AMENDED

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Wednesday 14th December 2011 commencing at 09.30 hours in the Committee Room, Conquest Hospital

1.	Welcome and Apologies for Absence			09.30
2.	Monthly Award Winner(s)			
3.	Declarations of Interest			
4.	Minutes of the meeting held on 28th September 2011		A	09.40
	Matters Arising		B	
5.	Chief Executive's report		C	09.45

QUALITY & PERFORMANCE

6.	Clinical Quality and Safety a) Clinical quality and safety report b) Serious Incident report	Assurance	D	09.55
7.	Performance report	Assurance	E	10.25
8.	Board Assurance Framework a) Bi-monthly update b) Care Quality Commission Standards – Assurance report	Assurance	F	10.55

BREAK **11.15 – 11.25**

STRATEGY

9.	Shaping our Future	Assurance	G	11.25
10.	Foundation Trust	Assurance	H	11.40
11.	Board development	Approval	I	11.50
12.	Transfer of PCT properties to ESHT	Assurance	J	12.10

AMENDED

GOVERNANCE & ASSURANCE

13.	Reports from Board sub-committees: a) Audit Committee b) Finance and Investment Committee c) Quality and Standards Committee d) Remuneration and Appointments Committee	Assurance	K	12.20
14.	Corporate Governance documents	Ratification	L	12.40
15.	Winter Plan	Assurance	N	12.50

ITEMS FOR INFORMATION

16.	Questions from members of the public			13.00
17.	Closed Session Resolution	Approval	M	13.10
18.	Date of Next Meeting **Wednesday, 25th January 2012, at 9.30 am in the Shepherd Room, Battle Memorial Hall**			

STUART WELLING
Chairman

8th December 2011

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

A meeting of the Trust Board was held in public on Wednesday 28th September 2011 in the St Mary's Board Room, Eastbourne DGH

Present: Mr Stuart Welling, Chairman
Ms Mary Lynch, Non-Executive Director
Mr Paul Roche, Non-Executive Director
Mr Maurice Rumbold, Non-Executive Director
Mr Robert Smart, Non-Executive Director
Mr Ken Smith, Non-Executive Director
Mr Darren Grayson, Chief Executive
Mrs Jane Hentley, Director of Nursing
Mr Andy Horne, Chief Operating Officer/Deputy Chief Executive
Dr David Hughes, Medical Director
Mr David Meikle, Director of Finance

In attendance: Ms Monica Green, Director of Human Resources
Dr Amanda Harrison, Director of Strategic Development and Assurance
Mr George Melling, Commercial Director
Dr Simon Weston-Smith, Clinical Lead - Pathology (for item 79/2011)
Mrs Trish Richardson, Corporate Governance Manager (minutes)

69/2011 **Welcome and Apologies for Absence** **Action**

Mr Welling welcomed Jeremy Alford, Non-Executive Director – NHS East Sussex, Clive Baldwin, Joint Staff Side representative, Janet Colvert, Chair of LINks, Dr Peter Nash, Chairman of the Friends of Eastbourne Hospital and Liz Walke, Chair of the Save the DGH campaign to the meeting.

He reported that apologies for absence had been received from Dr Walmsley, Divisional Director - Planned Care, Dr Wilkinson, Divisional Director - Unscheduled Care and Mr Zaidi, Divisional Director – Integrated Care.

Ms Walke presented a letter on behalf of the Save the DGH campaign to the Chairman who stated that he would ensure that it was circulated to members of the Board. **SW**

70/2011 **Monthly Award Winner**

Mr Welling reported that this month's winner was Kevan Worrall, Clinical Coding Support Clerk, who has been nominated by a number of his colleagues in the department because "he always went the extra step, never moaned and always had a smile on his face. He also helped other departments with work that he did not have to and this all helped the department to meet important financial deadlines."

Mr Welling stated that unfortunately Mr Worrall was not able to attend the meeting so his award would be presented to him at a later date.

71/2011 **Declarations of Interest**

There were no declarations of interest reported in connection with the agenda.

72/2011 **Minutes and Matters Arising**

a) Minutes

The minutes of the Trust Board meeting held on 31st August 2011 were approved as an accurate record and signed by the Chairman.

b) Matters Arising

67/2011a Maternity Services

It was noted that the action arising from the last meeting had been completed.

54/2011a Outpatient Letters

Dr Hughes reported that the system currently in place for patients receiving copies of outpatient letters had required patients to indicate that they wished to receive the letters and the take up had not been significant. Consequently, the Clinical Board had reconsidered the system and agreed that outpatient letters would be sent out to all patients unless they indicated that they did not wish to receive them.

73/2011 **Chief Executive's Report**

Mr Grayson reported that the Trust's performance position was still mixed but substantial work had taken place to reduce the number of patients waiting over six weeks for diagnostic scans resulting in significant improvement and a positive impact on achieving the 18 week standards.

Mr Grayson noted that there was still some progress to be made on reducing the backlog in relation to orthopaedic patients waiting more than 18 weeks.

Mr Grayson reported that the average wait for all specialities was now 11 weeks.

He highlighted that the new metrics for A&E were reflected in the performance report and further work was required to demonstrate achievement with the four new standards but the Trust was continuing to deliver and exceed the 95% standard of patients waiting no more than four hours in A&E.

Mr Grayson reported that financial performance still remained a challenge and, although some progress had been made helped by moving the Trust into turnaround, more progress was required.

He noted that a number of important reports would be considered later in the meeting concerning the transformation of the organisation. With regard to the Shaping our Future: the Clinical Strategy he noted that the Board had spent a large amount of time in private session meeting with the clinical leads and working through the proposed models of care.

He reported that in relation to organisation development appointments would be made to the leadership positions in the Clinical Units by the end of the week and then the process would move on to work through the more junior management and supervisory posts so that by the end of the calendar year the majority of management posts across the organisation would have been reviewed.

He noted that the Board would also be considering proposals to change the way in which the organisation governed itself and substantial changes to the way the Board worked. In addition, there would be changes to executive decision making in that he was proposing to review and merge the functions of the current Business and Clinical Boards into one Clinical Management Team meeting so that both clinical and business decisions would be integrated and made in the right place at the right time.

He reported that the CQC had visited both the Eastbourne and Conquest hospital sites the previous week and the verbal feedback received had been positive although there was still progress to be made in some areas but the stated view of the inspection team was that there had been a noticeable transformation since their previous visits in February. He anticipated that the written reviews of the visits would be received in the next few weeks.

Mr Grayson thanked Mrs Hentley and Dr Hughes and their teams for all the work they had undertaken in this area.

Mr Roche queried the impact of the organisation development work on ensuring financial turnaround and implementing the clinical strategy.

Mr Grayson stated that ideally the work should have taken place sequentially over three to five years but this had not been possible due to the scale of change required.

Mr Smart asked whether the new Clinical Unit leaders were aware of the expectations and accountability in their roles and Mr Grayson assured the Board that they understood the scale of the challenge facing them and he would be arranging to see all the leaders in the next few weeks to reinforce this.

Resolved:
The Board received the Chief Executive's report for September.

74/2011 **Clinical Quality and Safety**

a) Monthly Report

i) Care Quality Commission (CQC)

Mrs Hentley reported that the CQC Oversight Group (COG) had further refined the action plan template to ensure that it reflected the need to focus on improving and sustaining compliance.

She noted that the community services had taken a different approach to monitoring compliance prior to the integration on 1st April 2011 and a review and alignment of the two templates would take place in October. In future each Clinical Unit would have a compliance plan which would be monitored through the regular performance review process.

She reported that the Provider Compliance Assessments (PCAs) were used to inform the regulator of the organisation's compliance with each of the outcomes on an ongoing basis and a three monthly cycle of review of PCAs was being introduced. The evidence recorded in the PCAs was being collated into an electronic library and in hard copy so that the organisation could provide good and salient evidence the next time the CQC visited.

Mrs Hentley reported that the CQC awareness training sessions were now being targeted to the Clinical Unit management teams so that they understood their responsibilities in this area.

Mr Roche queried how the fundamental cultural change was being implemented in the organisation so that compliance with the CQC outcomes became part of day to day business.
Mrs Hentley stated that there would be quality reviews on a monthly basis with the Clinical Unit leaders where specific quality metrics, patient experience and other intelligence would be reviewed. These reviews were based on the methodology that had been used in the weekly reviews which had been important in building staff understanding of their responsibilities and accountability and would help to give the ward to Board view. She anticipated that in twelve months the quality reviews would develop to review innovations in practice and be a springboard for development.

Ms Lynch reported that she had attended the weekly review meetings and found them to be both challenging but also supportive in encouraging ward teams to find solutions to issues.

ii) Healthcare Associated Infections (HCAI)

Mrs Hentley reported that the Trust was continuing to meet its trajectory with regard to the MRSA stretch target.

She noted that there had been a rise in Clostridium Difficile (C Diff) cases in July and August which had resulted in the monthly limit for those two months being exceeded but the Trust remained within trajectory for the stretch target of 55 cases for the year. Neighbouring acute Trusts had also shown a similar variation.

Mr Rumbold queried whether there was any indication that this rise would continue and Mrs Hentley stated that there was no particular indication at this time. Mr Grayson stated that there had only been two cases reported for September at this point in time.

Mr Grayson reminded the Board that the stretch limit of 55 cases was a local target and was below the national limit set by the Department of Health.

Mrs Hentley reported that a Department of Health comparison showed that the South East Coast SHA was the second lowest SHA in England for C Diff cases. Mrs Hentley agreed to circulate the comparison together with the Department of Health target for C Diff to Board members outside of the meeting. **JH**

Resolved:
The Board noted the report and took a good level of assurance around the processes in place to achieve compliance with CQC outcomes and HCAI limits.

b) Safeguard Adults At Risk (SAAR) Annual Report

Mrs Hentley presented the annual report which was a high level summary of the work undertaken over the last year.

She stated that Adult Social Care (ASC) was the lead agency for safeguarding and she was the executive lead for safeguarding within the Trust and was a member of the East Sussex Multi-Agency SAAR Board. The CQC was also represented on this Board.

She reported that internally within the Trust there were two groups for safeguarding vulnerable adults, the first of which was the ESHT SAAR Group which met bi-monthly and reviewed the overarching strategy, monitored and regulated SAAR incidents, reviewing trends and ensuring compliance with policy.

She stated that the ESHT SAAR Operational Group was set up in March 2011 following the CQC inspection and recommendations and she chaired this group which met on a fortnightly basis. This group reviewed and monitored all alerts within the Trust in partnership with ASC and training compliance.

She reported that a Level 4 safeguarding review was taking place at the Eastbourne DGH looking at a number of cases and the processes behind them. This was a joint review being undertaken between the Trust, ASC, PCT and the CQC. She anticipated that the formal report would be received in October.

Mr Smith asked whether the safeguarding training was also available to agency and bank staff and Mrs Hentley stated that the training had initially been targeted at Band 6 and 7 nursing and midwifery staff to ensure that there were senior levels of staff on the wards who understood the safeguarding process and a compliance target of 70% for training for this level of staff had been set by March 2012. She stated that the current compliance level was 68%. She stated that training was available for agency and bank staff and this was often carried out through interventional episodes of training carried out directly on wards. She was working with Human Resources to ensure that this type of training was captured in the compliance data.

Mr Rumbold queried whether the levels of referrals had risen as the awareness had risen and whether there were any trends coming through. Mrs Hentley stated that there had been a rise initially but this had now smoothed out and, whilst there were more alerts at Eastbourne DGH than the Conquest, there were no trends focusing on one specific ward or area.

Ms Lynch reported that at the weekly review meetings the ward teams had worked through scenarios around safeguarding, mental capacity and deprivation of liberties and staff awareness of the requirements was very good.

Resolved:
The Board noted the report and was reassured around the processes in place to protect vulnerable adults.

75/2011 **Performance Report**

a) Operational Performance

Mr Horne reported that the new performance standards for A&E were now included in the performance report and the Trust was concentrating on ensuring that the flow of patients through the department was correct and he anticipated an improvement in performance in the future.

In relation to the 18 weeks standards he stated that there had been the expected dip in performance for admitted patients as the organisation caught up with the work. He still expected the standard to be achieved by the end of October.

He reported that there had been some improvement in cancer standards but there had been some problems with breaches in August due to the holiday period.

He highlighted that GP referrals in July and August were above the profile and this was being monitored as if this trend continued it could cause problems in achieving 18 weeks, particularly in orthopaedics. Work was taking place with GP commissioners and PCT to ensure that the demand and supply was evened out.

Ms Lynch noted the improved performance in the 2 week GP referral to a first outpatient appointment for breast symptoms standard and Mr Horne stated that the process had been changed and discussions were taking place with the PCT and GP commissioners to encourage the use of electronic booking which would also help to improve the process. He noted that the percentage of GPs using electronic booking in East Sussex was very low compared to the rest of the country.

b) Quality & Safety Dashboard

Mrs Hentley reported that there had been a change in the process of how falls were recorded since May which had led to a rise in numbers in July. She noted that the number of falls causing injury to patients was less than in preceding years.

She noted that performance continued to be above standard for presentation to CT scan within 24 hours.

Mrs Hentley reported that the new graph covering expected deaths on the Liverpool Care Pathway was focusing on patients at the end of life and putting them on the appropriate pathway. Further work was required on both sites to achieve the standard and this linked to the work around the Hospital Standardised Mortality Rate (HSMR).

Mr Welling enquired why the hospitals had a lower number of patients on the Pathway and Mrs Hentley stated that this partly related to education, training and awareness of staff. Dr Hughes stated that Dr McNeillis was working on increasing the recognition of patients who were at the end of life as part of the work around HSMR. Mr Welling requested that there be a report at the next meeting of why the Trust was at the current position and the plans in place to address this. **JH/DH**

Mrs Hentley reported that as from October the Long Term Conditions Clinical Unit would be taking on the responsibility for pressure ulcers and there would be further information at future meetings.

Mrs Hentley reported that the Trust had now set a 5% reduction target for delayed discharges from critical care and further work around patient flows was required to achieve this reduction on a sustained basis.

Dr Hughes reported that in relation to HSMR there had been a significant improvement on previous years and the Trust was now expected to be an insignificant outlier. He stated that if any area was shown as a significant outlier, the team would drill down to the individual specialities and he was able to report that there had not been any significant clinical risks identified but difficulties had been identified in the accuracy of clinical coding and this was being addressed.

c) Financial Performance

Mr Meikle reported that the financial position for August showed a £340k overspend with expenditure still outstripping income during the month.

He highlighted that there was a new report in the financial section relating to divisional performance on budgets which was a subjective analysis across various pay and non-pay areas. The pay variance included costs above budget on agency and bank staff to cover vacant posts currently being held.

Mr Meikle stated that on the non pay side drug spend was currently £600k year to date but this included a 10% reduction for CRES already built in.

Mr Meikle noted that the organisation had moved into turnaround for the last six weeks and weekly meetings were taking place with the divisions and directorates and speciality deep dives had taken place; the opportunities identified from these now needed to be maximised.

He stated that discussions were continuing with the PCT and SHA over potential additional income and he hoped that these would be concluded in the next few weeks in order to be able to reflect the decision in the month 6 figures.

He noted that there had been a cash injection from the commissioners of £7m had been received and a further £7m cash working loan had also been negotiated on the basis that the CRES would be achieved in the latter half of the year and the loans would be repaid in the last quarter of the financial year. This would enable the Trust to pay suppliers more promptly and achieve a more acceptable Better Practice Payment Code percentage.

Mr Meikle stated that the organisation was continuing to develop plans for 2012/13 and was currently forecasting a £18.5m CRES requirement plus any underperformance from this year and any non-recurring actions taken during the year.

Mr Welling stated that the Trust needed to ensure that the discussions were resolved with the SHA and PCT to provide certainty on the year end position and the credibility of the Trust depended on the delivery of £17.5m CRES in year.

Mr Grayson reported that since the month 5 figures had been issued it was clear that in many parts of the organisation traction was in place and commitments were being met but not across the whole organisation. The protocol for escalation was that delivery against actions was reviewed in weekly meetings and where actions were not being delivered then it was escalated up to himself. This would be part of the discussions he would be having with the clinical leaders.

Discussion took place on how the £30m and £17.5m CRES should be presented in relation to budgets and it was agreed that this should be considered at the first meeting of the Finance & Investment Committee.

Mr Smith requested that the workforce figures also provide a breakdown of vacancies so that the Board could assure itself that safe levels of service were being maintained in areas where there were vacancies.

Ms Green stated that it would be possible to provide a breakdown of substantive staff across budget and therefore show the number of vacancies and this would be provided in the next report. **MG**

Resolved:
The Board noted the performance report for August and the actions being taken to address performance issues.

76/2011 **Board Assurance Framework**

Dr Harrison presented the latest update of the Board Assurance Framework and noted that it had been reviewed by the Audit & Integrated Governance Committee at its meeting on 7th September where a number of comments had been made which would be incorporated into the November update. In addition there would be further amendment to the structure and content as part of the change in governance arrangements. She stated that it was still very much a work in progress. She noted that the RAG rating indicated where there were insignificant controls or levels of assurance.

Mr Smart stated the Audit & Integrated Governance Committee recognised that good improvement had been made on the Framework but were of the view that some of the categories were too all embracing and that information governance should be included as a gap in assurance.

Dr Harrison stated that the Audit Committee should also be ensuring that there was a direct link between the Board Assurance Framework and the Trust Risk Register.

Ms Lynch queried whether the RAG rating for risk 1.1 should still be red and it was agreed that it should remain at risk until the outstanding Warning Notice was lifted and compliance on a day to day basis with CQC outcomes could be demonstrated.

Resolved:
The Board noted the September update subject to the amendments suggested by the Audit & Integrated Governance Committee.

77/2011 **Shaping our Future: The Clinical Strategy**

Dr Harrison reported that the Board had in a number of sessions over the last few months been informed of the work behind the models of care and they had also been debated in a wide range of meetings with clinical staff, stakeholders, partner organisations and commissioners.

Dr Harrison noted that her report outlined the work undertaken to develop the eight models of care and she was asking the Board to agree these models of care as the basis for the next stage of the work. This would involve the development and prioritisation of a range of appraisal criteria that would be used to appraise a number of delivery options for each model. This would be undertaken through a programme of engagement with staff, patients and the public, the local GP commissioning consortia and the PCT cluster.

She stated that this would ensure that by the end of December 2011 the Trust would be able to identify clear delivery options for implementing service change for consideration by the Board and the Health Overview and Scrutiny Committee (HOSC) and this would enable HOSC to agree those areas where formal consultation was required and inform the Board's decision on the optimal delivery options. She anticipated that where formal consultation was required this would commence in January 2012.

Dr Harrison reported that the proposed model of care for maternity proposed by the Maternity Review Board had been informed by three independent reviewers with expertise in midwifery, obstetrics and gynaecology and paediatrics. The Maternity Review Board had concluded its work and the report of the independent reviewers would be circulated to the Board for detailed discussion at its seminar on 12th October. The proposed model of care formed part of this report and had been recommended by the Maternity Review Board (with two abstentions) for agreement by the Trust.

Mr Welling stated that this was about developing an integrated healthcare service for the people of East Sussex and there had been an enormous amount of work undertaken to arrive at this stage. The proposed models of care were currently going through an assurance process led by individual Board members to ensure that any changes in service proposed in December or following public consultation would meet the four tests as set out by the Secretary of State for Health:

- Support of GP commissioners
- Clarity on clinical evidence base
- Strengthened public and patient engagement
- Consistency with current and prospective choice

Mrs Colvert requested that as much notice as possible be given for the engagement sessions and Mr Grayson agreed to share the detailed engagement plan with her in the next few days. **AHa**

Mr Meikle reported that that it was not possible at this stage to give an indicative economic analysis of the strategy as there will still too many assumptions to be made but he was confident that this was the correct direction of travel against the financial backdrop.

Resolved:
The Board approved the models care subject to the assurance process currently being undertaken by Board members and the next steps in the process.

78/2011 **Revised Governance Arrangements**

Dr Harrison presented the rationale for changes to the Board committee structure and the terms of reference and noted that there would be a requirement to review and change the Scheme of Delegation and the membership of the committees needed to be finalised.

Mr Welling stated that the part of the Board development programme would be supporting the non-executive directors chairing committees to ensure that the committees functioned appropriately. He stated that he would be discussing with the non-executive directors on an individual basis the chairmanship and membership of the four new committees. **SW**

He stated that the wider Board development programme would be discussed at the Board seminar on 12th October.

Mr Grayson stated that he was planning to bring the Business and Clinical Boards together into one clinical management meeting as referred to earlier in the meeting.

Mr Grayson also noted that there was a proposal in the report to move to bi-monthly Board meetings in public and therefore the next Board meeting in public would take place on 30th November 2011.

Ms Lynch queried how the review of the Scheme of Delegation would be taken forward and Dr Harrison stated that it was already being reviewed and that it was anticipated that only minor amendments would be required. The Board agreed that Chairman's action could be taken to approve these amendments. **SW/ AHa**

Ms Lynch queried how the work programmes would be developed so as to ensure that there was no duplication in the committees.

Mr Welling stated that it would be the role of the Company Secretary to work with the chairman of each committee to ensure that there was coherence.

Mr Horne noted that there was no reference to performance in any of the terms of reference and it was agreed that this should be included within the Quality & Standards Committee terms of reference. **AHa**

Resolved:
The Board approved the proposed changes to the committee structure and terms of reference including the inclusion of performance in the terms of reference for the Quality & Standards Committee and this new structure would be implemented from 1st October 2011.

79/2011 **Modernisation of the Pathology Network**

Mr Horne presented the report and noted that the Board had considered the network proposal and the internal proposal in depth in private seminar sessions.

He stated that the report gave a detailed evaluation of the four possible options for pathology services and, having reviewed the investment and the size of the transformation required, the view of the pathology service was that they could deliver an internal rationalisation which would deliver the majority of the benefits outlined in the network and outsourcing proposals at a reduced cost.

He stated that if the Board supported option 4 then it would mean rejecting the Sussex and East Surrey network option but there would still be opportunities to work collaboratively with neighbouring Trusts on certain aspects of the service.

Dr Weston-Smith stated that an internal reconfiguration option was able to be proposed as the service had worked for a number of years as a single unit across site very effectively. He believed that the service was very efficient and would deliver the quality required through a good team of leaders in the service. He stated that the pathology service universally supported the internal reconfiguration option.

Mr Horne stated that a large amount of work had gone into developing the network option and this would be picked up locally to help to drive the internal reconfiguration.

Mr Welling expressed the Board's thanks to Dr Weston-Smith and his colleagues for all their hard work leading to this proposal.

Resolved:
The Board agreed that option 4 should be progressed to a full business case noting the anticipated savings levels.

80/2011 **Interim Health & Safety Policy**

The Interim Health & Safety Policy was approved by the Board having been circulated electronically for approval on 18th August 2011.

81/2011 **Questions from Members of the Public**

a) Pevensey Ward Redevelopment

Dr Nash expressed his concern on behalf of the Friends of Eastbourne Hospital at the delays in the above development, especially as the Friends had currently raised £575,000 of public money towards the redevelopment.

Mr Welling stated that he wished to assure the Friends and members of the public that the Board was totally committed to the Pevensey ward redevelopment and he shared their concerns about the delay in the scheme.

Mr Grayson reported that the scheme had been transformed since its first inception and the proposal was now that the redevelopment would be linked with the proposal by Brighton & University Sussex Hospitals Trust (BSUH) to put two linear accelerators on the EDGH site and he understood that there had been a donation of £500,000 from the National Kidney Unit to provide a satellite renal dialysis unit within the development. The overall development was being led by BSUH and therefore the timing of the Pevensey ward redevelopment was dependent on the overall timescales.

Mr Melling reported that the overall business case would be going to the BSUH Board meeting next month and at the same time he would be providing a revised business case to this Board as it had been augmented further due to the clinical changes and there was also a proposal that the day unit should be moved into Berwick ward with the inpatient unit being housed within the radiotherapy unit.

Mr Welling stated that a presentation would be given to the Friends at their AGM on 17th November and a timeline would not be given for the development until the Trust was satisfied that it was guaranteed. **SW**

b) Models of Care – Maternity Services

Ms Walke stated that there had been some abstentions to the Maternity Review Report and that a centralised unit was probably not realistic.

Mr Welling stated that it was not for the Trust to determine what went into the independent report but to receive the report and then consider the options.

He suggested that if there were issues Mrs Walke was not happy with then she should raise them with the chairman of the Maternity Review Board.

Dr Harrison stated that it was recorded within the Shaping our Future: The Clinical Strategy report that there had been two abstentions to the Maternity Review Report but there were no delivery options within the model of care which was one part of the overall report.

82/2011 **Closed Session Resolution**

The Board resolved that representatives of the press and other members of the public would 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.

83/2011 **Date and Time of Next Meeting**

Wednesday, 30th November 2011, at 09.30 am – venue to be confirmed.

Signed ……………………………………………

Position …………………………………………...

Date ……………………………………………….

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 28.09.11 Public Trust Board Meeting

Agenda Item	Action	Actioned By	When	Progress
69/2011a – Welcome and Apologies for Absence	Letter from Save the DGH Campaign to be circulated to Trust Board.	Chairman	Asap	Completed
74/2011a)ii) – HCAI	Department of Health comparison of SHA rates for C Diff and Department of Health national limit to be circulated to the Board outside of the meeting.	Director of Nursing	Asap	Completed
75/2011b) – Quality and Safety Dashboard	Report on Liverpool Care Pathway to come to next meeting.	Director of Nursing/ Medical Director	14.12.11	On agenda
75/2011c) – Financial Performance	Breakdown of substantive staff across budget to be provided in the next report	Human Resources Director	14.12.11	In report
77/2011 – Shaping our Future: The Clinical Strategy	Detailed engagement plan to be shared with Mrs Colvert	Director of Strategic Development and Assurance	Asap	Completed
78/2011 Revised Governance Arrangements	Chairmanship and membership of the four Board-level committees to be discussed by Chairman with NEDs.	Chairman	Asap	Completed
	Corporate governance documents to reviewed and approved by Chairman's action.	Chairman	Asap	Completed and on agenda for final ratification
	Performance standards to be included in terms of reference of the Quality and Standards Committee	Director of Strategic Development and Assurance	Asap	Completed

81/2011a – Pevensey Ward Redevelopment	Presentation the redevelopment to be provided at the Friends AGM.	Chairman	17.11.11	Completed

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	5
Subject:	Chief Executive's Report
Reporting Officer:	Chief Executive

Action: This paper is for **(please tick)**

Assurance	√	Approval		Decision	

Purpose:

The purpose of this paper is to provide assurance to the Board in relation to performance, clinical strategy and relationships and reputation.

Introduction:

The intention of the report is to highlight areas of particular note across the three categories of performance, clinical strategy and relationships and reputation.

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

Progress is being made in the key areas that comprise the national performance framework and there is confidence that in quarter three the new standards in Accident and Emergency will be delivered and the treatment of 90% of patients needing admission in 18 weeks or fewer.

October saw peaks in demand for unscheduled care, particularly at Eastbourne, that challenged the Trust operationally and led to breaches of the rules on single sex accommodation. .

In October substantial progress was progress was made in improving the Trust's financial performance.

Work is underway on the new endoscopy building at the Eastbourne DGH providing the additional capacity required to deliver endoscopy services 'in-house'.

The National Operating Framework was published in November and the measures it contains require the Trust to make savings and deliver improvements in access and quality of care.

Benefits:

Continuing to focus on the themes of performance, strategy, relationships and reputation will assist the Trust in moving to a sustainable position for the future ensuring safe and quality services for patients and achieve the aim of becoming a Foundation Trust in the future.

Risks and Implications
If the Trust is not able to maintain its performance, deliver its clinical strategy and improve its relationships and reputation, this could engender a lack of confidence from patients and the public in our services and stop our progression to a Foundation Trust.

Assurance Provided:
Assurance is provided on performance, clinical strategy and organisational development and relationships and reputation in the report.

Proposals and/or Recommendations
The Board is asked to take assurance from the Chief Executive's 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?
No assessment was required.

For further information or for any enquiries relating to this report please contact:	
Name: Darren Grayson, Chief Executive	**Contact details:** (13) 5653

East Sussex Healthcare NHS Trust

CHIEF EXECUTIVE REPORT

1. Introduction

1.1 This report shares my reflections on some of the most significant aspects of the life of the Trust since the last Board Meeting in September.

2. Performance

2.1 In October we continued to make progress in the key areas that comprise the national performance framework and we are confident that in quarter three we will be able to deliver compliance with the new standards in Accident and Emergency and with the treatment of 90 per cent of patients needing admission in 18 weeks or fewer. For access to cancer care our performance (September data) has improved generally but for access to breast cancer we are not achieving the required 93% at two weeks standard – due to a combination of service issues and patients choosing not to take-up appointments within two weeks when offered. In all these areas our approach has been to work with clinicians to re-design and improve the efficiency of patient pathways and make targeted additional investments to achieve defined improvements in performance; in this way we will make sustainable changes that deliver improved performance over the long term.

2.2 October saw peaks in demand for unscheduled care, particularly at Eastbourne, that challenged us operationally and led to breaches of the rules on single sex accommodation. The Board is aware that this was caused by the temporary use of the day surgery facility as the admissions lounge and, whilst the staff in that area are confident that patients' privacy was maintained at all times, it was nonetheless a breach of Department of Health guidelines. An urgent review has been undertaken and the Board will wish to assure itself that appropriate arrangements preventing a recurrence have been implemented.

2.3 The organisation continues to put enormous effort into improving our financial performance and in October we made substantial progress in most areas generating a small surplus when transitional support has been taken into account. Nonetheless as we move into the winter the drive to maintain delivery of our efficiency programme will continue. The additional income indicated from commissioners gives us the opportunity to focus on delivering the sustained reduction in the run-rate that we require and build a plan for next year that is realistic and achievable.

2.4 Work is underway on the new endoscopy building at EDGH and is due to complete late summer 2012 providing the additional capacity we need to deliver all our endoscopy services 'in-house' and cope with the expected rise in demand as a result of the expansion in the bowel screening age range planned for next year.

2.5 Work is also well underway on planning the new radiotherapy building at EDGH that will also house the new Pevensey ward and a satellite renal dialysis unit. An Outline Business Case for this latter development will be with the Board at its meeting in January 2012. Both these developments are receiving substantial grants from the Friends of Eastbourne Hospital for which the Board will wish to record its appreciation.

3. Shaping Our Future

3.1 We are at a crucial stage in developing our strategy – Shaping our Future. It has become clear that many aspects of our plans can and will be delivered by re-designing what we do to improve quality for patients and drive out efficiency improvements. It is equally clear that some aspects may require reconfiguration to deliver the benefits and that public consultation may therefore be indicated. Today the Board will receive an update on progress and will be asked to confirm assurance on the models of care, note that delivery options are being developed with full engagement of stakeholders and agree the appraisal criteria. In November the HOSC received a report on progress and recorded its support for continuing to work with us.

4. Relationships and Reputation

4.1 The National Operating Framework was published in November. The measures it contains will continue to require us to make savings and deliver improvements in access and quality of care. The next period will be even more demanding than the last and our focus on long term clinical and financial sustainability is even more important. The Framework confirms the intention to establish fully functioning Clinical Commissioning Groups (CCGs) from April 1st 2013 and in shadow form from April 1st 2012. Locally Hastings and Rother GPs have confirmed their intentions to be a CCG as have GPs in Eastbourne, Hailsham and Seaford. GPs in the Havens and the High Weald continue to consider how they wish to work in the future and consequently the Trust will be relating to two, three or four local CCGs and there remains an expectation that they will collaborate in their work with us.

4.2 Finally the new SHA NHS South of England began its life in October and has engaged in helping the NHS in Sussex develop its plans for improved performance in this year and next. Particular attention has been given to safety, quality and finance which the Board will wish to welcome.

Darren Grayson
Chief Executive

5th December 2011

East Sussex Hospitals NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	6a
Subject:	Clinical Quality and Safety
Reporting Officer:	Jane Hentley, Director of Nursing

Action: This paper is for (please tick)

Assurance	√	Approval		Decision	√

Purpose:

This report provides the Board with matters relating to clinical quality and safety in the Trust, and this month the focus is one key area related to end of life care and use of the Liverpool care Pathway.

Introduction:

This report discusses the on going work on End of Life care, and in particular the use of the Liverpool care pathway, and our performance to date, with recommendations for further action.

Other key quality and safety indicators are discussed in the main performance report.

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

More information is given on the progress with the use of the Liverpool care pathway in hospital, and the plans required for taking this forward in the organisation.

Benefits:

The benefits to the Trust of supporting the actions identified within this report are improved patient experience and patient safety along with improved compliance with relevant standards.

Risks and Implications

The risks to the Trust are that non compliance has the potential for affecting Trust reputation and for the standards of patient safety and patient experience.

Assurance Provided:

Assurance is provided within the report for on going actions required.

Proposals and/or Recommendations

The Trust Board is asked to discuss and note the progress on actions associated with work on End of Life care, and note the proposal for a new Trust wide group.

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

What risk to equality & human rights (if any) has been identified from the impact assessment?

No equality and human rights impact assessment has been conducted for this report.

For further information or for any enquiries relating to this report please contact:	
Name: Jane Hentley, Director of Nursing	**Contact details:** (13) 5855

East Sussex Healthcare NHS Trust

CLINICAL QUALITY AND SAFETY REPORT

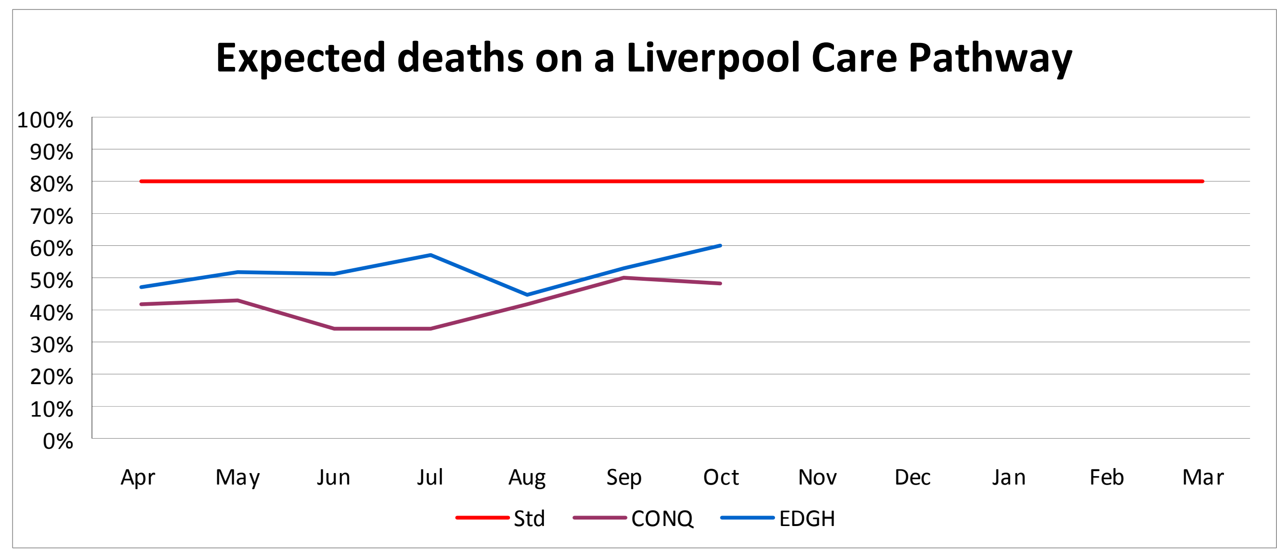
1. Introduction

1.1 This report discusses the on going work on End of Life care, and in particular the use of the Liverpool Care pathway (LCP), and our performance to date, with recommendations for further action.

1.2 Other key quality and safety indicators are discussed in the main performance report.

2. Liverpool Care pathway and End of life care

2.1 This month the Trust Board will note that there is a new performance table focusing on expected deaths, and the use of the LCP, which is the nationally recognised tool used in all areas of health care for those patients who are expected to die and who need to follow a prescribed pattern of care.



2.2 Within the organisation there is a specific LCP development group which has oversight of this target in conjunction with the Mortality and Morbidity Oversight Group (MMOG).

2.3 The target of 80% of expected deaths on the LCP was chosen through discussion at both groups, and further discussion on actions will be tabled at the next MMOG on 9th December 2011.

2.4 Comments made by the two groups on the significance of the data and actions required are:

- There is rapid progression in training and rolling out of the LCP in the community setting. A QIPP funded project started early this year and is progressing very well.

- Since forming a new Healthcare Trust the potential benefits of an organisation crossing community and acute settings has been embraced by the LCP development group and the membership has changed to cover LCP development and sustainability in all settings.
- The LCP is a small part of the end of life care pathway in general.

2.5 One key action proposed and agreed by all members of the LCP group is that a new Trust wide End of Life Care Group should be re-instated with Executive board leadership/membership to help drive the changes forward.

2.6 If agreed, this group could further work around all aspects of end of life care and link into the clinical strategy work already underway.

2.7 Benefits are likely to be:

- Increased awareness and a change of culture accepting death as a natural process.
- Improved identification of the dying patient (through education and culture change).
- Identified leads in each Division to ensure end of life care is accepted as a part of every Divisions responsibility.
- Work streams relating to end of life care have a formal reporting process (rapid discharge at end of life; advance care planning; learning and development; specialist palliative care team).
- Additional KPIs around end of life care will be developed including those which measure the number of patients dying in their preferred place of care. This would include ensuring improved use of community hospital beds; better rapid discharge and empowered/skilled community nursing supporting patients at home with support of local voluntary sector staff.

2.8 From a specific LCP facilitation perspective the aim would be to bring sustainability plans together moving support from specialist palliative care teams to end of life care nurse leads in each division.

2.9 The data would enable divisions to focus on clinical areas that might not be identifying dying patients and ensure that they utilise the support of learning and development initiatives and the specialist palliative care team. Further development of this approach requires the input and leadership of an end of life care group.

3. Recommendation for items in report

3.1 The Trust board is asked to note the analysis against the target set for use of the Liverpool Care Pathway, and discuss the proposal on support for a Trust wide End of Life care Group.

JANE HENTLEY
Director of Nursing

December 2011

East Sussex Healthcare NHS Trust

Trust Board

Serious Incident Activity November 2011

1. Introduction

1.1 A report on Serious Incidents (SIs) is produced each month and presented bi-monthly at Clinical Management Executive (CME) to provide assurance that they are being managed, investigated and acted upon appropriately and that action plans developed from the Root Cause Analysis (RCA) investigations are carried out within appropriate timescales and appropriately embedded within the Trust's policies and processes.

1.2 This paper looks specifically at those incidents that are considered as SIs following the guidance from the National Patient Safety Agency's (NPSA) 'Framework for Reporting & Learning from Serious Incidents Requiring Investigation'.

1.3 This report provides information on trends and significant issues from SIs in the Trust and demonstrates the high priority given to monitoring patient safety throughout the Trust. The report demonstrates the Trust's desire to provide excellent care and positive clinical outcomes, which is a key strategic theme for the organisation.

1.4 The report demonstrates year on year trends, themes, monthly activity and compliance levels for closure of incidents and with action plans both as an organisation as a whole and for individual divisions.

2. Background

2.1 This report demonstrates the level of compliance with the NPSA and Care Quality Commission's (CQC) requirements for reporting timescales, levels of investigation. The report includes numbers and themes of incidents, a yearly progressive trend and contributory factors of incidents which have been closed.

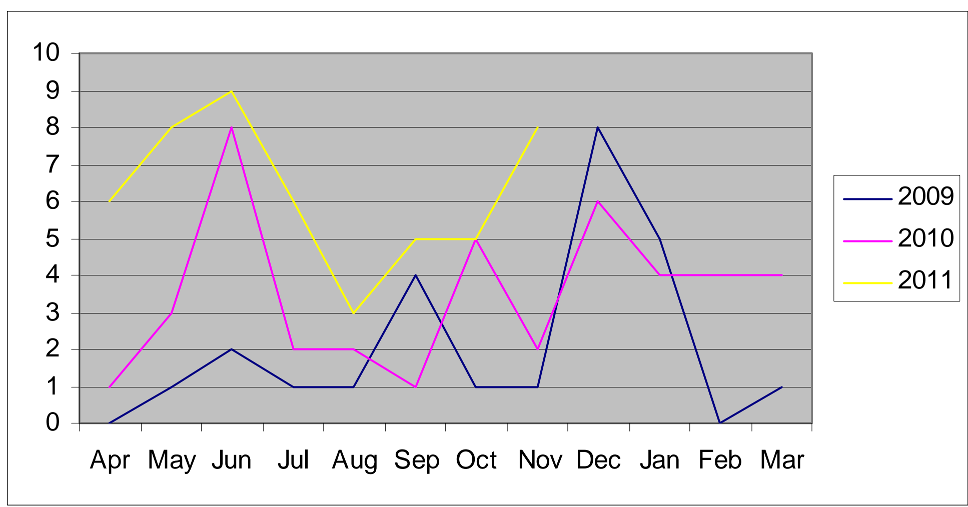
2.2 Reports are presented to CME on a bi-monthly basis. SIs with a high or catastrophic severity outcome are also reported within 2 working days to the NPSA via the National Report & Learn System. The NPSA reports directly to the CQC.

2.3 Serious Incidents will be reviewed each month by the Pan Sussex Scrutiny Group and feedback is provided by the PCT.

3. Trends

Year on Year Trend of Numbers of SI Reported

3.1 The graph below shows year on year trend of the number of SIs. The higher numbers in 2011 are due to the integration of the organisation with community services on 1st April 2011 and the requirement to report Pressure Ulcers Grades 3 and 4 as SIs.

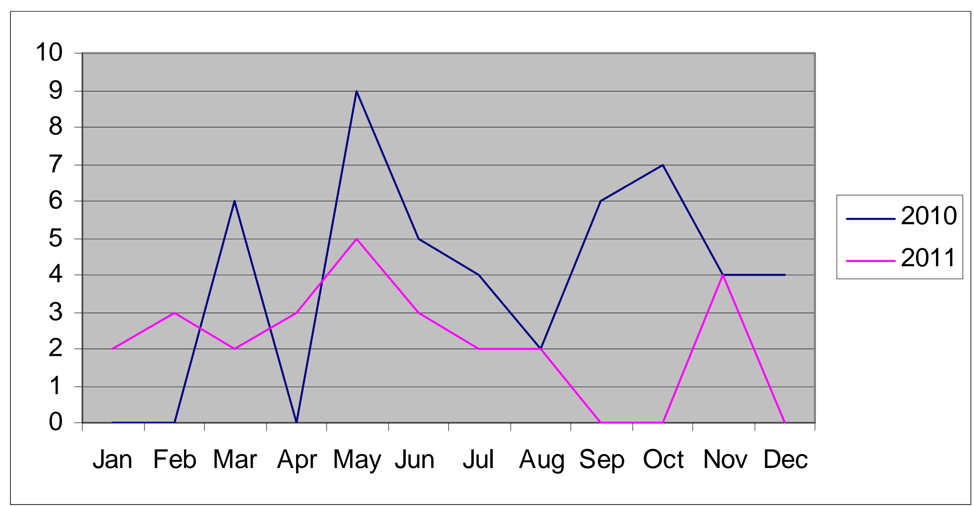


3.2 The table below shows year on year trend of numbers of SIs reported from each clinical division. 2011 numbers are to date.

	2010	2011
Corporate Services (inc IC)	9	8
Integrated Care	14	12
Planned Care	11	14
Urgent Care	13	30
Total	47	64

Year on Year Trend of Numbers of Serious Incidents Closed

3.3 The graph below shows the numbers of SIs closed during 2010 and 2011.

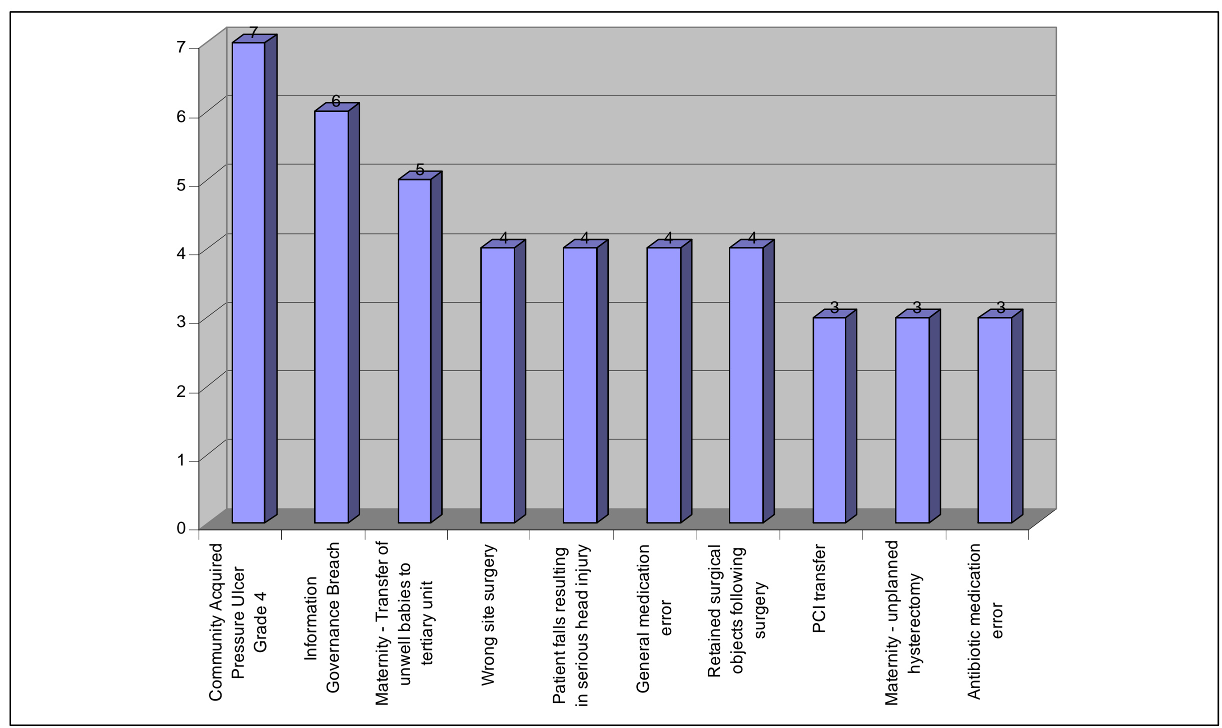


3.2 There were a total of 47 SIs opened during 2010 and 46 are now closed (98%). Up until November 2011 there have been 62 opened and 26 have been closed (42%). It should be noted that 2011 figures include community incidents.

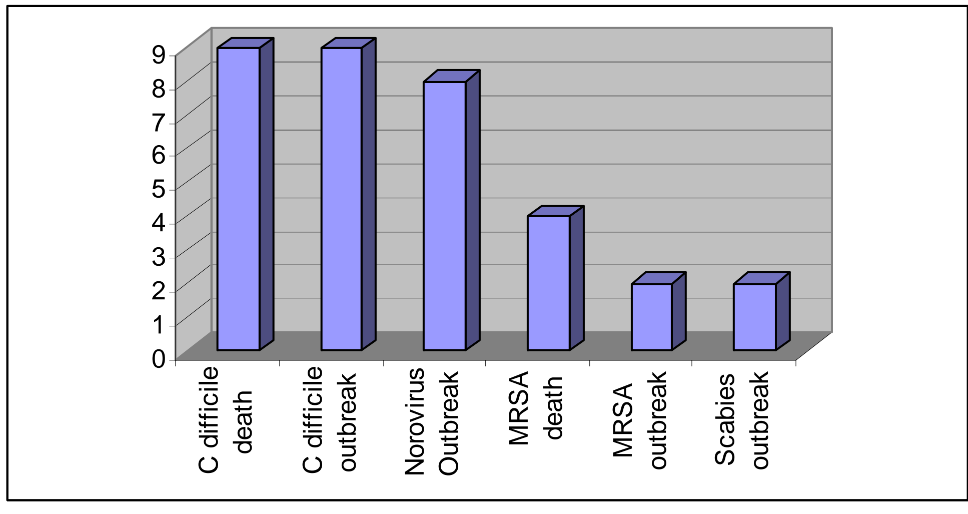
3.3 The table below shows year on year trends of numbers of incidents closed from each clinical division.

	2010	2011
Corporate Services (inc IC)	12	4
Integrated Care	11	10
Planned Care	12	5
Urgent Care	11	7
Totals	46	26

3.4 The graph below shows the top 10 themes of SIs reported (excluding infection control incidents).



3.5 The graph below shows the top 5 themes of infection control incidents reported as SIs:



4. Serious Incidents Reported in November 2011

4.1 There were eight new SIs reported during October 2011 all of which were reported from acute sites (see below). There were no SIs reported from the community sites.

4.2 There was one 'Never Event' reported during November 2011 (see below):

- **2011/21162**
  Corporate Services (Information Governance)
  Reported date 4 November 2011
  Failure to respond to Freedom of Information requests
  Completion due date = (45 days) 12 January 2012

- **2011/21138**
  Planned Care
  Reported date 4 November 2011
  Amputation of lower leg, delay in Doctor review
  Completion due date = (45 days) 12 January 2012

- **2011/21787 (NEVER EVENT)**
  Planned Care
  Reported date 6th October 2011
  Retained throat pack following dental surgery
  Completion due date = (60 days) 10 February 2012

- **2011/21807**
  Planned Care
  Reported date 15 November 2011
  Patient information faxed to Horder Centre via insecure route
  Completion due date = (45 days) 20 January 2012

- **2011/21997**
  Planned Care
  Reported date 18 November 2011
  Grade 4 Hospital Acquired Pressure Ulcer Glynde Ward EDGH
  Completion due date = (45 days) 23 January 2012

- **2011/22056**
  Corporate Services (Infection Control)
  Reported date 18 November 2011
  Scabies Outbreak Baird, Egerton and Irvine Units Conquest.
  Completion due date = (45 days) 23 January 2012

- **2011/22712**
  Commercial Services
  Reported date 29 November 2011
  Grade 3 Pressure Ulcer Michelham Unit EDGH
  Completion due date = (45 days) 3 February 2012

- **2011/22737**
  Reported date 29 November 2011
  Post operative deterioration and intestinal bleed
  Completion due date = (45 days) 3 February 2012

5. SIs closed during November 2011

5.1 **2009/12863** was closed.

5.2 **2011/9254 (MRSA outbreak McDonald Ward)** to be closed when confirmation of learning is evidenced.

5.3 **2011/13165 (Maternal death)** to be closed when an amended RCA is submitted.

5.4 **2011/17099 (Injury to deceased during transfer to fridge)** was closed as not considered to be a SI.

5.5 **2011/17026 (allegation of sexual assault prior to admission)** was closed as not considered to be a SI as occurrence was before patient was admitted.

5.6 There has been an increase in the number of incidents that are not closed when initially reviewed by the Pan Sussex Scrutiny Group. There are currently 30 RCA reports which have been submitted for closure but are either awaiting review by the group or requests for more information or assurance that actions have been implemented.

6. Compliance with 45/60 Working Day Target for Completion of Investigation

6.1 Eleven RCA investigation reports were submitted to the PCT for closure in November 2011. Eight of these were submitted within the 45/60 working day time frame, compliance level 73%.

7. Compliance with Action Plans

7.1 There are currently 511 actions on the action plan database of which 361 have been completed. There are 98 actions which are overdue for completion which leaves 52 ongoing but within target date. Therefore the overall compliance with the organisation's action plans arising from SIs which are complete or within target date is 79%.

7.2 The table below shows the divisional action plan compliance percentages:

	Total Actions	Actions Complete	Incomplete	Actions Overdue	Compliance Level
Corporate Services	130	115	15	15	88
Integrated Care	80	46	34	21	74
Planned Care	140	91	49	25	82
Urgent Care	122	70	52	37	70

7.3 An action plan tracker is sent to the divisions every month as a reminder and a tool to use for updating the PCT as to actions completed, progress against actions and any change in expected completion dates. The tracker is also used to record any further information or evidence of assurance as required by the Pan Sussex Scrutiny Group for their next review meeting.

8. Feedback from PCT

8.1 The Pan Sussex Scrutiny Group has requested that where a Pressure Ulcer is reported as both a Serious Incident and a SAAR Alert, that a copy of the SAAR Report should be included as part of the RCA report provided for the SI.

8.2 These reports are owned by Adult Social Care and therefore as a Trust we are not in a position to be able to provide the reports without referral to Adult Social Care. A suggestion has been made to the PCT that requests for the reports are made direct to ASC from the PCT for RCAs in which these reports are required but to date no confirmation has been made that this process is acceptable to them and we continue to receive feedback that these reports are missing and refusal to close as a result.

9. Conclusion

9.1 Eight SIs were reported in November 2011.

9.2 One of the eight incidents reported was classified as a Never Event.

9.3 Three SIs were closed in November 2011 and two will be closed upon receipt of further evidence.

9.4 There are 34 SIs that have previously been submitted to the PCT that are outstanding and waiting for closure.

9.5 Eleven RCA investigation reports were submitted in November 2011 for closure and seven of these were submitted within the 60 working day time frame.

9.6 Total compliance with action plans is 79%.

9.7 The issue of the PCT's requirement for access to SAAR reports for all SIs that are also reported as SAAR Alerts is currently unresolved but a Task and Finish group has been set up which will look into all issues relating to Pressure Ulcer reporting.

2 December 2011

East Sussex Healthcare NHS Trust

Date of Meeting:	21 December 2011
Meeting:	Trust Board
Agenda item:	6b
Subject:	Serious Incidents Activity November 2011
Reporting Officer:	Director of Nursing

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

Purpose:

To provide the Board with assurance that Serious Incidents are being managed, investigated and acted upon appropriately and that action plans developed from the investigations are carried out within appropriate timescales and embedded within the organisation's policies and process.

Introduction:

The report provides information on trends and significant issues from Serious Incidents reported by East Sussex Healthcare NHS Trust as well as highlighting compliance levels with required time frames for closing incidents and implementing action plans.

All RCA reports submitted for closure are reviewed by the Pan Sussex Scrutiny Group (PSSG) who after consideration will either close the incident or return them to ESHT for further information or evidence of assurance.

All RCA reports submitted to the PSSG are also reviewed by ESHT Serious Incident Review Group to assess the RCA for contributory factors.

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

1. Urgent Care Division – higher level of reporting than previous years (section 4.2)
2. More RCA reports are being returned to ESHT for further information before being closed by PSSG. There are currently 30 outstanding RCA reports waiting for further consideration of closure (section 6.2)
3. No SI closed October 2011 (section 6.1)
4. Feedback from PCT regarding a requirement for access to SAAR reports when incidents are reported as both SAAR Alerts and SI (section 9.1). These reports are raised by Adult Social Care and requests for these reports should come directly from the PCT to ASC for access.

Benefits:

- Improvements in the level of RCA reports that are being returned for further information from the PSSG and shorter time frame from submission to closure.
- In some cases it may be possible to avoid duplication of investigation and administration if the SAAR report is submissable to the PCT for such SIs.

Risks and Implications
• Any 'Never Events' reported may incur penalties or fines for costs of treatment or care to be reimbursed to the PCT. • Failure to report SI may result in the organisation not achieving a good report by the Care Quality Commission ("Essential Standards of Quality and Safety") about its compliance levels. • Bad publicity from media interest in SI both locally and nationally. • Complaints, claims and litigation.

Assurance Provided:
Compliance with 45/60 working days is being monitored and poor compliance or patient safety issues raised are referred to the Patient Safety Committee. Serious Incident Review Group monitoring of all RCA reports for contributory factors which are reported to the Patient Safety Committee.

Proposals and/or Recommendations
• That ESHT be provided with feedback from PSSG as to how we can improve the level of RCA reports that are closed. • That the PCT approach ASC regarding the access to SAAR reports when required for closure of a SI.

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: Jane Hentley, Director of Nursing	**Contact details: 13 4569** (13) 5855

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	7
Subject:	Performance Report
Reporting Officer:	Chief Operating Officer Director of Nursing Director of Finance & Performance

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

Purpose:

The attached document provides information on the Trust's performance data for the seven months to the end of October 2011 against key performance framework indicators, financial targets and the revised forecast out turn.

Introduction:

Cumulatively to the 31st October 2011 the Trust has a run rate overspending of £4.5m and an overspending against plan of £6.0m.
Based on the current financial and operational performance at month 7, and on the basis that we are continuing to discuss with the commissioners transformational financial support the year end forecast has been revised to a surplus of £1.3m which is in line with the original plan.

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

Despite the prospect of additional non recurring commissioner income support the consequential impact on future years' savings, and therefore the long term viability of the Trust, the following actions have been taken and are ongoing:

- Ensuring the continued delivery of the key performance measures to the end of March 2012
- The voluntary move to place the Trust into turnaround mode.
- The current external support has been extended in order to increase the capability and capacity to deliver the required level of savings to at least £17.5m
- The development of more radical proposals, where all expenditure is deemed as discretionary.
- To explore and investigate savings ideas that will start to deliver the expected efficiencies in 2012/13.

Elective access targets showed improvement in October, although performance was still below the 90% 18w RTT target. Action plans previously put in place to address 6 week diagnostic issues are ensuring that the backlog has further reduced from month 6.

Clinical quality metrics show delivery against infection control targets with 0 MRSA cases in October against a target of 1. As in month 6 there were 2 CDiff cases in Month 7. The year to date total cases reported to 31, marginally below plan year to date.

Workforce numbers continue to perform above revised budgets largely due to undelivered CRES targets. Sickness levels rose 4.14%, marginally above the 3.9% target.

Benefits:

To provide the organisation confidence that the Trust is hitting its targets and statutory obligations against an agreed framework of KPIs.

The Trust will ensure effective action is taken to deliver the forecast year end outturn and manage the impact on future year's financial performance and viability.

Risks and Implications

Bringing Divisional and Directorate overspending under control combined with the achievement of the CRES savings target presents a considerable challenge in order for the Trust to deliver its planned surplus and remain on the FT trajectory.

Assurance Provided:

The Trust Board is made aware of the financial position and performance against KPIs, and can scrutinise the impact of non delivery of the financial surplus, and the corrective actions required to address the situation.

Proposals and/or Recommendations

The Board is asked to note the following actions have been taken and are ongoing:

- Delivery of the key performance measures to the end of October 2011
- The voluntary move to place the Trust into turnaround mode.
- The current external support has been extended in order to increase the capability and capacity to deliver the required level of savings to at least £17.5m
- The Trust will continue to discuss and pursue the additional external revenue support through the SHA and PCT, with an expectation that this will be resolved by Q2.
- The development of more radical proposals, where all expenditure is deemed as discretionary.
- To explore and investigate savings ideas that will start to deliver the expected efficiencies in 2012/13.

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

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

None.

For further information or for any enquiries relating to this report please contact:	
Name: David Meikle, Director of Finance	**Contact details:** (14) 2251

PERFORMANCE REPORT

October 2011

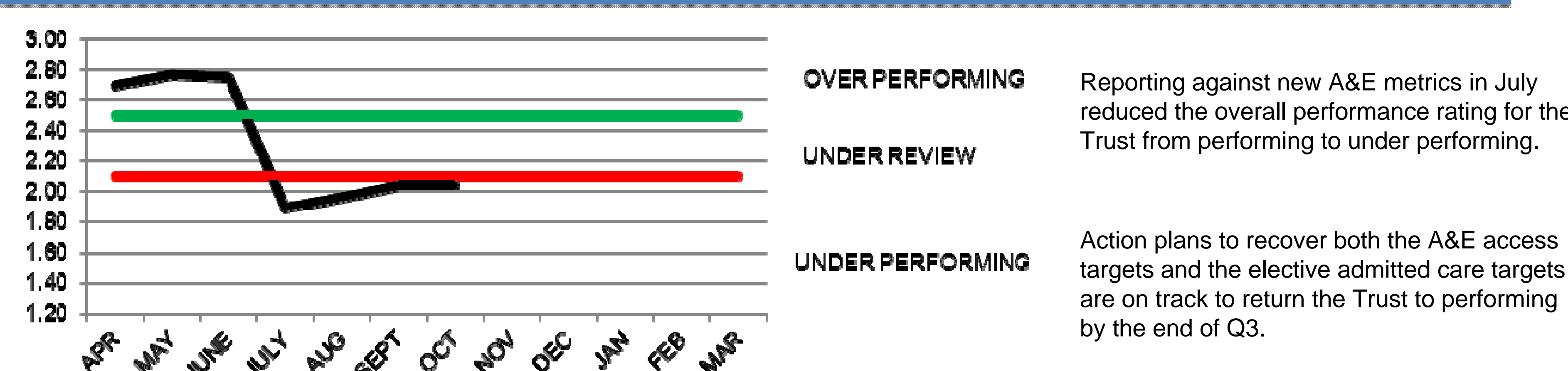
Executive Summary

	In Month	Forecast	
NATIONAL PERFORMANCE FRAMEWORK			The Trust continues to be rated as under performing largely as a result of unmet access targets despite continued improvement against 18 week RTT. Forecast is to be rated as performing by the end of Q3.
QUALITY AND SAFETY			Mortality and infection control continue to perform ahead of plan. However there is a slight increasing trend in drug administration errors which a re currently being investigated by the Patient Safety Committee.
ACCESS			The new A&E access targets continue to under perform but show improving trends and all but two cancer targets were achieved in month. 18 week targets continue to improve and 6 week diagnostic scoping breaches decreased in month. These are being addressed through increased capacity during Q3.
FINANCE			Run rate to the end of month 7 was £4.5m deficit. The forecast outturn is for the Trust to achieve 1.3m surplus but is dependant upon transformational support being agreed with commissioners.
DIVISIONS			Budgets and performance goals have been re-aligned to reflect the new Divisional structure. All three operational divisions are overspent largely due to unmet CRES targets.

Contents

National Performance Framework Scorecard	4
Quality & Safety Dashboard – Trust Level	5
Access Targets – 18 Weeks, 6 Weeks, Cancer and A&E	7
Finance	8
QIPP / CQUINS	18
Workforce	19
Divisions – Urgent Care	20
Divisions – Planned Care	21
Divisions – Integrated Care	22
Exception Reports	23

National Performance Framework - Scorecard



Reporting against new A&E metrics in July reduced the overall performance rating for the Trust from performing to under performing.

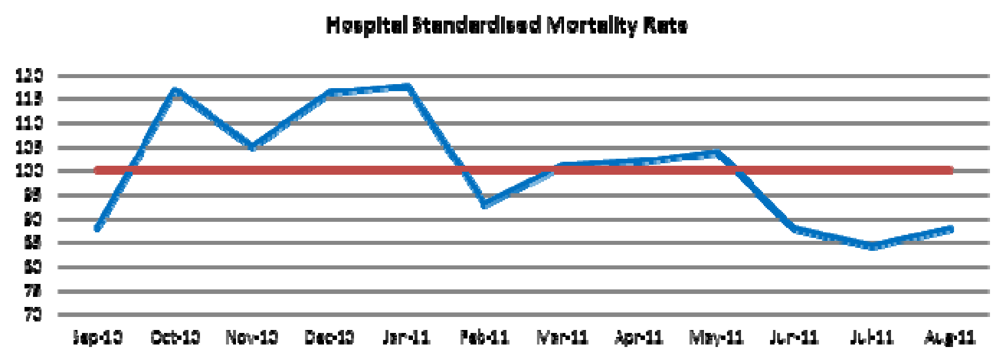
Action plans to recover both the A&E access targets and the elective admitted care targets are on track to return the Trust to performing by the end of Q3.

Exceptions: The following metrics are currently performing below the required thresholds as set by the DH:

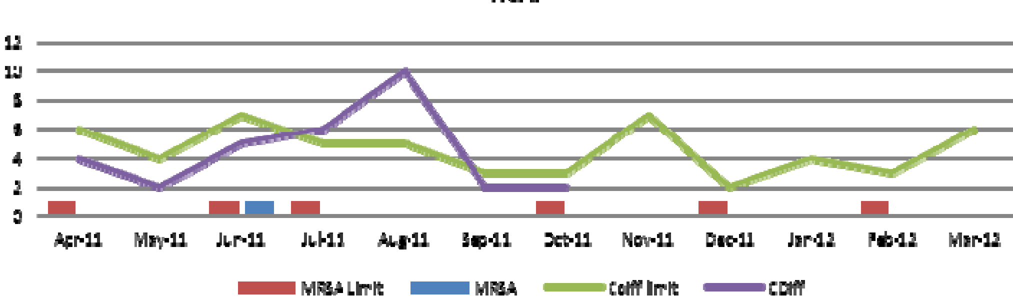
Quality of service	Thresholds		Performance
Performance Indicator	**Performing**	**Under-performing**	**Actual**
Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	5%	Achieve the thresholds for at least one indicator in each of the two groups	6.1%
Time to initial assessment - 95th centile	15 mins		41.0
Time to treatment in department - median	60 mins		79.0
RTT - admitted - 95th percentile[@]	<=23	>27.7	28.00
RTT - non-admitted - 95th percentile[@]	<=18.3		23.00
RTT - admitted - 90% in 18 weeks	90%	85%	80.7%
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	76.0%
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	56.8%

- It should be noted that the only cancer target not met in September was for 2 WW breast screening.
- 18 week access targets continue to improve but are not forecast to all be achieved until the end of Q3.
- Stroke performance is reported to August 2011.
- Further detailed reports for individual metrics are included elsewhere in the report.

Quality & Safety Dashboard – Trust Level

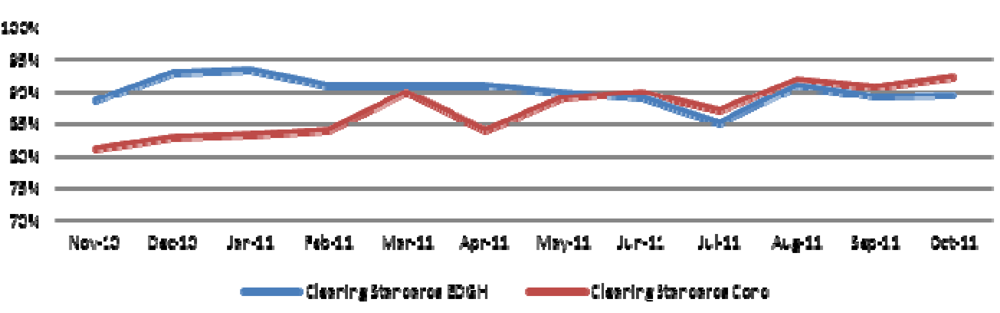


- HSMR remains under review by the mortality review group which continues to have a positive impact on the relative risk of the Trust.
- Performance to the end of August indicates a relative risk of 87.80 compared to an expected rate of 100.



•The Trust has been set a target ceiling of just 6 MRSA cases for 2011/12.
In the 7 months to October 2011 there has been just one case.

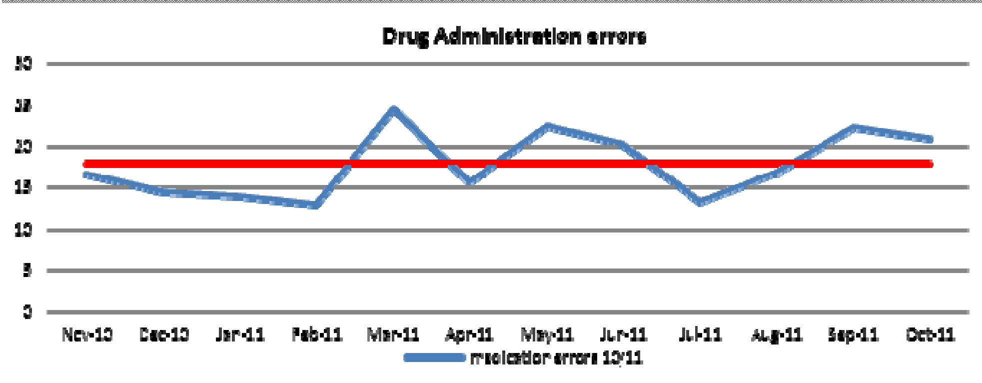
- C.Diff has reported level of 31 cases against the first 6 months profile of 33.



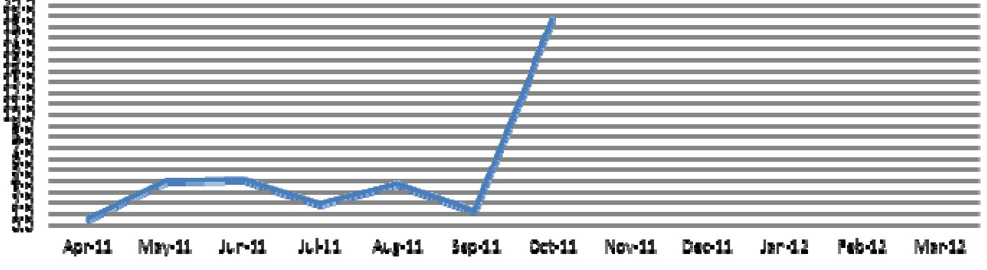
•The cleaning standards audit reviews 3 key areas: Nursing , housekeeping and maintenance with a target to achieve 86% compliance.

- October results were ESHT 91%,(EDGH 89.4%, Conquest 92.3%).

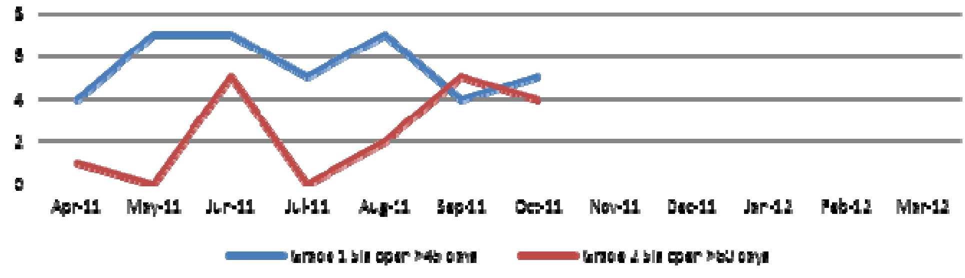
Quality & Safety Dashboard – Trust Level



- Drug Administration Errors form part of the revised Safer Smarter Care / HIA measures.
- Performance above the baseline prompts referral to the Patient Safety Committee for review.
- Performance to the end of October is subject to review by the Patient Safety Committee.

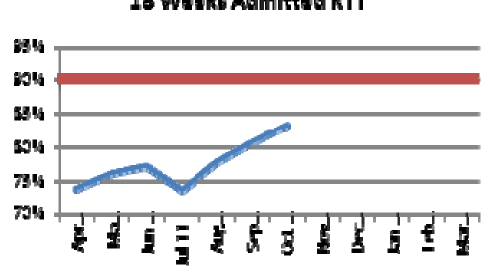


- Single Sex accommodation breaches are required to be reported per 1,000 completed episodes of care.
- Performance in September was 18.54 per 1000 Beddays
- Equivalent to 170 Breaches
- Increase of 17 from previous month and 16 above YTD average

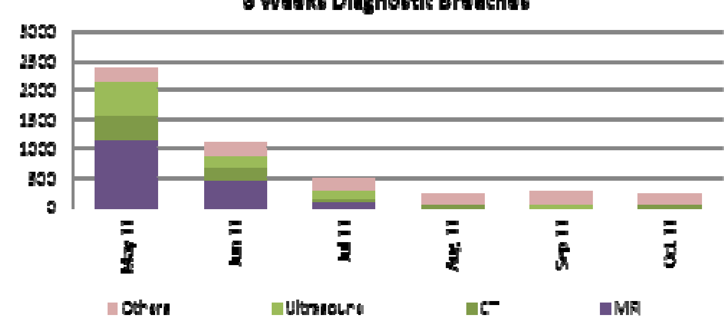


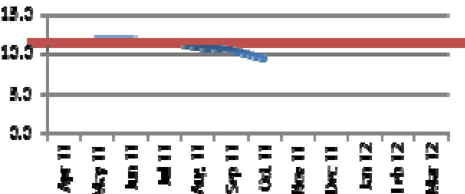
- The number of Serious incident investigations remaining open after 45 days and 60 days includes all ESHT (acute and community) as of June 2011.

East Sussex Healthcare Trust
Access Targets



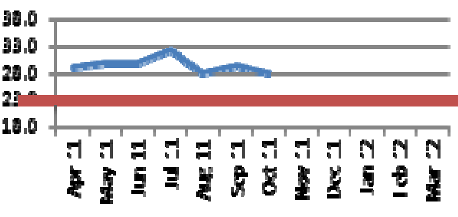
- RTT will improve as backlog is tackled through targeted use of 3rd party and ad-hoc capacity whilst Divisions continue to improve core capacity and reduce non-elective pressure on elective bed-stock.



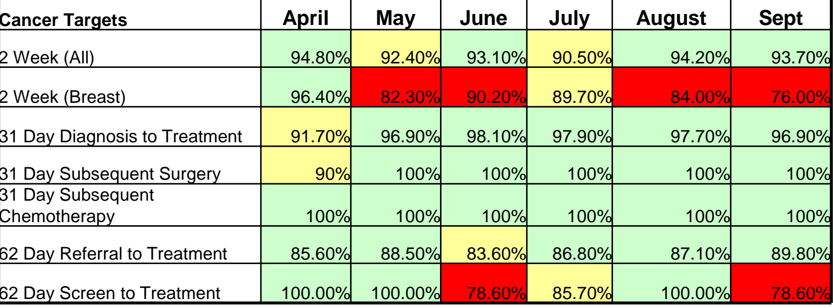


- The median wait time fell to 9.43 weeks achieved the in October falling for the Third consecutive month.

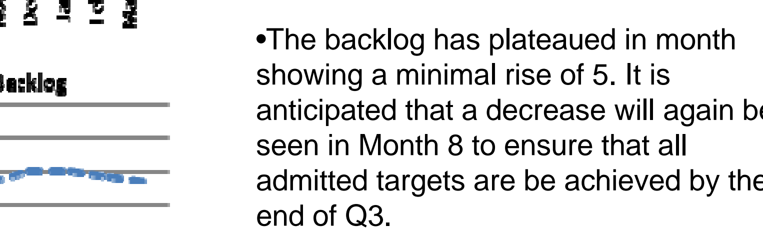
- 6 Week diagnostic backlog improved in October, with due to additional third party capacity . The eradication of the backlog is unlikely to be achieved until the end of December however.



•95th centile fell in October to 28 weeks, but remaining outside of target.



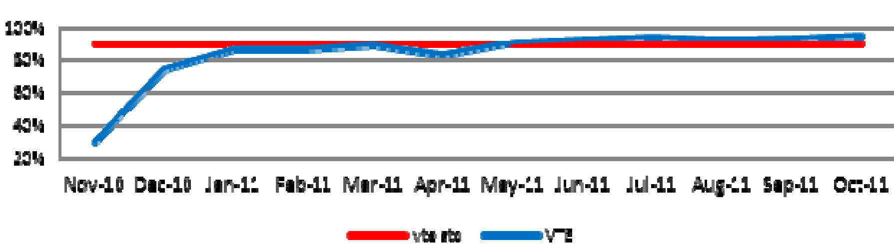
Cancer Targets	April	May	June	July	August	Sept
2 Week (All)	94.80%	92.40%	93.10%	90.50%	94.20%	93.70%
2 Week (Breast)	96.40%	82.30%	90.20%	89.70%	84.00%	76.00%
31 Day Diagnosis to Treatment	91.70%	96.90%	98.10%	97.90%	97.70%	96.90%
31 Day Subsequent Surgery	90%	100%	100%	100%	100%	100%
31 Day Subsequent Chemotherapy	100%	100%	100%	100%	100%	100%
62 Day Referral to Treatment	85.60%	88.50%	83.60%	86.80%	87.10%	89.80%
62 Day Screen to Treatment	100.00%	100.00%	78.60%	85.70%	100.00%	78.60%

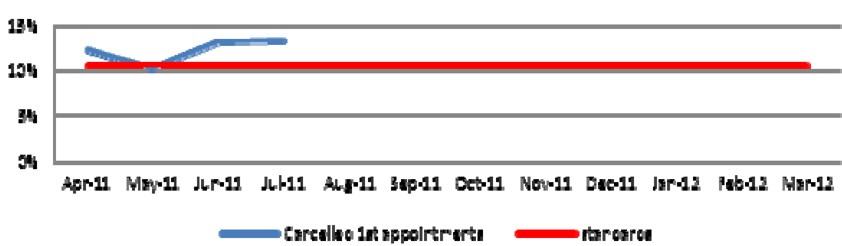


•The backlog has plateaued in month showing a minimal rise of 5. It is anticipated that a decrease will again be seen in Month 8 to ensure that all admitted targets are be achieved by the end of Q3.

- Cancer targets are reported one month in arrears.
- 2 WW Breast referrals missed the target in month (*see exception report*).
- 62 Day Screen to Treatment Missed target *(see exception report)*

CQUINS (*QIPP*)



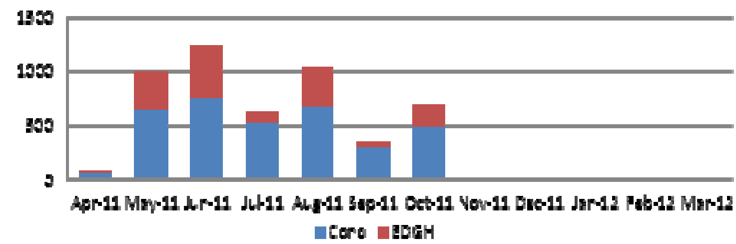


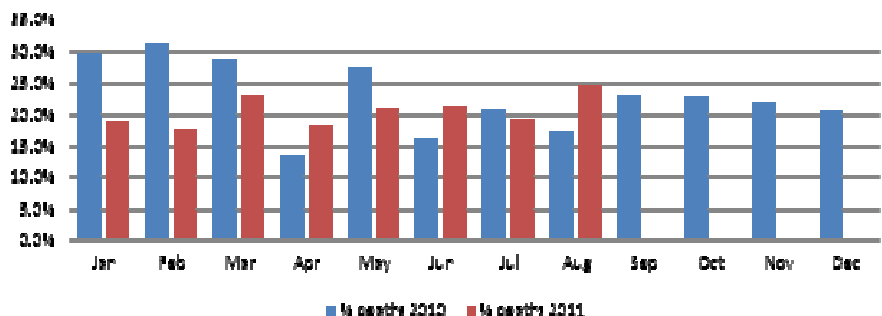
VTE

0.1% (approx: £375k) of Trust turnover will be earnt if the Trust achieves 90% VTE assessment in each month during 2011/12.

Outpatient Cancellations

Current performance in reducing year on year cancellations is distorted by the impact of re-designing clinic templates in most specialities resulting in patients being cancelled and re- booked into the new structures. Clean data is expected to be reported in November.





Critical Care Transfers

A CQUIN payment of approx: £500k will be received for a year on year reduction in delayed transfers. Performance to the end of October averaged 716hrs per month 24% better than the 949hrs per month in 2010/11.

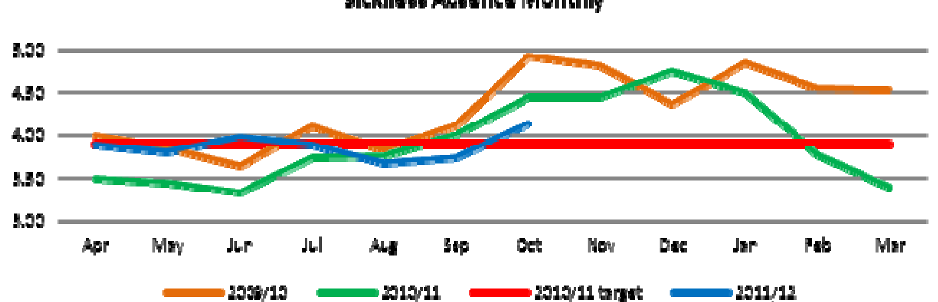
Workforce

	Threshold			Year to Date	
	Green	Amber	Red	Target	Actual
WTE in post (actual w orked)				6315.21	6528.7
Paybill (£m)				139.86	147.25
Staff turnover	<10%	10%<>12%	>12%	10%	9%
% of Bank, agency and overtime spend					8.15%

	Threshold			Year to Date	
	Green	Amber	Red	Target	Actual
Induction	=>90%	80%<>90%	<80%	90%	81.50%
Fire	=>90%	80%<>90%	<80%	90%	65.27%
Manual Handling#	=>90%	80%<>90%	<80%	90%	59.26%
Infection Control	=>90%	80%<>90%	<80%	90%	68.37%
Information Governance					69.91%

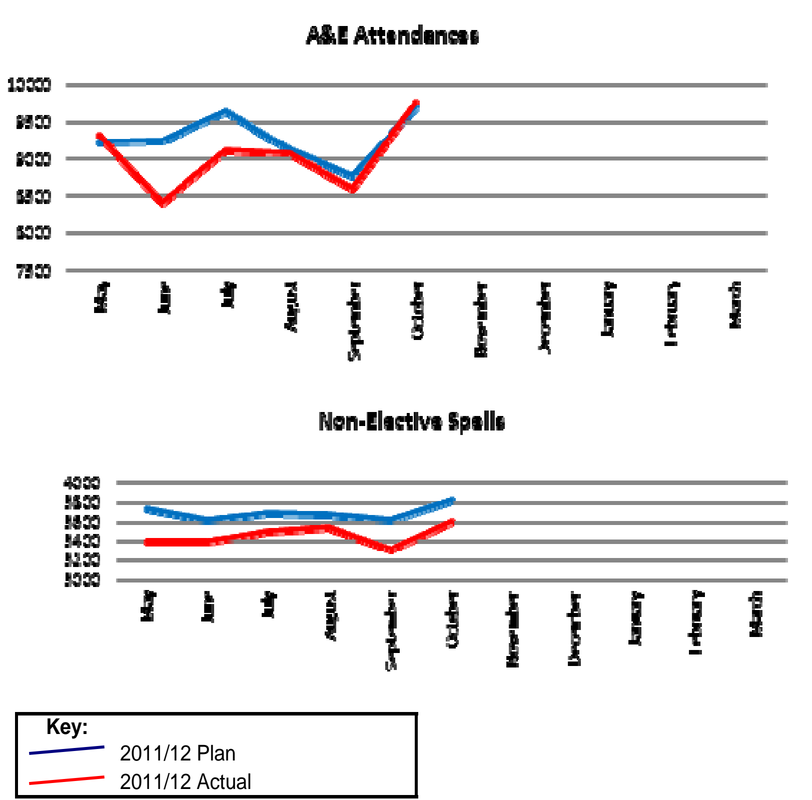
#From 1/4/11 Manual Handling requirement for Clinical staff reverted from 3 year to annual renewal for former Hospitals Trust staff.

	Threshold			Annual rate	
	Green	Amber	Red	Target	Actual
Appraisals completed in last 12 mnths					62.28%
sickness rates	<3.9%	3.9%<>4.4%	>4.4%	3.9%	4.14%



- Staffing employed is greater than budget reflecting unmet CRES savings resulting in a year to date overspend.
- A change in mandatory training requirements from a three year cycle to annual re-testing has led to the apparent reduction in performance in 2011/12. The Trust expects to achieve the required targets by the year end.
- A new appraisal system was introduced in April reporting Appraisals undertaken since April 2011. A target of 85% is still expected to be achieved by the end of Q3.
- Monthly sickness rose above target but remained below the comparable 2010/11 figure for the third consecutive month in October at 4.14%.

Urgent Care Division

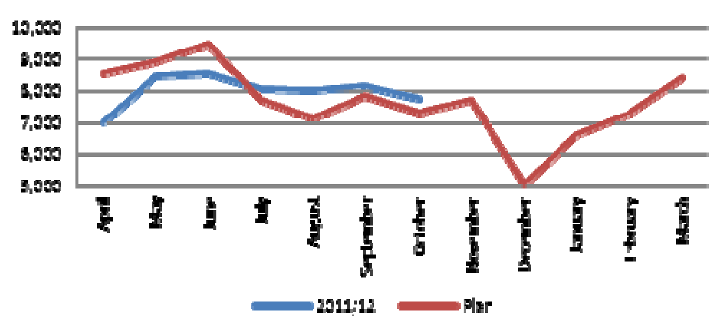


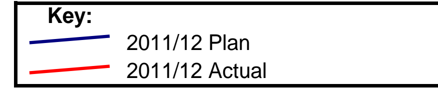
	In Month	YTD
• A&E 4 hour target:	96.10%	96.11%
• Unplanned Re-Attend Within 7 days (5%)	6.10%	
• Left without being seen (5%)	3.80%	
• Initial Assessment - 95% within 15 mins	41 mins	
• Time to treatment median wait (60 mins)	79 mins	
• Ambulance turnaround:		
- Arrival to handover (15 mins)	17.2 mins	19.5 mins
- Handover to clear (5 mins)	18.1 mins	16.0 mins
• Average LOS:	6.8	6.6
• DTCs (%):	2.2%	2.2%

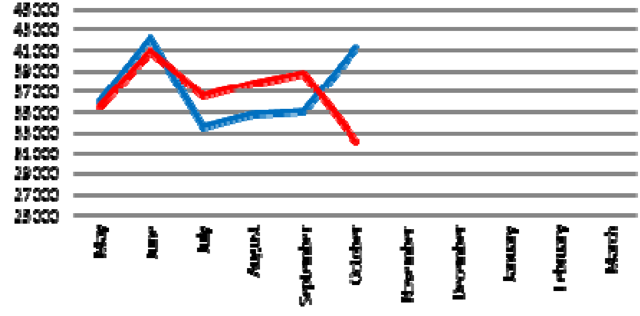
- A&E attendances rose during October in line with seasonal plans, performing on profile in activity terms.

- Non-elective admissions also rose during October . Average length of Stay remained at 6.8 days in October but the overall fall in emergency admissions in 2011/12 has supported the planned closure of beds.

Planned Care Division







			In Month	YTD
·	New to Follow Up:		1.42	1.42

Elective Spells

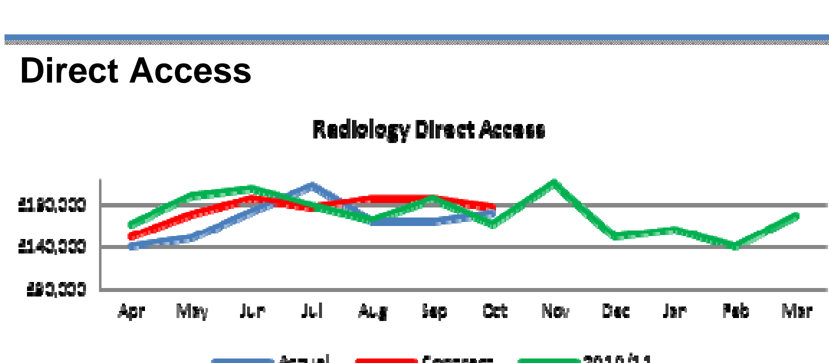
5000
4500
4000
3500
3000

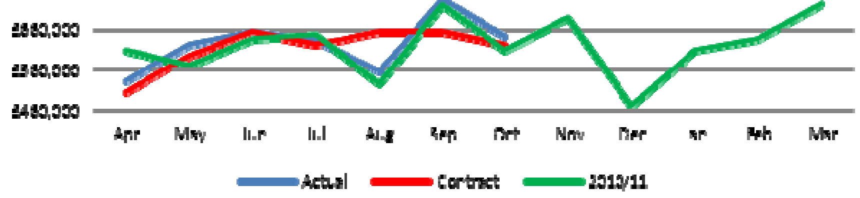
May June July August September October November December January February March

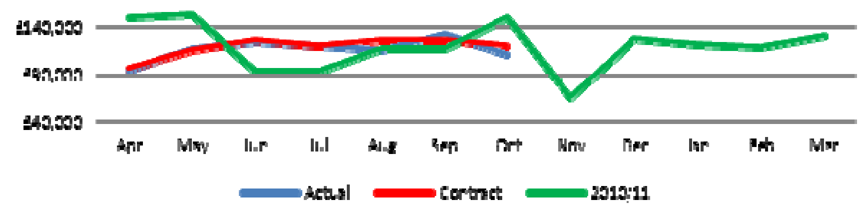
	In Month	YTD
D/C Rate:	79.69%	79.87%
Average LOS:	2.35	2.59
Cancellations:	0.60%	0.58%

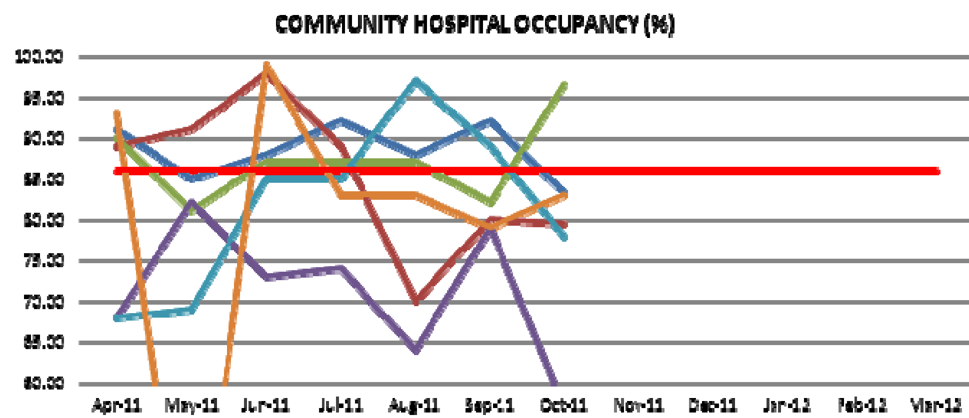
- Outpatient performance is ahead of profile for the third month largely due to demand management plans not achieving expectations.
- Elective activity continues to perform ahead of plan as a result of improving capacity to meet 18 week RTT targets. However, this is partially countered by the reduction in LOS further reducing excess bedday income.
- Elective income is expected to at least achieve contract levels by year end.

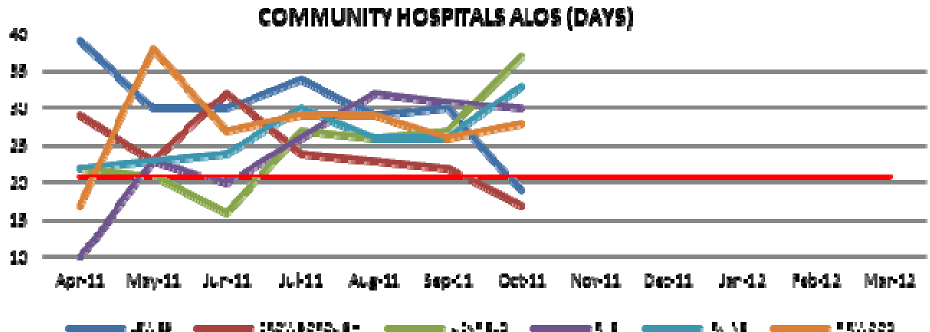
Direct Access











- Occupancy rates in Firwood increased to 125% indicating an increase in the number of beds available . Uckfield also rose to 96%. Rye dropped significantly to 57%.

- Length of stay remains higher than planned increasing pressure on community beds.

Financial Summary – October 2011

Headlines

- Overall the Trust generated a small in month surplus of £0.3m, including additional monthly transitional income from commissioners of £0.8m.
- October was also the lowest recurring spend in month since the start of the financial year.
- Year to date (YTD) the Trust run rate deficit is cumulatively £4.5m. This YTD includes the assumption that the Trust will receive full year additional commissioner support of £9m and consequently a proportionate sum, £5.3m, has been included in the YTD position.
- Subsequent discussions with the PCT now indicate that a further £6m full year income support is likely to be agreed. However, no account of this additional support has been taken into account in the YTD position.
- On the basis that commissioner full year support increases to £15m the forecast is that the original planned surplus of £1.3m will be achievable. This additional income support is covering a range of non recurring costs, including consultancy costs, redundancy costs and quality costs associated with the CQCs recommendations.

Key Issue	Summary	Year to Date	Outturn
Key Performance Indicators	Measured against Monitor criteria the year to date (YTD) performance is a red rating of 1 and forecast out turn KPIs performance is an amber rating of 2.	R	A
Financial Summary	Cumulatively to 31st October 2011 the Trust has a run rate overspending of £4.5m and an overspending against plan of £5.7m. This year to date position (YTD) includes the assumption that the Trust will receive full year additional commissioner support of £9m. No account has been taken in the YTD position of further full year support of £6m likely to be agreed with the commissioners. This additional income support is covering a range of non recurring costs, including consultancy costs, redundancy costs and quality costs associated with the CQCs recommendations. On the basis of receiving full year support of £15m the year end forecast remains a surplus of £1.3m which is in line with the original plan.	R	A
Activity & Income	Excluding the additional commissioner support overall NHS patient income was slightly above financial plan although marginally behind on the activity plan, thereby reflecting the increased complexity of the case mix delivered. Private patient income remains below plan YTD.	A	G
Expenditure	Pay and ad hoc costs are cumulatively overspent by £7.3m against plan. Non pay including 3rd party is cumulatively overspent by £4.1m. The delivery of CRES savings and the control of pay expenditure remain key to returning the trust to financial balance.	R	R
CRES plans	Of the Trust's total £30m savings programme £15.8m of savings have been identified. Year to date £5.8m has currently being achieved against a target of 8.1m, equivalent to a conversion rate of 71%.	R	R
Balance Sheet	in order to maintain liquidity the Trust has requested a £20m working capital loan over 5 years in order to address the Trust's longer term cash requirements including compliance with the BPPC.	A	A
Cash Flow	Cash management continues to be important as the cash position remains challenging.	A	A
Capital Programme	At the end of October capital expenditure amounted to £3.2m and the capital programme remains on target to meet the Trust's capital resource limit at the 31st March 2012.	G	G
Risk Summary	As a result of the YTD performance the overall Monitor risk rating at 31st October 2011 was a rating of 1. The forecast outturn is an amber rating of 2.	R	A

Income & Expenditure – October 2011

Headlines

- In the month the run rate improved by £0.3m reducing the cumulative run rate deficit to £4.5m.

- However, this improvement was largely due to the inclusion of expected additional commissioner support.

- Following discussions with the commissioners the initial assumption was that the Trust will receive additional full year income support of £9m. Therefore, 6 months of this annual sum,£4.5m, has been proportionately included in the YTD position.

- Subsequent discussions with the PCT now indicate that a further £6m full year income support is likely to be agreed. However, no account of this additional support has been taken into account in the YTD position.

- On the basis that commissioner full year support increases to £15m the forecast is that the original planned surplus of £1.3m will be achievable.

I&E Monthly Trend	Aug £m	Sep £m	Oct £m	YTD £m
Income	32.0	35.1	31.9	219.2
Expenditure				
Pay	-21.3	-20.9	-20.8	-146.6
Ad Hocs	-0.1	-0.1	-0.1	-0.6
Non Pay	-9.9	-9.5	-9.2	-65.3
3rd party	-0.5	-0.4	-0.2	-1.9
Capital Charges	-1.3	-1.3	-1.3	-9.3
Deficit	-1.1	2.9	0.3	-4.5
Normalised/Contingency Adj.	-2.2	-2.2	0	0.0
Normalised Net Surplus/(Deficit)	-3.3	0.7	0.3	-4.5

£000s	In Mth Plan	In Mth Actual	Variance	YTD Plan	YTD Actual	Variance	Annual Plan
NHS Patient Income	27,148	28,886	1,738	192,288	198,378	6,090	324,166
Private Patient/ ICR	377	321	-56	2,636	2,074	-562	4,519
Trading Income	435	401	-34	3,047	3,008	-39	5,224
Education	691	691	0	4,844	4,844	0	8,280
Other Non Clinical Income	1,540	1,595	55	10,902	10,929	27	18,620
Total Income	**30,191**	**31,894**	**1,703**	**213,717**	**219,233**	**5,516**	**360,809**
Pay Costs	-19,851	-20,813	-962	-139,601	-146,610	-7,009	-243,574
Ad hoc Costs	0	-88	-88	-263	-637	-374	-219
Non Pay Costs	-8,377	-9,244	-867	-56,195	-65,594	-9,399	-90,700
3rd Party Costs	-155	-234	-79	-1,144	-1,870	-726	-277
Other	-1	46	47	-5,706	326	6,032	-8,318
Total Costs	**-28,384**	**-30,333**	**-1,949**	**-202,909**	**-214,385**	**-11,476**	**-343,088**
EBITDA	**1,807**	**1,561**	**-246**	**10,808**	**4,848**	**-5,960**	**17,721**
Profit/Loss on Asset Disposal							
Depreciation	-826	-698	128	-5,828	-5,552	276	-9,958
PDC Dividend	-511	-508	3	-3,574	-3,555	19	-6,126
Interest	-26	-43	-17	-178	-219	-41	-304
Net Surplus/-Deficit	**444**	**312**	**-132**	**1,228**	**-4,478**	**-5,706**	**1,333**
Normalised Contingency Adjustment	0	0	0	0	0	0	0
Normalised Net Surplus/-Deficit	**444**	**312**	**-132**	**1,228**	**-4,478**	**-5,706**	**1,333**
EBITDA	**1,807**	**1,561**	**-246**	**10,808**	**4,848**	**-5,960**	**17,721**
Debtors	78	-8,800	-8,878	546	-14,651	-15,197	466
Creditors	-802	15,338	16,140	-1,908	31,636	33,544	-668
Other	0	-151	-151	0	-504	-504	3,797
CF from Operations	**1,083**	**7,948**	**6,865**	**9,446**	**21,329**	**11,883**	**21,316**
CAPEX	-2,925	-3,982	-1,057	-7,012	-9,383	-2,371	-13,409
Proceeds from Asset Sales	0	0	0	0	6	6	6
Interest Rec'd/Paid	2	1	-1	8	11	3	18
Net movement in loans	0	0	0	-837	-837	0	-1,674
PDC	0	0	0	-3,078	-2,994	84	-6,157
Other	-27	19	46	-187	105	292	-324
Net Cash Inflow/Outflow	**-1,867**	**3,986**	**5,853**	**-1,660**	**8,237**	**9,897**	**-224**

Balance Sheet & Cash Flow – October 2011

Headlines

- The forecast balance sheet is modelled on the assumption that the Trust is forecast to make a £1.3m surplus at year-end.
- Operationally cash remains very tight with resulting poor BPPC performance and a high value of outstanding creditors on the balance sheet.
- As part of its approved cash strategy, the Trust is now working on securing a substantial working capital loan to be drawn down in March 2012. This loan will support future payments to suppliers and provide liquidity to assist with the Trusts Foundation Trust aspirations.
- Any working capital loan taken in year will have an impact on future years CRES plans as repayments must be made from surpluses.

Cash Flow Statement October 2011 - 12 Month Projection

£000s	Nov	Dec	Jan 2012	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Income												
Block Contract	25,602	25,602	23,602	19,602	16,602	26,500	27,000	27,000	27,000	27,000	27,000	27,000
Deanery	460	460	460	460	460	465	465	465	465	465	465	465
Loan	0	3,147	0	0	0	0	0	0	0	0	0	0
Sales ledger	2,413	2,998	2,799	3,099	5,398	3,000	3,750	3,000	3,250	3,000	3,750	3,000
Interest Receivable	1	2	1	1	2	2	2	2	2	2	2	2
Donated Assets	32	25	25	25	25	25	25	25	25	25	25	25
RTA/VAT/Sundry	103	100	100	100	100	100	100	600	100	100	100	100
Total Income	**28,611**	**32,334**	**26,987**	**23,287**	**22,587**	**30,092**	**31,342**	**31,092**	**30,842**	**30,592**	**31,342**	**30,592**
Expenditure												
Payroll costs	12,773	12,520	12,840	12,540	12,540	12,500	12,500	12,500	12,500	12,500	12,500	12,600
Tax/NI/Super	8,200	8,200	8,200	8,200	8,200	8,200	8,200	8,200	8,200	8,200	8,200	8,200
Non Pay expenditure	10,228	8,986	6,739	2,047	1,111	8,700	8,700	8,700	8,700	8,500	7,000	8,000
Capital programme	1,000	1,000	1,000	1,000	750	1,000	1,000	1,000	1,000	1,000	1,000	1,000
PDC dividend	0	0	0	0	3,047	0	0	0	0	0	3,316	0
Working Loan repayment	0	0	0	0	667	0	0	0	0	0	667	0
Capital Loan repayment	0	0	0	0	170	0	0	0	0	0	170	0
Loan interest	0	0	0	0	115	0	0	0	0	0	111	0
Total Expenditure	**32,201**	**30,706**	**28,779**	**23,787**	**26,600**	**30,400**	**30,400**	**30,400**	**30,400**	**30,200**	**32,964**	**29,800**
Net inflow/outflow	**-3,590**	**1,628**	**-1,792**	**-500**	**-4,013**	**-308**	**942**	**692**	**442**	**392**	**-1,622**	**792**
Opening balance	9,767	6,177	7,805	6,013	5,513	1,500	1,192	2,134	2,826	3,268	3,660	2,038
Closing balance	6,177	7,805	6,013	5,513	1,500	1,192	2,134	2,826	3,268	3,660	2,038	2,830

£000s	Nov	Dec	Jan 2012	Feb	Mar
EBITDA	**2,587**	**2,575**	**2,575**	**2,575**	**2,537**
Change in Trade Receivables	3,023	3,023	3,023	3,023	3,025
Change in Trade Payables	-8,073	-5,991	-6,194	-4,971	-5,087
Other	-153	-153	-153	-153	119
Net Cash Inflow	**-2,616**	**-546**	**-749**	**474**	**594**
Capital Spend	-1,000	-1,000	-1,000	-1,000	-750
Dividends	0	0	0	0	-3,047
Financing/Other	26	3,174	-43	26	-810
Net inflow/outflow	**-3,590**	**1,628**	**-1,792**	**-500**	**-4,013**

BALANCE SHEET £000s	Restated Opening B/Sheet	Outturn Actual	Forecast Mar 2012
Non Current Assets			
Property plant and equipment	201,152	198,834	201,500
Intangilble Assets	168	152	140
Trade and other Receivables	1,225	1,341	1,000
	202,545	**200,327**	**202,640**
Current Assets			
Inventories	6,947	6,791	6,650
Trade and other receivables	11,446	26,533	12,137
Other current assets	176	134	170
Cash and cash equivalents	1,500	9,779	1,500
	20,069	**43,237**	**20,457**
Current Liabilities			
Trade and other payables	-30,258	-57,311	-28,223
DoH Loan	-1,674	-1,674	-1,674
Borrow ings - Finance Leases	-306	-257	-304
Provisions	-345	-374	-361
	-32,583	**-59,616**	**-30,562**
Non Current Liabilities			
Trade and other payables	-4,103	**-3,622**	-4,027
DoH Loan	-8,557	-7,720	-6,883
Borrow ings - Finance Leases	-1,532	-1,325	-1,194
Provisions	-2,623	-2,572	-2,761
	-16,815	**-15,239**	**-14,865**
Total Assets Employed	**173,216**	**168,709**	**177,670**

BALANCE SHEET £000s	Restated Opening B/Sheet	Outturn Actual	Forecast Mar 2012
Financed by			
Public Dividend Capital (PDC)	107,407	107,407	110,556
Revaluation Reserve	82,217	82,189	82,189
Income & Expenditure Reserve	-16,408	-20,887	-15,075
Total Tax Payers Equity	**173,216**	**168,709**	**177,670**

Key Performance Indicators – October 2011

Headlines

KPIs

- The Trust's plan is for a £1.3m surplus to be achieved at 31 March 2012.
- The YTD EBITDA Margin achieved of 2.2% remains an amber risk rating of 2.
- The EBITDA achieved as a percentage of plan has improved to 44.9% but remains a red rating of 1.
- The I&E surplus margin of -0.7% is below plan and has improved to an amber rating of 2.
- The liquidity ratio has been adjusted for an estimated 30 day Working Capital Facility (WCF) to make it comparable with Monitor's assessment criteria. Including the WCF the liquidity ratio remains 7 days and a risk rating of 1.
- The overall YTD KPI rating as measured against Monitor criteria remains a red rating of 1.
- Based on the revised year end forecast run rate surplus of £1.3m the overall year end rating would be a rating of 2.

National & Local Measures:-

- The basis for calculating the national measure of BPPC figures for NHS invoices was revised at month 2 in accordance with the Audit Report which required payments in respect of Tax, NI and Superannuation to be excluded from the calculation. As a result this rating is now reported as red.

KPIs	YTD Plan	Actual
EBITDA Margin (%)	5.1	2.2
EBITDA Achieved (% of plan)	100.0	44.9
Return on Assets (excl. dividend) (%)	4.7	-0.7
I&E surplus margin (%)	0.6	-2.0
Liquidity Ratio (days)	18	7
Overall Monitor Risk Rating	3	1

National & Local Measures	YTD Plan	Actual
Income v Plan (£m)	213.7	219.2
Expenditure (before financing costs) v Plan (£m)	202.9	214.4
CRES Plans (£m)	8.1	5.8
BPPC – Trade invoices by value (%)	95	42.5
BPPC – NHS Invoices by value (%)	95	58.9

Monitor Ratings	YTD Risk Rating
EBITDA Margin	2
EBITDA % Achieved	1
Return on Assets Employed	2
I&E Surplus Margin	2
Liquidity Ratio	1
Overall Risk Rating	1

Activity & Contract Income – October 2011

Headlines

- Contract income was slightly above financial plan although marginally behind on the activity plan, thereby reflecting the increased complexity of the case mix delivered in month.

- Overall patient related income is now above plan for the year to date (YTD) following the inclusion of £5.2m YTD anticipated additional commissioner support. The full year additional commissioner support being discussed is now forecast to increase by £6m to £15m.

- Although overall elective activity is up by 3.7%, elective inpatient activity specifically is down. This earns the Trust higher income than day case activity and consequently total elective income is 1.0% below plan.

- A richer case mix for emergency admissions than planned means that although activity is down by 5.8%, associated income is up by 4.1%.

- Overall outpatient type activity is up by 5.2%, however, the impact on income is adverse by 3.3%. First and follow up activity is down although procedures and nurse led clinics are up by a similar amount. National grouper changes and cessation of previously imposed commissioning rules are contributory causes.

- A&E attendance are cumulatively below plan by 2.1%.

- Significant earlier ITU and SCBU activity over performance has reduced but is still over plan. It should be noted that these are volatile areas.

Activity	Current Month Plan	Current Month Actual	Current Month Variance	YTD Plan	YTD Actual	YTD Variance
Day Cases	3,038	3,494	456	22,112	23,811	1,699
Elective Inpatients	894	842	-52	6,673	6,050	-623
Emergency Inpatients	3,766	3,472	-294	25,730	24,227	-1,503
Total Inpatients	**7,698**	**7,808**	**110**	**54,515**	**54,088**	**-427**
Excess Bed Days	2,810	2,092	-718	19,410	16,501	-2,909
Total Excess Bed Days	**2,810**	**2,092**	**-718**	**19,410**	**16,501**	**-2,909**
Consultant First Attendances	8,324	8,379	55	61,929	58,859	-3,071
Consultant Follow Ups	12,384	13,133	749	93,180	90,649	-2,531
OP Procedures	3,084	3,689	605	21,293	24,268	2,975
Other Outpatients inc WA & Nurse Led	9,302	11,721	2,419	67,858	83,487	15,629
Community Specialist	261	126	-135	1,800	1,545	-255
Total Outpatients	**33,355**	**37,048**	**3,693**	**246,060**	**258,808**	**12,748**
A&E Attendances (excluding type 2's)	8,811	8,786	-25	63,534	62,179	-1,355
ITU Bed Days	403	656	253	3,046	3,442	396
SCBU Bed Days	280	268	-12	2,040	1,684	-356
Radiology - Direct Access	4,947	5,051	104	34,158	34,209	51
Pathology - Direct Access	247,177	256,768	9,591	1,706,697	1,726,282	19,585
Physio - Direct Access	3,214	2,979	-235	22,197	21,887	-310

Income £000's	Current Month Contract	Current Month Actual	Current Month Variance	YTD Contract	YTD Actual	YTD Variance
Inpatients - Electives	4,581	4,988	407	35,075	34,720	-355
Inpatients - Emergency	6,687	6,943	256	45,942	47,742	1,800
Excess Bed Days	644	524	-120	4,445	3,810	-635
Outpatients	4,074	4,115	41	29,793	28,810	-983
Other Acute based Activity	1,549	1,926	377	11,361	11,840	479
Direct Access	932	934	2	6,429	6,396	-33
Block Contract	6,453	6,492	39	45,159	45,391	232
Other i.e. National CEAs, etc	508	808	300	2,012	5,743	3,731
Other Block/Adj	391	373	-18	2,770	3,011	241
Subtotal	25,819	27,103	1,284	182,986	187,463	4,477
High Cost Drugs	1,130	1,578	448	7,907	9,332	1,425
Device Exclusions	199	205	6	1,395	1,583	188
GRAND TOTAL	**27,148**	**28,886**	**1,738**	**192,288**	**198,378**	**6,090**

Divisional Performance (budgets) – October 2011

Headlines

- The divisional performance after 7 months is as follows:-
- **Planned Care -** The division is overspent by £6.1m. The principle year to date overspendings are pay £2.3m, unidentified savings of £3.1m and contract underperformance of £1.1m.
- **Urgent Care** - The division is overspent by £3.9m. The principle year to date overspendings are pay £4.4m, unidentified savings of £1.4m offset by contract over performance of £1.9m.
- **Integrated Care -** The division is over spent by £3.6m. The principle year to date overspendings are pay £0.9m and unidentified savings £2.4m.
- **Commercial** - The division is overspent by £1.2m principally due to unachieved savings and private patient income shortfalls.
- **Corporate Services** - The division is overspent by £2.6m principally due to consultancy, £2.2m and redundancy costs £0.3m.

Divisional Performance	In mth Plan	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
Planned Care	2,265	1,993	-272	18,171	12,041	-6,130
Urgent Care	3,336	2,812	-524	22,860	18,932	-3,928
Integrated Care	-2,493	-2,569	-76	-15,135	-18,784	-3,649
Total Clinical Divisions	**3,108**	**2,236**	**-872**	**25,896**	**12,189**	**-13,707**
Commercial Directorate	-2,390	-2,394	-4	-16,013	-17,241	-1,228
Corporate Services	-2,305	-2,414	-109	-15,035	-17,651	-2,616
Central Items	-1,281	-1,204	77	-15,279	-8,999	6,280
	-5,976	**-6,012**	**-36**	**-46,327**	**-43,891**	**2,436**
Income	3,312	4,088	776	21,659	27,224	5,565
Normalised Contingency Adj	0	0	0	0	0	0
Total	**444**	**312**	**-132**	**1,228**	**-4,478**	**-5,706**

Workforce Plan FTE	Actual FTE	Divisions Pay Analysis	In mth Plan £000's	In mth Actual £000's	Var £000's	YTD Plan £000's	YTD Actual £000's	Var £000's
1,598	1,684	Planned Care	-5,765	-6,179	-414	-40,939	-43,193	-2,254
1,504	1,693	Urgent Care	-4,920	-5,549	-629	-34,957	-39,339	-4,382
1,657	1,616	Integrated Care	-5,727	-5,630	97	-39,670	-40,559	-889
4,759	**4,993**	**Total Clinical Divisions**	**-16,412**	**-17,358**	**-946**	**-115,566**	**-123,091**	**-7,525**
1,085	1,050	Commercial Directorate	-2,038	-2,016	22	-14,476	-14,411	65
471	486	Corporate Services	-1,483	-1,527	-44	-9,829	-9,745	84
1,557	1,536	**Total Non-Clinical Divisions**	**-3,521**	**-3,543**	**-22**	**-24,305**	**-24,156**	**149**
		Central Items	82	0	-82	7	0	-7
6,315	**6,529**	**Total Pay Analysis**	**-19,851**	**-20,901**	**-1,050**	**-139,864**	**-147,247**	**-7,383**

CRES Plans – October 2011

Headlines

- The overall in-year identified CRES forecast is now £15.8m which leaves a £14.2m gap between the forecast and the £30m savings target.

- Year to date (YTD) identified CRES forecast was for £5.8m and against this the YTD achievement is £8.1m.

- Overall 30.3% of the identified schemes have been rated green and have been actioned or have a confirmed start date.

- Amber schemes at 7.1%, are expected to deliver, though their start date is later in the year. The values have been adjusted for the part year effect.

- In respect of the savings programme in addition to the £4.6m red savings schemes there still remains £14.2m of unidentified savings which Divisions need to address as a priority.

- Ernst Young are continuing to work with the Trust to improve the CRES delivery as this is a key area underpinning the delivery of the overall planned Trust surplus.

	11/12 Target £000's	Total Identified £000's	RED £000's	AMBER £000's	GREEN £000's	Unidentified £000's
Planned Care	7,830	2,297	1,420	113	765	5,533
Urgent Care	9,961	4,204	943	564	2,696	5,757
Integrated Care	6,494	3,709	987	626	2,096	2,785
Commercial Directorate	2,980	3,096	971	819	1,306	-116
Corporate Services	2,735	2,471	247	0	2,224	264
Divisional Schemes	30,000	15,777	4,567	2,123	9,087	14,223
Central Initiatives						
Total Savings Schemes	**30,000**	**15,777**	4,567	**2,123**	**9,087**	**14,223**
			15.2%	7.1%	30.3%	47.4%

Year on Year Comparisons – October 2011

Headlines

- Following the integration of Community Services into the Trust no comparative expenditure figures are currently available. Therefore the expenditure comparison table has been excluded from this report.
- Total Inpatients are 1.0% below last year's numbers.
- Outpatients are 5.1% lower than last year .
- A&E attendances are 0.6% lower than this time last year.

Activity	2011/12 YTD Actual	2010/11 YTD Actual	Increase / Decrease Yr on Yr	% Increae / Decrease Yr on Yr
Planned Same Day	23,811	21,477	2,334	10.9%
Elective Inpatients	6,050	6425	-375	-5.8%
Emergency Inpatients	24,227	26,707	-2,480	-9.3%
Total Inpatients	**54,088**	**54,609**	**-521**	**-1.0%**
Elective Excess Bed Days	1,161	2,741	-1,580	-57.6%
Non elective Excess Bed Days	15,340	18,667	-3,327	-17.8%
Total Excess Bed Days	**16,501**	**21,408**	**-4907**	**-22.9%**
Consultant First Attendances	58,859	67,455	-8,597	-12.7%
Consultant Follow Ups	90,649	96,146	-5,497	-5.7%
OP Procedures	24,268	21,788	2,480	11.4%
Other Outpatients (WA & Nurse Led)	83,487	85,416	-1,929	-2.3%
Community Specialist	1545	1813	-268	-14.8%
Total Outpatients	**258,808**	**272,618**	**-13,811**	**-5.1%**
A&E Attendances	62,179	62,534	-355	-0.6%
ITU Bed Days	3,442	3,092	350	11.3%
SCBU Bed Days	1,684	2,066	-382	-18.5%
Radiology - Direct Access	34,209	34,295	-86	-0.3%
Pathology - Direct Access	1,726,282	1,694,487	31,795	1.9%
Physio - Direct Access	21,887	21,466	421	2.0%

Capital Programme – October 2011

Headlines

Summary:-

During September capital expenditure increased by £0.4m and now totals £3.2m. Commitments entered into increased in the month by £0.3m taking total commitments to £4.5m against the total capital resource of £8.7m.

The capital programme currently has a planned £0.4m over commitment which will be managed during the year to ensure the Trust meets its approved capital resource limit (CRL) at 31 March 2012.

Transfer of Community Medical equipment & IT assets:-

The SHA has also now advised the proposed accounting and technical funding arrangements for the transfer of community medical equipment & IT assets. The proposal from the SHA/DH is for an increase in CRL of £3.1m equal to the value of the transferred assets. As the CRL increase will be equal to the cost of the transferred assets there is no impact on the current overall Trust over planning margin.

Capital Investment Programme £000s	2011/12 Previous Programme	2011/12 Revised Programme	2011/12 Current Commitment	Expenditure YTD
Capital Resources				
Depreciation	7,846	7,846		
Community Med Equip & IT Funding	1,750	817		
League of Friends Support	500	0		
Leasing of Med Equip & CT Scanner	3,578	3,565		
Gross Capital Resource	13,674	12,228		
Less Donated & Leasing Financing	-4,078	-3,565		
Capital Resource Limit (CRL)	**9,596**	**8,663**	**-**	**-**
Capital Investment				
Divisions Medical Equipment	3,578	3,565	90	23
Less Leasing	-3,578	-3,565	0	0
Net Divisions Medical Equipment	**0**	**0**	**90**	**23**
Information Systems	1,779	879	343	13
Facilities	531	831	327	152
Minor Capital Schemes	1,000	1,000	578	578
Endoscopy Development	3,042	1,542	523	466
Refurbishment General Shared Areas	361	471	63	33
Mortuary Redevelopment - Conquest	600	600	10	0
Pevensey Ward Redevelopment	500	0	2	2
Catheter Laboratory - DGH	792	792	792	678
CQC A&E and MAU requirements	250	624	384	384
Electronic Staff Rostering	160	231	231	197
Vanguard - DGH	208	208	208	172
Single rooms - Conquest	650	100	7	7
Car Parking - Conquest	0	450	30	1
Commitments Bfwd from 2010/11	402	636	611	344
Other	447	661	281	176
Sub Total	**10,722**	**9,025**	**4,480**	3,226
Donated Asset Purchases	545	759	565	349
Donated Asset Funding	-1,045	-759	-565	-349
Net Donated Assets	**-500**	**0**	**0**	0
Sub Total Capital Schemes	**10,222**	**9,025**	**4,480**	3,226
Overplanning Margin (-) Under Commitment (+)	-626	-362	4,183	
Net Capital Charge against the CRL	**9,596**	**8,663**	**8,663**	**3,226**

Key Performance Indicators & Reserves – October 2011

Headlines

- The YTD EBITDA percentage achieved, including the normalised contingency adjustment, is 44.9% of the planned value at £10.8m. This has resulted in a (0.7%) Return on Assets at 31st October.
- The liquidity ratio has been adjusted for an estimated Working Capital Facility to make it comparable with Monitor's assessment criteria. The resulting actual liquidity ratio number of days has remained at 7 compared to the planned level of 18 days.
- Funding for High Cost Drugs and Device Exclusions is issued to divisions from reserves as the costs arise.

Underlying Performance	2010/11 Outturn	2011/12 Plan	2011/12 YTD
EBITDA	10,208	10,808	4,848
Normalised Contingency Adjustment			0
Total EBITDA	10,208	10,808	4,848
Divided by:			
Total Income	299,624	213,717	219,233
Normalised Contingency Adjustment			0
EBITDA Margin	**3.4%**	**5.1%**	**2.2%**
EBITDA % Achieved			
Actual EBITDA	10,208	10,808	4,848
Divided by:			
Budgeted EBITDA	16,864	10,808	10,808
EBITDA % Achieved	**60.5%**	**100.0%**	**44.9%**

Financial Efficiency £000s	2010/11 Outturn	2011/12 Plan	2011/12 YTD
Total EBITDA	10,208	10,808	4,848
Less Depreciation & Amortisation	-8,467	-5,828	-5,552
	1,741	4,980	-704
x 360	360	360	360
/ Number of Days	360	210	210
Divided by:			
Opening balance sheet	181,631	183,447	183,447
Closing balance sheet	183,447	178,053	178,053
	365,078	361,500	361,500
Divided by 2	182,539	180,750	180,750
Return On Assets	**1.0%**	**4.7%**	**-0.7%**
Net surplus/ deficit	-4,704	1,228	-4,478
Less fixed asset impairments	298		
	-4,406	1,228	-4,478
Divided by:			
Total Income	299,624	213,717	219,233
Normalised Contingency Adjustment			0
I&E surplus margin	**-1.5%**	**0.6%**	**-2.0%**

Liquidity £000s	2010/11 Outturn	2011/12 YTD
Opening assets <1yr		
Trade & NHS debtors	11,446	26,533
Accrued income	176	134
Cash	1,500	9,779
Opening liabilities <1yr		
Trade & NHS creditors	-25,739	-57,311
DH Loan		-1,674
Accruals	-651	-631
In year working capital facility	24,118	30,626
	10,850	**7,456**
Divided by:		
Total costs in yr x-1	289,416	214,385
Multiply by (days)	360	210
Liquidity Ratio	**13**	**7**

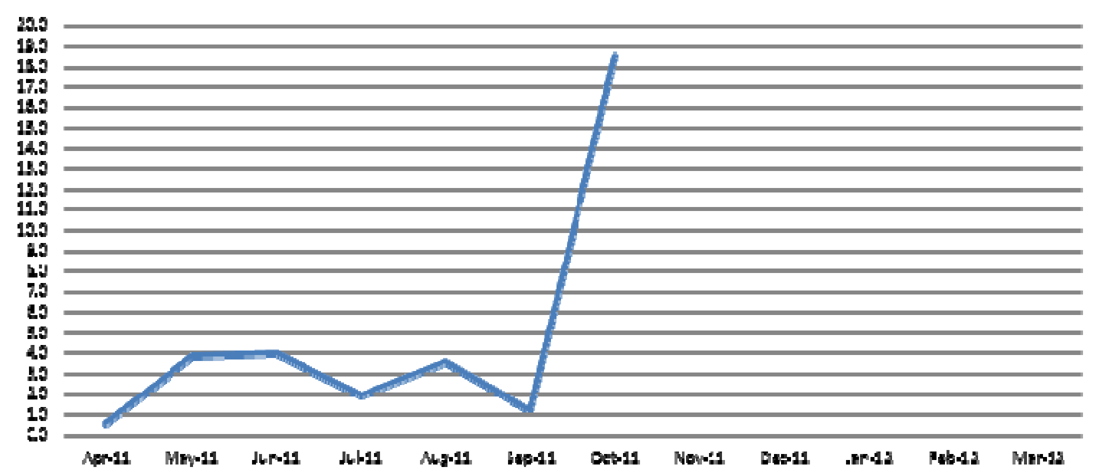
Reserves £000s	Opening Reserves	Issued	Closing Reserves
Wage Award and other Pay pressures	500	-500	0
CQUIN	1,081	-106	975
High Cost Drugs	12,465	-6,872	5,593
Device Exclusions	2,350	-1,275	1,075
Community Investments	1,642	-342	1,300
Contingency	3,820		3,820
Total	**21,858**	**-9,095**	**12,763**

Exception Reports

The following reports/ exception reports are included:

- Single sex accommodation
- 6 Weeks diagnostics
- Breast Cancer
- Community ALOS and Occupancy (to follow)
- 18 Weeks RTT

Exception Report – DSSA COMPLIANCE



Analysis:

- Rate of 18.54 per 1000 bed days
  - Equivalent to 170 breaches
  - Increase of 17 from previous month
  - Increase of 16 from YTD average

•Relates to the use of the Day Surgery Unit at Eastbourne DGH as an Admissions lounge, as a a result of bed pressures and the need to use the existing Admissions Lounge for additional inpatient beds.
•Day Surgery Unit team utilised the existing guidance to record all incidents when patients were in mixed sex accommodation and reported this accordingly.
•SSA is closely monitored and rectified within the inpatient setting but has not historically been an issue within the day surgery setting.
•Whilst this data is circulated on a weekly basis the current reporting system does not have a built in 'trigger' system that would raise an alert to increasing numbers of breaches.

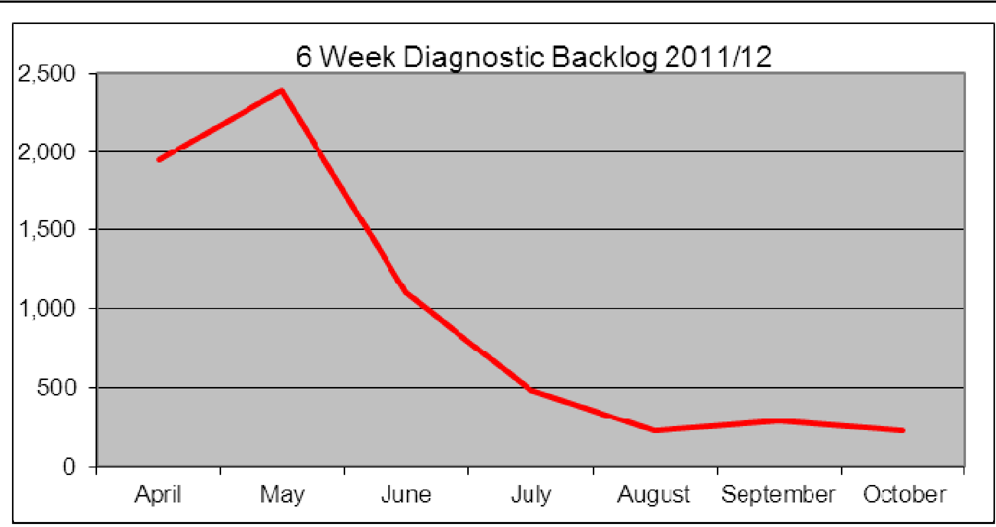
Actions:
A risk assessment has been undertaken in Day Surgery and due to the measures that have been taken to protect patients' privacy and dignity this patient group are not deemed to be breaches of SSA. As a result should this area be utilised in the future for elective admissions this will not create further breaches.

The information team are reviewing the reporting system to ensure all key personnel receive the information and will ensure the reporting system provides the ability to rapidly monitor and if necessary intervene regarding SSA breaches.

The Deputy Chief Operating Officer and Deputy Chief Nurse are undertaking an investigation to seek assurance that this key imitative is considered in future escalation plans. This investigation will also ensure that there is a clear validation process prior to submission of data.

Exception Report – 6 Week Diagnostics

Performance to Date



Analysis:

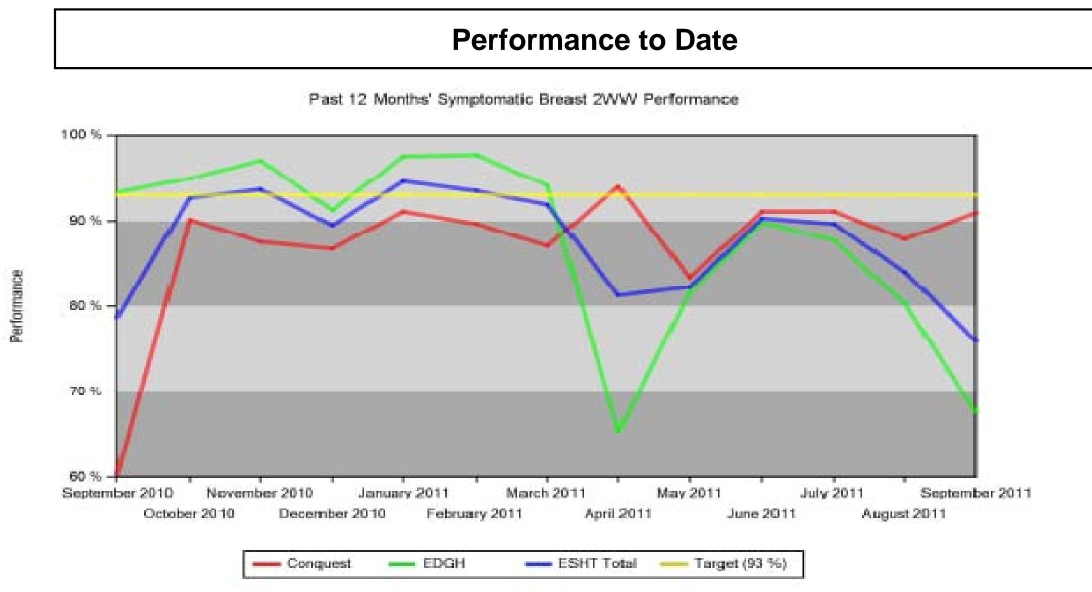
- The Trust planned to have eradicated all 6 week imaging backlog by the end of July 2011.
- The backlog represents just 2% of the total monthly workload completed for diagnostics and just 6% of the total waiting list.
- Scopes account for 81% of the current backlog, with Audiology and CT imaging making up the remaining 19%.
- Scope capacity has increased in-house by over 20% (700+ scopes) in the first six months of 2011/12 when compared to the equivalent period of 2010/11.

Actions:

- Endoscopy – Additional capacity has been sourced from third party providers to help maintain cancer targets within two weeks. Plans are in place to provide additional Endoscopy using a Vanguard Endoscopy facility to relieve the backlog and generate headroom whilst further core capacity is developed. This is unlikley to eradicate the backlog before the end of Q3.
- Imaging – Action plans to improve capacity for diagnostic imaging have largely been delivered over the last three months. The outstanding CT backlog and overall shape of the CT wait list continues to be tackled by increased short term, third party capacity whilst underling core capacity is enhance through capital development works.
- Audiology - The Audiology department has received a 25% increase in direct referrals in the first six months of 2011/12. Following the retirement of one of the Lead Audiologists at the Conquest the Department the service acorss the Trust has undergone a service review.This has released resources that will allow the department to employ Band 2 technicians that can be trained to repair hearing aids releasing a qualified audiologist. To facilitate the expansion of the department without investing in extra diagnostic rooms, we are considering a more flexible approach to the current timetable. This will be cost neutral and increase productivity. In parallel the patient pathway is being mapped so that we can formulate a capacity and demand model that will support the 6 week diagnostic waiting times. As an interim measure, extra clinics have been sourced.

Exception Report – 2 Week Wait Breast Screening

Performance to Date



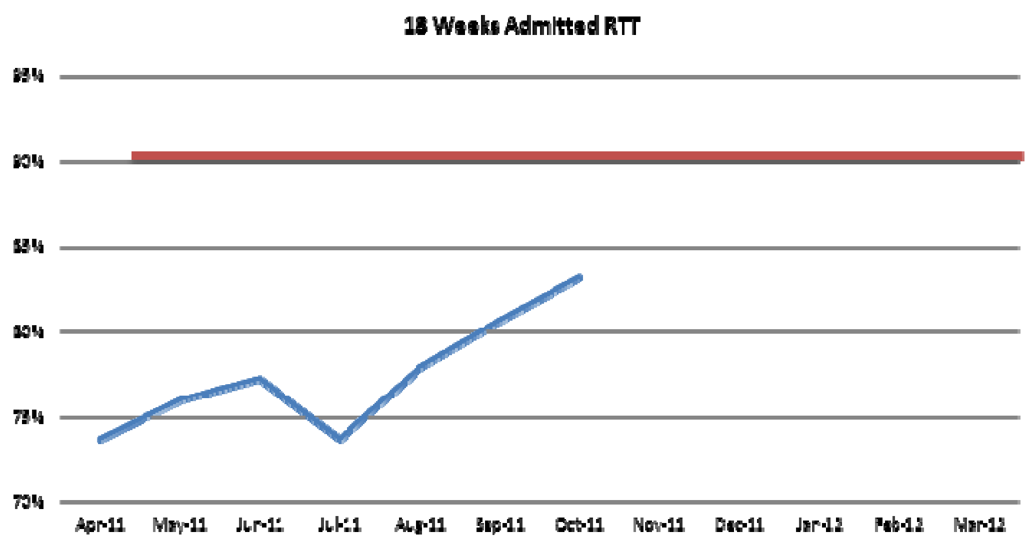
Analysis:

- This is a performance measure that monitors the percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected.
- In August the performance fell below the 93% target achieving just 84%, equivalent to 19 breaches.
- 8 Breaches were due to patients choosing dates beyond the 2 week limit.
- A further 13 were due to consultant absence.
- 7 were Cancelled at Short notice from SMA clinic

Actions:

Pilot due to commence in November with a Pathway Nurse Conquest to encourage attendance at clinic within 2 week and follow patient journey to ensure potential delays are highlighted and escalated and kept to a minimum.
Meetings taken place with 2ww clerks to ensure escalation policy in place. Meeting at EDGH with Appointments Manager, 2ww clerk, Breast Surgeon, PA and Gen Mgr to improve liaison and understanding.

Exception Report – 18 Week RTT



Analysis

•.83% performance at month 7

•Risen for 3rd consecutive month

•Median wait has fallen to 9.43 weeks

Actions

• Targeted Use of 3rd party capacity for backlog

• Targeted use of ad-hoc capacity for backlog

• Focussed work from divisions to improve core capacity to reduce non-elective pressures

• Anticipated that targets will be achieved by 31st December 2011

East Sussex Hospitals NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	8a
Subject:	Board Assurance Framework
Reporting Officer:	Director of Strategic Development and Assurance

Action: This paper is for **(please tick)**

Assurance	√	Approval		Decision	

Purpose:

The Board Assurance Framework (BAF) is presented to the Board for consideration having been updated by the lead Directors for the principle risks as part of the bi-monthly review process. The Board is asked to identify if there are issues presented within the BAF which the Board would like to consider in more detail at future meetings to inform Board Agenda planning.

Introduction:

The Trust Board should ensure that adequate and effective risk management processes are in place as well as arrangements for gaining assurance about the effectiveness of these processes.

The BAF identifies the principle risks in relation to each of the organisation's strategic aims and objectives along with controls in place and assurances available on their effective operation. It highlights where there are gaps in controls or assurance and informs the Board of the areas where it should be scrutinising the actions the organisation is taking to manage the principle risks.

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

The Board Assurance Framework identifies potential risks to the achievement of strategic objectives and supports the Board to perform its key functions.

Since the last report to the Board, following discussions with Andrew Corbett-Nolan of the Good Governance Institute (GGI) on its format, the BAF has been revised to follow the format recommended by the GGI and the front page now details the purpose of each column.

The tracker document highlights any positive assurances received during the period and any further gaps in controls or assurance that have also been identified by the lead Directors. It also indicates whether there has been any change in the RAG rating.

The RAG rating for principle risk 1.1 has been decreased as the Director of Nursing is of the opinion that better assurance is now being provided through the compliance process. However, when the Audit Committee reviewed the BAF at its meeting on 16th November 2011, their view was that the RAG rating should revert to red due to only partial assurance being provided on clinical audit processes at the present time.

Updates to actions and dates/milestones are noted in blue on the BAF.

Benefits:
Identifying the principle strategic risks to the organisation allows the Board to ensure that these risks are effectively controlled and mitigated and that the Board receives assurance that the management of strategic risks is effective and results in the Trust 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:
This report provides the Board with assurance that the strategic risks have been identified and will be used to inform internal controls processes.

Proposals and/or Recommendations
The Board is asked to note the November update and identify if there are issues presented within the BAF which the Board would like to consider in more detail at future meetings to inform Board Agenda planning.

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

For further information or for any enquiries relating to this report please contact:	
Name: Amanda Harrison, Director of Strategic Development & Assurance	**Contact details:** (14) 8972

East Sussex Healthcare NHS Trust

BOARD ASSURANCE FRAMEWORK – TRACKER DOCUMENT

NOVEMBER 2011 UPDATE

		Lead	**Positive Assurances Received**	**Further gaps in controls/assurances**	**RAG RATING**			
					SEP 11	**NOV 11**	**JAN 12**	**MAR 12**
Objective – details the objective relating to the Trust's aims								
No of risk.	Risk – details the risk in achieving the objectives	Lead Director	This column details any actions that have been taken to remove or mitigate gaps in controls or assurance and note any controls or assurances added since the last review	This column details any additional gaps in controls/assurances that have been identified since the last review	This column details the RAG rating for each risk at each review			

	Lead Director
COO	Chief Operating Officer
CD	Commercial Director
DoF	Director of Finance
DoN	Director of Nursing
DSDA	Director of Strategic Dev & Assurance
MD	Medical Director

Low levels of assurance and/or control	R
Medium levels of assurance and/or control	A
High levels of assurance and/or control	G

No change to rating	↔
Rating decreased	↓
Rating increased	↑

		Lead	Positive Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
1.	**Improving Quality & Access by aiming to make safe patient care our highest priority**							
1.1	We are unable to achieve and demonstrate compliance with CQC and NHSLA standards and as a result do not maintain and improve patient safety and the quality of care we provide	**DoN**	From October due to improved assurance moved to monthly reviews being held at Ward Sister level. Complicance Oversight Group (COG) monitors the action plans for essential standards of care. COG moving from weekly to monthly meetings as assurance has improved.	Governance process agreed but not yet embedded.	**R** ↔	**A** ↓		
1.2	We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in financial penalties, an adverse impact on our reputation with the public and commissioners and on our market share	**DoF/ MD/ DoN**	Action has been taken to address HPA outlier letters re SSI relating to hip surgery.		**R** ↔	**R** ↔		
1.3	Lack of clinical leadership and ownership and lack of managerial capacity and capability means that services are not developed and delivered in line with best clinical practice and our strategic aims leading to poor clinical outcomes for patients	**MD**	Assurance process put in place to test cases for change demonstrably based on evidence. PAPs identifying workforce implications. New governance structure now in place.		**R** ↔	**R** ↔		

		Lead	Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
1.4	We are unable to develop collaborative relationships with partner organisations within or outside the NHS resulting in an impact on our ability to operate efficiently and effectively within the local health economy	**DSDA/ COO**	Trust reps members of newly formed local Health Economy Boards – UCN, Elective, Integrated. GPs, Commission-ers, Adult Social Care invited to be members of Strategy Board. Greater collaboration with BSUH and MTW through networks. Series of networks, eg stroke, cardio, path, where GPs/Trusts across Sussex meet to discuss work of speciality and ensure embedded across county. Community elements picked up within divisional structures. Single Performance Conversation – monthly high level meeting of Trust, GPs, PCT, SHA to monitor performance.		**A** ↔	**A** ↔		

		Lead	Positive Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
2.	**Meeting local needs by aiming to improve and enhance patients' experiences and clinical outcomes, and working in partnership to meet the needs of our local population**							
2.1	We are unable to respond to local commissioning intentions and demand management plans by adapting our capacity and activity resulting in a financial impact	**COO**	Series of networks, eg stroke, cardio, path, where GPs/Trusts across Sussex meet to discuss work of speciality and ensure embedded across county. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Regular reports to CLT on SIs and performance to ensure improvements made where necessary.		**A** ↔	**A** ↔		
2.2	We are unable to define our strategic intentions and service plans and cannot deliver a sustainable service configuration or develop an Integrated Business Plan that supports our Foundation Trust application	**DSDA/ DoF**	HOSC engagement in clinical strategy and plans for delivery at service level.		**A** ↔	**A** ↔		
2.3	We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population	**DoN/ MD**	New governance structure now in place. COG meetings moved from weekly to monthly due to improved assurance.	Lack of strategy for patient experience – needs to be linked with clinical strategy and Trust objectives and aims.	**R** ↔	**R** ↔		

		Lead	Positive Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
2.4	We are unable to benefit from the formation of an integrated healthcare Trust by adapting pathways and successfully securing service contracts for integrated care leading to an inability to deliver improvements in performance	**COO/ DoF**	New organisational structure implemented Oct 11 resulting in acute and community fully integrated at clinical unit level. Integrated performance report now being used.		**A** ↔	**A** ↔		

		Lead	Positive Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
3.	**Effective management of resources by aiming to use our resources efficiently and effectively for the benefit of our patients and their care, and ensuring our services are clinically and financially sustainable**							
3.1	We are unable to deliver our financial targets (revenue and capital) and this impacts on the Trust's liquidity and planned investments	**DoF**	Refocused CRES delivery through the application of turnaround principles and external support.		**R** ↔	**R** ↔		
3.2	We fail to meet our legal and statutory responsibilities which results in legal proceedings that incur reputational damage and financial cost	**DSDA**	Action plans developed and being monitored through Compliance Oversight Group on monthly basis. New governance structure implemented from Oct 11		**R** ↔	**R** ↔		
3.3	We are unable to effectively plan, train and manage our workforce in line with our strategic plans and operational requirements leading to a mismatch between staffing provision and service needs resulting in a financial and quality impact	**HRD**	Workforce Assurance Group established. Regular workforce assurance meetings with PCT/SHA. Single Performance Conversation meetings. PAPs identifying workforce implications. Integrated performance report introduced.		**A** ↔	**A** ↔		
3.4	We are unable to effectively align our estate and IM&T infrastructure to our operational and strategic requirements leading to an impact on delivery	**CD/ DoF**	Business Board approval of business case 26.8.11.		**A** ↔	**A** ↔		

		Lead	Positive Assurances Received	Further gaps in controls/assurances	RAG RATING			
					SEP 11	NOV 11	JAN 12	MAR 12
3.5	We are unable to respond effectively to the rapidly changing external policy environment resulting in poor decision making and inability to deliver sustainable strategic change	**DSDA**			**A** ↔	**A** ↔		

East Sussex Healthcare NHS Trust

BOARD ASSURANCE FRAMEWORK (NOVEMBER 2011 UPDATE)

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
	What controls/ systems we have in place to assist in securing delivery of our objective	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered	Where we are failing to put controls/ systems in place/ Where we are failing to make them effective	Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective	Notes on slippage or controls/assurance failing		Rates the level of assurance that the risk is being managed effectively		Where the risk is associated with actions by others or handover at boundary

* Assurance level: Effective controls definitely in place and Board satisfied that appropriate assurances are available = GREEN
Effective controls thought to be in place but assurances are uncertain and/or possibly insufficient = AMBER
Effective controls may not be in place and/or appropriate assurances are not available to the Board = RED
(NB The Board will need to periodically review the GREEN controls/assurances to check that these remain current/satisfactory)

Assurance trends:
↑ = a worsening of the Trust's position (since the last update)
↓ = an improvement in the Trust's position (since the last update)
↔ = no change in assurance this quarter

Lead Director	**COO**	Chief Operating Officer	**CD**	Commercial Director	**DoF**	Director of Finance	
	DoN	Director of Nursing	**DSDA**	Director of Strategic Development & Assurance	**HRD**	Director of Human Resources	
	MD	Medical Director					

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Strategic Objective 1 – Improving Quality & Access by aiming to make safe patient care our highest priority										
Principle Risk 1.1 We are unable to achieve and demonstrate compliance with CQC and NHSLA standards and as a result do not maintain and improve patient safety and the quality of care we provide										
	CQC inspection NHSLA inspection	CQC action plan CQC risk profile Identified clinical leads Clinical quality & safety report Performance report Serious Incident reports Patient Surveys Quality Accounts Clinical Governance Annual Report Clinical Governance Forward Plan Staff Survey External Audit Internal Audit Risk Management Strategy Leadership walkabouts.	Weekly quality reviews and audits of standards of nursing care conducted by senior nursing team conducted during July, August & September 2011. From October due to improved assurance moved to monthly reviews being held at Ward Sister level. Complicance Oversight Group (COG) monitors the action plans for essential standards of care.	Governance process agreed but not yet embedded.	CQC review of compliance reports have identified major concerns and lack of compliance against 10 regulations. Board assurance on integrated organisation is not yet in place. Board members to get direct assurance from services and observation are not used to maximum benefit.	1.1.1 Action plans to be reviewed monthly by COG 1.1.2 Quarterly report on compliance to Quality & Standards Committee. 1.1.3 Leader-ship walkabouts to be reviewed to ensure link into Quality Transformation Plan monitoring. 1.14 NHSLA programme manager job description developed, recruitment to post taking place. 1.1.5 Outcome of CQC re-inspection on 11.9.11 awaited.	Review Mar 12 **Nov 11** **Dec 11** **Dec 11**	**AMBER** ↓	**DoN**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
			COG moving from weekly to monthly meetings as assurance has improved. Peer review NEDs challenge on 23.8.11 reviewing PCAs and action plans for outcomes 1, 4 & 7. Programme manager approved 24.6.11. Outcome Leads to be responsible for policies required for NHSLA compliance.					AMBER		

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 1.2 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in financial penalties, an adverse impact on our reputation with the public and commissioners and on our market share										
	HCAI targets SSA standards GP consortia CQC inspection NHSLA inspection Operating Framework Commiss-ioning contract Health Protection Agency Information Governance Toolkit	CQC risk profile Clinical Quality & Safety Report Performance report SSA monitoring HCAI monitoring Patient Surveys Quality Accounts PEAT inspection HOSC LINK External Audit Internal Audit Dr Foster	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Action has been taken to address HPA outlier letters re SSI relating to hip surgery.	Delivery mechanisms and monitoring of 18 week performance are not effective – performance has deteriorated. Delivery mechanisms and monitoring of diagnostic waits and urgent referrals are not effective – performance has deteriorated.	Lack of fully integrated performance reporting means Board does not get clear perspective on all aspects of organisation performance and the progress made to achieving Trust objectives.	1.2.1 Revised delivery plans detailing remedial actions required to bring performance to target by quarter 3.	Dec 11	**RED** ↔	**DoF**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 1.3 Lack of clinical leadership and ownership and lack of managerial capacity and capability means that services are not developed and delivered in line with best clinical practice and our strategic aims leading to poor clinical outcomes for patients										
	Clinical strategy Organisation development strategy Workforce strategy	Job planning aligned to aims and objectives. Clinical Quality & Patient Safety reports Patient Surveys Dr Foster	Assurance process put in place to test cases for change demonstrably based on evidence. PAPs identifying workforce implications. New governance structure now in place.	Clinical leadership for clinical strategy needs to be strengthened and cases for change must demonstrably be based on evidence. Organisation development strategy developed but part delivered meaning clinical leadership is not yet embedded.	Job plans in place, need further development and alignment to reflect clinical strategy and operational need – assurance of full alignment required. Clinical quality and safety need to be part of integrated governance process and reported to Board.	1.3.1 Complete detailed cases for change to deliver implementation of the clinical strategy. 1.3.2 Majority of Clinical Unit appointments made and job plans being aligned to reflect clinical strategy and operational needs. 1.3.3 Develop workforce strategy 1.3.4 Integrated governance processes being developed to support new governance structure.	Dec 11 Mar 12 Mar 12 Dec 11	**RED** ↔	**MD**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 1.4 We are unable to develop collaborative relationships with partner organisations within or outside the NHS resulting in an impact on our ability to operate efficiently and effectively within the local health economy										
	Developing relationships with GP consortia and commission-ing intentions. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship and reporting to HOSC. Programme of meetings with key partners including ESCC and MPs.	Participation in Clinical Leaders Group. Clinical Strategy. Communica-tions Strategy	Trust reps members of newly formed local Health Economy Boards – UCN, Elective, Integrated. GPs, Commission-ers, Adult Social Care invited to be members of Strategy Board. Greater collaboration with BSUH and MTW through networks. Series of networks, eg stroke, cardio, path, where GPs/Trusts across Sussex meet to discuss work of speciality and ensure embedded across county.	Stakeholder map not yet fully developed meaning key relationships are not identified. Communica-tions strategy not yet developed meaning key messages are not reaching stakeholders.	Marketing strategy not yet developed and therefore assurance cannot be provided that the Trust is actively and effectively participating in the local market or developing and responding to market opportunities. 7 day working not embedded across medical staff – hot spot areas – urgent care coverage for discharge planning, critical care anaesthetic cover.	1.4.1 Working with other acute Trusts collaboratively on 18 weeks – Sussex operational meeting. 1.4.2 Trust working with clinical commissioning executive to identify priorities and strategic aims. 1.4.3 Marketing strategy to be developed in support of clinical strategy.	Review Mar 12 Review Mar 12 Mar 12	**AMBER** ↔	**DSDA/ COO**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
			Community elements picked up within divisional structures. Single Performance Conversation – monthly high level meeting of Trust, GPs, PCT, SHA to monitor performance.					AMBER		

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Strategic Objective 2 – Meeting local needs by aiming to improve and enhance patients' experiences and clinical outcomes, and working in partnership to meet the needs of our local population										
Principle risk 2.1 – We are unable to respond to local commissioning intentions and demand management plans by adapting our capacity and activity resulting in a financial impact										
	Clinical strategy development informed by commission-ing intentions. GPCC and PCT involved in development of clinical strategy. QIPP delivery managed through Urgent, Planned and Integrated Care Boards aligned to clinical strategy.	Activity plan Workforce planning	Series of networks, eg stroke, cardio, path, where GPs/Trusts across Sussex meet to discuss work of speciality and ensure embedded across county. Written reports to CME on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Regular reports to CLT on SIs and performance to ensure improvements made where necessary.	Extent and effectiveness of commissioning demand management plans for urgent and planned care not yet clear resulting in a risk that activity and income fall before capacity can be reduced	Pathway development	2.1.1 Joint working on agreeing priorities, demand management and strategic aims with Clinical Commissioning Executive. 2.1.2 MSK project commenced across Trust and local health economy. 2.1.3 Work with consortia/Cluster to meet QIPP targets. 2.1.4 Redesign work – unscheduled care.	Review Mar 12 Review Mar 12 Review Mar 12 Review Mar 12	**AMBER** ↔	**COO**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
						2.1.6 Decrease in medical admissions and opd referrals – further discussion with commissioners to demonstrate demand management schemes working. No cost base pulled out to date because of uncertainty.	Review Dec 11	AMBER		

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 2.2 – We are unable to define our strategic intentions and service plans and cannot deliver a sustainable service configuration or develop an Integrated Business Plan that supports our Foundation Trust application										
	Department of Health Monitor	Clinical strategy Workforce strategy Estates strategy IT strategy	HOSC engagement in clinical strategy and plans for delivery at service level.	Clinical strategy still in formulation leading to risk that services continue to develop adhoc and that the annual plan is not aligned to the delivery of the Trust's aims and objectives.	HOSC views on whether delivery plans represent significant service change not yet known. Modelling of overall impact of delivery plans on achievement of Trust's aims and objectives.	2.2.1 Develop Trust model to test impact of clinical strategy 2.2.2 Integrated approach to Annual Business Plan for 2012/13 bringing together redesign elements of strategy with cost improvement and efficiency plans.	HOSC mtgs Nov 11 Jan 12 1st cut Dec 11	**AMBER** ↔	**DSDA** **DoF**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 2.3 – We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we are not the provider of choice for our local population										
	Operating Framework CQUIN indicators Commission-ing contract Quality Accounts legislation	CQC National surveys South of England SHA benchmarking PROMs Equality strategy Equality impact assessments Patient surveys Staff survey Clinical quality & safety reports Clinical Audit Plan Communicat-ions strategy Marketing strategy Dr Foster SHMI PPI strategy Internal patient experience surveys Complaints data	New governance structure now in place. COG meetings moved from weekly to monthly due to improved assurance.	Information on PROMs and patient experience is incomplete and not yet benchmarked. Insufficient triangulation of clinical governance information and impact on patient outcomes. Some gaps in equality & diversity data mean that we cannot track the outcomes of action to ensure the Trust delivers its equalities duties.	Lack of strategy for patient experience – needs to be linked with clinical strategy and Trust objectives and aims.	2.3.1 New governance structure to be embedded 2.3.2 COG monitoring action plans to ensure compliance. 2.2.3 HSMR – improvement plan to go to CME on 25.11.11 for approval to reduce overall mortality rates to a target of 80 over two years to avoid being an outlier for both Dr Foster and SHMI indicators. 2.3.4 Embed responsibilities through organisational development and in particular development of CUs.	Review Mar 12 Review Mar 12 Nov 11 Dec 11	**RED** ↔	**DoN/MD**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
						2.3.5 Options appraisal being undertaken re patient experience data collection to improve intelligence.	Dec 11	RED		

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 2.4 – We are unable to benefit from the formation of an integrated healthcare Trust by adapting pathways and successfully securing service contracts for integrated care leading to an inability to deliver improvements in performance										
	Operating Framework Commission-ing intentions	Clinical strategy Workforce strategy Estates strategy IT strategy Performance reports Clinical quality & safety reports Serious incident reports Workforce planning	New organisational structure implemented Oct 11 resulting in acute and community fully integrated at clinical unit level. Integrated performance report now being used.	Lack of an integrated contract including both acute and community services.	Clinical strategy not yet complete. Lack of fully integrated performance report. Lack of workforce, estates and IT strategies.	2.4.1 Through turnaround reviewing each speciality on an individual basis to map out pathways from community to acute and back again so that care can be provided in the most effective and appropriate manner. 2.4.2 Development of integrated contract.	End Dec 11 Apr 12	**AMBER** ↔	**COO/ DoF**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Strategic objective 3 – Effective management of resources by aiming to use our resources efficiently and effectively for the benefit of our patients and their care, and ensuring our services are clinically and financially sustainable										
Principle risk 3.1 – We are unable to deliver our financial targets (revenue and capital) and this impacts on the Trust's liquidity and planned investments.										
	Commission-ing intentions Financial information systems	Capital programme Finance reports Audit reports	Refocused CRES delivery through the application of turnaround principles and external support.	Plans to deliver total CRES targets are not fully developed and implemented resulting in impact on financial performance, achievement of control total and an impact on Trust's cash position.	Lack of a cash plan linked to CRES and capital programme	3.1.1 Development of a cash strategy – ongoing discussions with commissioners and SHA – report to FIC.	Nov 11	**RED** ↔	**DoF**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 3.2 – We fail to meet our legal and statutory responsibilities which results in legal proceedings that incur reputational damage and financial cost										
	CQC IG Toolkit NHSLA Health & Safety Executive Information Commission-er	Clinical governance processes. Corporate Governance structures. HR processes.	Action plans developed and being monitored through Compliance Oversight Group on monthly basis. New governance structure implemented from Oct 11	CQC, NHSLA and IG compliance assessment processes that are fit for purpose for the integrated organisation	CQC review of compliance reports have identified major concerns and lack of compliance against 10 regulations. General NHSLA assessment of organisation does not take place until 2012.	3.2.1 Outcome of CQC re-inspection on 9.11.11 awaited. 3.2.2 Quality Transformation Plan being developed – outline plan to CME Nov11 full plan to QSC Jan 12 3.2.3 Plan for NHSLA assessment preparation – recruitment to programme manager post taking place.	 Nov 11 Jan 12 Dec 11	**RED** ↔	**DoN/ DSDA**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 3.3 – We are unable to effectively plan, train and manage our workforce in line with our strategic plans, operational requirements and financial restrictions leading to a mismatch between staffing provision and service needs resulting in a financial and quality impact										
	Development of workforce strategy: - to align workforce plans with strategic direction and other delivery plans; - to ensure a link between workforce planning and quality measures	Workforce assurance group to ensure that workforce aspects of the clinical strategy and delivery plans are met and to ensure compliance with CQC and other regulatory bodies. Workforce assurance process with NHS Sussex. Staff utilisation reports. Integrated performance report. Staff survey action plan implementation. Workforce strategy to be developed to reflect clinical strategy.	Workforce Assurance Group established. Regular workforce assurance meetings with PCT/SHA. Single Performance Conversation meetings. PAPs identifying workforce implications. Integrated performance report introduced.	Integrated reporting process not yet established. Workforce strategy to be developed and aligned with clinical strategy.	Performance report is not currently integrated so the impact of workforce on the Trust's objectives is not fully understood.	3.3.1 Develop processes and systems to improve data quality and reporting. 3.3.2 Ensure clinical strategy development is based on sound workforce intelligence and informs development of a robust workforce strategy. 3.3.3 Workforce elements of Primary Access Points being developed.	Ongoing Mar 12 Mar 12	**AMBER** ↔	**HRD**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 3.4 – We are unable to effectively align our estate and IM&T infrastructure to our operational and strategic requirements leading to an impact on delivery										
	Clinical strategy Integrated Business Plan Capital funding	Estates strategy IM&T strategy		Lack of an appropriate estates strategy. Delay/failure of national IT programme means that the Trust cannot support the effective development of electronic records that support new models of clinical care. Incomplete infrastructure map for IM&T.	Existing estate suitability and usage. Comprehen-sive backlog maintenance plan. IM&T strategy is a draft document that will be refined once clinical strategy is finalised.	3.4.1 Conduct a Six Facet Estate Survey to obtain core estate information – secure funding estimated £300k to include community hospitals; invitation & award of service contract; survey with written report. 3.4.2 Develop draft estates strategy content framework. 3.4.3 Align estate survey with clinical delivery options. 3.4.4 Estates Strategy Board presentation and approval.	Aug 11 – Jan 12 Dec 11 – Feb 12 Mar 12 – Apr 12 Jun 12 Jul 12	**AMBER** ↔	**CD/DoF**	

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
						3.4.5 Consider options for IM&T systems that support the delivery of integrated care through the development of an IT Strategy.	Jan 12	AMBER		

Risk Ref	Key Controls	Potential sources of assurance	Positive Assurances	Gaps in control	Gaps in assurance	Actions planned/ Update	Date/ Milestone	Assurance level* (RAG rating)	Lead Director	Boundary conditions
Principle risk 3.5 – We are unable to respond effectively to the rapidly changing external policy environment resulting in poor decision making and inability to deliver sustainable strategic change										
	Horizon scanning by Executive team and Board. Board seminars. Board development programme. Revised governance arrange-ments enhancing Board assurance and decision making.	Policy documents and Board reporting reflect external policy. Strategic development plans reflect external policy.		Further design of Board development programme delayed.		3.5.1 Board development programme designed to reflect external policy environment and preparation for FT.	Dec 11	**AMBER** ↔	**DSDA**	

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	8b
Subject:	Care Quality Commission Standards – Assurance Report
Reporting Officer:	Dr Amanda Harrison – Director of Strategic Development and Assurance

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

Purpose:

The purpose of this report is to provide a summary of the progress made in developing a system and process that enables the Board to be provided with assurance that the organisation is meeting its statutory requirements in relation to compliance with the Care Quality Commission (CQC) regulations.

Introduction:

This report sets out how assurance will be sought and how data and evidence that provides assurance will also be utilised to drive quality improvement and support performance management

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

The assurance process will ensure that evidence is gathered that the organisation can meet the statutory requirements because appropriate policies are in place and are being implemented through an agreed process, that compliance with agreed process is measured and monitored and that appropriate changes in outcomes are delivered. The new assurance team is currently working with the divisions to implement and embed appropriate reporting and the collection and collation of evidence that provides assurance. At its next meeting the Board will be provided with a report which sets out the level of compliance against each of the CQC standards and the robustness of the assurance evidence that supports this assessment.

Benefits:

A robust system of assurance will provide evidence to the Board, the local population, commissioners of services and external regulators that the organisation is able to monitor its compliance and taken action to improve outcomes for patients.

Risks and Implications:

Without robust systems of assurance and risk management the organisation will not be able to comply with Outcome 16 of the CQC's essential standards of care.

Assurance Provided:
This report provides assurance that the organisation is actively working within revised organisational structures to deliver a robust assurance process that supports the Board to make decisions and act on areas where care is not meeting required standards

Proposals and/or Recommendations
The Board is asked to note the contents of the report.

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

For further information or for any enquiries relating to this report please contact:	
Name: Dr Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:** (13) 4355

East Sussex Healthcare NHS Trust

Care Quality Commission – Assurance Report
November 2011

1. Context

1.1 Compliance with the Care Quality Commission Essential Standards of Quality and Safety will give assurance to the local population, commissioners of services and the Trust Board that the organisation is continuously seeking to improve the outcomes for patients and achieve its vision to be the healthcare provider of choice for the people of East Sussex.

2. Introduction

2.1 The purpose of this report is to provide a summary of the progress made against the action plans developed following the Care Quality Commission's (CQC) visits to the Trust during this year and provide assurance that actions are in place to address the issues identified in order to improve patient outcomes.

3. Assurance

3.1 Outcome leads have been identified for each of the 16 essential standards of care as set out by the CQC. Outcome leads are responsible for reviewing any ongoing action plans and Provider Compliance Assessments (PCA) to ensure that these reflect an accurate view of the Trust's current level of compliance. Following changes in individual roles and responsibilities and as part of the implementation of the Trust's new organisational design, the individual accountabilities for delivery of all aspects of the action plans have been reviewed by the Compliance Oversight Group and, where necessary, reallocated.

3.2 In addition there is currently a review of the systems used to gather, record and evaluate accurate information about the quality and safety of the care, treatment and support the Trust provides. The new assurance team recruited on 7th November 2011 will support the divisions to develop their reporting on compliance and risks as part of an assurance process. The role of this team is to work with the divisions to develop and implement processes for seeking and providing assurance and identifying appropriate data and evidence that will measure and provide robust indications of the delivery of quality care. This will include evidence that covers:

- Policy – evidence that the delivery of the outcome and compliance with regulations supported by appropriate organisational policy. For example a complaints policy
- Process – evidence that there is an agreed process to deliver the policy. For example complaints documentation, an electronic complaints management system, training programmes for staff

- Performance – evidence that the process is working including data that provides assurance in a dynamic/realtime way. For example, data on the percentage of complaints processed according to the required standards, training records, information that demonstrates we are picking up the quality issues from complaints and the feedback loop is compete
- Outcome – evidence that there has been beneficial change and we have achieved the outcome/change intended. For example, we know that complaints in a given area have fallen or that action taken as a result of a complaint has delivered a measurable change.

3.3 A set of quality metrics will be developed which will sit along side other sources of evidence to provide assurance. A review of quality indicators that contribute to the evidence base for achievement of standards and regulatory compliance is currently being undertaken. This evidence will also support the quality improvement function led by the Director of Nursing and Medical Director who will work with the divisions to consider the best approach to drive up quality and sustain compliance in practice. In addition the evidence will be used to support the performance management of the divisions against compliance with quality standards, performance targets and the delivery of related action plans

3.4 In order to gain assurance of compliance the review and reporting of progress is currently monitored through the Compliance Oversight Group (COG) to ensure that divisions and corporate directorates can give assurance that the required actions are being delivered. Following the recent restructure of the organisation this process is currently under review, and work is ongoing to ensure that the processes in place are able to give the required assurance, such as exploring the potential for each clinical unit to have their own Provider Compliance Assessment per outcome rather than organisation wide.

3.5 Failure to comply with the Essential Standards of Quality and Safety and act on any recommendations made by the Care Quality Commission may result in serious implications for the Trust in terms of patient care and organisational risk. Any identified risks to compliance that cannot be mitigated at individual, team, or service level are escalated and placed on the Trust's risk register in order that the risks can be mitigated and monitored through the risk management processes.

4. Conclusion

The assurance process is being developed to ensure improved monitoring and risk management processes are in place and embedded. Additionally a revised set of quality indicators that will provide assurance of compliance is being developed to ensure that robust processes are in place for seeking assurance of compliance against the Essential Standards of Quality and Safety from within the Divisions and that the necessary evidence is in place to provide assurance of compliance across the organisation.

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	9
Subject:	Shaping our Future: The Clinical Strategy
Reporting Officer:	Director of Strategic Development and Assurance

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

Purpose:

This paper provides the Board with an update on the development of Shaping our Future: the Clinical Strategy. It gives an outline of the work that has been undertaken to develop the delivery options for the eight primary access points and sets out the outcome of the work currently underway in the pre-consultation phase. This includes a draft of the appraisal criteria that will be used to appraise a number of delivery options for reach model. These have been developed through a programme of engagement with our staff, patients and the public, the local GP Commissioning Consortia and the PCT cluster.

The Board is asked to discuss and agree the proposed appraisal criteria as the basis for undertaking an initial options appraisal. The options appraisal will test the viability of each of the proposed delivery options by assessing their impact in the following areas:

- Access and Choice
- Quality and Safety
- Clinical Sustainability
- Financial Affordability
- Deliverability

The Trust will take steps to collate and assess an evidence base in support of the options appraisal and will engage with stakeholders to ensure that this evidence base addresses their key concerns in relation to each option. The purpose of this work is to ensure that by the end of December 2011 the Trust is able to identify viable delivery options for implementing service change for consideration by the Board and the HOSC. This will enable the Trust to identify those areas where formal consultation is required and in turn will inform the Board's decision on the optimal delivery options. It is anticipated that where formal consultation is required this will commence in February 2012. The HOSC has indicated that it would expect to undertake consultation where the changes proposed are significant and that this is likely to primarily be those options where reconfiguration is an option although this will depend on the scale, scope and impact of the change.

Introduction:

The work on the clinical strategy Shaping our Future has made good progress. Through a clinically led process of stakeholder engagement delivery options have been developed for each of eight primary access points: Maternity, Paediatrics, Trauma and Orthopaedics, General Surgery, Acute Medicine, Accident and Emergency, Stroke and Cardiology. These clinical areas have been prioritised as they are strategically important; representing the majority of activity undertaken by the Trust and having multiple interdependencies with other areas of clinical care/services.

The paper summarises the timeframes and key milestones for the pre consultation phase. The draft delivery options for each primary access point are in development and are published on the Trust's website along with an early indication of whether these may be delivered through productivity improvements, service redesign or service re-configuration. The proposed criteria to be used to assess the delivery options is outlined in the paper along with a summary of the assurance carried out to date by Trust Board members. The Board will be presented with the first output from the Trust wide model that is being used to support the assessment of the impact of the proposals for all 8 primary access points for the Trust as a whole.

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

The purpose of the pre consultation phase is to:

- Ensure that the delivery options and assessment criteria are developed with full internal and external engagement
- Structure the engagement to undertake an options appraisal using clear criteria and with a full understanding of the potential impact
- Ensure that overarching services such as critical care, diagnostics, community service provision, end of life care, long term conditions and health and wellbeing inform and are aligned to delivery plans in the eight areas through a robust governance structure.
- Undertake equality impact assessments initially for the models of care and then for the identified delivery options
- Undertake a Trust Board assurance process and quantify and address the gaps identified by the Board Assurance process

The information presented is drawn from detailed work that has been undertaken to develop the delivery options for each of the eight areas. Options have been developed in consultation with stakeholders to ensure a full range is considered. These will provide the basis for further engagement with a wide range of stakeholders that will allow them to challenge and test the models, options and data on which they are based. Delivery options will include proposals for operational efficiency, service redesign and service reconfiguration.

The next steps will be to identify and prioritise the criteria that will be used to appraise the potential delivery options for each model of care. This will include ensuring that the options appraisal uses national and local evidence along with independent scrutiny. The impact of each of the delivery options on activity, resources, income and costs, staff, quality and safety and demand will be analysed to inform the options appraisal using a bespoke programme developed for use in the Trust to support scenario planning.

When this stage of the work is complete a business case for each of the eight primary access points will be developed that will include:

1. A clear strategic context and rationale for the proposed models of care in each area which links to the wider strategy and the clinical, financial and operational impact.
2. The clinical case for change including prospective benefits and risks along with the evidence base comprising national and local benchmarks, best practice case studies and examples of service models successfully implemented elsewhere.
3. An analysis of the impact on access, , equality, quality, activity, demand, resources, staffing income and costs which will were possible be quantified.
4. The main delivery options for change.
5. Proposed options appraisal criteria
6. A first cut options appraisal

The impact analysis will be used to drive a Trust wide analysis that has been developed with clinicians to reflect the specific circumstances of the Trust and which will be used to assess whether the collective impacts of service delivery plans are sufficient to deliver the agreed strategic outcomes.

Formal consultation will be required where the HOSC considers that the proposal represents 'significant service change'. This methodology will ensure that should any delivery option include a proposal for such a change the formal consultation will be based on proposals which can be developed to meet the four tests as set out by the Secretary of State for Health:

- Support of GP commissioners
- Clarity on clinical evidence base
- Strengthened public and patient engagement
- Consistency with current and prospective choice

A communications and engagement plan has been developed to support this process.

The defined process will provide the Board with the assurance that appropriate criteria and a full range of options have been considered for each primary access point. It will detail the full range of quality measures and the scope of engagement, whilst ensuring a robustness of data and evidence to support the options appraisal. In addition a more in-depth assurance process is set out in two stages; assurance on the model of care and subsequently, assurance on the options development and appraisal process led by a Board member will be undertaken as set out to ensure the detail of each case for change is understood.

Benefits:

Developing specific service level delivery options aligned to the overall strategic framework agreed by the Trust Board will help to ensure that the Trust delivers against its strategic aims and objectives and achieves the outcomes agreed by the Board. Developing and testing the models of care and delivery options through a process of broad engagement will help the organisation to ensure that proposals for each primary access point are robust and have properly considered all perspectives on the risks and benefits of each option before a decision is made. This methodology will also ensure that any proposals that require formal public consultation have been developed with due regard to the conditions required for a successful reconfiguration proposal placed by the Secretary of State

Risks and Implications

Failure to deliver service delivery plans that can be implemented will put achievement of the Trust's aims and objectives at risk.

Assurance Provided:

This report provides the Board with assurance that progress is being made on the development of the clinical strategy with appropriate levels of engagement.

Proposals and/or Recommendations

The Board is asked approve the process set out in the document.

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

For further information or for any enquiries relating to this report please contact:	
Name: Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:** (13) 4355

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	10
Subject:	Foundation Trust Application
Reporting Officer:	Director of Strategic Development and Assurance

Action: This paper is for **(please tick)**

Assurance		Approval	√	Decision	

Purpose:

The Trust's timeline for Foundation Trust (FT) application has been confirmed by the Department of Health (DH) with a date for final submission to the DH in October 2013. A satisfactory application at this stage would allow the Monitor process to commence shortly afterwards with the aim being that the Trust's would be authorised by April 2014.

Introduction:

The national policy intention for all NHS provider Trusts to achieve FT status by 2014 has been clearly set out by the Secretary of State. The Board has determined the strategic issues that need to be addressed in order to ensure the organisation is clinically and financially sustainable and can demonstrate the governance and quality standards required. The work currently underway to progress the clinical strategy, improve clinical quality and achieve financial targets through turnaround will be the bedrock of a successful FT application. In discussion with the Primary Care Trust, the Strategic Health Authority (SHA) and the DH timelines have been established for an FT application that allows these issues to be addressed and progress to be made against the key FT application milestones.

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

The attached Tripartite Formal Agreement sets out the terms under which the timeline has been agreed as well as the issues to be addressed and actions to be taken by the Trust and the SHA in order that progress can be made against the agreed timeline. It also identifies the principle risks to achievement.

The Board recently discussed the need to put in place a Board development plan to support the Board through the application process and work to progress this is underway. Programme governance arrangements will be put in place to ensure the plan is progressed effectively and that key risks are identified and addressed.

Benefits:

Confirmation of the FT timeline allows the development of robust programme management to ensure the timescales required for the FT application are met.

Risks and Implications

There is a risk that a FT application will be seen as an end in itself rather than as a product of the strategic improvements currently underway in the Trust. In addition there is a risk that the FT timeline is impacted by delays or underperformance against strategic plans.

Assurance Provided:
The Director of Strategic Development and Assurance is the lead co-ordinating director for this work. Programme Management resources are established within the directorate to support the programme governance recommendations.

Proposals and/or Recommendations
The Board is asked to formally approve the TFA and to discuss the principle risks in relation to the delivery of the TFA. A project plan and programme governance arrangements will be presented to the Board at its January meeting for assurance with action being taken between now and then to establish the work programme.

Outcome of the Equality & Human Rights Impact Assessment Screening
What risk to Equality & Human Rights (if any) has been identified from the impact assessment?
No assessment was required.

For further information or for any enquiries relating to this report please contact:	
Name: Dr Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:** (13) 4355

TFA document

Supporting all NHS Trusts to achieve NHS Foundation Trust status by April 2014

Tripartite Formal Agreement between:

- East Sussex Healthcare NHS Trust
- NHS South East Coast
- Department of Health

Introduction

This tripartite formal agreement (TFA) confirms the commitments being made by the NHS Trust, their Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

Specifically the TFA confirms the date (Part 1 of the agreement) when the NHS Trust will submit their "FT ready" application to DH to begin their formal assessment towards achievement of FT status.

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in part 2a. The signatories for each organisation are as follows:

NHS Trust – Darren Grayson, Chief Executive Officer
SHA – Candy Morris, Chief Executive Officer
DH – Ian Dalton, Managing Director of Provider Development, DH

Prior to signing, NHS Trust CEOs should have discussed the proposed application date with their Board to confirm support.

In addition the lead commissioner for the Trust will sign to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. In the future, the agreed actions assigned to SHAs will be taken over by the National Health Service Trust Development Authority (NTDA).

The objective of the TFA is to identify the key strategic and operational issues facing each NHS Trust (Part 4) and the actions required at local, regional and national level to address these (Parts 5, 6 and 7).

Part 8 of the agreement covers the key milestones that will need to be achieved to enable the FT application to be submitted to the date set out in part 1 of the agreement.

Standards required to achieve FT status

The establishment of a TFA for each NHS Trust does not change, or reduce in any way, the requirements needed to achieve FT status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve FT status. The purpose of the TFA for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve FT status. The TFA should align with the local QIPP agenda.

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, the quality of services will be further strengthened. Achieving FT status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

Part 1 - Date when NHS foundation trust application will be submitted to Department of Health

1 October 2013

Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

as covered in this agreement.

Darren Grayson, CEO of East Sussex Healthcare NHS Trust	Signature Date: 29.09.11

Candy Morris, CEO of NHS South East Coast	Signature Date: 29.09.11

Ian Dalton, Managing Director of Provider Development, DH	Signature Date:

Part 2b – Commissioner agreement

In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

Amanda Fadero, CEO of NHS Sussex Cluster	Signature Date: 29.09.11

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

The Trust is registered with the CQC without conditions

Financial data (figures for 2010/11 should to be based on latest forecast)

	2009/10 £000's	2010/11 £000's
Total income	282,787	299,623
EBITDA	15,286	10,192
Operating surplus\(deficit)	350	(4,704)
CIP target	13,907	17,700
CIP achieved recurrent	11,113	13,200
CIP achieved non-recurrent	2,794	3,400

The Trust's main commissioners are NHS East Sussex Downs and Weald and NHS Hastings and Rother.

Further information

Serving a population of 500,000 the Trust provides acute medical, surgical, paediatric and maternity care, plus a comprehensive range of community services, along with diagnostic and therapy provision. It operates from two district general hospitals - Conquest Hospital in St Leonards-on-Sea and Eastbourne District General Hospital and a further 18 registered sites. The Trust also provides a range of outpatient and day surgery along with Intermediate Care beds at Bexhill Hospital, Uckfield Community Hospital, Lewes Victoria Hospital Crowborough Hospital and Rye, Winchelsea and District Memorial Hospital along with midwifery-led services at Crowborough Birthing Centre

The Trust was formed following the merger of East Sussex Hospitals Trust with the East Sussex Community Health Services (the provider arm of NHS Hastings and Rother and NHS East Sussex Downs and Weald) on the 1st April 2011.

Total income for the new Trust is £361m (2011/12) which includes £69m for the integrated community services.

The Trust will require significant capital expenditure over the next five years to deliver the agreed clinical strategy although the exact amount will be clarified over the next 12 months once the detailed implementation plans are agreed.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT

Issue	
Strategic and local health economy issues	
Service reconfigurations	☒
Site reconfigurations and closures	☐
Integration of community services	☒
Not clinically or financially viable in current form	☐
Local health economy sustainability issues	☐
Contracting arrangements	☐
Financial	
Current financial Position	☒
Level of efficiencies	☒
PFI plans and affordability	☐
Other Capital Plans and Estate issues	☒
Loan Debt	☐
Working Capital and Liquidity	☒
Quality and Performance	
QIPP	☐
Quality and clinical governance issues	☒
Service performance issues	☒
Governance and Leadership	
Board capacity and capability, and non-executive support	☒

The Trust is in the process of developing its Clinical Strategy. The Strategic Framework has been developed and approved by the Board and the development of implementation and delivery plans is underway. The Strategy has been developed on the basis that the Trust would integrate with community services from April 2011. The strategy will identify those areas where service reconfiguration, service redesign or further operational efficiency are required to ensure a sustainable service model and deliver quality and outcome improvements. Models of care for eight strategic service areas have been developed with the model of care for maternity services being developed through an independent maternity review board. Stakeholder engagement arrangements and liaison with the HOSC are well advanced. The Trust will commence a process for pre-consultation engagement from October 2011 to develop options for delivery of the agreed models of care and the criteria through which these will be appraised. Initial options appraisal will be undertaken during this period and this will ensure that by December 2011 it is clear which options will require formal consultation and which can proceed to implementation without this. If consultation is required this will commence in January 2012. This will enable the Trust to finalise all aspects of its clinical strategy by April 2012.

The Trust is in negotiation over the support required to mitigate the impact of its 2010/11 financial deficit on subsequent years. Despite delivering substantial cost improvement programmes in the course of the year, and achieving breakeven over the final few months, the deficit accumulated in the early part of the year precluded the achievement of the planned surplus. Additional one-off support will also be required to fund the cost of transformation. Efficiency savings for 2011/12 in the region of 7.5% (£30m) CIP are developed but contain a number of high risks to delivery

Following a planned unannounced visit by the CQC in February 2011 the Trust was issued with three warning notices in respect of its compliance with the regulations of the Health and Social Care Act along with a requirement to take action in a number of areas to achieve full compliance with the regulations. The Trust has developed and implemented detailed action

plans in all these areas. Following a reactive inspection in April 2011 and inspections as part of a national review of Dignity and Nutrition in May two of the warning notices were lifted and a further warning notice in respect of Regulation 9 was issued. The CQC noted that the Trust had made progress in a short period of time but that further action was required. The Trust reviewed and revised its action plans to ensure that the short and long term actions required to achieve compliance are being implemented and the Board has scrutinised the organisations compliance in detail. The Board has indicated to the CQC that considerable progress is being made and that embedding and sustaining compliance is part of an overall programme of transformation and organisational redesign currently being implemented. The Trust is currently awaiting the CQC's view on its current level of compliance.

The Trust merged with East Sussex Community Health Services on April 1st 2011 which will have a positive impact on the Trust's ability to deliver its clinical strategy and improve quality and outcomes for patients particularly in the provision of services that support prevention of exacerbation of illness and intermediate and other community based care. The preparation for the merger was undertaken in a very short time frame and was intensively managed. Plans are in place to manage the integration; these will see the organisational structure and governance revised to reflect the changed nature of the new organisation. The transformation enabled by the integration process will be delivered through the implementation of the Clinical Strategy and the Organisation Development Plan both of which were developed on the assumption of integration.

Board development is a central plank of the OD plan. Following the resignation of the Chair with effect from April 1st 2011a new Chair has been appointed and commenced his role in mid-July 2011. A governance review to ensure the organisation is prepared for FT has concluded and its recommendations will be implemented from October.

Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement	
Strategic and local health economy issues	
Integration of community services	☒
Financial	
Current financial position	☒
CIPs	☐
Other capital and estate Plans	☐
Quality and Performance	
Local / regional QIPP	☐
Service Performance	☒
Quality and clinical governance	☒
Governance and Leadership	
Board Development	☒
Other key actions to be taken (please provide detail below)	☐

The Board receives regular reports on quality and patient experience with detailed reporting on areas of concern or where the Trust is an outlier for example HSMR. The Board has approved a detailed action put in place to address the concerns raised by the CQC in the recently published review of compliance reports following their planned compliance visit in February 2011. The action plan will be updated on receipt of further reports including those from the follow up visit conducted in April 2011. The Board will receive regular reports on progress made against the plan and their impact on achievement of compliance in all areas. The Board will be taking steps to strengthen opportunities for regular Board level review of frontline clinical services to include areas where concerns or risks to compliance have been identified. This review will cover all 20 registered sites following the merger with community services.

Clinical Strategy:

- Development of implementation plans – high level strategic change indentified by June 2011
- Modelling of proposed change to ensure its ability to deliver financial, performance and quality improvements

Finance:

- Negotiation of support to mitigate the impact of 2010/11 financial deficit on subsequent years.
- Agree transitional support (with associated cash injection) to fund the cost of transformation.

Performance

- Implementation of plans to redress current performance shortfalls (particularly on 18 weeks RTT, which will be challenging in an environment of financial constraint)

Quality and Clinical Governance:

- Respond to concerns raised by CQC to demonstrate compliance
- Review of Clinical Governance arrangements – to follow on from organisational governance review

Governance and Leadership

- New Chair takes up appointment July 2011
- Organisational Governance review May 2011 and implementation by October 2011 onwards
- Implementation of OD plan including Board development and complete organisational structure underway – full implementation of organisational structure by October 2011

Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Local health economy sustainability issues (including reconfigurations)	☐
Contracting arrangements	☐
Transforming Community Services	☒
Financial CIPs\efficiency	☒
Quality and Performance Regional and local QIPP	☐
Quality and clinical governance	☒
Service Performance	☒
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below)	☐
NHS SEC FT assurance process plus monitoring of the vertical integration of the community and acute services from the two predecessor organisations (from an operational, systems and governance point of view) as well as on-going management of finance, quality and operational performance. Lead: Regional director of provider development Milestones: as below. Agree an appropriate financial support package with the Trust and its lead commissioner to mitigate the impact of the 2010/11 financial deficit on subsequent years and fund the one-off costs of transformation. Lead: Director of finance and performance	

Part 7 – Supporting activities led by DH

Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☐
Short/medium term liquidity issues	☐
Current/future PFI schemes	☐
National QIPP workstreams	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☐
No key actions to be taken by DH identified at this stage.	

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

Date	Milestone
January 2012	Commence public consultation on service changes
April 2012	Clinical strategy finalised
June 2012	Draft IBP & LTFM submission to SHA
November 2012	Draft IBP & LTFM submission to SHA
December 2012	Board to Board with SHA
December 2012	Commence FT public consultation
February 2013	HDD Phase 1
April 2013	Draft IBP & LTFM submission to NTDA
July 2013	HDD Phase 2
August 2013	Final submission to NTDA
September 2013	Board to Board with NTDA
October 2013	Submission to DH

Project oversight elements of assurance process augmented by sanctions set out in NHS South East Coast Performance and Intervention policy.

Each of the milestones are points where the Trust is assessed against the eight domains by the SHA to ensure that appropriate progress has been made versus the assurance timeline. Feedback is provided to the Trust and when appropriate remedial action taken to ensure the process is kept on schedule.

Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the NTDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA. Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement. In the future, the agreed actions assigned to SHAs, will be taken over by the National Health Service Trust Development Authority (NTDA).

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
The challenging requirements and timescales for savings and improved financial performance cannot be met	Lead David Meikle/Andy Horne CIP delivery supported by programme office Clinical Strategy tested for ability to deliver/support financial efficiency and savings Robust monitoring of delivery at SBU and Divisional Level as well as cross Trust
Aspects of the implementation of the Clinical Strategy may require formal consultation and be subject to high levels of political and public concern	Leads: Amanda Harrison/Andy Horne/David Hughes Maternity review underway with stakeholder engagement Close working relationship with HOSC Secure robust level of clinical leadership and involvement in planning Ensure patient and public engagement Continue to inform and build relationships with local politicians
Integration with community services does not deliver proposed service or efficiency benefits	Leads: Andy Horne/Amanda Harrison Clinical Strategy deliver plans fully reflect potential of integrated organisation to reconfigure and improve patient pathways, deliver efficiencies and quality improvements OD plan focused on ensuring effective integration and transformation
There is a period of instability whilst the organisation is restructured to reflect merger with community services and a new Chair is inducted	Lead: Darren Grayson/Amanda Harrison Delivery of OD plan includes communications strategy and board development plan. Governance review will ensure organisation is positioned to deliver governance required as FT Strengthen clinical leadership through Clinical Units and divisions
The organisation is unable to deliver quality improvements and achieve/maintain compliance with CQC standards	Lead Jane Hentley/ David Hughes Delivery of actions required to address concerns raised by CQC Increased Board focus on monitoring implementation of action plans

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	11
Subject:	Board Development-update
Reporting Officer:	Director of Strategic Development and Assurance

Action: This paper is for **(please tick)**

Assurance	√	Approval		Decision	

Purpose:

This report builds on the board paper provided in September which set out the skills and attributes the Non Executive Directors will need to develop to lead the Trust through challenging times to Foundation Trust (FT) status over the next 2-3 years. The report summarises the outcomes of the board member review process and outlines the key elements of board development that will encompass all members and those that will be tailored to meet individual needs.

Introduction:

Investment of time and commitment to Board development is essential to the strategic leadership of the Trust, particularly through such a challenging period in its history. The NHS has developed a governance model that mirrors commercial models, with unitary boards established where executive and non executive directors share governance responsibilities. In order to lead the Trust on its improvement journey and to maintain the trajectory towards FT status, board members will need to make full use of their existing skills, develop individual and collective leadership qualities and deepen their knowledge of the Trust and the wider health economy.

The assessment of Non Executive Directors has identified some strengths and development needs that need to be addressed as part of the FT development process.

To date, around half of the aspirant FTs applying for authorisation have been deferred by Monitor because of issues with board capacity and capability. We need to make sure that we are taking advantage of every opportunity to address our development, build on our qualities and resolve our development needs.

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

Board development will take time and commitment from all board members.
Some board development activities will involve the whole board; others will involve individual members.
Board members are well-placed to share knowledge and expertise with each other as part of the development programme, and there are talented staff within the Trust who will be able to support the programme.
Where possible real-time, task based development will take place using board seminars and other opportunities. We will also seek to learn from best practice models and other Trusts in similar positions. The Board needs to invest in team development, especially as it is evolving a different way of working and new members will be joining over the next few months.

Strong relationships between members will be essential, where constructive challenge and support during testing times can be relied upon to improve the Trust's performance overall.

Benefits:

The whole Trust is undergoing a transformational change programme. The board must be seen to lead that process from the front and set the tone for new ways of working.

Risks and Implications

Failure to deliver the necessary progress as a Board may contribute to the Trust making insufficient progress to achieve Foundation status or to satisfy external regulators. The organisation takes its lead from the behaviour and style of the board, so the cultural change programme we are setting for the Trust will be inhibited if the Board does not make the transition required.

Assurance Provided:

The report provides assurance that a programme is being developed that reflects the needs identified from national and internal information and that will ensure quality outcomes are secured that will meet the needs of the Trust and that are valued by board members.

Proposals and/or Recommendations

The Board is asked to discuss the plans and to engage in future development activities in order to ensure that the programme can be implemented and its impact evaluated.

Outcome of the Equality Impact Assessment Screening

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

None

For further information or for any enquiries relating to this report please contact:	
Name: Dr Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:** (13) 4355

East Sussex Healthcare NHS Trust

Trust Board Development Programme: Update.

1. Introduction

1.1 The purpose of this report is to update board members on the purpose and implementation of the Board Development Programme. The proposed programme has been informed by the organisational drivers for development including the development of the clinical strategy, the changing commissioning environment and the financial and quality challenges the organisation faces. Developmental needs have also been identified through a range of assessments and observations of the Board and Board members. In addition reference has been made to documents published by Monitor and others on optimal Board functioning and governance.

1.2 The Trust Board is committed to investing in a programme of development to ensure that individually and collectively it is well-placed to give strategic leadership to the organisation through challenging times in the short-medium term and to give confidence to external stakeholders that the Trust is on course to become a successful Foundation Trust (FT).

1.3 It is recognised that the Board is in an ongoing process of formation with new executive and non executive members expected to join over the next few months. However, it is essential that a programme of development continues and is increasingly focused on developing a Board that is fit for purpose to operate effectively in the current context, prepare for the future and assimilate and learn from new members. Therefore the programme seeks to meet the developmental needs of the existing Board, anticipate future development needs as the organisation prepares for FT status and build in opportunities for reviewing and refreshing the programme as the Board develops and changes.

1.4 The Board must also work effectively with partners in the local health economy to help establish the Trust as a credible, high quality partner of choice. This will become increasingly important as patients, service users and commissioners have more choices to make and competition for resources becomes fiercer. The Board will need to demonstrate how it operates within a unitary model, with a common voice, in order to gain the confidence of strategic partners and national decision makers.

1.5 For the Board development programme to be effective all members will need to put in time and commitment. As far as possible, the programme will run alongside the existing Board work programme but there will be a requirement for some extra activities and some members will need to spend more time reading or in 1-1 sessions honing their skills or building their knowledge in a particular area. Progress and quality of outcomes will be monitored by the Chairman.

2. Background

2.1 East Sussex Healthcare Trust (ESHT) has embarked on a course of actions that will ensure that the Trust is able to:

- Provide excellent services for patients
- Deliver and develop services within the available resource envelope
- Assure patients, commissioners, partners and regulators that patient safety, care quality and financial balance are maintained and improved
- Develop as a sustainable NHS healthcare provider, achieving authorisation by the Independent Regulator of NHS Foundation Trusts (Monitor).

2.2 Key to all this is leadership by the board, and the appropriate governance systems that will enable the board to demonstrate grip and that it is performing its statutory functions. The Chairman has enhanced the Board by inviting all non-voting directors and Divisional Directors to participate in all formal and informal Board meetings. The Board development programme will be extended to all those who participate in these forums. Some core elements that will address the requirements of the Monitor process may be focused on those members who will meet directly with Monitor; however, experience of similar assurance processes such as World Class Commissioning has shown that full participation of all the board members in the preparation phases has strengthened the final performance at external assurance enormously.

2.3 In September and October 2011 briefing papers were provided to the Board that set the scene for the Board development programme. The areas covered included: the role and value of Non Executive Directors (NEDs); board governance models; key tasks; the Nolan Principles for public life; key competencies that a NED should possess based on Monitor and the Appointments Commission. The current competencies of each NED was considered against these in various ways:

- existing information and material, including various board and committee observations
- individual interviews with each of the non-executives
- a document review of board and committee papers.

2.4 Using a Maturity Matrix Developed by the Good Governance Institute (appendix 1) the Board has assessed its own performance in July 2011 and set a target for future performance (appendix 2). This has been pivotal in assessing Board-wide development needs. In addition a maturity matrix was developed and used to present an overview of the development needs of each NED against FT standards and requirements.

2.5 The appraisal, performance management and personal development of Executive Directors are managed by the Chief Executive according to Trust policy. However, as the programme is developed it will be important to ensure that Executive Directors' performance and development needs as members of the unitary board are also assessed.

The Executive Directors should participate fully in a similar process to that which the NEDs have recently undertaken and they will take part in the board development programme to ensure that they become active members of a single, unitary board with a shared approach and robust relationships.

2.6 There will need to be a separate programme of development for the Executive team that will support and complement the Board development programme as well as optimising executive functioning and leadership of the Trust's operation.

2.7 This report focuses on how to take the whole Board development programme forward and does not attribute specific development requirements to any individuals.

3. Programme content

3.1 Before describing the content of the board development programme it is important to put the proposals into context. The Board has been undergoing a period of significant change in parallel with the Trust, and there is more to come. Along with changes to personnel, a significant change in style, tone and expectations will challenge for existing members as well new additions (executive and non executive).

3.2 All board members will need to have a shared agreement on:

- The standards of behaviour and conduct within which the board does its business and members manage relationships
- Roles, relationships, functions and responsibilities both individually and collectively
- The standards of performance, quality and patient safety that the board expects for patients and service users
- How they know what good looks like for this Trust, including outcome measures for quality, culture, performance, innovation and ROI.

3.3 All board members will need to develop:

- An in-depth understanding of the business and the environment within which the Trust operates
- A thorough grounding in the journey towards Foundation Trust status and how it ties in with performance improvement
- An understanding of the requirements of achieving FT status and be able to explain to staff, patients, governors and stakeholders the benefits of FT status for local people.

3.4 In order to reach these levels of performance the Board will need to work very well together as a unified team, teasing out the blocks to excellent performance and establishing modus operandi as a team so that the Board operates at a high level of behavioural as well as governance maturity.

3.5 The team development component of the programme will be made more complex by the addition of new members over the next 6-9 months. As members leave and join, time must be given by the whole board to learning lessons from departures, forming as a new team, enabling recruits to influence and shape the dynamic and providing a supportive induction process that enhances their contribution.

3.6 The Board has been operating more as a meeting than a unified team, and time will need to be given to building relationships and trust informally not only through undertaking work together but by taking time out to understand motivation, share values and learn about different styles of working and communication. Whilst some elements can be achieved through completion of leadership tasks, time should also be allocated to debating some of the basic behavioural standards and testing them out to establish a board charter or modus operandi which commits all members to adhere to basic behavioural norms. Having done this fundamental activity, working together on the priority leadership tasks will become easier.

3.7 The Board should use facilitation to challenge itself to work in different ways and set new standards of behaviour and to enable challenging discussions to take place in a managed environment.

3.8 Putting the Trust on a much firmer footing is the top priority for the Board; doing so will ensure progress is also made towards FT status. Priorities for development identified through the assessment process outlined above are:

Functioning as an effective unitary board	Including: evidence based decision making Board committee reviews
Engagement in practice	Including: how to develop meaningful clinical engagement and evidence its impact How to work with local communities Who are our stakeholders and what difference do they make?
Quality outcomes	Including: the role of the board in setting the agenda for quality; performance managing quality; how does quality improve efficiency and can we prove it?
Risk	Including: risk appetite; market development; scenario planning and testing; evaluating service failure
Finance	Including: from the basics to break even. What is the value of FT? What are our financial risks? Balancing long term risk with short term imperatives.

3.9 To date, around half of the aspirant foundation trusts (FTs) applying for authorisation have been deferred by Monitor because of issues with board capacity and capability. We need to make sure that we are taking advantage of every opportunity to address our development, build on our qualities and resolve our development needs.

3.10 As an aspirant FT the organisation and Board will be able to access some national support but the Board will also need to challenge itself at regular seminars and workshops. Programme activities will include:

- Masterclasses on essential topics of strategic importance
- Partnering with another aspirant FT
- Mock Board to Board with structured preparation, 1-1 and group feedback and follow-up work
- Group and individual "catch up" sessions on issues that people feel less confident about.

3.11 These cycles of work will become increasingly FT specific as the Trust proceeds along the timeline. For example, the work on the strategy will take shape as Trust develops the Integrated Business Plan (IBP). Board workshops will anticipate the timetable so that the Board will be prepared to set the overall direction and make an informed contribution to the IBP as it takes shape.

3.12 Where possible the Board should use in-house expertise or exchanges with staff from other Trusts to give a broader perspective and offer opportunities for staff to have direct access to the Board. The Board should use facilitation to support it to challenge itself and to raise its game.

3.13 Details and timings for the outline programme are set out in the attached document (appendix 3). This programme is developed in detail for the next six months and in outline thereafter and has been informed by the timeline agreed within the Tripartite Formal Agreement which sets out the Trust's agreed pathway to FT status. It also indicates which elements of the programme should be delivered in the following ways:

- In house –delivered by board members
- Facilitated in house – delivered by board members with external facilitation
- External peer to peer – delivered in conjunction utilising the expertise of and/or sharing learning with other similar organisations
- External – external support secured through a procurement exercise to an agreed specification
- Access to national programmes – through the FTN or other external national development programmes

3.14 We will also need to make best use of programmes and support provided by national organisations such as the Foundation Trust Network. Where additional external support is required it is proposed that we seek the best quality, most cost effective option that meets our requirements. The procurement will be managed by an executive director and specifications will be developed with the active involvement of the Board.

3.15 Individual board members will have actions within their own personal development plans (PDPs) which they will need to address. This may include filling a skills or knowledge gap, reviewing style or behaviour, gaining experience to complement that which they brought with them to the Board or learning something new as they take on a new role.

A tailored programme will be set up with each board member and signed off with the chair, with agreed outcome measures and timescales. These activities may involve the board member taking some time outside regular meetings to address their specific need.

3.16 Where coaching support, for example on style or behaviour is required, this will be sourced with the involvement of the board member and may be part of an externally procured contract or an individual package.

4. Conclusion

4.1 The Board's development as the strategic leadership team of the Trust is critical to the organisation's long term sustainability. Every board member is a member of the team wherever they are, and in every setting. The ambassadorial role will become increasingly important as the Clinical Strategy goes out to public consultation and our FT application gathers pace. Every time the Board meets as a whole group, a committee, in a formal or informal discussion it will be working on its development as a team.

4.2 The board should maximise opportunities to learn from each other and acknowledge that the development programme will pose challenges for each member at different stages of the process, It will want to monitor the impact and benefit that the investment it makes in its development has for staff and patients across the Trust and the way key stakeholders respond to the Board and the changes that it will make.

4.3 The Board has challenged the Trust significantly this year by redesigning the organisation, integrating two providers, and setting out a different culture based on clinical leadership with the patient and service user at the centre of everything we do. The challenge that has been set for staff needs to be mirrored by a programme of Board challenge and development to ensure that it is fit to lead a FT and successfully achieves FT status by 2014.

4.4 The Board is asked to discuss the plans set out in the progress report and support the recommendation that a detailed programme be commissioned in January 2012.

Fiona Endersby Solo Consultancy,
Andrew Corbett Nolan Capsticks/GGI,
Amanda Harrison Director of Strategic Development and Assurance

December 14th 2011

www.good-governance.org.uk

Good Governance Review:

The Good Governance Institute Self Assessment Maturity Matrix
developed by John Bullivant, & Andrew Corbett-Nolan
v 4.1a June 2011

Key Elements:	NO	1: Basic level - Principle Accepted	2: Early progress in development: agreement of commitment & direction	3: Firm progress in development	4: Results being achieved	5: Maturity - comprehensive assurance: exemplar
1. Purpose and vision	NO	Organisational purpose debated and agreed. Values and priorities have been identified.	Priorities and stretch goals have been agreed with stakeholders. Any non-compliance with funders/commissioners plan/priorities is explained.	Board has agreed ethical values combined with a robust mechanism for adding and removing services and/or care settings against these.	Evidence that priorities stretch goals are being met. We have regular reviews of strategy.	We have an annual board debate on organisational purpose, and how in-year achievements or issues impact on this.
2. Strategy and planning	NO	Strategic prioritisation process in place predicated on quality and aimed to protect long-term priorities from short-term pressures. Market Analysis is completed	Delivery plan is developed for each aspect of our service /location. Productivity plans for workforce, infrastructure and partnerships built into contracts & new project initiatives.	An annual cycle of board activity is in place, & is tested annually for completeness & strategic balance. The BAF is used as a key instrument to ensure strategic focus.	Board papers are organised to consider systematically clinical, finance, quality, workforce, diversity, Health and Safety etc. implications to decisions before the board.	We have evidence that strategic issues are followed through, eg achieving our operational plan and agreed outcomes, meeting key strategic milestones, Horizon scanning a routine event
3. Leadership	N O	The roles of all board members are clear, agreed and specified.	A board succession plan is in place for directors and senior executives. Diversity at board level is valued.	We have an induction and development programme in place for board and aspirant board members.	The board is leading rather than following agendas	Board is recognised by stakeholders & within the organisation and with partners for joined-up decision taking & adding value
4. Finances	N O	All in-year plans are costed and trajectory of spend/savings is established to achieve breakeven/target.	Budget, cost pressures and efficiency targets are clearly identified to the board.	Longer-term investments are protected from short-term pressures.	Unexpected in-year pressures are costed and actioned within two months.	We have a network of partnerships with other community organisations and hospices to improve service delivery and organisational fitness
5. Risk and agility	N O	Known risks are identified and continuity plans in place. Operational risk is captured systematically using the risk register.	We have a process to prospectively evaluate risk, such as a risk committee with this remit.	Our risk appetite including market expansion has been discussed and agreed. This has been built into our plans.	Continuity plans are regularly tested. The board uses scenario or similar exercises to develop joint understanding of risk and opportunities.	We systematically evaluate serious service failures elsewhere, & the board is engaged in 'Could it happen here' scenario tests or discussions.
6. Information, analysis and assurance	N O	Assurance framework is organised to promote focused discussion on key organisational /business issues.	Assurance framework covers activity, cost and quality. Information and assurance are aligned to targets, standards and priorities.	Control mechanisms are in place for all elements of the assurance framework. Internal and clinical audit provides dynamic assurance.	A high degree of risk sensitivity can be demonstrated throughout the organisation. This is reviewed by the board.	The board is confident that it has intelligent analysis and assurance across all the organisation's operations.

	NO	1: Basic level - Principle Accepted	2: Early progress in development: agreement of commitment & direction	3: Firm progress in development	4: Results being achieved	5: Maturity - comprehensive assurance: exemplar
7. Quality, efficiency, innovation and outcomes	N O	An efficiency plan has been established. Quality and safety implications for this are explicit.	The organisation has agreed reduction targets agreed for iatrogenic harm and wasted resources.	Efficiency plans for workforce, infrastructure and partnerships are built into contracts and new project initiatives.	A comprehensive performance management approach has been established. Any alternative provision required has been identified.	We have evidence of year on year improved productivity in services, workforce and estate.
8. Probity and reputation	N O	The board has explicit and accepted. standards of conduct in place.	All boards members are clear about when to absent themselves from board discussions.	The conflicts of interest register is updated by the board and staff monthly. Identified conflicts are reviewed and any appropriate actions taken.	The board has agreed how probity will be expected in all partners and contractors. This written into contracts and agreements.	The board in its deliberations routinely considers reputational risk.
9. Decision making and decision taking	N O	Decision making includes appropriate consultation and option/impact appraisal. This includes equality impact assessments.	Information processing and analysis is focussed on priorities.	Intelligent information is routinely generated for the board, other stakeholders and regulators.	The board takes decisions based on evidence.	Board decision taking has been improved through the availability of real-time information, and informed discussions about trends and other analyses.
10. Service user, staff, stakeholder and public engagement	N O	Our engagement and consultation policies are in place and are consistent with our mission and values.	We recognise service users, staff and the public as resource to help focus, design and deliver service improvement.	We have a systematic system of accountability to the local community in place..	We have effective clinical engagement in place, and evidence this by our clinicians regularly demonstrating improvement initiatives that are put into operation.	Effective partnership working and governance between organisations is in place
11. Board supports and main committee structures	NO	The audit committee/ clinical governance committee role has been developed to take on a holistic independent scrutiny function.	The board secretary or chief risk officer holds a compliance assurance and tracking role for all assurance issues. The board receives regular reports on these activities.	The workload and agendas for the board, committees and board task and finish groups are planned, with a systematic communication process between these activities.	The audit committee/clinical governance committee workload is manageable. The work of internal and external auditors and advisors is aligned to supporting better board assurance.	We have reviewed our main governance systems and structures to ensure that these remain fit for purpose.
12. Appraisal process of directors, and other feedback	N O	We are clear about the roles and developmental needs of our senior executives and directors and governors	Directors competences are known, and any gaps identified,	The Chair reviews individual directors contribution to the board at least annually.	Board induction and individual director development processes are in place.	Our annual review informs our board development programme.

East Sussex Healthcare NHS Trust
Good governance maturity matrix – 13th July, 2011 AS AGREED BY BOARD
Green = complete to July 2011 – Red = progress to be made by October 2012

Issue	**No**	**1. Basic level –** *principle accepted*	**2. Early progress –** *agreement of commitment and direction*	**3. Firm progress**	**4. Results being achieved**	**5. Maturity –** *comprehensive assurance - exemplar*
1. Purpose and vision						
2. Strategy and planning						
3. Leadership						
4. Finances						
5. Risk and agility						
6. Information, analysis and assurance						

7. Quality, efficiency, innovation, outcomes						
8. Probity and reputation						
9. Decisions						
10. Engagement						
11. Board supports and committees						
12. Director development						

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	12
Subject:	PCT Estate – Future Ownership and Management of Estate in the Ownership of Primary Care Trust in England
Reporting Officer:	George Melling

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

Purpose:

The purpose is to report on the properties within the community that fall into the Transferring Community Services (TCS) initiative.

Introduction:

We have reviewed and are reporting upon 23 properties that are currently under the ownership of Primary Care Trusts (PCTs). The purpose of the review was to establish where the ownership of the properties should lay following the TCS.

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

As previously reported, NHS Trusts are to be given the opportunity to acquire part of the PCT estate deemed 'service critical clinical infrastructure' that is integral to the provision of community services commissioned from these NHS bodies.

These premises include

- Accommodation with high specification equipment, theatres and wards
- Community Hospitals

Transfer of agreed properties will be at Nett book value, final details to be determined. Transfers will be subject to an option to acquire in favour of Secretary of State for Health and an overage provision, triggered by one of the following:-

- Provider fails to retain a service contract
- Vacates a property
- If NHS Trust ceases to exist
- Insolvency of the organisation

The option to acquire will apply if the whole or only part of a building is affected.

Overage provision will be based on 50% of any profit. In the case of a loss, no overage will be required by Secretary of State for Health.

Leases on properties deemed to provide 'service critical clinical infrastructure' should be assigned to the NHS Trust.

Property transfer will be based on transfer to the majority occupier**.** Majority means occupying more than 50% of the lettable floor area.

It is required that proper arrangements are made to document the occupancy rights of minor occupiers. Agreement should be reached with regard to shared costs. In the case of properties to be transferred, this must be completed prior to completion of the legal transfer.

PCTs will also be expected to ensure that all liabilities, obligations and any warranties relating to the estate, are transferred to the transferee.

Approval Mechanism

Applications by ESHT for the PCT properties listed below have already been made to the Strategic Health Authority, these applications were made on the 31st of October 2011.

Review Panels (including NHS Sussex) have now been established to consider the property applications made for all PCT properties and over the coming months the Review Panels covering the East Sussex Downs and Weald Area and Hastings and Rother PCT area will be reviewing the property applications made by ESHT in line with the Department of Health guidance. The work of the review panels is expected to take the remainder of the calendar year.

Potential Impact

The following properties have been reviewed and are considered as suitable for transferring into the ESHT portfolio, therefore ESHT have completed applications for the following PCT properties where Community Services are being provided:

Crowborough Hospital Site (includes Crowborough Hospital and Grove House)

Avenue House Site (includes Avenue House, Centenary House and the Annex)

*Scott Unit

*Paediatric Development Unit

*Upwyck House

*Eastbourne Park (1st Floor)

Hailsham Health Centre

*Units 5 & 6 Apex Way, Hailsham

Lewes Victoria Hospital Site (includes Lewes Victoria Hospital, Meadow Lodge and Orchard House)

Newhaven Rehab Site (includes Newhaven Rehab and Newhaven Poly Clinic)

Uckfield Hospital

*66 London Road

Bexhill Hospital Site (includes Bexhill Hospital, The Irvine Unit and the Bexhill Health Centre)

Ore Clinic

Arthur Blackman Clinic

Sedlescombe Road

Unit 10, Wheel Farm

Ian Gow

*8 Old Ladies Court

*Princes Park Health Centre

Heathfield Health Centre

Peacehaven Clinic

*Rye Memorial Care Centre

(* Leasehold properties)

Details of properties can be provided upon request by contacting Mark Paice, Assistant Commercial Director, Estates Division

Conclusion
The guidance has been followed and each building has been reviewed. All of the properties listed above are suitable for transferring into ESHT estate.

Recommendation:
It is recommended the 23 premises identified as satisfying the TCS criteria are approved as being suitable for transferring into the ESHT property portfolio.

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

For further information or for any enquiries relating to this report please contact:	
Name: Mark Paice, Assistant Commercial Director, Estates Division	**Contact details:** (14) 7513

East Sussex Hospitals NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	13
Subject:	Board Sub-committee Reports
Reporting Officer:	Director of Strategic Development & Assurance

Action: This paper is for **(please tick)**

Assurance	√	Approval	√	Decision	

Purpose:

The attached report provides a summary of the first meetings of the Board sub-committees held in November.

Introduction:

The Trust Board approved a new governance structure at its meeting on 28th September 2011 and approved the establishment of the following committees:

- Audit Committee
- Finance and Investment Committee
- Quality and Standards Committee
- Remuneration and Appointments Committee

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

The attached report provides a summary of the key discussion points at each meeting.

The committees also reviewed and amended their terms of reference and these are attached for approval by the Trust Board.

The Chair and non executive members of the Board Committees have been appointed by the Chairman and are:

Audit Committee: Chair: Paul Roche, NED Members: Maurice Rumbold, Ken Smith

Remuneration and Appointments Committee: Chair: Stuart Welling, Mary Lynch (until 31st January 2012), Paul Roche, Maurice Rumbold

Quality and Standards Committee: Chair: Maurice Rumbold, NED members: Paul Roche, Mary Lynch (until 31st January 2012)

Finance and Investment Committee: Chair Ken Smith, NED members: Maurice Rumbold.

In addition to the above as part of the governance review the Chair has appointed Maurice Rumbold to be the Senior Independent Director

Benefits:
The new governance arrangements will enable the Board to increase its effectiveness and impact.

Risks and Implications
Failure to implement the new arrangements effectively will result in the Board being unable to fulfil its statutory responsibilities.

Assurance Provided:
This report provides the Board with assurance that effective governance arrangements are in place.

Proposals and/or Recommendations
The Board is to note the summaries of the meetings and approve the amended Terms of Reference.

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

For further information or for any enquiries relating to this report please contact:	
Name: Amanda Harrison, Director of Strategic Development and Assurance	**Contact details:** (13) 4355

East Sussex Hospitals NHS Trust

AUDIT & INTEGRATED GOVERNANCE COMMITTEE

1. Introduction

1.1 The Audit Committee meeting was held on 16th November 2011 and a summary of the issues discussed is provided below.

2. Terms of Reference

2.1 The Committee agreed the terms of reference subject to an amendment to wording of the membership section to reflect that the chairman of the Audit Committee was also a member of the Quality and Standards Committee and are attached at Appendix 1.

2.2 The minutes of the previous Audit and Integrated Governance Committee held on 7th September 2011 were approved and are attached at Appendix 2.

3. Governance and Assurance/Risk and Risk Management

3.1 The Committee approved the revised arrangements for governance and assurance in the Trust which would support the Trust to fulfil its task to improve outcomes for patients and assure the Board and external regulators that quality services were being delivered.

3.2 The Committee also supported the approach being taken to risk and risk management.

4. Work Programme

4.1 The Committee approved the draft work programme for the Audit Committee.

5. Board Assurance Framework and Risk Register

5.1 The Committee reviewed the Board Assurance Framework in conjunction with the Risk Register following the bi-monthly review by the lead Directors and noted the amendment to the RAG rating to principle risk 1.1.

5.2 The Committee considered that the RAG rating for this risk should remain at red due to only partial assurance being provided on the clinical audit processes at the present time.

6. Clinical Audit Programme Mid Year Review

6.1 The report stated that only partial assurance could be provided on the process for clinical audits due to a level of uncertainty about the methodology of collecting the data as some audits had been conducted independently of the clinical effectiveness team register of mandatory clinical audits.

6.2 The Committee requested an update report for its next meeting.

7. External Audit

7.1 The External Auditor presented the Annual Audit Letter for 2010/11 and this was discussed and some amendments were discussed. The Annual Audit Letter will be presented to the Trust Board at its meeting in January.

7.2 The External Auditor noted that arrangements were in place for the annual review of the financial statements and internal controls and outlined the work to be undertaken on the value for money conclusion.

8. Local Counter Fraud Service

7.1 The Committee received the progress report and noted the actions being taken in respect of investigations.

7.2 The Committee also received a presentation from NHS Protect on its work and agreed that the themes arising from the NHS Protect report on Anti-Fraud cases should be fed into its work programme.

9. Internal Audit

9.1 The Committee received the progress report and noted that six audits had been completed since the last meeting and reviewed their conclusions.

10. Financial Controls

10.1 The Committee received an update from the Director of Finance on financial controls.

11. Standing Orders, Standing Financial Instructions and Scheme of Delegation

11.1 The Committee ratified the amendments to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation which had been reviewed following the integration of acute and community services and the implementation of the new governance structure.

12. Conclusion

12.1 The Trust Board is requested to:

- note the summary of the Audit Committee meeting held on 16th November 2011 including the minutes of the Audit and Integrated Governance Committee meeting held on 7th September 2011 (appendix 2)
- approve the amended Terms of Reference (appendix 1)

Paul Roche
Audit Committee Chairman

30th November 2011

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 provide assurance to the Board on:

(1) the effectiveness of Trust governance, risk management and internal control systems;

(2) the integrity of the financial statements of the Trust and in particular the Trust's Annual Report;

(3) the work of internal and external audit and any actions arising from their work;

(4) compliance by the Trust with legal and regulatory requirements.

The Audit Committee will review the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

The Committee should 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.. 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 and attendance

The Committee and the Committee Chairman will be appointed by the Chairman of the Trust Board.

The Committee shall consist of three Non Executive Director members, one of whom shall be the Chairman of the Committee. One member should also be a member of the Quality and Standards Committee.

One member should also be a member of the Finance and Investment Committee and at least one member of the Committee should have recent and relevant financial experience. Other Non executive directors of the Trust, including any designate non-executive directors but not including the Chair, may substitute for members of the Audit Committee in their absence.

At least once a year the Committee should meet privately with the internal and external auditors only.

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 Statement of Internal Control.

4. Quorum

Quorum of the Committee shall be two members one of which shall the Chairman of the Committee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, can be counted in the quorum.

5. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

6. 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.

7. Duties

7.1 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, Statement of Internal Control 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 Trust's Equality Delivery System (EDS)
- 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 Statement of Internal Control
- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification
- 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
- 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

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.

7.2 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.

7.3 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.

7.4 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 .

7.5 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.

7.6 Partnership and other inter-organisational arrangements

The Committee shall review and provide assurance to the Board in respect of any formal partnership arrangements or other inter-organisational agreements where the Trust is a party.

8. 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.

9. 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.

10. 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 Statement of Internal Control 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 with budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Committee should

The Committee shall review and propose changes to the standing orders and standing financial instructions as requested by the Board.

11. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary 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 Statement on Internal Control, 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. This may be facilitated by independent advisors if the Committee considers this appropriate or necessary.

These Terms of Reference shall be reviewed by the Trust Board at least annually.

EAST SUSSEX HOSPITALS NHS TRUST

AUDIT & INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Audit & Integrated Governance Committee (AIGC) held on Wednesday 7th September 2011 in St Mary's Board Room, Eastbourne DGH

Present: Mr Robert Smart, Non-Executive Director (Chairman)
Mr Maurice Rumbold, Non-Executive Director
Mr Ken Smith, Non-Executive Director
Ms Mary Lynch, Non-Executive Director

In attendance Mr David Meikle, Director of Finance & Performance
Mr Stephen Hoaen, Head of Financial Services
Mr Andrew Lynas, PKF
Mr Michael Townsend, South Coast Audit (SCA)
Dr Debbie McGreevy, Deputy Director of Assurance (for item 3)
Mr George Absi, Clinical Effectiveness Manager (for item 3)
Ms Mandy Collins, Clinical Governance Facilitator for item 3)
Mr James Gibbons, Chief Information Officer (for item 4)
Miss Chris Kyprianou, PA to Director of Finance & Performance (Minutes)

1. Apologies for Absence and Declarations of Interest **Action**

An apology for absence was received from Mr Roche, Dr Harrison and Ms Hentley.

There were no declarations of interest received in connection with the agenda.

2. Minutes of previous meeting

The minutes of the meeting held on 8th June 2011 were agreed as an accurate record and signed by the Chairman.

Matters Arising

It was noted that matters arising from both the 8th June meeting and the 18th May meeting were on the agenda for today's meeting.

3. Clinical Quality & Safety Report – Clinical Audit Forward Plan

Mr Absi gave an update on the progress regarding the implementation of the Clinical Audit Plan 2011/12 and summarised

the key issues highlighted in the report.

Mr Absi reported that that 83% of the Clinical Audit plan was currently running to schedule, which was high in view of the resources being redirected to the CQQ visit, and due to the organisation's restructure.

It was noted that a new Clinical Audit Policy was out for consultation which looks at strengthening accountability and responsibilities of management in having oversight of their areas' clinical audit programme, ensuring quality clinical audit is undertaken, action plans are monitored/quality improvements implemented and re-audits take place to evidence improvements. The policy also looks to strengthen education and training.

Mr Absi reported that there was also a need for a Clinical Audit Strategy which seeks to improve clinical audit in the following areas:

- New Trust integrated Audit Database which has improved performance regarding monitoring
- Education and training
- Patient and public involvement
- Communication networks
- Promotion of clinical audit
- Engaging junior doctors
- Clinical audit/clinical governance newsletter

It was noted that the programme this year was more CQC assurance focused.

Dr McGreevy reported that the as result of the CQC, action plans were currently under constant revision, and Dr Harrison and Dr McGreevy have been reviewing the outcome of the action plans. These have identified that a greater number of local audits need to take place currently on a weekly basis until there was assurance that these new actions have been embedded.

Ms Lynch raised some issues in the report and queried the number of meetings taking place. Dr McGreevy reported that the restructure and the governance review that was currently taking place intends to reduce the number of meetings. The clinical units will take responsibility for delivery of clinical governance and the assurance managers will work closely to support them to provide professional expertise and advice along with internal scrutiny.

Dr McGreevy reported that there would be 3 new Divisional Clinical Governance Manager posts, one in each division, each of whom will lead on a quality area i.e. patient safety, patient experience and clinical effectiveness. The Divisional Clinical Governance Manager lead for Clinical Effectiveness will work with the Assurance Manager (Clinical Effectiveness) to identify mandatory audits, who

is going to undertake them, how they will be supported, how they are going to provide assurance that the actions have been undertaken and lessons learned disseminated.

Ms Lynch commented on the action plan and stated she did not feel it gave measurable outcomes, and requested clarification on what was meant by ‘completed’. Mr Absi confirmed that this meant that the action plan had been drawn up. Ms Collins reported that in respect of community services, they used ‘green’ for an audit that was completed in terms of a report and an action plan drawn up, and ‘blue’ for a report where the action plan had been completely implemented to the extent which was considered suitable to sign off. This was agreed as way of clarifying the progress status of an action plan.

Discussion also took place on the Clinical Quality and Safety Report. This will be reviewed as part of the governance review process to ensure that the Trust Board receive all relevant information about significant issues or risks to the organisation.

Resolved:
The Committee noted the report

4. Information Governance (IG) Update

Mr Gibbons gave an overview of the status of Information Governance (IG) within the Trust against the national IG framework requirements for 2011/12.

This was related to South Coast Audit’s (SCA) extensive review of Information governance.

Mr Townsend reported that a thorough IG review was undertaken using the IG toolkit set of evidence as at 15th March 2011. The results were that East Sussex Healthcare was not that far out of line with what was found around the patch. The report was given limited assurance, however, the Trust had provided responses to SCA’s recommendations which provided an update of the most current position and/or new evidence being uploaded to the Toolkit for the final submission of 31st March 2011. This additional evidence was being reviewed as part of the 2011/12 computer audit plan. It was reported that significant assurance could then be achieved provided the latest management responses to the recommendations were backed up with suitable evidence.

Mr Gibbons informed the Committee that at the time of the audit some of the evidence was not collated onto the system, however, the trust had moved on significantly as a lot of work has gone on with collating the supporting information between the 15th March and the end of the financial year.

Mr Gibbons gave an overview of the problems which led to the Trust not delivering the toolkit and explained the improvements that had been made. The Trust now has a full time IG Team consisting of an IG Manager, a support post and an Information Securities Manager which looks at the technical solutions so the process was much more robust. The team also support the delivery of the IG Steering Group and co-ordinate Trust engagement and delivery to the required toolkit standards.

Mr Gibbons explained the process that was in place to enable the Trust to gain significant assurance. The IG Steering Group had been reinvigorated and an action had been put in place to ensure it can deliver level 2 on all areas was place, with the required evidence, with designated leads and with monthly checks.

Mr Gibbons reported that the IG team were working very closely with the Sussex Health Informatics Service (HIS), from an IT perspective, to ensure that all the data flows were secure and that this was an ongoing review programme which identifies any gaps. An update report was due to be presented to the IG Steering Group in October.

One issue was whether the overall scoring would be reduced as a result of the combined organisation since April. Ruth Paine was making sure that the policies and procedures in both organisations were the same and that there were no gaps that would cause the scoring to drop below the 60% that was previously reported. It was noted that 66% was the minimum standard that needs to be achieved this year. Mr Gibbons confirmed that the Trust was currently still at 60%.

Mr Smart suggested that SCA be invited to attend the Steering Group meeting in October to enable them to provide an update to the next AIGC drawing the Committee's attention to any outstanding gaps. **JG/MT**

The Committee recognised the work that Mr Gibbons and the IG team were undertaking and noted the report.

Mrs Lynch requested assurance that gaps in vacancies should not affect the preparedness of the Trust in the audits. Mr Meikle reported that organisational change does increase risk to the organisation and the Executive Team were reinforcing the organisational priorities and objectives and this has been added as an organisation risk to the Assurance Framework, together with the non achievement of the IG toolkit.

The Chairman asked Mr Gibbons to give an overview on where the Trust was with regard to IT services particularly with the integration of community services. It was acknowledged that there are a number of significant challenges recently developed that now need to be reflected in the risk register and assurance framework. The key areas **DM**

discussed included delivering a single PAS service, PACS contract renewal, the future of the Sussex HIS, electronic patient records and infrastructure stability. The Chairman requested that these be taken forward to the October Board Meeting. Mr Meikle reported that the plan was to review the issues in depth at the October Board Seminar.

Resolved:
The Committee noted the report and recognised the work that the IG Team were undertaking

5. Assurance Framework & Risk Register

Dr McGreevy reported that she had been appointed Deputy Director of Assurance and was presenting the report on behalf of Dr Harrison. She asked the Committee if they agreed with the RAG rating, if they felt there were any risks missing and if they had any comments on the report.

The Chairman highlighted that the four main risk areas in the Assurance Framework were:

- Quality issues – discussed under item 3
- Current financial position – to be covered in item 6
- Strategic plan – delay in the presentation of a strategic plan
- Management issue – OD – being dealt with outside this meeting

The Chairman reported that improvements could be made to the documentation as there there was an element of duplication and the assurance framework did not seem to tie in with the risk register. It was noted that the risk register had certain risks which do not actually indicate what action was taken. The Chairman felt that the lack of a strategic plan should be red, rather than amber, and that IT should be added and highlighted as a major risk. It was agreed that it would also be helpful to have a realistic date on the assurance framework to indicate whether the actions were on track. **DMc**

Dr McGreevy said she would take the comments back to Dr Harrison and try to make the report tighter and sharper. Ms Lynch queried the risk register and whether this was an out of date version. Dr McGreevy said she would look into this. **DMc**

It was agreed that an updated assurance framework and risk register would be presented to the next Committee meeting in November, but that it would be presented to the Management Board first. **AHa**

6. ESHT's Performance as reported in the Audit Commission's NHS financial year 2010/11

The Chairman presented the report from the Audit Commission: NHS

financial year 2010/11 which showed that East Sussex Hospitals was one of 9 organisations out of 276 which had failed to achieve financial balance in 2010/11.

The Chairman commented that it was surprising to note how so many organisations managed to achieve financial balance and was disappointing to note that East Sussex Hospitals were one of the 9 that had failed.

Mr Meikle outlined the wider context that it was the Government's intention that all providers would move towards FT status by 2004. Within that there was a group that would not attain FT status, mainly those funded by private finance initiative.

Discussion took place on whether the income and PbR position were correct.

Mr Hoaen gave an update on some comparison work he had started with Bournemouth and other local providers which showed that our costs in generating the income was a far greater percentage than other providers. One of the issues highlighted was the Market Forces Factor (MFF) which is meant to equalise the cost of living across the country. ESHT's MFF factor was the lowest of any of the areas that was looked at. A suggestion was made that Mr Meikle should re-visit the MFF issue at some point. **DM**

Discussion took place on what more could be done to try to improve efficiencies. Mr Meikle explained that the Trust was working closely with EY and specific specialties to review the efficiencies in these areas.

It was agreed the there should be hard push on the comparison with Bournemouth and that Mr Meikle would discuss with Mr Grayson the possibility of a meeting with Bournemouth

It was agreed that a report of the new focus from EY, together with the work that has been going on at the weekly task and finish meetings would be presented to the September Trust Board. **DM**

Mr Townsend reported that there was a piece of work in their 2011/12 plan to review, at a very high level, cost analysis, targets, budgets, etc. and they will review how things have gone over the last 6 months, and the robustness of the final 6 months of the year to give some level of assurance. Work for this will start in October and a preliminary report would be presented to the November meeting. **MT**

7. PKF Progress Report

Mr Lynas provided the Committee with an update on their audit work. It was noted that the two audits which remained outstanding were:

- Integration with community – the plan was to start this audit in the next few weeks
- CIP audit – scheduled for October

It was noted that all other audits for this year was complete.

It was agreed that there would be an update on the integration with community audit at the November meeting. **LLT**

Resolved:
The Committee noted the progress report.

8. South Coast Audit Progress Report

Mr Townsend presented the second interim progress report which covered the work completed since the last full Committee meeting in May.

Mr Townsend reported that SCA were making good progress and that there had been a couple of small changes in the work of the annual plan. Deloitte had undertaken some work on the Register of Interest; and the emergency dental audit has been pushed back a couple of months into 2012/13. It was agreed to move that time to allow SCA to undertake some more comprehensive work on the transfer of Community staff payroll, clinical record keeping and clinical coding.

It was noted that the following audit assignments were currently underway:

- Follow up – Critical IT system – Disaster Recovery Planning
- Cost Improvement Planning (management response to initial draft report overdue.)
- Board Reporting (effectiveness)
- Clinical Report Keeping
- Safeguarding Adults
- Medicines Management

It was noted that the following audit assignments have been completed since the last meeting:

- Information Governance – Limited Assurance
- Quality Accounts – Significant Assurance
- Recruitment & Retention – Limited Assurance

The IG audit was discussed under item 4.

With regard to the Recruitment and Retention Audit, Mr Townsend gave an overview of the 7 high priority points that had been identified.

Discussion took place on investing on a software system for HR to automate and improve some of the procedures. Mr Meikle explained the process of submitting proposals to the Capital Approvals Group for funding of software. It was agreed that Mr Meikle would raise this issue with Mrs Green. **DM**

It was agreed that Mrs Green would be invited to the next meeting in November. **DM**

Mr Townsend drew the attention of the Committee to the summary of outstanding high priority action points in Appendix D.

Resolved:
The Committee noted the report from SCA.

9. LCFS Work Plan and Progress Report

Mr Meikle presented the LCFC work plan and progress report on behalf of Deloitte.

The Chairman highlighted an individual case on page 11 of the progress report (Appendix 1) relating to an allegation that a Consultant was undertaking work at private hospitals during Trust time, and queried when this allegation was raised and if the issues can be speeded up. Mr Meikle reported that he would request further information from Deloitte. **DM**

It was suggested that for the robustness of the report it would be helpful to include further information on the outcome of the subject, such as whether they had gone through the disciplinary route.

It was agreed that Mr Meikle would pick up these issues with Deloitte. **DM**

Resolved:
The Committee noted the LCFS work plan and progress report.

10. Review of Aged Debtors

Mr Hoaen presented the report on the Review of Aged Debtors and summarised the highlights.

It was noted that there was a significant increase in the outstanding level of debt which relates specifically to two invoices:

- £7m which has now been paid for rephrasing £10m from the back quarter of this years contact to current, with the intention that implementation of the Trust CRES schemes would remove this impact in the last quarter
- £1.9m which relates to West Kent PCT which is an annual contract which ESHT invoiced upfront and they have continued

to pay a monthly instalment

Mr Hoaen reported that removing those two brings the trust to the same level of debt that it had six months ago. Work was ongoing with Brighton and with Sussex Partnership Trust and a mutual payment process has been instigated to keep cash flowing between the two organisations.

The Chairman asked Mr Meikle for an update on discussions with the SHA. Mr Meikle reported that discussions had taken place on 5th September and a follow up meeting between the SHA and PCT was due to be held on 6th September and it was hoped that any feedback would be given by the end of this week which would be reported to the September Board.

Resolved:
The Committee noted the report.

11. Information Pack

The Committee noted the contents of the Information Pack.

(i) Performance Reviews

Ms Lynch queried the inconsistency of the way the Performance Reviews were conducted. It was noted that the Performance Review process would be much more robust and accountable in future. Ms Lynch asked how often Performance Reviews were held. Mr Meikle explained that these were monthly. However they were currently meeting with the divisions on a weekly basis. Two of these weeks were to review their CRES action plan, the third week was to go through their I&E statement and budget statement in detail and the fourth week they had an overall performance meeting.

(ii) Minutes from meetings

Mr Rumbold reported that some of the minutes that were included within the information pack raised issues relating to Consultants and appraisals. He suggested that the Committee request an update on work plans and appraisals to see how much progress had been made. It was agreed that the Medical Director would be invited to the next meeting to give an update on this and any other issues raised. **RS**

12. Any Other Business

Mr Meikle reported that as part of the OD work in the organisation, the consultation for the Finance & Performance Department was now complete. One of the changes being made was that Mr Hoaen will move to Head of Finance Management, and a replacement will be sought for Mr Hoaen's role as Head of Financial Services.

13. Date of Next Meeting

Wednesday 16th November 2011 starting at 9am, in the Committee Room, Conquest

East Sussex Hospitals NHS Trust

FINANCE AND INVESTMENT COMMITTEE

1. Introduction

1.1 The Finance and Investment Committee meeting was held on 9th November 2011 and a summary of the issues discussed is provided below.

2. Terms of Reference

2.1 The Committee agreed the terms of reference subject to the inclusion of the Chief Operating Officer in the membership.

2.2 The amended terms of reference are attached at Appendix 1 for the Board's approval.

3. Performance Report

3.1 The Committee reviewed the performance report for the six months ending 30th September 2011 covering 18 weeks, 2 week cancer waits, stroke performance and A&E access performance.

4. Finance

4.1 The Committee received reports on the following:

- CRES performance and action plan
- Consultant fees
- Strategic financial plan re clinical strategy
- Capital performance
- Cash strategy
- Capital project status

5. Conclusion

5.1 The Trust Board is requested to note the summary of the Finance and Investment Committee meeting held on 9th November 2011 and approve the amended Terms of Reference (appendix 1).

Ken Smith
Finance and Investment Committee Chairman

30th November 2011

East Sussex Healthcare NHS Trust

Finance and Investment Committee - terms of reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Investment 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 Finance and Investment Committee will provide support to the Trust Board in regard to understanding:

- the future financial challenges and opportunities for the Trust
- the future financial risks of the organisation
- the integrity of the Trust's financial structure
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of investment management
- the robustness of the Trust's cash investment approach
- the investment and market environment the Trust is operating in,
- the financial and strategic risk appetite that is appropriate for the organisation
- the process for business case assessments and scrutiny and the process for agreeing or dismissing investment decisions depending on the above

The Committee shall develop and work to an annual programme. 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 and attendance

The Committee and the Committee Chairman shall be appointed by the Chairman of the Board of directors. The membership of the Committee shall be as follows:

- Two non-executive directors, one of whom should be on the Audit Committee but not be the Audit Committee Chair.
- The Chief Executive.
- The Director of Finance.
- The Chief Operating Officer

- The Director of Assurance and Strategic Development
- The Medical Director

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

4. Quorum

Quorum of the Committee shall be three members, one of whom shall be a non-executive director. Fully briefed deputies should be sent in the absence of a core member.

5. Frequency

Meetings shall be held at least four times a year and at such other times as the Chairman of the Committee shall require.

6. Authority

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employers are directed to cooperate with any requests made by the Committee.

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

7. Duties

The Committee shall review and monitor the longer-term financial health of the Trust.

In particular its duties include:

- Reviewing the financial environment the Trust is operating within, and supporting the Board ensure that its focus on financial and business issues continually improves
- Supporting the Board understand and secure the financial and fiscal performance data and reporting it needs in order to discharge its duties
- Understanding the market and business environment the Trust is operating within
- Understanding the business risk environment the organisation is operating within, and helping the Board to agree an appropriate risk appetite for the Trust

- Supporting the Board agree an investment and business development strategy and process
- Supporting the Board agree an integrated business plan

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to delivery its operational plans

8. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Trust Secretary 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 statement on internal control and by exception as and when necessary.

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

These terms of reference shall be reviewed by the Trust Board at least annually.

East Sussex Hospitals NHS Trust

QUALITY & STANDARDS COMMITTEE

1. Introduction

1.1 The Quality & Standards Committee meeting was held on 9th November 2011 and a summary of the issues discussed is provided below.

2. Terms of Reference

2.1 The Committee agreed the terms of reference subject to an amendment to the quorum to two Non-Executive Directors and the amended Terms of Reference are attached at Appendix 1.

3. Working Arrangements – link with the Trust Board and Audit Committee

3.1 The different remits of the Board sub-committees were discussed and how they would link together. The remit of this Committee would be to ensure that the Trust was taking actions to improve quality and that assessment of compliance was based on sound evidence.

4. Governance and Assurance

4.1 The Committee approved the revised arrangements for governance and assurance in the Trust which would support the Trust to fulfil its task to improve outcomes for patients and assure the Board and external regulators that quality services were being delivered.

5. Quality Metrics

5.1 The Committee received a report on the development of a quality framework to provide the Board to Ward visibility of quality based on national best practice to support the Trust to fulfil its task to improve outcomes for patients. A standardised set of quality metrics would be developed to identify areas for improvement and monitor the implementation and outcomes of improvement actions.

6. Performance Metrics

6.1 The Committee agreed that it would receive reports on the various performance targets including cancer, infection control and stroke and it was important to ensure that the Trust could provide evidence of compliance and performance improvement where risks were identified including feedback from patients.

7. Work Programme

7.1 The Committee agreed that the work programme should include the performance standards, compliance, quality accounts and feedback from patients

8. Conclusion

12.1 The Trust Board is requested to note the summary of the Quality and Standards Committee meeting held on 9th November 2011 and approve the amended Terms of Reference at Appendix 1.

Maurice Rumbold
Chair – Quality and Standards Committee

30th November 2011

East Sussex Hospitals NHS Trust

REMUNERATION AND APPOINTMENTS COMMITTEE

1. Introduction

1.1 The Remuneration and Appointments Committee has met on 12th October and 30th November 2011 and a summary of the issues discussed is provided below.

2. Terms of Reference

2.1 The Committee agreed the terms of reference.

3. Chief Executive

3.1 The Committee undertook the annual review of the Chief Executive's salary and received a report from the Chairman on the Chief Executive's mid year performance review.

4. Directors

4.1 The Committee undertook the annual review of the Directors' salaries and received a report from the Chief Executive on the Directors' mid year performance reviews.

5. Organisation Development

5.1 The Committee received an update on the organisation restructuring.

6. Conclusion

6.1 The Trust Board is requested to note the summary of the Remuneration and Appointments Committee meetings held on 12th October and 30th November 2011.

Stuart Welling
Chairman

8th December 2011

East Sussex Healthcare NHS Trust

Date of Meeting:	14th December 2011
Meeting:	Trust Board
Agenda item:	15
Subject:	Winter Planning
Reporting Officer:	Chief Operating Officer

Action: This paper is for (please tick)

Assurance	√	Approval		Decision	

Purpose:

To provide the Trust Board with the Trust's 2011/12 Winter Plan for managing activity through the peak winter demand, and the East Sussex and Pan Sussex escalation process.

Introduction:

Winter plans are necessary to give clear guidance on management of patient flows and demand surges through the winter period. This plan provides detailed guidance on expected actions at differing levels of escalation over the winter period. It should be used as guidance both in hours, and for out of hours management of services.

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

The Whole System Escalation Plan (WSEP) received final sign-off on November 14th. The WSEP, which details the steps needed to activate whole systems support, is now included in the papers circulated.

Benefits:

Clarity of guidance relating to managing patient flows and operational escalation status.

Risks and Implications

If winter plans are not in place both within the Trust and the whole system, it would not be possible to manage patient flows and escalate to the whole system if necessary.

Assurance Provided:

Operational preparedness, and linkages to Whole System Plans.

Proposals and/or Recommendations

To assurance the Trust Board that the Trust and whole systems planning is now in place for this winter period.

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

What risk to equality & human rights (if any) has been identified from the impact assessment?

To be completed

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

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ADMINISTRATIVE GUIDANCE NOTES

CAPACITY/WINTERPLAN2011/12

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Signature& Date	November 2011

Multi-disciplinaryEvaluation/Approval

Name	Title/Speciality	Date:

Ratification Committee

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CONTENTS

1. Introduction 3

2. Structure of Plan 3

3. Operational Readiness

3.1 Executive& operational lead 4
3.2 Managing capacity 4
3.3 Site management 6
3.4Additional supportfor patient flow 7
3.5 Cancellation of surgery 8
3.6 Mortuaryservices 9
3.7 Christmas & New Year Plans 10
3.8 Flu Pandemic Implementation Strategy 10
3.9Major Incident Escalation 10
3.10 Human Resources 10

4. NHS/Social Care Joint arrangements 11

5. Critical Services 12

6. Preventative measures 14

7. Communications 14

Appendices

Appendix 1 Escalation Resource Plan
Appendix 2 Whole Systems Escalation Policy

East Sussex HealthcareTrust

CAPACITY/WINTER PLAN

2011/12

1. Introduction

1.1 This plan exists to ensure that the trust has a co-ordinated and appropriate responsetoseasonalvariationsinboth elective and emergency activity. It is accepted that these pressures can occur at any time throughout the year and thus this plan will be activated whenever the executive team deem it to be necessary.

1.2 The aim of this plan is to ensure that:

1.2.1 Seamless, safe & timely care is provided despite variations in demand.

1.2.2 The trust is able to continue to maintain its contracted position, targets and operational standards.

1.2.3 The best use is made of available resources, both internally and in the local health economy in respect of bed usage.

1.2.4 Robust plans and responses to variations are in place in conjunction with the local health economy

2. Structure of plan

2.1 The operating model and communication approach is a key component of the overall plan. Decisions must be made in a structuredway and that communication isconsistent,bothinternallyandexternally.

2.2 Capacity and escalation plans are necessaryto define the steps that each service will take to manage additionaldemand. Clear guidance of actions to be taken is laid out in both the Trust's Escalation Resource Plan (ERP) (see Appendix 1) and Trust and Divisional Business Continuity Plans (BCPs) which can be accessed via the Intranet.

2.3 A defined forward planning and decision making framework is highlighted in the plan to ensure coordination and effective response.

2.4 The plan is aligned to the East Sussex whole system overarching winter plan and escalation process.

3. OperationalReadiness

3.1 Executive and Operational Lead

The Deputy Chief Operating Officer is leading the Trust's day-to-day preparations for winter pressures, supported by Divisional resources and the Trust's emergency planning officer. Atexecutive level, the Chief Operating Officer/Deputy Chief Executive is the nominated

lead, and the COO is also the nominated lead for the Trust- wide emergency planning and business continuity perspective.

3.2 Managing Capacity

3.2.1 Internally demand and capacity forward planning and monitoring will be carried out through the bi weekly forward planning meetings (FPM), chaired by the Deputy Chief Operating officer.

3.2.2 A n y alterations in bed compliment due to capital/refurbishment plans will be discussed at the FPM. Actions required to maintain service delivery will be taken and communicated via the bed conference calls and bed status report.

3.2.2 The whole systems operational group meet via conference call twice a week (Tuesdays and Fridays) to discuss delayed transfers of care(DTCs) and plans to reduce numbers, as well as whole system demand and capacity issues. There continues to be a drive to reduce the number of DTCs within both hospital sites and reflects the commitment from all organizations involved to work together in new and different ways to ensure that the number of patients delayed is minimized and that any associated risk is shared across organizations.

3.2.3 Whole Systems Escalation process (WSEP) the whole systems task group will be convened if deemed necessary by the Chief Operating officer or his deputy as per the WSEP plan (Executive Director out of hours).

3.2.4 Capacity& demand predictive and actual activity information is reviewed at the Forward planning group and actions taken accordingly to address any issues. This includes South East Coast Ambulance Service (SECAMB) data as well as internal measures.

3.2.5 The implementation of opening or closing identified escalation beds will be agreed by the Chief Operating Officer or his nominated deputy (or Director on-call) but only after the following has happened:-

- Discussion has been had between the Divisions at ADN level (or nominated deputies out of hours)
- A plan for de-escalation is agreed
- Clear review and governance arrangements throughout escalation and de-escalation are agreed by the ADNs (or nominated deputies out of hours)

3.2.6 The bed utilization plan for next day electives will be formulated in the daily elective meetings (on both sites) held with the site team and relevant general managers. This meeting is inclusive of all Divisions.

3.2.7 The Trust and Divisional business continuity plans will be used when adverse events occur. This is now a separate process from major incident planning.

3.2.8 Monitoring of infection controlissues will be carried out at the bed conference calls. Representatives fromthe infection control team will attend and work with the site team to placepatients appropriately andgiveadvice. In the event of an infection outbreak being declared, business continuity plans will be set in place, with Clinical leadership given by the DIPC.

3.2.9 Following review of the predicted surgical elective & emergency activity from March 2011 to October 2011, it is clear that the Planned Care Division must maintain elective activity within their current bed stock in order to achieve and maintain delivery of 18 week access targets. The possibility of swing beds from Planned Care has been discounted for this winter period. Therefore, the Urgent Care Division must manage activity surges and increased bed stock demands within the Divisional bed stock and ward footprint, with plans in place to open additional capacity as required. This includes isolation capacity expansion and the management of intermediate care beds within the community settings. The opening of this additional capacity can occur only after those actions at 3.2.5 have occurred.

3.2.10 Additional capacity can be found by utilizing the following areas:-

CONQUEST

(a) 28 beds as a swing ward to meet winter demand levels for urgent care (Murray ward). This can, in extreme periods of pressure, be supplemented by:-

(b) 12 BEDS ON MacDonald ward (current discharge area)

RISK - closure of the current discharge area would be a risk in terms of managing patient discharge and flows out of the hospital.

EDGH

(a) 12 beds on Polegate ward (current discharge area)

RISK - closure of the current discharge area would be a risk in terms of managing patient discharge and flows out of the hospital.Alternative discharge areas must be established in this eventuality, and the current default area for this is within the physiotherapy department.

(b) 5 beds on CDU

RISK - patient assessment and triage within the AE department would be compromised, resulting in slower decision making and streaming of patients out of the AE department. This would put the AE department under pressure in terms of maintaining the AE quality indicators and KPIs.

3.2.11 The Urgent Care Division must ensure that there is sufficient medical cover at weekends to support discharge and routine patient review to help maintain the discharges and timely decision making for patient care and pathway management.

3.2.12 If surgery, gynaecology or trauma exceed their bed allocation, the same principles of bed escalation and discharge escalation within the division will apply.

3.3 Site Management

3.3.1 The site managers co-ordinate elective and emergency patient flow on both hospital sites, and work closely with the relevant Associate Directors, Clinical Unit managers, Heads of Nursing and the Deputy Chief Operating Officer.In addition, they will deal with site issues.Staffing issues are the responsibility of the clinical matrons and ward managers within the Divisions during the hours of 8.00 am – 4.00 pm, and will be overseen and appropriate actions taken by the site team out of these hours.

3.3.2 In escalation (amber onwards) there are three cross site bed conference calls held at 09.30,12.30, &16.00 hours (more as deemed necessary). Operational staff use a task list (contained within the ERP) which gives guidance on internal triggers & actions required at times of escalation.

3.3.3 The WSEP has been developed which will support the Trust in its management of bed pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners.

3.3.4 In addition, to ensure a timely and consistent whole system response when levels of DTCs at the Trust reach 24 and above, the escalation to the whole systems task group is authorized by the Chief Operating Officer or his deputy. Senior managers will report into the COO or Deputy COO on outcomes and seek support for further escalation as required. (this will be Exec Directors out of hours)

3.3.5 The Chief Operating Officer or his deputy, will require updates from a nominated General Manager of the day relating to escalation issues, with assurance that the escalation plan has been followed. The COO or his deputy will provide support/advice /intervention as required (Exec Director OoHs)

3.3.6 Communications of actions taken at the conference calls will be bythe bed report (sent out via email). Actions in the bed report will be linked to the indicators and triggers in the ERP. Actions from the 9.30 am bed conference call must be clearly communicated to all relevant staff and agencies (eg Consultant On Call / Adult Social Care) by 10am. The actions must be clear with expected outcomes and timescales for reporting back to the site office.

3.3.7 Each morning, the site team will produce a list of outliers (medical and surgical specialties) for distribution to the medical teams. This is to ensure that the patient whereabouts are known and medical teams and MDTs should manage the outliers proactively and we the aim of repatriating them to appropriate speciality beds as soon as possible, or ensuring timely discharge, 7 days per week.

- Stroke & trauma patients are to have direct access to specialty beds
- The site teams are to concentrate on ensuring patient flow & nursing staffing to be managed by clinical matrons &medical staffing by general managers.
- No patientsare to be admitted from any access point unless agreed by the site teams
- The admissions areas will not be used as in-patient areas.

3.3.8A daily situation report (SITREP)is agreed by a designated executive director and reported to the Strategic Health Authority (SHA).

3.4 **Additional Support for Patient Flow**

3.4.1 Named ASC workers are allocated to all medical wards and meet twice weekly to do board rounds on their wards with the discharge nurses and the lead nurse for the ward. In additionMDTs are now attended by ASC and the discharge nurse. This is vital to ensuring ward staff have accurate and current information relating to discharge planning. This process is being further reviewed in November 2011 by the Deputy COO, and the Urgent Care Division, to try to establish a step change in discharge processes and support.

3.4.2 Additionalmedical support is in place for Saturday & Sunday to review in patients and ensure weekend discharges

3.4.3 Hospital Intervention Team (HIT)team will continue to cover weekends for Accident & Emergency (A&E), Medical Assessment Unit (MAU) and Medical Short Stay Unit (MSSU) on both sites

3.4.4 Extended bed conference on Friday 9.30 am to discuss plans for weekend or Bank holidays, including identified patients for discharge.

3.4.5 AdditionalPatientTransportService (PTS) arrangements for the winter periodandthroughoutChristmasandtheNew Year are being discussed and confirmation will be discussed atthe forward planning meetings.

3.4.6 Seven day therapies to be in place for medical wards from December 1st

3.4.7 Twice weekly whole systems operationalmeetings to continue, concentrating on appropriate placement of patients in the community and DTC's.

3.4.8 Integrated Community Access Point (ICAP) to circulate daily information of bed availability and demand, including number of patients that have been

referred and those accepted.

3.5 Cancellation of Surgery

In the event of ***excessive*** demand and elective surgery needs to be cancelled, the following process must be adhered to.

3.5.1 The designation of beds for the next day for electives will be carried out in the daily elective meeting held with the site team and relevant general managers. A ll Divisions must be represented in this planning process to ensure all patients are prioritized according to clinical need and safety. Any proposed cancellations will be discussed with the Chief Operating Officer or his deputy.

3.5.2 Requirements

HSC 2001/14 LAC (200/2)17 declares that a system must be in place to ensure that cancellations of urgent elective surgery and prolonged trolley waits in A&E are reported and all necessary action is taken to ensure that these are minimized with the Trustworking towards a zero tolerance

3.5.3 Decision

The decision to cancel a scheduled elective operation lies with the Chief Operating Officer or deputy.The decision will be made in conjunction with the Planned Care Divisional Associate Director or nominated deputy, the Clinical Unit Manager the admitting consultant and the site team and afterthe Protocol for Cancellation of Operations has been implemented.

3.5.4 Reporting

The cancellation(s) will be reported as per the Referral Management Administrative Guidance

3.5.5 FollowupAction

Followingcancellationofanyelective operation the Planned Care Division is responsible for ensuring that the patient is given a date either on day of cancellation or within the next two working days.

The Admissions staff are responsible for ensuring that the PAS record includes details of previous cancellations. This information will be taken into account should further cancellations be required.

3.6 Mortuary Services

3.6.1 The trust currently has storage capacity as follows:

Mortuary	Permanent BodyFridge Storage	Permanent Body Freezer Storage	Temporary Storage	Total Potential Storage Capacity
Conquest	42	4	34	80
EDGH	60 (+24 = 84)	5	12	101
Total	126	9	46	181

3.6.2 The trust has good working relationships with the local funeral directors who have in the past responded, as able, to requests for support in times of increaseddemand,includingweekend and Bank Holidays. It is anticipated that this level of service will continue. December 28/29/30 will be routine working days. Monitoring of the body stores will be undertaken on a daily basis, and decisions will be made at times of peak demand for storage about utilizing the Eastbourne store to support then Conquest site.

3.7 Christmas & New Year Plans

3.7.1 The trust will produce a document detailing service arrangements to enable smooth consistent service deliveryduring the Christmas and New Year period by December 1st

3.8 Flu Pandemic Implementation Strategy

3.8.1 The Trust has previously provided details of its contingency plans and expert groups to facilitate integrated planning and delivery of a pandemic response with partner agencies throughout the health economy (including the SHA, NHS Sussex, PCTs, SECAMB and local authorities). As of November 7th, national guidance for winter 2011/12 has not been issued, so existing arrangements and policies are still current.

3.8.2 If a pandemic occurs, as per national definitions, the HospitalCoordination Group will meet on a daily basis and business continuity will be in place.

3.9 Major incident escalation

3.9.1 The trust has a Major Incident Plan and participates in the PCT emergency planning group. Following integration of the acute and community provision, the Trust is further developing plans for exercising the integrated Major Incident plans. Across the County, further work is required with Clinical Commissioning Groups to understand roles and responsibilities, and this will be addressed through the whole system emergency planning processes.

3.10 Human Resources

3.10.1 The Trust is currently projecting a budgeted staffing establishment (ie in respect of permanent staff, bank, agency and overtime) of 6306.67 ftes by the end of the financial year.

3.10.2. All Trusts are monitored on a monthly basis by the SHA, for the DH, through FIMS/WIMS returns.There is also access to trust information through the electronic staff record data warehouse.

3.10.3 As at the 30th September 2011, the Trust's monthly sickness absence rate was 3.74% (the annual rate was 4.19%). This is below the rate for the Hospitals Trust last year. The Trust's annual sickness target for March 2012 is 3.9%. Central absence reporting arrangements can be implemented should the trust experience high levels of staff sickness absence or adverse weather conditions.Centralabsence reporting arrangements can be implemented should the trust experience high levels of staff sickness absence or adverse weather conditions.

3.10.4Measures have been taken to review skill mix and nursing establishments based on the nationally recognized acuity and dependency tool and this data will be integrated into thebase line nursing establishments. Each Division is responsible for forward planning duty rotas to ensure best use of staff and maximizing flexible working arrangementsand these are reviewed on a daily basis. Staffing levels are discussed and monitored at the FPM in relation to the predicted activity.

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4. **NHS/Social Care Joint Arrangements**

4.1 The development of community based services is essential to reduce dependence on the acute setting and to provide an alternative to hospital admission.

4.2 All referrals for intermediate care assessment are dealt with by a single point of access telephone number (ICAP) which isresponded to by a clinician and appropriateaction taken to ensure patients are assessedfor suitability for intermediate care and for thetransfer to be expedited bythe team as required.

4.3 A single telephone access number system(HERMES) operates which takes all calls for GP emergencies and is responded toby a clinician (nurse or emergency nurse practitioner).

4.4 The WSEP has been developed which willsupport the trust in its managementof bed pressures. The policy includes triggers for escalation and incorporates interventions required to support ESHT by all local partners.

4.7 Thehealtheconomyisoptimizing arrangements for discharge into community/social care by providing 7 day a week out of hours access to community & social care teams.

4.8 Actions are being taken to minimiseinappropriate attendances through alternative routes. PCT led communications across the county are in place.

5. Critical Care Services

5.1 ESHT has the funded capacity for 11 Level 3 Critical Care beds (Conquest 6, EDGH 5) and 8 Level 2 Critical Care beds (Conquest 5: EDGH 3). This capability can be flexed to meet demand. Flexibility to manage demand peaks is available through overnight post-operative recoveryservices at Eastbourne DGH.

This service provides overnight Level 2 care in the Post Anaesthetic Care Unit within the Operating Department and enables complex elective surgery to go ahead irrespectiveof the bed state in ICU/HDU.

5.2 The Critical Care Outreach Team has been particularly successful since it was introduced in November 2004. The aim ofthis team is to provide support, both clinically and educationally, to the ward staff and junior doctors in order that patients may be prevented from requiring Level 2 or Level 3 support in the intensive care units. This level of support has prevented a number of admissionsto the units and will continue throughout the year. It also has a crucial role in following up patients discharged from critical care and helping to avert re-admissions.

5.3 The Critical Care Delivery Group will continue to meet to steer the direction of critical care services for the Trust.

5.4 The Sussex Critical Care Network is wellestablished. The Critical Care Units only look outside our transfer network for Critical Care beds once all potential of ‘in network placements’ have been exhausted.

5.5 <u>CriticalCare ReportingArrangements</u>

5.5.1 The impact of pressures on the critical care bed state is reported in the following ways:

- Cancelledoperationsduetolackofan ITU bed are reported through the Theatre Information System.
- Use of extra non funded beds or any change in category (from Level 2 to Level 3) are reported through the WardWatcher©system and reported by the Critical Care Audit NursetotheCriticalCareDelivery Group.
- Transfers of patients to other Critical Care Units are recorded on the Critical Care Transfer Form. The clinical matron/general manager for critical care will be informed and will inturn inform the Chief Executive via the Director of Operations.

  Out of hours site managers are informed who will escalate information to the executive team viathe On Call Manager.
- Critical care level 2&3 beds are declared through Unify to SHA on a daily basis

5.5.2 All transfers out of our transfer Network will be reported to the relevant Chief ExecutiveandRegionalDirector.

5.6 Escalation ofCriticalCareServices

5.6.1 In the event that there is insufficient funded capacity to meet the demand for critical care services, the following actions will be taken:

- An unfunded bed will be utilised inthe first instance. A clinical decision will be required as to whether the existing patients or the patients requiring admission wouldbe more appropriately managed in another critical care facility.

- It is possible to ventilate in the theatre recovery area for a limited period of time, whilst arrangementsare made to either transfer a patient from critical care to a general ward, or arrange to transfer a patient to another criticalcare unit within ESHT.
- In the event that there are no beds within ESHT, other critical care units within the local transfer Network will be approached for a bed. If necessary, the patient will remain in theatre recovery until a bed is located.

- In the event that it is considerednecessarytoundertakeatransfer, arrangements are in place via the Policy for the Management of Critical Care Beds andSussex Critical Care Network Interhospital Transfer Protocol. This will be a Consultant-to-Consultant referral. TheChiefExecutivewillbe informed of this decision.

- It is possible to ventilate in the Accident and Emergency Department in life threatening circumstances only, until either theatre recovery or the critical care unit is able to take the patient.

- Discussionswill be held between the critical care consultants and the clinical matron or unit managers toassess whether it is possible to mobilise nursing staff from one unit to another if the risk in moving patients is too great.

6. Preventative measures

6.1 The trust is participating in the NHSflu immunisation strategy for seasonal and swine flu, including the strategic purchasing of the recommended flu vaccine.

6.2 The staff vaccination programme is now underway, with a series of clinics arranged across the trust's sites.Key areas/departments such as A&E, ITU, MAU will be targeted through outreach clinics. Occupational Health has this as a clear priority for the coming months. A variety of internalcommunicationsisbeingused to advertise and promote clinics.

6.3 The Trust's communication department co-operates with communication leads from the local PCTs and Social Services toensure that the media relation plans forwinter are agreed and in place, including the campaigns, 'Choose Well' and 'keep Safe in Winter'.

7. Communications

7.1 The Head of Communications will ensure that all external communications are directed at the right areasand that local communities are aware of how they can help their local NHS.

7.2 The trust co-operates with communication leads from the local PCTs, ASC & SECAMB to ensure that the media relationsplans for winter are agreed and in place.

7.3 This ensures a whole health economy approach and a consistent message throughout East Sussex. Over previous years the pro-active media relations plan has been derived from the guidance issued by the DH Choose Well Campaign

7.4 There are established procedures for handling reactive media relations and adhoc adverse incidents/crisis for some time. Robust out-of-hours on-call arrangements are in place for directors and senior managers.

7.5 The trust provides proactive informationto the SHA via a daily SITREP. The trust will use appropriate spokespersons including the Chief Executive, chief Operating Officer, Chief Nurse and Divisional Directors.

7.6 The Director of Strategy & Governance, together with the Head of Communications, takes the lead in the event of adverse publicity about services, supported, if necessary, by the Chief Executive, Chairman, the executive team and board directors.

7.7 A communications infrastructure is in place for supporting all trust work. It includes team briefing, core brief, e-mail, Intranetand Internet facilities to help the timely cascading of information.

7.8 Front line staff report operational problems or issues to their line managers. Any media contacts are reported to the Head of Communications.

7.9 Staff are kept informed about preparations for winter through the existing communications infrastructure. The trust's Capacity/Winter Plan is widely circulated to staff, East Sussex PCTs, ASC and SECAMB and information re support available from other departments andagencies is circulated when available.

7.10 The communications department has robust plans in place to ensure their ability to support national programmes of public information in relation to the use of Health Services.

ADMINISTRATIVE GUIDANCE NOTES

EscalationResourcePlan
DRAFT 5

Written/Produced By:	Title/Directorate	Date:
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Person Responsible for Monitoring Compliance &Review	Chief Operating Officer
Signature & Date	

Multi-disciplinaryEvaluation/Approval

Name	Title/Speciality	Date:

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CONTENTS

1.	Contents	Page 2
2.	Background	Page 3
3.	Purpose of guidance	Page 3
4.	Process to follow	Page3 - 4
5.	Definition of ERP levels ofEscalation	Page 4 - 5
6.	Co ordination and assessment of information	Page 5 - 6
7.	ERP Level 1 - Normal Service	Page 7 – 8
8.	ERP Level 2 – Concern	Page 9 – 10
9.	ERP Level 3 – Severe Pressure	Page 11 – 13
10.	ERP Level 4 – Potential Service Failure	Page 14 - 16

EscalationResourcePlan

1. Background

Within the NHS it is now recognised that 'overcapacity' can occur at any time of the year and has introduced the philosophy of 'whole system capacity planning' (HSC 2001/014). The response of the Trust is to produce an Escalation Resource Plan (ERP) which triggers specific measures when the Trust is operating beyond normalcapacity.

2. Purpose of Guidance:

The purpose of the policy is to ensure that the Trust maintains patient safety and service delivery, when experiencing capacity pressures. This is vital in maintaining public confidenceandthereputation of the Trust. It is to ensure that all disciplines are clear on the actions required at various degrees of pressure and that processes are in place to enable an efficient response.

3. Process to Follow:

Cross site operational conference calls are held three times a day (9.30, 12.00, 16.00 and 19.00 hours). A bed report and action plan is provided immediatelyafter each operational conference call detailing the current and predicted situation within the organization, taking into consideration other 'whole system' issues.

A judgement is made on the information available that indicates the current status of the organisation, based on 4 levels:

- ERP Level 1 (Normal service - Green)
- ERP Level 2 (Concern – Orange)
- ERP Level 3 (Concern – Red)
- ERP Level 4 (Potential Service failure - BLACK)

The plan isin operation at all times and should generallyoperate at level 1, when the Trust is in a steady state. The decision as to thecurrent level is based on the factors/ triggers detailed below. The triggers are a combination of measures that are based on daily data, as well as the extreme of failure of vital services or support from departments/workforce required to maintain services. Each level has a number of triggers that, if not met, require an escalating level of response to be activated.

Changes to the response level will be communicated via the 'bed report and action plan' (please refer to Appendix 1) sent via email following each conference call. Additional communications will be discussed at the conference calls as required as per plan (Appendix 1), according to level of escalation.

The four levels or response are designed toincrease operational resources in line with demand, to cope with periods of high activity and maintain the service provision.

4. ERP Levels

ERP Level 1- Normal service - Green

The Trust is operating normally. Demand is at expected levels and being managed effectively.Resourcing is satisfactory and therefore workload is consideredacceptable. There are no excessive demands on the Trustdue to weather, significant events, NHS capacity or technology issues. **The Trust ismeeting its key performance targets.**

ERP Level 2 - Concern – Amber

Five or more of the following factors/triggers need to be met beforedeclaringthis level:

- Over 10 **confirmed** A&E Breaches across site in previous 12 hours
- Less than 10 beds closed per site
- <6 beds available on MAU or <2 beds on SAU, per site before 10.00am hrs
- Medical outliers >15 but <30 per site
- <10 additional beds open per site
- DTC's across site between <24 but <30
- Difficulty admitting TCI's but no cancellations on day
- Nursing Staffing issues - <10 staff per shift, per site
- Medical staffing issues affecting front end or service delivery e.g.assessment times in A&E >4hrs<6hrs
- Up to 5 Ambulances unable to off load within 30 minutes within a defined 8 hour period (0.00hrs_08.00hrs, 08.00hrs_16.00hrs. 16.00hrs-00.00hrs)
- Less than 10 additional beds open across site
- Less than 1, level 3 critical care beds per site
- Less than 20 discharges identified per site (potential & confirmed)

Actions required to be taken at this level are in appendix 1

ERP Level 3 - Severe Pressure – Red

Six or more of the followingfactors/triggers need to be met beforedeclaringthis level:

- A&E flow KPIs are npt being achieved
- Over 20 **confirmed**A&E breaches across site in the previous 6 hours
- No beds available in MAU/SAU
- More than 10 beds closed per site
- More than 20 additional beds open per site
- DTC's across site above 30
- Medical outliers >30
- Electivecancellations24hrspreviously
- TCI's cancelled on the day
- Nurse Staffing issues - >10 nursing staff per shift, per site
- Medical staffing issues affecting front end or service delivery, e.g. assessment times in A&E >6 hours
- More than 6 ambulances unable to offload within 30 minutes within a defined 8 hour period (0.00hrs -08.00hrs, 08.00hrs -16.00hrs, 16.00hrs-00.00hrs)

- No level 3 critical care beds per site
- Less than 5 discharges identified per site
- No beds available on MAU or SAU across site

Actions required to be taken at the level are in appendix 1.

ERP Level 4 - Potential Service failure - BLACK

Factors/Triggers at level 4 are:

- When RED triggers have continued for over 72 hours and not expected to resolve within the next 24 hours, Chief Operating officer/Deputy to liaise with the Whole Systems Group for consideration toescalation to BLACK status. (Director on call out of hours)

- Implement Trust Business Continuity Policy (See Trust policy) due to the inability of the Trust to maintain normal service delivery due to adverse incidents, e.g. severe weather conditions, infection outbreak, extraordinary depletion of resources, loss of priority fuel supplies. In these cases, business continuity plans will be activated (see Trust and Divisional business continuity plans). Business Continuity meetings must have a note taker assigned and a full pack of notes and information relating to the management of the incident must be maintained and kept for evaluation once BC has been stood down.

- Inform Chief Executive

5. Co-ordination & Assessment of information

- The Patient Flow Manager or nominated deputy (Urgent Care Division) will chair the operational conference meetings where the assessment of triggers will be carried out and the current level agreed. The Chief Operating Officer/Deputy will be advised, in particular, when escalation/de-escalation to another level is required. In their absence, this responsibility will lie with the Associate Director of Urgent Care.

- Current and any change in response levelswill be disseminated via the ‘Bed report and action plan’ by email, following every conference call. In times of extreme pressure, additional information will be circulated via communications team.

- The operational conference calls will be the focal pointfor discussions and actions relating to escalation. If business continuity is implemented, the clinical site management offices will be the central hub for communication and meetings.

- The Chief Operating Officer/Deputy will consider additional meetings and frequency as required.

- The escalation process and bed reports are widely published. Every member of staff has a responsibility to know the current level of status and what action is required of them.

ERPLEVEL1- NORMALSERVICE

ERPLEVEL1-NORMALSERVICE

ACTION	RESPONSIBLE	IMPACT	REVIEW
Staffing		PREVENTATIVEACTIONSREQUIREDTOSUSTAINPERFORMANCEANDPATIENTCARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALLS
HighlightdailystaffingshortagestoCM'storeportbackwithinan agreedtimeframe	CSM's/CM's		
Weekendstaffingcoverrequiredforforwardplanning,reportback withinanagreedtimeframe	CM's/CSM's		
Staffingcoverforbankholidayperiodrequiredforforwardplanning, reportbackwithinan agreedtimeframe	CM's/CSM's		
PatientFlow,WardRounds,Discharges			
Limiteddischarges-escalatetouregnet and Planned Care DivisionGM's&DivisionalAdministrators	CSM's/CM's/GM's		
Identifyearlydischarges,expediteconfirmeddischargesusingthe DischargeLounge	CSM's		
Potentialdischarges- clarifyplan,andactionasnecessary	CSM's/ WardTeams		
Ensureall wardroundshavecommencedby9.30am,escalatetoGM's if notachieved	CSM's/GM's		
DeliverDischargeproforma&reinforceneedfor infotobeavailableby 12pm	CSM's		
Reinforcedischargebenchmarkforeachward	CSM's/ HON		
PatientFlow-A&E			
MonitorPtflowatfrontend,liaisewithA&EleadsforhourlySitRep	CSM'sbothsites		
Highlightallpotentialbreachesat2.45hoursthatdonothaveaplan	A&ELeads/CSM'sbothSites		
Highlightallpotentialbreachesat3.15hoursthatdonothaveaplan	CSM'sBothsitestoCM		
A&ELeadtoadviseCSM'sifAmbulancescannotbeoffloaded>15 mins	A&ELeads/CSM'sbothSites		
EscalateallambulancequeuingissuestoHoN Acute Medicine, if wait timeslikely to exceed 30mins	CSM'sBothsites/HON		
Report>3ambulanceswaitingtooffloadatanygiventimetoCM	CSM'sBothsites/ HON		
EscalateallunresolvedsiteissuestoCM	CSM'sBothsites/ HON		
CriticalCareBeds			
ConfirmplanforPatientswhoaresuitabletomovefromcriticalcare areasITU/HDU	CSM'sbothsites /ITUConsultants		
InfectionControl			
ICNreviewofsideroomprovision(Monday&Wednesday)	ICNbothsites/CSM's		
ICNreviewofspecificinfectioncontrolissues	ICNbothsites/CSM's		
WholeSystems			
TwiceweeklyOperationalConferenceCall	DN/CM,CSD		
BoardRounds-MonAM/WedPM	HON		

ERPLevel1 - NormalService - Green - Notes
1.TheTrustisoperatingnormally
2.Demandisat expectedlevelsandbeingmanagedeffectively
3.Resourcingissatisfactorythereforeworkisconsideredandacceptable
4.TherearenoexcessivedemandsontheTrustduetoweather,significanteventsNHSCapacityortechnologyissues
5.TheTrustismeetingitskeyperformancetargets

ERPLevel2-Concern- fivetriggersneedtobemetfordeclaringthislevel:

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL2-CONCERN	**Staffing**	**Staffing**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINTCARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Staffingissues-<10nursingstaffpershift, perSite	HighlightdailystaffingshortagestoHON'storeport backwithinan agreedtimeframe	CSM's/HON		
		Weekendstaffingcoverrequiredforforwardplanning, reportbackwithinanagreedtimeframe	HON/CSM'sboth sites		
		Staffingcoverforbankholidayperiodrequiredfor forwardplanning,reportbackwithinanagreed timeframe	HON/CSM'sboth sites		
	Medicalstaffingissuesaffectingfrontend servicedeliverye.g.assessmentwaiting timesinA&E>4hoursbut<6hours	ReviewMedicalStaffingCoverforkeyareas	GM'S/ADs		
	PatientFlow,WardRounds,Discharges	**PatientFlow,WardRounds,Discharges**			
	<6bedsavailableonMAUor<2beds availableonSAUacrosstheSite	Earlydischarges,utilisedischargeloungeinorderto createcapacityingatewayareas	CSM's/MAU/SAU Teams		
	<20discharges(potentialandconfirmed) identifiedperSite	Limiteddischarges- escalatetoPlanned and Urgent Care Divisons GMs and HsoN.	CSM's/HON/GM's		
		Identifyearlydischarges,expediteconfirmed dischargesusingtheDischargelounge	CSM'sbothSites		
		Potentialdischarges-clarifyplan,expediteasable	CSM's/ WardTeams		
		Ensurethatallwardroundshavecommencedby 9.30am,escalatetoGM'sif notachieved	CSM'sbothsites/ GM's		
		DeliverDischargeproformatoallwardsandreinforce needforinfotobeavailableby12pm	CSM'sbothsites		
		Reinforcedischargebenchmarkforeachward	CSM'sbothsites/ GM's		
	Medicaloutliers>15but<30perSite	Identifymedicaloutliers,ensurerobustmanagement planinplace	MedicalTeams		
	<10bedsclosedperSite	Reviewrationaleforclosedbedsandreportatcross siteconferencecall	CSM'sbothSites		
	<20additionalbedsopenperSite	Reviewrationaleforadditionalopenbedsandreport atcrosssiteconferencecall	CSM'sbothSites		
		Reviewcancellationnonurgent/ cancerstreamTCI's	CSM's/GM's		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL3-CONCERN	**PatientFlow- A&E**	**PatientFlow-A&E**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Over10confirmedA&Ebreachesacross thesiteintheprevious12hours	MonitorPtflowatfrontend,liaisewithA&Eleadsfor hourlySitRep	CSM'sbothsites		
		ContactHERMES/PCT(GP's),SouthEastHealthre: currentoperationalstatus	CSM'sbothSites		
		Highlightallpotentialbreachesat2.45hoursthatdonot haveaplan	A&ELeads/CSM's bothSites		
		Highlightallpotentialbreachesat3.00hoursthatdonot haveaplan	CSM'sBothsites		
	Upto5Ambulancesunabletooffload within30minuteswithinadefined8hour period(0.00Hrs- 08.00Hrs,08.00Hrs- 16.00Hrs,16.00Hrs-00.00Hrs)	A&ELeadtoadviseCSM'sifAmbulancescannotbe offloaded>15mins	A&ELeads/CSM's bothSites		
		EscalateallambulancequeueingissuestoHON Acute Medicine ifwaittimeslikely to exceed30mins	CSM'sBothsitesto HON		
		Report>3ambulanceswaitingtooffloadatanygiven timetoHON Acute Medicine.	CSM'sBothsitesto CM,CSD		
		LiaisewithSECambregardingcurrentoperational status	CSM/HoN		
		EscalateallunresolvedsiteissuestoCM	CSM'sBothsitesto CM		
	CriticalCareBeds	**CriticalCareBeds**			
	<1Level3criticalcarebedperSite	ConfirmplanforPatientswhoaresuitabletomovefrom criticalcareareasITU/HDU	CSM'sbothsitesliaise withITUConsultants		
	InfectionControl	**InfectionControl**			
	InfectionControlIssuesimpactingon bedcapacity	ICNreviewofsideroomprovision(Monday& Wednesday)	ICNbothsitestoCSM's		
		ICNreviewofspecificinfectioncontrolissues	ICNbothsitestoCSM's		
	WholeSystems	**WholeSystems**			
	DTC'sacrossSite> 24but<30	TwiceweeklyOperationalConferenceCall	DN/Patient Flow		
		BoardRounds-MonAM/WedPM	HoNs		

ERPLevel2-Concern-Notes
1.AdditionalAttendeesat crosssiteconferencecall–Nursing leads allDivisions,GM'SDivisionalRepresentatives
2.Outof Hours-GMtochairthecrosssiteconferencecallsandattendeitherhospitalsiteasrequired.GM to remain on site till 7pm at least.

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ERPLevel3 - Severe Pressure-Sixormoreofthefollowingtriggersneed tobemet before declaring thislevel:					
	TRIGGERS	**ACTIONS**	**RESPONSIBLE**	**REVIEW**	**IMPACT**
ERPLEVEL3-SEVEREPRESSURE	**Staffing**	**Staffing**		**PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE**	**REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL**
	Staffingissues- >10 nursingstaffpershift,per Site	HighlightdailynursingshortagestoHONs toreportbackwithinan agreedtimeframe,reviewuseofspecialistnurses&reviewuse of alternativestaffinggroups	CSM's/ HONs		
		Noshortnoticeleavetobegranted<48hours/reviewnon essentialtraining,considerre-scheduling	DivisionalDirectorsand ADs, and ADNs		
		Weekendstaffingcoverrequiredforforwardplanning,report backwithinanagreedtimeframe	HONtoCSM'sbothsites		
		Staffingcoverforbankholidayperiodrequiredforforward planning,reportbackwithinanagreedtimeframe	HON toCSM'sbothsites		
	Medicalstaffingissues affectingfrontendservice deliverye.g.assessment waitingtimesinA&E>6 hours	Re-deploymedicalstafftothefrontend	DivisionalDirectors/ADs		
		Medicalstudyleave/trainingsessionstobereviewed&stopped asnecessary	DivisionalDirectors&A Ds		
		Audithalfdaystobecancelled	DivisionalDirectors/ADs		
		Consideruseoflocums	DivisionalDirector/ADs		
	PatientFlow,Discharges	**PatientFlow,WardRounds,Discharges**			
	NobedsavailableonMAU orSAUacrosstheSite	Earlydischarges,utilizedischargeloungein ordertocreate capacityinacute access points	CSM's/WardTeams		
	Lessthan5discharges identifiedperSite	Limiteddischarges- escalatetoUrgent and Planned Division ADsandDivisionalAdministrators	CSM's/ADS/HONs//GM's		
		Identifyearlydischarges,expediteconfirmeddischargesusing theDischargelounge	CSM'sbothSites		
		Potentialdischarges- clarifyplan,andactionasnecessary	CSM's/WardTeams		
		ContinueGrandRounds	DivisionalDirectorstoreport backtoCSM's		
		DeliverDischargeproforma&reinforcebenchmark,infotobe availableby12pm	CSM'sbothsites		
		Reinforcedischargebenchmarkforeachward	CSM'sbothsitesHONs		

	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
ERPLEVEL3-SEVEREPRESSURE	**PatientFlow**	**PatientFlow-BedCapacity**		PREVENTATIVEACTIONREQUIREDTOSUSTAINPERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMESDAILYCROSSSITECONFERENCECALL
	Morethan10bedsclosed perSite	Reviewrationaleforclosedbedsandreportatcrosssite conferencecall	CSM'sbothSites		
	Morethan20additional bedsopenpertheSite	Reviewrationaleforadditionalopenbedsandreportatcross siteconferencecall	CSM'sbothSites		
	TCI'scancelledontheday	ReviewplangoingforwardforTCI'sexcepturgentandcancer stream. No cancellations without agreement of COO/Deputy COO	CSM'sbothSites		
	Electivecancellations24 hourspreviously				
	PatientFlow- A&E	**PatientFlow-A&E**			
	A&E flow KPIs not being met	MonitorPtflowatfrontend,liaisewithA&Eleadsforhourly SitRep	CSM'sbothsites		
	Over20confirmedA&E BreachesacrosstheSite intheprevious6hours	ContactHERMES/PCT(GP's),SouthEastHealthre:current operationalstatus,requestalternativespathways/admission avoidance	CSM'sbothSites		
		Highlightallpotentialbreachesat2.45hoursthatdo nothavea plan	A&ELeadstoCSM'sboth Sites		
		Highlightallpotentialbreachesat3.15hoursthatdonothavea plan	CSM'sBothsites/HON		
		Openadditionalbedcapacityincludingdaysurgery&other clinicalareas	CSM'sbothsites		
	Morethan6Ambulances unabletooffloadwithin30 minuteswithinadefined8 hourperiod(0.00Hrs-08.00Hrs,08.00Hrs-16.00Hrs,16.00Hrs-00.00Hrs)	A&ELeadto adviseCSM'sifAmbulancescannotbeoffloaded> 1hour,implementcohorting	A&ELeadstoCSM'sboth Sites		
		Escalateallambulancequeuingissuesto CMifwaittimes exceed30mins	CSM'sBothsites/HON		
		Report>3ambulanceswaitingtooffloadatanygiventimeto CM	CSM'sBothsites/HON		
		LiaisewithSECambregardingoperationalstatus,consider Divert	Chief Operatingg Office/Deputy COO/ AD UCD		
		EscalateallunresolvedsiteissuestoPatient Flow Manager	CSM'sBothsites/ HON		

	TRIGGERS	ACTIONS	RESPONSIBLE	REVIEW	IMPACT
ERPLEVEL3-SEVEREPRESSURE	**CriticalCareBeds**	**CriticalCareBeds**		PREVENTATIVEACTION REQUIREDTOSUSTAIN PERFORMANCEANDPATEINT CARE	REPORTBACKTOTHREETIMES DAILYCROSSSITE CONFERENCECALL
	NoLevel3criticalcare bedspersite	ConfirmplanforPatientswhoaresuitabletomovefromcritical careareasITU/HDU	CSM'sbothsitesliaisewith ITUConsultants		
	InfectionControl	**InfectionControl**			
	InfectionControlIssues impactingonbedcapacity	ICNreviewofsideroomprovision(Monday&Wednesday)	ICNbothsitestoCSM's		
		ICNreviewofspecificinfectioncontrolissues	ICNbothsitestoCSM's		
	WholeSystems	**WholeSystems**			
	DTC'sacrossSite>30	IncreaseOperationalConferenceCallstodaily	DN/CM,CSDwithWhole System		
		BoardRounds- MonAM/WedPM	CM's		
		Chief Operating Officer/Deputytoinformwholesystems taskgroup	COO/DeputyCOO (AD UCD if COO/DCOO not available)		

Notes:
1.AdditionalattendeesatBedMeetings-DivisionalDirectors,COO&/ or DeputyCOO,ADsADNsSenior Facilitiesrepresentation
2. RepresentationfromA&ELeads
3.ASC&PCTProvidertobepresentat9.30hoursand12.00hrsbedmeetings
4.Outof Hours-GMtoattendbedmeetingandeitherHospitalSiteasrequired. Must remain on site till 7pm handover at least.
5.Outof Hours-ExeconCalltochairbedmeetingsandattendeitherHospitalSiteasrequired

ERPLevel 4–PotentialServiceFailure-Triggers:

1.**WhentheREDTriggerscontinueforover72hoursandarenotexpectedtoresolvewithinthenext24hours.**LiaisewithWholeSystemsTaskGroupfor considerationtoelevatetoBlackStatus:

2.ImplementBusinessContinuityPlansduetoinabilityoftheTrusttomaintainnormalservicedeliveryduetoadverseeventse.g.severeweather conditions,infectionoutbreak,extraordinarydepletionofresources,lossofpriorityfuelsupplies-inthesecasesbusinesscontinuityplanswillbeactivated

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4- POTENTIALSERVICEFAILURE	**Staffing**	**Staffing**		POTENTIALSERVICEFAILUREWHICHWILLAFFECTPERFORMANCEAND PATIENTCARE	REPORTBACKTOCROSSSITECONFERENCECALL
	Staffingissues- >10 nursingstaffpershift,per Site	HighlightdailynursingshortagestoHONs to reportbackwithinanagreedtimeframe,review useofspecialistnurses& reviewuseof alternativestaffinggroups	CSM's/HONs		
		Noshortnoticeleavetobe granted<48hours/ reviewnonessentialtraining,considerre-scheduling	DivisionalDirectorsandADs/ ADN's		
		Weekendstaffingcoverrequiredforforward planning,reportbackwithinanagreedtimeframe	HONs toCSM'sbothsites		
		Staffingcoverforbankholidayperiodrequiredfor forwardplanning,reportbackwithinanagreed timeframe	HONs toCSM'sbothsites		
	Medicalstaffingissues affectingfrontendservice deliverye.g.assessment waitingtimesinA&E>6 hours	Re-deploymedicalstafftothefrontend	DivisionalDirectors&ADs		
		Medicalstudyleave/trainingsessionstobe reviewed& stoppedasnecessary	DivisionalDirectors&ADs		
		Audithalfdaystobecancelled	DivisionalDirectors&ADs		
		Consideruseofagencystaff	DivisionalDirectors&ADs		
	PatientFlow,Ward Rounds,Discharges	**PatientFlow,WardRounds,Discharges**			
	Lessthan5discharges identifiedperSite	Limiteddischarges- escalatetourgent Care and Planned Care DivisionsandDivisional Administrators	CSM's/ HONs/GM's		
		Identifyearlydischarges,expediteconfirmed dischargesusingtheDischargelounge	CSM'sbothSites		
		Potentialdischarges-clarifyplan,andactionas necessary	CSM's/WardTeams		
		InstigateGrandRounds	DivisionalDirectors		
		DeliverDischargeproforma&reinforce benchmark,infotobeavailableby12pm,reinforce dischargebenchmark	CSM'sbothsites		
		CancelallTCI's (last resort)	GM's/AdmissionsTeam		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4-POTENTIALSERVICEFAILURE	**PatientFlow**	**PatientFlow-BedCapacity**		POTENTIALSERVICEFAILUREWHICHWILLAFFECTPERFORMANCEANDPATIENT CARE	REPORTBACKTOCROSSSITECONFERENCECALL
	Nobedsavailableon MAUorSAUacrossthe Site	Earlydischarges,utilizedischargeloungeinordertocreate capacityingatewayareas	CSM's/WardTeams		
	Morethan10beds closedperSite	Reviewrationaleforclosedbedsandreportatcrosssite conferencecall	CSM'sbothSites		
	Morethan20additional bedsopenpertheSite	Reviewrationaleforadditionalopenbedsandreportatcross siteconferencecall	CSM'sbothSites		
	TCI'scancelledonthe day	ReviewplangoingforwardforTCI'sexcepturgentand cancerstream	CSM'sbothSites		
	Electivecancellations24 hourspreviously				
	PatientFlow- A&E	**PatientFlow-A&E**			
	A&Eperformanceis below98%	Monitorflowatfrontend,liaisewithA&Eleadsforhourly SitRep	CSM'sbothsites		
	Over20breachesacross thesiteintheprevious6 hours,allextracapacity bedsopen	Highlightallpotentialbreachesat2.45hoursthatdonot haveaplan	A&ELeadsto CSM'sbothSites		
		ContactHERMES/PCT(GP's),SouthEastHealthre: currentoperationalstatus,requestalternativespathways/ admissionavoidance	CSM'sbothSites		
		Highlightallpotentialbreachesat3.15hoursthatdonothave aplan	CSM'sBothsitestoHoN		
	Morethan6Ambulances unabletooffloadwithin 30minuteswithina defined8hourperiod (0.00Hrs-08.00Hrs, 08.00Hrs-16.00Hrs, 16.00Hrs-00.00Hrs)	Escalateallambulancequeuingissuesto ClinicalMatron, CSDif waittimesexceed30mins	CSM'sBothsitestoHoN		
		Report>3ambulanceswaitingtooffloadatanygiventimeto HoN Acute medicine and patient Flow Manager.	CSM'sBothsitestoHoN		
		LiaisewithSECambregardingoperationalstatus,consider Divert	Chief Operating Officer/Deputy COO		
		Escalateallun-resolvablesiteissuestoPatient Flow Manager	CSM'sbothSites		
	CriticalCareBeds	**CriticalCareBeds**			
	NoLevel3 criticalcare bedspersite	ConfirmplanforPatientswhoaresuitabletomovefrom criticalcareareasITU/HDU	CSM'sbothsitesliaisewithITU Consultants		

	TRIGGERS	ACTIONS	RESPONSIBLE	IMPACT	REVIEW
ERPLEVEL4	**InfectionControl**	**InfectionControl**		POTENTIALSERVICE FAILURE	REPORTBACKTO CROSSSITE CONFERENCECALL
	InfectionControlIssues impactingonbed capacity	ICNreviewofsideroomprovision(Monday&Wednesday)	ICNbothsitestoCSM's		
		ICNreviewofspecificinfectioncontrolissues	ICNbothsitestoCSM's		
	WholeSystems	**WholeSystems**			
	DTC'sacrossSite>30	DailyOperationalConferenceCall	DN/Patient Flow Manager		
		BoardRounds-MonAM/WedPM-addinFriday	HoNs		
		DailyWholeSystemsTaskGroup	Chief Operating Officer/Deputy (AD UCD if COO/DCOO not available) Exec Director OoHs		

Notes:

1. AdditionalattendeesatBedMeetings-DivisionalDirectors,COO/Deputy COO,ADs,ADNs
2. Facilitiesrepresentation

2. RepresentationfromA&ELeads

3.InHours– COO/Deputy COO (AD UCD if COOs not available) **Out of Hours, Exec Director on call.**

4.Outof Hours-GMtoattendbedmeetingandeitherHospitalSiteasrequired. Must remain on site till 7pm at least.

5.Outof Hours-ExeconCalltochairbedmeetingsandattendeitherHospitalSiteasrequired

6.ForadditionalactionspleaserefertoTrustBusinessContinuityPlan

East Sussex Whole System Overarching Winter Plan

Contributing Organisations:
ESDW & H&R PCT's
East Sussex Healthcare Trust
Sussex Partnership Foundation Trust
East Sussex County Council
NHS Direct
South East Health
Health Protection Unit
SECAMB

Index

1.0 Executive Summary
Sussex Wide Planning

2.0 Operating Model
Operating model within System & role of group
2.1 Changes to Current Practice
2.2 Business Continuity and Emergency Response
2.3 Communications

3.0 Staffing Consideration across the economy
3.1 Staff sharing
3.2 Staffing and capacity
3.3 Out of hours
3.4 Summary of System Plans
3.5 Intermediate Care
3.6 Support from Independent sector and Adult Social Care
3.7 Supporting vulnerable persons
3.8 Adverse weather plans
3.9 SECAmb and transport
3.9.1 NHS Direct

4.0 Capacity and Escalation Planning
4.0 Capacity planning
4.1 Whole System Escalation Process
4.2 Primary Care Support
4.3 Dental
4.4 Mental Health
4.5 Pharmacy

5.0 Infection Control
5.1 Flu Campaigns and Vaccination programme
5.2 Infection control policies
5.3 Noro virus and outbreak management plans

6.0 Appendix
Whole System Escalation Process
Definition of a Major Incident

Executive Summary

This paper describes the way in which East Sussex Health and Social Care Economy will respond to the additional demands of winter and peak pressures throughout the year.

This is an operational document and it is intended that it is referred to throughout the winter period for guidance. It should be noted that this is a high level plan describing how the services will work together as part of a coordinated response and does not replace the detailed work taking place within each service to identify, in detail, precisely how the additional demands of winter will be met.

Planning Context

All providers are expected to be able to demonstrate that they have:

- detailed projections of likely demand informed by historic patterns of activity, seasonal fluctuations and other factors such as the impact of significant service changes and prolonged holiday periods
- Robust plans in place to meet the expected levels of demand and to continue to meet all agreed contractual requirements, targets and service standards.

Any substantive departure from core service delivery will require approval with the commissioner.

Structure of the Plan

- The operating model and communication approach is the key foundational component of the overall plan. We need to ensure decisions are made in a structured way and that outgoing messages are consistent, both internally and externally. Staffing considerations across the health and social care economy are of primary importance.
- Transparency of learning from previous years into planning for the following year
- Going into winter the system needs to be working as well as it can be.
- Capacity and escalation plans are necessary to define the steps that each service will take to absorb additional demand and the trigger points at which each Organisation will call an Escalation Task Group
- Sharing of information to support service delivery and Whole System pathways. There is a Christmas and New Year Duty/ On call managers rotas and service opening times/ contact details for all East Sussex Organisational services which is shared across all services.

Leads and Sussex Wide System Alignment for Planning

Across the LHE, each organisation has identified senior personnel who are the named Winter Planning leads. Due to the nature of the patient 'flow' to BSUH, this includes the leads for Brighton and Hove and West Sussex.
These individuals are fully cognisant of the expected increases in demand likely to occur over the winter period and are charged with leading, coordinating and implementing the necessary actions required at an organisation level, across the LHE and Sussex to mitigate the impact of any increases in demand and/or in the event of adverse weather, pandemic flu outbreaks
Winter alignment across Sussex is being progressed with the sharing of winter plans and learning with Sussex winter leads who will be in regular contact throughout the winter period in particular for the BSUH catchment area. These arrangements will be formalised in a series of meetings between Brighton and Hove CCGs, West Sussex CGs, BSUH and East Sussex CCGs. Alignment and assurance has been gained that East Sussex Adult Social Care will provide regular liaison with Brighton BSUH and this will be maintained during any event that requires implementation of the Capacity Plan (System Pressure Plan) or any associated plan.

2.0 Operating Model

The Urgent Care Network is the Programme Board responsible for the overarching delivery of the Urgent Care Programme, monitoring of demand and capacity issues across the urgent care system and monitoring impact of delivery of projects.
The ultimate point for decision making for the implementation of the winter plans across East Sussex will be the East Sussex System Pressures Planning Group which convenes monthly throughout the winter period (more frequently if required) The group consists of representatives from all key Organisations Operational and Communications Departments. The first meeting of this group will be held in September. The meeting will focus on work that has been ongoing since the review and wash up meetings held from Winter 10/11 to ensure lessons learnt have been incorporated into the review of this years plan.
The key purpose of the Group is ensuring that an overview of activity and demand is discussed and any remedial actions that are required to be implemented are agreed and communications regarding these actions are managed in a synchronised manner without burdening key operational managers with extra meetings. The monitoring of the implementation of the agreed actions and any further actions required is the responsibility of the members of Whole System Escalation Task Group whose role will be discussed in the Capacity and Escalation section of this document.

Role of the Group

The role of the Group is to ensure that the plans of the partner organisations are co-ordinated and integrated to optimise the level and quality of health and social care services available to the residents of East Sussex during the period of expected increased demand during the winter and other times of high pressure throughout the year.

To properly discharge its responsibilities the Group will

- Share and examine the winter plans of all the partner agencies ensuring that they complement each other and that any intra-agency gaps in service are identified and resolved

- Identify and implement any additional measures it considers are necessary and practical to increase the robustness and effectiveness of the winter planning arrangements

- Establish a mechanism for regularly monitoring the operational effectiveness of the plans and for resolving any difficulties that arise

- Undertake an evaluation of the effectiveness of the 2011/12 winter planning arrangements in the Spring of 2012 to inform future planning cycles

Accountability

The Group will be chaired by a PCT officer who will provide support to the Group.
The Group will report to the Urgent Care Network (who will receive its minutes once approved)
The Plan will be signed off by the CCE and Area Management Team to ensure awareness and ownership of the plan.

Frequency of Meetings

The Group will meet monthly via face to face and conference calls. The frequency will increase if necessary in response to operational pressures, however it is expected that the Escalation Task Group will take a lead on operational issues and decisions.

2.1 Changes from current practices

This section describes enhancements/changes to what are essentially ‘business as usual’ processes.

- Whole System Pressure Planning Group meeting will be increased if pressures increase to ensure co ordination of actions
- Each service to have a named individual responsible for attending the meeting or nominating a deputy to do so
- Each service to ensure that their representative is aware of who their on call manager is and the process for calling an escalation Task Group
- Infrastructure has been agreed to utilise the Whole System Escalation process to convene a conference call at short notice should this be required
- Expediting system changes to support operational readiness

2.2 Business Continuity and Emergency Response

NHS Sussex (the PCT Cluster) has effective Major Incident and incident response plans designed to ensure the lead and coordination of the Sussex NHS response to any major incidents. These plans involve multi-agency contact via a Director On-Call and an On-Call Emergency Response Management Team member (Emergency Preparedness Manager).

As per the SHA target, NHS Sussex also maintains an over-arching Business Continuity Policy, Executive Policy Statement, and Management Program. Each NHS Sussex operating site including Friars Walk maintains a site-specific Business Continuity plan. These arrangements are drafted in accordance with S25999, the British Standard for Business Continuity, and these arrangements have been in place since 31.3.11, as required by the SHA.

These over-arching arrangements and plans together detail the PCT’s internal readiness arrangements and response activities and its external obligations as a Category 1 responder under the Civil Contingencies Act 2004. As part of these arrangements, the PCT Major Incident plan describes LHE coordination by PCT’s and wider links to non-health responders via the Local Resilience Forum - the Sussex Resilience Forum, to ensure that joint arrangements are complete and are effective.

As part of the supporting planning arrangements, the PCT requires that an effective local Escalation Procedure exists which is agreed by local NHS Trusts and partner agencies, and which deals with Capacity issues across the LHE.

In the extreme event that normal business failure can not be corrected by business continuity plans then the Emergency Preparedness Plans should be invoked.

Internal Organisations triggers and actions include the point for instigating/considering business continuity in order to manage capacity appropriately across the LHE. Details of the local escalation plan and triggers can be found in the Appendix.

The NHS Sussex On Call Director will be called to support escalation processes should these be required to go wider than our LHE. Coordination of Sussex wide response is led by the NHS Sussex On Call Director.

2.3 Communications in East Sussex Health Economy

Communications plans for accessing services

The communications team are working collectively across Sussex to ensure a joined-up and consistent approach this year. NHS Sussex will coordinate a winter communications campaign on behalf of all of the local areas and CCGs. This will include a range of channels to communicate the key messages around access to services, including PCT and council websites, materials such as leaflets, partners’ newsletters and publications, local community groups, the local media and social media. The campaign will be supported by local established mechanisms to ensure that changes to operational aspects of services, including change of opening hours or restrictions on services, are widely communicated across the LHE. Included in these updates is information to direct people to others sources of information and support.

Choose Well

Choose Well will be the key focus of the winter communications campaign, both locally across Sussex and regionally, ensuring people are aware of the range of services available and where to get the most appropriate health services. NHS Sussex will explore all communication channels to inform the public and encourage them to

use the most appropriate services, including e-communications, the local media and via partners in health and social care such as the local authorities.

Internal communications

NHS Sussex will use established internal communications systems, including newsletters, and email, to ensure staff and stakeholders know the preparations and arrangements for winter. Mechanisms are in place to report up any problems or issues. The systems are also capable of quick effective messaging should circumstances require it around changes to working hours or closure of offices. NHS Sussex will also coordinate use of the PCT's internets and extranet to host information (via N3, so accessible via any NHS site) to advise staff what to do in the event of adverse weather or other situations where they may be unable to get into work – this includes possible redeployment to different Trusts/sites according to need.

Flu communications

NHS Sussex will coordinate communications activity to support the seasonal flu vaccination campaign on behalf of all of the local areas and CCGs. This will include providing practices with access to the national patient leaflet, supporting practices will communications to patients, publicity for the campaign via local media, content on websites, and work with our partners in the wider health economy including local authorities to endorse and support the key messages, particularly around encouraging the 'at-risk' groups to get the vaccination. We will also explore posters and leaflets should extra support be needed during the campaign, with resources available from last year, which proved very useful. NHS Sussex will also work with providers through established mechanisms to encourage staff vaccination for those eligible, including using e-communications, newsletters and email.

3.0 Staffing Considerations and plans

3.1 Staff sharing during adverse incidents

Following review of last winter a recommendation to establish agreed protocols and processes to be able to share staff across Organisations within safe working, professional accountabilities/standards and contractual agreements was agreed.
As a result ESHT HR Departments have been preparing plans, policy amendments and processes to support delivery of this. Protocols and processes are available from Moira Tenney Deputy HR Director.
A communications plan to support staff awareness of processes to follow in the event of adverse weather and/or system pressure will be run from November onwards.

3.2 Staffing and Capacity

The PCT's are seeking assurance that staffing availability and capacity to meet demand with services across Christmas and New Year from all core Organisations. It is the responsibility of each Organisation to ensure that staffing levels are sufficient to meet the expected demands on it's services as part of the winter planning and preparation.

Processes for monitoring of staffing levels and escalation of any issues have been included into the Whole System escalation process.

3.3 Out of Hours Arrangements

Availability of services such as the Integrated Night Service (Social Care support workers and registered nursing) 7 days per week will support managing patients within the Community and support pro active discharge out of accident and emergency departments. This service has been established during the year and will support initiatives for developing and increasing access to swift assessment and response preventing unnecessary admissions.
Access to this service is coordinated via the Integrated Community Access Point (Health and Adult Social Care) which is also co located with the Emergency Response Team for Adult Social Care which helps to provide robust support and access to urgent assessment for possible urgent respite cases and vulnerable adults. Referrals are open to lifeline and CRESS and these have been positively received in preventing unnecessary admissions when a carer becomes unwell.

South East Health are able to flex staffing if requested to support increase in demand at walk in centres and out of hours services. Clinical cover arrangements for oohs is based on volume data and expected experience. At all periods of high volume standby GPs and additional telephone triaging GPs are rostered.
All SEHL cars are fitted with winter tyres at the start of October for the winter period and wheel chains available. Brighton and East Sussex has the use of 3 cars, 2 of which are 4x4 as well as the access to 4x4 assistance.
End of Life care has been identified through an internal audit of MAU activity as a priority area. Processes to support urgent end of life care referrals have been agreed with local hospices and Community Nursing services and contact details to activate this support shared with both HERMES and the Integrated Community Access Point

The Integrated Community Access Point is available over 24 hours, 7 days per week including all Bank Holidays which supports discharge coordination into Community Health and Adult Social Care Living at Home services.

Minor Injury Units within Uckfield, Lewes and Crowborough are available 7 days per week 08.00 – 20.00 hours from 1st November and processes and criteria for SECAMB to transport appropriate patients to these units and the Walk in Centres at Hastings and Eastbourne instead of A&E have been agreed. A campaign to increase SECAMB staff awareness and use of these pathways is underway and monitoring has been established to provide feedback to providers.

3.4 Summary of System Plans

Across the LHE work has progressed with implementation of key QIPP plans. These include:

1. Prevention of avoidable hospital admissions/ accessible and responsive community services
   - COPD Service within ESDW area
   - Neighbourhood teams (collaborative health and social care approach) multi disciplinary teams working around primary/community care to pro actively identify and support patients gradually deteriorating or those identified as frequent users/high risk of emergency care admission to maintain them within their own home or appropriate community facility
   - Implementation of the GP Urgent Care Dashboard to support identification of high priority/frequent user patients (focussed roll out to support delivery of neighbourhood teams and practices with high emergency care activity)
   - Havens/Lewes engagement with BSUH plans around ambulatory care
   - Commissioning of Integrated Night Service – Health and Social Care teams across East Sussex to support A&E discharges overnight of patients who may require support to settle back home, home assessment to identify key support needing to be in place the next day with follow up mechanisms (including carer crisis and lifeline referrals) and a focus on prevention of avoidable hospital admission. All teams are expected to work closely with the A&E Departments which will include pathways to be established with BSUH
   - Complete review of Community Matron role and re design of service – new service model currently being commissioned
   - Established access to BSUH RACOP and establishing similar service at ESHT
   - 7 day x ray access at Uckfield and communication plan to support promotion with local area

2. Effective MDT working and discharge planning
   - Establishment of a 7 day hospital intervention team. Health and Social Care multi disciplinary team based within A&E/MAU on both ESHT sites 7 days per week to expedite discharges out to Community
   - Joint commissioning of a 7 day a week community voluntary service to support frail elderly discharges out of A&E/MAU and wards at ESHT and settle back home
   - Electronic discharge summary to GP practices
   - Develop the effective use of estimated discharge dates in planning discharge
   - Focus work on end of life care and joint DNACPR across the system

3.5 Community and Intermediate Care Services

Access to Community intermediate care services and beds is now available 7 days per week through the Integrated Community Access Point (ICAP). This access point provides opportunities for Adult Social Care and Community Teams to pro actively manage their demand and capacity jointly for Intermediate Care referrals, flexing support for teams where needed. The service supports HERMES (GP admission referral management system) in pro actively supporting prevention of admission pathways

Capacity information within Intermediate Care is shared with East Sussex Acute Hospitals on a twice daily basis to support communications for capacity at bed management meetings. ESHT and BSUH are able to inform ICAP of high priority for discharges out of acute hospital via the escalation processes.

3.6 Support from Independent Sector and Adult Social Care

East Sussex Adult Social Care reviewed contractual arrangements for the provision of domiciliary services and these are now monitored via the Quality Monitoring Team regularly to ensure accordance with contract.
20 geographical areas are each covered by 3 Framework Providers who, as part of the contractual arrangements, are expected to pick up 80% of the work offered to them in their allocated areas. Where a Framework Provider is unable to pick up a piece of work, providers on the approved list will be approached. Performance against the new contracts will be closely monitored by the Quality Monitoring Team. There are no cut off points for the commissioning of domiciliary care in relation to bank holidays / winter holiday periods.

Quality Monitoring will liaise with contractors and service providers (domiciliary and residential providers) at the earliest practicable time to ensure that where appropriate, business continuity plans are enacted and to determine the likely impact on service provision and how this can be mitigated. This could include, in the instance of an extreme weather event, the use of four by four vehicles and the identification and prioritisation of the most vulnerable service users who must receive a service.

Quality Monitoring maintain a list of vulnerable service users and will inform service providers of those service users considered to be high risk.

Quality Monitoring currently liaise with providers ahead of predicted peaks in demand (school and public holidays / winter holidays) to ensure that sufficient staff are in place to meet demand and support discharge activity. This practice will continue.

Two weeks prior to holiday periods (Bank Holiday's, school holiday's, Christmas etc), staffing will be reviewed on a daily basis by service / unit managers. If potential difficulties are identified, managers will complete the reporting template 'Capacity Plan' and forward to their Operations Manager.

3.7 Identification of Vulnerable Persons and continuity of service

Adult Social Care have reviewed processes to ensure persons who are vulnerable within the Community are identified and information for these priority cases shared with the provider services to ensure that should business continuity be enforced these individuals will be given a continuity of service. These include adults who have a current Safeguarding Adults at Risk (SAAR) alert, but may live with or have an independent carer, as well as individuals who live alone and are isolated.

As part of the business continuity plans for health services, caseloads must be reviewed and vulnerable patients identified to ensure consistency of service provision during periods of adverse weather. Community Matrons are integrated with the Community Nursing service to provide support to this process.

3.8 Adverse Weather and Coordination of resources

Learning from 2010 identified: Access to 4 x 4 vehicles was hampered by a lack of a co ordinated approach which supported the local groups and businesses to be able to prioritise the requests for assistance.

As a result of this an agreed process has been developed for all requests to be supported and triaged by the lead managers, designated to request 4x4 vehicle support on behalf of their organisations. These requests must meet the requirements of essential clinical need and continuity of essential services (please see Memorandum of understanding for full process and attached Algorithm in the Appendices).

The PCT is supportive of the Sussex Resilience Group plans to provide a County wide tactical team which will be called into operation via the Escalation process and Gold Resilience. This team will implement coordination of transportation issues such as access to 4x4 vehicles across the County should snow or severe weather require their use.
Further details can be found in the **Sussex Adverse Weather Plan**

Priority areas for gritting have been agreed with the County Council and these include the access to both ESHT hospital sites. We have identified priority areas as the Minor Injury Units based at Lewes, Uckfield and Crowborough and Walk in Centres in Hastings and Eastbourne. We have requested that grit be made available

for estates use at each of the Community Hospital sites and staff to be informed of their responsibilities to support management of entrances and car parks during out of hours times.
A full list of gritting routes and grit bins for East Sussex can be found at:
http://www.eastsussex.gov.uk/roadsandtransport/roads/maintenance/saltingandgritting
Please click on the link for interactive map

3.9 SECAMB and Patient Transport

SECAMB operate a REAP (Resource Escalation Action Plan) system, incorporating six levels of escalation which are reviewed annually based on pervious winter periods and times of increased demands or challenge. The Resourcing Escalatory Action Plan (REAP) will form the backbone of the Trusts response; as part of the REAP procedure an Emergency Dispatch Centre (EDC) on day surge process has been established that will provide the Trust with short notice capability to surge several vehicles. Along with this significant planning has been undertaken to support the maintenance of standards during Quarter 3 which has traditionally proved to be a challenging period. SECAmb now operates a single Computer Aided Dispatch (CAD) system across its three EDC's which enables seamless deployment of resources across the whole SECAmb area.

Following a view of Business Continuity Incidents related to adverse weather over the past couple of winters SECAmb has reviewed 4x4 requirements and have increased its 4x4 capability with the purchase of additional Land Rover Discovery's which have patient carrying capability. Key personnel are currently being trained in their use and these will be strategically placed across the SEC. Along with this SECAmb have developed contingency plans to provide additional 4x4 capacity via pre-agreed contracts and utilising voluntary 4x4 clubs.

Following the introduction of NHS Pathways into SECAmb's EDC's clinical support has increased which will enable more patients to receive advice and more appropriate referrals. Contingency plans are in place within the EDC's to provide additional call taking capacity and clinical advice during periods of increased demand.

The introduction of NHS Pathways has also seen the development of a Directory of Service (DoS) and SECAmb is working closely with PCTs to ensure key services and referral options are recorded on the system.

The introduction of Paramedic Practitioners continues across the Trust which linked to the introduction of the DoS will enable patients to be treated in or near to their home and thereby reduce the need to transport patients to hospital.

The introduction of the Front Loaded Service Model (FLSM) is being accelerated where possible. This will see the most qualified clinician attending the patient and being able to make sound non conveyance decisions.

SEC wide handover procedures are being monitored via lead commissioner arrangements and at local operational level liaison meetings. Plans are agreed with local hospitals to monitor and improve handover compliance via electronic data capture and acute trust contracts contain handover compliance clauses.

In addition to emergency services SECAmb also provide Patient Transport Services (PTS). As part of the Sussex-wide PTS contractual agreements for 2011/12 SECAmb have worked with commissioners and acute, community and mental health providers to support improvements in quality and timeliness of provision. This work continues and although significant progress has been made and SECAmb are very keen to maintain that progress and adopt new and flexible working practices. Business continuity and escalatory arrangements do however, need to be confirmed and tested prior to the winter period and commissioners may want to seek additional assurance this is in place.

- PTS discharges to be available as commissioned throughout the year.

  It is the SECAmb's intention to provide a reliable and responsive patient transport discharge service to the acute trusts as commissioned. Our plans have identified that when there is a demand for discharges, due to adverse weather, there is also a corresponding reduction in out-patient activity, therefore PTS capacity to key patient groups, including discharges should be maintained.

  Frank Sims is the lead for the commissioning of PTS services in Sussex and SECAmb has been working with his team regarding commissioned activity/specification.

In addition SECAmb have increased 4x4 response capability from last year, both in terms of vehicles and trained personnel, this should result in a reduction in on-day staffing issues caused adverse weather and consequently better vehicle availability for both A&E and PTS.

PTS managers will monitor performance and responsiveness of service while maintaining close links with colleagues in the acute trusts, particularly when the health system is challenged, on an hour by hour basis if necessary.

- Hospital Handovers

  SECAmb has agreed with all the acute providers/commissioners across Sussex, Surrey and Kent that the inbound screen handover compliance should be at 80%. SECAmb continues to work with partners in acute trusts to minimise handover delays and improve inbound screen compliance within agreed procedures.

3.9.1 NHS Direct

NHS Direct works as a National Virtual Call Centre with the capability to "load share" across all of the 32 contact centres which offers flexibility and the ability to move calls across centres and to manage peaks and troughs in activity relative to capacity. This allows us to offer a very high degree of resilience and flexibility, ensuring that in periods of high activity, calls are routed to unaffected areas and a consistent service is provided.

To prepare and maintain business as usual during high demand NHS Direct will complete rigorous scheduling of frontline staff to meet forecasted call volumes, use bank and agency health and nurse advisors to manage peaks in demand, support and help staff get to work during inclement weather. Proactively use the welcome telephone messaging to manage patients' expectations on call-back times for non-urgent symptoms, and to provide relevant self-care information for non-urgent symptoms, where appropriate. Manage support from external suppliers to maintain systems and facilities provision. Continued expansion and promotion of the online health and symptom checkers as the first port of call for patients with internet/smartphone access. Rapid internal messaging to all staff to advise and update on national and local pressures within NHS Direct and wider healthcare communities. NHS Direct will also maintain liaison with the Ambulance Service re service levels. In addition, during this busy period, we will continue with the plans put in place over the Christmas and New Year.

For details of the winter plan and escalation process please see appendices.

4.0 Capacity and Escalation Planning

Capacity planning across the system is being coordinated through the Whole System Pressures Planning Group. An urgent care dashboard has been developed which forms part of the monitoring and identification of historical trends to support planning. Assurance from East Sussex Adult Social Care, Primary Care, South East Health and East Sussex Community Health Services is also being sought and it is these Organisations responsibility to ensure adequate staffing and availability of services to meet the expected peaks in demand. Assurance to meet expected peaks and staffing capacity particularly on the build up to Christmas and after New Year has been sought.
Bed mapping across Acute and Community services to ensure capacity matches expected demand is taking place.
Processes to flex capacity utilising independent sector can be agreed within the escalation process and decision is agreed by Directors within the Task Group. Interim arrangements to flex capacity, when needed, with BUPA have already been agreed. The PCT has access to a further 23 beds within the private sector with an additional flex of a further 10 should this be required.
Capacity management is being incorporated into the Sussex Wide planning (Lead Organisation Brighton and Hove City PCT)

East Sussex County Council and East Sussex Healthcare Services will participate in twice weekly capacity calls with BSUH and these will be reviewed regularly and increased should pressures increase.

All organisations have confirmed that they expect all services to be available as per contracts over the winter period.

Critical Care
Critical care networks and communication processes are in place. Transport and escalation plans are fully in place and used regularly. The critical care facilities on both sites are used flexibly to meet the demand.

4.1 Escalation

East Sussex follow an agreed process to implement Whole System support, during periods of excessive peaks in demand across any of the key Health or Social Care services throughout the year. This support can be accessed by any Organisation wishing to call an escalation alert Task Group
This escalation process will also support implementation and Communication for any of the Winter Plans which are required to work across Organisational boundaries.
Escalation process and contacts will be shared with neighbouring Organisations to avoid boundary issues when managing peak activity.
Escalation process will be used should a neighbouring Organisation require support to provide capacity within East Sussex for our residents who have accessed acute services elsewhere.

The Escalation process is included in the appendix for information.

During escalation the system may require Business Continuity to be called within Community services in order to pro actively manage increasing pressure. This process will be agreed and enabled by the Escalation Task Group and is supported within Organisational Business Continuity Policies across East Sussex.

4.2 Primary Care Support

East Sussex now has over 67% of Primary Care practices offering extended service hours.
There are two Walk in Centres centrally located within Eastbourne Town and Hastings town centres which are open 365 days per year from 08.00 – 20.00 hours, offering GP and Practice Nurse consultations
These centres alongside our Minor Injury Units located at Lewes, Uckfield and Crowborough will offer support to patients with minor ailments and work with our Primary Care and Community services
We have reviewed criteria for these services and developed a protocol with SECAMB to ensure, where appropriate that patients requiring minor injury or primary care treatment are conveyed to these Units rather than the A&E Depts across East Sussex (including Acute sites at BSUH and MTW)
All practices have Business Continuity Plans, many of which have been tested operationally during last year's snow and Swine Flu outbreak.

4.3 Dental Care

Local dentists will provide core services as per contract. Emergency Dental Services are provided 7 days a week, including all bank holidays. (This service has received additional funding over the last year.) Information with regards contacting the EDS service will be posted to A&E, the general public, GPs and pharmacists during November and will form part of the Choose Well campaign. PCSS run a helpline, to direct people to the most appropriate service.

4.4 Mental Health & Learning Disabilities

Activity in mental health services is generally stable over the winter although there can be reduction in planned activity and a small increase in unscheduled care but this sits within operational parameters. The main influence on this is weather conditions. The normal performance framework applies for emergency and routine wait times (4 hours and 4 weeks respectively). The Crisis Resolution Team and Enhanced Community Mental Health Teams will be available over the Christmas and New Year periods.
Protocols between ESHT and SPFT have been agreed to limit the numbers of patients to be transferred from the Department of Psychiatry to A&E.
The Woodlands Beds have re opened and enhanced liaison services are now available for Older Peoples Mental Health into Intermediate Care beds and Acute Trust sites to support assessment of patients and advice for staff.
When 'normal' bed capacity is full there are agreed escalation plans e.g. leave beds, urgent clinical reviews, and accelerated discharge with support from CRHT. In-patient wards are identified as priority, with professional leads providing clinical interventions.

Staffing capacity is planned according to previous activity levels, to ensure adequate staff are in place. The main risk to the service is staff sickness, in this event the service would need to concentrate on priority referrals, and routine referrals would take longer to be seen which may end up in a breach in waiting to be assessed / treated.
Across all MH services; in adverse weather situations e.g. snow, vulnerable people are visited at home and non clinical staff are redeployed to provide ancillary functions
Business continuity plans and staffing contingency are in place across all Learning Disability Units provided by Community Health Services

4.5 Pharmacy

East Sussex is well served with Pharmacies. Information to the public and out of hours services regarding local pharmacy opening hours and access during Christmas and New Year will be made available through Communication campaigns and posted to relevant Departments such as Accident and Emergency and Minor Injury Units, out of hours service providers and local newspapers. This information is also made available to NHS Direct.

There are nine; one hundred hour per week pharmacies across the county and at least one of these (Station Plaza Hastings) will be open 365 days per year and reflect the opening times of the walk in centre in Hastings. In addition there are several extended hours pharmacies based in supermarkets which will open later into the evening and approximately 6 hours on a Sunday. In the past community pharmacies have worked with the PCT to provide additional services at short notice to maintain supplies of medication in pandemic circumstances and utilised their delivery services to ensure those in need receive medication quickly. During bad weather many multiple pharmacies utilise their business continuity plans maintain service by redeploying their staff as appropriate.

5.0 Infection Control and Outbreak Management Plans

5.1 Flu Campaigns and vaccination programme

Pandemic Flu plans and co ordination of services are in place and will remain throughout this winter.

East Sussex Seasonal Flu Group meets from August until March. The remit of this group is to encourage the uptake of immunisation by priority patient groups and frontline health and social care staff. The agenda of the meeting covers an annual update of the programme including any concerns received from primary care. The primary care Flu LES is developed within the group. Communications are involved to publicise the programme with radio broadcasts, leaflet distribution and media updates. Pharmacies are involved in the development of PGDs and training issues. East Sussex Healthcare Trust occupational health attend as the responsible service for community and acute staff vaccination programmes. District Nursing services are involved to help resolve any issues regarding housebound patients.

Primary care payments are made through the agreed LES promoting the uptake of vaccination by priority patients groups, as defined by the department of health. Good practice guides are available on the PCT website for all who follow the programme. All immunisation data is downloaded onto Immform and the PCT offer support through clinical governance in doing this.
The staff vaccination programme is advertised and staff encouraged to attend. Numbers of healthcare workers attending for flu vaccination are recorded via Immform. . Carers are offered the influenza vaccine with their GP practices.

5.2 Infection Control Policies

East Sussex service providers have reviewed Infection Control policies.

Normal business operations at ESHT includes isolation capacity, this will be maintained throughout the winter period. Should a definitive outbreak occur within the Acute Trust, ESHT will instigate a daily outbreak meeting chaired by the DIPC which will include all divisions to ensure that overall management of capacity and demand is maintained.

Decisions regarding the need to cohort patients internally within the Acute environment must include the Acute Trust DIPC.

Surrey and Sussex Health Protection Unit have produced an *Outbreak Plan for Communicable Disease (*May 2010)
Mandatory training for all clinical staff groups is monitored through HR processes and line management.
Occupational Health advice regarding infection control for hospital based Adult Social Care Assessors has been agreed and this is being shared with Acute Trust and Adult Social Care Operational managers to ensure consistency of understanding around ability and timescales to assess patients within a closed ward or infected ward area.

The Health Protection Unit will inform DIPC's / Deputy DIPC of outbreaks within Care Homes and other relevant issues that would impact on demand or capacity within Health or Social Care services.

5.3 Norovirus & Outbreak Management Plan

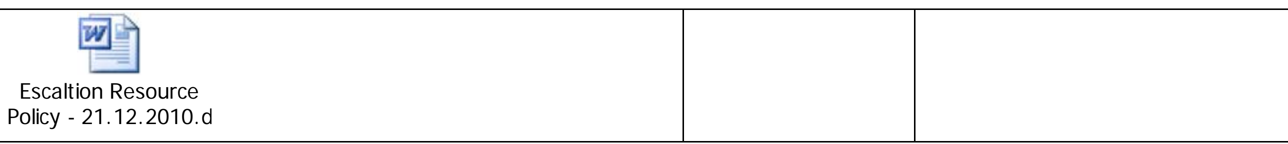
East Sussex is supporting the use of the norovirus toolkit which has been developed in association with NHS West Midlands and South East Coast SHA..
The Health Protection Unit (HPU) advises Care Homes on responding to outbreaks. The HPU also monitor incidence of cases.
The HPU have agreed to inform the Deputy DIPC/Senior Infection Control Nurse at NHS East Sussex Hospitals NHS Trust when an outbreak of diarrhoea and vomiting in a nursing or residential care home is suspected. This is done with the home's permission and on a strictly confidential basis. The HPU will provide follow up information if the situation warrants this but will not routinely provide additional information.

The HPU have undertaken a communications campaign with all Registered Care/Nursing Homes within East Sussex to re enforce infection control advice about managing infected cases within the care home environment and re iterating good hand-hygiene amongst care home staff. The HPU has also agreed a protocol for admitting patients to an acute environment from a care home that has an infection alert.

Following learning from last years outbreak processes for management of an outbreak in hotels has been agreed. Environmental Health are supporting advice and guidance to hoteliers and coach companies on an appropriate management process.

Appendices

	Publication Date	Author
East Sussex County Council Pressures Plan ESCC Systems Pressures Plan revise	2011/12	
South East Health Plan F:winter plan service pro forma 11 12 all ar	August 2011	Mary Jones
NHS Direct Plan and Escalation 20110916 Winter Capacity Plan 2011-2 NHSD Escalation Plan - Stakeholder Su	September 2011	Katherine Pitts, NHS Direct
SHA Ambulance Whole System Hospital Handover And Turnaround Policy SHA Handover Turnaround Policy V1	May 2010	Sue Harris/Lisa James/Helen Medlock
SHA Ambulance Protocol For Initiating And Agreeing Ambulance Diverts And A&E Closures SHA Ambulance Divert Policy April 201	February 2010	Paul Benson, Lisa James, Sue Harris, Helen Medlock
Outbreak Management Plan HPU Outbreak Control Plan S S HPU v 0 9 (a	May 2010	HPA
Seasonal Flu – Preparedness Seasonal Flu Vaccination - Prepare	2011/12	Jenny Greenfield
Memorandum of Understanding 4x4 Vehicle Access draft MOU NHS Sussex June 2011.do Updated Algorythmn Dec 2010.doc		David Wolfe
East Sussex Whole System - accessible and responsive community services (BSUH particular) East Sussex Accessible Responsiv	September 2011	Gemma Dawson
ESHT Escalation Resource Policy		Pauline Butterworth



Whole System Escalation Process

Introduction

The NHS now accepts that 'over capacity' can occur at any time of the year and has introduced the philosophy of 'Whole System Capacity Planning' (HSC 2001/014).
East Sussex Health and Social Care have produced this protocol which triggers specific measures when one or more Organisations are operating at significant and sustained levels of increased activity.

Roles and Responsibilities

The Whole System Escalation Process can be triggered by any Health or Adult Social Care Organisation within East Sussex.
BSUH may trigger escalation when trying to resolve cross border issues.

Each Organisation is responsible for monitoring their internal triggers on a daily basis and ensuring that a process for co ordination and assessment of information is in place across their operational services which informs the Senior Managers.
All Organisations need to ensure that timescales for swift escalation of operational issues that could impact on Whole System pathways are also in place.

Operational Group Members Roles

Operational Group Members are to be fully briefed with their own organisations Alert status and capacity PRIOR to the Conference call in order to be able to agree to Action Plan.

The Group members will be expected to make operational decisions regarding any actions planned at the time of the conference call and therefore have the ability within their own Organisations to take those actions forward immediately

Escalation Task Group Members Roles

Escalation Task Group Members are responsible for whole system communications and monitoring of agreed actions across Organisations that will support alleviation of system pressure. They are responsible for agreeing to Black Alert status and wider communications with SHA areas should this be required.
Members of the group must be at a suitable level of authority to agree Organisational actions being aware of possible impacts on wider service delivery and outcomes.
Group members can request that Business Continuity Plans be invoked across Organisational Boundaries to support reduction in system pressure and may also call a central co ordinating hub similar to that used within the Major Incident Plans.

Out of Hours

The Escalation Process will be actioned via the Duty Directors on call rotas for any of the Organisations and as these may relate to some non operational Directors it is therefore advisable that support and participation on the Conference call may be required from the Operational Managers Duty Rotas.

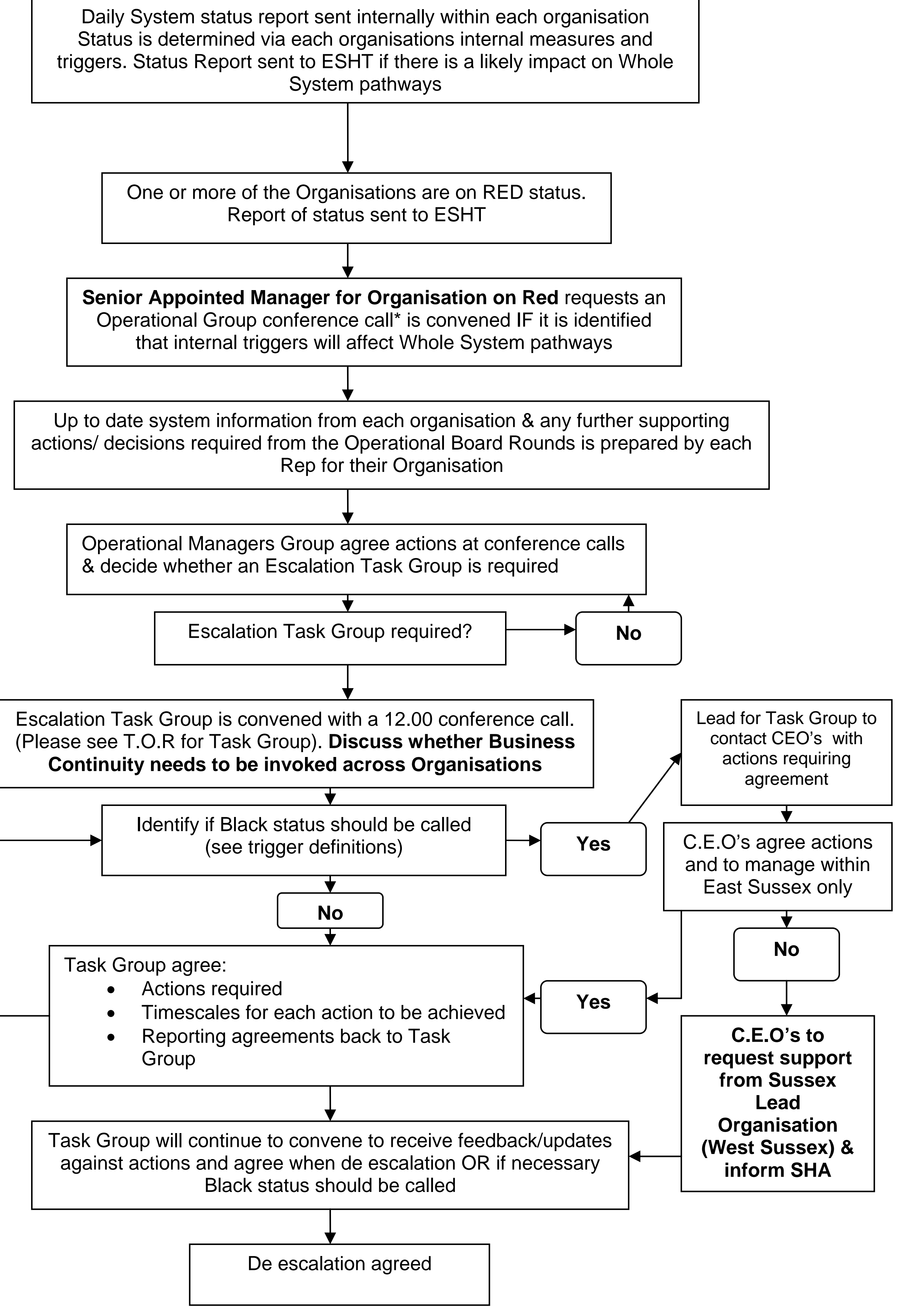
It is the responsibility of the Duty Director within each Organisation to seek attendance from their Operational Managers on the Conference call to support any decision making

Process to Call Escalation Task Group

Organisational Lead Director (or on call Duty Director for Out of Hours) must contact Organisational leads via contact numbers in terms of reference section to request a task Group conference call and agree time of call.

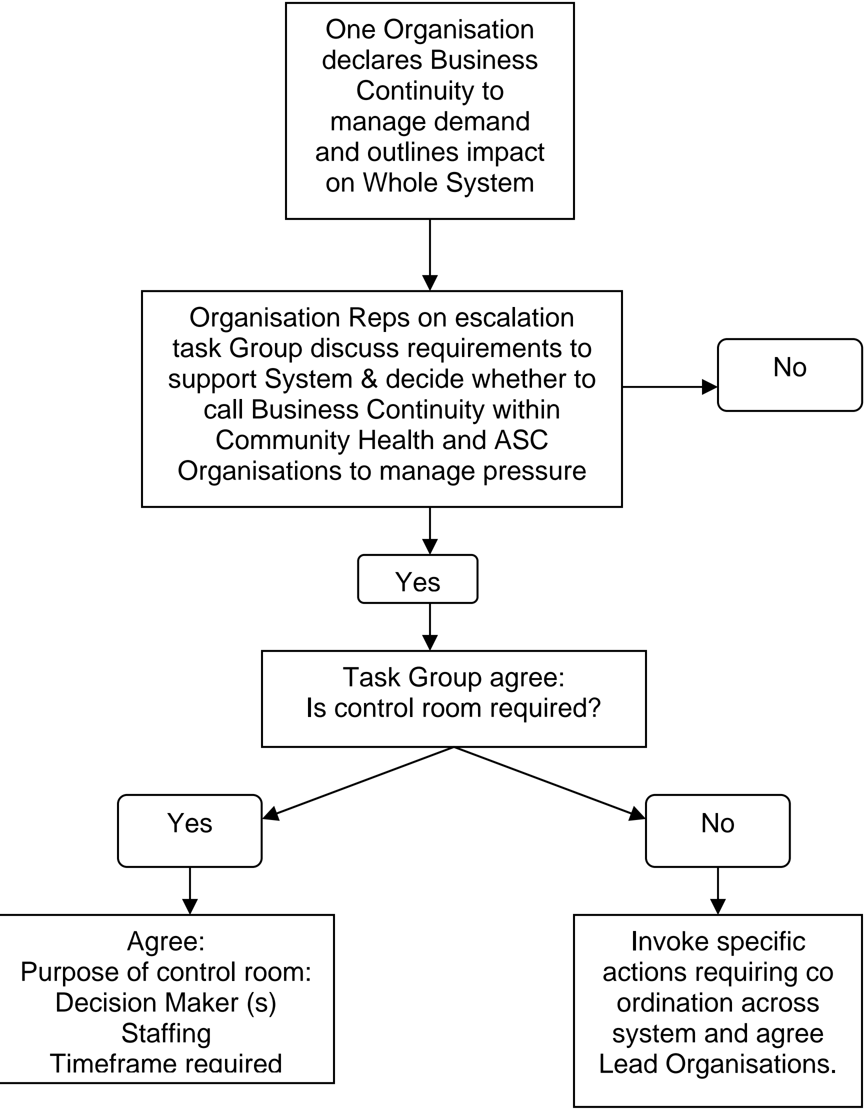
Conference call number to be used is: **0844 84 84 84 0 – passcode 485320#**

Whilst on each conference call group members must agree any times for follow up calls.



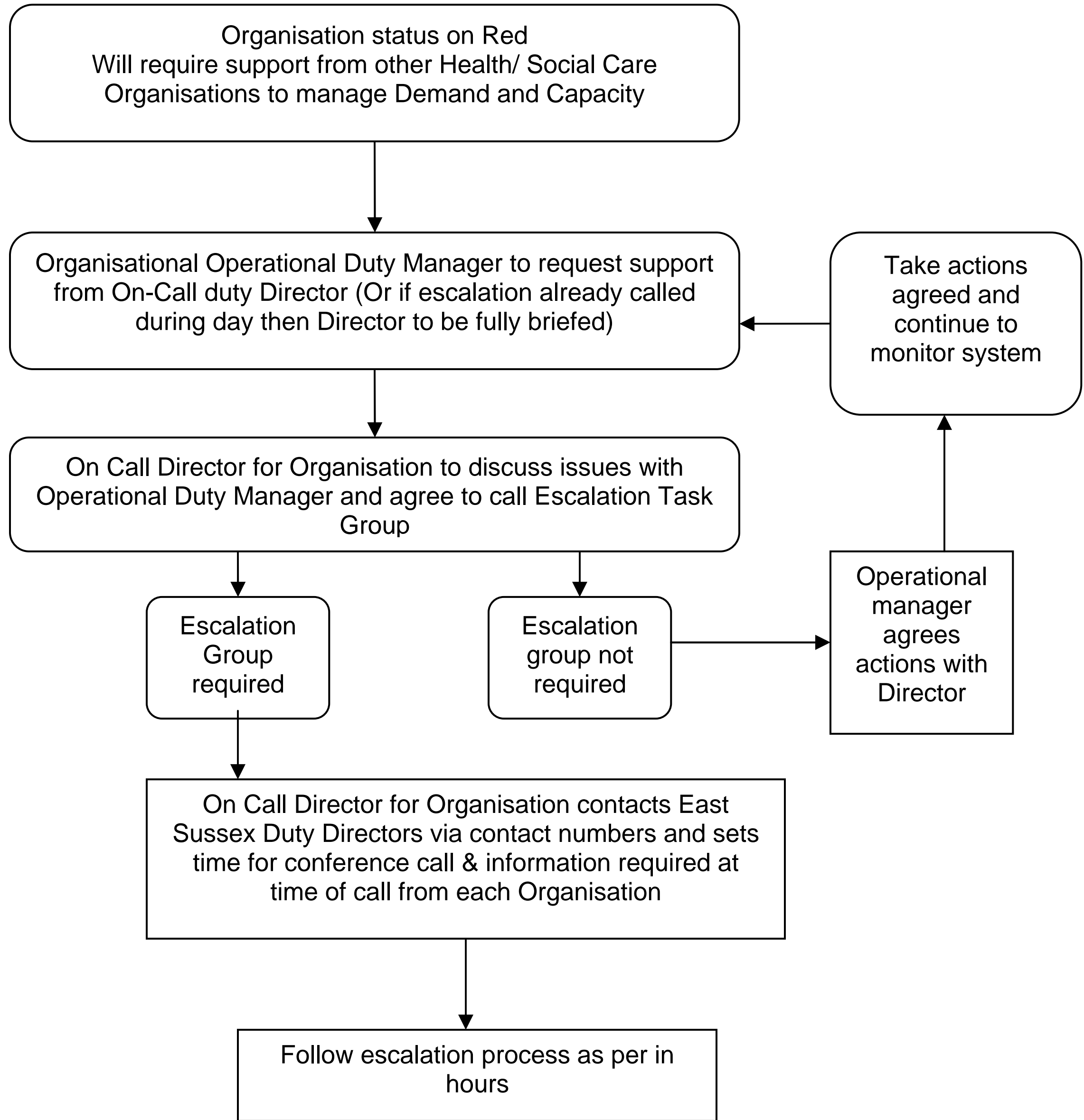
Daily System status report sent internally within each organisation Status is determined via each organisations internal measures and triggers. Status Report sent to ESHT if there is a likely impact on Whole System pathways
One or more of the Organisations are on RED status. Report of status sent to ESHT
Senior Appointed Manager for Organisation on Red requests an Operational Group conference call* is convened IF it is identified that internal triggers will affect Whole System pathways
Up to date system information from each organisation & any further supporting actions/ decisions required from the Operational Board Rounds is prepared by each Rep for their Organisation
Operational Managers Group agree actions at conference calls & decide whether an Escalation Task Group is required
Escalation Task Group required?
No
Escalation Task Group is convened with a 12.00 conference call. (Please see T.O.R for Task Group). Discuss whether Business Continuity needs to be invoked across Organisations
Lead for Task Group to contact CEO's with actions requiring agreement
Identify if Black status should be called (see trigger definitions)
Yes
C.E.O's agree actions and to manage within East Sussex only
No
No
Task Group agree:
Actions required
Timescales for each action to be achieved
Reporting agreements back to Task Group
Yes
C.E.O's to request support from Sussex Lead Organisation (West Sussex) & inform SHA
Task Group will continue to convene to receive feedback/updates against actions and agree when de escalation OR if necessary Black status should be called
De escalation agreed

Whole System Business Continuity Incident Control



Please note that Organisational Business Continuity Plans & Major Incident: Control Room should be read and referred to in conjunction with this document.

Escalation Process: Out of Hours



Escalation Process

EAST SUSSEX LOCAL HEALTH ECONOMY: ESCALATION PROTOCOL (VERSION 3 October 2011)

<table>
<tr><td>GREEN</td><td colspan="2">LEADS:</td></tr>
<tr><td><u>Organisation</u></td><td><u>Indicators / Triggers</u></td><td>Actions</td></tr>
<tr><td>ALL</td><td>SWEP definition: Sufficient capacity to handle all emergency admissions and electives due for admission in the next 4 hours</td><td>Monitor capacity across whole organisation, and escalate to Amber as soon as appropriate triggers are met</td></tr>
<tr><td>PCT</td><td>System operating to contract(s)</td><td>Review activity via regular Performance board.</td></tr>
<tr><td>ESHT (combined acute and community)</td><td>Normal service</td><td><u>Staffing</u>
• Highlight daily staffing shortages to CM's to report back within an agreed timeframe - CSM's / CM's
• Weekend staffing cover required for forward planning, report back within an agreed timeframe - CM's / CSM's
• Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe - CM's / CSM's
<u>Patient Flow, Ward Rounds, Discharges</u>
• Limited discharges - escalate to Medical & Surgical Division GM's & Divisional Administrators - CSM's / CM's /GM's
• Identify early discharges, expedite confirmed discharges using the Discharge Lounge - CSM's
• Potential discharges - clarify plan, and action as necessary - CSM's / Ward Teams
• Ensure all ward rounds have commenced by 9.30am, escalate to GM's if not achieved - CSM's / GM's
• Deliver Discharge proforma & reinforce need for info to be available by 2pm - CSM's
• Reinforce discharge benchmark for each ward - CSM's / CM's
<u>Patient Flow - A&E</u>
• Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep - CSM's both sites
• Highlight all potential breaches at 2.45 hours that do not have a plan A&E Leads / CSM's both Sites
• Highlight all potential breaches at 3.15hours that do not have a plan CSM's Both sites to CM
• A&E Lead to advise CSM's if Ambulances cannot be offloaded > 15 mins A&E Leads / CSM's both Sites
• Escalate all ambulance queuing issues to Clinical Matron, CSD if wait times exceed 30 mins CSM's Both sites / CM
• Report > 3 ambulances waiting to offload at any given time to CM CSM's Both sites / CM</td></tr>
</table>

		• Escalate all unresolved site issues to CM - CSM's Both sites / CM Critical Care Beds • Confirm plan for Patients who are suitable to move from critical care areas ITU / HDU CSM's both sites / ITU Consultants Infection Control • ICN review of side room provision (Monday & Wednesday) ICN both sites / CSM's • ICN review of specific infection control issues ICN both sites / CSM's Whole Systems • Twice weekly Operational Conference Call - DN / CM, CSD • Board Rounds - Mon AM / Wed PM - CM's
SECAmb	No delays offloading ambulances. Ambulance call volumes within expected levels.	No action for SECAmb
Primary Care	No capacity issues	No action for Primary Care
Adult Social Care	No capacity issues	Admission avoidance and discharge activity is not impacting in any way on ASCs ability to deliver personalised care and self directed support within budget.

Movement to Amber status governed by internal protocols, plus:

Following consultation with their relevant directors any of the following partners can decide to escalate from green to amber and will brief/advise green leads as appropriate:

AMBER		
Organisation	**Indicators / Triggers**	**Actions**
All	**SWEP definition - Sufficient capacity to admit all emergencies and higher priority electives**	Daily system status report sent internally to identify cause and effect of system pressures Status Report sent to Lead Director if there is a likely impact on whole system pathways
PCT		• Ensure all health assessments that are PCT responsibility are expedited • Advise Hermes GPs advised to maximise care pathways via RACOP
ESHT (combined acute and community)	Staffing ➢ Staffing < 10 nursing staff per site. ➢ Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E > 4 hours but < 6 hours. Patient Flow, Discharges ➢ <6 beds available on MAU or <2 beds available on SAU per Site before 10am ➢ <20 discharges (potential & confirmed) identified per site ➢ Medical outliers >15 but < 30 per site. ➢ < 10 beds closed per site (occupied / unoccupied) ➢ < 20 additional beds open per site ➢ Difficulty in admitting TCI's but no cancellations on the day Patient Flow – A&E	Staffing • Highlight daily staffing shortages to CM's to report back within an agreed timeframe - CSM's / CM's • Weekend staffing cover required for forward planning, report back within an agreed timeframe - CM's / CSM's both sites • Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe - CM's / CSM's both sites • Review Medical Staffing Cover for key areas - GM'S / SGM's Patient Flow, Ward Rounds, Discharges • Early discharges, utilise discharge lounge in order to create capacity in gate way areas - CSM's / MAU / SAU Teams • Limited discharges - escalate to Medical and Surgical Division GM's and Divisional Administrators - CSM's / CM's /GM's • Identify early discharges, expedite confirmed discharges using the Discharge lounge - CSM's both Sites • Potential discharges - clarify plan, expedite as able - CSM's / Ward Teams

	➢ 10 confirmed A&E breaches across the site in the previous 12 hours ➢ Up to 5 ambulances unable to offload within 30 mins within a defined 8 hour period (00.00 - 08.00, 08.00Hrs - 16.00, 16.00Hrs - 24.00HHrs) Critical Care Beds ➢ < 2 Level 3 critical care bed per site Infection Control ➢ Infection control issues impacting on bed capacity Whole Systems ➢ DTC's across site > 24 but < 30	• Ensure that all ward rounds have commenced by 9.30am, escalate to GM's if not achieved - CSM's both sites / GM's • Deliver Discharge proforma to all wards and reinforce need for info to be available by 2pm - CSM's both sites • Reinforce discharge benchmark for each ward - CSM's both sites / GM's • Identify medical outliers, ensure robust management plan in place - Medical Teams • Review rationale for closed beds and report at cross site conference call CSM's both Sites • Review rationale for additional open beds and report at cross site conference call - CSM's both Sites • Review cancellation non urgent / cancer stream TCI's - CSM's / GM's Patient Flow - A&E • Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep- CSM's both sites • Contact HERMES / PCT (GP's), South East Health re: current operational status - CSM's both Sites • Highlight all potential breaches at 2.45 hours that do not have a plan - A&E Leads / CSM's both Sites • Highlight all potential breaches at 3.00hours that do not have a plan - CSM's Both sites • A&E Lead to advise CSM's if Ambulances cannot be offloaded > 15 mins - A&E Leads / CSM's both Sites • Escalate all ambulance queuing issues to Clinical Matron, CSD if wait times exceed 30 mins - CSM's Both sites to CM, CSD • Report > 3 ambulances waiting to offload at any given time to CM, CSD - CSM's Both sites to CM, CSD • Liaise with SECamb regarding current operational status - CSM / CM, CSD • Escalate all unresolved site issues to CM CSM's Both sites to CM Critical Care Beds • Confirm plan for Patients who are suitable to move from critical care areas ITU / HDU - CSM's both sites liaise with ITU Consultants Infection Control • ICN review of side room provision (Monday & Wednesday) - ICN both sites to CSM's • ICN review of specific infection control issues - ICN both sites to CSM's Whole Systems • Twice weekly Operational Conference Call DN / CM, CSD • Board Rounds - Mon AM / Wed PM - CM's
SECAmb	1 or 2 ambulances delayed >30 minutes Ambulance demand breaching predicted peaks	Emergency Dispatch Centre (EDC) duty dispatch manager to contact crews on site and obtain SITREP, consider deployment of duty operations manger to A&E department.
Primary Care		SEH: Duty Manager actions to include: • Review demand on service • Activate standby staff as indicated Advise out of hours staff re current status to encourage delay or avoidance of admission wherever possible PCT: Primary care will deal with capacity issues within

		current contractual arrangements with the PCT. It is only when it escalates to Red that service suspensions will be considered – and then only related to flu pandemic rather than winter pressures more generally.
Adult Social Care	• Significant shortfall in capacity in residential/ nursing home sector due to e.g. home closures, admissions suspended due to safeguarding issues, lack of suitable placements • Lack of capacity in homecare (both directly provided and independent sector) • 30% reduction in Social Work / assessment capacity impacting on response times to Sec2s/5s	• Service Placement Team to prioritise referrals from hospital assessment teams and those for admission avoidance over referrals from the community • Deploy available staff flexibly to maximise assessment capacity

Escalation from Amber to Red:

IF THE ABOVE ACTIONS FAIL TO ALLEVIATE THE PRESENTING PROBLEMS A CONFERENCE CALL MAY BE REQUESTED BY ANY OF THE ABOVE PARTNERS.

RED	(LEADS: As per 'Amber': Operational Managers Group	
Organisation	**Indicators / Triggers**	**Actions**
ALL	**SWEP definition - Insufficient capacity to admit all emergency and higher priority electives Local definition – system under severe pressure, delivery of key performance targets compromised**	Senior appointed operational manager for RED organisation request a task group if identified that internal triggers will affect whole system working Task group operates as per terms of reference Task group will continue to convene to receive feedback/updates against actions and agree when de escalation OR if necessary BLACK status should be called Agree and communicate reversion of escalation as appropriate.
PCT		Participates in a task group via a conference call by 12.00pm. Based on the findings: • Implement first stage access to independent contracted beds • Convenes daily conference calls (engaging ESHT, ESCHS, ESCC, SECAmb,) • Consider whether to request escalation/cover beyond the local health economy
ESHT (combined acute and community)	Staffing ➢ Staffing > 10 nursing staff per shift per site ➢ Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E > 6 hours Patient Flow, Discharges ➢ No beds available in MAU or SAU per Site ➢ < 5 discharges identified per site ➢ Medical outliers > 30 per site ➢ 10 beds closed per site ➢ > 20 additional beds open per site ➢ TCI's cancelled on the day ➢ Elective cancellations in the previous 24 hours Patient Flow – A&E ➢ 20 confirmed A&E breaches across the site in the previous 6 hours ➢ > 6 ambulances unable to offload within 30 mins within a defined 8 hour period (00.00 - 08.00, 08.00Hrs - 16.00, 16.00Hrs - 24.00HHrs) ➢ A&E Performance <98% Critical Care Beds ➢ No Level 3 critical care beds per site Infection Control ➢ Infection control issues impacting on bed capacity Whole Systems ➢ DTC's across site > 30	Staffing • Highlight daily nursing shortages to CM's to report back within an agreed timeframe, review use of specialist nurses & review use of alternative staffing groups - CSM's / Clinical Matrons • No short notice leave to be granted < 48 hours/ review non essential training, consider re-scheduling - Divisional Directors and SGM's / DN's • Weekend staffing cover required for forward planning, report back within an agreed timeframe - CM's to CSM's both sites • Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe - CM's to CSM's both sites • Re-deploy medical staff to the front end - Divisional Directors / SGM's • Medical study leave / training sessions to be reviewed & stopped as necessary - Divisional Directors & SGM's • Audit half days to be cancelled - Divisional Directors / SGM's • Consider use of locums - Divisional Director / SGM Patient Flow, Ward Rounds, Discharges • Early discharges, utilise discharge lounge in order to create capacity in gate way areas - CSM's / Ward Teams • Limited discharges - escalate to Medical and Surgical Division SGM's and Divisional Administrators CSM's / CM's /GM's • Identify early discharges, expedite confirmed discharges using the Discharge lounge - CSM's both Sites • Potential discharges - clarify plan, and action as necessary - CSM's / Ward Teams • Continue Grand Rounds - Divisional Directors to report back to CSM's • Deliver Discharge proforma & reinforce benchmark, info to be available by 2pm - CSM's both sites • Reinforce discharge benchmark for each ward - CSM's both sites CM's Patient Flow - Bed Capacity • Review rationale for closed beds and report at cross site conference call - CSM's both Sites • Review rationale for additional open beds and report at cross site conference call - CSM's both Sites • Review plan going forward for TCI's except urgent and cancer stream - CSM's both Sites Patient Flow - A&E • Monitor Pt flow at front end, liaise with A&E leads for hourly SitRep - CSM's both sites • Contact HERMES / PCT (GP's), South East Health re: current operational status, request alternatives pathways / admission avoidance - CSM's both Sites

		• Highlight all potential breaches at 2.45 hours that do not have a plan - A&E Leads to CSM's both Sites • Highlight all potential breaches at 3.15hours that do not have a plan - CSM's Both sites / CM • Open additional bed capacity including day surgery & other clinical areas - CSM's both sites • A&E Lead to advise CSM's if Ambulances cannot be offloaded > 1 hour, implement cohorting - A&E Leads to CSM's both Sites • Escalate all ambulance queuing issues to CM if wait times exceed 30 mins - CSM's Both sites / CM • Report > 3 ambulances waiting to offload at any given time to CM - CSM's Both sites / CM • Liaise with SECamb regarding operational status, consider Divert - Deputy Ops Director / Ops Director • Escalate all unresolved site issues to Clinical Matron, CSD - CSM's Both sites / CM Critical Care Beds • Confirm plan for Patients who are suitable to move from critical care areas ITU / HDU - CSM's both sites liaise with ITU Consultants Infection Control • ICN review of side room provision (Monday & Wednesday) - ICN both sites to CSM's • ICN review of specific infection control issues - ICN both sites to CSM's Whole Systems • Increase Operational Conference Calls to daily - DN / CM, CSD with Whole System • Board Rounds - Mon AM / Wed PM - CM's • Ops Director / Deputy Ops Director to inform whole systems task group - Ops Director / Deputy Ops Director
SECAmb	3-4 ambulances waiting >30 minutes Ambulance response to emergency calls compromised	Deploy duty bronze operations manager or Clinical Team Leader to A&E department to liaise with hospital staff and update Emergency Dispatch Centre (EDC), inform duty silver operations manager. EDC silver manager to liaise with hospital on call mgr.
Primary Care	Suspension of "Non-Core" services – specifically relates to flu rather than more general winter pressures	SEH: During OOH period SEH Duty Manager will notify SEH Senior Manager on Call of situation Actions to include all at amber plus: Telephone call/ email to GPs, nurses and non-clinical staff as necessary to gain additional cover Non-clinical staff to take on emergency additional roles where skills have been identified in the planning stage For all primary medical services contracts: **Level 1: Suspensions of non core services – specifically related to flu pandemic** Where practices apply to suspend non core activity, these decisions may be delegated by the Escalation Committee and approved without further action being taken once an agreed trigger point is reached. The PCT should notify all primary care providers at a point when it is considered reasonable to suspend non core services: these activities could be suspended across the PCT area until further notice. At this point, income protection arrangements should be introduced – these may be introduced by the DH in some regions before others. These decisions will be made nationally once PCTs have made a case for such arrangements with their SHA via the designated Flu Pandemic Director. Details of core and non core services have been agreed.
Adult Social Care	• Significant shortfall in capacity in residential/nursing home sector due to e.g. home closures, admissions suspended due to safeguarding issues, lack of suitable placements. • Lack of capacity in homecare	• Deploy available staff flexibly to maximise assessment capacity in sector experiencing most critical pressure (i.e. hospital or community) • Work with NHS partners to identify and commission appropriate additional resources to target particular pressure points. • Service Placement Team to prioritise referrals from sector experiencing the most critical pressure (i.e. hospital or community).

	(both directly provided and independent sector) • 40% reduction in Social Work / assessment capacity impacting on response times to Sec2s/5s. • Delays attributable to Adult Social Care are increasing whilst the number of planned ASC discharges are decreasing	

Escalation from Red to Black:

- When RED triggers have continued for over 72 hours and not expected to resolve within the next 24 hours. Director of Operations/Deputy to liaise with the Whole Systems Group for consideration to escalation to BLACK status.

IF THE ABOVE ACTIONS FAIL TO ALLEVIATE THE PRESENTING PROBLEMS A DIRECTOR LEVEL TASK GROUP CONFERENCE CALL MAY BE REQUESTED BY ANY OF THE ABOVE PARTNERS to REVIEW THE ACTIONS IN RED, CONFIRMING THAT THEY HAD ALL BEEN EXPEDITED & 2. DECIDE WHETHER TO ESCALTE TO "BLACK" STATUS. EACH WOULD BRIEF THEIR CHIEF EXECUTIVES ACCORDINGLY.

At this stage, organisations affected should be considering implementing Business Continuity Plans.

BLACK	(Leads: As per red, plus: Directors as per terms of reference for escalation task group.)	
Organisation	**Indicators / Triggers**	**Actions**
ALL	**(SWEP definition - Insufficient capacity to admit all emergency and higher priority electives definition – system under extreme pressure, risk to life and limb.**	Managed at Head of Service/Director level where appropriate Trust director on-call contacts SHA Duty Director Task Group convenes **twice daily** to review escalation status until able to stand down Request escalation / cover beyond local health economy Agree and communicate reversion of escalation as appropriate. .
PCT		Status declaration signed off by PCT Duty Director or manager with delegated authority. Co ordinates a task group via a conference call by 12.00pm. Based on the findings: • Implement second stage access to independent beds beds (x8) • Access appropriate continuing care provision outside the normal payment limits
ESHT (Combined Community and acute)	Staffing ➢ Staffing > 10 nursing staff per shift ➢ Medical staffing issues affecting front end service delivery e.g. assessment waiting times in A&E > 6 hours Patient Flow, Discharges ➢ No beds available in MAU or SAU per Site ➢ < 5 discharges identified per site ➢ Medical outliers > 30 per site ➢ 10 beds closed per site ➢ 20 additional beds open per site ➢ TCI's cancelled on the day ➢ Elective cancellations 24 hours previously Patient Flow – A&E ➢ 20 confirmed A&E breaches across the site in the previous 6 hours ➢ > 6 ambulances unable to offload within 30 mins within a defined 8 hour period (00.00 - 08.00, 08.00Hrs - 16.00, 16.00Hrs - 24.00HHrs) ➢ A&E Performance <98% Critical Care Beds ➢ No Level 3 critical care bed per site	Staffing • Highlight daily nursing shortages to CM's to report back within an agreed timeframe, review use of specialist nurses & review use of alternative staffing groups - CSM's / CM's • No short notice leave to be granted < 48 hours/ review non essential training, consider re-scheduling - Divisional Directors and SGM's / DN's • Weekend staffing cover required for forward planning, report back within an agreed timeframe - CM's to CSM's both sites • Staffing cover for bank holiday period required for forward planning, report back within an agreed timeframe - CM's to CSM's both sites • Re-deploy medical staff to the front end Divisional Directors & SGM's • Medical study leave / training sessions to be reviewed & stopped as necessary - Divisional Directors & SGM's • Audit half days to be cancelled - Divisional Directors & SGM's • Consider use of agency staff - Divisional Directors & SGM's Patient Flow, Ward Rounds, Discharges • Limited discharges - escalate to Medical and Surgical Division SGM's and Divisional Administrators - CSM's / CM's /GM's • Identify early discharges, expedite confirmed discharges using the Discharge lounge - CSM's both Sites • Potential discharges - clarify plan, and action as necessary - CSM's / Ward Teams • Instigate Grand Rounds Divisional Directors • Deliver Discharge proforma & reinforce benchmark, info to be available by 2pm, reinforce discharge benchmark - CSM's both sites • Cancel all TCI's GM's / Admissions Team Patient Flow - Bed Capacity • Early discharges, utilise discharge lounge in order to create capacity in gate way areas - CSM's / Ward Teams • Review rationale for closed beds and report at cross site conference call - CSM's both Sites

	Infection Control ➢ Infection control issues impacting on bed capacity Whole Systems ➢ DTC's across site > 30	• Review rationale for additional open beds and report at cross site conference call - CSM's both Sites • Review plan going forward for TCI's except urgent and cancer stream CSM's both Sites Patient Flow - A&E • Monitor flow at front end, liaise with A&E leads for hourly SitRep - CSM's both sites • Highlight all potential breaches at 2.45 hours that do not have a plan - A&E Leads to CSM's both Sites • Contact HERMES / PCT (GP's), South East Health re: current operational status, request alternatives pathways / admission avoidance - CSM's both Sites • Highlight all potential breaches at 3.15hours that do not have a plan CSM's Both sites to CM • Escalate all ambulance queuing issues to Clinical Matron, CSD if wait times exceed 30 mins CSM's Both sites to CM • Report > 3 ambulances waiting to offload at any given time to CM, CSD CSM's Both sites to CM • Liaise with SECamb regarding operational status, consider Divert Deputy Ops Director / Ops Director • Escalate all un-resolvable site issues to CM- CSM's both Sites Critical Care Beds • Confirm plan for Patients who are suitable to move from critical care areas ITU / HDU CSM's both sites liaise with ITU Consultants Infection Control • ICN review of side room provision (Monday & Wednesday) - ICN both sites to CSM's • ICN review of specific infection control issues - ICN both sites to CSM's Whole Systems • Daily Operational Conference CallDN / CM, CSD • Board Rounds - Mon AM / Wed PM - add in Friday - CM's • Daily Whole Systems Task Group - Ops Director / Deputy Ops Director
SECAmb	Unable to offload at A&E/MAU/CDU/etc Cat A response target < 70% Ambulance delays directly affecting response to 999 calls	EDC ensure red actions have been undertaken, duty silver managers EDC and operations to consider escalating to gold.
Primary Care	Acute trust unable to admit GP referrals to MAU or ward Level 2 & 3 trigger points – flu escalation strategy.	SEH: During OOH period SEH Senior Manager on call will be aware from red status previously Wherever clinically safe, patients contacting the call centre with routine (i.e. non-urgent) conditions will be advised to delay accessing health services SEH Senior Management will attend affected bases to co-ordinate clinical service and support prioritisation processes **Levels 2: Managed Suspension of services and** **Level 3: Full Suspension of Services** Where there is a request from practices to suspend some or all core services, however, the PCT will need to ensure patients can still access these services either by: • redeploying staff to support practices, or; • by requesting a "buddy" practice to care for the list of patients.
Adult Social Care	Demand for services significantly outstrips capacity	Exercise freedoms available as a result of declaration of major incident.

	to provide them. • 50% reduction in Social Work / assessment capacity impacting on response times to Sec2s/5s.	Restrict delivery of services to those in the highest category of need to assure the continued safe operation of acute hospital services and secure the immediate safety of the most vulnerable in the community

Terms of Reference
Operational Managers Group

Purpose
The Operational Managers Group will be the Primary Group for discussing System pressures and agreeing immediate remedial actions required by each organisation in order to sustain and improve effective patient pathways. It will oversee the Action plans agreed and monitor impact.

Terms of Reference

- To alert the Whole System to immediate or imminent pressures that will have an impact on Whole System pathways
- Members are to be fully briefed with their own organisations Alert status and capacity PRIOR to the Conference call in order to be able to agree to Action Plan
- Group should be able to operate 7 days a week
- To discuss options for maintaining system throughput
- To agree remedial actions required by each organisation
- To performance monitor action plans
- To agree if Black Alert status may be required and take actions to co ordinate and call Escalation Task Group. All members are to ensure that the Escalation Task Group Reps are fully briefed with all information regarding pressures and actions taken to date
- To ensure accurate recording of triggers leading to Alert Status in order to analyse for any trends
- Membership is appropriate to the level of Authority required to agree to remedial actions

Proposed Membership

Organisation	Post Held	Contact Details	2nd Contact details
East Sussex Healthcare Trust	Whole System Patient Flow Manager	**Pauline Butterworth 07795258828**	**Flowie Georgiou 07824868864**
East Sussex PCT's & Adult Social Care	Head of Continuing Health Care	**Mark Shipman 07876037328**	**Sally Keeffe 07825682628**
Adult Social Care East Sussex County Council	Head of Assessment and Care Management	**Andy Cunningham 07769239142**	**Bryan Lynch 07879117405**

Terms of Reference
Escalation Task Group

Purpose
The Escalation Task Group will be the Accountable Group for discussing System pressures and agreeing immediate remedial actions required by each organisation in order to sustain and improve effective patient pathways. It will oversee the Action plans agreed and monitor impact.

Terms of Reference

- Members are to be fully briefed with their own organisations Alert status and capacity PRIOR to the Conference call in order to be able to agree to an Action Plan
- Membership is appropriate to the level of Authority required to agree to remedial actions
- Task Groups will set up within 4 – 24 hours dependent on urgency level agreed by the Operational Managers Group
- Group should be able to operate 7 days a week
- To review actions taken by the Operational Managers Group to date and discuss requirements for any further actions by any of the Organisations
- To agree to frequency of calls required
- To performance monitor action plans
- To agree if Black Alert status or Business Continuity across Organisations needs to be called
- Should Black Alert Status be called each member is responsible for ensuring that the C.E.O's are fully briefed
- Agree communications to the SHA and C.E.O's
- To maintain Whole System communication
- To agree when de escalation is called and ensure appropriate communication of this across the system
- All Leads are responsible for ensuring that a Rep for their Organisation is available on all calls
- The Task Group will hold quarterly meetings to review trends and issues arising from the escalation process

Proposed Membership

Organisation	Post Held	Contact Details	2nd Contact details	Out of Hours Contact Numbers for Organisation
East Sussex Healthcare Trust	Deputy Director of Operations	**Jane Darling, 07826 533763**	**Andy Horne 07919306376**	**01323417400 On Call Exec Director**
East Sussex CCGs	Hastings and Rother CCG Lead Manager	**Graham Griffiths.** **Office: 01273 485430** **Mobile: 07500228282**	–	**Director on-call: Dial 08448 222 888 and quote pager number 944577 to call handler and dictate your message**
Adult Social Care East	Assistant Director	**01273 481167** **07808 061802**	**07919227627**	**07919227627**

Sussex County Council	Operations			
South East Coast Ambulance Trust	Senior Operations Managers	**James Pavey, Brighton, Hove and Rother (East Sussex) 07798 926037 Lorna Stuart, West Sussex 07768 253488 Peter Radoux, Crawley & Horsham area 07770 252438**	**On-call Silver manager, Contact via Emergency Dispatch Centre.01273 402114**	**Via Emergency Dispatch Centre, Duty Dispatch Manager. 01273 402114**
Sussex Partnership Foundation Trust		**Neil Waterhouse 07798641723**	**John Beeton 07919484576**	**On call manager 01323 440022**
BSUH		**On call Manager and On Call Director 01273 696955 ask switchboard to bleep**		**On call Manager and On Call Director 01273 696955 ask switchboard to bleep**

Agenda: Task Group Conference Calls

Item Number	Agenda	Lead
1.	Introductions from all members on Task Group call	
2.	Outline of system pressures and reason for invoking Task Group	
3.	Operational Managers report re: decisions and actions requiring authorisation	
4.	Agree actions and timescales	
5.	Discussion/Decision re: invoking actions requiring co ordination across system via Lead Orgs	
6.	Discussion/decision re: establishing Control Room for East Sussex and role/ purpose of the Room & length of time likely to be required for staffing. Refer to Business continuity and emergency plans for guidance	
7.	Agree alert status	
8.	Time of next conference call	

Communications Lead Organisations

Details	Contact No.	e-mail address

PCT to contact South East Health		Senior.Manager@sehnp.nhs.uk
PCT to contact Hermes	**0300 130 3045**	hermes@harmoni.co.uk
PCT to contact SECAMB	**On-call Silver manager, Contact via Emergency Dispatch Centre.01273 402114**	
PCT to contact GP's via Communications Team and Head of Primary Care	**ESDW Kristy Bernard, 01273 485360** **H&R Linda Owen 01424 735646**	Kirsty.Owen@esdwpct.nhs.uk Linda.Owen@hastingsrotherpct.nhs.uk
PCT Coordination of South East Coast Escalation call to lead Organisation – West Sussex		
ASC to contact Independent providers (residential/care homes and home care) via Service placement team	**Duty Pager Number 07699 715805**	
ASC to inform ICAP and agree action/priorities required to support process	**0300 678 0010**	esdw-pct.icap@nhs.net
Public Communications	**Lead PCT Comms Team Jamie Whitburn**	Jamie.whitburn@esdwpct.nhs.uk

Useful Out of Hours ASC Hospital Contact Numbers

Details	Contact Numbers
EDGH	**01323 417400 (Bleep 0665)** **01323 414905**
Conquest Hospital	**01424 757007** **07748933043**
Operations Manager on Duty	**07876 037312**
Head of Service on Duty	**07919 227627**
DPS Resource Officer	**07733 484891**
EDS	**01323 636399**
ICAP	**0300 67 800 10**

Action Plan: Escalation Task Group **Date:**

Action Agreed	Lead Responsibility	Timescale	Update

Task Group Outcome Monitoring Form

Date Task Group Called	Organisation Initiating Task Group	Internal Indicators Causing trigger	Issues Affecting implementation of Action Plan	Timescale from Task Group forming to De escalation

APPENDICES

NHS EAST SUSSEX DOWNS & WEALD/NHS HASTINGS & ROTHER

DECLARATION OF INTERNAL MAJOR INCIDENTS

1. At an SHA EP Steering Group discussions took place relating to declaring an internal major incident and the appropriateness of this action. It was agreed to follow-up the question of whether it would be possible to standardise (capacity) escalation triggers.

2. Having researched the DH guidance on the declaration of internal Major Incidents. The latest DH guidance: Strategic Command Arrangements for the NHS During a Major Incident (published in December 2007) clarifies the situation on page 6/7 paragraphs 5 and especially 6:

3. Throughout this underpinning document, the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders. If the emergency does not meet this criteria then it is a Business Continuity Incident (BCI). (SECAMB declaration of a BCI on 13th January 2010 during the snow disruptions is a good example of a BCI).

4. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition above. Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising solely from staff shortages, waiting list pressures, management failures or other local institutional deficiency, they should invoke their business continuity plans. The accompanying ethical and medico-legal endorsement that will support NHS organisations and staff in an appropriate escalation response will not be applicable in other circumstances.

5. It is therefore clearly up to individual NHS organisations to manage their business continuity

pressures whether due to bed capacity or staff shortages. The escalation plans trusts develop will naturally reflect models which best fit their organisation. This will result in the escalation triggers differing in meaning from neighbouring trusts, but this should have no consequential impact.

David Wolfe Head of Emergency preparedness & Response

APPENDIX 3

Agenda and Action Log for Pan Sussex Escalation Calls

Agenda Topic	Status Updates	Actions agreed	Responsibility	Timeline
Escalation status of each provider, including requests/proposals to resolve				
Divert from affected Trusts (agreeing time limit, borders etc)				
Involvement with other agencies eg liaison with SoE, Social care etc…				
Communications – internal and external and by whom				
Further conference calls or stand down				

Business Continuity Management

Severe Weather Plan

Version 2.0

Issued November 2011

The Information contained within this document is strictly confidential and is exclusively for the use of East Sussex Hospitals employees

Severe Weather Plan

Distribution

The East Sussex Hospitals plans are distributed to authorised personnel to assist in the definition and understanding of responsibilities and procedures related to a business disruption which has been caused by a physically disastrous event. This plan, therefore, is intended for an individual's use only while an employee of East Sussex Hospitals.

Upon any business unit change of employment status, it is each individual's responsibility to return their assigned copy and all duplicates and duplicate parts thereof, to their respective management.

No one outside of East Sussex Healthcare NHS Trust will be permitted to read, review, copy or audit the plan without prior written approval.

Amendments

Date amended	Page	Section	Notes

This Plan was produced by the Trust Emergency Planning Officer who gratefully acknowledges the help and assistance from East Sussex Fire & Rescue Service in its preparation.

Index

Page

Amendments 2
Summary 4
Aims and Objectives 5
Exercising, validation and review 5
Risk Assessment 6
Roles and Responsibilities 7
Notification of staff and partners 7
Partner telephone numbers 8
Severe Weather warning actions 9
Met. Office Severe weather warnings 10
Generic step level actions 11
Risks to normal levels of service 12
Generic management considerations 13
Appendix A. Heavy rain fall / flooding risk 16
Flood risks in East Sussex 16
Environment Agency Flood Warning codes 17
Appendix B. Gales or storm force winds 18
Wind speeds – The Beaufort Scale 18
Management considerations 19
Appendix C.
Tornadoes 20
Appendix D.
Heavy Snow 21
Appendix E.
Extreme Cold 22
Appendix F.
Operation of Trust Snow Desks 27
4x4 contact details 28
Appendix G.
Algorithm for use for Sussex 4x4 Response 30
Appendix F.
Heatwave 31

Summary

Purpose

East Sussex Healthcare Trust (ESHT) has a dual responsibility in dealing with Severe Weather events, that of a responder and also a need to ensure Business Continuity allows that response to continue. This document forms part of the ESHT Business Continuity Plan. It specifically refers to procedures and processes that are required to ensure the continued provision of critical services provided by East Sussex Healthcare whilst the subject of, or as a direct effect of a **Severe Weather** incident either local or elsewhere in the country or near Continent.

Management strategies and team composition will be as defined within the Business Continuity Policy

Scope

Severe or extreme weather can take many forms and have differing impacts on our ability to deliver our critical functions to an appropriate level.

Severe Weather events cover the following types:-

- Heavy rain – resulting in flooding
- Gales or storm force winds – resulting in structural damage or storm surge flooding
- Heat wave – as defined by the Met Office/DoH
- Heavy snow
- Extreme cold
- Tornadoes

Impact scope

Within the terms of the Civil Contingencies Act 2004 (CCA) ESHT is required to continue providing service as far as practical whilst the Trust is itself the subject of an emergency.

This will present specific impacts on the service during Severe Weather events as follows:

- Loss of premises – destruction, denial
- Staff absence – transport, illness, as carers, as victims
- Information and communications technology - disruption
- Utilities supplies – water shortages, power outages
- Equipment supply chain – internal, external
- Other supplies – fuel, food, finances

Operational Procedures

Operational procedures are not covered in this document but may be referred to.

Aim

To provide direction and guidance to managers in the event of a Severe Weather incident and to assist in enabling ESHT to maintain critical functions.

Objectives

- To assist ESHT to prepare and where appropriate take mitigating actions to improve its capability to deal with a Severe Weather event.
- To provide information and welfare support to all staff.
- To maintain staffing levels and resource allocation during severe weather.
- Inform, liaise and communicate with partner agencies.
- To deal with the event in a professional, effective and efficient manner.
- Promote community recovery and return to "business as usual" as soon as possible.

Generic Plan

The Severe Weather Plan includes the following:

- A generic process that shall be followed in any Severe Weather event.
- Understanding of Warnings.
- Likely impact of different weather types.
- Appendices giving specific guidance or considerations for different weather events
- Reference - Resilience Forum Plans, ESHT BCP.

Exercising and validation

A legal requirement exists under the CCA that plans should be exercised.

For purposes of exercising the procedures contained within this document are deemed to be additions to Business Continuity Plans and will not be exercised in isolation.

For example: A major incident exercise could involve a severe weather scenario.

Plan Review

This plan will be reviewed annually by November 1st and also on each occasion that it is used to respond to a severe weather incident.

Weather Warning Risk Assessment

The table below is intended as a guide to the likely impact of severe weather given varying ground, precipitation levels and wind forces. Where there is a doubt of risk to life or damage to multiple properties being affected, consultation with the Environment Agency Duty Flood Officer and partner agencies should commence immediately.

Impact	Likelihood	Risk	Action
Considerable risk to sea defences likely to generate Severe Flood warnings with risk to life and widespread damage to property which may or may not include Trust premises.	Above normal high tides, south or south-westerly winds force 8 or above.	**Very High**	**Activate Plan**
	Ground conditions saturated. More than >50mm of rain in 24 hours		
	Forecast of Storm surge		
Widespread disruption to transport and likely to effect Service Delivery	Imminent forecast of heavy snow > 100mm with possible drifting		
	Partner Agencies Activate emergency plans		
Conditions likely to cause problems to Health & Welfare and increased admissions	Imminent forecast of Extreme cold or Heat Wave conditions (As defined by Met Office thresholds)		
Risk to sea defences localised flood warnings some flooding of property and roads contact partner agencies and monitor flood warnings from the EA Or widespread surface water flooding	Above normal high tides, south or south-westerly winds up to force 8	**High**	Monitor weather and flood warnings **Consider activation of plan**
	Ground conditions saturated. Up to 50mm of rain in 24 hours		
	Forecast of snow >50mm greater than 60% confidence		
	Forecast of Extreme cold or Heat Wave conditions		
	Extreme rainfall >50mm in 8hours		

Impact	Likelihood	Risk	Action
Some over topping of sea defences. Likely to generate local flood watches and minor flooding to low lying areas. Monitor flood warnings from the EA	Above normal High tides winds up to force 6	**Medium**	Monitor weather and flood warnings **Consult with partners**
	Ground conditions Saturated. up to 25mm of rain in 24 hours		
	Early warning of snow >60% confidence		
Likely to generate local flood watches and minor flooding to low lying areas. Monitor flood warnings from the EA	Medium or low tides, ground conditions normal, winds less than force 6. Less than 25mm of rain in 24 hours	**Low**	Monitor weather and flood warnings

Roles and Responsibilities

Roles and responsibilities of various individual and group roles.

Role	Responsibilities
Emergency Planning Officer	Monitor weather warnings. Consider the risk and likelihood. Consider tide times and height. Consult with EA and Met Office and partner agencies. If there appears to be reason to consider further action inform Clinical Site Management Team (CSMT), Senior Manager or Chief Operating Officer or , out of hours, on Call Director If the decision is taken to activate the plan, ensure arrangements for a Emergency Management Team (EMT) are being put in place. Assist CSMT to inform partner agencies if plan is activated.
Clinical Site Management Team (CSMT)	Monitor weather warnings, inform Emergency Planning Officer and Duty / On Call Manager / Director if there is cause for concern. If the plan is activated, notify partner agencies (with assistance from EPO if available) Advise staff of potential severe weather via Comms. Team Instigate any other appropriate response e.g. during heavy snow ensure HR are opening the Snow Desks and that 4x4 drivers have been alerted.
Communications Team	Notification of staff and media press statements

Notification of Staff and Partners

In the event of activating this plan it will be important to inform our staff and partner agencies of our intentions. This will need to be co-ordinated to ensure the correct information goes to the correct people.

The Emergency Planning Officer (EPO), if available, can assist with informing partner agencies.

The table below lists those to be notified.

The numbers marked * are NOT publically available and are for the use of Category 1 Responders only. These will be removed from some copies of this plan.

The Emergency Planning Officer (EPO), if available, can assist with informing partner agencies.
Contact details for EPO - Pager via switchboard.
Mobile 07825 680369

To be notified	By	Means of contact	Telephone number
Directors and Managers (including on call)	CSMT	Telephone and e-mail	Via ESHT switchboard
Staff	Comms team	Email & intranet	Not applicable
Sussex Police	CSMT/EPO	Sussex Police Control Room	01273 665566* Direct to Duty Inspector
Brighton & Sussex University Hospitals	CSMT	RSCH Switchboard	01273 696955
Western Sussex Hospitals	CSMT	Worthing Hospital Switchboard	01903 205111
NHS Sussex	CSMT / EPO	Duty ERMT pager	08448 222888 Pager 502270
East Sussex County Council Emergency Management Team	CSMT / EPO	Office hours Out of hours via Lifeline	01323 747090 01323 644422 / 410051
South East Coast Ambulance	CSMT / EPO	Lewes EDC	01273 488412*
East Sussex Fire and Rescue Service	CSMT / EPO	Fire Control. Eastbourne	01323 462462*
Environment Agency Kent & East Sussex	CSMT / EPO	National Incident Control	0845 850 3518*

Severe Weather Warnings

Severe and Extreme Weather Warnings

Warning maps are shown on the Met Office website and are colour coded

	Green	Yellow	Amber	Red
Warning	None	Advisory	Early	Flash
Risk	Very Low / Low	Moderate (be aware)	High (be prepared)	Very High (take action)
Warnings issued	None	Issued daily at 11am As routine	Updated daily and Severe weather is expected in the next few days	As required and indicates weather is imminent or already occurring
% Probability	≤ 20 / 20%- 40%	40%- 60%	60%- 80%	≤ 80%
Headline	No severe weather expected	Moderate risk of severe weather	High risk of Severe weather	Severe weather is occurring or is imminent
Impact		Moderate risk of some damage to Infrastructure or local disruption	High risk of damage or disruption	Very high risk of damage and disruption
Advice		Check weather forecasts	Remain vigilant. Consider possible areas that could be affected Regularly check for Weather updates	Take any possible precautions. Access latest weather updates
ESHT Considerations		Check high tide times Assess previous impacts Of severe weather on the Hospitals. Consider Getting further advice From Met Office or EA Duty Flood Manager Or Trust EPO.	Check high tide times Assess previous impacts Of severe weather on the Hospitals. Consider Getting further advice From Met Office or EA Duty Flood Manager Or Trust EPO.	Contact Trust EPO For latest updates or to liaise with Met Office or EA Duty Flood Manager. Consider advising Estates & Facilities Duty Officer. Consider need for an EMT to be formed. Discussions between CSMT, Senior Manager, Director or those on Call. EPO to consider attending the daily conference calls between CSMT
Actions by Trust		EPO to monitor forecasts and circulate information.	EPO and CSMT to monitor forecasts. EPO to update information. Possible that staff will need to be advised using intranet	EPO to advise CSMT and On Call manager by telephone if alerts received out of hours. EPO to circulate any other information by email.
Communications to staff		Consider the need to advise staff of the potential for bad weather	Consider the need to advise staff of the likelihood of bad weather	Consider the need to warn staff of the approaching or imminent bad weather
Plan activation?		Plan MAY be required	Review Plan and prepare to activate if needed	Consideration should be given to activating the plan.

More information on warnings at www.metoffice.gov.uk/weather/uk

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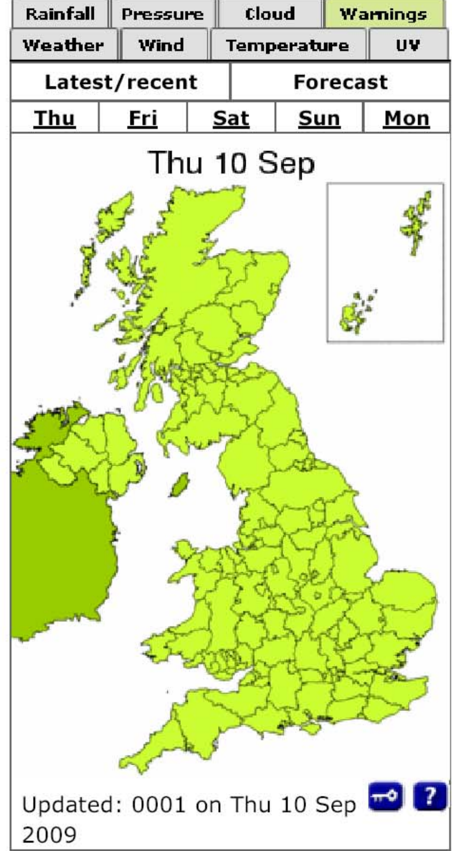
UK: severe weather warnings



Digital Map Data:
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Postcode information:
© Royal Mail Group PLC (2006)

Weather warnings overview

No warnings have been issued for the UK

Map regions coloured show where severe weather warnings have been issued.

The Met Office has responsibility for providing weather warnings for the UK.

For further information on the impacts caused by the weather go to our severe impacts severe weather impact links.

To ensure that you see the latest warnings you should refresh this page.

Flash warnings of severe or extreme weather

These are issued when the Met Office has 80% or greater confidence that severe weather is expected in the next few hours. If warnings have been issued, click on the region affected to see more detail.

Region affected	Warning type	Valid from	Valid to

No flash warnings have been issued for the UK.

Early warnings of severe or extreme weather

These are issued when the Met Office has 60% or greater confidence that severe weather is expected in the next few days.

Risk of disruption	Warning	Valid from	Valid to

No early warnings have been issued for the UK.

Advisory of severe or extreme weather

These advisories are issued by 1300 daily as routine, though they may be updated at other times if required. They indicate confidence of expected severe or extreme weather. Early warnings and Flash Warnings supersede advisories when confidence levels are 60% or greater.

Risk of disruption	Warning	Valid

No advisories have been issued for the UK.

Step Level Procedure (Generic)

Invocation

At any time where the response of ESHT is compromised due to severe weather a Senior Manager will be advised of the situation, typically this will be through the CSMT

Senior Manager Role

The Senior Manager will decide upon the evidence whether further action is appropriate and if an Emergency Management Team is required to manage the incident.

Recovery

CSMT will monitor the loading placed upon East Sussex Healthcare and relax the contingency conditions if appropriate.

Contingency Steps will be monitored continuously and readjusted at shift-change and /or at the twice daily video conferences which may be increased dependant on the incident and impact on the Trust.

Risks to normal level of Service

Each section of the plan lists the potential problems with our ability to deliver a normal and acceptable level of service. Department and Service Business Continuity plans identify critical functions and will provide guidance or actions.

The table below lists the risks many of which apply to more than one type of weather event.

RISK	Considerations	Action
Staff Shortage	• Reduced staffing on wards and in essential departments. • Relocate staff to assist in critical functions. • Consider reduction of elective and outpatient services and redeployment of staff • Consider the use of assistance from partners or voluntary agencies i.e. ESCC, NHS Sussex, St John Ambulance, British Red Cross, Private Hospitals • Consider preparing spare staff accommodation for staff unable to get home. • Provide refreshments and consider extending service of hot food for staff beyond normal operating hours. • Recalling staff back to duty	On the instruction of CSMT
Difficulty or inability to move staff or patients due to road conditions, flooding, deep snow etc.	• Short term hire of 4 X 4 vehicles. Use of Sussex 4x4 Response. • Request air support from partner agencies i.e. Sussex Police, Military. • Request Mutual assistance from services with off road vehicles e.g. MCA. • Request assistance from voluntary sector for 4x4 vehicles for discharges e.g. St John Ambulance • Request assistance from voluntary sector for staff transport e.g. Sussex 4x4 Response, All Terrain Vehicles, Raynet, Beachy Head Chaplaincy, St John Ambulance, Red Cross • Set up staff transport desk(s) to coordinate use of 4x4 vehicles.	On the instruction of CSMT
Hazardous driving conditions	• Seek advice from Highways Agency and Sussex Police about road conditions. • Warn all staff of the conditions and hazards • Restrict vehicle movements to essential journeys only • Request updates from Trust drivers on conditions locally	EPO and Communications Team
Potential for increased demand on ED and other services	• Increase staffing in ED, MAU and SAU • Consider redeployment or calling in additional specialist staff e.g radiographers, plaster technicians • Media messages informing the public to only attend hospital if essential • Messages to GP services via PCT to restrict hospital admissions to emergency cases only • Message to nursing homes via PCT and ESCC to restrict hospital admissions to emergency cases only. • Consider stock levels of essentials e.g. plaster, blood, medical gases etc and check availability / time for re-supply	On the instruction of CSMT
Disruption or potential of to utility services (See Staff welfare)	• Contact suppliers for potential for the loss of supply • Departments refer to Business Continuity Plans • Possibly hire generators, mobile toilets, heaters etc for critical sites • Consider obtaining emergency drinking water supplies.	Estates and Facilities

Risk	Considerations	Action

Staff welfare and monitoring	• All managers will monitor staff operations to ensure welfare issues are identified early and appropriate provisions put in place during utility failures • The provision and preparation of food and hot beverages will be compromised. Heating or ventilation systems are likely to fail. • During extreme conditions staff will often work longer hours (Remain on duty) • Rest periods may need to be increased • Staff accommodation may need to be made ready to allow staff to stay on site • Additional provision of hot drinks may be required, ensure Catering Manager is consulted and consider, if needed, use of the voluntary sector – WRVS, Red Cross, Salvation Army or outside caterers	All Managers
	Hypothermia Monitor signs and symptoms provide regular breaks and warm refreshments	All managers
	Dehydration. Monitor signs and symptoms provide regular breaks and liquid refreshments	All managers
	Heatstroke. Monitor signs and symptoms provide regular breaks, relax PPE and / or uniform requirements (move to scrubs ?) and provide sufficient liquid refreshments	All managers

Generic Management Considerations

Consider	Informed by	Comments
Putting staff on stand-by for a Major Incident	EPO CSMT	This will give notice to staff to be prepared and allow them to respond quickly in the event of a major incident, or business continuity incident, being declared.
Sending staff home or allowing them to work from home	CSMT Senior Managers / Directors	Where a warning is received of impending weather conditions may prevent staff from travelling home at their normal time. Consider sending staff home early or providing on-site accommodation. Consider use of 4x4 or other specialist vehicles for staff transport.
Prepare areas for staff to sleep and obtain refreshments if they are unable to get home	CSMT Estates and Facilities	Open up available spare accommodation and ensure that feeding and refreshment arrangements are in place for staff who can not get home or who elect to stay on site due to distance to travel to their homes.
Relocation of key equipment and staff	CSMT	If weather forecast is worse for one hospital area than another consider moving staff and equipment to the worst affected site, ahead of the weather, to increase resilience at that hospital.
Print off flood maps of areas likely to be affected	EPO Medical Photography	Large maps of areas likely to be effected will assist in response and planning
Consider getting additional advice from *Environment Agency*	EPO CSMT	The Environment Agency keep up to the minute information on water levels in rivers and streams and may be able to provide updated information on areas to be affected.
Facilities and estates may deploy additional resources	Facilities and Estates	Dependant on the cause they may be able to offer extra staff for snow clearance or gritting, placement of sand bags, deployment of fans etc

Appendix 'A' - Heavy Rainfall/ Flooding risk

Introduction

Heavy rainfall can occur at any time of the year and depending on previous weather and ground conditions may result in serious disruption. Good examples would be summer storms after a long hot and dry spell, or where the ground is already saturated.

In addition to the high risk flood areas identified many localised areas are subject to surface water flash flooding.

This Plan contains the Flood Warning Action Codes and the considerations which may assist Managers in making an assessment of the risk and impact any flooding may have.

Risks to Service

- Staff shortage
- Hazardous driving conditions
- Inability to deliver community based services
- Potential for increased presentations at EDs
- Disruption to Utility Supplies
- Increased hazards to staff
- Staff Welfare

Consider	Informed by	Comments
Actioning local flood plans.	EPO	Local multi-agency response plans have been produced for Lewes, Seahaven, Pevensey, Bulverhythe, Uckfield and Rye
Sending a Liaison Officer to a multi-agency control	EPO	To liaise and assess the situation with other agencies This action is recommended in the local response plans but may be considered prudent in other flood risk areas
Consider need for additional precautions at EDGH	Estates and Facilities EPO	During a flooding event consideration of the possibility that the DGH may be affected and additional safeguarding measures e.g. sandbags, checking pumps in cellar areas etc may be prudent. The four community hospitals are all on higher ground and not shown as in immediate danger from fluvial flooding.
County Council *Emergency Planning*	EPO	May be able to provide local information on roads and availability of equipment and resources e.g. sandbags, pumps etc. Also the link for military assistance if patients in danger from flooding at a hospital.

The flood risks in East Sussex

Pluvial – rainfall

Fluvial – stream /river

Tidal - Tidal surge

Location	Flood Risk
Lewes	Pluvial/Fluvial/Tidal
Uckfield	Pluvial/Fluvial
SeaHaven	Tidal
Bulverhythe	Tidal
Pevensey	Tidal
Rye	Tidal

Flood Warnings

Flood warnings are issued in the categories below. Each flood warning will relate to a specific flood area. Information regarding flood areas and the likely number of properties to be affected is held within MISR.

These warnings may be in force prior to any severe weather warning

Flood Code	Issued	Impact	Action
FLOOD ALERT	Two hours to two days in advance of flooding.	Flooding is possible. Be prepared	Emergency Planning Officer to monitor situation
FLOOD WARNING	Half an hour to one day in advance of flooding	Flooding is expected. Immediate action required	Emergency Planning Officer to inform Chief Operating Officer, CSMT, On Call Manager or Executive of warning and consider activating plan
SEVERE FLOOD WARNING	When flooding poses a significant threat to life.	Severe flooding. Danger to life.	EPO to advise Chief Operating Officer, On Call Manager or Executive and suggest that we **Activate plan.** EPO to inform CSMT and Managers of the warning and provide information regarding the impact from the Environment Agency. Notify partner agencies when plan has been activated.
Warnings no longer in force	Warnings no longer in force	No further flooding is currently expected in your area.	EPO to issue an 'all clear'

Appendix 'B' – Gales or Storm Force Winds

Introduction

The prevailing wind across the UK is from a south-westerly direction this has the potential to cause problems due to our location on the south coast the combination of high tides and gale force winds could cause over- topping, breaches within sea defences or storm surges.

Additional problems may result from high winds along the coast which could result in fallen trees and an increased risk from road crashes.

Risks to Service

- Staff shortage
- Reduced ability to provide community based services
- Hazardous driving conditions
- Increased potential for injury around the hospital sites
- Potential for increased attendance at EDs and MIUs.
- Disruption to Utility Supplies
- Staff Welfare

Warnings and information

Strong wind warnings will be issued as with any severe or extreme weather event. The Beaufort scale is reproduced below. The value lies in its ability to estimate wind speed using common objects as the reference point, without the aid of weather instruments.

Beaufort number	Wind speed				Mean wind speed (kt / km/h / mph)	Description	Wave height		Sea conditions	Land conditions
	kt	km/h	mph	m/s			m	ft		
0	0	0	0	0-0.2	0 / 0 / 0	Calm	0	0	Flat.	Calm. Smoke rises vertically.
1	1-3	1-6	1-3	0.3-1.5	2 / 4 / 2	Light air	0.1	0.33	Ripples without crests.	Wind motion visible in smoke.
2	4-6	7-11	4-7	1.6-3.3	5 / 9 / 6	Light breeze	0.2	0.66	Small wavelets. Crests of glassy appearance, not breaking	Wind felt on exposed skin. Leaves rustle.
3	7-10	12-19	8-12	3.4-5.4	9 / 17 / 11	Gentle breeze	0.6	2	Large wavelets. Crests begin to break; scattered whitecaps	Leaves and smaller twigs in constant motion.
4	11-16	20-29	13-18	5.5-7.9	13 / 24 / 15	Moderate breeze	1	3.3	Small waves.	Dust and loose paper raised. Small branches begin to move.
5	17-21	30-39	19-24	8.0-10.7	19 / 35 / 22	Fresh breeze	2	6.6	Moderate (1.2 m) longer waves. Some foam and spray.	Smaller trees sway.
6	22-27	40-50	25-31	10.8-13.8	24 / 44 / 27	Strong breeze	3	9.9	Large waves with foam crests and some spray.	Large branches in motion. Whistling heard in overhead wires. Umbrella use becomes difficult.
7	28-33	51-62	32-38	13.9-17.1	30 / 56 / 35	Near gale	4	13.1	Sea heaps up and foam begins to streak.	Whole trees in motion. Effort needed to walk against the wind.
8	34-40	63-75	39-46	17.2-20.7	37 / 68 / 42	Gale	5.5	18	Moderately high waves with breaking crests forming spindrift. Streaks of foam.	Twigs broken from trees. Cars veer on road.
9	41-47	76-87	47-54	20.8-24.4	44 / 81 / 50	Strong gale	7	23	High waves (2.75 m) with dense foam. Wave crests start to roll over. Considerable spray.	Light structure damage.
10	48-55	88-102	55-63	24.5-28.4	52 / 96 / 60	Storm	9	29.5	Very high waves. The sea surface is white and there is considerable tumbling. Visibility is reduced.	Trees uprooted. Considerable structural damage.
11	56-63	103-117	64-72	28.5-32.6	60 / 111 / 69	Violent storm	11.5	37.7	Exceptionally high waves.	Widespread structural damage.
12	>63	>117	>72	>32.7	N/A	Hurricane	14+	46+	Huge waves. Air filled with foam and spray. Sea completely white with driving spray. Visibility very greatly reduced.	Considerable and widespread damage to structures.

Consider	Informed by	Comments
Actioning local flood plans.	EPO	Local response plans have been produced for Lewes, Seahaven, Pevensey, Bulverhythe, Uckfield and Lewes.
Suspending all but essential journeys	Police and Highways Agency	This policy is used by Sussex Police
Consider sending staff home early	CSMT EPO	If safe to do so and patient care not compromised. Consider making staff accommodation available for staff to stay on site, include additional catering if required.
Met office web site	EPO	Monitoring current wind charts of neighbouring areas may assist in gauging the potential of the approaching weather. Use of the Met Office Hazard Manager site for Emergency Planning.
Highways agenc	EPO	Monitoring the Highways Agency web site for up to date information on road conditions and closures.
County Emergency Planning		May be able to provide local information on roads and availability of equipment and resources.

Advice on driving in such weather is also provided by the Highways Agency who operate a traffic light coded warning system.

Appendix 'C' – Tornadoes

Introduction

There is a history of tornadoes striking the south coast sometimes with considerable impact on local communities. There is little in the way of preparation for tornadoes, however the Met Office are now providing warnings when atmospheric conditions are suitable for tornadoes to develop.

Risks to Service

- Hazardous driving conditions
- Sudden rise in ambulance arrivals
- Increased potential for injury around each site
- Disruption to Local Utility Supplies
- Staff Welfare

Tornadoes within the British Isles are most likely to occur during the spring and early summer. Satellite and radar imagery can assist in identifying conditions for tornadoes to form.

Tornadoes can produce very localised winds of up to 100mph, they can last for seconds or many minutes and can track over several kilometres.

Severe structural damage can occur and can be life threatening. They can uproot trees, over turn cars as well as a large risk of damage and injury from flying debris.

It is often the case that one street can be devastated while the next street can be almost unaffected.

The impact of a tornado can place a huge drain on resources and will likely result in a major incident being called by the Fire & Rescue Service or other Category 1 Responder.

Considerations

Inform all partner agencies as early as possible if a dramatic increase in related injuries present at EDs or MIUs.

The possible need to evacuate areas of the hospital if the site is damaged by a tornado.

Staff difficulties if public transport is disrupted by damaged areas.

Staff welfare if their homes are within an affected area or if schools are involved.

Appendix 'D' - Heavy Snow

Introduction

Although the climate is changing there is still a risk from heavy snow this may be as result of very low temperatures as cold winds blow in from Eastern Europe or Scandinavia. History has shown that this can often give moderate or heavy snow falls in the south east. Alternatively where a very cold air flow meets a moist warm airflow from the west there is often a period of intense snow often resulting substantial accumulations. The winters of 2009/10 and 2010/11 were a prime example.

This type of weather is often difficult to predict as the right atmospheric conditions need to be present

Additional guidance

Appendix 'E' gives additional guidance to be considered

Risks to Service

- Staff shortage
- Unable to provide community based services e.g. midwives
- Hazardous driving conditions
- Increased hazards to staff
- Potential for increased attendances at EDs and then fracture clinics
- Potential for increase in trauma related surgery.
- Disruption to Utility Supplies
- Hypothermia
- Staff Welfare

Warning

When a warning of snow is forecast this will be via the normal severe or extreme weather warning service.

Heavy snow can have a dramatic effect on our ability to provide a normal level of service. Staff may not be able to reach their normal place of work. The ambulance service may not be able to accommodate discharges from hospitals, outpatients and day surgery patients may not travel. There may also be interruptions to utility services, where this is the case departments should refer to specific **Business Continuity Plans.**

Consider	Action	Comments
Staff traveling home When a forecast is received which may prevent Staff traveling home at their normal time it may be prudent to send staff home early unless this will impact on patient care.	CSMT EPO Executive Decision	May be better to open up accommodation so staff can stay on site and ensure business continuity.
Move staff or equipment between sites If snow is forecast for one hospital but not the other it may be prudent to redeploy staff or equipment.	CSMT	This may assist with responding if the weather arrives.
4 x 4 Crewing Confirm availability of 4 x 4 vehicles	CSMT Snow Desk EPO to assist if required	Sussex 4x4 Response Voluntary agencies MCA. Beachy Head chaplaincy
4 x 4 Hire Consider temporary hire of 4 x 4 vehicles for staff transport, pharmacy, commercial activities, patient discharges.	CSMT Executive decision. Facilities and estates	All emergency services will be trying to hire vehicles either for self drive or with crews. **Act early if required**
Response to nearest NHS premises Depending on the time of a heavy snow fall advise staff to report the their nearest hospital if safe to do so	Executive decision	HR Policy for severe weather already in place.
Welfare *Consider welfare arrangements for staff who may not be able to get home or may have to work longer shifts*	CSMT	Open up staff accommodation and enhance refreshment and catering capabilities
Clinical staff *Specialist staff such as clinicians and nurses could be collected by 4 x 4 vehicles*	CSMT EPO	This may be feasible especially where staff live in rural areas.
Information gathering *Contact hospitals regularly for a situation report on current conditions*	CSMT	Increase frequency of conference calls.
Consider Activating Business Continuity Plan	CSMT	
Consult regularly with County Council Emergency Planning, County Highways and key partner Agencies	EPO Estates and Facilities.	Agencies can possibly offer some form of mutual assistance
Monitor Met Office website or contact directly *Also available through Hazard Manager.*	EPO	To enable assessment and planning over the coming hours or days
Set up staff transport desk (Snow Desks) and dedicated telephone lines for coordination of use of 4 x 4 vehicles for staff transport.	HR CSMT Assisted by EPO	To ensure staff transport is prioritised for those living in rural areas or whose role is critical to BCM.

Appendix 'E' – Extreme Cold

Introduction

Periods of extreme cold weather are not uncommon within the UK. Extreme cold weather can have a major impact on many aspects of normal day life, including a sharp increase in mortality rates among the elderly and vulnerable.

Risks to Trust

- Hazardous driving conditions
- Increased risk to staff travelling to work or at work
- Potential for increased attendances at EDs and admissions
- Disruption to Utility Supplies
- Hypothermia
- Staff Welfare

Warnings

Warnings of extreme cold are issued via the Met office website or through Met Office Public Weather Service Advisor. The threshold values below are used as a level of alertness for responding agencies. The DoH Cold Weather Plan 'Protecting health and reducing harm from severe cold' was issued on November 1st 2011.

Guide to alert levels

The Cold Weather Plan sets out actions at four Cold Weather Alert Levels

Cold Weather Plan Levels	
Level 1	**Long-term planning** ***All year***
	Winter preparedness programme ***1 November–31 March***
Level 2	Severe winter weather is forecast – Alert and readiness *60% risk of severe cold in the following days*
Level 3	Response to severe winter weather – Severe weather action
Level 4	Major incident – Emergency response *Exceptionally severe weather or threshold temperatures breached for more than six days*

Level 1: Winter preparedness – long-term planning

Level 1 includes long-term strategic planning activities that can take place throughout the year. For example:

- **Health and social care services and professionals** should work with partner agencies to identify those most at risk from seasonal illness and to improve their resilience to severe winter weather.

- **Individuals and communities** should consider what they can do in advance to prepare for cold winter weather, such as insulating their homes and making sure that those at risk are receiving the benefits they are entitled to.

Level 1: Winter preparedness – general preparation

Level 1 also includes general winter preparations, running alongside seasonal activities such as the annual flu vaccination programme.

- **Health and social care services and professionals** should work with partner agencies to co-ordinate cold weather plans and support communities to help those at risk. They should also make plans to deal with a surge in demand for services, identify those at risk on their caseloads and encourage all staff to get their flu jabs.

- **Individuals and communities** should take steps to prepare for winter, such as: getting a flu jab if they are in a risk group; insulating their homes and protecting water pipes from freezing; looking out for vulnerable neighbours; and checking their entitlements and benefits.

Level 2: Severe winter weather is forecast

A Level 2 alert is triggered when there is a 60% risk of severe cold weather lasting at least 48 hours forecast to arrive within the next two or three days.

- **Health and social care services and professionals** should make sure that all those at risk have been identified and can be contacted. If visiting clients, they should check that their rooms are adequately heated. More general actions include implementing business continuity, communicating public media messages and making sure that all staff are aware of winter plans.

- **Individuals and communities** should stay tuned to the weather forecast and keep themselves stocked with food and medications, check room temperatures, keep an eye on people at risk and make sure that they are getting their benefits and entitlements.

Level 3: Response to severe winter weather

A Level 3 alert indicates that the severe winter weather forecast at Level 2 is now occurring, and is expected to impact on people's health and on health services.

- **Health and social care services and professionals** should activate plans to deal with a surge in demand for services and mobilise community and voluntary support. They should contact those at risk in person or by phone every day while the severe weather lasts and ensure that they are receiving their entitlements. Other actions include communicating public media messages to staff and ensuring that staff are in a position to help and advise clients.

- **Individuals and communities** should take immediate action to minimise the harmful effects of the weather, including: setting daytime room temperature to 21°C and bedroom night temperature to at least 18°C; dressing warmly and eating well; and checking on those you know are at risk.

Level 4: Major incident

A Level 4 alert indicates a major incident. It means that exceptional winter weather affects one or several parts of the country and is so severe that it creates widespread transport disruption and/or threatens the operation of health and social care services.

Level 4 alerts require a cross-government response at a national level. However, there are some actions that can be taken by the health sector, such as:

- continuing to take Level 3 actions during the emergency period;
- Making sure that all local healthcare providers can continue to operate, for example by adequate clearing of snow and gritting to ensure safe emergency access; and
- Risk appraisals on how the wider population, outside at-risk groups, is likely to be affected by the extreme conditions.

Consider	Action	Comments
Increased stocks of salt and grit Check operation and servicing of gritting trailers and snowploughs.	Estates and Facilites should consider by 1st November annually and then again on receipt of severe cold weather warnings.	Monitor stocks of grit and salt to ensure supply is always available. Quickly replenish stocks in case of further cold weather closely following the previous event.
Outside stores are to be checked regularly to ensure that vulnerable equipment is not exposed to freezing	Estates and Facilities Stores staff	Maximum use to be made of under cover storage for vehicles and equipment
Footpaths to main entrances from bus stops, car parks and pedestrian entrances as well as from staff residencies are checked and salted / gritted	Estates and Facilities to use additional staff if required.	Monitor situation and lay grit as appropriate to minimise slip hazards (it is better to lay grit before freezing if possible) Pay particular attention to Power, Water and Gas supplies
Consider Fire Safety warnings regarding safe home heating for staff residencies	Estates and Facilities Fire Safety Officer	It may be prudent to do this with partner agencies such as the Fire & Rescue Service
Consider contacting local Hire Companies regarding availability of heaters	Estates and Facilities	If problems with heating systems for hospitals or staff residences

Managers should regularly contact staff regarding any specific welfare issues relating to extreme cold weather.	All Managers	Refer to HSE guidance on room temperatures etc
Consider redeployment of staff to EDs, MIU and fracture clinics. Consider operating additional fracture clinics Consider stocks of Plaster of Paris, crutches, etc Consider stocks of theatre packs for orthopaedic trauma. Consider availability of theatres, orthopaedic surgeons and theatre staff	CSMT and Managers	Monitor ED and MIU attendances and get early warning of rapid increase in fracture cases requiring treatment, surgery and referral

Appendix F

Operation of the Trust Snow Desks.

Location	Areas covered	Special remarks
EDGH HR Offices **01323 414937**	EDGH Lewes Victoria Hospital Uckfield Community Hospital Crowborough Community Hospital Firwood House* Newhaven Polyclinic	*Includes ICAP – office staffed daily 0800-2200. Integrated Night Service (INS) 2200 -0800 hrs requires 4x4 transport throughout shift from Lewes and Firwood sites.
Conquest. Chairman's Office **01424 757090**	Conquest Rye Community Hospital Bexhill Hospital Irvine Unit	Integrated Night Service (INS) 2200 -0800 hrs requires 4x4 transport throughout shift from Bexhill.

The Snow Desks must prioritise staff transport based on essential clinical need initially, then on location. This should ensure that vehicles collect as many essential staff as possible from the same postcode area or en route to their destination. Non-clinical support staff can also be classified as essential when involved in medical records, catering, housekeeping, portering and other estate and facility services that are essential to keep the hospitals operating safely.

Morning journeys to bring staff into work should be planned to commence as close to the 4x4 drivers home or base as possible, keeping driving distances to a minimum. It may be beneficial to plan morning journeys by 1930 hrs the previous evening and pass those details to drivers at that time.

All 4x4 drivers are volunteers and will require adequate rest and meal breaks, with the provision of free hot drinks and food being arranged at Trust sites. Suitable rest and refreshment areas must be identified and notified to drivers, together with tokens or vouchers in order to obtain food and drinks.

Volunteer drivers cannot be expected to work extended hours, they are giving their time and we must be happy with what they offer, even if they wish to go 'off duty' and we still have staff to move. Volunteers cannot be expected to continue to operate once public transport and taxis have resumed services around towns, bearing in mind that some rural or hilly locations may still be inaccessible other than by 4x4 vehicles. Every effort should be made to 'stand down' volunteers as soon as practicable after ensuring they are thanked for their assistance and that we have their contact details and whether they are willing to assist again, should the need arise. This is particularly important for those individuals who volunteer and are not part of a voluntary organisation or organised group.

It can take some time for a response to be made, firstly as groups activate their callout system and secondly due to driving conditions. The requests for assistance should be made as early as possible once the need, or likely need, is identified. It is better to have them 'on standby' and then 'stood down' rather than having to wait extended periods for a response. **There is an algorithm for the use of Sussex 4x4 Response at Appendix G on Page 30.**

Use of the Military

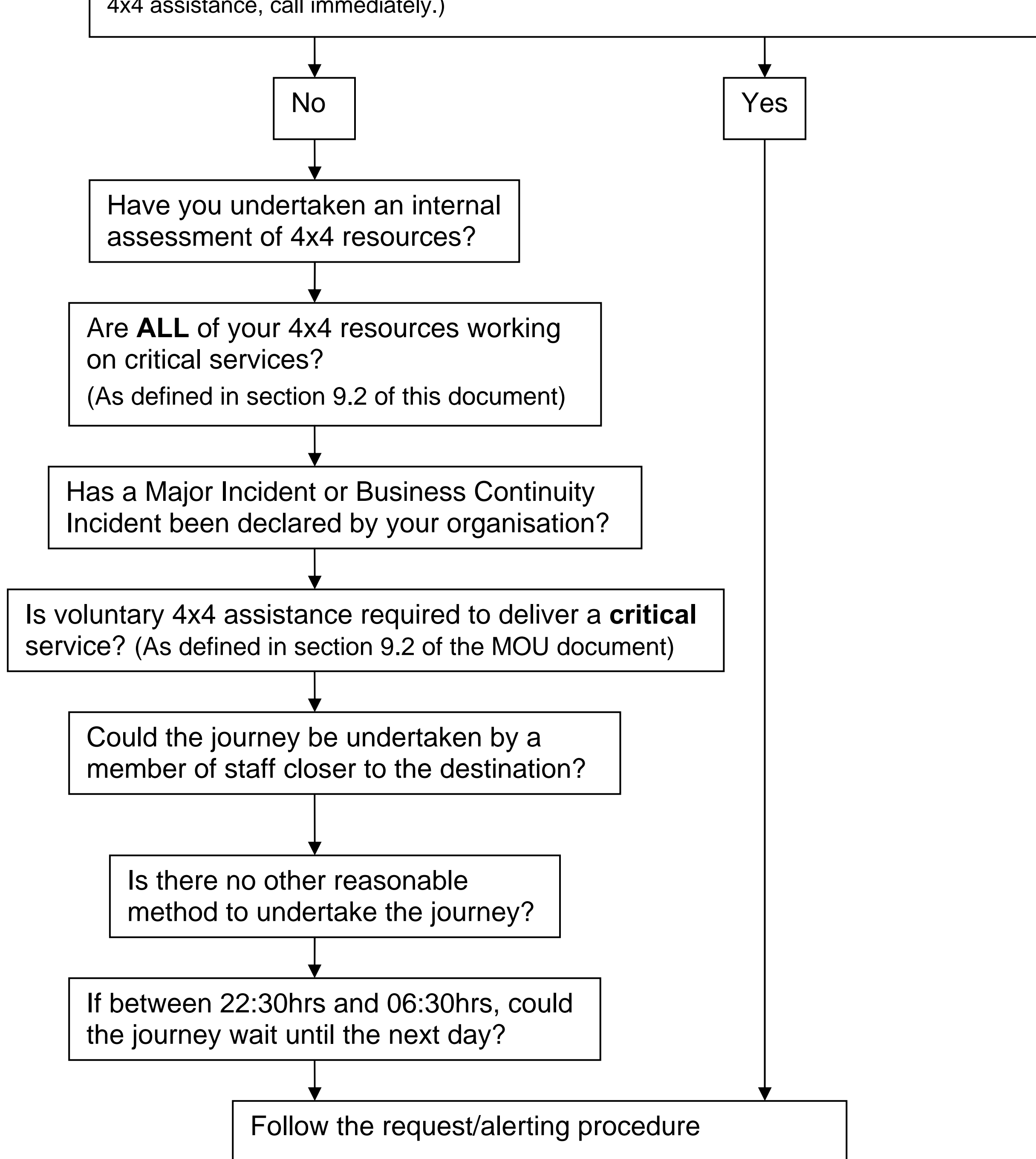
Military Assistance to the Civil Authorities (MACA) has to be requested by the Chief Executive through the Department of Health. Free assistance is only given to save life, otherwise there is a full re-charge of costs and these are generally much higher than using private contractors. In extreme circumstances, and to save life, some military assistance may be available but it is essential that the request is made through the correct channels. The Emergency Planning Officer can offer further advice if required.

4x4 staff transport assistance.

Organisation	Numbers	Availability	Restrictions	Contact details
Sussex 4x4 Response	12+ vehicles	Volunteers	Essential staff only Can assist in all areas	Co-ordinator (24hr) 07077 079428
Beach Head Chaplaincy	1 or 2 only	Volunteers	Eastbourne area only. Only whilst access to Beachy Head is blocked	Ross Hardy 07525 324530 Ben Russell 07843 083204
All Terrain Vehicles	3 or 4 only	Volunteers	Hastings / Bexhill areas only.	01424 200120 07970 683563
Raynet	Upto 6	Volunteers	Will set up radio communications and supply 4x4 vehicles Can assist in all areas.	**From December 7th main contact is** **Dick Jefferies** **01323 845418** **07704 141261** **until 6th December 2011 contacts are** Mr A Young 01323 471146 XDir 07803 033216 or Mr J Eade 01424 871621 07802 887880
St John Ambulance	4x4 cars and ambulances	Volunteers	Staff transport and 4x4 ambulances for hospital discharges	Duty Pager (24hr) 07659 114213
British Red Cross	4x4 cars and ambulances	Volunteers	Staff transport and 4x4 ambulances for hospital discharges	Duty Pager (24hrs) 07659 125170
Coastguard (MCA) East Of Beachy Head	varies	Depends on maritime emergencies	Normally stays east of EDGH. Staff transport and will respond on blue lights for emergency transfers of clinical staff, blood etc	Dover Control (24hr) 01304 210008
Coastguard (MCA) West Of Beachy Head	varies	Depends on maritime emergencies	Normally stays west of EDGH. Staff transport and will respond on blue lights for emergency transfers of clinical staff, blood etc	Solent Control (24hr) 02 392 552100
East Sussex Fire & Rescue Service	Emergency only	Emergency only	Life saving journeys only. Will consider transfer of blood and urgently needed clinical staff but only to save life.	999 ask for Fire

Sussex Police	Emergency only	Emergency only	Life saving journeys only. Will consider transfer of blood and urgently needed clinical staff but only to save life.	999 ask for Police
David Brabant	1 vehicle	Individual volunteer	Lives at Seddlescombe	07850 690054

Appendix 'G'
Decision Making Process When Requesting Sussex 4x4 Response Assistance



If you have answered yes to any of the above questions (excluding the 999 box), please reconsider the need for your request, and if necessary contact your Single Point of contact to discuss.

Appendix 'H' – Heatwave

Introduction

Climate change means heat waves are likely to become more common in England.

The Trust is required to have a Heatwave Plan for use during the period June 1st to September 15th each year when a Heatwave Alert system is in use.

Please refer to the Trust Heatwave Plan for more information.

By the 2080s, it is predicted that an event similar to that experienced in England in 2003 will happen every year.

Heat wave conditions can last for several days or weeks and can have a dramatic impact on health and the services we are able to provide.

Risks to Service

- Heat exhaustion
- Dehydration
- Increase in elderly or young patients including those with chronic illness
- Rise in incidents involving fire particularly grass or bush fires
- Staff welfare due to high temperature
- Risk of equipment failure due to excessive heat
- Potential for disruption to Utility Supplies
- Disruption to transport networks

Warning

Although warning lead times are longer for heat wave it is still possible for a short notice warning to be issued should atmospheric conditions change rapidly.

Health symptoms and potential impact on staff

Heat strokes.

Normally we sweat, and this keeps us cool on hot days. On very hot days our bodies can sweat excessively. This can lead to headaches, dizziness and even death.

Dehydration.

This is the loss of water from a body. It can cause tiredness and problems with breathing and heart rates.

Sunburn

Damage to the skin which can be painful and may increase the risks of getting skin cancer.

Air pollution

It is thought that one third of the deaths caused by the heat wave in the UK were caused by poor air quality.

Consider	Action	Comments
Exposure to extreme hot weather will impact on health symptoms may include. • Heatstroke • Dehydration • Sunburn	All Managers to monitor staff and working conditions related to Extreme hot weather Advice available from Occupational Health	Managers to increase monitoring of staff, and to provide additional breaks and sufficient quantities of liquid refreshment
Rise in incidents around sites involving dry vegetation and putting Trust premises at risk.	Estates and Facilities Fire safety messages relating to the dangers of an increased risk of fire in dry undergrowth	Consider partnerships with other stakeholders e.g. Fire & Rescue Service
Potential for disruption to Utility Supplies	All Mangers to familiarise staff and themselves on the relevant Business Continuity Plans	The demand for electricity during hot weather due to a much greater use of air conditioning and increased resistance in supply equipment
Disruption to transport networks, Possible impact on staff availability	All Mangers to familiarise staff and themselves on the relevant Business Continuity Plans In relation to staff shortage	Public transport and road conditions are commonly disrupted during hot weather Monitor media and Highways agency web site.
Community Health in General Vulnerability of the Elderly and Young	All Managers and staff	There is an increased risk to the elderly and young and wherever we consider support to other stakeholders and those members of staff who have a carers role.
Longer term potential for drought conditions	Strategic Managers	With the increased demand on water supplies and climate change it may be prudent to explore a longer term strategy including how hospitals can be made cooler.

Pan Sussex Escalation Process

All health economies will have locality winter escalation/communication processes in place.
The following process is for higher escalation between localities when local solutions are insufficient with an aim to return the health care system to an acceptable & safe operational position.

TRIGGERS: any of the below

- Provider faces significant pressures and moves into major Business Continuity Plan/PURPLE or BLACK for over 24 hrs.
- LHE are responding but the position does not improve.
- >2 providers in PURPLE or BLACK escalation

↓

ESCALATION PROCESS:

- Provider in difficulty initiates PAN SUSSEX escalation process by the Director in charge calling partner organizations on call Directors.
- The Provider Director co-ordinates conference call of all providers*

*Chair to be agreed at first call, proposed to be a neutral party to lead serious incident.

↓

INITIATING PROVIDER DIRECTOR sets up conference call,

- Conference number: to be shared
- Contact each core Provider and NHS Sussex On Call Director
- Include other agencies as appropriate e.g. LA's, SPFT.
- Advise SoE (East)
- Consider boundary LHE eg. Surrey, Hampshire, Kent.

↓

CHAIR CO-ORDINATES a Sussex Wide Management plan that includes:

- Escalation status of each provider, including proposals to resolve escalation eg actions to reduce delayed discharges, critical care transfers, elective capacity etc.
- Divert from affected Trusts (agreeing time limit, borders etc)
- Actions required from all partners to be recorded
- Communications – internal and external and by whom
- Further conference calls or stand down
- Actions to be emailed from chair to all organizations for handover/record

Appendices: (1) All organisations contact detail
(2) Whole system South East Coast Handover Turnaround Policy including SECAmb Divert
(3) Agenda and action pro-forma

Version 3 Nov 18 2011

APPENDIX 1

PAN SUSSEX
DIRECTOR ON CALL CONTACT NUMBERS

Organisation	Director on call	Contact number
BSUH	Duty Manager and Director contactable via switchboard	01273 696955
ESHT	On Call director, contactable via switchboard	01323 417400 (EDGH) 01424 755255 (Conquest)
LA's	Brighton & Hove – Duty General Manager East Sussex - On Call Director West Sussex : Daytime On Call Director Out of hours Duty Manager	01283 295555 07808 601802 01243 382693 or 07595 964221 01903 694422
NHS Sussex	On Call Director	Pager no. 08448222888
SASH	On-Call Manager/On-Call Director via switchboard	01737 768511
SCT	Via Brighton General Hospital	01273 696011
SECAmb	Duty Dispatch Manager	01273 488303
SPFT	On Call Manager	01323 440022
WSHT	Duty On Call Director	01903 205111
SoE (East)	Director on Call pager	02082 426155