts, would be presented to the Committee in the future.

Mr Wilkinson updated the Committee on the reactive investigations being undertaken by LCFS.

The Committee noted the Local Counter Fraud Service Investigations Update.

b) Work Plan for 2016/17

Mr Wilkinson explained that the style of LCFS's work plan had been amended in order to align it with their self-review tool. He noted that the Trust had received green ratings on all but two standards:

2.4 Code of Conduct
Mr Wilkinson explained that the Trust had codes of conduct for some staff groups, but did not have a code for all staff. He noted that the Trust would not be able to achieve a green rating until a code of conduct for all staff was introduced. Mr Meikle agreed to speak to Monica Green in order to find out the reasons why the Trust did not have a code of conduct for all staff. **DM**

c) 3.1 Review of Policies

Mr Wilkinson explained that LCFS had been invited to review all new and revised policies to ensure that any potential loop holes that would enable fraud to be committed were identified and closed. He noted that he thought that the amount of hours that this would take would be disproportionate to any benefits received.

022/16 External Audit Plan for 2016/17

Mr Etherington presented BDO's external audit plan for 2016/17. He noted that materiality had been set at 1.5% of gross expenditure (£5.9 million), which was slightly reduced from 2% in the previous year. He explained that this reduction had taken place at most NHS Trusts.

Mr Etherington highlighted that three significant audit risks had been identified:

1. Management override of controls (inherent risk), to be addressed

by carrying out focussed risk based testing of journals at year end.
2. Revenue recognition presumption of risk of fraud
3. Transfer of community services related to HWLH

Mr Etherington noted that no significant issues had been identified following BDO's audit fieldwork, although an issue had been identified concerning the authorised signatory database during 2015/16 and improvement work was being undertaken.

The Committee noted the External Audit Plan for 2016/17

023/16 Draft Annual Governance Statement

Mrs Wells presented an early draft of the annual governance statement and noted that it could not be finalised until year end. She reported that Mr Townsend had already provided helpful comments on the draft statement.

She asked the Committee to consider whether the Governance Statement should specifically outline any significant control issues at the end of the document. She noted that the definition of what constituted a control issue was open to interpretation, and that the draft, although highlighting concerns throughout, did not contain any identified significant control issues.

Mr Stevens said that he felt that reference should be made to some of the issues faced by the Trust and the Committee agreed that it should be highlighted that there were no significant control issues other than those already outlined within the body of the report.

Mr Etherington explained that the Draft Governance Statement would be audited at the end of year, and that he would be surprised if no significant issues were identified.

Mrs Wells said that she would update the draft Governance Statement prior to submission to the TDA on 23rd April. She asked for any further comments from the Committee on the statement to be sent to her.

024/16 Changes in Accounting Policies

Mr Hoaen explained that his report detailed changes that had been made to the manual of accounts. He explained that these changes would impact on the Annual Report and Accounts for 2015/16.

He noted that one of the required changes was an alternative site valuation and that a report had been commissioned, and had arrived, from district valuers which was being reviewed by finance team. He

explained that the valuation would be subject to audit to ensure that it was accurate. Mr Stevens asked for information about the alternative site valuation to be brought before the Committee in June, prior to sign off of the Annual Report and Accounts. **SH**

025/16 Tenders & Waivers Report

Mr Meikle presented the Tenders & Waivers Report. He reported that there had been a recent slight increase in tenders and waivers, which related to the Quality Improvement Plan. Mr Meikle noted that he was happy that the Tenders and Waivers were appropriate

The Committee noted the Tenders and Waivers Report.

026/16 Information Governance Toolkit

a) IGT Toolkit Report

Mrs Wells reported that the IG Toolkit was due to be submitted on 31st March and that this would be done with a percentage score of 71%. She praised Ruth Paine for the outstanding work she had done in collating the Trust's evidence.

b) IGT Year End Submission 2015/16

The Committee noted the Information Governance Toolkit Update.

027/16 Date of Next Meeting

The next meeting of the Audit Committee will be held on:

Wednesday, 1st June 2016, at 10.00 am in the Committee Room, Conquest.

Signed: ……..

Date: ……

East Sussex Health Care NHS Trust

Audit Committee Annual Report 2015/16

1. Introduction

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the *Audit Committee Handbook*, published by the HFMA and Department of Health.

The Handbook outlines that the remit of the Committee should not be limited to the traditional focus on review of financial issues. It states that "The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an Assurance Framework."

2. Meetings of the Committee

The Committee is chaired by a non-executive with a financial background and membership comprises himself and 2 non-executive directors; thus reflecting and meeting the need for independence and objectivity. The Committee convened on five occasions throughout the financial year and all meetings were quorate. Meetings were also held with auditors in private session.

3. Principal review areas

This annual report reflects compliance with the key duties of the Committee as set out in the terms of reference [attached as Appendix A].

3.1 Governance, risk management and internal control

The Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit opinion, external audit opinion and other appropriate independent assurances and considers that the Annual Governance Statement was consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supported Board approval of the Annual Governance Statement.

Throughout the year the Committee reviewed the Trust's Board Assurance Framework (BAF) and Risk Register. Identifying the principle strategic risks to the organisation allows the Committee to provide assurance to the Trust Board that these risks are effectively controlled and mitigated, supporting the Trust in achieving its strategic aims and objectives.

The Committee has oversight of the completeness of the risk management system. Clinical Units and Corporate representatives attended the Committee on a rotational basis to present their clinical audit plans and risk registers, outlining mitigating actions and demonstrating that risk is becoming increasingly embedded throughout the organisation

The Committee received the Annual Research Governance Report and were assured that the Trust has an effective system in place for managing the research activity and performance to deliver effective governance processes.

Progress against achieving compliance with the Information Governance Toolkit was monitored throughout the year. The Trust successfully achieved level 2 and this was verified by internal audit.

The Committee reviewed the Trust's Annual Quality Account and noted compliance with statutory requirements

3.2 Internal audit

The internal audit service is provided by TIAA Limited. Throughout the year the Committee worked effectively with internal audit to strengthen the Trust's internal control processes. It approved the detailed programme of work and considered the major findings of internal audit and that the Head of Internal Audit opinion and Annual Governance Statement reflected any major control weaknesses.

The Committee noted sustained improvement in responding to Internal Audit recommendations and were assured that appropriate controls are in place.

3.3 External audit

The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. In addition, the Committee received reports and briefings (as appropriate) from the external auditors in accordance with the national requirements. These included; the Annual Audit Letter, Final Accounts Memorandum and report on the audit of financial statements, in addition to briefings on specific issues.

Updates were provided on the implementation of recommended actions arising from audit reviews.

3.4 Counter Fraud Services

Counter fraud services were provided by TIAA Limited. The Trust remains committed to ensuring fraud, bribery and corruption does not proliferate within in the organisation. To support this TIAA have developed a presence within the organisation and have continued to raise awareness of counter fraud.

The Trust is fully compliant with the directions issued by the Secretary of State in 1999, the NHS Standard Contract (2012) and the NHS Counter Fraud and Corruption Manual.

The Committee approved and monitored the counter fraud work plan for 2015/16. A counter fraud representative attends each meeting and updates on actions being taken in respect of investigations.

3.5. Clinical Audit

At each meeting the Committee received a report on progress against implementing the Clinical Audit Forward Plan 2015/16, ensuring that the system in place allowed lessons learnt from clinical audit activity to be shared effectively, and recommendations for improvement to be implemented in a timely manner.

The Chair of the Clinical Audit Steering Group or a nominated representative attended Audit Committee meetings where possible.

At the year end the Trust had not participated in the National Diabetes Audit due to software issues and the Committee were supportive of this being resolved. The Committee continued to emphasise the need to move to a position of reporting on the learning from audits.

The Trust's proposed strategic clinical audit priorities for 2016-19 were reviewed by the Committee. These will be integrated into the Trust's Quality and Governance strategy and within a revised Clinical Audit policy and procedure. It had become apparent during the year that a number of "local" clinical audits were not being completed for different reasons. It was also established that the number of clinical audits being started was rather more than for other provider trusts of a similar size. It was agreed that in future Clinical Audits would need the approval of the Medical Director before they were committed to.

3.6 Management

The Committee challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process included calling managers to account when considered necessary to obtain relevant assurance.

The Committee also works closely with the executive directors to ensure that the assurance mechanisms within the Trust are fully effective and that a robust process is in place to ensure that actions falling out of external reviews are implemented and monitored by the Committee. This included review of tenders and waivers, losses and special payments, declaration of interests, gifts and hospitality, sponsorship and ex gratia payments.

Members of the Committee are also members of other Board sub-committees including Quality and Standards and Finance and

Investment and this provides additional assurance and triangulation of information.

3.7 Financial reporting

The Committee reviewed the annual financial statements before submission to the Board and considered them to be accurate.

4 Review of the effectiveness and impact of the Audit Committee

4.1 The Committee performed its duties during the year as delegated by the Trust Board and mandated through governance requirements, ensuring compliance with and further developing good practice through:-

- continuous self assessment and review of its effectiveness; and
- assessing itself against the checklist in the Audit Committee Handbook.

5. Conclusion

The Committee is of the opinion that this annual report is consistent with the Annual Governance Statement and external audit reviews and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Mike Stevens
Audit Committee Chair

June 2016

Appendix A

Audit Committee Terms of Reference

East Sussex Healthcare NHS Trust

Audit Committee - Terms of Reference

1. Constitution

The Board has resolved to establish a committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Trust Board.

2. Purpose

The Audit Committee will support the Board by critically reviewing governance and assurance processes on which the Board places reliance. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls.

The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.

3. Membership

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members.

One of the members will be appointed Chair of the Committee by the Trust Board Chairman. One member should also be a member of the Quality and Standards Committee and one member a member of the Finance and Investment Committee.

At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee.

Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4. Attendance

Members of the Committee are expected to attend all meetings; if this is not possible then another non-executive director may substitute as outlined in the preceding paragraph.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend the meetings.

At least once a year the Committee should meet privately with the internal and external auditors.

The Chief Executive and other executive directors shall be invited to attend particularly when the Committee is discussing areas that are the responsibility of that Director.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process of assurance that supports the Annual Governance Statement.

The Company Secretary shall attend the meetings to provide appropriate support and advice to the Chairman and committee members.

5. Quorum

A meeting of the Committee shall be quorate if at least two members are present, one of whom shall be the Chairman of the Committee or his delegated nominee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, may form part of the quorum.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committees prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

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

8. Duties

8.1 Governance, Risk Management and Internal control

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

- the clinical governance system of the Trust, including the clinical audit programme

- the information governance system, including requirements under the NHS Information Governance Toolkit

- the research governance system relating to any research activity the Trust may be engaged with

- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the

Annual Governance Statement

- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service

- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis.

- the Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.

- the Committee will be responsible for forming a panel to procure and appoint both internal and external auditors

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission

- NHS Litigation Authority
- Other regulators and inspectors
- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Standards Committee and the Finance and Investment Committee. In reviewing the work of the Quality and Standards Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Standards Committee on how this function should best be utilised.

8.6 Hosted arrangements

The Committee will review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.8 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.9 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

- changes in and compliance with accounting policies and practices.

- unadjusted mis-statements in the financial statements.

- significant judgments in preparation of the financial statements.

- significant adjustments resulting from the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9. Reporting arrangements

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

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 24th February 2016 at 9.30am – 11.30am, in St Mary's Board Room, Eastbourne DGH

Present
Mr Barry Nealon, Non-Executive Director (chair)
Mr Mike Stephens, Non-Executive Director
Ms Jackie Churchward-Cardiff, Non-Executive Director
Mr David Meikle, Interim Director of Finance
Mr Philip Astell, Deputy Director of Finance
Mr Richard Sunley, Acting Chief Executive
Mrs Pauline Butterworth, Acting Chief Operating Officer
Dr David Hughes, Medical Director

In attendance
Gemma Lawrence, PMO Programme Manager
Hayley Barron, Senior Project Manager
Michele Elphick, Pathology Project Executive
Mr Garry East, Assistant Director for Delivery & Performance
Ms Miranda Kavanagh, Non-Executive Director (observing)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. No apologies had been received.	**Action**
2.	**Minutes of Meeting of 27 January 2016** The minutes of the meeting held on 27 January 2016 were agreed as an accurate record.	
3.	**Matters Arising** (i) PMO Project Update Ms Lawrence, Ms Barron and Mrs Elphick were welcomed to the meeting to present an update on projects. The Committee received an update on progress on the proposed implementation of the following key projects due to be implemented in 2015/16.	

- Vital PAC patient bedside monitoring
- Community and Child Health system – overview and phase 1
- Community and Child Health system – phase 2
- Electronic Document Management
- Clinical correspondence 2015/16
- Managed Print Service
- Windows 7 / Office 2010 migration
- Pathology Managed Equipment and Rationalisation – more detailed highlight report to follow
- Health Records Service Improvement
- Oasis PAS Hardware Upgrade
- GS1 Programme
- PACS Remediation Project

The following key issues were highlighted:

VitalPAC
This project had ended, however it was agreed that this would remain on the project list and Ms Lawrence would add the real time bed state option paper to it so that progress could be monitored. Ms Lawrence would liaise with Clare Lippiatt and Mrs Butterworth to ensure that this is finalised. **GL/PB**

Community & Child Health
Project extended by 6 months to September 2016 resulting in revenue pressures. Concerns raised by the Committee over the pace of this project. It was agreed to invite Andy Slater, Project Executive, to the next meeting for further discussion on this project. **DM**

GS1 Programme
Ms Lawrence confirmed that a GS1 Programme Board was scheduled for 23 March 2016. Further information on the position of this project would be available in May and an update would be provided at the May 2016 Finance & Investment Committee Meeting. **GL/AS**

Managed Print Service
Mr Meikle had received an update from the Project Manager explaining that due to tendering constraints, the full business case would not be available until the June 2016 Finance & Investment Committee.

Pathology Managed Equipment and Rationalisation
Ms Barron provided the Committee with a detailed report. It was noted that the contract had been agreed in principle. The financial model and implementation plan was being finalised by Roche and would be attached to the contract ready for signature, anticipated to be ready by 4 March 2016, subject to TDA authorisation. Evidence of two TDA conditions sent to TDA – awaiting feedback. Also awaiting

	letter from Trust Auditors to evidence that the final condition was being met. The Estates plans were on schedule. Estates works had commenced on both sites. Phase 2 was currently out to tender, closing on 29 February 2016. The Trust was awaiting feedback from Roche regarding the implementation plan and final version of the financial model. ***Health Records Service Improvement*** Rationalisation of health records storage progressing. Options discussed as part of the business case reviewed at Senior Leaders forum on 23 February 2016. Detailed business case to be presented to March Finance & Investment Committee and to the April Board Meeting. Ms Kavanagh asked if a benefits realisation exercise takes place once the project is closed. Ms Lawrence said that this did not happen routinely, however this was something that had been identified as a gap. Following discussion it was agreed that the Project Executive for each project should be made accountable for the benefits realisation as one of the stages of the project and that closed projects should remain on the list until this happens and they have reported to the Business Development Group. It was agreed that the PMO team would feed back to the Project Executives following today's meeting and where the Committee required further information on a project, the Project Executive would be invited to attend the Committee to give an update. <u>(ii) Grip & Control Measures</u> Mr Meikle reported that the Trust continues with grip and control measures within the organisation. The objectives are to: • Improve the I&E position over short to medium term - Ensure controls are in place and effective – general, nursing agency, medical agency - Agree improvement plan by Clinical Directorate and move to delivery - Support Directorates in delivery and improved reporting - Agree opportunities for improvement in Procurement and Pharmacy including PBR excluded drugs • Establish management rhythm and processes for improved control - Daily and weekly reporting - Executive reporting - Improved BI and reporting	**GL/ Liz Fellows** **GL**

- Identify and effect short term improvements on key support processes
  - HR (recruitment, holiday management, maintenance of bank)
  - E-Rostering
- Review current CIP delivery mechanisms and identify opportunities
- Review plans for income risk and cash flow/ WC measures
- Review Projects and Programmes to see where budgets can be reclaimed and overrun risk mitigated
- Align short term improvements with current management, planning and performance review processes to establish as business as usual by 30 June 2016.

The areas of focus are:

- Agency usage against targets, reflecting capped agency rates. In addition bringing into play consistent and timely use of health roster.
- CIP against targets and cadence, developing control and accountability
- HR processes timelines of recruitment, vacancy progress and identifying new ways of working
- Procurement, control or ordering including pharmacy
- Lord Carter delivery against targets

It was agreed that the Committee would receive a regular update on progress on the implementation of the actions.

(iii) HWLH Stranded Costs

Mr Meikle presented the Committee with a paper updating them on the position on the stranded costs facing the Trust after the loss of the HWLH community services contract.

Since the last report, further work had continued to analyse the stranded costs and identify the areas where these costs fell and potential mitigations. In the light of the current business planning process and CIP plans, the Trust was investigating whether there was the ability to increase the CIP targets against these areas.

The stranded costs were split showing indirect costs apportioned across the main areas. The costs needed to be reviewed to understand the impact of the loss of community services as there were potential savings within these. It was agreed that these costs would need to be monitored.

It was proposed that:

	1. As part of the business planning and CU challenge, the areas that might have been directly impacted upon the service change are reviewed and where necessary, budgets are reduced. 2. Assume that for the majority of overheads that the stranded costs are assumed within overall level of CIPs 3. Continue to discuss with HWLH CCG the possibility of short term (16/17) financial support to mitigate the costs (iv) Business Planning Update 2016/17 This was discussed under agenda item 6 below. (v) Urology Service Review Mrs Butterworth had received a list of urology requirements from Mr Garnett and confirmed that she was working with Mr Hardwick to look at specific issues. It was agreed to review this at the March Finance & Investment Committee. Urology had been invited back to the April 2016 meeting to present the progress against their action plan. (vi) Capital Programme update A capital programme update was provided under agenda item 4 below.	**PB**
4.	**Integrated Performance Report – Month 10** **& Capital Programme update** Mr East presented the Committee with the Integrated Performance Report for month 10 (January 2016). The following key highlights were noted: • RTT incompletes continue to meet the 92% standard with a final figure of 92.1%. • Diagnostic performance did not meet the < 1% target in January. The final position was 3.81%. • A&E performance remains challenged and under the target. • Cancer targets remain challenged with only the 31 day standard being achieved although January showed improvement on December's position. Mr Meikle presented the Finance Report at month 10. It was noted that the Financial performance at month 10 was a run rate deficit of £4.1m which was £2.3m adverse to plan. This has increased the year to date deficit to £40.6m, which is £11.1m greater than plan.	

	The impact on the forecast outturn of this deterioration in performance is currently being assessed, alongside any potential mitigation in actions that will recover the position. Any mitigation would ensure that patient safety and quality are not compromised through a Quality Impact Assessment review. Mr Meikle gave an update to the Committee on the workforce usage at month 10. The Committee reviewed the 2015/16 CIP performance by theme and it was agreed that the back office and income generation should be congratulated on their CIP achievement. The Chairman asked for a progress report against the Estates and Facilities CIP target for the current year. The Committee received an update on the current performance of the capital programme which reflected the revisions made by the CAG (Capital Approvals Group) at its meeting on 12 February 2016. The Committee noted the current performance of the capital programme, the significant risks arising from the deferral of capital schemes in order to bring the capital programme into balance and the further revision of the capital programme will be required by the Capital Approvals Group in order that the Trust does not breach its capital resource limit (CRL) at 31st March 2016. It was noted that the CAG were meeting on a fortnightly basis during the remainder of the financial year in order to deliver a balanced position as at 31 March 2016. **Action** **The Committee noted the Performance, Finance and Workforce update at month 10, and also noted the current performance of the capital programme.**	**DM**
5.	**2015/16 Forecast Outturn** Mr Meikle presented the Committee with some slides and drew their attention to the clinical units forecasts taking the run rate for the first 10 months and projecting forward at month 11 and 12. The following key messages were highlighted: • In month 10 (January 2016) the Trust generated a £4.1m deficit, £2.3m greater than plan • This had increased the year to date deficit to £40.6m, £11.2m greater than plan. • Key drivers of the deteriorating performance were: increasing agency costs, escalation beds, quality improvement plan implementation costs and CIP slippage.	

	• The forecast out turn had been updated this month to a £48m deficit by year end. The following recovery in year actions were noted: • Continued implementation of FD approval for all overtime. • Continued implementation of FD approval for all non-clinical vacancies. • Implementation of prior approval for all agency commitments: - Establishment of a weekly temporary workforce usage review - Establishment of a bi-weekly Temporary Workforce Review Group with a wide remit to review all aspects of temporary workforce spending including deep dives into specific areas of concern • Establishment of a monthly Efficiency Improvement Group • Freeze on non-essential procurement • Continued discussions with the commissioners re additional income (Healthy Hastings, QIP support, stranded cost support, Winter funding) **Action** **The Committee noted the 2015/16 Forecast Outturn & Downside Case**	
6.	**Business Planning update 2016/17** Mr Meikle tabled a waterfall slide showing the movement from the 2015/16 outturn at £48m deficit to a planned budgeted deficit in 2016/17 of £47.7m The Committee reviewed the waterfall diagram in detail, analysing the various components of cost savings and cost pressures. **Action** **The Committee noted the planned deficit of 2016/17 and agreed to review further at next month's meeting.**	**DM**
7.	**Coding Review** Mr Meikle presented a paper summarising some of the challenges that the Clinical Coding Department have been facing. It was noted that an external review of the Clinical Coding department has been requested The scope of the review is to: • Review the current structure and establishment of the team	

	and, taking into account local and national drivers and constraints, recommend a sustainable solution for recruitment and retention. • Review the current working and coding practices of the team and make recommendations for further improvement. • Review external reports regarding the quality of the coding within the trust and the recommendations for assurance. • Review the mitigating actions in place for assurance purposes and make any further recommendations. • Review current trial projects and make recommendations for further clinical unit / clinician engagement. • Review the current action plans and audit log for assurance and make further recommendations. • Review the depth of coding, the level of comorbidities and any other key data sources and track any changes over time against the possible impact on mortality statistics Proposals for the review have been requested and a decision on procurement will be made once these are received. An interim report will be provided to the April Committee meeting with a final report due in May. **Action:** **This Committee noted that an external review of Clinical Coding has been requested and an interim report will be provided at the April Committee meeting.**	**DM**
8.	**Procurement Quarterly update** Mr Astell provided the Committee with an update on the progress within the Procurement function in the delivery of the Trust's cost improvement programme and improving compliance levels through proactive engagement with cross-functional stakeholders. He presented a paper providing assurance that the next iteration of the Procurement Strategy will be aligned with the procurement related recommendations made in Lord Carter's final report including the roll out of the 'Procurement Transformation Programme'. The Committee noted the current tenders in progress and the contracts awarded and associated savings During Q4 the team will focus to deliver savings through product switching, supplier rationalisation and by securing additional rebates from suppliers. It was noted that the Procurement team had delivered cash savings of £1.8 million in the current year to date against its annual CIP target of £2 million. In addition, the team is currently working on 10 projects	

	which are likely to deliver additional cash savings both during the current and next financial year. The Chairman raised the issue of the review of the cleaning service that arose from the market testing programme and asked for an update on progress against plans that were put in place. **Action:** **The Committee noted the progress made against the target and key metrics.**	**CH**
9.	**Tenders Schedule and Business Cases** The Committee received a schedule providing up update on current tenders as at 16 February 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders in the pipeline: • Community Diabetes Service for Brighton & Hove and High Weald Lewes & Havens CCGs. • Non-Invasive Ventilation Service • Direct Access Hearing Services With regard to the Direct Access Hearing Services tender, it was noted that an AQP had been received with a deadline date of 3 March 2016. Support from Strategic Partnerships had been secured. No business cases had been approved by SLF since the last report. The Trust had now entered the annual business plan process and therefore only cases relating directly to patient safety, or those already in process will be reviewed. **Action** **The Committee noted the update on tenders and business cases.**	
10.	**Business Cases for Review** There were no Business Cases for review **Action** **There were no Business Cases for review.**	
11.	**2015/16 Work Programme** **2016/17 draft Work Programme** The work programmes for 2015/16 and 2016/17 were noted. It was agreed that the Committee should review the Laundry Service	

	again and that this would be added to the work programme. It was suggested that the Committee receive assurance on the budget setting process. The Chairman indicated that this would be covered in the Board Business Planning session on 16 March 2016. **Action** **The Committee noted the work programmes for 2015/16 and 2016/17.**	**CH**
12.	**Date of Next Meeting** The next meeting will take place on Wednesday 30 March 2016 at 9.30am – 11.30am in the Committee Room, Conquest	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 30th March 2016 at 9.30am – 11.30am, in the Committee Room, Conquest

Present
Mr Barry Nealon, Non-Executive Director (chair)
Mr Mike Stevens, Non-Executive Director
Ms Jackie Churchward-Cardiff, Non-Executive Director
Mr David Meikle, Interim Director of Finance
Mr Richard Sunley, Acting Chief Executive
Dr David Hughes, Medical Director (part)

In attendance
Gemma Lawrence, PMO Programme Manager (for item 3)
Andy Slater, Director of Strategy and Chief Clinical Information Officer (for item 3)
Mrs Alex Graham, Head of Financial Management (for item 6)
Mrs Jo Brandt, Head of Performance & Planning(for item 7)
Mrs Michelle Clements, General Manager, Facilities (for I tem 12)
Mrs Liz Fellows, Senior Project Manager (for item 14)
Miss Chris Kyprianou, PA to Finance Director, (minutes)

1.	**Welcome and Apologies** Mr Nealon welcomed members to the Finance & Investment Committee. Apologies had been received from Pauline Butterworth and Philip Astell.	**Action**
2.	**Minutes of Meeting of 24 February 2016** The minutes of the meeting held on 24 February 2016 were agreed as an accurate record.	
3.	**Matters Arising** (i) PMO Project Update Dr Andy Slater and Ms Gemma Lawrence were welcomed to the meeting to provide a Projects update. At the previous meeting it had been agreed that where detailed information was required on a specific project, the Executive Lead would be invited to attend.	

Community & Child Health

Dr Slater updated the Committee on the position of the Community & Child Health Project.

It was noted that when the Project was initially commenced, it was due to be completed by 31 March 2016. Dr Slater explained that the project had been delayed for a number of reasons. This had been extended by 6 months to September 2016 resulting in capital and revenue pressures.

Stage 1 of the project was complete, which was to move services off PIMS and Clinicom by the end of March 2016, and this delivers some financial benefits.

Stage 2, to finish off any mobile working and migration of services to SystmOne that were started in stage 1, was currently on hold.

It was noted that there was an audit underway to review IT/ infrastructure requirements and a full options paper be written to agree the way forward and potentially a new full business case to request further funding if the agreed option requires this.

It was agreed to look at this again at the next meeting.

VitalPAC

Ms Lawrence confirmed that a VitalPAC options paper had been presented to the last IM&T Steering Group. It was noted that further analysis was required and costs still needed to be scoped.

Ms Lawrence explained that there were issues with going with VitalPAC for bed management.

It was noted that a report had been sent to Pauline Butterworth and Clare Lippiatt was awaiting feedback.

Ms Lawrence confirmed that she had added the benefits to the Programme Report and as requested at the last meeting, this has now been done for all projects.

GS1 Programme

A Programme Board for GS1 was held the week commencing 21 March 2016. It was noted that this Project would be looked at in greater detail at the May 2016 Finance & Investment Committee Meeting.

Health Records Service Improvement

This item was discussed under agenda item 14 below.

	(ii) Grip & Control Measures Mr Meikle reported that the process and systems that were described at the last meeting were still in existence. A further analysis on agency spend and number of beds open had shown that the Trust had managed to maintain costs despite the growing number of beds occupied from October 2016. **Other Matters Arising – Carried forward to April meeting** (iii) Urology Service Review Mrs Butterworth had received a list of urology requirements from Mr Garnett and confirmed that she was working with Mr Hardwick to look at specific issues. It was agreed to review this at the April Finance & Investment Committee. (iv) Integrated Performance Report – Month 10 The Chairman asked for a progress report against the Estates and Facilities CIP target for the current year. (v) Coding Review An interim report will be provided to the April Committee meeting with a final report due in May. (vi) Work Programme It was agreed that the Committee should review the Laundry Service again and that this would be added to the work programme. This had been added to the work programme for July 2016.	**PB** **RS** **DM**
4.	**Integrated Performance Report – Month 11** Mr Sunley presented the Committee with the Integrated Performance Report for month 11 (February 2016). The following key highlights were noted: • RTT incompletes continue to meet the 92% standard with a final figure of 92.2%. • Diagnostic performance did not meet the < 1% target in February. The final position was 2.44%. • A&E performance remains challenged and under the target. • Cancer 2 Week Wait Symptomatic standard achieved with 99.1% in February and although the 2 Week Wait standards remain challenged, it did show considerable improvement with a final position of 92.5% against a target of 93%. The 31 day	

	standard continued to achieve. Mr Meikle presented the Finance Report at month 11. It was noted that the financial performance at month 11 was a run rate deficit of £3.9m which was £0.2m adverse to plan. This had increased the year to date deficit to £44.5m, which is £11.4m greater than plan. The impact on the forecast outturn of this deterioration in performance was currently being assessed, alongside any potential mitigation in actions that will recover the position. Any mitigation would ensure that patient safety and quality are not compromised through a Quality Impact Assessment review. The Committee discussed the Workforce trajectory under agenda item 8 below. **Action** **The Committee noted the Performance, Finance and Workforce update at month 11**	
5.	**5 year Strategic Capital Programme 2016/17 – 2020/21** Mr Meikle presented the Committee with a paper summarising the proposed 5 year capital plan which has been discussed and agreed by the Trust's Capital Approvals Group (CAG) at its meeting on 8th March 2016. The original Capital Plan ("Plan A") was developed based on the scenario that external capital funding of £16.5m was not available to the Trust. Therefore the Trust's internally generated capital of £11.4m per annum has been re-shaped to fund over a period of 3 years the investment of £16.5 in A&E and Radiology. A further paper ("Plan B") was circulated which showed the £16.5m funded through borrowing from the centre with the business case approved and the re-shaped capital programme that would result from the £16.5m coming in. The re-shaped programme focused heavily on the Estates Strategy and the £35m that was required over the period to enact that strategy, and also the developments on A&E and Radiology, including the CT and MRI scanner. These were both in draft and gave the Committee the opportunity to consider the capital funding position and its phasing across the strategic period, and drew the attention of the Committee to the risks associated with limited capital resources. The capital programme had been under severe pressure throughout the 2015/16 financial year with demand for capital expenditure far out stripping available resources. The draft papers presented proposed a plan for 2016/17 and also set out the longer term capital aspirations	

	for the Trust. Mr Meikle assured the Committee that the proposed 2016/17 capital plans were affordable within the provisional Capital Resource Limit (CRL). It was noted that the capital programme is reviewed by the CAG on a monthly basis during the year and if the expected slippage does not occur it may be necessary to carry out a formal mid-year review in order to re assess the over planning margin to ensure the trust meets its Capital Resource Limit (CRL) at 31 March 2017. The Committee felt it would be helpful to have someone from IT attending this meeting. It was noted that Andy Bissenden, Associate Director of IT, was due to attend the April meeting to report on IM&T Investment. Mr Meikle reported that the business case for the £16.5m would be presented to the Finance & Investment Committee in May and to the Trust Board in June, in parallel with the TDA approval process. **Action** **The Committee approved the draft 5 year capital programme recommended by the CAG, noted this included the proposal for new Capital Investment Loans over the planning period and noted that the proposal was to lease all medical equipment in 2016/17.**	**DM** **DM**
6.	**2016/17 Revenue Business Plan** Mr Meikle presented the Committee with a 2016/17 Revenue Business Plan which was still work in progress. This included information on the: • Activity modelling and income assumptions • 2016/17 budget assumptions • Bridge from 2015/16 outturn • Cost pressures analysis • CIP progress Mr Meikle reported that lengthy and detailed contract negotiations with the commissioner had been taking place. It was noted that the commissioners had agreed to move from a cap and collar contract towards a PbR based contract. The Committee noted the move to PbR based acute contract and the reduction of the management support and was supportive of this approach.	

	The Committee received a summary of the cost pressures requiring commissioner funding (not budgeted). The Committee questioned the process of moving towards commissioner support for these developments and received assurance from Mr Meikle that systems and processes were in place. The Committee noted the risks that need to be managed and the mitigations that have been put in place. Mr Meikle reported the following next steps: • Clinical Unit sign up to budget envelopes • Finalisation of CIP programme for 2016/17 • 6th April plan sign off for activity, performance, finance including cash and capital • Submission 11th April to TDA • 13th April retrospective sign off by Board • Savings plans to QIA panel for sign off • 5 year plan submission June 2016 • Contract sign off with CCGs and other Commissioners **Action** **The Committee approved the 2016/17 Revenue Business Plan and noted that this was still work in progress and delegated authority for the Board Chairman and F&I Committee Chairman to approve the submission to the TDA on 11 April 2016.**	
7.	**EBITDA Quarterly Report – Q3** Mrs Brandt presented the Committee with the 2015-2016 Q3 EBITDA statement, the 2015-2016 quarterly EBITDA comparison statement and the Patient Cost Benchmarking opportunity cost statement. The Committee noted: - The 2015-2016 Q3 EBITDA deficit position for the clinical units - The number of service lines that had negative EBITDAs - The 2015-2016 quarterly EBITDA variances. - The effect on the 2015-16 EBITDA of using Patient Cost Benchmarking average unit costs when applied to ESHT inpatient activity for top 5 specialties only. Fines & Penalties were not included within the Q3 EBITDA and the 2015-2016 Q3 EBITDA statement had been reconciled to the Trust's finance report. **Action:** **The Committee noted the EBITDA statement position and recommended that the Committee continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews,**	

	and to return at a subsequent meeting to update on their progress.	
8.	**Recruitment Trajectory** The Committee received an update on vacancies and recruitment plans across the Clinical Units of the Trust. The reduction of the Trust's temporary workforce is a key objective as the Trust strives to increase quality and reduce costs. A robust recruitment plan with specific actions and timelines linked to a reduction in temporary staff is critical in giving the Board assurance that this objective is being implemented. It was noted that the next stage was to include in the trajectories temporary workforce projections to ensure that the total workforce demand is captured and appropriate workforce supply recruited to. **Action:** **The Committee noted the Recruitment Trajectory.**	
9.	**Community Rebasing Project Update** The Committee received an update on the position of Community Rebasing Project. The project was initiated within the Trust in May 2013 with a view to improving the alignment of funding for community services. The purpose of the project is to ensure that the Trust is appropriately reimbursed by each of the new commissioning bodies for the work it undertakes and to help inform decisions (by both the Trust and its commissioners) about the future provision and commissioning of individual community services. It was noted that the project was put on hold from April 2015 and it had been decided to restart it when the current contracting round for 2016/17 had been finalised. The cost matrix for community services would need to be refreshed in the light of the loss of High Weald, Lewes and Havens CCG community services in order to improve the accuracy of the costs associated with the provision of these services. Beyond the initial work on updated costs and assessing affordability, the project will focus on service specifications, the development of 'unit of service' currencies to support service line reporting and, potentially, cost per case reimbursement. Mr Stevens questioned central cost allocation methodology which will be addressed by the Rebasing Project. The Committee received the draft Terms of Reference which were due to be presented Executive Directors Meeting in April.	

	Action **The Committee noted the current position on the Community Rebasing Project**	
10.	**Job Planning update** Dr Hughes provided the Committee with an update on consultant job planning. It was noted that the Clinical Unit (CU) leads and General Managers continued to progress with job planning in their clinical areas and the process was now much more robust. Individual meetings are taking place with each specialty at which their planned activity and requirement for medical staffing is compared to their capacity to meet this demand. Adjustments are then made to job plans as a result of this. Having embedded the new clinical management and leadership structure, the CU Leads are implementing and managing a more rigorous approach to job planning to ensure expenditure remains within budget whilst maintaining high quality services. The majority of all consultants have working job plans, of whom over 80% have already had their job plans negotiated for the year 2015 - 2016 as part of the business planning process against the projected demand. Work is now ongoing to ensure that 2016 – 2017 job plans are reflective of current workload. The Assistant Medical Director – Workforce, with the assistance of the revalidation and job planning team, has been encouraging and working with the CU and Specialty Leads and the GMs to transfer all former job plans on to the new template. There is a now a firm grip on the timing of these job planning meetings and pressure is being escalated with weekly monitoring of the progress of individual consultant's job plans. The Committee reviewed the update on the job planning compliance and their trajectories provided by each Clinical Unit. Dr Hughes reported that the target was to have 90% completed in the new format by September 2016. The Committee asked for a review of the trajectories for the September meeting. **Action** **The Committee noted the Job Planning update.**	**DH**
11.	**Lord Carter update** There was no further update and this item was therefore deferred to the April Committee Meeting.	

12.	**Housekeeping/Cleaning Modernisation Plan** Mrs Clements was welcomed to the Committee, to provide an update on the Housekeeping / Cleaning Modernisation plan as requested at the last meeting. She gave a progress update and outlined the activities that had had an impact on the initial agreed outcome and efficiency realisation. On 2 June 2015 the Trust Board had agreed to the recommendations that market testing for Soft FM services be suspended for a minimum of two years to allow the in house teams to progress with on-going Service Modernisation plans. The Cleaning / Housekeeping Modernisation plan was one of a number of schemes designed to increase productivity and realise further efficiencies. The review identified the requirement to change staffing rosters and realign staff working hours. All rosters had been realigned to ensure that the staffing levels were at an appropriate level to be able to meet the agreed service level specifications. The Committee noted the broad principles that were used to develop the Modernisation plans. The aim was to have full staff realignment in place by 31 May 2016. It was noted that to meet the Trust service requirements the initial forecasted efficiencies will not be realised. In the main this related to pressure from additional support requirements / continued use of "open" wards which were supposed to have been closed. The Committee acknowledged the work undertaken in modernising the Cleaning and Housekeeping services within the Trust, and the ongoing activity pressures and CQC/NSC requirements and impact on Housekeeping / Cleaning services. The Committee supported the realignment of budget resources to meet activity/service needs to include continuation of an enhanced cleaning team and requirement for additional support to Gardner / Decham wards. It was agreed that Mr Meikle would review budget allocation for 2016/17 **Action** **The Committee acknowledged the work undertaken and supported the realignment of budget resources to meet the activity/service needs to include continuation of enhanced cleaning team and requirement for additional support to Gardner and De Cham Wards.**	

		DM
13.	**Tender & Service Developments** The Committee received a schedule providing up update on current tenders as at 21 March 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders in the pipeline: • Non-Invasive Ventilation Service • Direct Access Hearing Services Mr Meikle reported that notification had been received the previous week of a further tender on Elective Services in High Weald. It was noted that the Making Every Contact Count business case was agreed at the Senior Leaders Forum on 14 March 2016. This is fully funded by the CCG. **Action** **The Committee noted the update on tenders and business cases.**	
14.	**Business Cases for Review** (i) Direct Engagement Model & Weekly Payroll Service Mr Meikle presented a business case seeking approval for a direct engagement and weekly payroll outsourced service. The estimated savings based on a 60% conversion (not all locums will agree to the new arrangements) would be £0.6m in a full year. Depending on the scale and scope, (including other staff types), savings of £1m is possible.. The Temporary Workforce Reduction Group approved the initial Project Initiation Document 4 March 2016. The Committee agreed the business case and procurement route. **Action** **The Committee agreed that following an evaluation of the short listed suppliers, The Trust procure a temporary workforce solution that delivers a direct engagement model, a managed local bank and an outsourced weekly payroll for bank staff.**	

	(i) Health Records Improvement Programme - Centralisation of Health Records Mrs Fellows updated the Committee on the findings and recommendations of the independent review of the plans to centralise the Health Records library at Apex Way, Hailsham, with satellite services at the acute sites. Over a number of years, issues with the Trust's Health Records service had been identified both in terms of the ability to provide an effective service and significant health and safety concerns. One of the key projects to address this was the centralisation of the health records library. Concerns had been raised by staff regarding centralisation and therefore the Trust had commissioned an independent review of the plan. The paper presented provided an overview of the independent review and as a result, sought approval of the centralisation of the health records library. Mrs Fellows sought approval of the Committee for the additional investment in an accelerated archiving/iFIT tagging programme to ensure maximum benefit was gained from the centralisation The Committee noted the risks and implications of not proceeding with the centralisation of health records and supported the continuation of this project and the additional funds required. **Action** **The Committee supported the continuation of the project to centralise the health records library, retaining clinic preparation and satellite services on both acute sites, and approved the additional funds required.**	
15.	**2016/17 Work Programme** The Committee noted the 2016/17 work programme. **Action** **The Committee noted the work programmes for 2016/17.**	
16.	**Date of Next Meeting** The next meeting will take place on Wednesday 27 April 2016 at 9.30am – 11.30am in St Mary's Board Room, Eastbourne DGH.	

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on Wednesday 27th April 2016 at 9.30am – 11.30am, in St Mary's Board Room, Eastbourne DGH

Present
Mr David Clayton-Smith, Chairman, (for Barry Nealon, Chair)
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mr Philip Astell, Acting Director of Finance
Dr David Hughes, Medical Director (part)

In attendance
Mr David Meikle, Financial Consultant
Mrs Jo Brandt, Head of Performance & Planning(for item 7)
Mr Steve Garnet, Clinical Lead - Urology
Ms Claire Bishop, Service Manager – Urology
Miss Chris Kyprianou, PA to Finance Director, (minutes)

001/16	**Welcome and Apologies** Mr Clayton-Smith welcomed members to the Finance & Investment Committee. Apologies had been received from Barry Nealon, Jackie Churchward-Cardiff and Pauline Butterworth.	**Action**
002/16	**Minutes of Meeting of 30 March 2016** The minutes of the meeting held on 30 March 2016 were agreed as an accurate record.	
003/16	**Matters Arising** (i) Community & Child Health Dr Bull reported that work was continuing around the fact that SystemOne was currently unfit for purpose and Dr Slater was working with Andy Bissenden on what the proposals were to address that issue. It was noted that the GPs were moving to EMIS and the Trust needed to ensure that it could link up to EMIS, and this would form part of the digital roadmap that was being developed by Dr Slater and Andy Bissenden. (ii) VitalPAC	

	At the last meeting Ms Lawrence explained that there were issues with deploying VitalPAC for bed management. A report had been sent to Pauline Butterworth and Clare Lippiatt was awaiting feedback. It was agreed to follow this up and ask for an update to be sent to the Finance & Investment Committee.	**PB**
	(iii) Urology Service Review This item was discussed at depth under agenda item 8 below.	
	(iv) Integrated Performance Report – Month 10 The Committee had asked for a progress report against the Estates and Facilities CIP target for the current year. Mr Astell read out an email received from Mr Hodgson, Associate Director of Estates & Facilities, which explained that, although on paper they had failed to deliver £750K out of the £1,500K CIP for FY15/16, the projected overspend was circa £500, so in essence an additional £250K had been delivered by virtue of one-off savings initiatives etc. The Committee requested a more detailed report for the May meeting.	**CH**
	(v) Coding Review Mr Meikle reported that the Coding Review had started and a report would be available for the May Meeting.	**DM**
	(vi) 5 year Strategic Capital Programme 2016/17 – 2020/21 Discussion had taken place at the last meeting on representation from IT at the Finance & Investment Committee. It had been agreed that Andy Bissenden, Associate Director of IT, would attend the April meeting to give an update on IT Investment; however this item had now been deferred to the May Meeting.	**PA**
	(vii) Community Rebasing Project Update It was noted that the draft Terms of Reference for the Community Rebasing Project were due to be presented to the Senior Leaders forum on 9 May 2016.	**PA**
	(viii) Grip & Control Mr Meikle assured the Committee that the Grip & Control Mechanisms that had been put in place were continuing. It was noted that there was an information flow issue which was being picked up with the Business Intelligence team. However, the daily, weekly and fortnightly controls that were put in place were still continuing. The next steps were to look at the Procurement Service.	

004/16	**Integrated Performance Report – Month 12** Due to the late circulation of the Integrated Performance report, and the absence of anyone available to present the report, it was agreed to focus on the Finance section, and that if Committee members had any questions relating to the Performance section, to email Mrs Butterworth direct. It was noted that the Integrated Performance Report is reviewed at a number of various forums, including the Trust Board, the Senior Leaders Forum, QIPP Review, CCG Review, TDA Review and the Finance & Investment Committee. Discussion took place on whether certain sections of the report could be reviewed at certain relevant Committees. Dr Bull said that the report was well compartmentalised and suggested the Board be asked if the following Committees could focus on the following relevant sections: Section 1 – Performance - Quality & Standards Committee Section 2 – Finance - Finance & Investment Committee Section 3 – Workforce - Workforce Committee Mr Astell presented the Finance Report at month 12. The Committee noted that in month 12 the Trust incurred a deficit of £3.5m, which was £1.4m adverse to plan. The main cause of the adverse position in the month was a £2.7m overspend on operating costs, of which £1.7m related to pay. The agency spend in the month was £2.7m, which represented a continuation of the rising trajectory of agency costs over the last year. Improvements in recruitment and control should see the agency bill falling as the Trust moves into 2016/17. The adverse variance on expenditure in the month was partly offset by a £1.1m favourable variance on income. The final outturn position for the year (subject to audit) is a deficit of £48m, as previously projected. This was £12.8m adverse to the revised plan of £35.2m. The total overspend on pay was £11.6m and the agency bill for the year was £25.8m. Income was very marginally ahead of plan. Mr Astell tabled an updated Income and Expenditure summary and an updated Activity & Income summary. It was noted that the total income in the month was £31.4m against a plan of £30.2m, a favourable variance of £1.2m and brings the outturn position to £0.1m above plan. The Committee noted that the annual accounts were submitted by the deadline of 21 April 2016 and the Finance Department were currently working with the auditors.	**AB**

	Action **The Committee noted finance update at month 12 and would email Mrs Butterworth on any questions they had on the Performance Section of the report.**	
005/16	**Flash Report – Month 12** It was noted that this item had been superseded by the finance section within the Integrated Performance Report (discussed under item 4(i)) above.	
006/16	**Business Plan 2016/17** Mr Meikle reported that the 2016/17 Business Plan was submitted on 18 April 2016 with the deficit at £48m. No feedback had been received from NHSI. It was noted that the Trust had subsequently completed contract negotiations with the host commissioner moving to a PbR contract for acute services while maintaining a block contract for Community Services. It was agreed that details of the quantifiable cost of the junior doctors' strike would be reported in due course. Mr Astell stated that he had already been asked to agree for extra sessions to be provided to replace lost activity. Mr Bull asked for assurance that the Trust is not paying consultants above the BMA's guidelines. Any such requests should be subject to authorisation from the Director of Finance and the Medical Director. The Committee formally complimented Mr Meikle and Mr Astell on the contract negotiations as this had been a difficult round with hard work and compromise on both sides, but maintaining good relations and flexibility. **Action** **The Committee noted that the Business plan had been submitted and that the Trust had completed contract negotiations.**	**PA**
007/16	**Capital Programme Report for Year Ending 31 March 2016** The Committee received an update on the provisional capital outturn for 2015/16. It was noted that the 2015/16 capital programme was initially planned on the assumption that the Trust would have available two main sources of funding :- • Exceptional public dividend capital (PDC) for the planned clinical strategy £17.4m. • Internally generated capital funding planned within the limit of	

	depreciation £11.8m The clinical strategy additional resources were not approved during 2015/16, leaving just the core programme of £11.9m. It was noted that the Trust was facing a number of risks in relation to the limited capital resource available in 2016/17. The level of funds available to the Trust in recent years has constrained spending on backlog maintenance, medical equipment and IT infrastructure, which has resulted in delays in the replacement of essential equipment and a consequent increase in maintenance expenditure. The successful implementation of the IM&T strategy will require significant resources in future years. The Trust met its Capital Resource Limit (CRL) for the year with an underspend of just £5k. The Capital Approvals Group (CAG) will continue to review and monitor the capital programme on a monthly basis, paying particular attention to the risks associated with limited capital. It was noted that the Trust was preparing a business case for a £16.5m capital loan to fund unspent quality and safety concerns and ease pressure on tightly constrained internal capital resources Mr Meikle reported that it had been agreed by the Board that the Trust would continue to finalise the 2016/17 capital programme during April with a view to seeking Board sign-off in May. Dr Bull reported that that the following items should be prioritised: • mixed sex accommodation • Radiotherapy development • Radiology equipment Mr Meikle confirmed that these items were currently progressing and that Mr Hodgson was looking at options. Mr Meikle agreed to provide an update at the Executive Directors Meeting on 3 May 2016, and a plan for 2016/17 would be presented to the May Finance & Investment Committee. **Action** **The Committee noted the provisional year end outturn of the capital programme and the capital risks facing the Trust. A Plan for 2016/17 will be presented to the next meeting.**	**DM**
008/16	**Review of Capital Programme Outcome** This item was deferred to the May meeting. **Action** **This item has been added to the work programme for May 2016.**	

009/16	**Urology – Progress Against Action Plan**
	
	Mrs Brandt presented the Committee with an update on the action plan following the presentation of the Urology Service Review to the January 2016 Finance & Investment Committee meeting.
	
	Urology was chosen for a service review because it had an adverse Q2 2015-2016 EBITDA variance of -29% and a deficit of £1.8m. Recommendations were made following this review and the Urology management team had been asked to present an update on the progress made to date.
	
	The summary of findings was as follows:
	
	• 2014-15 Reference Cost Index was 121
	• Net loss at Q3 2015-16 was £-2.6m with the EBITDA improving by 2% to -27%. Loss related to inpatient activity only.
	• ESHT average unit cost for Urology inpatient activity (all pods) was £900 higher than the Patient Cost Benchmarking (PCB) average.
	• Cost outliers for ESHT compared to PCB were medical staffing, operating theatres and ward costs.
	• Average length of stay at ESHT of concern for non-elective inpatient activity, and was approximately 1 day longer than the PCB average. This correlated with the 2014-15 TDA reference costs benchmark data.
	• There was evidence of poor theatre utilisation.
	• Local tariff agreement negotiation with Commissioners must be secured to cover the robotic limited life consumables which currently cannot be recharged.
	• Urology wards had a high level of medical outliers.
	• Process for the coding of outpatient procedures was not satisfactory and led to a loss of income.
	• Low daycase rates
	
	The Committee noted the following actions to date:
	
	• Utilisation of pooled theatre lists – looking to use this list more creatively
	  - Changed Consultant ownership
	  - Cover Consultant annual leave with consultant as opposed to Registrar
	  - Move flat list work to Uckfield
	  - Reduce the length of the pooled session where Consultants have to travel between sites.
	• Theatre cases cancelled on day of surgery due to UTIs – GPs to test 3 days before surgery date. Letter issued to patient by Firle ward and highlighted to CCG
	• A review theatre lists has started. Friday morning is a teaching	

	list and therefore will take longer • Stone patients now put on a virtual outpatient list. Patients get direct referral into a stone clinic and are reviewed by a consultant and radiologist. • Business Case for the Urolift procedure versus current TURPs has been written - length of stay reduction as activity moves from Elective to Daycase plus theatre minutes. Consumable cost covered by the tariff. Training to take place on the 20th April • Met with Radiology General Manager regarding interventional radiology issues. Response was that with the current level of vacancies of interventional radiologists that this would not improve in the short term. Main area of concern was CT guided cryo ablation but the activity levels are relatively small • Two new service managers in Surgery have been recruited, thereby releasing Claire Bishop to concentrate solely on Urology Mr Garnett explained that the Trust used to be able to undertake day case surgery in a day case setting at Conquest and Uckfield but this had been stopped and the day case surgery was now taking place in main theatres. As part of the turnaround plan, everything was centred around main theatres. Urology were told that it would not affect their costs, however, they were now being penalised for using main theatres for doing day cases. Mr Bull said that this was counterintuitive and would be picked up at the Surgical Review. Mr Garnett made reference to the urolift procedure that would allow the Trust to do prostate surgery as a day case procedure rather than a 3 night stay. This had been raised at a previous Committee meeting and it was agreed that this should go ahead. However there were delays in agreeing the business case. Mrs Brandt explained that there were some questions that had been raised in the business case which they now had answers to, and this was currently being finalised. The next stage of the process would normally be for the business case to go to the Business Development Group but as this had already been agreed by the Finance & Investment Committee in January, it was agreed that this would not be necessary. It was noted that there were no capital costs, and that the reduction in tariff would be offset by a reduction in cost. Dr Bull queried the quality impact assessment on cases such as these. He emphasised the need to be really clear about the QIA. Mrs Brandt highlighted the importance of benefits realisation as part of the business case process. Discussion took place on interventional radiology issues. It was agreed that the division would need to identify what the generic issues were that were not within their control and share these through the Efficiency Improvement Group. One issue was A&E sending	**AB**

	patients directly to the urology wards in Eastbourne where they were not always being assessed by a urology registrar. Sometimes these patients were in fact surgical patients but could not be treated as such at the DGH as Hastings is the hot site for surgery. This was impacting on length of stay. Dr Bull said that he was pulling together a much wider discussion and meeting so that everybody was aware of the some of the work that has been going on with an external review that has been done of the urgent care flow though the hospital. It was noted that there were a number of things that were clearly not helping and there will be a full discussion with all the specialty leads and others to understand what that will be. Mr Garnett said that Mrs Brandt and Ms Bishop had done a lot of good work on the review which had highlighted a number of issues and this had been very helpful. Mr Garnett said there was a non elective length of stay issue where patients are treated acutely, and to avoid putting in a stent and sending a patient home to come in for a further procedure at a later stage, they are kept in, for one treatment, which may mean that they may need to wait a few days before getting them into theatre. It appears that they have a longer length of stay, but this is better for the patient. It was noted that discharging can also be a real problem and the division is going to try something along the lines of the orthopaedic discharge process. Ms Bishop said that they had started looking at the Specialist Nurse roles too. There was a ward based nurse who could be used more creatively around discharging. Ms Bishop said she would like to do a non elective LoS analysis and look towards some more nurse led services that would help to discharge patients quicker. Mr Astell asked whether the clinical unit were confident that they were reporting co-morbidities in the notes. Ms Bishop said that they needed to look at coding analysis and would be requesting a coding audit around outpatient procedures. Mr Garnett reported that for elective procedures there was a dedicated coding sheet that is competed in theatre but felt this was less well gathered for non elective procedures. Mr Garnett reported that Urology was now the surgical pelvic cancer site for Sussex and therefore any major pelvic surgery for Brighton and Eastbourne patients were done at Eastbourne. Mr Garnett provided Mrs Butterworth with a list of things that were required in order to support this prior to the agreement to treat BSUH patients, at the January meeting, which she had agreed to look into. This involved admin support, some ERAS admin support and some	**PB**

	development of high level care on the ward. It was noted that the Service Level agreement had still has not been agreed between the two Trusts. The business case which stated how much additional nursing and admin support was required had not yet been agreed. The original business case that had been written prior to the transfer of the BSUH patients to ESHT could not currently be located and Mrs Brandt agreed to look into this. With regard to the SLA ESHT are awaiting a response from the Contracting team at BSUH. Ms Bishop gave an update on the potential savings opportunity of £2.4m that were highlighted in the Lord Carter review. Mrs Brandt explained that Mr Garnett felt frustrated, as Service Lead, as he was unable to implement changes in nursing as this was not an area within his control, it is managed by the Head of Nursing. The Chairman asked if there was a mechanism where they can look at the whole pathway rather than individual components. Mr Bull said that there should be an opportunity to consider each of the services in the Clinical Unit reviews. **Action:** **The Committee noted the actions that Urology had put into place to improve its EBITDA statement position, at the same time improving quality and recommended that the work on the focus points highlighted in the Review continued. It was noted that the Efficiency Improvement Group (EIG) was responsible for monitoring the progress made on the focus points actions. Where support is required to Urology from members of the EIG to enable the actions to progress it is given. The Committee would continue to invite individual clinical specialties to attend the Finance & Investment Committee, to present the outcome of their deep dive reviews.**	**JB**
010/16	**2014/15 Education & Training Cost Collection** Mrs Brandt updated the Committee on the mandatory Department of Health Education & Training Cost Collection and presented the published 2014-15 Education Cost Indices for East Sussex Healthcare NHS Trust. It was noted that the Education and Training cost collection exercise was a nationally mandated collection of the costs to NHS providers in England of delivering clinical placements. The costs, reflecting the financial year, were first collected by the Department in 2013-14 and are now collected on an annual basis. All 230 NHS providers within the scope of the collection exercise returned data by the agreed deadline.	

	The data being collected as part of the annual collection exercise will, in time, be used to support the replacement of the current transitional tariffs with a more permanent set of tariffs that reflect the actual costs of the placements. It is unlikely that the Department of Health will use the outcomes of the 2014-15 collection to make any significant changes to the transitional tariffs. Decisions around potential changes to the tariffs to reflect the outcomes of the 2014-15 exercise are expected in December 2015, however any changes to the tariffs to reflect the outcomes of this exercise will be restricted to the redistribution of the existing funding envelope. Only at the point where a fully integrated collection of costs for both service and education and training is undertaken, will the Department understand any potential requirement to change existing budgets to reflect any cross-subsidisation. The data collected in the 2014-15 exercise will also be used by Health Education England (HEE) to help establish a set of currencies which are realistic and appropriate for payment The following key issues were noted: • There is a good level of engagement with education leads • The quality of information received from education leads is improving • Ideally, more detail for differing costs between course years • Consultant questionnaire response rates needs to be higher • Clarity needed on certain cost components • The 2014-15 guidance was better than that for 2013-14 • 2015-16 guidance has been issued but templates not available until May 16 • Benchmarking analysis of the 2014-15 submission is on-going Mrs Brandt reported that although the Junior Doctors' contract will not affect the 2015-16 collection, it would appear to place a greater emphasis on the educational needs of the doctors in training and will include contractual terms and additional pledges from Health Education England (HEE). Mrs Brandt asked for some help in raising the response rates for the Consultant questionnaires. Out of 130 questionnaires sent out by the Medical Education Manager, only 13 were returned. Dr Hughes said he would liaise with Mr Shuber & Mr Zaidi to assist to raise the profile of the collection within the Trust. Dr Hughes reported that this would be reviewed at the Education Committee. Dr Hughes also stated that the completion of consultant job plans must identify those SPAs that relate to education and training. Mrs	**DH**

	Brandt said that she had worked with the medical revalidation team and that the consultant job plan templates had been amended to assist with this issue. **Action** **The Committee noted the Education & Training Cost Indeces and agreed to assist in raising the profile of the collection within the Trust and securing consultant engagement.**	
011/16	**2014/15 Reference Cost Audit** Mrs Brandt presented the Committee with the draft findings and overall conclusion of the audit undertaken by PWC on behalf of Monitor of the 2014-15 reference cost collection submitted by East Sussex Healthcare NHS Trust. The purpose of the audit was to provide assurance that reference costs had been prepared in accordance with Monitor's Costing Guidance. East Sussex Healthcare NHS Trust was one of the selected providers being audited in 2015-16 to improve the quality of cost information used to set national and local prices. The primary driver behind the Trust's selection was the fact that its reference cost submission had not been subject to audit in the previous two years. PWC state that the draft was prepared for discussion purposes only and should not be relied upon; the contents are subject to amendment or withdrawal and their final conclusions and findings will be set out in their final deliverable. PWC on behalf of Monitor concluded in their draft report that the Trust's 2014/15 Reference Cost Return's preparation was **not compliant** with Monitor's Costing Guidance. The cumulative cost quantum affected by errors identified in the audit was 6.92% of the total quantum in the Trust's return. As such this was over the threshold identified for non-compliance, which was 5%. It was noted that there was a four week period for the Trust to comment on the draft report, challenge and provide evidence and subsequent action plans. The deadline was 11 May 2016. Monitor's expectations were that the report, once finalised, would have an action plan from the Trust which PWC would review and sign off. The completed report would then be presented to the Audit Committee. Monitor expects that the action plan is implemented through the Audit Committee (or relevant Committee) and will in some instances follow up with organisations to assess progress.	

	Ahead of this Monitor would like a brief call with the Director of Finance, Audit Committee Chair and PWC to discuss the report and action plan. This is expected to take place within approximately 5-6 weeks. However, as the action plan was being implemented through this Committee, it was agreed that, Mr Nealon would be involved in the call rather than the Audit Committee Chair. It was agreed that Mrs Brandt would present a paper to the May meeting to gain Board approval as follows: *The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee is required to confirm the following in relation to the reference cost return (or provide details of non-compliance):* *(a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection;* *(b) the Director of Finance has, on behalf of the board, approved the final reference cost return prior to submission;* *(c) the reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance* *(d) information, data and systems underpinning the reference cost return are reliable and accurate;* *(e) there are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice; and* *(f) costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.* **Action** **The Committee noted the overall conclusion of the draft audit report and agreed that the final completed report is presented to the Audit Committee but that the action plan is implemented through the Finance & Investment Committee. It was noted a paper would be presented to the May meeting to gain Board approval of the above items (a) – (f).**	
012/16	**Lord Carter update** The Committee received an update on the Trust's response to the NHS Productivity and Efficiency Programme (NHS PEP or 'Lord	

	Carter Review'). This briefing provided outlined progress to date on each of the work stream that were initially driven by the Department of Health (DH) and which is now passing to NHS Improvement. It described the Trust's continuing engagement in the project and the steps being taken to ensure that the Trust validates and exploits the true potential efficiency improvement opportunities that are identified. 1. The Trust has received reports from the NHS PEP that provide indicative savings opportunities based on the metrics developed as part of the programme; 2. The indicative data and methodology contain a number of flaws and the Trust is liaising with the Lord Carter team to arrange for these to be corrected; 3. The Trust has established an Efficiency Improvement Group (EIG), whose work includes the development of a co-ordinated response to the Lord Carter findings; 4. The July meeting of EIG received a number of presentations on the Lord Carter work streams and agreed a number of actions. It was noted that Procurement will be included in the presentation at the next meeting. **Action** **The Committee noted the contents of the report and the further assurance provided.**	**PA**
013/16	**Quarterly Review of Aged Debts** The Committee received an update on the current level of aged debt at the end of March 2016, split between NHS and non NHS and segmented into operational categories. Overall levels of debt over 90 days old increased, from £592k at the end of December 15 to £1.3m at the end of March 2016. However the percentage of over 90 day debt to the total debt had only increased slightly from 14% at 31st December 2015 to 15.2% at 31st March 2016. Out of the above-mentioned £1.3m over 90 days, £725k was outstanding from Brighton & Sussex University Hospital NHS Trust; The Trust were continuing to negotiate reciprocal payments and are in contact on a weekly basis. Having cleared NHS Property Services, the account is again starting to age. This account and Brighton remain our 2 top priorities. The target remains 5%, so although progress continues to be made,	

	the Trust is not yet in compliance with this KPI. **Action** **The Committee noted the current aged debt position.**	
014/16	**IT Investment** This item was deferred to the May meeting. **Action** **Item deferred to May meeting.**	**ABiss**
015/16	**Tender & Service Developments** The Committee received a schedule providing up update on current tenders as at 20 April 2016. The schedule is monitored by the Business Development Group (BDG) on a fortnightly basis. The Committee noted the position of the following PQQ/tenders in the pipeline: • Non-Invasive Ventilation Service – currently at clarification stage • Direct Access Hearing Services – AQP has been submitted • Elective Service - AQP due for submission on 13 May 2016 It was agreed that Mr Astell would check on the position of the accreditation for the Direct Access Hearing Services AQP. Mr Bull queried whether there was a robust system in place in terms of picking up what was coming through the portal on tenders, and horizon scanning for future tenders. It was noted that this used to fall under the remit of the Business Planning team which was led by the Director of Strategy. All posts within this team are now vacant and the funding and responsibility had temporarily been picked up by Finance. It was agreed that this will be resolved as part of the Strategy discussion including the need to get some resource into the team as quickly as possible. **Action** **The Committee noted the update on tenders.**	**PA** **AB/DM/ PA**
016/16	**Business Cases for Review** <u>(i) Salary Sacrifice Car Scheme</u> The Committee received and supported a business case for the introduction of a salary sacrifice car scheme for staff. **Action** **The Committee supported a business case for the introduction**	

	of a salary sacrifice car scheme for staff.	
017/16	**2016/17 Work Programme** The Committee noted the 2016/17 work programme. The Chairman commented on the number of items on the work programme for May. It was noted that Gemma Lawrence had asked for the two items on PMO to be deferred to the June Meeting. IT Investment would be added to the work programme for May. **Action** **The Committee noted the work programme for 2016/17.**	
018/16	**Date of Next Meeting** The next meeting will take place on Wednesday 25th May 2016 at 9.30am – 11.30am in the Committee Room, Conquest.	

East Sussex Healthcare NHS Trust (ESHT)

Quality and Standards Committee

Minutes of the Quality and Standards Committee Meeting

Tuesday, 12th January 2016
St Mary's Board Room, Eastbourne DGH

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

In attendance: Sally Herne, Improvement Director
Mrs Jayne Cannon, Head of Nursing - Surgery for 4.5
Ms Davina Toomey, Deputy Head of Nursing - Surgery
Mrs Edel Cousins, Assistant Director of HR (Workforce Development) for 4.1
Mrs Sara Songhurst, Deputy Director of Nursing
Mr & Mrs Upton for item 2.0

Mrs Trish Richardson, Strategic Planning Project Manager (minutes)
Janice Smith, Capsticks (observer)

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 apologies for absence had been received from:

Mr Richard Sunley, Acting Chief Executive Officer
Dr James Wilkinson, Assistant Medical Director, Quality
Dr Jamal Zaidi, Assistant Medical Director, Workforce
Matt Hardwick, General Manager – Surgery
Jenny Darwood, General Manager – Urgent Care
Sarah Wilmer, Head of Nursing – Urgent Care

2.0 Patient Story

Mrs Webster welcomed Mr & Mrs Upton to the meeting and explained that they had participated in a DVD outlining their story.

She advised that the DVD also included the stories of two other families and their different experiences of care at the Trust but the underlying thread in all three cases was poor communication and its impact on patient experience.

The short version of Mr & Mrs Upton's story was shown and Mrs Webster explained that the full DVD was being shown as part of nurse induction, would be used as part of the next cohort of student interviews and work was taking place with the medical education department to include in the induction programme. It was also planned to show it in a Grand Round so that the consultant body would have an opportunity to view it.

Mrs Webster advised that the DVD would also be shown at the Dignity Day event on 1st February which Mrs Upton would also be attending and invited members to attend. Mrs Bernhauser thanked Mr & Mrs Upton on behalf of the Trust Board for attending and for their participation in the DVD which was greatly appreciated and would benefit the whole organisation.

Mr Upton asked if the doctors mentioned in the DVD would be recognised as the DVD became more widely shown and Mrs Webster confirmed that the doctors concerned had been informed.

Mr Ellis thanked Mr & Mrs Upton who left the meeting.

3.0 Minutes and Matters Arising

3.1 Minutes of the Previous Meeting

The minutes of the meeting held on 2nd November 2015 were agreed as a correct record.

3.2 Matters Arising

The action log was reviewed as follows:

Health Records Deep Dive

Mr Ellis noted that it had been a relatively positive report from Mrs Byers at the last meeting re the move of medical records to Hailsham but subsequently there had been industrial action by the administrative staff affected and further discussed at the Trust Board meeting on 6th December. There had been no indication given at the last meeting that there was anything wrong with the people side of move and it was agreed that staff should be briefed for future deep dives to give the full picture, whether positive or negative.

Never Events Policy and Framework and Serious Incident Framework
Mrs Wells reported the assurance evidencing compliance with regulations, particularly in relation to Duty of Candour, had been timetabled the May meeting.

RAG rating for Mandatory Training and Appraisal Compliance
Mrs Cousins reported that it had been decided to revert to the original RAG rating in order to show progress in compliance.

Mrs Cousins reported that the large group of appraisals with the medical secretaries had been undertaken to clear a backlog as there had been the service had been in a state of flux for some time. The medical secretaries were offered follow up on a 1:1 basis but it had been fed back to the manager that it was not sustainable going forward for a manager to undertaken 30-40 appraisals. Dr Hughes noted that the consultants did not regard themselves as the line manager of the secretaries as they often had a pooled group.

Infection Control Steering Group (ICSG) Minutes
Mrs Webster apologized that the ICSG minutes were not available which was due to a timing issue but they would come to the next meeting.

She reported that the individual cases of C Diff had been reviewed and a number of issues in relation to cleaning issues had been addressed and the CCG had made two further visits and were happy with progress. She reported that the TDA, with an external assessor, would be conducting a review in early February to provide assurance.

She reported that there had been no further MRSA cases but there had been a Norovirus outbreak over the Christmas period.

3.3 **Terms of Reference/Work Plan**

Mrs Wells reported that she had undertaken an annual review of the terms of reference and noted that the Board was proposing to establish a People & Organisation Development Committee to seek assurances around staff engagement but there would still be some cross over between the two committees.

She outlined the reporting structure and noted that some groups would move across to the new Committee once it was set up. Mrs Webster advised that PSCIG should be removed from the list as it had been disbanded.

Mrs Wells would review them further and send around for comments and the final version would come back to the next meeting. **LW**

The work planner was noted.

4.1 Quality Improvement Plan (QIP)

Mrs Webster presented that status update and advised that the QIP group met on a weekly basis and a report went to the Senior Leaders Forum where there was clinical unit representation.

She highlighted that the second page contained an update of actions completed in the last two months and actions planned for the next two months, key risks and mitigating actions, and milestones.

She reported that the Trust was using Prederi to provide PMO support whilst the Trust's own PMO realigned to provide a dedicated resource to manage the project and they had worked with the operational leads to ensure that actions met objectives, were evidence based and were sustainable. She referred to the dashboard which highlighted progress against the CQC domains and were able to be tracked back to the plan.

She reported that a discussion had taken place with the CQC yesterday regarding the urgent care medical staffing warning notice as the Trust would not be able to address this by March. The CQC had accepted that emergency medical recruitment was a national issue and they had extended the deadline to June 2016 to allow the Trust time to have discussions with stakeholders on a revised model of care. Dr Hughes reported that he was speaking to the Royal College of Emergency Medicine on Friday to ask them to undertake a review of the two departments.

Mrs Herne stated that the main concern was that the actions represented in the plan was not matched to root causes and Mrs Webster confirmed that reflected the conversations Prederi had had with leads.

Mrs Churchward-Cardiff commented that this committee was enabled to set the agenda but the ownership of quality within the organisation felt reactive. Mrs Butterworth agreed and suggested that a quick peer review be undertaken to review each other's actions and assure ourselves that the question had been answered.

4.2 Deep Dive into MRSA Bacteraemia Issues for Surgery and Urgent Care

Ms Toomey reported that two patients on Seaford 4 had been diagnosed with MRSA in the space of two months and in both cases they had not been identified quickly, not risk assessed and their decolonisation treatment not started in good time. The unit had undertaken a RCA for both patients, discussed them at ward meetings in July and September, discussed at the Surgical Clinical Unit meetings in June and October.

She reported that the learning had resulted in the surgical wards on both sites introducing a daily handover, part of which related to MRSA, the ward clerk printed off the daily MRSA status for the ward and the duty nurse actioned it.

She advised that there was a comprehensive action plan which was displayed on the ward which had been presented at the Urology governance meeting.

Mrs Cannon reported that the cases had been discussed in a number of forums including the main Clinical Unit governance meeting as well as urology. She advised that for the second patient a joint RCA had been undertaken with MAU as the patient had been there for the first 48 hours.

Mrs Churchward-Cardiff asked if it was clear why the checks had broken down on this particular ward and Mrs Cannon confirmed that they were and this was the reason for the process being put in place where MRSA status was reviewed daily by the registered nurse and the learning had been shared across other surgical wards on both sites.

Mrs Webster reported that the cases had also been discussed at the Trust Infection Control Group.

4.3 **Mandatory Training and Appraisal Compliance**

Mrs Cousins presented her reported and advised that a root cause analysis was being undertaken to align competencies to roles. She was pleased to report that compliance was at the highest level since reporting had started and acknowledged the significant efforts of the clinical units in ensuring staff were trained and appraised but the challenge would be maintaining that level.

She advised that there had been a specific reference in the CQC report to safeguarding and there had been a focus on completing workbooks.

Mrs Butterworth commented that Health & Safety and fire training were the two big issues across the patch and asked what could be expected from Learning & Development to support compliance. Mrs Cousins advised that certain roles were mandated for classroom fire training and she had been assured by the fire team that they had planned sufficient courses but she could ask if they had any other plans. Mrs Butterworth asked if the fire trainers could have conversations with the individual clinical units to see how to make the training work and Mrs Cousins agreed to do this.

The Committee acknowledged the good progress made and that this was the best position the Trust had ever recorded. However, greater focus was still required in some areas to support green compliance across the Trust.

4.4 **Annual Serious Incident Report**

The Committee received the annual serious incident report and noted that it related to

the period ended April 2015. The timing issue was as a result of the dissolution of the Patient Safety Committee. The Committee also received the most recent quarterly Serious Incident report. It was noted that reporting and review of incidents had improved; a weekly patient safety summit was in place which was well attended and supported early identification of issues and shared learning.

It was noted that the Trust reported 3 Never events in November and these were being fully investigated. An update would be provided in the next report.

AW

4.5 **CAS Alerts**

The Annual CAS Alert Report was tabled and the Committee commended the robust process in place. There were 107 alerts in the period and no breaches.

4.6 **Patient Experience and Complaints Report**

Mrs Webster provided an overview of the complaints report for the quarter. There were 49 new and 15 reopened complaints. Mrs Wells advised that Datix did not have a field for collating cause of reopened complaints and this was a manual calculation. Complaints were classified as reopened for a number of reasons such as MP requesting information or complainant raising new concerns. This would be reviewed.

Mrs Webster reported that the number of staff in the complaints team had been increased, quality of responses had improved and the team was being aligned to clinical units to provide greater support.

4.7 **Minutes of Health and Safety Steering Group**

The Health and Safety Steering Group minutes were noted and it was noted that clinical representation at the meeting had not been good due to issues with the video link.

Mrs Webster updated on the Serious Incident following the failure of the electricity power supply; this tested health and safety and major incident preparedness.

4.8 **Assurance Framework and High Level Risk Register**

The Committee reviewed the updated Board Assurance Framework and High Level Risk Register.
It was noted that three gaps in assurance and control had been removed as there was now sufficient assurance that actions had been completed. Health Records and Emergency Department configuration remained red and the financial plan had moved from amber to red. It was noted that a number of

the risks were encapsulated in the Quality Improvement Plan. Mrs Wells advised further estates high level risks would be added to the risk register following a process of validation.

4.9 **Morbidity and Mortality**

The report was noted. Dr Hughes highlighted that the paper had been received at the Board and the Trust was working with the TDA to assure processes and mortality and morbidity would be discussed in detail at a future Board seminar. **DH**

5.0 **Quality Account and Quality Improvement Priorities**

The Quality Account timetable was noted. Mrs Wells noted that a patient engagement event was planned for 4th February and Mrs Churchward-Cardiff commented that the Trust should plan these earlier to give sufficient notice to patients and this was agreed.

6.0 **Deep dive**

It was agreed to deep dive into staff engagement and culture, visible leadership and Mrs Kavanagh would be invited to attend as Chair of the new People and Organisational Development Committee.

It was agreed that another area for a future meeting would be policies. Mrs Wells advised that this was being considered by internal audit but from a different perspective.

7.0 **Date of the Next Meeting**

Monday, 7th March 2016
2.30pm – 4.30pm
Committee Room, Conquest Hospital

East Sussex Healthcare NHS Trust

Date of Meeting:	8th June 2016
Meeting:	Trust Board
Agenda item:	16
Subject:	Use of Trust Seal
Reporting Officer:	David Clayton-Smith, Chair

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

Purpose:

To keep the Board informed of the use of the Trust Seal since the last Board meeting.

Introduction:

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

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

Use of Trust Seal

The Trust Seal has not been used since the last meeting in April 2016.

Proposals and/or Recommendations

The Board is asked to note that the Trust Seal has not been used since the last Board meeting.

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

Name:	**Contact details:**
Lynette Wells, Company Secretary	lynette.wells2@nhs.net