EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 26th September 2017, commencing at 09:30 in the Hastings Centre, The Ridge, Hastings TN34 2SA

	AGENDA		**Lead:**	**Time:**
1.	1 Chair's opening remarks 2 Apologies for absence 3 Monthly award winner(s)		Chair	0930 - 1030
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 25th July 2017	A	Chair	
4.	Matters arising	B		
5.	Improvement Hub	C	DS	
6.	Quality Walks Board Feedback		Chair	
7.	Board Committee Feedback	D	Comm Chairs	
8.	Board Assurance Framework	E	DCA	
9.	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
10.	Integrated Performance Report Month 4 (July) 1. Quality & Safety 2. Access & Responsiveness 3. Finance 4. Sustainability 5. Leadership & Culture	Assurance	G	DN/MD COO HRD DF	1030 - 1130
11.	Mortality Learning From Deaths Policy	Assurance	H	MD	

STRATEGY

					Time:
12.	Financial Special Measures Update	Assurance	I	DF	1130 - 1145

GOVERNANCE AND ASSURANCE

					Time:
13	Annual Reports: 13.1 Safeguarding 13.2 Equality 13.3 Fire Safety	Assurance	J	DN DCA COO	1145 - 1215
14	Winter Preparedness	Assurance	K	COO	
15	Board sub-committee minutes: 15.1 Audit Committee 15.2 Finance & Investment Committee 15.3 Quality & Safety	Assurance	L	Comm Chairs	

ITEMS FOR INFORMATION

				Time:
16	Use of Trust Seal	M	Chair	1215 - 1230
17	Questions from members of the public (15 minutes maximum)		Chair	
18	Date of Next Meeting: Tuesday 28th November 2017, St Mary's Boardroom		Chair	

David Clayton-Smith

David Clayton-Smith

Chairman

24th August 2017

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
DN	Director of Nursing
HRD	Director of Human Resources
MD	Medical Director

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 25th July 2017 at 09:30 in the St Mark's Church Hall, Bexhill.

Present: Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Ms Miranda Kavanagh, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Dr Adrian Bull, Chief Executive
Mrs Joe Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Ms Sharon Gardner-Blatch, Deputy Director of Nursing
Miss Jan Humber, Joint Staff Committee Chairman
Dr Debbie McGreevey, Assistant Director – Revalidation (for item 070/2017 only)
Mr Ian Miller, Financial Improvement Director
Ms Philippa Slinger, Improvement Director
Mr Pete Palmer, Assistant Company Secretary (minutes)

056/2017 **Welcome**

1. Chair's Opening Remarks
Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public. He thanked Alice Webster for all the dedication and hard work she had given to the Trust during five years with the organisation, and wished her luck in her new role.

He welcomed Sharon Gardner-Blatch and Philippa Slinger to their first Board meeting in public.

2. Apologies for Absence
Mr Clayton-Smith reported that apologies for absence had been received from:

Mrs Sue Bernhauser, Non-Executive Director
Mrs Catherine Ashton, Director of Strategy
Ms Hazel Tonge, Acting Director of Nursing

3. Monthly Award Winners

Mr Clayton-Smith reported that the monthly award winner for May was Staff Nurse Angie Short, who received the award for her care and attention in looking after an aggressive patient and escorting him back to his care home.

The winner for June was Andy Bailey, for his work in developing an IT reporting suite for the Trust which had significantly contributed to the recent improvements in A&E performance.

057/2017 **Declarations of Interest**

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

058/2017 **Minutes**

The minutes of the Trust Board meeting held on 9th May 2017 were considered and were agreed as an accurate account of the discussions held. The minutes were signed by the Chair and would be lodged in the Register of Minutes.

059/2017 **Matters Arising**

There were no matters arising from May's meeting.

060/2017 **Feedback from Quality Walks**

Mr Reid reported that he had recently visited A&E departments on both sites. Staff welcomed the installation of screens showing live A&E performance data as they provided greater visibility to all staff. Concerns about the sustainability of staffing levels were discussed but teams felt that effective solutions were emerging. The proposed improvements in ambulatory care and the primary care streaming model were welcomed. Mr Reid found a consistent, caring approach being shown and patients felt very positive about the care they were receiving.

Mrs Wells explained that the Trust had received a lot of positive patient feedback via NHS Choices and a letter had been sent to the CQC about positive care within A&E. This has been fed back to teams.

Mrs Churchward-Cardiff reported that she had recently visited a number of Allied Health Professional teams and praised the work that they were doing and their positive attitude. She noted their innovation in trying to resolve a number of issues, including with equipment and telephone systems. Dr Bull reported that a tender for a fully digitalised telephone system, covering the entire Trust, would shortly be completed. He hoped that this would resolve the frustrations of staff and patients with the current system.

The Board noted the feedback on Quality Walks.

061/2017 **Board Committees Feedback**

1. Audit Committee

Mr Stevens reported that a number of technical accounting issues had arisen during the process of finalising the end of year accounts. He thanked the finance team and BDO for their hard work during the process.

He explained that the Trust had received an internal audit opinion of limited assurance for the year and that the Trust was looking at ways to improve this rating for 2017/18. Mrs Wells reported that audit recommendations had not been implemented by the Trust in a timely manner during the first half of 2016/17, and that this picture had significantly improved towards the end of the year as the Trust took greater control of the issues.

Mr Stevens reported that a review of effectiveness had been undertaken by the Audit Committee and had returned very positive feedback. Mr Reid agreed that good scrutiny and challenge was provided by the Committee, with strong internal audit input. The Trust would be changing their external auditors from BDO to Grant Thornton for 2017/18, and Mr Reid thanked BDO for their work with the Trust.

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee had recently focussed on financial recovery planning. A review of the effectiveness of the Committee had been undertaken, resulting in positive feedback from members. Recommendations were made that the Committee should make improvements to the number of papers considered during each meeting and the time allocated for discussion. A further concern was raised about the use of capital funds within the organisation and the Committee would have a broader strategic discussion about capital funding as a result. The Committee's terms of reference had been updated following the review of effectiveness.

During the previous year substantial improvements to quality within the organisation had been realised. The Committee was determined to ensure that the Trust's stringent financial targets did not affect the quality of care provided by the Trust.

Mr Clayton-Smith reported that Mr Nealon's term as a Non-Executive Director had recently been extended for a further three years to July 2020.

3. People and Organisational Development Committee

Ms Kavanagh reported that the Committee had recently spent time ensuring that its focus was correct. She was confident that the Committee now had correct attendance, and recent work on medical engagement had been very positive. Junior doctor representation

across all Board Committees was being considered. Ms Green agreed that the correct balance had now been struck by the Committee and Miss Humber noted that it was now a well-functioning Committee.

Mr Stevens explained that he felt that the formation of the Committee was a very positive step for the Trust and that he valued the work it was undertaking.

4. Quality and Safety Committee

Mrs Churchward-Cardiff reported that Quality and Safety (Q&S) Committee meetings had shown recent improvement, with increased attendance and strong presentations of reports. She noted that need for improved End of life Care (EOLC) and Mental Health Act training within the organisation.

Dr Walker agreed with the Committee's concerns about EOLC, reporting that while the Trust had improved considerably further work needed to be done. Plans for continued improvement were in place.

The Board noted the Committee Reports.

062/2017 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) had recently been discussed by the Q&S Committee and was due to be discussed by the Audit Committee the following day.

She proposed that the rating for mortality should move from amber to green as this was now within the expected range and had effective controls in place. She noted that the Q&S Committee had supported the recommendation to remove mortality from the BAF, explaining that progress would monitored elsewhere within the organisation while remaining an area of focus for the Trust. Specific focus would be maintained on improving outcomes for pneumonia, sepsis and acute myocardial infarction.

Dr Bull reported that work had been commissioned to develop innovation across the organisation and one of the topics included in this programme had been sepsis. The sepsis team had embraced this work and were looking at innovative methods of improvement.

Mrs Churchward-Cardiff reported that the Q&S Committee had been very assured that appropriate measures were in place to manage the risks associated with mortality. Ms Kavanagh noted that she had been very concerned about mortality when she had joined the Trust and felt assured by the improvements she had seen.

Mrs Wells reported that a new gap in control had been added to the BAF concerning the provision of aspects of seven day support services, explaining that the wording would be revised to better highlight which aspects were of concern. Dr Walker noted that both NHS Improvement

(NHSI) and NHS England (NHSE) had approved the Trust's plans for seven day working.

Mrs Wells recommended that the gap in control concerning patient transport should be removed as the service had improved greatly following transfer to a new supplier in April 2017.

Mr Reid noted that the gap in control concerning finance had been recently reworded to accurately reflect the Trust's current position.

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

They approved the change in the rating from mortality from Amber to Green, and its removal from the BAF. The also approved the addition of a gap in control concerning seven day support services and the removal of the gap in control concerning patient transport.

063/2017 **Chief Executive's Report**

Dr Bull reported that the Trust was confident that the improvements seen during the previous inspection by the CQC had been embedded within the organisation and were sustainable. A progress meeting would be held with the CQC team in August which would inform the timing and format of the next inspection of the Trust.

He reported that there had been a recent payroll issue for bank staff who were paid weekly, following the introduction of a new tax algorithm which had led to concerns that staff were being paid less. The issue had now been resolved. Mr Stevens asked whether the Trust had the capacity to offer a loan to staff under exceptional circumstances and Dr Bull confirmed that this option had been offered to staff.

Dr Bull reported that the Trust's financial recovery plan had been approved by NHSI and that the Trust was on track for delivering against the plan.

An accelerated improvement plan for A&E had led to improved four hour performance during April and May to 81% and further improvement in June to 88%. The Trust was targeting 90% performance during July.

Dr Bull reported that a recent peer review of trauma within the Trust by the Trauma Network had resulted in excellent feedback being received.

Following the Grenfell disaster cladding within the Trust had been tested and found to be compliant. An existing issue concerning sub-compartmentalisation on the EDGH site was being discussed with the fire department.

Mrs Churchward-Cardiff asked how gaps in rotas that arose due to the new junior doctor's contract were being addressed. Dr Bull explained that a rota review group had been set up to look at rotas from across the organisation in order to ensure compliance and to share learning. An electronic rota system for doctors would be introduced to aid this process and would help highlight any gaps in rotas that needed covering.

Dr Bull reported that the Trust had received very late notice of its junior doctor allocation from August, leading to issues with insufficient doctors and explained that this would be raised with Health Education England.

Mrs Churchward-Cardiff asked if other methods of covering gaps in rotas were being explored as this was likely to be a long term issue. Dr Bull replied that a task based skill mix review had been initiated to look at alternative ways of covering rotas. The use of associate physicians was being explored and a sponsor for these positions had been appointed. He reported that the Trust was starting to see greater numbers of applicants for posts due to its growing reputation.

064/2017 **Quality Special Measures Update**

Mrs Wells reported that at a recent Board Seminar quality special measures and what was needed to achieve a 'Good' rating had been discussed. The Executive team has looked at the requirements in detail following the Seminar and the areas of most concern were around EOLC and diagnostics. She explained that the CQC's Key Lines of Enquiry had changed and that Trust needed to demonstrate that it was compliant in all of the five domains.

Ms Slinger noted that she had only been in the Trust for four days so had yet to form an detailed opinion on the Trust. Her initial impression was of a Trust moving in the right direction and she explained that she would be closely involved in the process of planning for the inspections.

Mr Stevens suggested that high performing areas should be targeted to help them to become outstanding.

QUALITY, SAFETY AND PERFORMANCE

065/2017 **Integrated Performance Report Month 2 (May)**

Dr Bull noted that the presentation of the Integrated Performance Report had been updated to provide clarity and continuity. He asked for feedback on the changes from the Board.

<u>Access and Responsiveness</u>

Mrs Chadwick-Bell reported that 18 week RTT performance during May had been 92%, the first time the target had been achieved in over a year. The improvement had been sustained into June and was testament to the team's hard work.

Diagnostics performance had improved in May and continued to improve

during June. Cancer performance had been challenging and the 62 day target was now a national priority for delivery by October, with the Trust achieving 76% against a target of 85% in May. A daily process had been introduced which reviewed patients on day 40 of their pathway to identify and resolve any issues that existed. It was hoped that additional funding could be realised for additional capacity, including staff, clinics and theatre time to address the issue. The Trust had seen a 50% increase in referrals from previous years in some areas and received more referrals than any other organisation in the South East. Mrs Chadwick-Bell suggested that some time was spent at the next Board seminar to go through the various cancer standards to ensure that the new targets were fully understood by the Board. **PP**

A&E performance had recently been greatly improved following a four week challenge undertaken within the organisation. The improvements had come at no additional cost and had been realised by building on existing plans by taking greater grip and control of the issues. The Trust was undertaking work with the CCG to understand whether the significant increases in activity and conveyances to A&E were a one-off or a trend. Mrs Chadwick-Bell expected the GP led primary care front door within the Trust to be operational by October.

A system-wide plan for the management of urgent care was being introduced from 1st August and would continue to manage capacity and hold organisations to account throughout winter. Plans were being developed which included bed modelling, and capacity gap identification and planning.

Mr Nealon asked whether the Trust was as prepared for hot weather conditions as they were for winter. Mrs Chadwick-Bell explained that the Trust planned for surges, which could take place at any time of the year, so should be able to respond effectively to increased activity at any time. Mr Reid noted that additional funding for surges was no longer classified as a winter fund, but as a surge fund throughout the year.

Mrs Wells asked about the large increase in community nursing referrals compared to the previous year. Mrs Chadwick-Bell explained that the increase had been discussed with CCGs and by the Alliance Executive. Staff had responded well to the pressure, with first appointment standards maintained but follow up and repeat referrals had been affected. A block contract for the service meant that it was very difficult to increase staff numbers and the Alliance Executive had agreed to changes to working hours for the community nursing service to make it more efficient. The service was under significant pressure and was being supported as much as possible.

Ms Kavanagh asked whether the recent improvements in four hour performance were sustainable in the long term and Mrs Chadwick-Bell explained that she expected performance of 90% to be sustainable, but anticipated that this would be harder to maintain moving into winter. Dr

Bull explained that the Trust would make improvements throughout patient pathways to further improve performance, noting the recent introduction of a breakfast club at EDGH to encourage patients to get up and be ready for discharge early in the day.

Quality & Safety

Mrs Gardner-Blatch reported that the Q&S Committee had received assurance of an increased focus on Never Events within the organisation explaining that the investigative triumvirate of nurse, doctor and hospital director had proved to be very effective at managing issues.

Finance

Mr Reid noted that financial reporting within the IPR had been streamlined, with greater detail continuing to be considered by the F&I Committee.

He reported that the Trust had met its financial targets for Quarter 1 and that Cost Improvements Plans had been delivered during months 2 and 3. An underlying cash shortfall of £10-12million was adversely impacting the Trust and had led to partners and suppliers not being paid as quickly as the Trust would like. Discussions were taking place about the possibility of securing an emergency loan to resolve the issue. Continued delivery of the Trust's financial plans would help to improve the situation.

The Trust's Payment By Results contract had led to a £45-50million pressure on the local health economy and the Trust was working with partner organisations to mitigate the issue. Mr Reid reported much better grip on both beds and activity this year compared to the previous year which had led to a greatly improved understanding of issues.

Ms Kavanagh asked about the payment of invoices, and Mr Reid explained that the Trust tried to prioritise paying smaller suppliers. Outstanding invoices were reviewed on a weekly basis to ensure that there was as little impact on clinical services as possible, but a number of suppliers had threatened to cease provision of services.

Leadership & Culture

Miss Green reported that recruitment remained a challenge for the Trust with a reduction in medical staffing recruitment rates during the month. A number of initiatives were in place with focus on hard to recruit to areas. Turnover had increased slightly, both for the Trust and throughout the NHS and work was being undertaken to identify reasons and potential trends for staff leaving.

In September the annual staff survey would be launched. Throughout the year the Trust had been undertaking work on priorities identified following the previous annual staff survey and focussed work on divisional priorities had also been undertaken. An upward trend in staff recommending the Trust as a place to get treatment was being seen in

staff family and friends tests

Mr Stevens expressed concern about appraisal rates remaining below 75%, and Miss Green reported that the issue was being picked up with divisions in their IPRs. Dr Bull was confident that appraisals were taking place, but not always within 12 months. He noted that the Trust performed well compared to similar trusts, but hoped to see continued improvement in appraisal rates.

Mrs Churchward-Cardiff noted her concerns about the continued increases in the turnover rate, and Miss Green explained that the issue would be looked at in detail at the next POD Committee meeting.

Mr Nealon noted that considerable reductions in agency usage had been made, but total temporary staff spending from May 2016 to May 2017 had increased. Miss Green explained that the increase was due to increased establishment and Mr Reid reported that the increase would be looked at by the F&I Committee.

The Board noted the IPR Report for Month 2.

066/2017 **Financial Special Measures Update**

Mr Reid reported that NHSI had approved the Trust's financial plan for 2017/18. Key development areas had been identified to help the Trust meet financial targets with a focus on seven key workstreams. The financial plan required the Trust to realise efficiency savings of £28.7million during 2017/18 and Mr Reid anticipated that £40million worth of saving schemes would have been identified by August. Contingency plans were in place in the event that some of the schemes did not deliver as expected.

He reported that the Trust had delivered its financial plans for quarter one, noting that he expected increasing improvements as the year progressed. The Trust had a shortfall in staffing for full delivery of the plans, and he anticipated that an additional 5WTEs would be needed to ensure operational teams had the correct capacity to deliver plans.

Mr Clayton-Smith highlighted the importance of ensuring that quality and safety within the Trust was not affected by the financial issues. He praised the progress that had been made in agreeing the plan and in delivering on the first quarter's target. Dr Bull explained that the Trust was trying to save money by getting rid of waste and duplication and not by affecting quality. A staff suggestion scheme has been very effective in identifying potential savings.

Mr Nealon asked about measures being taken to ensure that elective surgery was protected when the system was under pressure. Dr Walker explained that during the busy winter period elective surgery had been protected..

Mrs Churchward-Cardiff asked whether additional staff appointed by the Trust to help deliver financial plans were permanent positions. Mr Reid replied that the Trust had spent some time rebuilding the capacity of teams to an appropriate level of staffing. Only sixteen positions were as a direct result of FSM and he anticipated a proportion of those roles would become permanent positions.

067/2017 **ESBT Alliance Options Appraisal**

Dr Bull reported that an accountable care system for the ESBT geographic area was being developed which would deliver health and social care in a combined, integrated manner. A recent workshop with stakeholders had considered four options set out within the papers and had concluded that option four, the merger of organisations or formation of a new organisation, was the preferred model. A recommendation that organisational arrangements should continue to be developed during a shadow year with the aim of creating single organisation in 3-5 years' time was being made to the governing bodies of all the organisations involved. Mr Clayton-Smith noted that the options appraisal process had been supported by both NHSE and NHSI and that the Alliance Board were happy that processes had been appropriately followed.

Dr Bull recommended supporting the proposal, and to commit to working in partnership with partner organisations to develop governance and single leadership for the delivery of healthcare by a single organisation. He explained that stakeholders had agreed to work and strengthen as an alliance (option three) until a single organisation could be formed.

Mrs Churchward-Cardiff noted her support of option four, but at pace explaining that the sooner a single organisation was formed, the sooner there would be no competing agendas to manage. Mr Stevens agreed that he would like to see plans progress at an increased pace.

Mr Nealon noted his concern about how organisations would work as an alliance with inherent tensions between competing budgets and priorities. Dr Bull replied that contract differences between that CCG and Trust were driven by regulators and that he hoped that this position would improve over the coming months as the stated aim of the NHS was to move towards integrated NHS systems.

Ms Kavanagh asked how the organisation would be resourced, as this was not explained within the papers. Mr Clayton-Smith explained that once agreement had been reached then work would begin on how a single organisation could be formed and how this process would be resourced.

Ms Kavanagh asked whether a key driver for change was financial. Dr Bull explained that while it was important to reduce the cost of the care system, improving the quality of care for patients with long term conditions made up of several pathologies by working in an integrated fashion was a bigger driver than any financial aspect.

The Board agreed to the recommendation to support option four, the merger of organisations or formation of a new organisation.

068/2017 **Proposed STP Governance and Leadership Model for System wide Transformation**

Dr Bull presented an update on the proposed Sussex and East Surrey Sustainability and Transformation Plan (STP) infrastructure, asking for approval of the revised governance arrangements. The establishment of a programme board with representation from the 24 organisations making up the STP was proposed, with an executive group sitting under this chaired by a part time executive chair. A clinical board had already been established and would sit alongside a financial board. Recommendations about the financial structure of the STP would be made once the governance structures had been agreed.

Mr Clayton-Smith explained that the development of a place based care system was fundamental to STP plans, noting the need to strategically plan services that would respond to local demands in the best possible way. He noted that the proposed structure was being presented to the Trust Board and to the Boards of all members of the STP.

Mr Stevens asked whether the proposed structures were robust enough to be able to make difficult decisions about healthcare within the STP. Dr Bull explained that a recent debate within the STP had focussed on the status of Brighton as a tertiary centre, and a consensus decision about this has been reached to continue to develop tertiary services. He felt that this demonstrated that the structure was already in place to make decisions, bring plans to a conclusion and to implement them.

The Board accepted the recommended governance arrangements.

069/2017 **Annual Reports**

1. Workforce Race Equality Standard 2016/17

Mrs Wells reported that the Equality and Diversity Steering Group had reviewed the Workforce Race Equality Standard (WRES) metrics in detail, noting that some of the staff sample sizes were very small and led to disproportionate statistical outcomes.

Ms Kavanagh reported that the WRES had also been discussed by the POD Committee where no significant items of concern had been identified. Miss Green noted that cultural awareness training was becoming increasingly important within the organisation due to the changing workforce.

Mr Stevens asked whether having junior doctor representation on Board Committees and at Board level would be beneficial and Miss Green replied that junior doctors would be asked if they would like to participate

when they joined the Trust.

Ms Kavanagh noted that the Board was not representative of the diversity of the organisation. Mr Clayton-Smith asked Miss Green to provide a report to a meeting of the POD later in the year on the positive actions being taken about issues raised by WRES. As Board vacancies arose consideration would be given to addressing the diversity of membership.

The Board noted the WRES annual report.

2. Organ Donation Annual Report 2016/17

Dr Walker presented an executive summary of organ donation within the Trust from April 2016 to March 2017, explaining that a longer report was available if requested. He thanked Dr Goswami for his work on organ donation. He explained that Dr Goswami had asked whether a NED might be interested in chairing the organ donation committee and Dr Walker agreed to follow this up. **DW**

The Board noted Organ Donation annual report.

3. Complaints Annual Report 2016/17

Ms Gardner-Blatch presented the Complaints Annual Report for 2016/17 noting a slight reduction in complaints received, with large improvements realised in the speed of responses by the Trust. The Trust would now focus on ensuring that responses were correct the first time by working to understand the actual issue that need to be addressed, and on reducing numbers of complaints that were reopened.

Mrs Churchward-Cardiff asked what actions the Trust took when patient complaints were upheld by the parliamentary ombudsman. Ms Gardner-Blatch explained that the Ombudsman made recommendations to the Trust which would then be actioned and evidenced to provide assurance. Action plans were shared with the complainant .Ombudsman and regulators.

Mrs Churchward-Cardiff noted concerns that the third biggest area of complaint concerned attitude. Ms Gardner-Blatch explained that work was being undertaken with wards around leadership and culture and it was hoped that this would lead to improved patient experiences. Dr Bull explained that he read every complaint letter and a disproportionate number of complaints about attitude related to agency staff.

Mr Stevens noted his concerns about the length of time taken to respond to complaints. Dr Bull agreed, explaining that while the Trust was responding to complaints more swiftly than it had previously done improvements could still be made.

The Board noted Complaints annual report.

070/2017 **Nursing and Medical Revalidation**

Dr Walker explained that the Trust had again achieved 100% compliance in medical revalidation and thanked the revalidation team for their hard work in achieving this. He was not aware of any other Trust achieving this level of compliance. A recent national revalidation report had made a number of recommendations, many of which the Trust was already compliant with.

Dr Walker noted that Dr McGreevey was due to retire in August, although would be coming back to work for the Trust on a part time basis. He thanked her for all her hard work during her time with the organisation.

Mr Nealon asked how the revalidation of locums was managed. Dr Walker explained that locum agencies had to undertake appraisal and revalidation of doctors if they were employed on a full time basis by the agency. The Trust became responsible for appraisal and revalidation of doctors moving from locum agencies to the bank, which posed a risk to the 100% compliance rate. The revalidation team supported bank doctors through this process.

Mrs Gardner-Blatch reported a similar success story with nursing revalidation, with over 99% compliance. A single nurse within the organisation had forgotten to complete the process and was now compliant. Dr McGreevey reported that she felt that the processes in place for nursing revalidation were very robust, noting that feedback received from members of staff had been excellent.

Mrs Chadwick-Bell asked how managers who were also registered nurses were supported in undertaking revalidation. Dr McGreevey explained that all registered nurses were responsible for their own revalidation. The Trust received an automatic notification about revalidation for any nurses on the NMC's register and supported them through the revalidation process.

Mr Clayton-Smith thanked Dr McGreevey for her hard work during her time with the Trust.

The Board noted Nursing and Medical Revalidation annual report.

071/2017 **Board Subcommittee Minutes**

1. Audit Committee

The minutes were reviewed and noted.

2 Finance & Investment

Mr Nealon emphasised that the Trust's cash position was unacceptable and that capital was very tight. He noted that Mrs Churchward-Cardiff

had attended the F&I meeting in May.

The minutes were reviewed and noted.

3. People & Organisational Development Committee

The minutes were reviewed and noted.

4. Quality & Safety

The minutes were reviewed and noted.

072/2017 **Any Other Business**

Dr Bull highlighted that he had attended the Dementia Training Simulation Workshop and had found it to be a very powerful experience. This had been funded by Trust charitable funds.

Mr Clayton-Smith said that he was committed to raising the profile of East Sussex and to highlight the positive work being undertaken. He highlighted that the Chair of NHS Providers would be visiting the Trust in July, the Chair of the CQC in August and the Chief Inspector of Hospitals in September.

073/2017 **Questions from Members of the Public**

Car Parking

Mr Cambell questioned the safety of the Trust's car parks as, following the relocation of ticket machines, pedestrian markings and clear pathways were no longer appropriate. He noted that ticket machines were difficult to read in sunny weather and Dr Bull agreed to follow up both issues. **AB**

Budgets

Mr Campbell had received an FOI list of budget holder plans vs actual spending, noting that it contained numerous examples where plans had been exceeded. Mr Campbell questioned whether budgets were reviewed before expenditure and if there were sanctions for overspends.

Mr Reid advised that the Trust was on a journey of budget management and that sanctions were not applied but support was provided, for example via weekly training sessions. There were some challenging areas, for example pharmacy, and there was a focus on such areas. Divisions were held to account at Performance Review Meetings.

Cost Flow

Mr Campbell raised a concern regarding peaks and troughs of cost flow within the organisation. Mr Reid acknowledged this, explaining that there was ongoing work within the finance department to address the issue.

Discharge Plans
Mr Campbell asked who was responsible for discharge plans at ward level. Dr Bull advised that this would this would be the Matron supported by the discharge team. All patients should have a treatment plan and an expected date of discharge.

Maternity Data
Mrs Walke advised that Office of National Statistics data for stillbirths appeared to show the Trust had a negative variation against the national average, and queried the reason for this. She noted that a report was due to be presented on maternity at the CCG meeting the following day and queried what this related to. Ms Gardner-Blatch agreed to review these matters and advise Ms Walke. **SGB**

Mortality
Mrs Walke queried whether mortality data could be split between community and acute and Dr Walker advised that RAMI already did that.

Travel
Mrs Walke welcomed the plans for placed based assessments as patient travel to and from hospital was not funded.

Junior Doctors' Contracts
Mrs Walke commended the Trust on their work with Junior Doctor rotas.

074/2017 **Date of Next Meeting**

Tuesday, 26th September 2017, in the Hastings Centre

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 25th July 2017 Trust Board Meeting

Agenda item	Action	Lead	Progress
065/2017 – PR Month 2	Cancer Standards to be discussed in detail during August's Board Seminar	Pete Palmer	Complete
069/2017 – Organ Donation Annual Report	Potential NED Chair of Organ Donation Committee Sought.	David Walker	Potential Chair identified and details passed to Organ Donation Lead. Complete.
073/2017 – Questions form Members of Public	Questions about car parking and ticket machines submitted. Dr Bull agreed to follow up.	Adrian Bull	Response sent to Mr Cambell. Complete.
073/2017 – Questions form Members of Public	Query about negative variation against national average for stillbirths. Ms Gardner-Blatch agreed to follow up.	Sharon Gardner-Blatch	Response set to Ms Walke. Complete

The Improvement Hub

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer:	Catherine Ashton

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)

Key stakeholders:		Compliance with:	
Patients	☐	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐

Other stakeholders please state: ……

Have any risks been identified ☐ *(Please highlight these in the narrative below)*	On the risk register?

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

East Sussex Healthcare NHS Trust (ESHT) is making a long-term commitment to develop and embed a culture of continuous improvement. The Improvement Hub has been established at ESHT to provide a range of support for staff, so that we can make use of all the talent and experience within the organisation to ensure that we continuously learn, adapt and improve.

The Improvement Hub will support continuous improvement at ESHT by:

- Developing and coordinating improvement training opportunities
- Ensuring there is support to design systems and processes that lead to clinical, service and quality improvements
- Bringing together expertise from across the organisation to share learning.

A range of initiatives have already been initiated through the Improvement Hub, which are detailed in the attached presentation.

2. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD)

The Board is asked to note the progress with setting up the Improvement Hub at ESHT and the range of initiatives being undertaken to roll out improvement training and provide support across the organisation.

East Sussex Healthcare NHS Trust

Audit Committee

1. Introduction
An Audit Committee was held on 26th July 2017, but as the final minutes have not yet been approved a summary of the items discussed at the meeting is set out below.

2. Matters Arising
Issues with Trust compliance with the National Diabetes Audit had been resolved and a partial audit return had been made for 2017, with a full return to be made for 2018. An electronic system to manage declarations of interest was due to be launched by the Trust to improve management and visibility of declarations.

3. Board Assurance Framework and High Level Risk Register
The Board Assurance Framework and High Level Risk Register were presented, having previously been reviewed by the Quality & Standards Committee and the Trust Board.

4. Risk Appetite
Following the Board Seminar on 21st June it was agreed that each Board sub-committee would review the draft risk appetite proposals in respect of the areas within their remit. The Committee considered the financial and compliance risk appetite.

5. Diagnostics and Surgery Clinical Audit & Risk Register
The division reported that they were undertaking all national audits and were fully compliant with NCEPOD. They reporting that their biggest risk concerned histopathology vacancies.

6. Fire Safety Annual Report
The Fire Safety Annual Report was approved to come before the Board in September.

7. Research & Development Annual Report Strategy
Risks were acknowledge due to reduced funding allocation from CRN KSS. Commercially sponsored research studies were planned to fund shortfalls in core funding.

8. Clinical Audit Update
The Committee agreed to help identify divisional leads for the seven day audit which opened in September.

9. Internal Audit Progress Report
There had been six final audit reports issued. Two give "Limited" assurance, one "Reasonable" assurance, two were operational reviews not carrying an opinion and one was a follow-up report.

10. Local Counter Fraud Service Progress Report
NHS Protect would be undertaking an inspection for counter fraud at the Trust on 5th and 6th September. The Committee would receive a copy of the inspection report.

11. External Audit Progress Report
The Auditors issues a limited assurance review for the Trust's Quality Account 2016/17 due to being unable to verify Venous Thromboembolism data quality.

12. Information Governance Annual Report
The Trust received "Substantial" auditor assurance for the IG Toolkit.

Mike Stevens
Chair of Audit Committee

12th September 2017

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Thursday, 28th September 2017, starting at 10.00 am
in the Committee Room, Conquest

AGENDA

1.	Apologies for absence		Mike Stevens
2.	Minutes of the meeting held on 26th July 2017	A	Mike Stevens
3.	Matters Arising	B	
4.	Board Assurance Framework and High Level Risk Register	C	Lynette Wells
5.	Security management systems annual report 2016/17	D	John Kirk
6.	EDGH & Fire Compartmentation	E	Mark Paice
7.	Clinical Audit Update & Annual Report	F	Emma Moore
8.	Internal Audit Progress Report	G	Adrian Mills
9.	Local Counter Fraud Service Progress Report	H	Chris Lovegrove
10.	External Audit: 11.1 Progress Report 11.2 Work Plan	I	Darren Wells
11.	Information Governance Toolkit Report and Registration Authority Report	J	Lynette Wells
12.	Review of Losses & Special Payments	K	Steve Hoaen
13.	Date of Next Meeting – Wednesday, 22nd November 2017 at 1000 in St Mary's Boardroom, EDGH		Mike Stevens

Quality and Safety Committee

1. Introduction

Since the Board last met a Quality & Safety Committee meeting was held on 19 July 2017 and minutes are due to be approved at the next meeting on 20 September 2017. A summary of the items discussed at the meeting is set out below.

2. Patient Story

The wife of a patient came to talk about her husband's experience of care in the Trust. They wanted to share the experience so that some of the issues, such as communication, could be addressed and improvements embedded in the Trust.

3. Board Assurance Framework

Key points - Increased assurance relating to mortality metrics
- Addition of a new risk relating to 7 day services
- Patient Transport risk was removed from the BAF

4. High Level Risk Register

Key points – Asbestos risk had been on the register for a significant period of time – management plan to be tested at the next IPR
- Ophthalmology risk – first stage of process map had been completed
- Lack of inventory and lifecycle plan for medical equipment to be added to the risk register
- VTE Risk Assessments risk reduced from 25 to 15

5. Risk Appetite

The Quality and Safety Committee discussed and approved levels assigned to Quality, Compliance, and Reputation of the Good Governance Institute Risk Appetite Matrix.

6. CQC Progress Report

Significant amount of work going in to End of Life Care but more pace needed. Diagnostics showing red but new leadership was resulting in progress. Assistant Director of Midwifery and Nursing had been invited to lead on childrens' transfer into adult services which needed more momentum.

7. ESHT 2020 Improvement Programme

Three areas of concern:
- Urgent and Emergency Care remained at amber
- Medical model – works on Seaford 1 and 2 at EDGH had commenced at risk and business case for funding for recruitment elements was being developed.
- Red to Green had been rolled out to surgical wards successfully but as this was recent was still showing amber.

8. Improvement Group Exception Report

Brief update – nothing to report by exception

9. Governance Quality Reports

- The Quality Account for 2016/17 had been completed and submitted
- Reduction in complaints backlog – fluctuating around 10
- Deep Dive for each Division relating to 2 themes, included patient representation and Healthwatch
- Duty of Candour compliance continued to improve.
- Challenges to completion of Serious Incident actions – this was being addressed
- Challenges to completion of National Audits and NCEPOD.

10. Safeguarding Annual Report – 2016 to 17
Approved subject to minor amendments.

11. Quality Strategy Review
Noted.

12. IPR Month 2 – Quality and Safety
A Never Event was being investigated. Morbidity and Mortality Policy was being reviewed to reflect new methods of learning from deaths.

13. Quality Improvement Priorities
Quality Account had moved from the Governance Team to the Strategy Team to allow them to be sighted on issues that might cause delay to delivery. A quarterly report would be submitted to the Executive Directors' meeting with milestone reports being submitted to the Quality and Safety Committee.

14. Deep Dive – End of Life Care
The final draft of the End of Life Care policy was being reviewed and would be presented to the Policy and Documentation Group for ratification before 20 September 2017. 31 policies relating to End of Life Care were in the process of being reviewed. Training had gone well and an electronic training package was being introduced for doctors. It was noted that the pace of progress needed to increase. The lead for EoLC had been passed to Hazel Tonge, current Acting Director of Nursing.

Sue Bernhauser, Chair, Quality and Safety Committee
12 September 2017

East Sussex Healthcare NHS
NHS Trust

Quality and Safety Committee – Agenda

Wednesday, 20 September 2017, 14.30 – 16.30, Committee Room, Conquest

1.0	**Welcome and Apologies for Absence**	Chair	14.30
2.0	**Patient Story**		14.35
3.0	**Minutes and matters arising**	Chair	14.55
3.1	Minutes of the Quality and Safety Committee meeting of 19 July 2017		
3.2	Action Log		
4.0	**Compliance and Risk**		15.05
4.1	Patient Safety and Quality - Board Assurance Framework	LW	
4.2	Patient Safety and Quality - High Level Risk Register	LW	
4.3	Asbestos Risk Update	TH	
4.4	CQC Progress Report – Sep 17 and Mock Inspection	LW	
4.5	ESHT 2020 Improvement Programme (including notes of QISG)	HT/LWa	
4.6	Review of Terms of Reference	AP	
5.0	**Safety and Quality**		15.40
5.1	Governance Quality Report (includes PSQG Report)	AP	
5.2	National Cancer Patient Experience Survey	HT	
5.3	Quality Section of the Integrated Performance Report Month 4	HT	
5.4	End of Life Care Policies including verbal update	HT	
5.5	Equality & Delivery System (EDS2) – Annual Report	KN	
5.6	Infection Control – Annual Report	LS	
5.7	Quality Impact Assessments Update	HT	
5.8	Winter Pressures	LW	
5.9	Radiology – verbal update	JH	
6.0	**Highlight Report**		
6.1	Highlight Report – Pressure Ulcer Update	RS	16:10

7.0	**Papers for noting** Healthwatch – Round the Clock Care Report	N/A	
8.0	**Deep Dive for next meeting**	Chair	16.20
9.0	**Any Other Business** - *Substantial items of any other business must be agreed prior to the meeting with the Chair.*	Chair	16.25
	Date of Next Meeting – Wednesday 22 Nov 2017, 14.30 – 16.30, St Mary's Boardroom, EDGH - Reports due by 13 Nov 2017		

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Thursday 28th September 2017
10.00am – 12.00pm
Princess Alice Room, EDGH with v/c to Room 3, Education Centre, Conquest Hospital

AGENDA

No.	Item	Timing	Paper	Presenter
1.	Welcome and apologies for absence			Chair
2.	2.1 Minutes of the meeting held on 15th June 2017	5 mins	✓	Chair
	2.2 Review of Action Tracker	5 mins	✓	Chair
3.	Feedback from sub-groups: 3.1 – Engagement & OD Group 3.2 – Education Steering Group 3.3 – Workforce Resourcing Group 3.4 – HR Quality & Standards Group	15 mins	✓	 LM MG MT MG
4.	Workforce Risk Register			MG
5.	Risk Appetite			LW
6.	Retention Strategy			MT
7.	Succession Planning/Talent Management update			LM
8.	Junior Doctors Report			GOSW/ MT
9.	Schwartz Rounds			Dr Farida Malik
10.	Items for information: 10.1 – Workforce Report 10.2 – Workforce Assurance Tool			Chair

11.	Any other business			Chair
12.	Date of next meeting: Thursday 14 December 2017 10.30am – 12.30pm Finance room, Duncan House, EDGH with v/c to Room 3, Education Centre, CQ			Chair

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Wednesday 27 September 2017, at 9am – 12pm
Committee Room, Conquest

DRAFT AGENDA

			Lead:	Time
1.0	**Welcome and Apologies for Absence**		Chair	9.00
2.0	**Minutes and Matters arising**			9.05
2.1	Minutes of the meeting held on 30 August 2017	Approval	Chair	
2.2	Action log	Assurance	Chair	
3.0	**Operational Financial Performance**			9.15
3.1	Integrated Performance Report – Month 5	Assurance	JR	
3.2	Contracts – Monthly Review	Assurance	JR	
3.3	Cashflow – Monthly Review	Assurance	JR	
4.0	**Divisional Assurance**			10.15
4.1	Out of Hospital		AT	
5.0	**Financial Strategy and Sustainability**			10.35
5.1	FRP progress update (inc. securing additional capacity)	Assurance	JR	
5.2	Clinical Services Review - update	Assurance	JD	
5.3	Financial & Business Planning Update 2018/19	Assurance	JR	
5.4	Alliance Executive Financial Plan 17/18	Assurance	JR	
5.5	Sussex & East Surrey STP Financial Plans	Assurance	JR	
6.0	**Costing and Coding/ Commercial Developments**			11.30

6.1	Market Developments Quarterly Report	Assurance	TR	
7.0	**Business Cases**			11.40
7.1	Estates Plan	Assurance	MP	
7.2	iMSK update	Assurance		
8.0	**Work Programme & Next Meeting**			11.55
8.1	2017/18 Work Programme	Assurance	Chair	
8.2	Next Meeting: Wednesday 25 October 2017 at 8.30am – 11.30am, St Mary's Board Room, Eastbourne DGH	Assurance	Chair	
9.0	**Minutes to Note – for information only**	Assurance	JR	
9.1	FISC – 21 August 2017			
9.2	Capital Resources Group – 16 August 2017			
9.3	Business Development Group – (? August tbc)			
9.4	Digital Steering Group – (any after 7 July 2017)			

Board Assurance Framework

Meeting information:			
Date of Meeting:	25 July 2017	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	.....		
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register? N/A	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

Attached is the updated Board Assurance Framework. Following agreement at the last Board meeting two items have been removed in respect of patient transport and mortality. The wording for the gap in assurance regarding seven day working (3.3.1) has also been revised.

There is one proposed addition 4.3.1 in relation to compliance with fire safety regulation, this relates to compartmentation at the DGH site. The action plan is being reviewed and will be shared with the fire service.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Audit Committee – 28th September 2017 Quality and Safety Committee – 20th September 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Trust Board is asked to:

- Review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks.
- Agree the addition of the gap in control regarding compliance with fire regulation.

Assurance Framework - Key

RAG RATING:

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

Status:

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

Key:	
Chief Executive	CEO
Chief Operating Officer	COO
Director of Nursing	DN
Director of Finance	DF
Director of Human Resources	HRD
Director of Strategy	DS
Medical Director	MD
Director of Corporate Affairs	DCA
Committee:	
Finance and Investment Committee	F&I
Quality and Standards Committee	Q&S
Audit Committee	AC
Senior Leaders Forum	SLF
People and Organisational Development Committee	POD

C indicated Gap in control

A indicates Gap in assurance

	Strategic Objectives:
1.	Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2.	All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.
3.	We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4.	We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5.	We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.
	Risks:
1.1	We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies.
2.1	We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.
2.2	There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.
3.1	We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.
3.2	We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.
3.3	We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners
4.1	We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.
4.2	In running a significant deficit budget we may be unable to invest in delivering and improving quality of care and patient outcomes. It could also compromise our ability to make investment in infrastructure and service improvement
4.3	We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan
4.4	We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.
5.1	We are unable to effectively recruit our workforce and to positively engage with staff at all levels.
5.2	If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

Strategic Objective 1: Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients

Risk 1.1 We are unable to demonstrate continuous and sustained improvement in patient safety and the quality of care we provide which could impact on our registration and compliance with regulatory bodies

Key controls	Effective risk management processes in place; reviewed locally and at Board sub committees. Review and responding to internal and external reviews, national guidance and best practice. Feedback and implementation of action following "quality walks" and assurance visits. Reinforcement of required standards of patient documentation and review of policies and procedures Accountability agreed and known eg HN, ward matrons, clinical leads. Annual review of Committee structure and terms of reference Effective processes in place to manage and monitor safe staffing levels PMO function supporting quality improvement programme iFIT introduced to track and monitor health records EDM implementation plan being developed Comprehensive quality improvement plan in place with forward trajectory of progress against actions.
Positive assurances	Internal audit reports on governance systems and processes Weekly audits/peer reviews eg observations of practice Monthly reviews of data with each CU 'Quality walks' programme in place and forms part of Board objectives External visits register outcomes and actions reviewed by Quality and Standards Committee Financial Reporting in line with statutory requirements and Audit Committee independently meets with auditors Deep dives into QIP areas such as staff engagement, mortality and medicines management Trust CQC rating moved from 'Inadequate' to 'Requires Improvement'

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	March CQC inspection reports published Sept 15, trust in special measures. Quality Improvement plan developed Improvement Director working with the Trust. Mar-16 In depth review of all warning notice actions by exec team . QIP monitored by stakeholders, medicines management and incident deep dive took place Mar-16. May-16 to Sept-16 2020 Quality Improvement Priorities agreed and key metrics developed to support compliance and monitoring. Commenced preparation for Autumn CQC inspection. Mock inspection took place end June, further mock planned end of July. Continued monitoring of QIP and preparation for CQC inspection. Nov-16 CQC inspection took place October - draft report expect Dec 16. Continuing with quality improvement priorities eg end of life care and optimising patient pathways. Jan-17 Draft report expected this month Mar-17 Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17 Jul-17 Action tracker in place and monitored with divisions and at Q&S. New CQC regulatory guidance being reviewed and communication plan developed to ensure Trust can evidence compliance. Sep-18 QIP in place. Continued monitoring of action tracker, internal inspection planned for 21 Sept. CQC progress meeting took place 22 Aug awaiting feedback on scope and timetable for inspection,	end Dec-17	◄►	DN	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

Risk 2.1 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report.
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance. Consistent achievement of 2WW and 31 day cancer metrics

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	IST review to supplement work with KSS Cancer network on pathway management. Focused work to improve 2ww performance position. Mar-16 - Achieved 2WW breast symptomatic in Jan and both standards in Feb. In addition, TDA support provided 2 days per week to focus on sustainability and 62 day achievement. May-16 Ongoing review and strengthened processes supporting improved performance against cancer metrics. 2WW achieved Feb/Mar, breast symptomatic not achieved Mar, 62 days improving. Jul-16 - Nov 16 Achieved 2 week wait and 31 day standard for last quarter. Clinically led Cancer Partnership Board commenced June . Cancer Action Plan providing continued improvements such as the reduction on 2 week wait triage delays. Nurse Advisor commenced October to support all cancer pathways and targets. Collaborative piece of work with CCG re 2WW criteria to ensure compliance with guidance and appropriately targeted referrals. Cancer Services and Specialist Medicine are working on a bid to the CCGs for specialist endobronchial ultrasound local provision Jan-17 Compliance with 2WW and 31 day. 62 days off trajectory at 72.^% Continuing to embed actions outlined above. Mar-17 Continued achievement of 2WW and 31 day standards. 62 days 84.1% off trajectory but improving. Number of programmes in place to support improvement including joint PTL tracking with both Brighton and Guys. May-17 Performance of 62 days below trajectory at 69.9% (latest data Feb 17) Greater focus on patient tracking with Guys being set up to run weekly in order to replicate the scrutiny on 38 day transfers currently in place with MTW and BSUH. Refer to monthly IPR for details of ongonig programmes of work to improve cancer metrics. Jul-17 Continued focus on 62 day achieved 76% (latest data Apr 17) trajectory 85% Sep-17 Presentation to Board Seminar in Aug. Continued progress in improving performance particular focus on achieving 62 day performance by end of Sept 17	end-Oct 17	◄►	COO	SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.2	C	Emergency departments require reconfiguration to support effective patient assessment-treatment time and subsequent discharge to other specialist/bed areas. CQC report identified privacy and dignity issues.	Meet SECAMB monthly to review on going issues and joint working to resolve. Action plan and escalation process in place Capital bid with TDA for review to support expansion; outcome awaited, planning permission being sought in advance. Dec-15 Capital bid to be considered by ITFF at end of Feb. Mar-16 AHSN developing proposal to support the Trust with patient flow in A&E areas which will have a positive impact on privacy and dignity. Risk remains red as reconfiguration still required. May-16 Finance application being redeveloped for submission to ITFF to support capital plans. Jul-16 Trust prioritising reconfigurations from own capital programme to support effective patient pathways and address privacy and dignity issues. Finance application being redeveloped for ITFF. Sept-16 Urgent Care Programme Board established. Multi-disciplinary summit being planned to further support improved patient flow. Nov-16 Number of improvements being implemented in A&E although some not fully introduced due to staffing and space concerns, particularly at Conquest site. May-17 Trust allocated A&E capital funding from DH - £700k for Conquest and £985k for DGH. This will support streaming in the emergency departments. Funding bid also submitted for wider Urgent Care Programme eg development of ambulatory care. Jul-17 Project in place streaming redevelopment commencing to be in place by Oct 17 Sep-17 Building work commenced at DGH for ambulatory care.	end Dec 17	◄►	COO	SLF
2.1.3	C	Focus required on patient flow and delayed discharges across Trust sites to minimise impact on emergency departments and support compliance with constitutional standards.	Nov-16 Principles of Medical Model approved by Urgent Care Board and SAFER bundle pilot of 6 wards commenced in October with aim of improving patient flow by discharging patients earlier in the day to enable patients to be “pulled” from A&E, CDU and AMUs earlier in the day. Jan-17 Continued pressure on Urgent Care and Patient Pathway. Urgent Care Improvement Plan ion place and monitored weekly against the 9 improvement areas to ensure the anticipated impact is being realised. Streaming has led to an improvement in the number of breaches. New clinical lead for EDs appointed. Daily Opex call in place to discuss system wide issues. Mar-17 SRO reviewing project and re-aligning to focus on five priority areas. Streaming pathways written up for sign-off with specialties. ESHT Principles of Effective Emergency Care published and communicated to consultant and junior medical staff. SAFER bundle being rolled out across the Trust. May-17 Achievement of key constitutional targets and trajectories remains challenging however, performance is improving . A number of actions completed and being embedded, refer to performance report. Continued focus and programmes of work around A&E management, medical model and improved discharge. July-17 4 week improvement challenge started June with a concerted effort across the Trust to meet the 4 hour clinical standard. Achieved significant improvement in meeting the A&E standard but increased A&E attendance made it difficult to sustain. A&E Improvement Plan is in place and monitored weekly against 9 improvement areas to ensure the anticipated impact is being realised. Streaming in particularly has shown a marked improvement in the number of minors breaches. Sept-17 A&E Attendance increased by 6.9% year to date. A&E performance 87.7% July, and improved to 92.5% in August.	end Dec17	◄►	COO	

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.

Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.5	C	Effective controls are required to ensure children requiring an appointment with a community consultant paediatrician are seen in a timely manner.	Feb-15 to Oct-15 Action plan implemented and waiting list backlog cleared. Patient Tracking List developed and activity being monitored. Jul-16 Wait time to be seen reduced to 6 months for initial community paediatrician assessment. Active recruitment for CDC coordinator and 2 substantive consultant posts. 2 locum consultants start 4th July. Further part time locum consultant starting Aug. Sept-16 Locums in place. Difficulties in division of acute and community patients undertaking validation exercise, moving to Systm one which will support this. Nov-16 Work ongoing as outlined above - no further update. Jan-17 Recruiting to 4 substantive posts interviews mid January, good field of candidates. Validation process in place and waiting list continuously monitored. Community paeds will be fully utilising Systm One by April. Mar-17 Continuing increase in referrals to community paeds, 3 locums supporting. New referrals first appointment reduced to 6 months. Ad hoc clinics for follow up. Systm One data being uploaded for 21 March go live. May-17 Continuing increase in referrals to community paeds, 3 locums supporting. New referrals first appointment continue at 6 months. Ad hoc clinics for follow up. Systm One data nearly completed upload – some consultants already live – Eastbourne site starting live first. Jul-17 50% increase in referrals to service over the last two years. Wait time for initial appt remains at 6 months. All consultants are live on system one. 2 locums in place and 1 locum has joined the Trust in a substantive post. No further ad hoc clinics as poorly attended. Commenced telephone follow up consultations Sept-17 Management of increased levels of referrals continues with locum doctors and telephone follow up consultations.	end Oct-17	◄►	COO	SLF Q&S

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.1.6	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Aug-15 Training requested from mental health team at CAMHS for ward nurses to ensure a competent and confident workforce. Mental health nurse requested via TWS to special the young people Reviewing options for cohorting mental health young people. Liaising with SPT and commissioners re purchasing adequate tier 4 beds. Oct-15-Mar 16 Creating amenity beds and liaising with SPT on a case by case basis for CAMHS patients. Joint working with SPT, CAMHS recruiting assessor to support appropriate pathway for these young people. Continued working with CAMHS and SPT to develop pathway. May-16 A& E Liaison Nurse appointed to Conquest, equivalent being recruited to DGH. HoN requested in-reach pathway from CAMHS for these pts and daily ward visit. HoN attending urgent help/crisis meeting care and attending CAMHS transformation board to raise profile of young people in crisis with commissioners and gain adequate investment for this cohort. Jul-16 Out of hours urgent help service increased weekend capacity from 2 to 4 staff. Business case submitted to CCG to increase workforce to meet the need of CYP in crisis. Awaiting decision. Meeting to be held 8th July to review the A& E Liaison Nurse at Conquest role. Training requested from mental health team at CAMHS for ward nurses. Sept-16 Improving system CAMHs Liaison nurse available every day. Some inappropriate admissions still but these are individually reviewed. Nov-16 Awaiting CAMHs Liaison nurse appointment for west of county. HoN meeting with SPFT and commissioners to discuss inequity of service provision for CYP admitted to children's ward who are resident in west of county, i.e delays in assessments and telephone assessment Jan-17 Situation being reviewed and monitored. GM meeting with CAMHs. Mental health nurse visits wards daily 9-5 Monday to Friday. Additional mental health training for ESHT nursing staff but need therapeutic intervention from CAMHS Mar-17 Strategy meeting planned and also meeting SPFT to discuss further support, need sufficiently skilled staff. Hospital Director CQ linking in with SPFT for mental health matters. Jul-17 Ward nurses having mental health training currently as part of away days. Special Observations Policy ratified and specials being requested ad hoc. Paediatric strategic work including mental health in reach plan Sep-17 - Meeting arranged to review issues on 25.09.17. Audit of children admitted to the paediatric ward with a mental health diagnosis commenced.	end Oct-17	◄►	COO	SLF Q&S
2.1.7	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting. May-17 Position resolved with community paediatrics due to data transition to Sytm One. Ongoing discussion to find Trustwide solution. Jul-17 All doctors validating Follow Up waiting lists and telephone Follow Ups now taking place. Longest waiter 36 weeks. Sep-17 IT reviewing to develop a follow up waiting list that can be easily complied from existing systems and monitored at a specialty/consultant level for volumes and timeframe for appointments	end Oct-17	◄►	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.	
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place Significant and sustained improvement in appraisal and mandatory training rates

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.2.1	A	Assurance is required that robust controls are in place in relation to mandatory training and appraisals are effective and evidenced by improved compliance in these two areas.	Appraisal process and paperwork redesigned along with a development programme for Appraisers. New L&D manager started Feb and key objectives to review mandatory training, develop competency work and identify further efficiencies. Rating moved from amber to green Mar-16 Review being undertaken to address compliance and quality of appraisal. New appraisal policy in place and additional support offered to staff with this process. Jan-17 Mandatory training compliance trust wide exceptions are safeguarding children level 3 is at 82.59% (urgent care is 55.93%); Safeguarding children level 2 is at 83%; information governance 84.9% (74.5% in urgent care). Appraisals currently at 79.2% lowest for a year. Training is being offered for any staff new to appraising staff, or who want a refresher. Mar-17 – Appraisal rate is 78.42% for January (latest figures), an upward trajectory since December although only a slight increase. Work is being done with A&E to support them in offering additional refresher training for newly appointed managers who undertake appraisals and also to ensure that all staff who need appraisal training can be booked on. Mandatory training figures are improving. The only exceptions are for safeguarding level 2 and 3 where levels are 71.74% (Chief Operating Officer) and 67.19% (urgent care) in two areas. May-17 Compliance improving slightly with Appraisal rate 78.89% and Mandatory Training 88.54% for March. Focussed work programme targeting areas and divisions where compliance requires improvement. Jul-17 Continued improvement in both Appraisal 81.73% and Mandatory Training 88.29% L&D continue to analysis and work with managers to achieve compliance. Sep-17 Continued improvement in both Appraisal 82.86% and Mandatory Training 89.56% all subjects reported to Board are now green (over 85%) and are nearing the 90% target. Risk that coming into the autumn/winter period levels may drop due to ability for staff to be released for training but we will continue to work with managers to maintain levels where possible.	end Sep-17	◄► Mar-16	HRD	POD SLF

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
2.2.2	A	The Trust needs to develop and support its clinical leadership to empower them to lead quality improvement in order to realise the ambition of becoming an outstanding organisation by 2020.	Jul-16 Reviewing medical leadership roles to ensure they are appropriately resourced. Faculty of Medical Leadership Programme in place. CEO leading regular meetings with consultant body. Medical education team continue to work with junior doctors to improve engagement and enhanced support. New Medical Director appointment (subject to central approval) Revision and reappointment of all key medical role job descriptions: CU Lead; Speciality Lead; Chairs of Clinical Boards (urgent care, elective, cancer); Chairs and ToR of key Medical Clinical Governance sub committees. Sept-16 New Medical Director in post, progressing appointments of Chiefs and deputies. Nov-16 Consultant meeting 3rd Nov with CEO, MD, FD. Faculty of Medical Leadership and management training for newly appointed medical leaders 8th and 9th November. Appointments made for Divisions of Medicine and Surgery/Anaesthetics/Diagnostics, but no appointment as yet for W+C. Chairs of Urgent Care and Elective Care Boards have been made. Jan-17 Final FMLM training end of Jan. All Chiefs now appointed, including Women's and Children. Specialist leads advertised. Mar-17 Most speciality leads now appointed. Job planning training to follow. Other training possibilities arranged eg for “case investigation” May-17 Developing with Health Education England bespoke leadership development programme for ESHT to support organisational leaders in transformation, systems leadership and improvement. Initial scoping meetings taking place. Jul-17 Cohort 1 of Leading excellence programme identified and invited to attend first programme commencing in August Sep-17 The first Cohort for Leading service programme has been identified and will commence in October. The pilot for the new managers induction programme will take place in September. A stakeholder event is being held in September to discuss the new Leadership and talent management strategy	end Dec-17	◄►	MD	POD

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.	
Risk 3.1 We are unable to develop and maintain collaborative relationships based on shared aims, objectives and timescales with partner organisations resulting in an impact on our ability to operate efficiently and effectively within the local health economy.	
Risk 3.2 We are unable to define our strategic intentions, service plans and configuration in an Integrated Business Plan that ensures sustainable services and future viability.	
Key controls	Develop effective relationships with commissioners and regulators Proactive engagement in STP and ESBT Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work. Relationship with and reporting to HOSC Programme of meetings with key partners and stakeholders Develop and embed key strategies that underpin the Integrated Business Plan (IBP) Clinical Strategy, Workforce Strategy, IT Strategy, Estates Strategy and Organisational Development Strategy Effective business planning process
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Monthly performance and senior management meetings with CCG and TDA. Working with clinical commissioning exec via East Sussex Better Together and Challenged Health Economy to identify priorities/strategic aims. Board to Board meetings with stakeholders. Membership of local Health Economy Boards and working groups Two year integrated business plan in place Stakeholder engagement in developing plans Service delivery model in place Refreshing clinical strategy to ensure continued sustainable model of care in place Trust fully engaged with SPT and ESBT programmes

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Challenged Health Economy and Better Together Work on-going. Trust developing clinical strategy. Sept-16 STP for Sussex and East Surrey now incorporates placed based care (ESBT) as one of its key elements. We continue to work proactively with commissioners and other providers to ensure that opportunities to deliver efficiencies at scale and pace are maximised. This includes working across STP boundaries. ESHT CEO is now joint SRO with CCG and ESCC leaders in the emerging Accountable Care Organisation Steering Group which will develop the delivery mechanism by which the challenged health economy issues will be tackled. Nov-16 STP has been submitted which includes 5 year plans reflecting the ESBT position. ESHT has been fully involved in developing these draft plans and they will be considered at November Board Seminar. Jan-17 STP now published and available on Trust website. ESHT continue to be involved in all appropriate work streams with a specific focus our local ESBT plans and the emerging Accountable Care model. Mar-17 Trust are continuing to work with all STP partners to further develop plans. Current work includes participation in the Acute Networks Steering group which is being facilitated by Carnall Farrar. Work is ongoing in developing the governance structures and framework for the ACO which is due to enter shadow form in April 2017 May-17 STP Programme Board is reviewing Carnall Farrar work to provide a broad strategic understanding of demand and capacity issues in our Acute Hospitals in the STP footprint and all partners are working closely together to consider how we can provide Acute services that will meet the future needs of our population sustainably. Jul-17 Our System wide placed based plans (ESBT) are the local delivery plan that aligns commissioners and providers in health and social care. We have undertaken significant work across the system to redesign care pathways and this is linked to our clinical strategy which is currently being consulted on. Work is ongoing with the wider STP work currently reviewing pathology provision along with other acute services. Sep-17 We are working with commissioners on an aligned financial and operational plan that will move the system to a balanced financial position. This will be agreed by the ESBT Alliance executive and progress against plan will be monitored by this group. We are starting some work on Acute strategy with support from the WSHT/BSUH medical Director and our own Medical Director Dr David walker. This will align with the Tertiary which is currently being developed by BSUH.	end Dec 17	◄►	DS	F&I SLF

Strategic Objective 3: We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.

Risk 3.3 We are unable to demonstrate that we are improving outcomes and experience for our patients and as a result we may not be the provider of choice for our local population or commissioners.

Key controls	Development of communications strategy Governance processes support and evidence organisational learning when things go wrong Quality Governance Framework and quality dashboard. Risk assessments Complaint and incident monitoring and shared learning Robust complaints process in place that supports early local resolution External, internal and clinical audit programmes in place Equality strategy and equality impact assessments
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Board receives clear perspective on all aspect of organisation performance and progress towards achieving Trust objectives. Friends and Family feedback and national benchmarking Healthwatch reviews, PLACE audits and patient surveys Dr Foster/CHKS/HSMR/SHMI/RAMI data Audit opinion and reports and external reviews eg Royal College reviews Quality framework in place and priorities agreed, for Quality Account, CQUINs

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.1	C	Effective controls are required to ensure the Trust achieves compliance with the four core 7 day service standards by 2020. There is a risk that the Trust may not achieve compliance with three of the four resulting in loss of reputation due to difficulties in funding, staff recruitment to manage increased rota requirements. Standards 5 (access to diagnostic tests), 6 (access to specialist consultant led interventions) and 8 (Patients with high-dependency care needs receive twice or one daily specialist consultant review depending on condition) are those at risk.	01/07/2017 7 Day Service Steering Group reporting into Clinical Effectiveness Group and Quality Improvement Steering Group. Project has support from Programme Management Office, with dedicated project lead assigned. Baseline audit being undertaken. Working closely with NHS England and NHS Improvement to gain best practice/lessons learnt from other Trusts Sept-17 Baseline template to be reviewed prior to distribution and gap analysis underway; Discussions with VitalPAC provider taking place. Strategy/Plan for submission to 7DS Steering Group. Project Initiation Document being drafted.	end Apr-18	◄► Jul-17	COO	SLF Q&S

Strategic Objective 4: We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.	
Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.	
Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place PBR contract in place Activity and delivery of CIPs regularly managed and monitored.
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed weekly by CLT and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.1.1	C	Ongoing requirement for assurance on the controls in place to deliver the financial plan for 2017/18, with an efficiency requirement of £28.7m, leading to a reduction in deficit for the Trust and exit from financial special measures.	July 2017 – the Trust has a detailed financial plan for 2017/18, initially approved by the Trust Board in January 2017 and which has been subject to an iterative development process. Both the Finance and Investment Committee, on behalf of the Trust Board, and NHSI Improvement – through the Financial Special Measures Team – have sought additional assurance and specification of the plan to ensure delivery. As at 3rd July, the Trust has approved CIP schemes of £32.3, against a CIP requirement of £28.7m, and is continuing to develop a pipeline of savings. As at the same date, the Trust has also recognised that additional resource is required to ensure delivery of key schemes. Internal and specialist resource has been deployed to directly support the workforce and CSR workstreams, as well as operational delivery teams around the patient flow and elective care workstreams, and the Trust has a process in train to secure further resource for procurement and commercial workstreams. A final presentation to both the Finance and Investment Committee and NHSI in July should allow the Trust to move more fully from 'planning' to 'delivery.' The Trust has delivered on plan to Month 2, and early indicators suggest delivery at Month 3. From Month 4, the level of risk increases, and the level of both delivery support and scrutiny/challenge will continue to increase to ensure adverse variance or emerging risk is identified and escalated at the right pace. Key risks to the financial position are articulated in the Board report, and discussed in more detail at the Finance and Investment Committee. The Trust has appointed a new Head of Contracts, to ensure early escalation of contentious contract issues, and has bolstered the Financial Management Team to ensure appropriate support for budget-holders. A detailed activity and bed management plan has been agreed with the operational teams and clinical units, and the Performance and Information team are providing regular updates on performance against the plan to ensure early identification and action of performance below expectations. Sept-17 – at Month 4, the Trust was reporting fully delivery of plan, noting a number of significant risks in respect of the profiling of elective activity, the CIP plan and the recoverability of income from Clinical Commissioners in East Sussex. The initial financial results from Month 5 indicate that August trading was below plan, and intensive work is in train to ensure that the plan was calibrated correctly and that all actions are in train to address variance and to ensure a return to plan. A full review of the deliverability of the CIP programme is in train and reforecast of the Trust's financial position will ne reviewed for the Finance and Investment Committee meeting in September 2017. The CCGs and the Trust are working, through CFO and DoF review, to develop a shared forecast for the activity-based outturn for the system for the year. There remain significant risks to the system financial position, as well as individual organisational positions. The Trust has reached provisional agreement with the CCG in the 16/17 issues (noting that a new set of challenges were subsequently issued) and has reflected the appropriate component of the cost in the year to date financial position.	Commenced and on-going review and monitoring to end Mar-18	◄►	DF	F&I

Risk 4.2: In running a significant deficit budget we may be unable to invest in delivering and improving quality of care and patient outcomes. It could also compromise our ability to make investment in infrastructure and service improvement
Risk 4.3: We are unable to effectively align our finance, estate and IM&T infrastructure to effectively support our mission and strategic plan.

Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital plans operational review on a monthly basis by the Capital Review Group, and detailed review by the Finance and Investment Committee, on behalf of the Board, on a monthly basis. Essential work prioritised within Estates, IT and medical equipment plans
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Trust achieved its CRL in 2015/16

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.2.1	A	The Trust has a five year plan, which makes a number of assumptions around external as well as internal funding. Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	May-17 – The Trust has set an initial capital plan for 2017/18, which reflects key organisational priorities and the funding available. The Trust continues to seek additional funding opportunities, including capital bids for specific investment schemes and dialogue with both the financial special measures team and NHS Improvement about alternative opportunities. The five year capital plan is being redeveloped and refreshed to reflect the challenges and opportunities facing the Trust. The Trust is in discussions with a range of third parties around alternative non-capital means of financing key programmes of change. Jul-17 – the Trust has an approved capital plan for the year, following a detailed prioritisation process, and this is reviewed by the Capital Review Group on a monthly basis, with interim checkpoints to refresh the forecast. The demand for capital is greater than that available, and the Trust has a number of applications for capital in with NHSI for loan capital (primary care streaming, and ambulatory care). The Trust is also working with a number of potential strategic partners and with the Friends to establish alternative sources of capital funding to ensure that the clinical infrastructure is maintained. It will be important to review the capital programme – both the spend and the demand for capital – on a regular basis through the CRG and FIC to maintain sight of risks to clinical quality. Sept-17 – Trust's approved capital plan continues in implementation. Year to date spend at Month 5 includes expenditure being incurred on the implementation of the ambulatory care units and the GP streaming centres, with PDC received from DH for the latter. Full year forecast for capital plan remains under careful review, with a number of key priorities requiring in-year funding and being balanced against the more strategic investment required. Significant investment in estates infrastructure required to address historical compartmentalisation issues in respect of the Eastbourne site – a requirement which has been given added focus through national developments and following an on—site review with NHSI support teams. Overarching requirement over next three years will be in the region of £12m, with the Trust working to develop a business case with NHSI support. F&I Committee keeps the full year forecast for the capital programme of the Trust under regular review, with quarterly deep dives.	On-going review and monitoring to end Mar-18	◄►	DF	F&I
4.3.1	C	Adequate controls are required to ensure that the Trust is compliant with Fire Safety Legislation.There are a number of defective buildings across the estate and systems which may lead to failure of statutory duty inspections. This includes inadequate Fire Compartmentation at EDGH	Sept -17 Ongoing programme behind schedule due to unable to gain decant ward and asbestos issues. Fire doors replaced and Stairs wells upgraded. EDGH Compartment project has been revisited in July to plan for upgrading compartmentation in Seaford and Hailsham Wards, which will require closing the Wards. Meeting held with ESFRS to discuss timescales for improvement	end Mar-18	NEW	CEO	Audit Committee

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources Participating in system wide development through STP and ESBT Alliance Strategy team monitoring and responding to relevant tender exercises
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established
	No GAPS identified
Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.	
Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.	
Key controls	Workforce strategy aligned with workforce plans, strategic direction and other delivery plans On going monitoring of Recruitment and Retention Strategy Workforce metrics reviewed regularly by Senior Leadership Team Quarterly CU Reviews to determine workforce planning requirements Monthly IPR meetings to review vacancies. Review of nursing establishment quarterly KPIs to be introduced and monitored using TRAC recruitment tool Training and resources for staff development In house Temporary Workforce Service
Positive assurances	Workforce assurance quarterly meetings with CCGs Success with some hard to recruit areas e.g. Histopathology and Paeds Full participation in HEKSS Education commissioning process Positive links with University of Brighton to assist recruitment of nursing workforce. Reduction in time to hire Reduction in labour turnover.

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
5.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties	Jan-17 Following increases in the establishment and sustained recruitment, substantive workforce numbers have continued to increase, from 5684 ftes to 5949 ftes (Apr-Nov). 80 offers made to overseas nurse. Introduction of a number of new roles to address recruitment issues. Project to introduce Doctors Assistants to support Junior Doctors, 6 starting Jan-17. Impact of this role will be evaluated and business case developed to roll out across the Trust. In discussions with Brighton University to establish Expect to work placements for Physicians Associates Aug-17 and appointable from Aug-18. GP Fellowship role being developed. Part of this will be to undertake some working hours in the acute sector in emergency medicine, rheumatology and dermatology. Mar-17 6 Doctors assistants started, positive impact on workload of Junior Drs, consideration will be given to roll-out to other Trust specialties. GP Fellowship role advertised, anticipated start date of Sept-17. Quarterly CU workforce planning and recruitment meetings commenced to review short medium and long term action plans to address recruitment issues. 7 Head hunters engaged to assist with Hard to fill positions. Overseas nurse recruitment continues with additional 76 Philippine nurses offered (start date Nov-17). EU nurses c30 offers. Targeted UK nurse campaign commenced Feb-17. Joined NHS Employers Retention programme, undertaking a project internally on the retention of staff. Attending local carers fairs to promote the Trust. May-17 Recruitment hotspots identified. Regular Department meetings to review vacancies established and action plans discussed.to address priority vacancies. Recruitment and Retention Policies examined as a method of addressing turnover and attraction issues.7 Head hunters engaged to assist with Hard to fill positions for Medical posts. Continued focus on overseas recruitment for registered nursing; 76 Philippine nurses offered (start date /Nov/Dec 2017.15 Italian nurses recruited in March/April. Additional visits to EU/Italy proposed to address future requirements and turnover. AHP- Workforce planning to be carried out to identify and address future requirements ((MSK contract).Recruitment campaign to support. Trial of Refer a Friend and Golden Handshake for Theatre nurses, with subsequent roll out across Trust. Workforce planning process developed to identify skill mix and new roles. Jul-17 Recruitment Incentives developed to assist with attracting suitable candidates for difficult to recruit areas. Utilising agencies on the preferred list of suppliers as Expressions of Interest. International Nurse recruitment continues. Regular monthly events planned and recruitment booklet being finalised. Continued development of new roles. Workforce reviews and planning sessions programed for autumn, linked to the business planning cycle. Sep-17. MEDICAL & DENTAL head-hunters engaged. Business case for single Agency working. Recruitment Incentives introduced. Other roles being developed e.g. GP in A& E ED Department REG NRS & MIDWIFERY Monthly Skype interviews from July to October for overseas international nurses. July event 13 offers made. Target 35-40 nurses. Rolling nurse recruitment adverts and selection-targeted approach for specific areas. ALLIED HEALTH PROFESSIONALS Headhunters engaged. Overseas recruitment campaign for O/Ts and P/Ts. SCIENTIFIC PROF & TECH Head-hunter activity. Targeted social media campaign	end Dec-17	◄►	HRD	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.	
Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.	
Key controls	Leading for Success Programme Leadership meetings Listening in Action Programme Clinically led structure of Clinical Units Feedback and implementation of action following Quality Walks. Organisation values and behaviours developed by staff and being embedded Staff Engagement Plan developed OD Strategy and Workstreams in place
Positive assurances	Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Embedding organisation values across the organisation - Values & Behaviours Implementation Plan Staff Engagement Action Plan Leadership Conversations National Leadership programmes Surveys conducted - Staff Survey/Staff FFT/GMC Survey Staff events and forums - "Unsung Heroes"

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Jan-17 Number of events involving staff in the development of their services are currently underway – Radiology services are currently holding a number of stakeholder events to support development of a robust Radiology Strategy. Clinical administration leaders are half way through their leadership programme Positive Feedback from participants positive. All managers will be required to attend the Management Essentials programme, commencing Jan which will outline expectations of them especially in terms of communicating and involving their staff. Further work is being carried out in bringing values to life through the development of a behavioural framework which outlines the behaviours we expect to see /not see linked to each value Annual national staff survey now closed. Response rate has increased to 46% Staff wellbeing team currently advertising Health Checks for staff aged between 40-70. Department is continuing to run a number of interventions linked to wellbeing including emotional reliance training, Pilates and Healthy weights. The team continue to visit different departments to look how they can support staff in the workplace. Clinical Units continue to try to improve engagement in their area Mar-17 The most recent CQC inspection (October 2016) found that staff were largely positive and well engaged. We have also seen an improvement in our Staff Engagement results and engagement score in the 2016 Staff survey results although we remain below average for many of the key findings . Work will continue to improve staff engagement at all levels of the organisation. May-17 Increasingly positive staff feedback. Quarterly Staff Family and Friends Test - significant year on year increase in two questions asked If a friend or relative needed treatment would you be happy with the standard of care provided by the organisation? increased from 61% Q4 2015 to 77% Q4 2016 . Would you recommend your organisation as a place to work? Increased from 38% Q4 2015 to 66% Q4 2016 Jul-17 – Work continues following staff feedback in the National Staff survey – working on the three corporate priorities agreed and each division has their own action plan. All areas encouraged to regularly feedback about actions taken .The latest Staff Family and Friends test has identified an increase in the number of staff who would recommend the trust for care and treatment to 80% but there has been a reduction in the number of staff who would recommend us as a place to work. We will be engaging with teams to find out more about this responses and what they feel will make a difference. Sep-17 Renewed focus on medical engagement . During Sept all consultants and SAS doctors will be asked their views on their experience of working here at the Trust via the national medical engagement survey. Divisions continue to look at different ways to improve staff engagement. Results from the most recent pulse surveys been published and shared with divisions . Overall the results are positive but we are investigating further how we are involving staff in decisions.	end Sep-17	◄►	HRD	POD SLF

Chief Executive's Report

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:	.....		
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The purpose of this report is to provide the Board with a summary update from the CEO's perspective.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

None.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

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

1. Introduction

During the month there was a major incident at Eastbourne caused by a cloud of gas which affected the coastline during one Sunday afternoon. Some 130 patients came to the emergency department where a full decontamination process had been established, since the nature and cause of the gas had not been identified. The cascade calls for attendance at the site worked well. Joe Chadwick Bell and Simon Badcott (shadowing) assumed Gold Command for the incident. Steve Rochester came in to take command of the incident. Senior clinicians involved included James Wilkinson, Wayomi Perera, and Zeki Atesli. Many members of staff stayed beyond their shift end or responded to calls. There will be a system-wide and Trust review of the incident and lessons to be learned with a report to come to the Board in due course.

2. Quality and Safety

A successful meeting was held in August with leaders of the CQC regional team. Presentations were made on key Trust initiatives such as emergency care, end of life care, and community services. A number of poster presentations were mounted and supported by members of staff from across the organisation. As a result of these discussions the CQC have announced that they will arrange for a limited inspection of ED, Well Led, and other services (to be determined) in November, with a view to recommending that the Trust come out of Quality Special Measures.

In early September, a mortality summit was held for senior clinical staff from across the organisation. This remains an area of significant focus. Our SHMI (rolling 12 month indicator) increased slightly to 111 in September but remains within normal limits. The Trust's position relative to other Trusts across the country has improved significantly in the past year. Focus continues on managing co-morbidities and on specific care pathways such as Sepsis, Venous Thromboembolism, Acute Kidney Injury, and Community Acquired Pneumonia. Our latest validated RAMI (**June 2016 – May 2017**) is **95**, compared with **108** for the same period last year – which is continuing to show improvement. Septicaemia and MI remain the main causes of mortality.

Earlier this month concerns were raised regarding the sterility of surgical packs that have been stored for a long time. As a precaution, we cancelled all non-urgent surgery while this was immediately investigated and resolved. We have now resumed full operating lists. As always, patient safely is our priority.

There has been an increased rate in Surgical Site Infections related to orthopaedics. 13 cases are being investigated. 9 hips and knees and 4 spine. To date there has been no common cause found. General precautionary measures have been taken.

Significant progress has been made in the development of end of life care. Over 1000 members of staff have now been through training. Training will in future be mandatory for all members of staff on a three year cycle. A number of operational policies have been adopted, including the notification of all patients nearing end of life to the site management team. On a recent national audit, ESHT had a relatively high proportion of patients who had died on a formal end of life plan.

3. People, Leadership and Culture

3.1 Recruitment & Retention

- International recruitment is continuing in the Philippines, India, Italy and Spain for Nursing, medical and AHP staff groups.
- 29 newly qualified Registered Nurses have been appointed and will join the Trust in October as HCA's, pending their full registration.
- Temporary Workforce: Continued progress on conversion of agency staff to bank.To date 36 Doctors have joined the Bank with a further 19 in process. 30 HCAs have joined the Trust's Bank.

3.2 Junior Doctors Contract

- Exception reports have slightly increased from 37 in May to 63 in July. Foundation rotas in medicine and orthogeriatrics have shown the most exception reports. A review of these rotas has taken place and changes made to ensure that the working hours are compliant.
- In order to improve the review and response time to Exception reports, Clinical Supervisors for trainees now respond rather than the Educational supervisors and training sessions for these clinicians have been arranged.
- Familiarisation sessions have taken place on Exception reporting for all new Junior doctors and Clinical supervisors
- Once the September and Higher trainees in October intakes occur all Trainees will be on the new 2016 contract
- The current Guardian of Safe Working Hours at the Conquest Hospital has indicated that he wishes to stand down, and an advert has been sent to all Consultants at the Conquest inviting expressions of interest in this role.

3.3 Staff Engagement

- Senior members of staff have been identified to apply to participate in Cohort 2 of the Leading Excellence programme which will commence in February. The programme for Cohort 1 begins shortly.
- Participants for the Leading Service programme due to start in October have been recruited and all places taken.
- Management essentials programme continues to be rolled out across the organisation.
- There is a Masterclass on Systems Leadership scheduled to take place in November 2017 as part of the Leading Excellence programme.

4. Finance and Capital

The Trust has delivered its financial plan at Month 4, with a year to date deficit of £16.3m. Cost Improvements of £4.2m have been delivered, in the context of continued improvements in performance and against national standards. The level of challenge for delivery across the rest of the financial year remains high, and continued focus on both operational financial performance and delivery of cost improvements will be required. The Trust Finance and Investment Committee reviewed progress and plans at Month 4, and requested continued work to maintain delivery. The Trust presented the position to the NHSI Financial Special Measures team in September, and received encouragement for continued delivery. As with the Finance and Investment Committee, the FSM team noted the level of risk to the overall financial position, and the lack of contingency for the Trust available in the event of additional financial pressures.

Clinical units and Divisions continue to focus on delivering their financial plans. Although the aggregate CU/Divisional position remains on plan with some teams over-delivering and others behind plan, there is continued work with all teams to ensure that all can be supported to deliver on the finances. Surgical and elective work is behind plan, and non-elective and emergency care is ahead of plan – reflecting the realities of operational delivery – and this is being exaggerated in part by the impact of the new national tariff HRG4+ which increases the payments for emergency and elective work. However, the Finance and Investment Committee have received

However, the financial position for the wider East Sussex Health and Social Care system remains challenging. Activity levels across all the services delivered by the Trust remain higher than our collective plans, leading to a significant system financial pressure. Through the Alliance Executive, the leadership teams of the ESBT partners are working to develop a shared financial plan for this year, and for the next five years. Good progress has been made in early September, but there remains much work to do to develop a jointly owned and deliverable plan that delivers the four key priorities of system control total, Trust control total, performance and quality standards, and investment in the (ESBT) future. The key principles agreed to date are a move towards an aligned incentive contract, shared accountability for the delivery of both Trust and system control totals, and the development of a financial plan which considers the Trust as a cost-centre within the overall financial position of ESBT.

Within the Trust, cash remains a challenge for 2017/18, with the level of payables having grown to an average of £58.5m in Quarter 1 2017/18 from £41.8m in Quarter 1 2016/17. The Trust is reviewing the invoicing and debtor management process to ensure that its own cash flow processes are robust, and that it is generating cash at the right pace to support the creditor balances. There is work to do to improve in this area, and the Trust is anticipating that this work will be complete by the end of September 2017, with a consequential beneficial impact on the funds available to pay suppliers.

The Trust has a limited capital budget, of £11.7m, which comes under significant pressure. This is being deployed to support the purchase of key clinical equipment, the continued strengthening of IM&T infrastructure and on specific programmes including the front entrances of both acute sites, the ambulatory care units and the refurbishment of the overall estate. The Trust has received additional capital from the Department of Health to deliver the new Primary Care streaming model, based at the front door of the Emergency Departments, and construction is underway. The Trust has spent £2.6m of the total capital allocation at the end of Month 4, but a number of significant projects are in train to prepare for Winter.

Business Support and Digital

The roll-out of the EDM (electronic document management) programme continues successfully, with high levels of positive feedback and good engagement across the organisation. This represents the first step in moving towards a full electronic patient record, and is a key milestone for the Trust. It sits alongside the electronic referrals process, which is also being implemented across the Trust and the wider system. The procurement of a digital telephony system is complete and implementation of this will begin in the last quarter of the financial year, with significant benefits to the organisation and to patients.

5. Access and Delivery

In August the Trust achieved over 90% performance against the four hour standard and, for the fourth month, over 90% for RTT. Compliance with the two week wait standard has been maintained. Diagnostic performance has improved but remains just above 1%. The 62 day

cancer target remains a challenge with focussed work being done in all specialties to manage performance. Central funds have been secured for additional initiatives to improve the position.

6. Strategy, Innovation and Planning

6.1 Strategy and Planning

A business planning schedule has been produced for the Trust which will ensure that our 18/19 financial and operation plans are prepared, scrutinised and agreed in a timely fashion. The draft Clinical Strategy is being taken to the ESBT Clinical forum in October for discussion before being returned to the ESHT Board for ratification. We are working closely with colleagues at BSUH to understand the priorities emerging from their strategy for tertiary services, which is currently being prepared. We are working with BSUH to ensure that our own acute services strategy is aligned with this work.

7. Corporate Affairs

7.1 The new Trust website was launched in September. The website offers a simpler way for members of the public to access the information they need first time, using a clearer design and layout, and refreshed information. The website has received broadly positive feedback from members of staff and public alike and we will use this feedback to adapt and amended the website over the next 12 months. We have also seen significant press coverage over this period, including a positive piece on BBC South East about the new simulation training suite at Eastbourne DGH and coverage on ITV Meridian about organ donation, which included part of an ESHT produced video.

7.2 The Trust's patient engagement work is developing and through the new website, members of the public and patients are now able to sign up to become 'members' of the Trust. Members will receive e-newsletters and invitations to events. This was promoted in the second edition of the #OurMarvellousTeams patient newsletter, which was published in early August. The Communications Team produced two short videos of staff outlining what they are most proud of and their greatest challenge, and of patients talking about the care they received at the Trust. The Communications Team also supported the Urology Department to hold a Departmental Open Day for members of the public and patients in September, this follows two successful Open Days in Cardiology and Ophthalmology.

East Sussex Healthcare NHS
NHS Trust

Month 4 – July 2017

TRUST INTEGRATED PERFORMANCE REPORT

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East Sussex Healthcare NHS
NHS Trust

Contents

East Sussex Healthcare NHS
NHS Trust

July 2017

Key Successes

- The Trust achieved the standard for RTT waiting times for the third consecutive month.
- A&E wait times continue to improve.
- The SHMI mortality indicator is within the expected limits.
- DTC performance continues to improve

Key Issues

- A&E Attendances remain at highest levels in over a year, adding pressure to the 4 hour target
- The higher than expected number of non-elective admissions is impacting on flow through the hospital
- Equipment failures and staffing issues impacted the Diagnostics standard
- The number of patients waiting over 62 days for cancer treatment is higher than expected.

Key Risks

- Delivery of the financial targets and savings plans

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

Quality and Safety

QUALITY AND SAFETY

East Sussex Healthcare NHS
NHS Trust

Indicators

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Total patient safety incidents reported	M	1499	1067	-28.8%	4643	4396	-5.3%	1317	
Total falls	M	152	125	-17.8%	597	552	-7.5%	149	
Falls assessment compliance	M	91.4%	90.3%	-1.1%	91.8%	89.8%	-1.9%	89.2%	
Total grade 2 to 4 pressure ulcers	M	34	39	14.7%	199	202	1.5%	55	
Pressure ulcer assessment compliance	M	92.0%	90.3%	-1.6%	89.8%	88.5%	-1.3%	91.5%	
Number of MRSA Cases	0	0	1	1	0	1	1	0	
Number of Cdiff cases	4	2	4	2	18	11	-7	3	
Number of MSSA cases	M	1	1	0	5	1	-4	1	
All ward moves	M	2313	2241	-3.1%	9225	8682	-5.9%	2232	
Night ward moves	M	416	418	0.5%	1729	1534	-11.3%	398	

Commentary

Whilst the number of falls has decreased against performance last year it should be noted that there has been a decrease in the assessment compliance.

Improvements are being seen in the prevalence of pressure ulcers and in infection control.

Once case of Cdiff was reported in July which is under investigation.

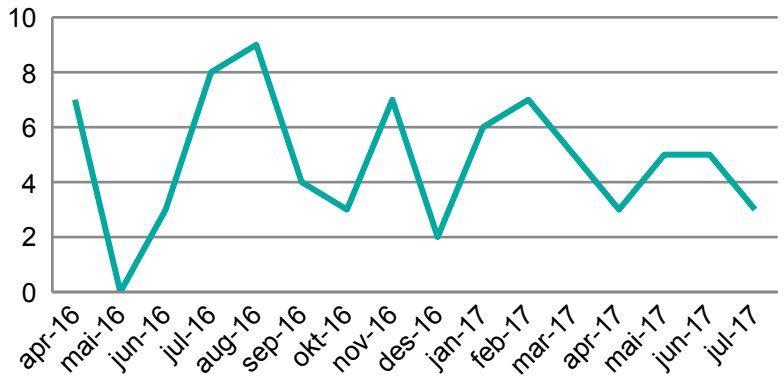
Serious Incidents reported in the last 3 months

SI Ref No / WEB number	Ward / Division / Hospital site	Reported Date on STEIS	Incident date	Brief Description of Incident	Status
2017/17528	Irvine Unit / Out of Hospital Care / Bexhill	12/07/2017	11/07/2017	Slips/trips/falls meeting SI criteria – Fractured neck of femur	In progress: due with CCG by 05/10/17
2017/18367	Richard Ticehurst SAU / Diagnostics, Anaesthetics and Surgery / Conquest	21/07/2017	19/07/2017	Slips/trips/falls meeting SI criteria – Fractured neck of femur	In progress: due with CCG by 16/10/17
2017/18679	Emergency Department / Urgent Care / Eastbourne	25/07/2017	20/07/2017	Slips/trips/falls meeting SI criteria – Fractured neck of femur	In progress: due with CCG by 18/10/17
2017/14408	James ward / Medicine / Conquest Hospital	06/06/2017	29/05/2017	Slips/trips/falls meeting SI criteria – fractured NoF	In progress: due with CCG by 30/08/17
2017/15620	ITU / Diagnostics, Anaesthetics and Surgery / Eastbourne DGH	19/06/2017	20/06/2017	**Never Event** - Surgical/invasive procedure incident meeting SI criteria – Misplaced naso-gastric tube	In progress: due with CCG by 13/09/17
2017/15640	Emergency Department / Urgent Care / Eastbourne DGH	19/06/2017	20/06/2017	Apparent/actual/suspected self-inflicted harm meeting SI criteria – attempted strangulation by a vulnerable patient	In progress: due with CCG by 13/09/17
2017/15671	ITU / Diagnostics, Anaesthetics and Surgery / Eastbourne DGH	21/06/2017	18/05/2017	Surgical/invasive procedure incident meeting SI criteria – patient died from sepsis due to necrotising fasciitis following laparoscopic surgery	In progress: due with CCG by 14/09/17
2017/16193	Cuckmere ward / Medicine / Eastbourne DGH	21/06/2017	27/06/2017	HCAI/Infection control incident meeting SI criteria – C diff on part 1 of death certificate	In progress: due with CCG by 20/09/17
2017/13275*	Day Surgery Unit / Diagnostics, Anaesthetics and Surgery / Uckfield Hospital	23/05/2017	22/03/2017	Surgical/invasive procedure incident meeting SI criteria – incorrect tooth removed - **Never Event**	Submitted to CCG 16/08/17; awaiting feedback/ outcome
2017/12835	Richard Ticehurst Surgical Assessment Unit / Diagnostics, Anaesthetics and Surgery / Conquest Hospital	18/05/2017	17/05/2017	Slips/trips/falls meeting SI criteria – fractured distal femur	Submitted to CCG 11/08/17; awaiting feedback/ outcome
2017/12509	Ophthalmology Outpatients Department / Diagnostics, Anaesthetics and Surgery / Conquest Hospital	15/05/2017	13/03/2017	Treatment delay meeting SI criteria – patient has experienced permanent loss of vision in left eye	Submitted to CCG 17/08/17; awaiting feedback/ outcome
2017/12068	Delivery Suite / Women's, Children's and Sexual Health / Conquest Hospital	09/05/2017	06/05/2017	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) – Intrapartum stillbirth	Submitted to CCG 01/08/17; awaiting feedback/ outcome
2017/13858	Baird ward (Medical Assessment Unit) / Medicine / Conquest Hospital	31/05/2017	28/05/2017	Sub optimal care of a deteriorating patient – death of an 18 year old patient who was found unresponsive on ward	In progress: due with CCG by 31/08/17

East Sussex Healthcare NHS Trust

Serious Incidents, Never Events and Patient Safety Incidents

Serious Incidents Reported



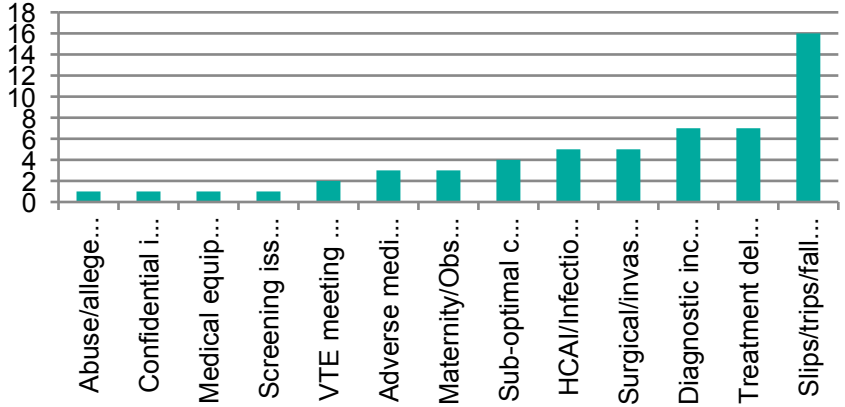
3 Serious Incidents were reported in July:

Slips/trips/falls meeting SI criteria – fractured NoF

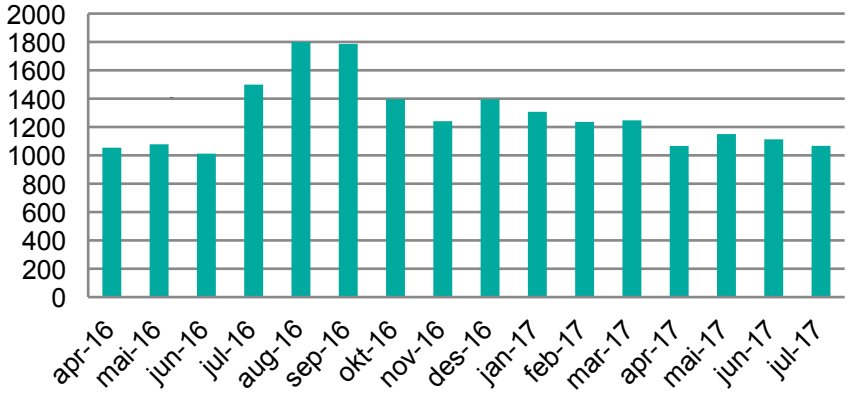
Slips/trips/falls meeting SI criteria – fractured NoF

Slips/trips/falls meeting SI criteria – fractured NoF

The graph below shows the STEIS categories of the Serious incident reported over the last year.



Patient Safety Incidents



Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Crude Mortality Rate	M	1.4%	1.4%	0.0%	1.7%	1.6%	-0.1%	1.6%	

Indicator Description	Target	Previous Months										
		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
HSMR (CHKS)	M	109	108	106	106	104	103	106	107	104	103	101
SHMI (NHS Digital)	M	1.11	1.1	1.1	1.09	1.09	1.09	1.09	1.09			

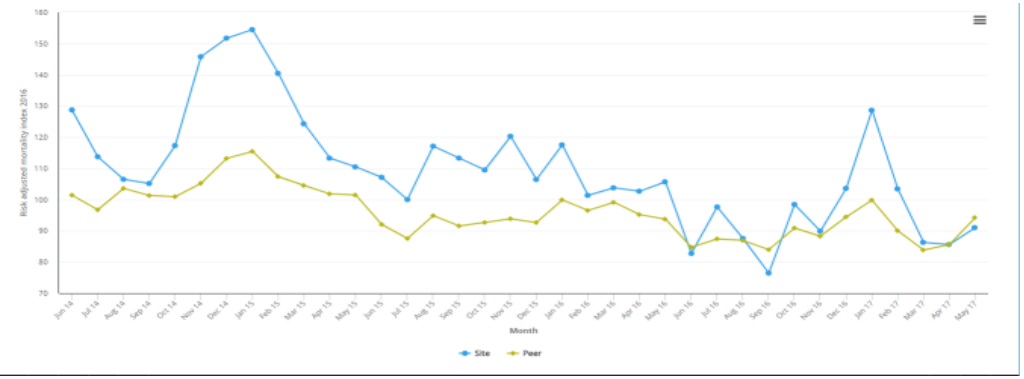
Commentary

- M&M reviews show a further improvement but still requires considerable effort with reminders. Appraisals for 2016-7 have started and individual M&M performance reports being compiled.
- Format of mortality review database has been changed to comply with the new “Learning from Deaths” project, and was launched this month. Mortality summit planned to give additional background on the new initiative and training on the database. We will report on Q4 avoidable deaths to the Board in Q2, and then have a rolling program of reports 3 months in arrears.

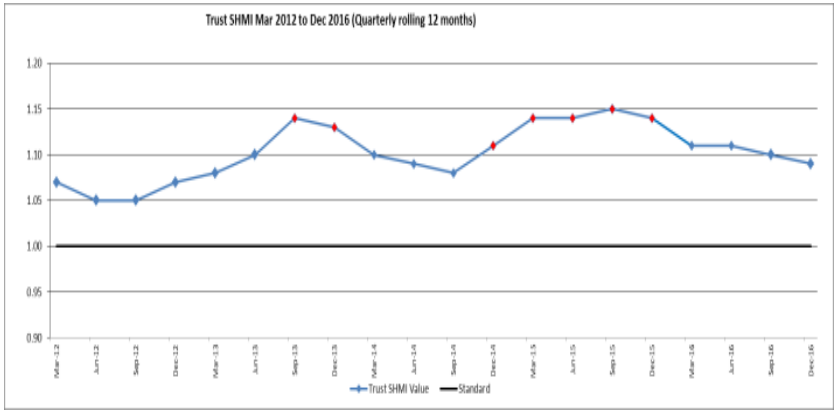
MORTALITY

East Sussex Healthcare NHS
NHS Trust

RAMI



SHMI (Rolling 12 months)



SHMI for the period January 2016 to December 2016 is the latest published and is 1.09. The Trust is currently within the EXPECTED range.

RAMI June 2016 to May 2017 (rolling 12 months) is 95 compared to 108 for the same period last year (June 2015 to May 2016). May 2016 to April 2017 was 96

RAMI shows a May position of 91 against a peer value of 94. The April position was 86 against a peer value of 86

Crude mortality shows June 2016 to May 2017 at 1.83% compared to June 2015 to May 2016 at 1.87%

The percentage of deaths reviewed within 3 months was 64% in April 2017 compared to 69% in March 2017

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Jan 16 to Dec 2016	Observed deaths	Expected deaths	SHMI
Pneumonia (except that caused by tuberculosis or std).	399	413.73	96
Septicaemia (except in labour), Shock.	166	139.49	119
Acute cerebrovascular disease.	146	132.74	110
Urinary tract infections.	114	101.61	112
Congestive heart failure; nonhypertensive.	108	102.00	106

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Number of complaints received	M	46	50	8.7%	234	195	-16.7%	52	

Commentary

50 new complaints received

70 complaints were closed

12 complaints were re-opened

91 complaints were open at the end of the month

5 open complaints were overdue

344 open complaint actions

615 PALS contacts were recorded across both sites

The main priorities for Patient Experience are:

•Continue to sustain the number of overdue complaints below ten (currently 5).

•Continue to follow up on those actions set from complaints in 2016/17

•To review the actions set when complaints are closed, ensuring the actions are SMART.

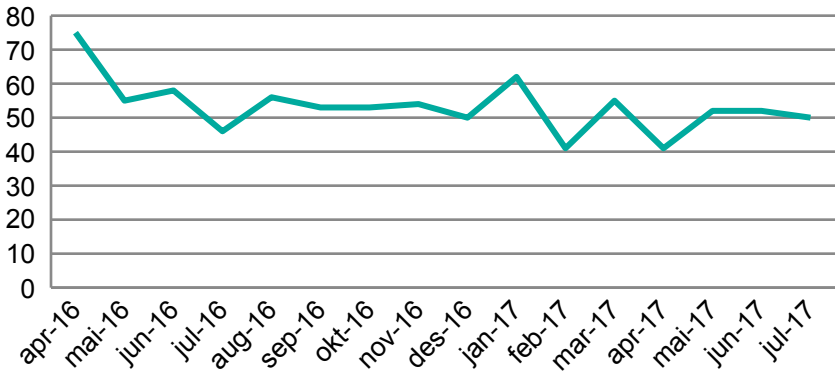
•Support Urgent Care to achieve FFT response rate

•Support the wards identified in the bottom ten FFT response rate tables.

East Sussex Healthcare NHS
NHS Trust

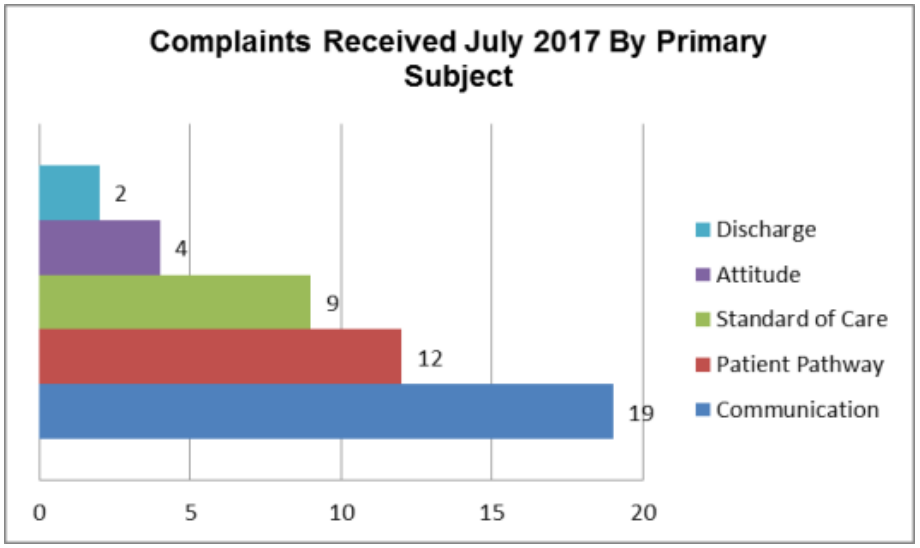
Complaints

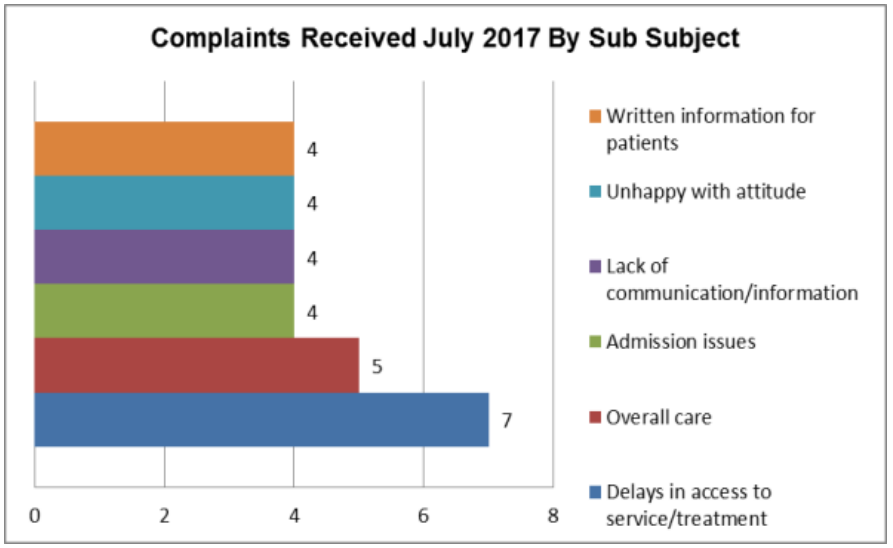
Complaints Received



The top categories for complaints in July were involving communication and pathway issues. Most of the pathway complaints involved delays to access for treatment or services.

Complaints assigned to standard of care (these include those categorised as "overall care" within the sub subject) involve concerns around care on wards, treatment in A&E and diagnosis





East Sussex Healthcare NHS
NHS Trust

Friends and Family

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Inpatient FFT response rate	45.0%	17.3%	43.0%	25.6%	15.6%	36.3%	20.7%	27.9%	
Inpatient FFT score	96.0%	97.9%	97.0%	-0.8%	97.5%	97.1%	-0.4%	97.1%	
A&E FFT response rate	22.0%	7.7%	10.9%	3.2%	8.7%	8.9%	0.1%	7.6%	
A&E FFT score	88.0%	86.4%	87.6%	1.2%	88.3%	87.5%	-0.8%	86.5%	
Outpatient FFT Score	M	97.0%	95.5%	-1.5%	95.9%	95.8%	-0.2%	95.6%	
Maternity FFT response rate	45.0%	25.6%	32.8%	7.2%	31.2%	38.9%	7.8%	35.5%	
Maternity FFT score	96.0%	96.1%	97.7%	1.6%	93.5%	98.1%	4.7%	96.4%	

Commentary

The FFT response rate continues to improve for inpatients and the score remains above the target. The A&E response rate remains low but is on an upward trend and is improved against monthly and year to date comparisons.

Both maternity and outpatients have improved and remain high for the scores.

Access & Delivery

ACCESS AND DELIVERY

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Four hour standard	95.0%	82.6%	87.7%	5.1%	83.7%	84.4%	0.7%	80.7%	
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	3.0%	2.9%	-0.2%	3.1%	3.0%	-0.1%	3.0%	
% Patients waiting less than 15 minutes for assessment in ED	M	91.8%	85.6%	-6.2%	92.5%	83.2%	-9.3%	86.4%	
% Patients waiting less than 60 minutes for treatment in ED	M	36.8%	39.1%	2.4%	40.0%	41.6%	1.6%	41.8%	
% Patients waiting less than 120 minutes for treatment in ED	M	65.0%	68.3%	3.4%	65.6%	69.9%	4.3%	70.1%	
% Patients that left without being seen in ED	M	1.4%	1.6%	0.2%	1.7%	1.4%	-0.3%	1.4%	
% Patients admitted from ED (Conversion rate)	M	23.5%	27.6%	4.1%	24.8%	26.7%	1.8%	26.3%	
Number of ambulatory care admissions with zero length of stay	M	561	836	275	2422	2870	448	572	
% of ambulatory care admissions with zero length of stay	M	38.4%	45.7%	7.4%	40.5%	44.0%	3.5%	39.1%	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Emergency Department attendances	M	10144	10596	4.5%	37671	40280	6.9%	9429	
Ambulance conveyances	M	3133	3219	2.7%	12044	12815	6.4%	3155	
Admissions via A&E	M	23.5%	27.6%	4.1%	24.8%	26.7%	1.8%	26.3%	

Commentary

Attendances continue to increase, up by 4.5% in month and 6.9% year to date. These increases are seen both in the number of self presenters and those being conveyed by Ambulance. Despite this increase the Trust has stabilised A&E performance in July with continued improvements into August.

Flow through the department is improving as demonstrated by the improvements in treatment time and the ambulatory pathway

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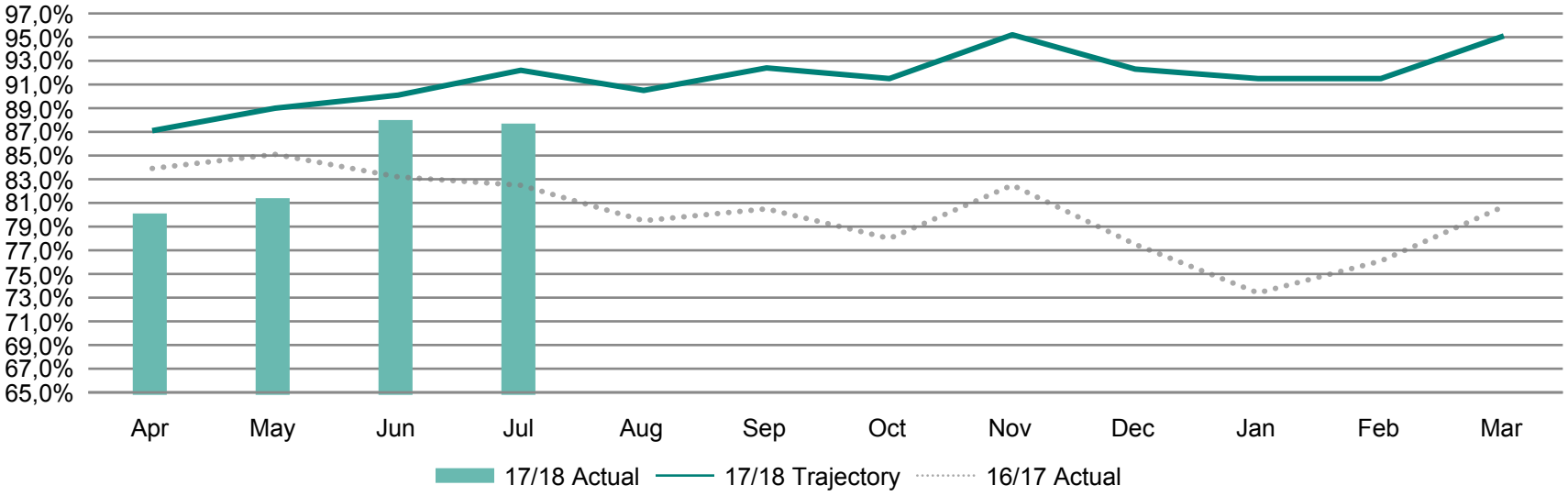
A&E Trajectory

East Sussex Healthcare NHS
NHS Trust



A&E performance declined very slightly in July with a Trust wide figure of 87.7%

Attendances remain on the increase across both sites and were up 4.5% on July 2016, and 6.9% year on year

Overarching Plan

East Sussex Healthcare NHS
NHS Trust

Preventing Admission
- Crisis response
- Extended HIT
- Frailty Teams
- DOS review
- Increase primary care access

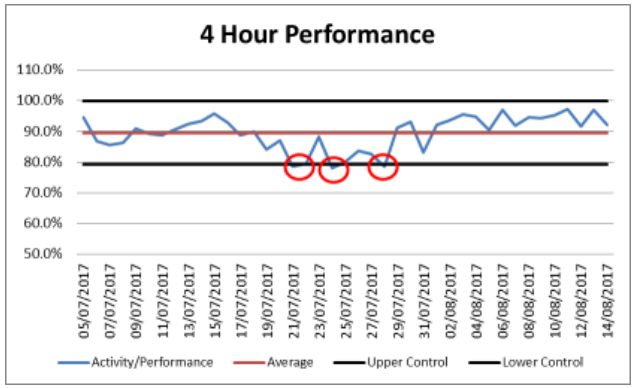
ED Processes
- Staffing profiles to meet demand
- Co-located primary care
- Streaming to speciality
- Appropriate use of CDU
- Separate minors stream and ENP capacity

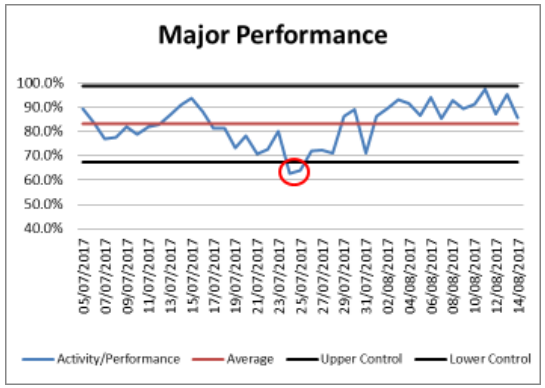
Medical Model
- Enhanced AEC and AMUs
- Frailty at front door
- Hot clinic access
- Speciality in reach to AMU
- Extended AEC opening hours

Patient Flow
- Red to Green
- Integrated Discharge Team
- Stranded patient review
- Daily discharge tracking
- Use of choice policy

Community
- Integrated Support Workers
- Care Home Plus
- Increased rates for NH
- Discharge to assess
- Trusted assessor

Operational Processes
- Capacity modelling
- Escalation and full capacity policy
- Extended clinical site management
- Improvement Director


4 Hour Performance
110.0%
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
06/08/2017
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control


Major Performance
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
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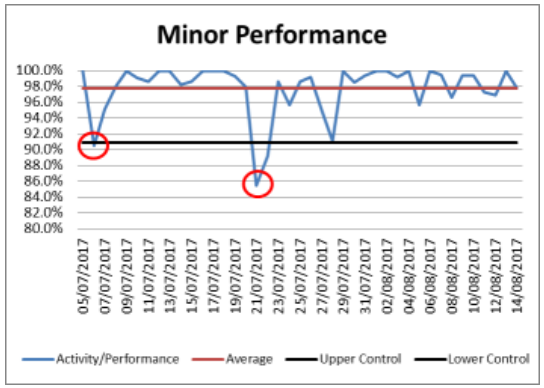
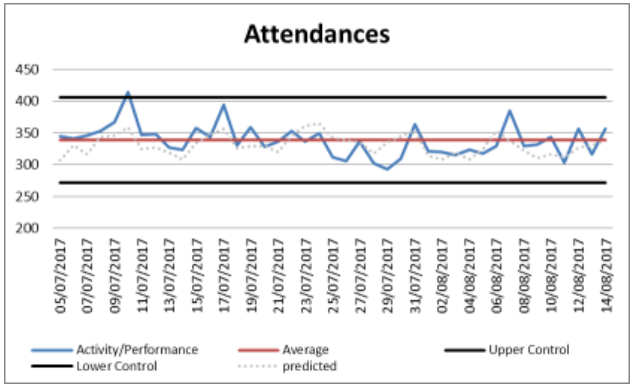
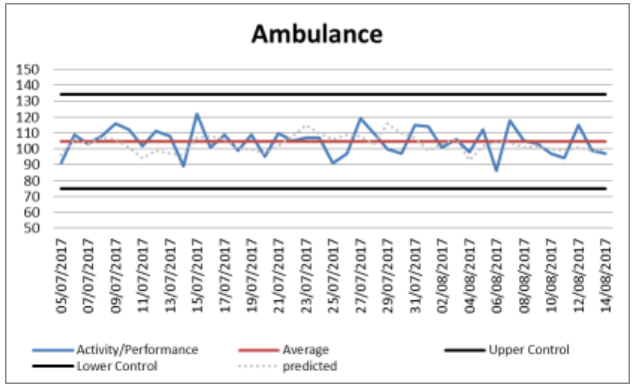
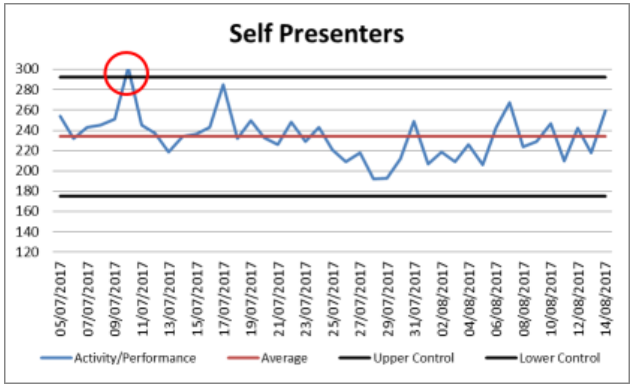
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control


Minor Performance
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
06/08/2017
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control


Attendances
450
400
350
300
250
200
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
06/08/2017
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control
predicted


Ambulance
150
140
130
120
110
100
90
80
70
60
50
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
06/08/2017
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control
predicted


Self Presenters
300
280
260
240
220
200
180
160
140
120
05/07/2017
07/07/2017
09/07/2017
11/07/2017
13/07/2017
15/07/2017
17/07/2017
19/07/2017
21/07/2017
23/07/2017
25/07/2017
27/07/2017
29/07/2017
31/07/2017
02/08/2017
04/08/2017
06/08/2017
08/08/2017
10/08/2017
12/08/2017
14/08/2017
Activity/Performance
Average
Upper Control
Lower Control

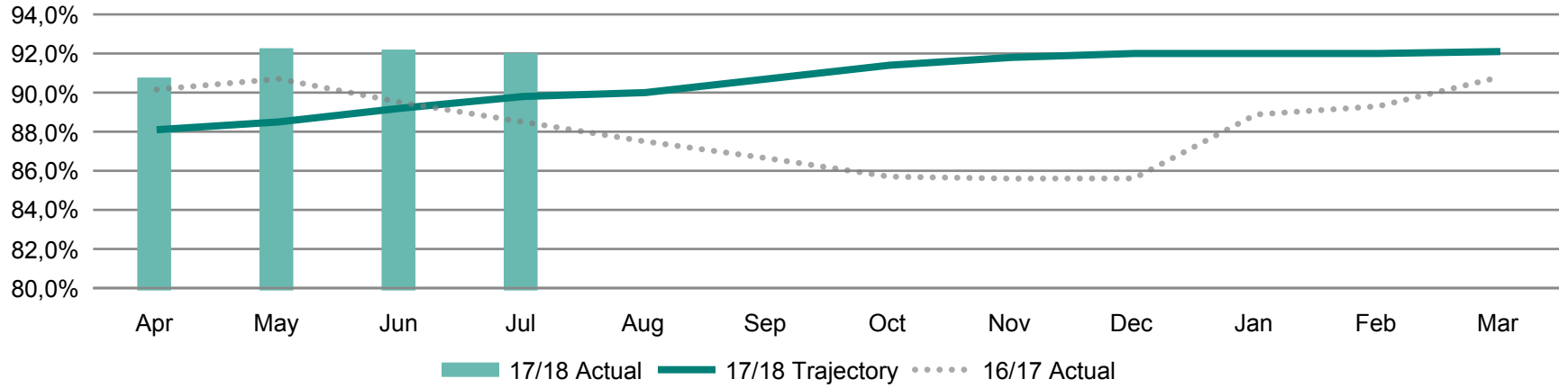
East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
RTT Incomplete standard	92.0%	88.5%	92.0%	3.5%	89.7%	91.8%	2.1%	88.9%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	3791	2315	-1476	13057	9861	-3196	3494	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	185	201	8.6%	609	1045	71.6%	279	
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	2.2%	1.7%	-0.5%	2.6%	2.6%	0.0%	1.9%	

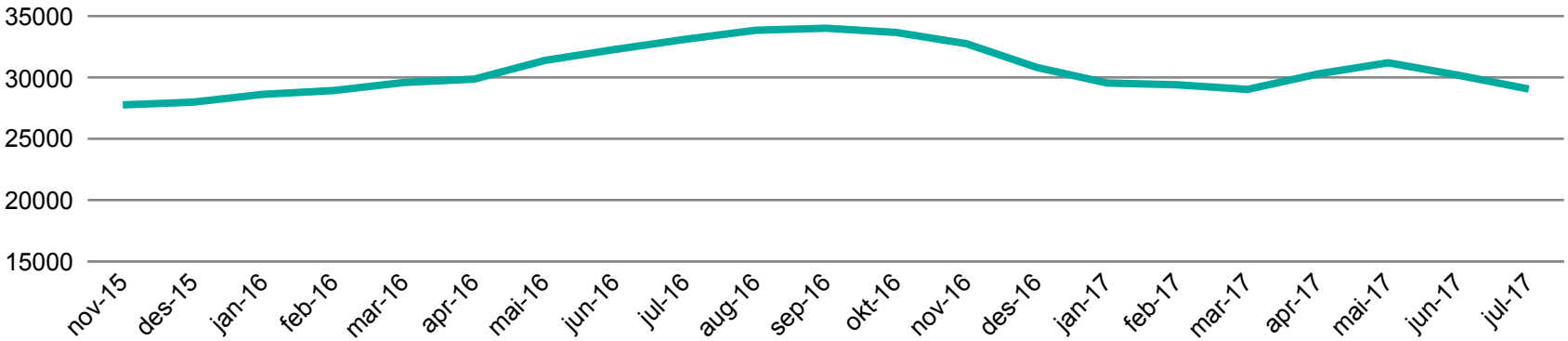
Commentary

The Trust continues to achieve against the RTT standard. Performance was 92.03% against the trajectory of 89.8%, with achievement of the standard for the third consecutive month. The waiting list has stabilised following a downward trend. An outsourcing plan is being discussed to supplement additional throughput in theatres and outpatient efficiencies to mitigate the impact of additional cost to the reduce the backlog.

RTT

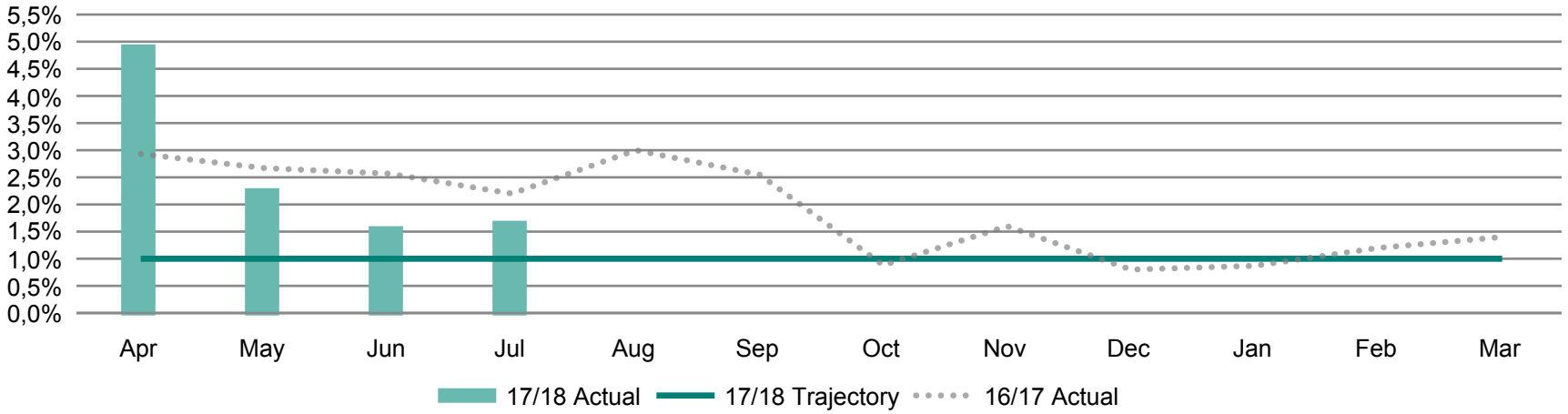


Month End Waiting List Size



Diagnostics

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	2.2%	1.7%	-0.5%	2.6%	2.6%	0.0%	1.9%	



Whilst diagnostics failed to meet the 1% standard with a performance of 1.7%, Additional radiology sessions have been planned in September to reduce the backlog and minimise further breaches. Discussions have also been held with the local CCG's regarding support from AQPs.

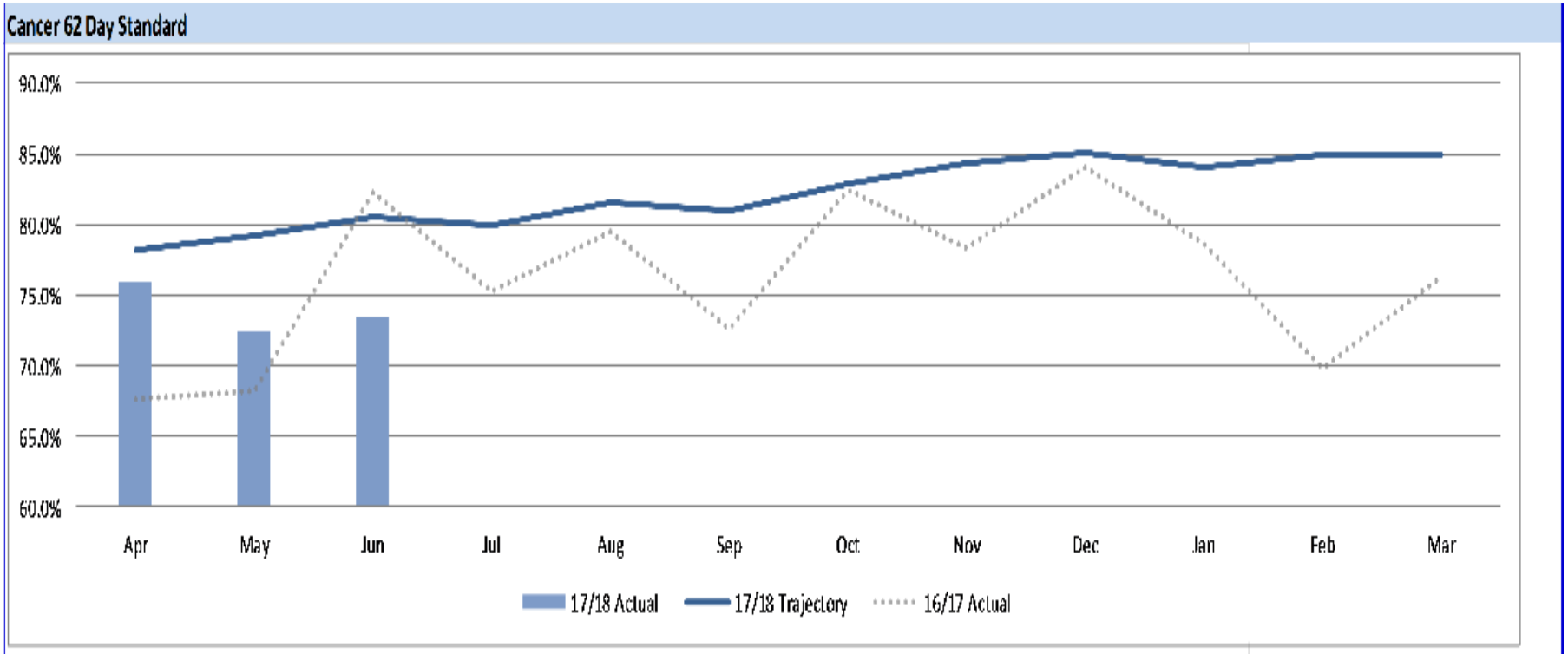
The breaches were:

Audiology	5
Sleep Studies	1
Endoscopy	7
Urodynamics	1
Radiology	94

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jun-16	Jun-17	Var	2016/17	2017/18	Var		
Cancer 2WW Standard	93.0%	96.5%	97.1%	0.6%	96.3%	96.3%	-0.1%	97.3%	
Cancer 62 day urgent referral standard	85.0%	82.3%	75.3%	-7.0%	74.0%	73.8%	-0.1%	76.7%	
Cancer 2WW Standard (breast symptoms)	93.0%	96.9%	95.8%	-1.1%	96.2%	96.0%	-0.2%	97.0%	
Cancer 31 day standard	96.0%	98.3%	97.7%	-0.6%	98.5%	98.0%	-0.5%	98.6%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	98.1%	

The trust continues to meet the 2 week wait target despite a continuing increase in referrals (up 5.5% against the same month last year and 2.7% year to date). This has been discussed with the local CCG's to ensure appropriate referrals and guidelines are being met. The trust is working hard to recover the 62 day standard ahead of the September target agreed with NHSI. The trust has adopted new daily teleconferences to increase the emphasis on ensuring all patients are being seen and treated within the timescales and is working across the south as a part of a collaborative to improve practice.

Cancer 62 Days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	78.2%	79.2%	80.6%	80.0%	81.6%	81.0%	82.9%	84.3%	85.1%	84.1%	85.0%	85.0%
17/18 Actual	76.0%	72.4%	73.4%									
16/17 Actual	67.6%	68.3%	82.3%	75.3%	79.5%	72.6%	82.5%	78.3%	84.1%	78.6%	69.9%	76.3%

June 2017 2WW Ref to First Treatment 62 Days													
Site	Seen/Treated			On Target			Breaches			Compliance			Target
	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	Conq.	EDGH	All	
Breast Cancer	9.0	4.0	13.0	9.0	3.0	12.0	0.0	1.0	1.0	100 %	75.0 %	92.3 %	85 %
Colorectal	9.0	5.5	14.5	5.0	4.5	9.5	4.0	1.0	5.0	55.6 %	81.8 %	65.5 %	85 %
Gynaecology	2.0	3.0	5.0	1.5	3.0	4.5	0.5	0.0	0.5	75.0 %	100 %	90.0 %	85 %
Haematology	1.0	4.0	5.0	1.0	1.0	2.0	0.0	3.0	3.0	100 %	25.0 %	40.0 %	85 %
Head & Neck	1.0	1.0	2.0	0.0	0.5	0.5	1.0	0.5	1.5	0.0 %	50.0 %	25.0 %	85 %
Lung	6.5	10.5	17.0	2.0	9.0	11.0	4.5	1.5	6.0	30.8 %	85.7 %	64.7 %	85 %
Other	2.0	2.0	4.0	2.0	1.0	3.0	0.0	1.0	1.0	100 %	50.0 %	75.0 %	85 %
Skin	5.5	18.0	23.5	5.5	18.0	23.5	0.0	0.0	0.0	100 %	100 %	100 %	85 %
Upper GI	6.0	6.0	12.0	6.0	3.0	9.0	0.0	3.0	3.0	100 %	50.0 %	75.0 %	85 %
Urology	9.0	28.5	37.5	6.0	17.0	23.0	3.0	11.5	14.5	66.7 %	59.6 %	61.3 %	85 %
Total	51.0	82.5	133.5	38.0	60.0	98.0	13.0	22.5	35.5	74.5 %	72.7 %	73.4 %	85 %

Breach reasons:
Elective Capacity - 4
Complex Pathway - 11
Diagnostic Delay - 3
Administration Delay – 1
Other* - 23

*This includes holidays and late transfers and delays at other trusts

62 Days Completed Actions

- Daily conference calls have been introduced for patient tracking and to reduce the level of breaches.
- Dedicated MP MRI slots functioning very well and reducing delays on this stage of the pathway. All joint PTLs now in place and functioning very effectively.
- In addition to the PTL meeting, additional intensive 62 Day PTL reviews are taking place (separate from the PTL meeting) within Cancer Services to try and reduce the number of patients experiencing longer waits. Next intensive review planned is Lung followed by UGI.
- Rotating dates of Cancer Partnership Board to facilitate GP Cancer Lead attendance to provide additional support to the Cancer Waiting Times agenda. Unfortunately the GP Cancer Clinical Lead has still been unable to attend despite rotation of days to accommodate.
- Collaborative working on NG12 continues with CCG partners. Additional scoping work underway for the straight to diagnostics element of the NG12. The forms went live from 1st April 2017. The impact of the new forms is being seen in significant increases in TWW referrals.
- Review of Oncology SLAs to ensure adequate capacity for ongoing increased demand. Review is underway and an initial introduction meeting has taken place with further review meetings scheduled for 16th June 2017. Final sign off due by the end of July. Thorough review of clinic capacity and demand has taken place as part of this process.
- Local EBUS service commenced 8th June 2017. First patients have now been seen locally; more complex patients still have to go to BSUH but there will be increasing numbers seen locally going forward.
- Deep dive analysis of Oncology backlogs in all tumour sites underway to establish case for additional ad hoc clinics to bring waits back into line with compliance. Additional ad hoc clinics have been agreed in order to clear backlogs.

62 Days Planned Actions

- Collaborative working on NG12 continues with CCG partners. Additional scoping work underway for the straight to diagnostics element of the NG12. The forms went live from 1st April 2017. The impact of the new forms is being seen in significant increases in TWW referrals.
- Review of Oncology SLAs to ensure adequate capacity for ongoing increased demand completed.
- Following funding agreement from NHSE, Fusion biopsy software for prostate patients has been purchased and training has commenced. Awaiting training to be completed.
- Local EBUS service commenced 8th June 2017. First patients have now been seen locally; more complex patients still have to go to BSUH but there will be increasing numbers seen locally going forward.
- Respiratory team investigating the introduction of electronic booking for Bronchoscopy.
- Deep dive analysis of Oncology backlogs in all tumour sites underway to establish case for additional ad hoc clinics to bring waits back into line with compliance. Additional ad hoc clinics have been agreed in order to clear backlogs.
- NHSI / NHSE Critical Friend visit took place on 10th August; revisit planned for September to concentrate on tracking processes and capacity and demand analysis.
- Bid to NHSE for £900k submitted, awarded £98k to increase theatre capacity for colorectal, TRUS / Template biopsy capacity and Oncology capacity. Additional resource in Radiology for MRI and CT also included in the award.
- Board presentation on 23rd August.
- Daily performance e-mails being circulated whilst in-phase screens being developed for cancer.

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Delayed transfer of care national standard	3.5%	7.7%	4.7%	-3.0%	6.4%	6.2%	-0.2%	7.4%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	0	1	1	1	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	2.4%			0.8%	0.0%	-0.8%	98.8%	
Outpatient appointment cancellations <6 weeks	M	34	51	50.0%	124	185	49.2%	43	
Outpatient appointment cancellations >6 weeks	M	1438	1429	-0.6%	4885	5423	11.0%	1307	

The Trust has been set a reduction target for delayed transfers of care, with an expected national reduction to 3.5% by September 2017, locally this target is 4.5%. Progress towards this has been made towards this this month with an achievement of 4.7% and therefore the Trust is on trajectory for the local measure.

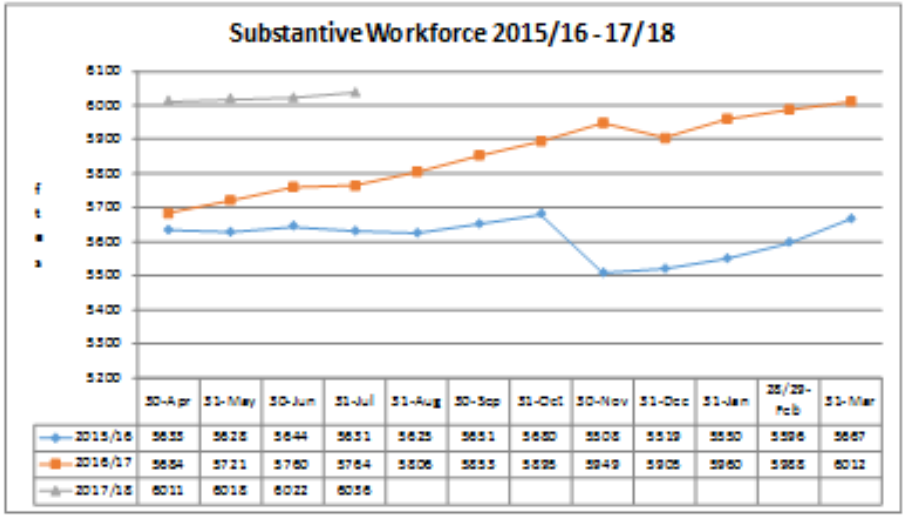
Leadership & Culture

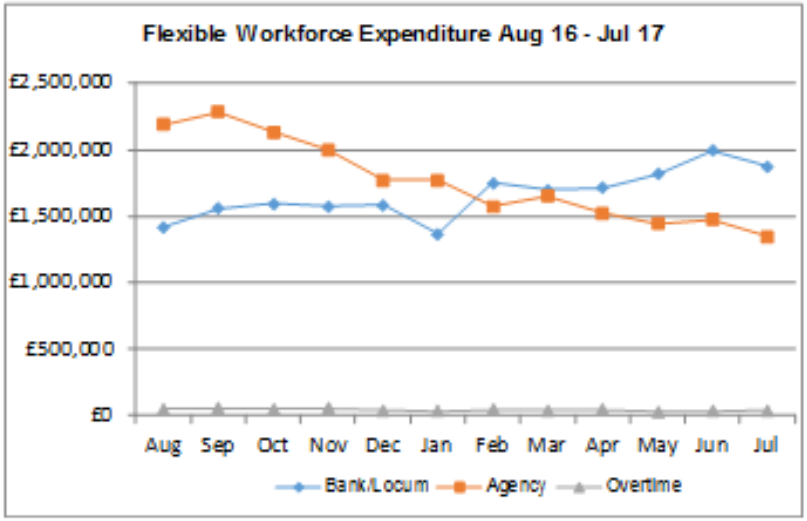
LEADERSHIP & CULTURE

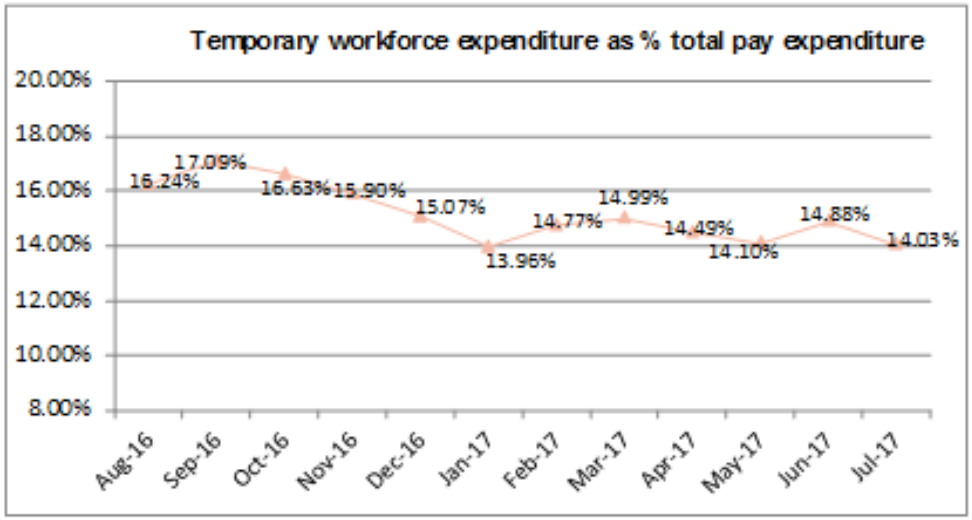
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Trust turnover rate	10.0%	10.0%	11.2%	1.2%	10.1%	11.1%	1.0%	10.2%	
Temporary costs and overtime as a % of total paybill	10.0%	15.0%	13.8%	-1.2%	15.1%	14.3%	-0.7%	15.1%	
Proportion of staff with up to date annual appraisal	85.0%	86.3%	81.6%	-4.7%	88.2%	81.0%	-7.2%	80.9%	

Commentary

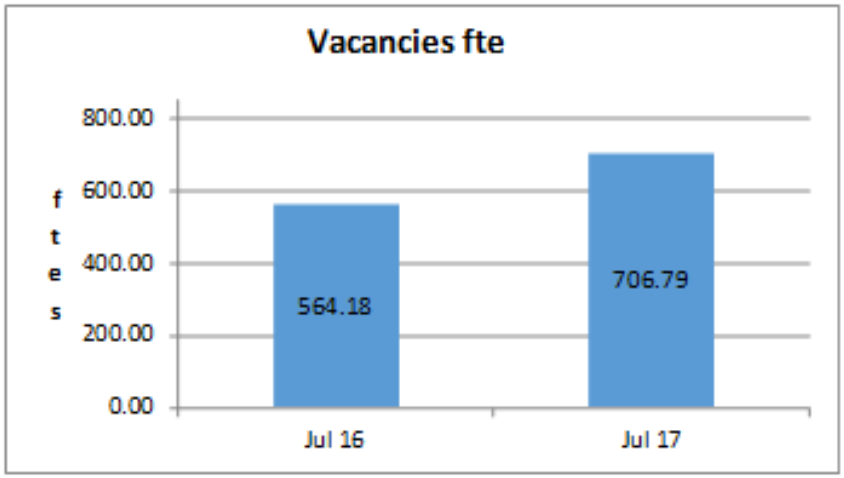
- Actual workforce usage of staff in May was 6663.43 full time equivalents (ftes), 164.44 ftes below the budgeted establishment.
- Temporary staff expenditure was £3,256K in June (14.03% of total pay expenditure). This comprised £1,876K bank expenditure, £1,342K agency expenditure and £38K overtime. This is a reduction of £245K overall compared to June.
- There were 706.79 fte vacancies (a vacancy factor of 10.57%).
- Annual turnover was 11.18% which represents 628.02 fte leavers in the last year.
- Monthly sickness was 4.42%, an increase of 0.58% from June. The annual sickness rate was 4.23%, an increase of 0.03%.
- The overall mandatory training rate increased by 0.74% to 89.34%. Compliance has increased in all subjects, with the exception of Trust Induction.
- Appraisal compliance increased 0.51% to 81.53%

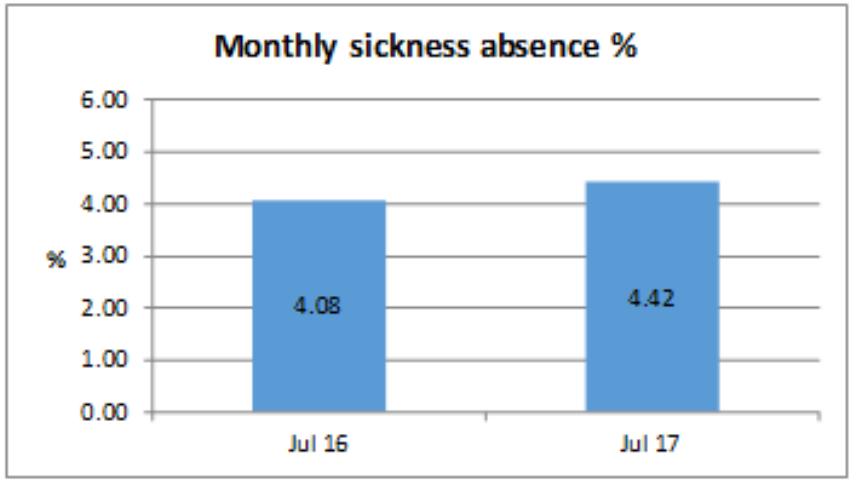

Substantive Workforce 2015/16 - 17/18
6100
6000
5900
5800
5700
5600
5500
5400
5300
5200
30-Apr 31-May 30-Jun 31-Jul 31-Aug 30-Sep 31-Oct 30-Nov 31-Dec 31-Jan 28/29-Feb 31-Mar
2015/16 5655 5626 5644 5651 5625 5651 5650 5506 5519 5550 5596 5667
2016/17 5684 5721 5760 5764 5806 5853 5895 5949 5905 5960 5966 6012
2017/18 6011 6018 6022 6056

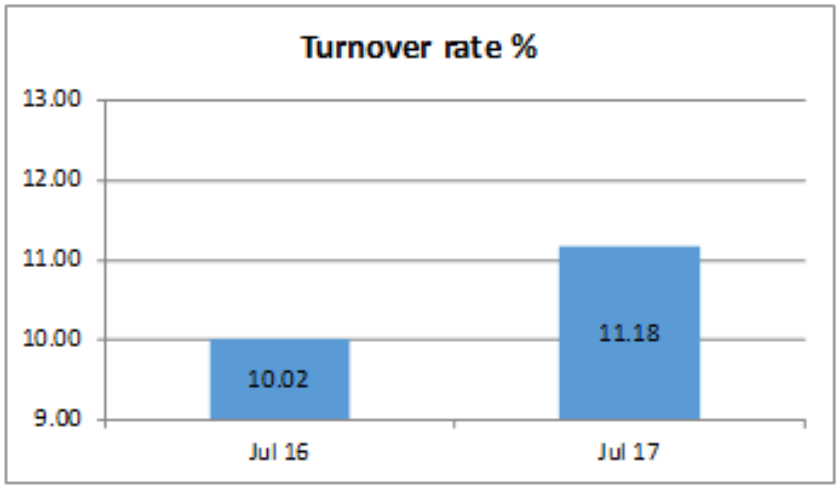

Flexible Workforce Expenditure Aug 16 - Jul 17
£2,500,000
£2,000,000
£1,500,000
£1,000,000
£500,000
£0
Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
Bank/Locum
Agency
Overtime

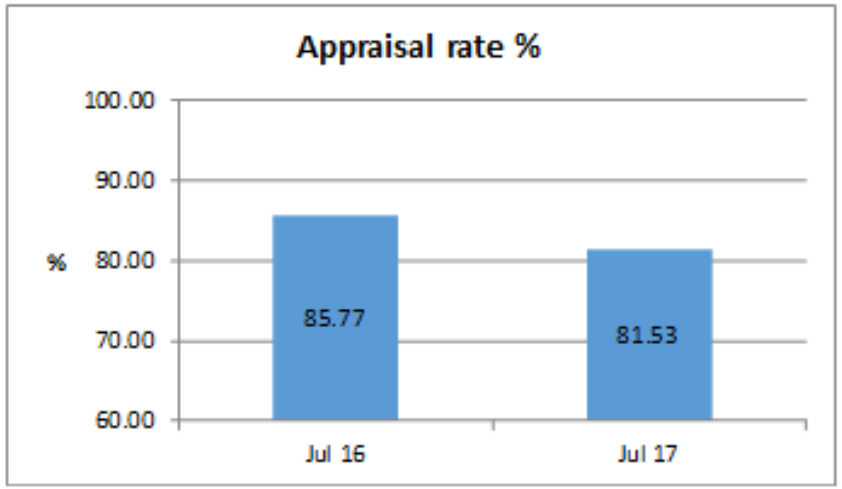

Temporary workforce expenditure as % total pay expenditure
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
16.24%
17.09%
16.63%
15.90%
15.07%
13.96%
14.77%
14.99%
14.49%
14.10%
14.88%
14.03%
Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17

East Sussex Healthcare NHS
NHS Trust

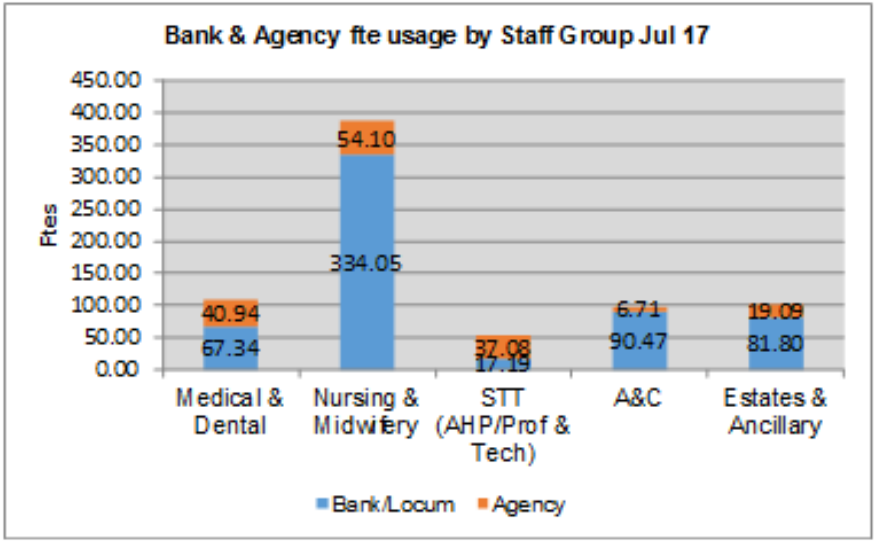


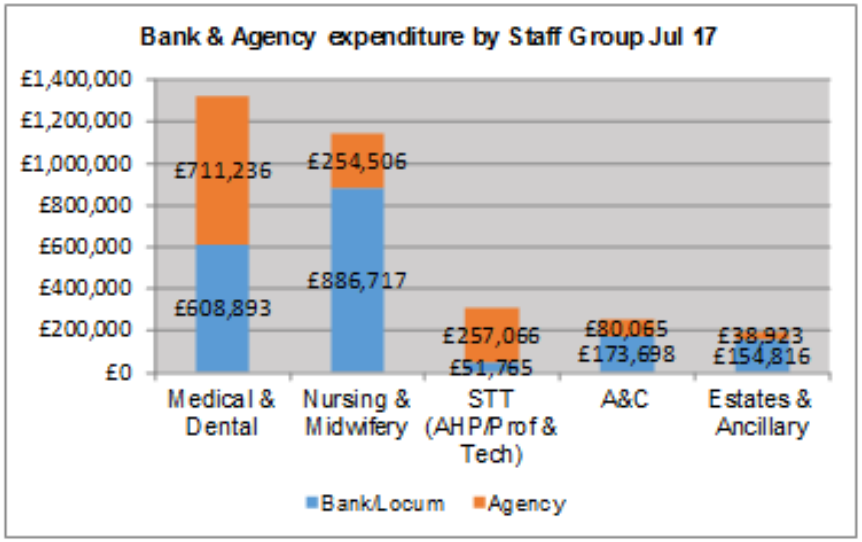






3. Recruitment

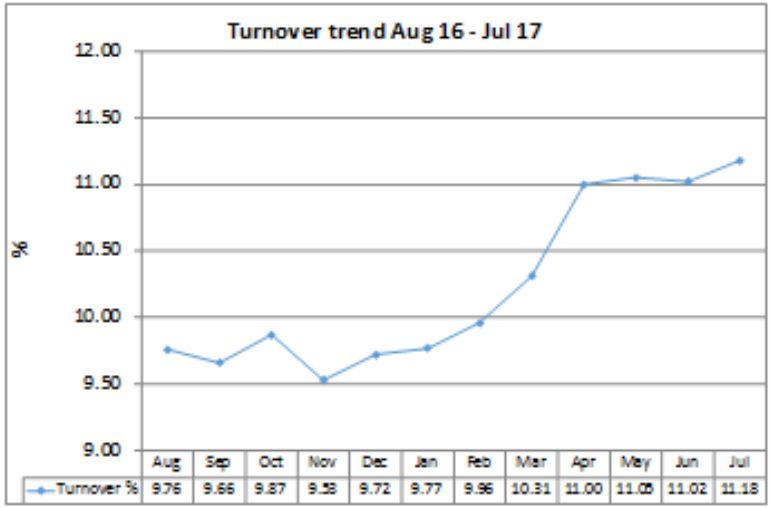




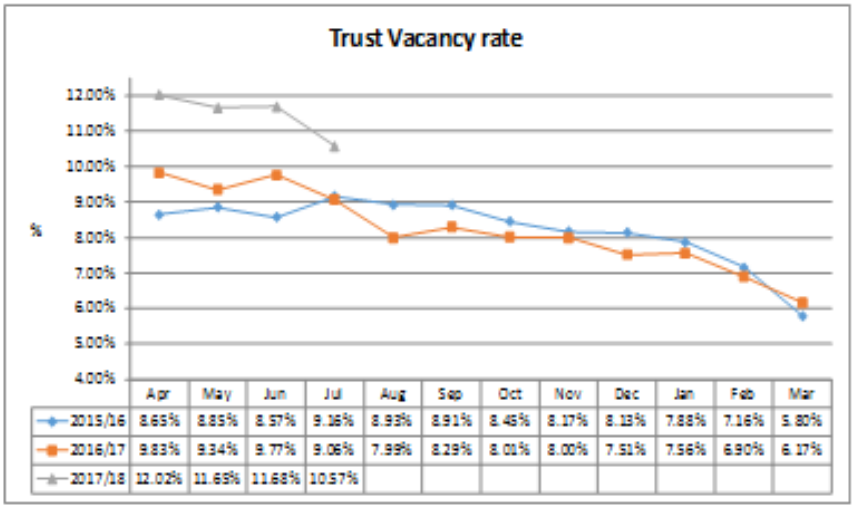
Budgeted establishment has reduced this month by 76.44 ftes due the ending of escalation funding after the first three months of the financial year plus an adjustment in Urgent Care pending agreement of the new medical model.

Temporary workforce expenditure reduced by £245K with a reduction of £118K in bank expenditure and a reduction of £131K in agency expenditure whilst overtime increased by £5K this month. Within the agency expenditure, however, there was an increase in nursing agency expenditure of £28K, which was offset by reductions in other staff groups. This seems, in part, to be a by- product of the ceasing of unqualified nurse agency leading to some additional booking of qualified staff.

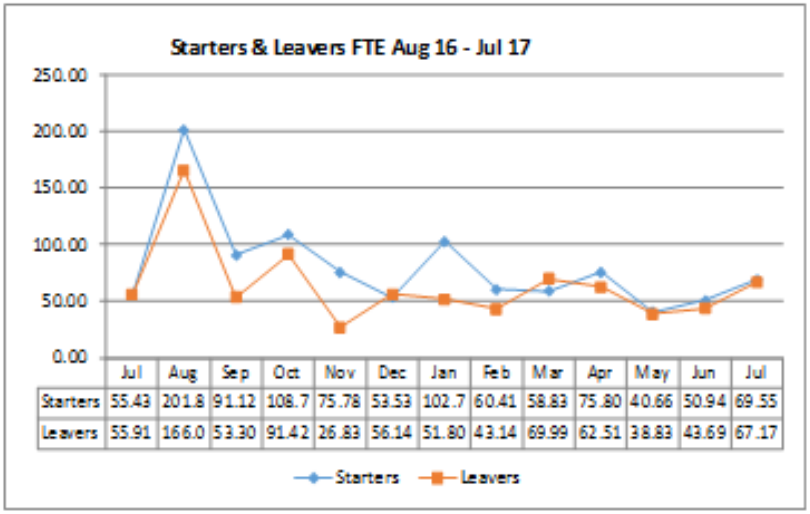
There is further evidence of a shift from agency to locum expenditure in General Surgery and Anaesthetics. Agency expenditure in Ultrasound has reduced this month with a return to normal activity levels, following a spike in June when they were covering the previous month's backlog. There was also a reduction in ODP agency at Conquest Theatres but this was offset by increased Theatre nursing agency. In Facilities there was a reduction in agency in July following a year to date correction of expenditure.



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Turnover %	9.76	9.66	9.87	9.53	9.72	9.77	9.96	10.31	11.00	11.05	11.02	11.18



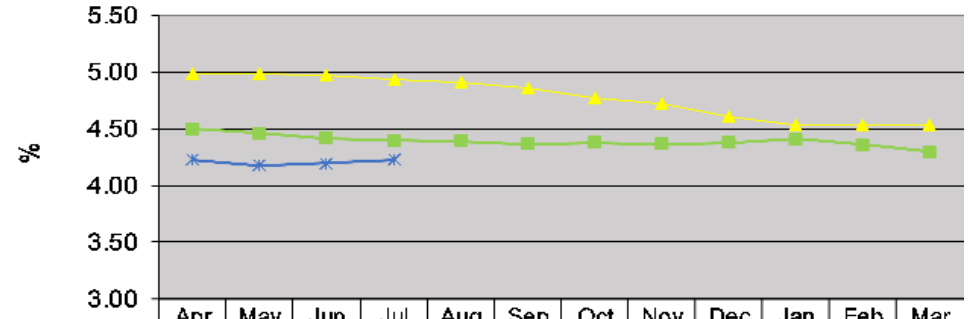
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8.65%	8.85%	8.57%	9.16%	8.93%	8.91%	8.48%	8.17%	8.13%	7.88%	7.16%	5.80%
2016/17	9.83%	9.34%	9.77%	9.06%	7.99%	8.29%	8.01%	8.00%	7.51%	7.56%	6.90%	6.17%
2017/18	12.02%	11.65%	11.68%	10.57%								



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Starters	55.43	201.8	91.12	108.7	75.78	53.53	102.7	60.41	58.83	75.80	40.66	50.94	69.55
Leavers	55.91	166.0	53.30	91.42	26.83	56.14	51.80	43.14	69.99	62.51	38.83	43.69	67.17

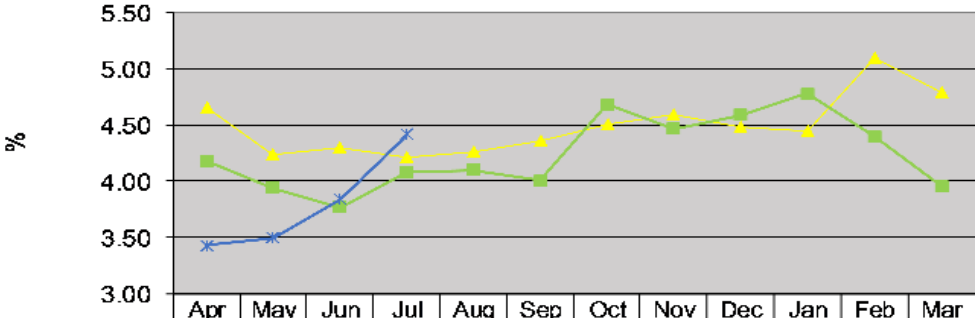
East Sussex Healthcare NHS
NHS Trust

Annual sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4.50	4.46	4.42	4.40	4.39	4.37	4.38	4.37	4.38	4.41	4.36	4.30
2017/18	4.23	4.18	4.2	4.23								

Monthly sickness rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4.65	4.24	4.30	4.21	4.26	4.36	4.51	4.6	4.48	4.45	5.10	4.79
2016/17	4.18	3.94	3.77	4.08	4.10	4.01	4.68	4.47	4.59	4.78	4.4	3.96
2017/18	3.43	3.50	3.84	4.42								

Monthly sickness has increased by 0.58% to 4.42% in July. There was a similar increase from June to July last year, though smaller. As a result, the annual sickness rate has also risen by 0.03% to 4.23%.

There were increases in sickness in all the Clinical Units. Urgent Care sickness increased by 2.39% to 10.32% (this is the area with the highest vacancy rate), Out of Hospital by 1.24% to 4.80%, Medicine by 0.82% to 4.11%, Diagnostics, Anaesthetics & Surgery by 0.45% to 3.75% and Women & Children's by 0.21% to 5.48%.

The Operational HR department have formulated an action plan to reduce sickness going forward. This includes,

a focus on hotspots with high absence and high backfill costs for sickness absence, with targeted actions and casework monitoring.

evidencing areas of weakness in absence management and reinforcing training on policy compliance (eg Return to Work interviews).

working with Occupational Health to fast track cases where appropriate.

reviewing employee relations cases and their impact on sickness rates

analysing reasons for absence and working with Occupational Health to target interventions

The action plan is reviewed weekly and a rolling programme of interventions is agreed and put in place.

7. Mandatory Training

Mandatory training course	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Induction %	95.43	95.99	95.76	95.11	95.52	95.04
Fire %	84.35	84.53	83.32	84.35	84.18	85.54
Moving & Handling %	89.02	89.45	88.71	89.23	89.67	90.21
Infection Control %	87.25	87.65	86.89	87.55	88.08	89.02
Info Gov %	84.24	87.25	83.74	84.26	84.41	85.77
Health & Safety %	88.51	87.55	87.63	88.09	88.77	89.56
Mental Capacity Act %	95.48	95.68	95.96	96.04	96.20	96.47
Depriv of Liberties %	97.67	97.88	98.07	98.04	97.82	97.97
Safeguard Vuln Adults	87.22	87.49	88.24	88.62	89.56	90.32
Safeguard Child Level 2	86.35	86.42	86.78	87.13	87.18	87.37

Clinical Unit Mandatory Training & Appraisals

Clinical Unit	Fire training	Man handling training	Induction	Infection Control training	Info Gov training	Health & Safety	Mental Capacity Act training	Depriv of Liberties training	Safeguard Vulnerable Adults	Safeguard Children Level 2	Safeguard Children Level 3	Appraisal compliance
Urgent Care	85.11%	88.30%	93.55%	88.30%	86.70%	90.43%	94.34%	92.50%	86.79%	89.31%	90.57%	92.18%
Medicine Division	89.07%	91.22%	94.57%	91.05%	87.78%	88.98%	95.34%	97.16%	90.18%	86.48%	n/a	83.68%
Out of Hospital Care Division	83.48%	87.54%	96.60%	87.54%	77.94%	86.94%	96.70%	99.45%	85.38%	83.61%	n/a	77.39%
Diagnostics Anaesthetics & Surgery	83.48%	87.92%	94.64%	85.92%	83.65%	90.58%	97.76%	98.68%	93.91%	90.10%	n/a	82.73%
Womens Childrens & Sexual Health Division	85.02%	90.44%	95.00%	88.45%	81.74%	85.59%	95.38%	96.20%	89.60%	86.27%	80.92%	79.85%
Estates & Facilites	83.31%	91.23%	100.00%	96.63%	95.11%	94.60%	n/a	n/a	n/a	n/a	n/a	91.27%
Corporate	88.90%	95.27%	92.86%	89.77%	92.08%	90.64%	98.43%	99.03%	93.65%	92.86%	87.50%	82.86%
TRUST	**85.54%**	**90.21%**	**95.04%**	**89.02%**	**85.77%**	**89.56%**	**96.47%**	**97.97%**	**90.32%**	**87.37%**	**82.23%**	**81.53%**

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

Concerted efforts have resulted in a marked increase in compliance for Information Governance and Fire Safety this month which will continue in order to achieve 90% compliance. This has been highlighted when sending the mandatory training matrix out to wards and services. All specialist trainers receive the matrix and actively target those areas with low compliance and provide additional sessions/team training if required to meet to demand.

The E-learning Support Technician is actively supporting areas of low compliance and there has been an increase in mandatory training completions via eLearning with 302 more completions when comparing Jan 2017 to June 2017.

DNAs (Did not Attend) continue to be an issue across all training and these are being highlighted to Divisions/Wards/Services to investigate.

Safer Staffing

Site Name	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
BEXHILL HOSPITAL	94.5%	98.6%	96.6%	121.5%
CONQUEST HOSPITAL	90.1%	107.4%	90.5%	112.0%
EASTBOURNE DISTRICT GENERAL HOSPITAL	89.2%	106.1%	90.7%	110.0%

From April 2014 all hospitals are required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

This is part of the NHS response to the Francis report which called for greater openness and transparency in the health service.

Information about staffing levels is published monthly.

Finance

FINANCE

Financial Summary – July 2017

Key metrics	Plan YTD	Actual YTD	Plan Out-turn	Forecast Out-turn
Agreed control total (exc STF) (£'m)	(16.5)	(16.2)	(36.4)	(36.4)
Agreed control total (inc STF) (£'m)	(14.4)	(14.3)	(26.5)	(26.7)
Efficiency requirement (£'m)	4.2	4.2	28.7	28.7
Cash balance (£'m)	2.1	2.1	2.1	2.1

Cash buffer £1.5

Better Payments practice code	Month Volume	Month Value	YTD Volume	YTD Value
Trade invoices	12.1%	22.8%	11.9%	24.2%
NHS invoices	34.9%	90.0%	27.2%	93.5%

Target: 95% on all categories

NHSI Finance and use of resources metrics	Plan YTD	Actual YTD	Plan Out-turn	Forecast Out-turn
Capital service cover rating	4	4	4	4
Liquidity rating	3	3	2	2
I&E margin rating	4	4	4	4
Distance from financial plan		1		2
Agency rating	1	1	1	1
Overall		3		3
Risk ratings after overrides		4		4

FSM override generates score of 4

Key Issue	Summary
Financial Summary	The Trust is reporting delivery of its FSM plan, this is slightly ahead of the ledger plan. The Trust continues to forecast full delivery of both the CIP targets and the year end control total. The Trust is still reporting a £0.2m adverse variance against STF driven by Q1 A&E performance (outcome of the appeal is still unclear). This was another challenging month operationally - the Trust continues to see higher than anticipated levels of non elective activity. The five clinical divisions are reporting in total £2.4m adrift from plan YTD. The Trust has received notification from the Treasury that it's future loans will be at 3.5% interest (previously 6%).
Efficiencies	The Trust continues to forecast full delivery of its £28.7m CIP plan for 2017/18. The governance structure is in place, and managing the overall programme, reporting to the Financial Improvement and Sustainability Committee, which meets each two weeks.
Balance Sheet	In addition to drawing down loan funding to support operational deficits, in line with the financial plan, the Trust is proposing to draw down £3.4m additional cash in September in lieu of STF funding, to be repaid when STF funding is received.
Cash Flow	Cashflow remains challenging resulting in increased creditor values and poor performance against the BPPC. The Trust has started reporting weekly on those creditors who have placed the Trust on stop or are threatening legal action.
Capital Programme	The overall capital programme has a significant level of over commitment as a result of demand for infrastructure and equipment requirements. The Capital Review Group (CRG) is closely monitoring capital spend and is forecasting delivery.

Variance Highlights – July 2017

Division	Variance against budget YTD (£'m) Other Income	Contract Income	Pay	Non pay	Total
Medicine	0.0	1.2	(0.4)	(0.4)	0.5
Surgery	(0.3)	(2.6)	(0.4)	(0.3)	(3.6)
Emergency Care	0.0	0.9	(0.3)	(0.0)	0.6
Womens & Childrens	0.1	0.8	(0.1)	0.0	0.8
Out of Hospital	(0.2)	0.5	0.7	(0.3)	0.6
Operational sub total	**(0.4)**	**0.8**	**(0.5)**	**(1.0)**	**(1.1)**
Estates & Facilities	(0.2)	-	0.2	(0.2)	(0.2)
Central and Corporate	1.0	(0.6)	0.7	0.3	1.3
Capital Charges	-	-	-	0.2	0.2
Donated assets adj	-	-	-	0.0	0.0
Total trading deficit	**0.4**	**0.1**	**0.3**	**(0.6)**	**0.3**
TEDDs	-	(0.3)	-	0.3	0.0
STF	-	(0.2)	-	-	(0.2)
Total deficit	**0.4**	**(0.4)**	**0.3**	**(0.3)**	**0.1**

Adverse variances less than £50k

Operational highlights

- Overall the five operational divisions are below plan by £1.1m (£0.8m M2).
- Excluding TEDDs and STF total contact income is ahead of plan, as a result of significantly increased activity levels. However, increased medical income has been offset by reduced surgical income, arising from increased non-elective activity.
- The impact of new tariff HRGv4+ is being worked through and may result in changes to the split of divisional contract income plan.
- ESBT investment (and pay costs) remain below plan leading to variances in the OOH CU.
- Agency, Medical and Prof & Tech combined with WLI payments drive overspends in pay.
- Non pay overspends are predominantly in drugs, clinical supplies and services.

Corporate highlights

- Estates and Facilities; car parking and laundry income are both slightly behind plan. Use of contractors is driving a higher than anticipated non-pay bill. The Finance Department will support estates with developing a plan to return to budget.
- Central and corporate are ahead of plan on income. Corporate vacancies and over delivery on other income offset overspends in non pay – Finance are supporting budget-holders to review all plans and help identify actions to mitigate overspending areas.
- TEDDs (Tariff Excluded Drugs and Devices) are pass through income and costs and therefore the variances net out.

More detailed variances and commentary can be found on pages five and six.

Income & Expenditure – July 2017

I&E Summary (£'m)	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	26.7	26.6	(0.1)	104.8	105.0	0.2	318.4	318.4	-
Tariff-Excluded Drugs & Devices	2.8	2.6	(0.2)	11.2	10.9	(0.3)	33.5	33.5	-
Private Patient / ICR	0.3	0.2	(0.1)	1.2	1.0	(0.2)	3.7	3.7	-
Other Non Clinical Income	2.7	3.2	0.5	11.6	12.2	0.6	34.5	34.5	-
Total Income	**32.5**	**32.6**	**0.1**	**128.8**	**129.1**	**0.3**	**390.1**	**390.1**	**-**
Pay - Substantive	(22.9)	(20.0)	2.9	(91.0)	(79.9)	11.1	(268.9)	(244.2)	24.7
Pay - Bank	(0.4)	(1.9)	(1.5)	(2.0)	(7.4)	(5.4)	(4.5)	(18.5)	(14.0)
Pay - Agency	(0.1)	(1.3)	(1.2)	(0.6)	(5.8)	(5.2)	(1.4)	(12.1)	(10.7)
Total Pay	**(23.4)**	**(23.2)**	**0.2**	**(93.6)**	**(93.1)**	**0.5**	**(274.8)**	**(274.8)**	**-**
Drugs	(3.3)	(3.4)	(0.1)	(13.2)	(13.9)	(0.7)	(39.7)	(39.7)	-
Supplies and services - Clinical	(2.7)	(2.7)	-	(10.9)	(11.6)	(0.7)	(33.2)	(33.2)	-
Supplies and services - General	(0.3)	(0.5)	(0.2)	(1.4)	(1.6)	(0.2)	(4.1)	(4.1)	-
Purchase of healthcare from non NHS bod	(0.3)	(0.4)	(0.1)	(1.3)	(1.7)	(0.4)	(3.9)	(3.9)	-
Consultancy costs	-	(0.1)	(0.1)	(0.1)	(0.3)	(0.2)	(0.4)	(0.4)	-
Clinical Negligence	(1.2)	(1.2)	-	(4.9)	(4.9)	-	(14.6)	(14.6)	-
Premises	(1.1)	(1.1)	-	(4.5)	(4.5)	-	(13.5)	(13.5)	-
Depreciation	(1.1)	(1.1)	-	(4.3)	(4.2)	0.1	(12.8)	(12.8)	-
Other	(2.2)	(1.9)	0.3	(8.4)	(7.1)	1.3	(21.3)	(21.3)	-
Total Non Pay	**(12.2)**	**(12.4)**	**(0.2)**	**(49.0)**	**(49.8)**	**(0.8)**	**(143.5)**	**(143.5)**	**-**
Total Operating Costs	**(35.6)**	**(35.6)**	**-**	**(142.6)**	**(142.9)**	**(0.3)**	**(418.3)**	**(418.3)**	**-**
Surplus/-Deficit from Operations	**(3.1)**	**(3.0)**	**0.1**	**(13.8)**	**(13.8)**	**(0.0)**	**(28.2)**	**(28.2)**	**(0.0)**
Financing Costs: Interest, PDC, Etc	(0.7)	(0.6)	0.1	(2.7)	(2.5)	0.2	(8.2)	(8.2)	-
Total Non Operating Costs	**(0.7)**	**(0.6)**	**0.1**	**(2.7)**	**(2.5)**	**0.2**	**(8.2)**	**(8.2)**	**-**
Total Costs	**(36.3)**	**(36.2)**	**0.1**	**(145.3)**	**(145.4)**	**(0.1)**	**(426.5)**	**(426.5)**	**-**
Net Surplus/-Deficit	**(3.8)**	**(3.6)**	**0.2**	**(16.5)**	**(16.3)**	**0.2**	**(36.4)**	**(36.4)**	**(0.0)**
Donated Asset/Impairment Adjustment	-	0.1	0.1	-	0.1	0.1	-	-	-
Operational Surplus/-Deficit	**(3.8)**	**(3.5)**	**0.3**	**(16.5)**	**(16.2)**	**0.3**	**(36.4)**	**(36.4)**	**(0.0)**
Sustainability & Transformation Fund	0.7	0.7	-	2.1	1.9	(0.2)	9.9	9.7	(0.2)
Net Surplus/-Deficit	**(3.1)**	**(2.8)**	**0.3**	**(14.4)**	**(14.3)**	**0.1**	**(26.5)**	**(26.7)**	**(0.2)**

Divisional Performance (1) – July 2017

Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Urgent Care:										
Contract Income	1.7	2.0	0.3	6.7	7.6	0.9	19.8	19.8	0.0	The contract income variance is driven by additional activity (M4 5% up on M3) and an uplifts to the tariffs not reflected in plan. YTD Pay overspends driven by the use of temporary staff (mainly medical, some A&C)
Other Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Pay	(0.8)	(1.0)	(0.2)	(3.7)	(3.9)	(0.2)	(10.5)	(10.5)	0.0	
Non Pay	(0.1)	(0.1)	0.0	(0.2)	(0.3)	(0.1)	(0.6)	(0.6)	0.0	
Total	**0.8**	**0.9**	**0.1**	**2.8**	**3.4**	**0.6**	**8.7**	**8.7**	**0.0**	
Medicine:										YTD Contract income is 4% above plan although NEL activity is on plan, DC well below plan and outpatients slightly above plan. In month pay costs was £0.5m lower than M3 although still over budget. Lease hire endoscopy scopes and the costs of pacemakers continue to drive the YTD non pay overspend.
Contract Income	7.3	7.4	0.1	28.2	29.4	1.2	85.8	85.8	0.0	
Other Income	0.3	0.3	0.0	1.3	1.3	0.0	2.6	2.6	0.0	
Pay	(4.6)	(4.7)	(0.1)	(19.3)	(19.7)	(0.4)	(56.0)	(56.0)	0.0	
Non Pay	(0.7)	(0.9)	(0.2)	(2.9)	(3.3)	(0.4)	(8.5)	(8.5)	0.0	
Total	**2.3**	**2.1**	**(0.2)**	**7.3**	**7.7**	**0.4**	**23.9**	**23.9**	**0.0**	
DAS:										YTD Contract income is 7% below plan, T&O is the biggest single driver. Analysis of the impact of HRG4+ is still being finalised but initial estimates suggest £0.1m negative impact per month on DAS. YTD pay; broadly £3.4m spend on temporary staff is offset by vacancies however WLIs (£0.5m) drive the adverse variance. Non pay overspend YTD is driven by Medical (£0.2m) and outsourcing (£0.2m)
Contract Income	9.5	8.6	(0.9)	36.3	33.7	(2.6)	112.1	112.1	0.0	
Other Income	0.5	0.4	(0.1)	1.9	1.6	(0.3)	5.8	5.8	0.0	
Pay	(7.3)	(7.4)	(0.1)	(29.2)	(29.6)	(0.4)	(87.4)	(87.4)	0.0	
Non Pay	(2.6)	(2.7)	(0.1)	(10.4)	(10.7)	(0.3)	(30.5)	(30.5)	0.0	
Total	**0.1**	**(1.1)**	**(1.2)**	**(1.4)**	**(5.0)**	**(3.6)**	**0.0**	**0.0**	**0.0**	
WAC										YTD Contract income is 5% ahead of plan however M4 saw a 4% reduction on the levels seen in previous two months. YTD pay; underspends in nursing don't quite offset the Medical agency overspends mainly in paediatrics and unbudgeted WLI payments.
Contract Income	3.8	3.9	0.1	14.7	15.4	0.7	44.2	44.2	0.0	
Other Income	0.0	0.0	0.0	0.1	0.2	0.1	0.3	0.3	0.0	
Pay	(2.5)	(2.5)	0.0	(10.0)	(10.1)	(0.1)	(29.7)	(29.7)	0.0	
Non Pay	(0.3)	(0.3)	0.0	(1.1)	(1.1)	0.0	(3.3)	(3.3)	0.0	
Total	**1.0**	**1.1**	**0.1**	**3.7**	**4.4**	**0.7**	**11.5**	**11.5**	**0.0**	

Divisional Performance (2) – July 2017

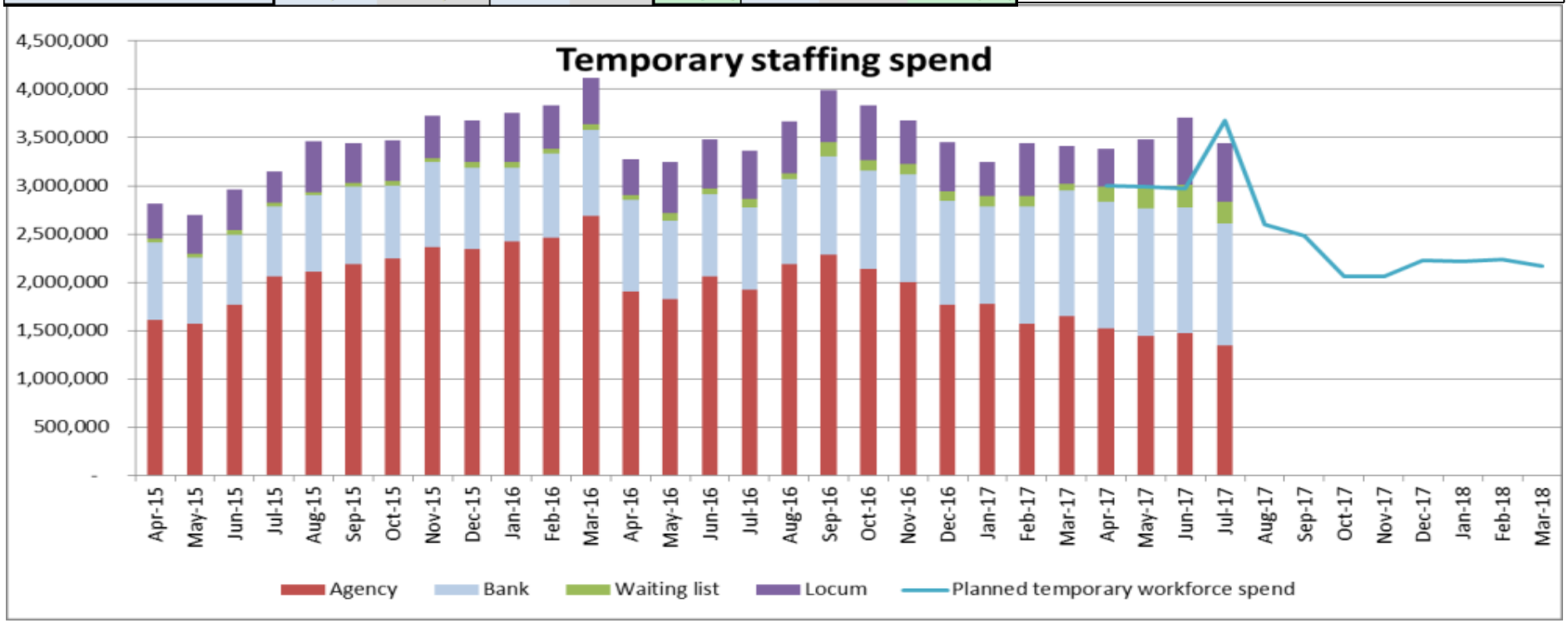
Divisional Summary (£'m)	In Month			YTD			Forecast			Notes
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
Out of Hospital:										PMU income 22% below plan YTD. Recruitment delays in ESBT drive the variance in both contract income and pay YTD. Drugs overspends (£0.5m YTD) are largely masked by underspends elsewhere including ESBT.
Contract Income	3.3	3.3	0.0	13.1	12.5	(0.6)	39.4	39.4	0.0	
Other Income	0.4	0.4	0.0	1.8	1.6	(0.2)	5.6	5.6	0.0	
Pay	(2.9)	(2.9)	0.0	(12.0)	(11.4)	0.6	(35.9)	(35.9)	0.0	
Non Pay	(1.1)	(1.3)	(0.2)	(4.5)	(4.8)	(0.3)	(13.6)	(13.6)	0.0	
Total	**(0.3)**	**(0.5)**	**(0.2)**	**(1.6)**	**(2.1)**	**(0.5)**	**(4.5)**	**(4.5)**	**0.0**	
Estates & Facilities:										Estates have delivered there income plan in M4 for the first time this year, increased car park income, radiotherapy utilities income off set the underperformance on Laundry income. In month pay and non pay both slightly underspent.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	0.6	0.6	0.0	2.3	2.1	(0.2)	6.9	6.9	0.0	
Pay	(1.4)	(1.3)	0.1	(5.6)	(5.4)	0.2	(16.7)	(16.7)	0.0	
Non Pay	(1.2)	(1.2)	0.0	(4.9)	(5.1)	(0.2)	(14.7)	(14.7)	0.0	
Total	**(2.0)**	**(1.9)**	**0.1**	**(8.2)**	**(8.4)**	**(0.2)**	**(24.5)**	**(24.5)**	**0.0**	
Corporate Services:										In month non pay overspends driven by back dated VAT charges, hosted funds and commercal opportunities CIP.
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	1.2	1.2	0.0	5.0	5.2	0.2	14.7	14.7	0.0	
Pay	(3.3)	(3.2)	0.1	(13.1)	(12.9)	0.2	(38.5)	(38.5)	0.0	
Non Pay	(2.1)	(2.6)	(0.5)	(9.0)	(10.0)	(1.0)	(25.3)	(25.3)	0.0	
Total	**(4.2)**	**(4.6)**	**(0.4)**	**(17.1)**	**(17.7)**	**(0.6)**	**(49.1)**	**(49.1)**	**0.0**	
Other:										Partial removal of Q1 STF funding linked to A&E performance drive the forecast contract income variance of £0.2m. TEDDs £0.3m above plan YTD for both income and non pay. Non pay plan (other) includes central reserves and capital charges.
Contract Income (TEDD	2.8	2.6	(0.2)	11.2	10.9	(0.3)	33.5	33.5	0.0	
Contract Income (Other	1.9	2.1	0.2	8.0	8.1	0.1	26.9	26.7	(0.2)	
Other Income	(0.1)	0.4	0.5	0.6	1.3	0.7	2.7	2.7	0.0	
Pay	(0.6)	(0.1)	0.5	(0.6)	0.0	0.6	(0.2)	(0.2)	0.0	
Non Pay TEDDs)	(2.8)	(2.6)	0.2	(11.2)	(10.9)	0.3	(33.5)	(33.5)	0.0	
Non Pay (Other)	(2.0)	(1.3)	0.7	(7.5)	(6.1)	1.4	(22.0)	(22.0)	0.0	
Total	**(0.8)**	**1.1**	**1.9**	**0.5**	**3.3**	**2.8**	**7.4**	**7.2**	**(0.2)**	

Workforce Pay Costs – July 2017

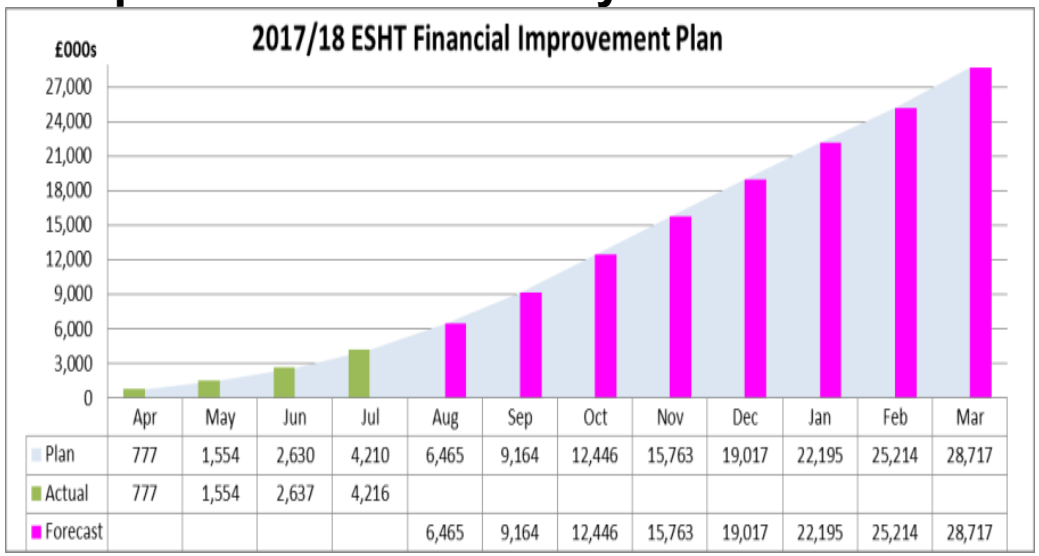
Staff Category £'m	FTE Plan	FTE Actual	In Month			YTD		
			Plan	Actual	Variance	Plan	Actual	Variance
Nursing	3,074	3,063	9.4	9.3	(0.1)	38.7	37.8	(0.9)
Medical	648	638	5.2	5.7	0.5	21.5	22.7	1.2
Administrative & Clerical	1,212	1,219	2.6	2.8	0.2	10.5	11.2	0.7
Prof & Tech	526	524	1.6	1.8	0.2	6.4	7.0	0.5
Professions Allied to Medicine	521	420	1.7	1.4	(0.3)	6.9	5.7	(1.2)
Ancillary	721	687	1.4	1.4	(0.1)	5.8	5.7	(0.1)
Senior Manager (Other)	122	102	0.7	0.6	(0.1)	2.9	2.5	(0.4)
Executive	8	9	0.1	0.1	(0.0)	0.4	0.4	(0.0)
Other Employees	(4)	-	0.6	0.0	(0.6)	0.4	0.1	(0.3)
Grand Total	**6,828**	**6,663**	**23.4**	**23.2**	**(0.2)**	**93.5**	**93.1**	**(0.4)**

Highlights

- YTD ward based nursing spend is over plan, this is offset by underspends predominately in ESBT and nursing vacancies elsewhere.
- YTD Medical overspends in WaCH, DAS & Medicine due to additional agency and waiting list premium costs
- M4 Prof & Tech overspends in surgery agency
- PAMS YTD under spends in OOH due to vacancies in ESBT and community



Cost Improvement Plan – July 2017

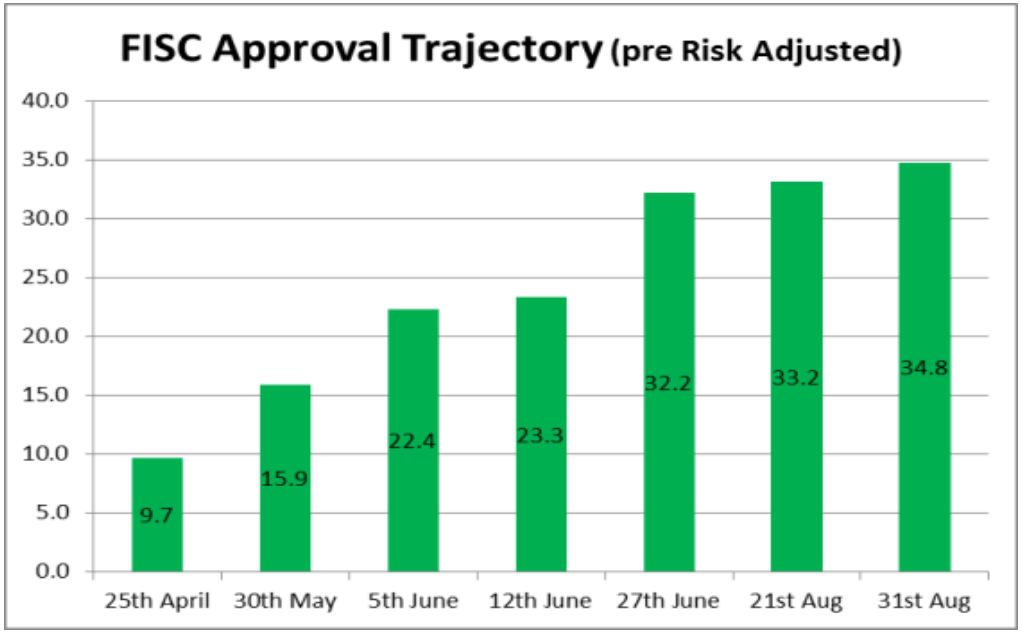


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	777	1,554	2,630	4,210	6,465	9,164	12,446	15,763	19,017	22,195	25,214	28,717
Actual	777	1,554	2,637	4,216								
Forecast					6,465	9,164	12,446	15,763	19,017	22,195	25,214	28,717

Headlines

- FISC has approved £33.2m of Projects to 21st August 2017, the remaining £1.6m is being worked up before the end of August. The trajectory graph below demonstrates this and shows that the Trust has identified £34.8m of plans, a risk adjustment has been applied to bring the value down to the £28.7m target.
- The Trust has delivered the CIPs for July and the YTD.
- Progress has been made on understanding the utilisation issues in Endoscopy and actions are being taken to improve this.
- The required actions for T&O escalations have now been completed and we should expect to see some improvement in August.

	£000's Year To Date		
Workstreams	Plan	Actual	Var.
Clinical Services Review	(0)	98	98
Data Quality & Clinical Networks	1,222	872	(350)
Elective Pathways	1,716	1,151	(565)
Grip & Control	1,148	1,353	205
Commercial Income	335	287	(48)
Procurement	357	343	(13)
Patient Flow	140	85	(55)
Agency & Premium Pay - Workforce	0	27	27
Central Risk Adjustment	(708)	0	708
Totals	**4,210**	**4,216**	**6**



	£000's Year To Date		
Workstream	Plan	Actual	Var.
Corporate	32	4	(28)
Estates & Facilities	83	69	(15)
DAS	1,932	949	(984)
Medicine	597	463	(134)
Urgent Care	382	588	206
WAC	202	185	(17)
Out of Hospital	307	481	174
Trustwide	674	1,478	804
Total	**4,210**	**4,216**	**6**

N.B. Trustwide to be allocated across Division

Activity & Contract Income – July 2017

Income (£'m)	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4.9	4.2	(0.7)	18.9	16.7	(2.2)	57.2	57.2	0.0
Inpatients - Emergency	6.8	7.7	0.9	26.6	30.4	3.8	79.5	79.5	0.0
Excess Bed Days	0.6	0.4	(0.2)	2.0	1.9	(0.1)	5.9	5.9	0.0
Outpatients	5.0	4.0	(1.0)	18.2	16.0	(2.2)	54.6	54.6	0.0
Other Acute based Activity	2.8	3.1	0.3	11.0	11.8	0.8	33.1	33.1	0.0
Direct Access	0.9	0.8	(0.1)	3.3	3.3	0.0	9.9	9.9	0.0
Block Contract	6.1	6.4	0.3	25.4	24.0	(1.4)	79.6	79.6	0.0
Fines & Penalties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	(0.4)	0.2	0.6	(0.7)	0.7	1.4	1.9	1.7	(0.2)
CQUIN	0.6	0.5	(0.1)	2.2	2.1	(0.1)	6.6	6.6	0.0
Subtotal	27.3	27.3	(0.0)	106.9	106.9	0.0	328.3	328.1	(0.2)
Exclusions	2.8	2.6	(0.2)	11.2	10.9	(0.3)	33.5	33.5	0.0
TOTAL	**30.1**	**29.9**	**(0.2)**	**118.1**	**117.8**	**(0.3)**	**361.8**	**361.6**	**(0.2)**

Activity	In Month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Inpatients - Electives	4,762	3,788	-974	18,153	15,632	-2,521	58,031	58,031	0
Inpatients - Emergency	3,576	4,798	1,222	14,073	15,718	1,645	42,162	42,162	0
Excess Bed Days	2,282	1,433	-849	8,979	7,597	-1,382	26,864	26,864	0
Outpatients	38,714	37,706	-1,008	146,310	152,691	6,381	478,441	478,441	0
Other Acute based Activity	12,051	12,793	742	47,258	50,763	3,505	148,432	148,432	0
Direct Access	303,828	297,246	-6,582	1,156,508	1,186,287	29,779	3,489,124	3,489,124	0
Other	703	673	-30	2,678	3,663	985	8,078	8,078	0

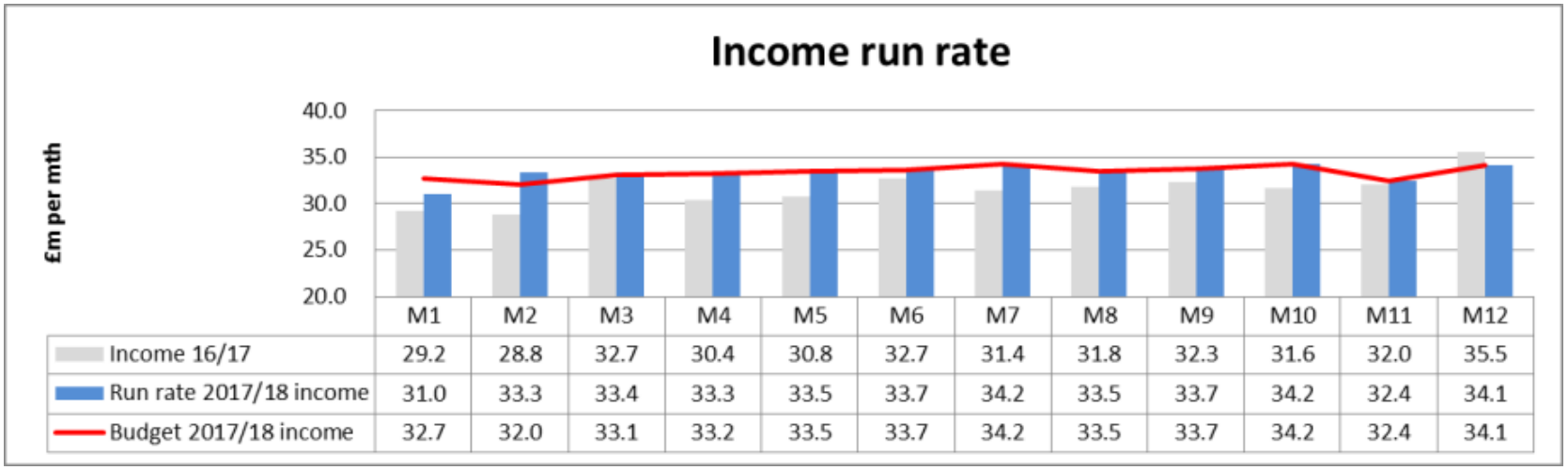
Activity Headlines

- Elective inpatients (day cases and inpatients) continue to trend below plan, the Trust is investigating the extent to which this is a planning issue or a consequence of pressures in urgent care.
- With the exception of excess bed days all other PODs are ahead of plan.

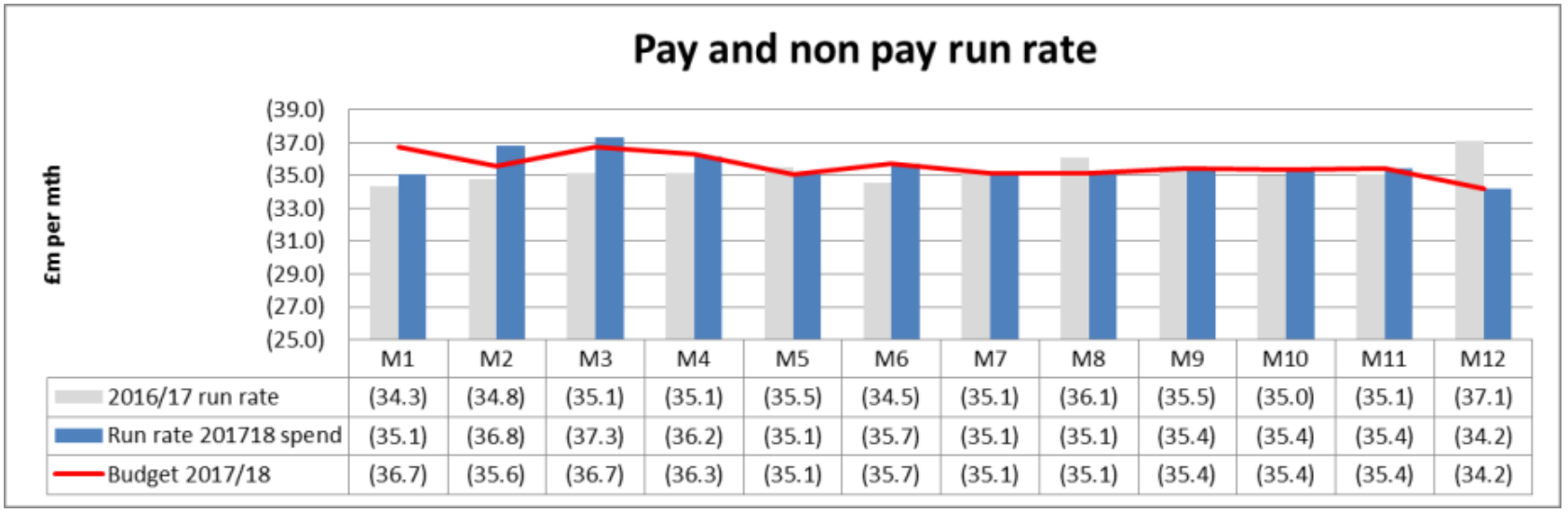
Income Headlines

- In total contact income is slightly below plan.
- Emergency income is significantly ahead of plan, whilst planned and elective care is behind plan – reflecting operational pressures.
- There has been a larger than anticipated impact of moving to HRG4+, whilst the movement for the Trust is understood to be positive it has created inter-divisional movements.
- Trust is investigating income variances to ascertain to what extent this they are caused by; a pricing issue; under or over statement of previous month or a genuine change in activity
- ESBT investment (and pay costs) remain below plan leading to variances in OOH

Trends – July 2017



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income 16/17	29.2	28.8	32.7	30.4	30.8	32.7	31.4	31.8	32.3	31.6	32.0	35.5
Run rate 2017/18 income	31.0	33.3	33.4	33.3	33.5	33.7	34.2	33.5	33.7	34.2	32.4	34.1
Budget 2017/18 income	32.7	32.0	33.1	33.2	33.5	33.7	34.2	33.5	33.7	34.2	32.4	34.1



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2016/17 run rate	(34.3)	(34.8)	(35.1)	(35.1)	(35.5)	(34.5)	(35.1)	(36.1)	(35.5)	(35.0)	(35.1)	(37.1)
Run rate 201718 spend	(35.1)	(36.8)	(37.3)	(36.2)	(35.1)	(35.7)	(35.1)	(35.1)	(35.4)	(35.4)	(35.4)	(34.2)
Budget 2017/18	(36.7)	(35.6)	(36.7)	(36.3)	(35.1)	(35.7)	(35.1)	(35.1)	(35.4)	(35.4)	(35.4)	(34.2)

Cash Flow – July 2017

13 month rolling cash flow statement (£'m)	Jul'17	Aug'17	Sep'17	Oct'17	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18	Apr'18	May'18	Jun'18	Jul'18
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Cash flows from operations	(2.2)	(1.6)	(1.4)	(0.4)	(0.8)	(1.0)	(0.5)	(2.3)	0.5	(0.9)	(0.9)	(0.9)	(0.9)
Depreciation and amortisation	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.2
Capital donations	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Trade and other receivables	(2.1)	2.0	2.3	2.0	1.0	(1.0)	1.0	0.2	0.7	0.1	0.5	-	-
Inventories	0.1	-	-	-	-	-	(0.3)	(0.3)	(1.0)	(0.0)	(0.0)	(0.0)	(0.0)
Trade and other payables	2.0	(2.9)	(0.4)	(2.1)	(0.7)	1.1	(1.5)	0.6	1.8	(1.2)	(1.5)	(1.2)	(1.2)
Provisions	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash from operations	**(1.1)**	**(1.5)**	**1.5**	**0.5**	**0.5**	**0.1**	**(0.2)**	**(0.7)**	**3.0**	**(0.9)**	**(0.8)**	**(1.0)**	**(1.0)**
Interest received	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Intangible assets	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Property, plant and equip.	(0.5)	(0.8)	(1.2)	(1.5)	(1.7)	(1.0)	(1.0)	(0.9)	(0.5)	(1.5)	(1.5)	(1.5)	(1.5)
Cash from investing activities	**(0.6)**	**(0.9)**	**(1.2)**	**(1.5)**	**(1.7)**	**(1.0)**	**(1.1)**	**(0.9)**	**(0.6)**	**(1.5)**	**(1.5)**	**(1.5)**	**(1.5)**
Loans - received	2.5	3.1	2.8	1.2	1.5	1.2	1.1	1.9	-	2.6	2.6	2.6	2.6
Loans - repaid	-	-	(0.2)	-	-	-	-	-	(0.2)	(0.1)	-	-	-
Other capital receipts	-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Interest paid	(0.3)	(0.5)	(0.8)	(0.1)	(0.1)	(0.0)	(0.3)	(0.5)	(0.7)	(0.1)	(0.1)	(0.2)	(0.2)
PDC dividend paid	-	-	(2.5)	-	-	-	-	-	(2.1)	-	-	-	-
Cash from financing activities	2.3	2.7	(0.6)	1.2	1.5	1.3	0.9	1.4	(3.0)	2.4	2.6	2.5	2.5
Increase/(decrease) in cash	0.6	0.3	(0.4)	0.1	0.2	0.3	(0.4)	(0.2)	(0.6)	0.0	0.3	(0.0)	(0.0)
Opening cash	2.1	2.7	3.0	2.7	2.8	3.0	3.3	2.9	2.7	2.1	2.1	2.4	2.4
Closing cash	**2.7**	**3.0**	**2.7**	**2.8**	**3.0**	**3.3**	**2.9**	**2.7**	**2.1**	**2.1**	**2.4**	**2.4**	**2.3**

Headlines

- The cash position of the Trust remains extremely challenging and maintaining liquidity and supply of goods and services requires constant management intervention.
- The August draw-down of RWCF is confirmed at the lower rate of 3.5%
- The Trust continues to work closely with NHSi to review options for drawing cash to meet current aged creditor balances.

Balance Sheet – July 2017

Headlines

• The forecast increase in non-current borrowings is in respect of the interim revolving working capital support facility (RWCF)

•Both payable and receivable balances remain high, with CCG disputed debtor invoices looking to be resolved in August (£2.8m).

•Full-time credit controller position interviewed for and appointed.

•Payable balances remain high due to lack of cash.

BALANCE SHEET £000s	Actual 31/03/2017	YTD Actual	Forecast 31/03/2018
Non Current Assets			
Property plant and equipment	237,135	235,398	238,634
Intangible Assets	1,860	1,900	1,980
Trade and other Receivables	1,308	1,186	1,308
	240,303	**238,485**	**241,922**
Current Assets			
Inventories	6,195	6,252	6,195
Trade receivables	29,734	24,074	26,002
Other receivables	11,072	26,040	9,617
Other current assets	0	0	0
Cash and cash equivalents	2,100	2,699	2,100
	49,101	**59,064**	**43,914**
Current Liabilities			
Trade payables	(23,586)	(38,943)	(16,470)
Other payables	(29,448)	(22,950)	(20,961)
DH Capital investment Loan	(427)	(427)	(427)
Other Financial Liabilities	0	0	0
Provisions	(502)	(341)	(502)
	(53,963)	**(62,661)**	**(38,360)**
Non Current Liabilities			
DH Capital Investment Loan	(3,126)	(3,126)	(3,126)
Borrowings - Revenue Support Facility	(89,662)	(103,447)	(126,757)
Other Financial Liabilities	0	0	0
Provisions	(2,488)	(2,522)	(2,488)
	(95,276)	**(109,095)**	**(132,371)**
Total Assets Employed	**140,165**	**125,793**	**115,105**
Financed by			
Public Dividend Capital (PDC)	153,562	153,562	155,247
Revaluation Reserve	104,708	104,707	104,708
Income & Expenditure Reserve	(118,105)	(132,476)	(144,850)
Total Tax Payers Equity	**140,165**	**125,793**	**115,105**

Capital Programme – July 2017

Headlines

• The Trust has an internally generated Capital Resource Limit (CRL) from depreciation of £11.7m.

•Recently agreed funding via PDC for GP streaming works is understood to increase the CRL.

•The Trust can also increase its CRL by receiving donations and these are planned to total £1.0m over the year.

•During the planning stage there was a £1.8m over commitment , this was agreed in the knowledge that capital schemes often suffer from slippage.

•Currently the plan is £7.0m over committed – with anticipated external funding of £3.1m anticipated to mitigate new projects - and the CRG are working to ensure the CRL is delivered at the end of the year.

•All areas of forecast over commitment continue to be reviewed and the Trust expects its CRL to be uplifted in August.

Capital Investment Programme (£'m)	Plan	Actual					Forecast
	2017/18	Apr	May	Jun	Jul	YTD	2017/18
Capital Resource Limit (CRL)	11.7	11.7	11.7	11.7	11.7	11.7	11.7
Anticipated CRL increase							1.7
Updated CRL (exc donated assets)	**11.7**						**13.4**
Donated asset funding	1.0	0.1	0.1	0.0	0.1	0.2	1.0
Total capital funding	**12.7**	**11.8**	**11.8**	**11.7**	**11.8**	**11.9**	**14.4**
Schemes							
Brought Forward	0.0	0.1	0.2	0.0	0.0	0.3	0.3
Estates - Brought Forward	1.3	0.1	0.1	0.2	0.1	0.5	1.7
Estates - Backlog Maintenance	1.9	0.0	0.0	0.0	0.0	0.1	2.1
Estates - Central	0.0	0.0	0.0	0.0	0.0	0.0	1.2
Estates - Clinical	0.1	0.0	0.0	0.0	0.0	0.0	0.1
Estates - Statutory	0.4	0.0	0.0	0.0	0.0	0.1	0.4
IT - Brought Forward	0.0	0.0	0.0	0.0	0.1	0.1	2.0
IT - Core	2.2	0.0	0.1	0.0	0.0	0.1	0.4
IT - FDM	0.4	0.2	0.0	0.0	0.0	0.2	0.2
IT - Other	0.2	0.0	0.0	0.0	0.0	0.0	0.2
Medical Equipment	2.0	0.2	0.0	0.0	0.0	0.3	2.0
Minor Capital	1.2	0.2	0.1	0.1	0.2	0.6	1.2
Unplanned Urgents	0.5	0.0	0.0	0.0	0.1	0.1	0.5
Donated Assets Purchased	1.0	0.1	0.1	0.0	0.1	0.2	1.0
Overplanning margin	-1.8						
Anticipated slippage							-5.3
Net Capital Charged against CRL	**12.7**	**0.9**	**0.6**	**0.5**	**0.7**	**2.6**	**14.4**

Receivables & Payables Performance – July 2017

Headlines

- The target achievement of BPPC is 95%, the Trust remains significantly below this target.
- Receivables have decreased but remain at a high value.
- Payables have marginally increased and continue to increase in age.

Trade Receivables Aged Debt Analysis - Sales Ledger System Only	NHS Debt Outstanding		Non-NHS Debt Outstanding	
	Current Month £000s	Previous Month £000s	Current Month £000s	Previous Month £000s
0 - 30 Days	3,439	5,916	1,640	2,186
31 - 60 Days	2,059	843	1,813	1,310
61 -90 Days	790	224	183	75
91 - 120 Days	192	11,234	50	1,660
> 120 Days	12,441	1,721	1,467	179
Total	18,921	19,938	5,153	5,410

Trade Payables Aged Analysis - Purchase Ledger System Only	No of Invoices		Value Outstanding	
	Current Month	Previous Month	Current Month £000s	Previous Month £000s
0 - 30 Days	5,439	6,186	5,751	7,076
31 - 60 Days	8,207	8,995	10,518	9,244
61 -90 Days	5,074	5,091	6,516	7,536
91 - 120 Days	3,141	3,483	4,980	5,328
> 120 Days	5,567	4,631	11,178	9,592
Total	27,428	28,386	38,943	38,776

Financial Risks & Mitigating Actions – July 2017

Risks	Mitigations
The Trust has a £28.7m savings requirement.	The PMO team has been strengthened to support work stream leads and provide scrutiny and assurance around the delivery governance. Weekly PMO meetings review delivery of the plan.
The costs of escalation and other attributable items may not be contained within the £3.1m funding envelope, including the costs of Winter.	Good progress has been made on achieving LOS reductions and discussions are progressing about closing unfunded capacity.
Outsourcing, WLI & ad-hoc clinics do not deliver the required improvement in RTT and 2 WW/ 62 day cancer targets	The Trust is developing a plan to deliver it's RTT target at the lowest possible safe cost, and has been successful in securing NHSE funding to support additional clinics for 62 day cancer.
Activity in some specialties is below plan and need further validation to identify where these trends may continue	Weekly activity tracking in place to monitor activity performance and a review of demand and capacity will be undertaken to ensure all specialties are matching resource requirements to demand
30% of the Trust's STF is contingent on A&E performance	Appeal submitted for Q1, Q2 performance has improved and performance for Q2 YTD is at 90%, with plans in place to implement GP streaming
Agency premium costs are currently mitigated by vacancies elsewhere.	The Trust is reviewing it's vacancy control process and has a detailed workforce efficiency workstream and plan.
A £4.2m provision for contract challenges has been made, including the outcome of the prior year disputed balances - there is a risk that total contract challenges will exceed this.	Close dialogue is in place with Commissioners to manage contract risks. A new Head of Contracts is refreshing the contracting reporting and management arrangements. Internal audit have been asked to review coding and income recording processes.

Sustainability and Strategy

SUSTAINABILITY

Strategy

Strategy and Planning

The Clinical Strategy has now been shared at Senior Leaders Forum and will be discussed at the Board Seminar in August. Once comments have been incorporated it will then be brought to Trust Board for ratification in September. The Clinical strategy provides a high level description of what the Trust will look like in 2022 and then more detailed plans at specialty levels of the actions that will be taken to deliver this.

ACO

A new health and care organisation (option 4) was agreed by the Trust Board as the preferred option for the ESBT Accountable Care Model. It was agreed moving to a stronger Alliance arrangement (option 3) by 2018 would deliver the best opportunity for addressing the challenges and ensuring future sustainability of a new health and care organisation We continue to work with our Alliance partners on streamlining key areas that will enable us to have a shared view of finances and performance data alongside our enhanced integrated teams.

STP

We continue to contribute to the work within the STP area exploring options for rapid access diagnostics to improve the cancer pathway, a pathology alliance, and rationalisation of Acute services where demand and capacity issues have been identified. We are currently working with BSUH to look at opportunities for clinical networking across our local area.

Activity

ACTIVITY

Activity Headlines

Day Case

- 9% down on plan year to date
- The largest area of variance both monthly and year to date is within Gastroenterology. Review of plan requested as includes additional activity against the 3rd room at Conquest.

Elective IP

- Year to date 7.1 below plan
- Most recent months show majority of underperformance in Orthopaedic Surgery and Urology.

First Outpatient

- 8% under Plan year to date
  - Ophthalmology has largest underperformance against plan c1000 YTD. Capacity continues to be 65 New Outpatients a week short of demand.

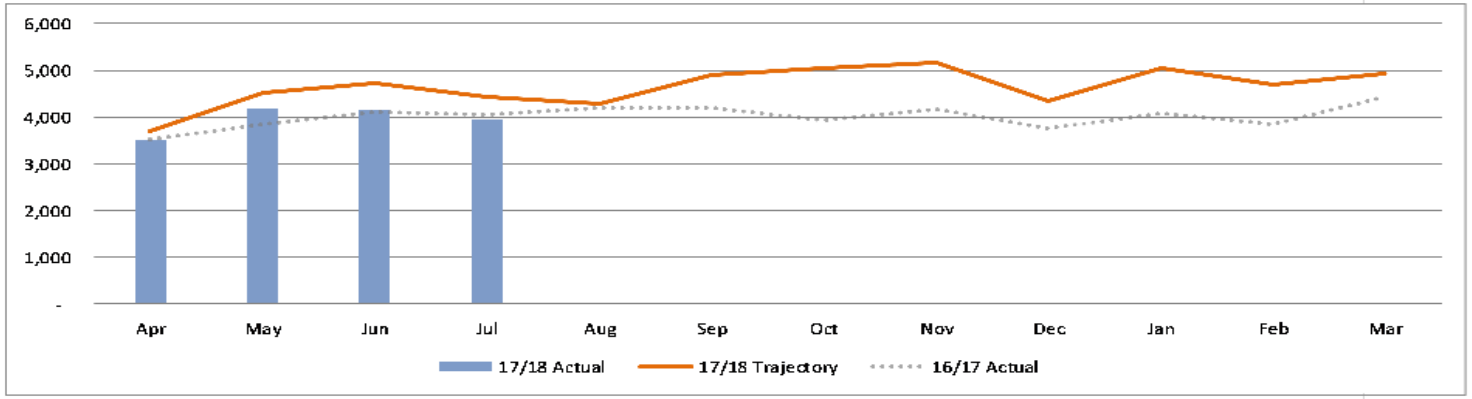
Follow-up

- Running against Plan year to date.

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
Emergency Department attendances	M	10144	10596	4.5%	37671	40280	6.9%	9429	
Ambulance conveyances	M	3133	3219	2.7%	12044	12815	6.4%	3155	
Admissions via A&E	M	23.5%	27.6%	4.1%	24.8%	26.7%	1.8%	26.3%	
Primary Referrals	M	8858	8043	-9.2%	36706	34290	-6.6%	8864	
Consultant to Consultant referrals	M	1651	1692	2.5%	6485	6462	-0.4%	1532	
2WW Referrals	M	1641	1732	5.5%	6588	6768	2.7%	1661	
Elective spells	M	715	593	-17.1%	2664	2458	-7.7%	650	
Day Cases	M	4036	3937	-2.5%	15515	15798	1.8%	4034	
Elective Beddays	M	2236	1850	-17.3%	8199	6803	-17.0%	1803	
Total Non-Elective Spells	M	3878	4167	7.5%	15479	15985	3.3%	3851	
Number of Emergency spells	M	3182	3538	11.2%	12982	13497	4.0%	3230	
Number of Maternity spells (ante and post partem)	M	378	331	-12.4%	1345	1339	-0.4%	335	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	318	298	-6.3%	1152	1149	-0.3%	287	
Non-Elective beddays	M	21927	21357	-2.6%	89893	87273	-2.9%	22673	

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Jul-16	Jul-17	Var	2016/17	2017/18	Var		
LOS									
Elective Average Length of Stay	M	3.1	3.1	0.0	3.1	2.8	-0.3	2.8	
Non-Elective Average Length of Stay	M	5.6	5.0	-0.5	5.8	5.6	-0.2	5.9	
Inpatient Average Length of Stay at intermediate care units	M	30.9	28.7	-2.1	30.2	30.3	0.0	31.5	
First outpatient attendances	M	9868	9542	-326	44304	43109	-1195	10772	
Follow-up outpatient attendances	M	22053	23863	1810	102158	104508	2350	24006	
First outpatient DNA rate	M	8.6%	9.1%	0.4%	8.7%	8.5%	-0.3%	8.9%	
New to follow up ratio	M	714.6	831.0	116.4	102158	104508	2350	769	
% Temporary files created as a proportion of all attendances									
Community nursing referrals	M	3994	4162	168	15625	16459	834	4197	
Community nursing total contacts	M	33720	35869	2149	138899	141308	2409	34825	
Community Nursing face-to-face contacts	M	19058	20372	1314	77770	80505	2735	19721	
Community nursing ALOS	M	20.4	4.5	-16	23.5	9.3	-14.2	15	
Waiting Times									
% SALT patients waiting less than 13 weeks	M	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Total SALT patients waiting	M	176	107	-69	657	547	-110	146	
% Podiatry patients waiting less than 13 weeks	M	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Total podiatry patients waiting	M	998	259	-739	3531	1154	-2377	436	
% Dietetics patients waiting less than 13 weeks	M	100.0%	93.8%	-6.3%	100.0%	97.6%	-2.4%	98.8%	
Total dietetics patients waiting	M	43	90	47	292	327	35	64	
% MSK patients waiting less than 13 weeks	M	100.0%	100.0%	0.0%	100.0%	92.1%	-7.9%	96.3%	
Total MSK patients waiting	M	1922	1021	-901	2240	5041	2801	1372	

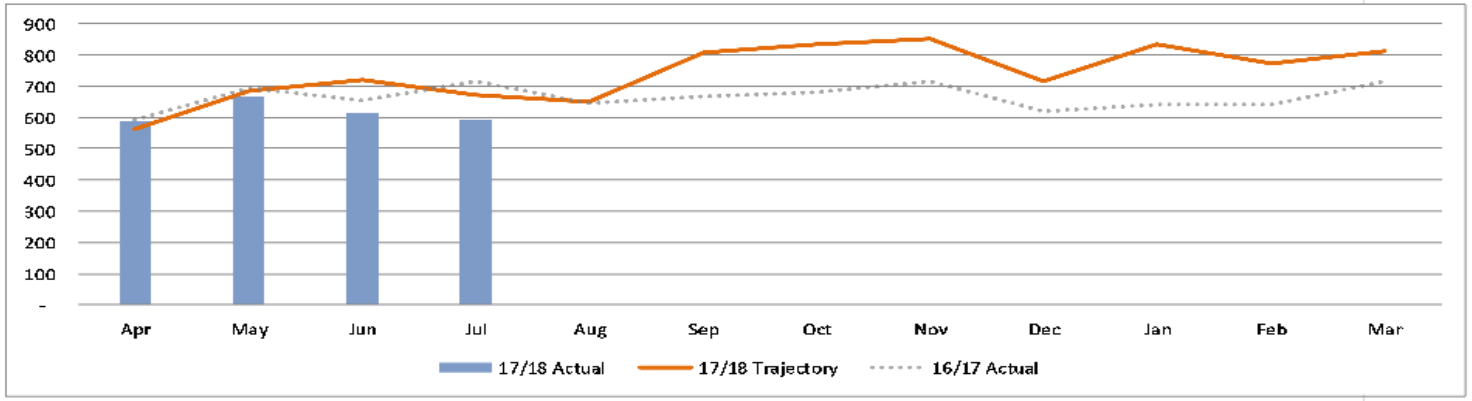
Daycase



YTD	
Plan	12,940
Actual	11,861
Var	-8.3%
16/17	11,479

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	3,706	4,508	4,726	4,422	4,293	4,893	5,035	5,153	4,331	5,053	4,687	4,915
17/18 Actual	3,509	4,192	4,160	3,937	-	-	-	-	-	-	-	-
Var	-5.3%	-7.0%	-12.0%	-11.0%								
16/17 Actual	3,521	3,839	4,119	4,036	4,199	4,207	3,933	4,165	3,755	4,087	3,831	4,437

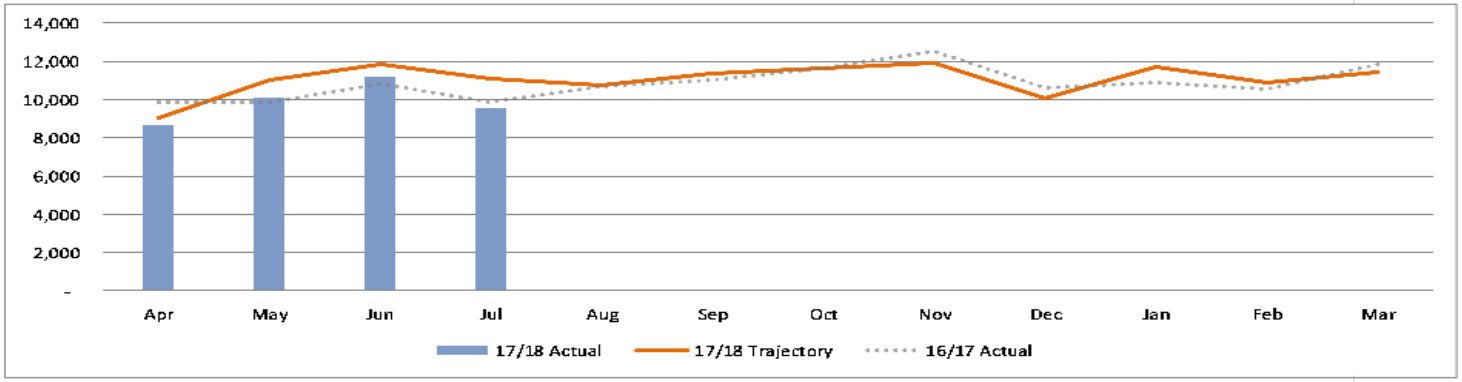
Elective IP



YTD	
Plan	1,972
Actual	1,865
Var	-5.4%
16/17	1,949

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	564	686	722	673	653	809	834	851	718	835	776	813
17/18 Actual	586	665	614	593								
Var	3.9%	-3.1%	-15.0%	-11.9%								
16/17 Actual	596	697	656	715	649	670	682	717	619	642	644	715

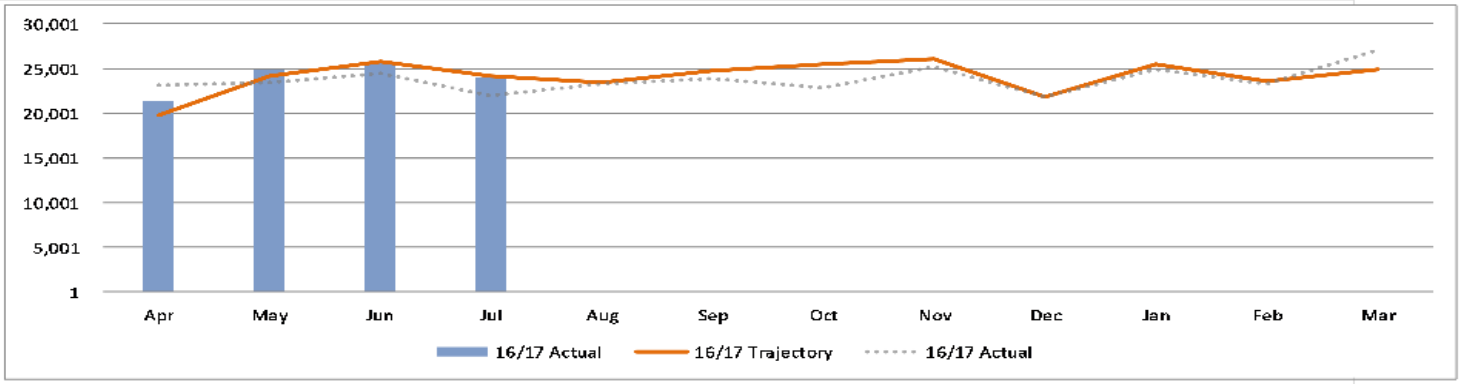
First Outpatient



YTD	
Plan	31,873
Actual	29,918
Var	-6.1%
16/17	30,567

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Trajectory	9,044	10,999	11,830	11,064	10,746	11,339	11,665	11,933	10,034	11,722	10,849	11,395
17/18 Actual	8,652	10,072	11,194	9,551	-	-	-	-	-	-	-	-
Var	-4.3%	-8.4%	-5.4%	-13.7%								
16/17 Actual	9,853	9,876	10,838	9,868	10,707	10,990	11,652	12,489	10,642	10,906	10,567	11,844

Follow-up Outpatient



YTD	
Plan	69,819
Actual	71,754
Var	2.8%
16/17	71,065

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17 Trajectory	19,855	24,156	25,808	24,156	23,443	24,743	25,456	26,045	21,905	25,572	23,681	24,864
16/17 Actual	21,338	24,860	25,556	23,918	-	-	-	-	-	-	-	-
Var	7.5%	2.9%	-1.0%	-1.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%
16/17 Actual	23,216	23,403	24,446	22,053	23,389	23,933	22,845	25,168	21,860	24,898	23,354	27,109

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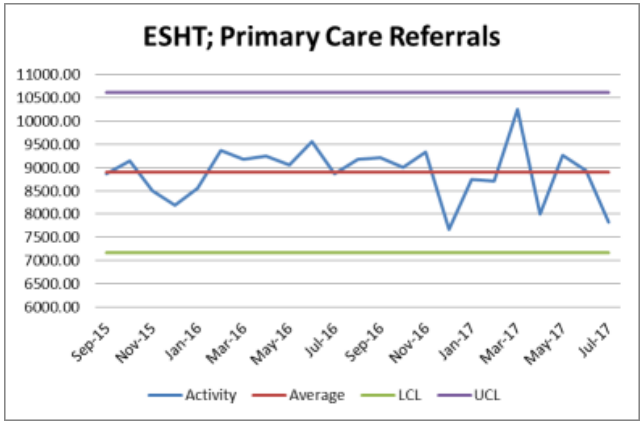
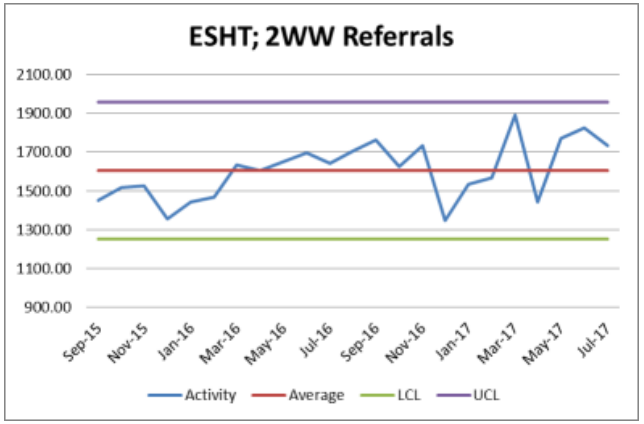
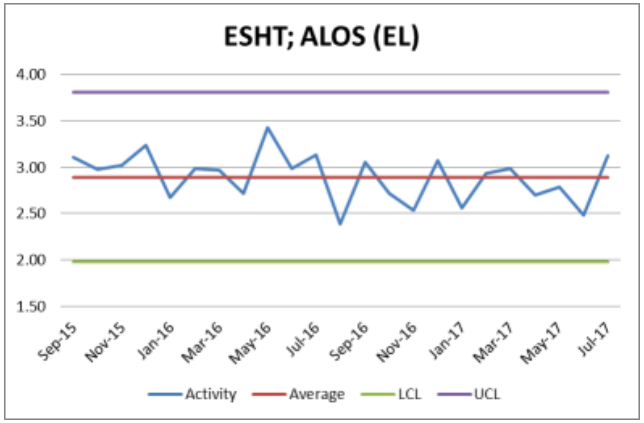
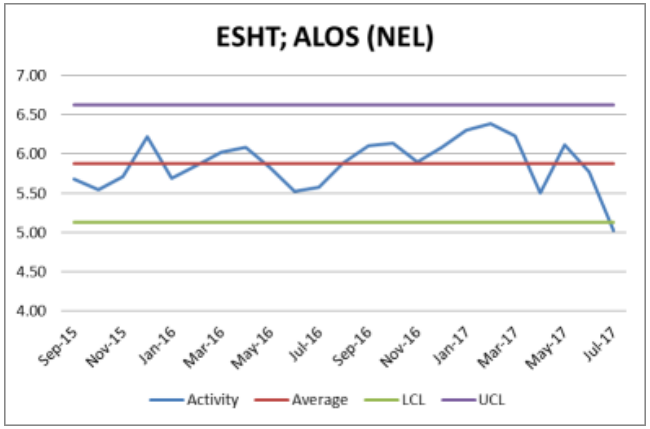








Primary care referrals have returned to normal levels following a sharp increase earlier in the year. July referrals are likely to increase as they are added to the system.

The referrals for two week waits continue remain on an upward trend but have stabilised over the last 3 months. The Trust is expecting further increases with the impact of various national campaigns.

Whilst elective average length of stay rose in July, non-elective ALoS continues on a downward trend. Furthermore, non-elective ALoS fell below the lower control limit in July. This would indicate a higher than expected number of patients discharged with low lengths of stay.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Integrated Performance Report – Month 4 (July)

Meeting information:			
Date of Meeting:	26 September 2017	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Trust Executives

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	X	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register?	Yes

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

Clinical Effectiveness

- Mortality indicators SHMI = 1.09 (Jan – Dec 2016), which is within the trusts expected range. The top diagnostic groups are pneumonia, septicaemia and acute cerebral disease.

Patient safety

- In June, there was one Never Event (misplaced naso-gastric tube) which has been investigated. A new system has been implemented requiring two people to check placement from x-rays. In May one never event occurred (wrong site surgery – wrong tooth). The rport has been completed and submitted to the CCG.
- In terms of serious incidents the biggest trend is falls resulting in a fracture. A new multifactorial risk assessment has been produced and will be piloted on 4 wards, combined with a new simulation training session to ensure assessments conducted effectively identifying the correct prevention measures to put in place.
- However, the overall number of falls continues to fall over the last year. In July 2016 there were 152, whereas in July 2017 there were 125.
- One MRSA case has been reported in July with no lapses in care identified.

Patient Experience

- Complaints performance has improved since April 2016 when 69 were overdue some over 100 days. In July there were 5 overdue and none of these were over 20 days. Our target is zero overdue unless a clear rationale. The top categories for complaints in July were communication and delays to treatment or services.

- Overall inpatient FFT scores indicate 97% would recommend the Trust, which is slightly lower that June 16 at 97.9%. Our response rate for inpatient FFT has continued to increase from 16% last year to 43% (stretch internal target of 45%) in July. Based on national data from May 17 figures this would place us in the top 14 trusts. A and E response rate is slowly improving but further work required.

Access and Delivery

In August the Trust achieved 87.7% performance against the four hour standard and, for the fourth month, over 90% for RTT, with a final position of 92.03%. Compliance with the two week wait standard has been maintained. Diagnostic performance has improved but remains just above 1% at 1.7%. The 62 day cancer target remains a challenge, achieving 73.4% with focussed work being done in all specialties to manage performance. Central funds have been secured for additional initiatives to improve the position.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Finance and Investment Committee
Senior Leaders Forum – 11 Sep 2017
Quality and Safety Committee – 20 Sep 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note this report

Mortality Report – Learning from Deaths 1st April 16 to 31st March 17

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	David Walker

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☒

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. This has included changing the mortality database to reflect the review process. This report details the actions taken and those still outstanding, to embed the process along with the first report and classification of deaths recorded and reviewed during 2016/17 financial year. The classification for these deaths has been mapped from the old system to the new. The importance of reviewing deaths within the 3 month timescale is critical to ensure the reporting is accurate and provides a useful overview on the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes and was highlighted to consultant staff at the recent mortality summit.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

The Mortality and Morbidity Policy has been reviewed and approved at the Clinical Outcomes Group in August 2017 which supports the learning from death process.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD)

The Board are requested to note the report and agree the format for future learning from death reports required on a quarterly basis.

The Board are asked to formally adopt the attached Mortality and Morbidity Policy.

Learning from Deaths Report

Executive Summary

In December 2016, the Care Quality Commission (CQC) published its review "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England". The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

This report has two elements;

- **Part 1** - An update of the progress to the Learning from Deaths requirements to meet CQC national recommendations;
- **Part 2** - The first Board report on learning from deaths using the national template;

The Trust is now compliant with the requirements outlined in the review. The data from the deaths reviewed during 2016/17 demonstrates 80% compliance to all death reviews although not all these would have been within the 3 month timescale. There are a total of 372 deaths not recorded on the mortality database as having a review. Only 3 deaths were deemed to be probably avoidable based on the new classification system during the year.

Part 1

A brief outline of the main requirements for learning from deaths detailed in the national CQC review are as follows;

- Appoint an Executive (DW) and Non-Executive Director (SB) to lead the learning from death process;
- Review as a minimum all inpatient and Accident and Emergency deaths;
- Ensure those conducting death reviews have the skills to conduct effectively and use the structured judgement review methodology suggested by the Royal College of Physicians;
- Provide quarterly reports to the Board on learning from deaths to include number of deaths, number reviewed and the classifications;
- Ensure clear policy in place to reflect the actions;
- Review all deaths involving patients with Learning Disabilities using the LeDeR programme (Learning Disabilities Mortality Review) – launched Sept 2017;
- Review deaths where bereaved families raised concerns;
- Raise concerns as incidents where identified and ensure reported to the National Reporting and Learning System (NRLS).

The Trust has achieved all the requirements in the bullet points above in terms of setting up the systems, updating the mortality database and describing the new processes within the Mortality and Morbidity Policy. The systems now need embedding into practice such as improving the timeliness of the death reviews. The table below details the main actions that have been completed and those on track for completion.

Action	Status / Completion Date	Owner
Mortality database changes completed to include the new National Learning from Deaths Template for review.	Completed	J. Wilkinson
Database guidelines distributed and training accessible.	Completed	J. Wilkinson
Review and amendment of Mortality and Morbidity Policy to include requirements from the National Guidance on learning from Deaths	Completed – Awaiting final ratification and uploading on intranet	A.Parrott / J. Wilkinson
New process established to identify where concerns have been raised by Family members or Relatives. The Bereavement Team ask each family if they had any concerns over the care provided. this is recorded on the database and concerns sent to the Associate Director of Governance to review and action as required – this could be through discussion with Medical Director (or Deputy) and Senior Nursing Team or escalation to weekly patient Safety Summit.	Completed	J.Knight / A.Parrott
Mortality Summit held for all Consultants to reinforce new processes and standards	Completed	D. Walker / J. Wilkinson
Reporting template for Consultant review rates developed and circulated	Completed	D. Walker
Learning from Deaths Trust Board report produced and presented for 2016/17 as example to confirm format.	Completed	A.Parrott / J. Wilkinson / J.Knght
Learning from Deaths Trust Board report produced and presented for Q1 data to next Board meeting after September 17	Oct 17	D. Walker
A summary report will be required for the Quality Account 2017/18 to include the data for the year and learning. Publish report in Trust Quality Account	Completed	E.Tate / J.Knight
Include the outstanding deaths requiring review within each quarterly report dating back to the 1st April 2017	Oct 17	J.Knight / D.Walker
Include a summary of number of deaths where family raised concerns and actions taken as a result within each Quarterly report	Oct 17	J.Knight / D.Walker
Include number of complaints and serious incidents raised following a death and include in quarterly report. Cross reference against the death review rating.	Oct 17	J.Knight / D.Walker
Continue to increase compliance with death reviews within the maximum of 3 months by Consultants	On-going	D.Walker / J.Wilkinson

Part 2

The Learning from Deaths Dashboard is the suggested tool to use for recording and reporting to the Board designed by NHS England. This report includes the data for all of 2016/17 but in future it will detail data in each quarter during the financial year. The additional information on family concerns, serious incidents and complaints and total number of deaths during the year still not reviewed will be included within the next report covering 2017/18 quarter 1.

See Learning from Deaths Dashboard

Author Ashley Parrott, Associate Director of Governance 7th September 2017

Dashboard produced/populated by Jacqui Knight

Learning from Deaths Dashboard - April 2016 to March 2017

Department of Health

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

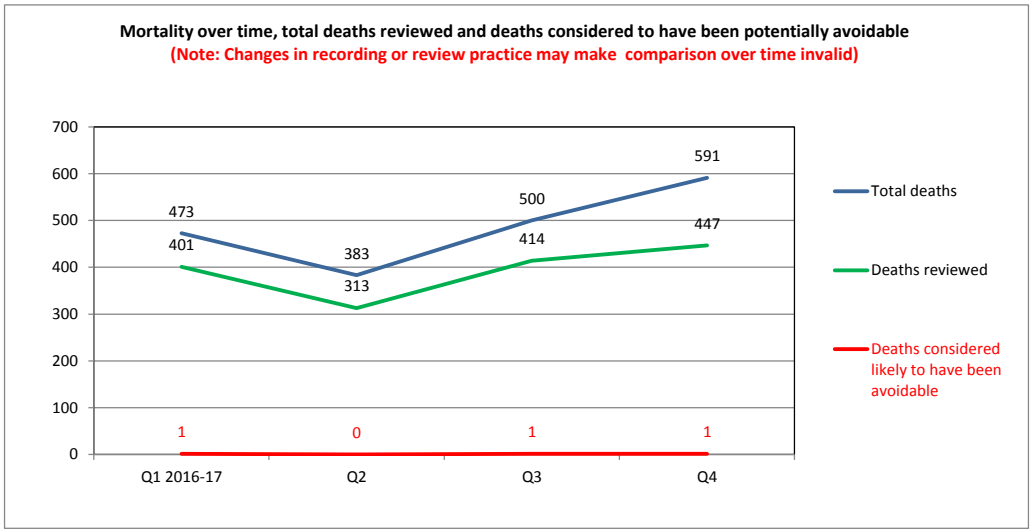
Summary of total number of deaths and total number of cases reviewed (between 1-4-16 to 31-3-17)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Time Series:	Start date	2016-17	Q1

End date	2016-17	Q4

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
168	187	127	147	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
591	500	447	414	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1947	0	1575	0	3	0



Total Deaths Reviewed

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	0.2%	This Year (YTD)	12	0.8%	This Year (YTD)	168	10.6%	This Year (YTD)	1397	88.4%

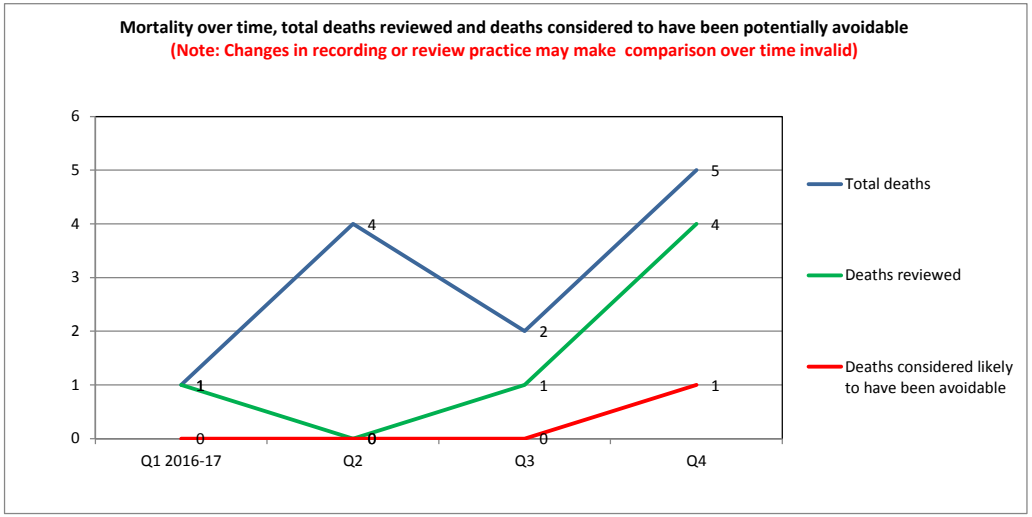
Data shown is as at 1/08/2017. The "This Month" above is based on March 2017 data. The totals are for the whole of 2016/17 financial year.
The Trust Death classification ratings of the 2016/2017 reviews have been mapped to the new national ratings in order to complete this dashboard for 2016/2017.The new categorisation has been established on the mortality database and is recording from July 2017 onwards.The Q1 for 2017/18 has been mapped to the new clasification. The 3 deaths where identified as potentally avodable have all been reported as incidents. Two are Amber (internal reports) and one was a seious incident. The numbers above exclude Learning Disability deaths

Summary of total number of learning disability deaths and total number reviewed

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Time Series:	Start date	2016-17	Q1	End date	2016-17	Q4

Total Number of Deaths in scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	1	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	2	4	1	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	0	6	0	1	0



In March 2016 the Mortality database was updated, allowing the Learning disability team to enter review comments for Learning disability deaths.
Data above for 2016/17 shows the Learning disability deaths which have been reviewed by the Trust Learning disability team prior to the national requirement of reviewing deaths using the new national LeDeR methodology.
The LeDeR (learning disability mortality review) programme will be implemented by the end of 2017 when Learning disability deaths will be reviewed against the new criteria.

East Sussex Healthcare NHS
NHS Trust

Mortality and Morbidity Policy

Version:	V4.1
Ratified by:	Senior Leadership Forum (TBC)
Date ratified:	TBC
Name of author and title:	Dr David Walker, Medical Director Dr James Wilkinson, Assistant Medical Director Jacqui Knight, Clinical Improvement Facilitator Ashley Parrott, Associate Director of Governance
Date Written:	
Name of responsible committee/individual:	Dr David Walker, Medical Director
Date issued:	
Issue number:	
Review date:	September 2019
Target audience:	Accountability - Clinical Unit Leads Responsibility - All clinical professionals Implementation – Clinicians, Clinical Unit Operational teams and central Governance Team.
CQC Fundamental Standard:	Regulation 17 – Good Governance
Compliance with any other external requirements (e.g. Information Governance):	
Associated Documents:	http://www.england.nhs.uk/ourwork/patientsafety/never-events/ Death Certification and the Coroner guidelines for medical staff incident Reporting and Management Policy

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1	Dec 2011	Dr Nick McNeillis Emma Tate	Comments from Consultation process	Change of review timeframe, from 2 months to 3 months.
V2	July 2014	Dr James Wilkinson Emma Tate	Changes in mortality review process and structures. Change in diagnostics provider from Dr Foster to CHKS.	
V3.0	November 2015	Dr James Wilkinson Emma Tate	Changes in Governance Structures	CGF role no longer exists – policy therefore amended. Job titles amended as per new Trust structure
V4.1	August 2017	Ashley Parrott James Wilkinson Jacqui Knight	Updated to include Government initiatives – Learning form Deaths.	Updated process, updated COG ToR, MRG ToR and added M&M RoR and M& M agenda.

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Clinical Outcomes Group		24/08/17
Policy Documentation Group		11/9/17

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

East Sussex Healthcare NHS Trust (ESHT) is committed to providing high quality patient care and to continuously improving patient safety and outcomes.

The review of inpatient deaths and mortality data is an essential clinical governance practice which provides Trust assurance that care is safe, effective and patient outcomes are improved through learning and implementing improvements.

2. Purpose and scope

The purpose of the policy is to provide a consistent and comprehensive framework in order to ensure:

- A standardised approach for reviewing inpatient deaths.
- The Mortality and Morbidity (M&M) process is used by Consultants and their teams to review, learn, make improvements and to provide assurance of a safe and effective service.
- Details of all reviews are clearly documented and records are centrally recorded on the Trust Mortality electronic database. This includes the clear recording of any actions and lessons.
- Roles and responsibilities are clearly identified and robust governance and reporting mechanisms are in place
- Clinical coding for all deaths is reviewed, wherever possible, as part of the M&M review process so there is confidence that risk adjusted mortality rates are based on accurate data.
- Mortality Alerts raised by internal or external sources are investigated consistently and actions are taken if required.
- Mortality data is utilised as part of a wider range of metrics to drive Clinical Improvement

The policy refers to deaths of:

- All inpatients in ESHT acute hospitals (Conquest and Eastbourne DGH) and
- Inpatients in community hospitals that have transferred from ESHT acute units.

3. Definitions

Mortality – relates to any in hospital death
Morbidity – relates to adverse outcomes

Serious Incident (SI) - an incident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death. (Ref: Incident Reporting and Management Policy)

Mortality & Morbidity Meetings (M&M meetings) - An M&M meeting is where a multi-disciplinary group review and discuss clinical cases, outcome data and related information, for example SIs, complaints and benchmarked mortality data.

4. Accountabilities and Responsibilities

4.1. Medical Director

- Carries overall accountability and responsibility for clinical issues relating to the review of Morbidity and Mortality.
- Will review any CUSUM (Cumulative Sum Charts) Relative Risk Outlier Alert from external sources and identify a Specialty Lead to undertake a detailed audit to understand the cause.
- Will respond to external enquiries about mortality such as the Care Quality Commission's (CQC) mortality outlier letters.
- Respond to confidential enquiries that examine morbidity and mortality related issues.

4.2. Assistant Medical Director

- Chairs the Mortality Review Group
- Reports concerns to Clinical Outcomes Group
- Lead for M&M to ensure the process is robust and effective in practice

4.3. Divisional Management Team

- Collate, analyse and triangulate qualitative and quantitative data and report emerging trends to the Senior Management Team.
- Monitor and ensure the closure of all action plans from M&M reviews and provide highlight and progress reports to the Chiefs of Division
- Utilise the CHKS system to analyse and monitor mortality data and provide training to users through the Governance team.

4.4. Chiefs of Divisions

- Will ensure all deaths within the division have had a mortality review within the 3 month requirement
- Ensure all action plans are implemented then closed once satisfactory evidence is provided.
- Will identify specialty M&M leads and a clinician to investigate mortality data
- Will identify a Lead for liaison with Clinical Coding
- Will ensure that the outcomes and learning from M&M reviews and mortality data are discussed at Governance and Audit Meetings.
- Will work with the Divisional Associate Director of Nursing to ensure that learning from deaths applied across the division and shared with other Divisions

4.5. Assistant Director of Nursing for Divisions

- Ensure nursing input into specialty M&M meetings
- Work with the Lead Consultant on the development and implementation of action plans from M&M reviews
- Ensure M&M information is included within the Governance meetings for Division
- Ensure implemented changes have the desired effects and are sustainable.

4.6. Speciality M&M Leads

- Will champion the M&M review process and take action to ensure full engagement at meetings.
- Ensure deaths reviewed within 3 month timescale
- Coordinate the M&M review meetings and actively encourage allied health professionals, Lead Nurses and Nursing/Midwifery staff to attend.
- Communicate concerns or trends to Chiefs of Division

4.7. Consultant Medical Staff

- Ensure review, within three calendar months of the patient's death, of all deaths of inpatients under their care in an acute hospital or in intermediate care unit having stepped down from their care in the acute hospitals.
- Participate fully in all M&M reviews and meetings, contributing knowledge and experience to the meeting.
- M&M attendance and mortality review rate will form part of the individuals appraisal
- Review the clinical coding of all patient deaths to ensure risk adjusted mortality data is based on accurate information, including patients' diverse characteristics.
- Ensure leadership and support of junior staff to ensure full engagement in the process.
- Review any 'Death in Low risk groups' identified and develop and implement action plans to improve patient's safety and outcomes.
- Challenge practice which has been demonstrated to be unsafe.
- Disseminate and communicate learning

4.8. Associate Director of Knowledge Management

- Will ensure the provision of mortality data to enable robust review at Trust level
- Will manage the Clinical Coding Process
- Will ensure attendance by clinical coders at M&M meetings across the trust
- Will support the Mortality Groups by ensuring headline data on Crude and Risk Adjusted Mortality data are produced monthly
- Will ensure analyst support for specific in depth review of Mortality data.

4.9. Clinical Improvement Facilitator

- Support the development and production of the Mortality and Morbidity processes, promoting awareness and improvement at every stage.
- Support the Medical Director and Assistant Medical Director for all aspects of M&M
- Provide advice & support on a day to day basis to clinical and non-clinical staff across the organisation leading to improvement in the management of M&M
- Manage the trust M&M database
- Provide monthly mortality data to enable robust review at Divisional level

4.10. Governance Support Officers

- Arrange and support M&M meetings for each specialty
- Ensure M&M meeting dates, discussion points, lessons learnt and actions are recorded on the Mortality database
- Log attendance and cases discussed at specialty M&M meetings

- Ensure that all open actions are reviewed for update/closure at specialty M&M meetings
- Ensure learning is shared at governance meetings
- Support the Clinical Improvement Facilitator in communicating to consultants that mortality reviews and cases for presentation are outstanding within their divisions

4.11. Patient Safety and Quality Group

This group is responsible for ensuring all escalated issues from Clinical Outcomes Group and others are reviewed and actions taken to address them. This group triangulates information across all areas of quality and safety.

4.12. Clinical Outcomes Group (Appendix D)

To have oversight and scrutiny on mortality data and drivers across the trust and ensure clinical specialties or conditions affecting mortality are managed safely. This will require managing task and finish groups and specific programmes to improve clinical care.
To review data and identify potential or actual outliers in mortality data and respond accordingly.
To ensure clinical specialties are collecting, monitoring and sharing clinical outcomes enabling early identification of improvement requirements and the sharing of success measures internally and externally. These may include patient reported outcomes (PROMS) patient reported experience measures (PREMS) and other measures of success following surgery/treatment.

4.13. Mortality Review Group (Appendix E)

To analyse and monitor a broad range of internal and external mortality data and indicators in association with other qualitative data to identify emerging trends or outlier areas.
To communicate areas of concern to Divisional and Specialty Clinical Leads requesting a review, report and associated action plan within 2 months, to be presented to the Clinical Outcomes Group (COG). Where an area of concern crosses Divisions the group will consider the most appropriate person(s) to undertake the review and recommend to COG for agreement.
To provide an exception report to the COG monthly, identifying all areas of concern and actions taken.

4.14. Divisional Governance meetings

Each Clinical Division conducts governance meetings to review and discuss all aspects of quality and safety. Any concern raised from this meeting is acted upon or escalated to the Divisional Integrated Performance Review. The Divisions review mortality data, outcomes, incidents, complaints, infection data, safeguarding and any other issues around quality.

4.15. Specialty M&M Meetings (Appendix F)

To be a multi-disciplinary group reviewing and discussing clinical cases, outcome data, lessons learnt and related information.
Meetings to be monthly, except for specialities where very few deaths occur. In this situation cases will be reviewed and discussed at a wider Audit meeting. If separate meetings, there will need to be an agreed process for ensuring the findings are shared and any actions co-ordinated. **See Appendix**
To routinely discuss all deaths with an ‘Overall care assessment’ of 1 or 2 – ‘Poor’ or ‘Very poor’ care, deaths in low risk groups, inquest cases and any additional discharges or deaths that the initial reviewer or consultant feel warrant wider discussion for other clinical or educational reasons.
To develop and monitor action plans for M&M cases which require further investigation.

To undertake a '2nd Stage Review' for all cases with an 'Overall care assessment' of 1 or 2 - 'Poor' or 'Very poor' care, entering issues identified and a level of avoidability score on the Mortality database.

5. Process

See Flow chart (Appendix A)

5.1. Administration

Details of all in-patient deaths are logged on the Mortality database by the bereavement office staff along with any concerns around care.

If any administrative errors on PAS (Patient Information System) for example, Primary Consultant or transfers of care must be reported to the Patient Administration System (PAS) team for amendment so all information systems are correct.

5.2. Review of Inpatient deaths

At the time of death certification, a summary of the key events during the admission must be documented on the electronic database (draft mortality review). This would normally be entered by the doctor certifying death, using the computers in the Bereavement Office.

The primary consultant at time of death is responsible for both death certification (see Death certification guidelines) and the M&M review.
All adult inpatient deaths are to be reviewed utilising the national Structured Judgement Review template on the Mortality database.
When signing off the review, the Primary Consultant will confirm the overall care rating and identify cases which need further discussion at M&M meeting.

If the patient spent the entire admission in Critical Care (ITU/HDU) the initial draft mortality review will be undertaken by ITU and the death placed on the admitting consultant M&M review list for further review and sign-off.
If the patient was transferred to ITU during admission, the draft review will remain the responsibility of the primary consultant at time of death. The ITU review record to be entered on the mortality database before primary consultant sign-off.

5.3. Post mortem reports

Post Mortem reports should be available within 28 days, unless delayed due to specialist histopathology testing, or an inquest is still pending.
A copy of the report will be attached to the inside cover of the notes in Histopathology and sent to the Primary Consultant's secretary. A second copy will be held by the Bereavement Service Manager.

5.4. Review at M&M meeting

The Clinical Improvement Facilitator will obtain patient details from the Mortality Database for deaths from the previous month and inform the Divisions.
Details of deaths outstanding for presentation at M&M meetings will also be highlighted to Divisions on a monthly basis. (Overall care rating 1 or 2, low risk deaths, Inquests and any deaths highlighted for discussion for other educational reasons)

The M&M meeting review should involve a systematic and comprehensive analysis of the facts to enable Consultants and Managers to understand and identify contributing factors or underlying causes for all deaths.
Discussion and learning points are to be entered on the Mortality database for all cases discussed at M&M meetings.

A second stage review at M&M meeting is required for all cases with an overall care rating of 1 or 2 (‘Poor’ or ‘very poor’ care), a level of avoidability score to be agreed and documented on the Mortality database.

Avoidability	Description
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable (more than 50:50)
4	Possibly avoidable but not very likely (less than
5	Slight evidence of avoidability
6	Definitely not avoidable

A case with a score of 1, 2 or 3 on the avoidability scale would indicate a governance cause for concern and should be considered under the criteria for a Serious Incident so therefore should be raised and discussed at the Weekly Patient Safety Summit. The Incident Reporting and Management Policy details the full process for serious incidents.

If the avoidability score is classified as 1, the Serious Incident (SI) guidelines should already be activated, please refer to the Incident Reporting and Management Policy.

In addition, SI investigations should be considered for the events below:

- If there is a 'cluster' of deaths in a particular diagnostic group or procedure - identified either through M&M reviews or via CHKS monitoring or a CUSUM alert
- If there is an Inquest which identifies failures in the process or care

5.5. Actions required following discussion of case.

If an action/Improvement plan is required following review/discussion of the case, this should be entered onto the Mortality Database. Open actions will be tracked at M&M meeting and closed on the database when completed.

5.6. Clinical Coding

Issues of coding accuracy arising from Mortality reviews should be discussed between the speciality and the Clinical Coding Department.

5.7. Timeframe for review process

Unless there are factors outside of the Trust's control, the standardised template should be completed at the earliest opportunity and within a maximum timeframe of three months from the month of death.

If an improvement plan has been identified this must be implemented within the timeframe specified – this will be monitored by the Division and the Mortality Review Group.

5.8. Inquest

Cases for Inquest should be expedited for review.
The review to be completed and presented at M&M meeting within 3 months, with discussion and learning points recorded on the mortality database.
The Clinical Improvement Facilitator will provide a record of the completed review to the Legal Department when requested for an Inquest.

A case undergoing an inquest where concern identified by the Trust should be reviewed and discussed at the Weekly Patient Safety Summit for a decision on whether an Amber (moderate harm) or Serious Incident (serious or catastrophic harm) investigation is required. This should then be dealt with following the Incident Reporting and Management Policy and then shared with the Coroner once approved through internal channels.
Duty of Candour will not be required if the coroner asked for a review of the case as part of the inquest when there had not already been an investigation triggered. This is because the family will already know the case is being reviewed and results will be shared with them at the inquest. If as per the Incident Reporting and Management Policy an incident was already identified a duty of candour should have happened prior to a request from the coroner.

6. Review of deaths for special groups

6.1. Infant or Child Deaths

The review process for baby and child deaths that occur in hospital aims to:

- establish, as far as possible, the cause or causes of each child death
- identify any potential contributory or modifiable factors
- provide on-going support to families
- ensure all statutory obligations are met
- learn lessons in order to reduce the risk of future child deaths

When an infant or child death occurs, an incident form should be completed immediately and a serious incident raised.
A review of the baby/child care will be undertaken by the head of nursing, a paediatrician and a representative from the Risk/Governance department. This review should be undertaken within 24 hours (48 hours if the death occurs at the weekend or on Public holidays) and documented. If no issues are identified by the review, a letter of condolence should be sent to the parents and the serious incident downgraded.
Where issues are identified by the review, a Duty of Candour letter will be sent and the serious incident remain open for full investigation
All deaths are to be discussed at an M&M meeting and any actions/learning points from the serious incident investigation/root cause analysis shared.
The mortality review will be completed on the mortality database by the primary consultant. The discussion and learning points from the M&M meeting will be recorded within the database review.

6.2 Stillbirths

When a stillbirth occurs an incident form should be completed immediately and the case reviewed at the daily risk meeting to evaluate the need for a professional review.
The final severity of the incident will be decided at the Weekly Patient Safety Summit. Where issues are identified by the review, a Duty of Candour letter will be sent and the serious incident/amber case will remain open for full investigation.
If an amber investigation is required, this will be undertaken by the divisional risk lead. If a serious incident is raised, this should then be dealt with following the Incident Reporting and Management Policy.
All learning points identified from the serious incident investigation will be shared with staff and the patient involved, and all actions highlighted by the investigation completed.
The Maternity Bereavement Checklist is available on the Trust intranet for staff dealing with any fetal loss.

6.3 Maternal Deaths

When a maternal death occurs an incident form should be completed immediately and a serious incident automatically raised. This should then be dealt with following the Incident Reporting and Management Policy. Where issues are identified by the initial review, a Duty of Candour letter will be sent and the serious incident will remain open for full investigation
All learning points identified from the serious incident investigation will be shared with staff and the patient involved, and all actions highlighted by the investigation completed.
The Maternal Death Guideline is available for staff on the Trust intranet under Obstetric and Gynaecology.

6.4 Deaths of Individuals with Learning Disabilities

Deaths of individuals with learning disabilities demands additional scrutiny under the Learning Disabilities Mortality Review Programme (LeDeR). This programme is commissioned by the Healthcare Quality Improvement Partnership for NHS England. The programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.
A summary of the review will be entered on the mortality database where a death has been reviewed under the LeDeR programme.

6.5 Deaths of Individuals with Mental Health Needs

Deaths of individuals with mental health needs will be reviewed on the Mortality database using the Royal College of Physicians structured case note review methodology and the Trust process followed to ensure a complete and robust review (Appendix A).

7. Review of Mortality Data

7.1. Mortality Data Metrics

Mortality data should be used in association with other metrics to understand the quality and performance of a Division, a hospital or the Trust; however areas which are highlighted as being significantly above the national benchmarks (Outliers) for particular diagnosis or procedure groups should be investigated to ascertain the causative factors. CHKS provides risk adjusted mortality rates and comparative analysis of the data in the form of:

- Risk Adjusted Mortality Index (RAMI)
- Hospital Standardised Mortality Ratio (HSMR)
- Summary Hospital level Mortality Indicator (SHMI).

- Cumulative Sum Charts (CUSUM) which demonstrate the difference between the expected and actual outcomes over a series of patients.

7.2. Mortality Alerts

If CQC Intelligent Monitoring or Imperial College generate a CUSUM Alert for an outlier diagnosis or procedure group, the Medical Director or Assistant Medical Director will review the information and identify a Lead Clinician, who will undertake a detailed review and report back findings to the Clinical Outcomes Group (COG) and Medical Director.

The M&M templates detailing the original Mortality reviews at the time of death can be retrieved from the mortality database to aid the investigation into associative factors.

7.3. Mortality data and reports by Group

Data Source	Mortality Review Group	Clinical Outcomes Group	Trust Board
Learning from Deaths dashboard	N/A	Quarterly	Quarterly
Mortality Scorecard – each Division	Monthly	Quarterly	N/A
Trust wide and site RAMI, SHIMI, Crude Mortality	Monthly	Monthly (Part of summary report)	
CUSUM Alerts – Trust wide by condition	Monthly	Monthly (Part of summary report)	N/A – By exception
Learning from M&M reviews	Monthly	Monthly (Part of summary report)	
Mortality review rate (performance)	Monthly	Monthly (Part of summary report)	
1 and 2 Care ratings reported	Monthly	Monthly (Part of summary report)	

7.4. Divisional Mortality Review

Divisions should routinely discuss and share lessons learnt from the reviewing of in-patient deaths and monitor divisional review rates on a monthly basis.

Divisions are required to maintain regular surveillance of all Mortality data, including crude mortality, to identify any emerging trends or patterns of concern where the data indicates higher than the expected mortality against the national or regional benchmarks and to investigate the causative factors.

Divisions are required to investigate and take action to reduce mortality for diagnosis and procedure groups identified as significantly above the national benchmark.

Mortality data and trends from M&M reviews of inpatient deaths should be routinely analysed and reported to the Mortality Review Group (MRG) and COG on the monthly KPI scorecard. Other quality measures are reviewed through the Patient Safety and Quality Group and Divisions..

7.5. Mortality reviews incomplete after 3 months

Every inpatient death must be reviewed within 3 months as described in this policy. Should a death review fall outside this period it must still be completed. A monthly report will be provided to each Division on their outstanding deaths awaiting a review. This will be escalated to the Divisional Integrated Performance review conducted by the Chief Executive.

7.6. Accuracy of Mortality database and information submitted

A quarterly quality review of randomly selected cases, looking at the accuracy of database entries, is undertaken by the Assistant Medical Director and Clinical Improvement Facilitator. The quality and quantity of the review entry on the Mortality database is assessed against the record of patient care documented in the patient notes.

7.7. Ensuring accuracy of mortality reviews

To provide assurance the deaths are reviewed accurately by individual Consultants and that the care ratings have been correctly allocated the following actions are undertaken on a monthly basis:

- A review of the cases where the family raised concerns about the care delivered will be checked against the care rating, incidents reported and where required the health records. Bereaved relatives are specifically asked if they had any concerns in care as part of the bereavement process.
- Serious Incidents and Amber Incidents where death occurred are cross checked against the care rating assigned.
- Inquests and claims not identified as an issue through a complaint, serious incident or amber incident are cross checked against the care rating.
- Complaints involving a patient death are cross checked against the care rating and where required the health records reviewed to determine if the rating was appropriate.

The above 4 tests should provide some assurance on a monthly basis the mortality reviews are accurate. If clear lapses in care are identified that are not matching the care rating a deep dive will be undertaken for the specialty concerned to ensure there are no other inappropriate ratings.

In addition to this any deep dive on specific conditions identified as a requiring review will include a check against the care rating when looking at each case. If inappropriate rating identified a trigger for a deep dive to the specialty on the reviews will be completed and reported to the Mortality Review Group.

8. Equality and Human Rights Statement

An Equality Impact assessment has been undertaken and specific advice sought.

9. Training

Divisional, specialty teams and individual consultants requesting this, will receive training in the use of the CHKS tools to enable them to understand and track relevant mortality data. This will be provided by the Clinical Improvement Facilitator or the supplier themselves, CHKS.

Incoming medical staff will receive instruction in how to access and use the electronic mortality database as part of their induction pack. Additional support is provided by the Bereavement Office staff on an ad hoc basis.

Training is now mandatory for medical staff with Clinical Coding providing training to repeat offenders

There are no other specific training requirements for this policy.

10. Monitoring Compliance with the Document

The monitoring of mortality reviews is an on-going process and will be managed through the Mortality Review Group and the Clinical Outcomes Group. The mortality indicators are tracked on a monthly basis and there are specific Key Performance Indicators in place for the Clinical Outcomes group that includes mortality review compliance.

Monitoring Table

Element to be Monitored	**Lead**	**Tool for Monitoring**	**Frequency**	**Responsible Individual/Group/ Committee for review of results/report**	**Responsible individual/ group/ committee for acting on recommendations/action plan**	**Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented**
Mortality Reviews	Medical Director	On-going audit	Monthly	Clinical Outcomes Group	Clinical Outcomes Group	Clinical Outcomes Group

11. Evidence base and references

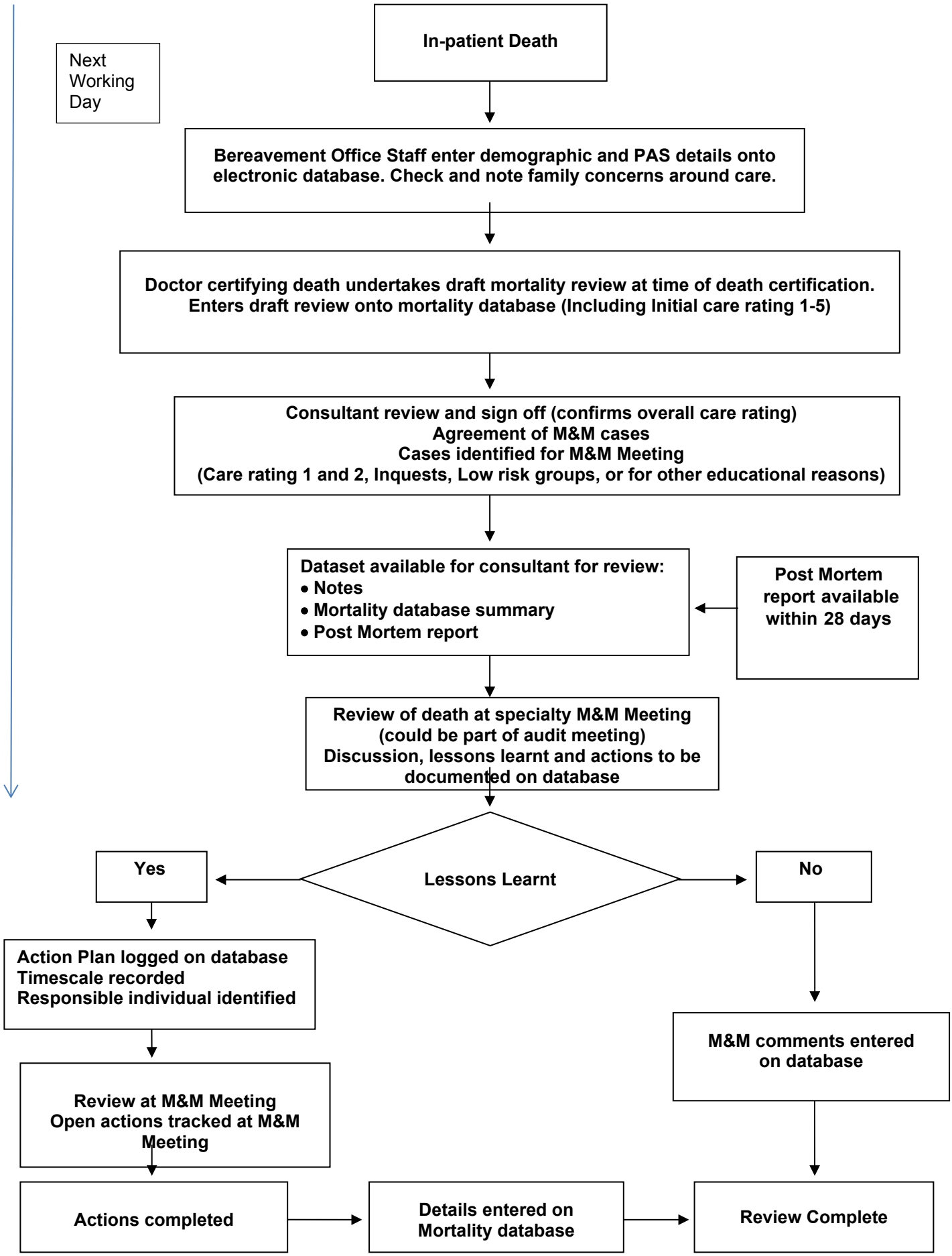
Mid Staffordshire, NHS Foundation Trust Inquiry; Independent Inquiry into care provided at Mid Staffordshire NHS Foundation Trust, Jan 2005 – March 2009 Chaired by Robert Francis QC. Published 24th February 2010

The Leeds Teaching Hospital NHS Trust 2009, Morbidity and Mortality Policy

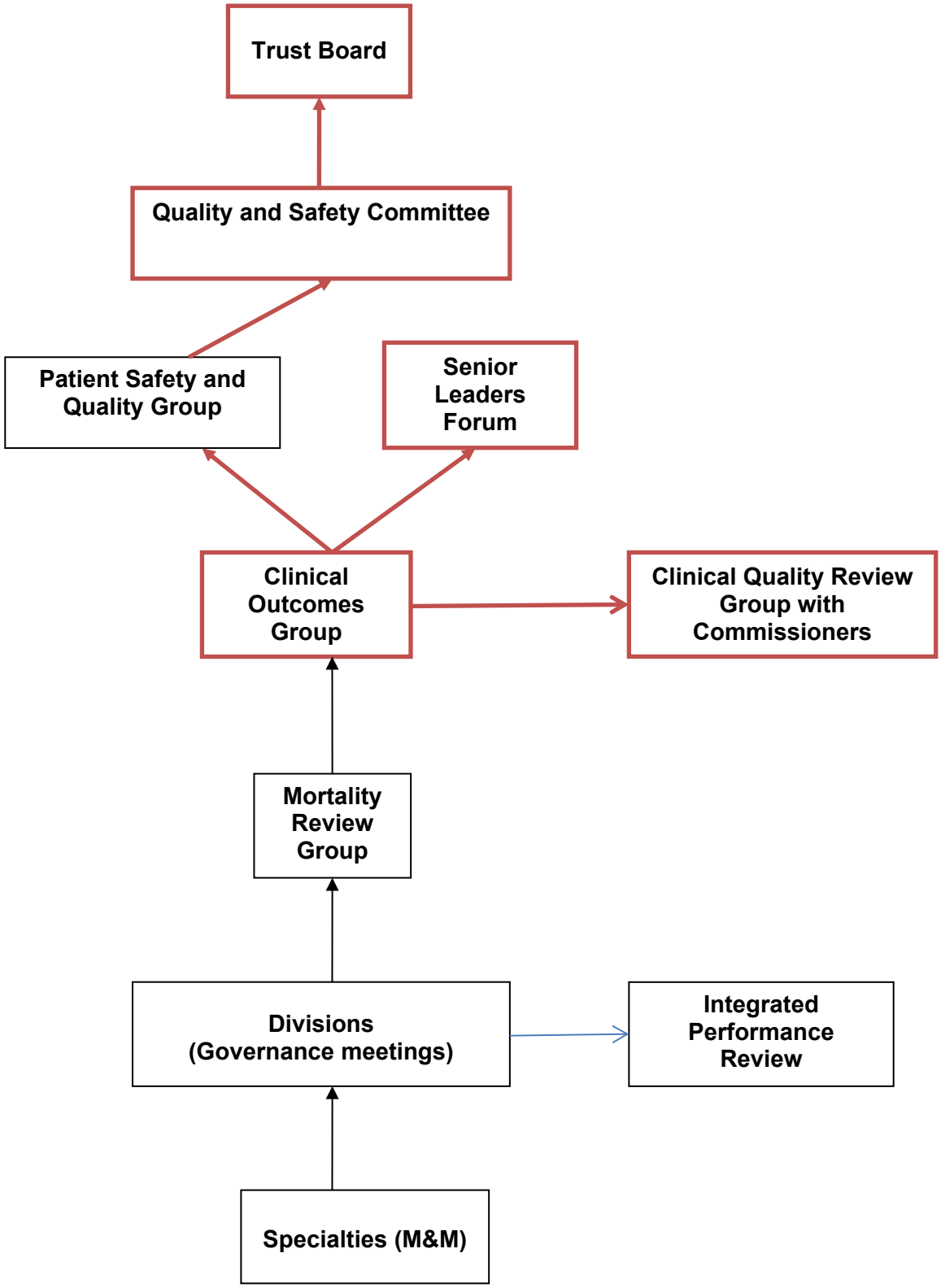
University of Leicester 2011, Morbidity and Mortality Reviews Policy

National Guidance on Learning from Deaths – National Quality Board March 2017

Appendix A: Flow Chart of Mortality Review Process



Appendix B: Mortality and Morbidity Reporting structure



Appendix C: Divisional M & M dataset

KPI – In hospital deaths
Number of deaths for review
Reviewed within 3 months
Number of Death classified and C D or E
Number above discussed at MDT M&M meeting
Number of deaths in Low risk groups (on database)
Post-Mortems
Deaths referred to Inquest
KPI – Mortality
Risk adjusted mortality index
In Hospital SHMI
Rates of deaths in hospital within 30 days of Non-elective surgery
Rates of deaths in hospital within 30 days of Elective surgery
Deaths in hospital within 30 days of emergency admission for hip fracture
Rate of death in hospital within 30 days of emergency admission with a heart attack (myocardial infarction) for patients aged 35 to 74
Deaths in hospital within 30 days of emergency admission for a stroke
Deaths in Low Mortality HRG Groups
Deaths in Low Mortality CCS Groups
KPI – Patient Safety
Complication Rate Attributed
Complication Rate Treated
Misadventure rate
Readmissions within 28 days
Risk Adjusted Length of Stay Index
Discharge to usual place of residence within 56 days of emergency admission from there with a stroke
Retained Instrument post operation
IV administration of mis-selected concentrated potassium chloride
Decubitus ulcer
Complications of anaesthesia
Post-operative pulmonary embolism or deep vein thrombosis
Post-operative sepsis
Post-operative acute respiratory failure
Accidental puncture or laceration
Potential in hospital fall resulting in hip fracture
% of patients discharged or transferred to a rehabilitation facility within 19 days of fracture neck of femur

Appendix D: Clinical Outcomes Group - Terms of Reference

East Sussex Healthcare NHS
NHS Trust

Clinical Outcomes Group - Terms of Reference

1. Purpose

To have oversight and scrutiny on mortality data and drivers across the trust and ensure clinical specialties or conditions affecting mortality are managed safely. This will require managing task and finish groups and specific programmes to improve clinical care. To review data and identify potential or actual outliers in mortality data and respond accordingly.

To ensure clinical specialties are collecting, monitoring and sharing clinical outcomes enabling early identification of improvement requirements and the sharing of success measures internally and externally. These may include patient reported outcomes (PROMS) patient reported experience measures (PREMS) and other measures of success following surgery/treatment.

2. Duties

Key Responsibilities include;

- Monitor Mortality Metrics for the organisation (HSMR, RAMI, SHMI)
- Monitor lessons learnt and actions on death reviews across the trust
- Monitor compliance and quality of M&M reviews across the trust
- Deep dive on mortality outliers, trends/ themes
- Monitor and review mortality and patient safety indicators at each specialty level
- Monitor and respond to VTE compliance
- Monitor and respond to Sepsis compliance
- Review and monitor risks to safety from mortality or mortality drivers
- Monitor and respond to EOLC compliance
- Monitor and respond to AKI compliance
- Review findings of inquests
- To ensure clinical specialties are collecting and reviewing clinical outcomes and to have oversight of these for the organisation
- To ensure successes from clinical outcomes are shared internally and externally and included within the Trust Annual Report
- To establish and monitor sub groups where required to ensure there is a robust review of mortality (Mortality Review Group)

3. Membership

Medical Director
Assistant Medical Director
Associate Director of Knowledge Management
Deputy Director of Nursing or Representative
Associate Director of Governance
Clinical Coding Data Quality and Audit Manager or Representative
Chief Medical Lead or nominated Deputy from each Division
Clinical Lead for each sub group (EOLC, VTE, Sepsis, AKI)
Project Manager for Mortality

4. Chair
Chair - Medical Director
Deputy Chair - Assistant Medical Director

5. Quorum
Minimum of 3 members including Chair

6. Frequency
Monthly

7. Reporting arrangements
This group reports to the Patient Safety & Quality Group

The terms of reference will be reviewed on an annual basis.

8. Notice of meetings
The agenda and papers will be circulated one week prior to the meeting. Dates and meeting venue will be established at the beginning of each financial year for the year ahead.

At the discretion of the Chair papers may be tabled at the meetings.

9. Conduct of meetings
Meetings of the Clinical Outcomes Group shall be conducted in accordance with its Terms of Reference.

10. Notes of meetings
The Medical Director's Personal Assistant shall take notes of all meetings of the Group, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

Next Review Date: 1/11/17

Appendix E: Mortality Review Group Terms of Reference

East Sussex Healthcare NHS
NHS Trust

Mortality Review Group Terms of Reference

Constitution

The Mortality Review Group is a working group established by and accountable to the Trust Clinical Outcomes Group (COG)

Membership

Chair - Associate Medical Director
Consultant – General Surgery
Associate Director of Knowledge Management or deputy
Assistant Director of Nursing
Clinical Coding Data Quality and Audit Manager
CHKS Consultant
Clinical Improvement Facilitator

Purpose

The purpose of the Mortality Review Group is to analyse and monitor a broad range of internal and external mortality data and indicators in association with other qualitative data to identify emerging trends or outlier areas.

The group will communicate areas of concern to Divisional and Specialty Clinical Leads requesting a review, report and associated action plan within 2 months, to be presented to the Clinical Outcomes Group (COG). Where an area of concern crosses Divisions the group will consider the most appropriate person(s) to undertake the review and recommend to COG for agreement.

The group will provide an exception report to the COG monthly, identifying all areas of concern and actions taken.

Specific objectives

The group will analyse and monitor -

- Key performance indicators for the review of all inpatient deaths within three months via the Trust Mortality Database and request exception reports from Divisions to COG, for any death classified as potentially having suboptimal care identified on the trust database (Deaths recorded with a death classification of C, D or E and deaths recorded with an overall care assessment of 1 or 2).
- Coroner's cases and Inquest cases on a monthly basis and specific review of Rule 43 Coroners reports.
- Numbers of referrals to the coroner, to be reported monthly by Divisions as part of scorecard.

- Monthly trust site and divisional mortality scorecard including crude mortality and trust HSMR/SHMI and RAMI
- Monthly mortality benchmarked performance data by Clinical Classification System (CCS) diagnostic Group available via CHKS
- CHKS Patient Safety Indicators and Mortality Dashboards at trust and divisional level
- Death in Low risk groups, requesting exception reporting to COG.
- Quarterly SHMI data, including post-discharge deaths.
- Weekend vs weekday Mortality on a quarterly basis
- CQC mortality indicators highlighted in the quarterly Intelligent Monitoring report.
- Instigate investigation of any CUSUM Alerts received from the Care Quality Commission (CQC)
- Quarterly review a random sample of electronic morbidity and mortality reviews to provide assurance of quality.
- National Audit data on Mortality such as TARN and ICNARC data.

Accountability

- The MRG is accountable to the Clinical Outcomes Group.
- An action log will be created and maintained for all actions identified by the group.
- The group will report to the Clinical Outcomes Group monthly, identifying key areas of concern and actions taken
- The group will communicate with Divisions or nominated individuals, to request review, action and exception reporting to COG on areas of potential concern.

Quorum

- The meetings will be considered quorate when at least 4 members are present, including the chair (or delegated chair).
- All members are expected to attend at least 8 of the scheduled meetings held within each 12 month period.

Frequency

The group will meet monthly.

Review of Terms of Reference

These terms of reference will be reviewed annually. The next review date is August 2018.

Appendix F (Part 1)

SPECIALTY MORTALITY & MORBIDITY REVIEW MEETING

TERMS OF REFERENCE

Constitution

East Sussex Healthcare NHS Trust has established Mortality and Morbidity meetings that will incorporate the review of all issues relating to speciality Morbidity and Mortality.

Membership

Membership shall comprise of:
Speciality M&M Lead Consultant
Speciality Consultants
Speciality Junior Doctors
Speciality Multi-Disciplinary Team Members
Coding department representative

Quorum

The meetings will be considered quorate when at least 3 members are present, including the chair (or delegated chair).
Consultants are expected to attend at least 60% of the scheduled meetings held per year.
Junior doctors are expected to attend at least 3 of the scheduled meetings held per year.
Meetings should be multidisciplinary, with nursing, management and coding input, as well as medical participation.

Purpose

The Mortality and Morbidity review meetings have been established as multi-disciplinary group reviews to discuss clinical cases, outcome data, lessons learnt and related information.

Duties

- Meetings should routinely discuss all deaths which fall into the following groups:
  - Deaths given a 'Classification' of C, D or E prior to the updated review template which now requires a 'Care rating' selection.
  - Deaths with a Consultant 'Overall care rating' of 1 or 2 – 'Poor' or 'Very poor' care.
  - Death in Low Risk Groups
  - Inquest cases
  - Any additional discharges or deaths that the initial reviewer or consultant feel warrant wider discussion, for other clinical or educational reasons.
- Develop and monitor action plans to deal with M&M cases which require further investigation.
- Complete '2nd Stage Review' on the Mortality database for all cases with a Consultant 'Overall care rating' of 1 or 2 - 'Poor' or 'Very poor' care.

Frequency

Meetings should be held monthly, except for specialities in which very few deaths occur. In this situation cases may be reviewed and discussed at a wider Audit or Clinical Governance meeting. If separate meetings, there will need to be an agreed process for ensuring the findings/lessons learnt are shared and any actions arising from these are co-ordinated.

Authority

To evaluate and respond to Morbidity and Mortality issues and use the Trust's Clinical Governance framework to initiate actions where necessary.

To use evidence based practice to reduce future healthcare risks within the Division and to highlight issues to be addressed by the Risk Management team if necessary.

Reporting Arrangements

Discussion and learning points of each case reviewed should be recorded on the Mortality database for assurance purposes. Attendance and cases discussed to be recorded on the Trust M&M attendance log.
Lessons learnt and issues to be highlighted should be reported to the Divisional Clinical Governance meetings on a regular basis and shared amongst speciality teams.

Review

The Mortality and Morbidity Review meeting Terms of Reference will be reviewed on an annual basis.

Appendix F (part 2)

Specialty Morbidity and Mortality Meeting

Agenda

- Attendance & Apologies
- Review of Mortality Log actions remaining open and any actions closed since last meeting
- Presentation and Review of any deaths with an overall care rating of 1-2 (or categorised as C, D or E prior to updated review system)
- Presentation and review of any deaths in Low Risk Groups
- Review of Inquest cases
- Presentation of any other patients (either mortality or morbidity) agreed for discussion
- Agreed actions arising from deaths reviewed at this meeting
- AOB
- Details of next meeting

The category grading of all mortality cases presented should be reviewed in the light of the discussion at the meeting.

Appendix G – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

East Sussex Healthcare NHS
NHS Trust

Due Regard, Equality & Human Rights Analysis

Title of document:
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.
Please include a brief summary of intended outcome:

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age		
	• Disability (including carers)		
	• Race		
	• Religion & Belief		
	• Gender		
	• Sexual Orientation (LGBT)		
	• Pregnancy & Maternity		
	• Marriage & Civil Partnership		
	• Gender Reassignment		
	• Other Identified Groups		
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**		(Ensure you comment and link to main policy with page/paragraph number)
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	(Ensure you comment and link to main policy with page/paragraph number)	
4.	**Please evidence how this work / policy seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	(Ensure you comment and link to main policy with page/paragraph number)	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	(Ensure you comment and link to main policy with page/paragraph number)	
6.	**Please evidence how this work / policy**	(Ensure you comment and link to main	

	will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?	policy with page/paragraph number)
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	(Ensure you comment and link to main policy with page/paragraph number)
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	(Ensure you comment and link to main policy with page/paragraph number)
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	(If yes ensure you comment and link to main policy with page/paragraph number)

Financial Special Measures – Board Update

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer:	Director of Finance

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☒
Staff	☐	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes, as appropriate	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The Trust remains in Financial Special Measures. A monthly review meeting is held with the central FSM team, with the Chair, Chief Executive, Director of Finance and Director of Financial Improvement presenting the Trust position, and progress on a regular basis. An update on progress since the July Board meeting is attached, based on and reflecting the August 2017 FSM update. The Trust continues to deliver well against the objectives set within the FSM programme, but there remain significant risks to delivering the overall financial plan for the year – continued focus over the remainder of the financial year will be required to ensure continued delivery.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

n/a – the FSM presentation was reviewed and considered by Executive Directors and at the Finance and Investment Committee.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD

The Board is asked to review the contents of the attached update report.

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

Financial Special Measures
Board Update – September 2017

East Sussex Healthcare NHS
NHS Trust

Executive Summary – Key Messages (1)

- We have fully delivered the plan in the first 4 months of the year, the Trust has delivered the required CIPs YTD and is on track for delivery of £28.7m of CIPs, achieving the £36.4m control total. At Month 5, there are emerging risks around delivery of the plan and careful action will be required.

- CIPs developed currently stand at £34.8m; over 20% above the required delivery – recognising that there is risk in the programme, but ensuring mitigation. A full review of deliverability is in train, during September 2017.

- The Acting Director of Nursing and the Medical Director, with the support of the Quality Improvement Director, are undertaking a full refresh of the Quality Impact Assessment – a number of risks to overall deliverability, rather than quality, have been attached.

- The Trust's income forecast is on plan and the forecast is above the CCG demand plan. The scope of the Internal audit review on income capture has been reviewed and agreed with the FSM team and the work will commence in September for presentation at the October checkpoint.

- Discussions are ongoing with Clinical Commissioners about resolving any 16/17 financial issues, with a plan for final agreement by mid-September. Joint work is in train to shape a financial forecast for 2017/18, alongside a system financial recovery plan.

- For 2018/19, the Trust has committed to having a full plan in place by 31st December 2017.

Executive Summary – Key Messages (2)

East Sussex Healthcare NHS
NHS Trust

- Cash remains a significant challenge, with non-cash I&E movements and increases in debtors driving pressure on creditors. Immediate action has been taken to improve recovery and payment, and a review of the growth of debtors/creditors is in train. .

- Month 5 trading was adverse to plan, with a decline in elective and outpatient activity. Extensive work is in train to understand the drivers of the reduction in activity, noting the impact of holiday leave. CIP performance is on track, although individual schemes are variable in the level of performance. Grip and control measures are having a more sustained impact than key workstreams around workforce and data quality, and options to explore enhanced delivery are being explored within the Finance Department.

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Requirements from the FSM Letter of 26 July 2017

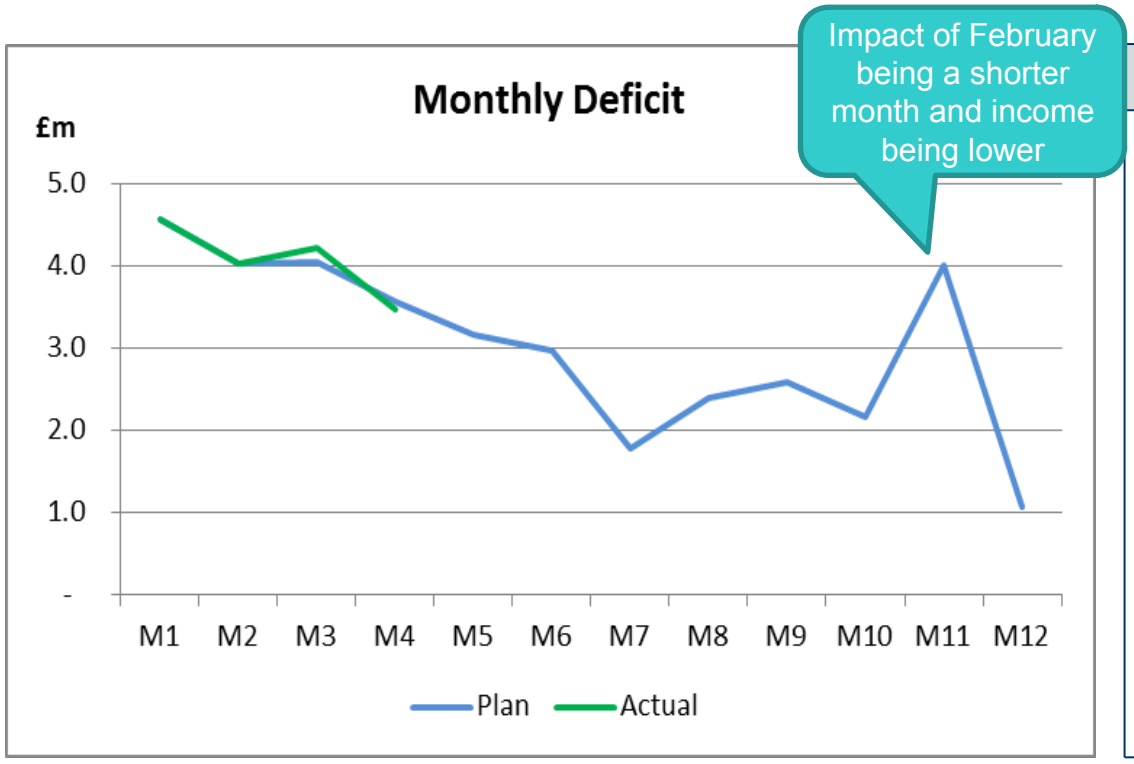
Actions	Progress
Submit a revised plan to NHSI Central Finance team	Complete
Resolved 16/17 Income issue with CCGs	Complete – Included in slide 11
Secured Additional Resources needed to deliver the plans	Complete – Included in slide 10
Confirmation that the remainder of the £34.8m is green rated	Complete – included in slide 9
Progress against M4 & YTD, including any variances, demonstration of delivering CIP's and run rate reducing	Complete – Included in slides 5-7
The key milestones and performance indicators (financial and non financial) that underpin CIP delivery (e.g. monthly workforce indicators such as headcount/WTE reductions, the conversion of agency staff to bank/substantive), including: • Progress against these key activity milestones/operational metrics that give assurance about the financial impact planned for future months i.e. your forward looking / lead indicators.	Complete – Weekly Highlight report to Execs and Flash Report containing relevant indicators shared with FSM Team
The level of financial contingency you have built up over the course of the year including progress with pipeline development	Complete – Included in slide 9
Confirmation that you remain confident of delivering your 2017/18 Control Total	Confirmed
The scope and proposed timescales of an Internal Audit review of your income capture processes	Scope of works shared and agreed with NHSI, report to be covered in October checkpoint.

Trust Financial Performance – Month 4 YTD

East Sussex Healthcare NHS Trust

- The graph illustrates the actual monthly performance to month 4 against the monthly planned deficit position. This demonstrates we are on track with plan.
- The Trust is still forecasting to achieve £36.4m deficit for 2017/18 and an exit run rate in quarter 4 of £7.9m, compared to 2016/17 of £12.9m.

	Year To Date			
£m	Plan	Actual	Var.	CIP Var.
Income	129.0	129.1	0.1	(0.1)
Pay	(93.6)	(93.1)	0.5	0.2
Non-Pay	(51.7)	(52.2)	(0.5)	(0.1)
Total	(16.3)	(16.3)	0.0	0.0



Trust Summary

- In total contact income is ahead of plan, excluding tariff excluded devices, as a result of significantly increased activity levels.
- Increased medical income has been offset by reduced surgical income, arising from increased non-elective activity.
- Community investment (and pay costs) remain below plan leading to variances – but no adverse impact on Trust.
- All adverse variances are reviewed through Finance and IPR discussions.
- The Trust continues to see higher than anticipated levels of non elective activity.

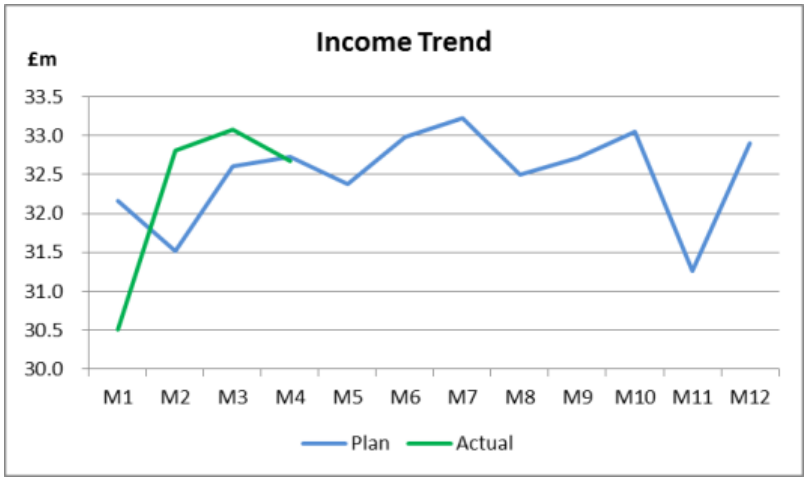
Further information is included at Appendix 1 & 2

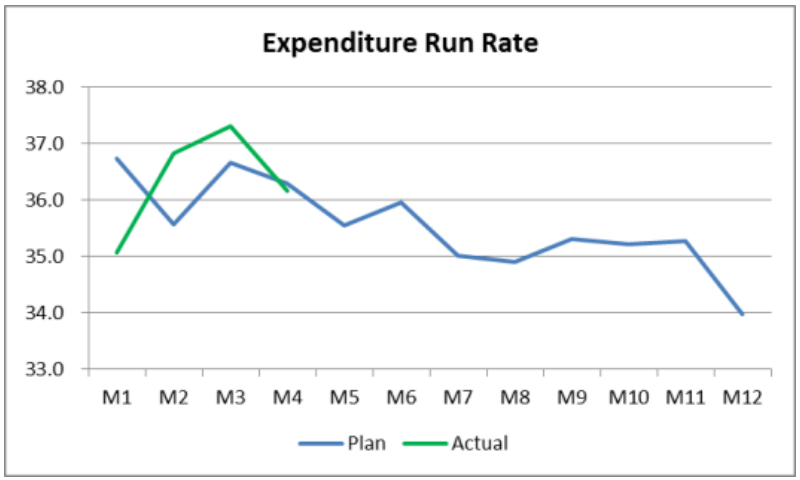
Monthly Trend

East Sussex Healthcare NHS Trust

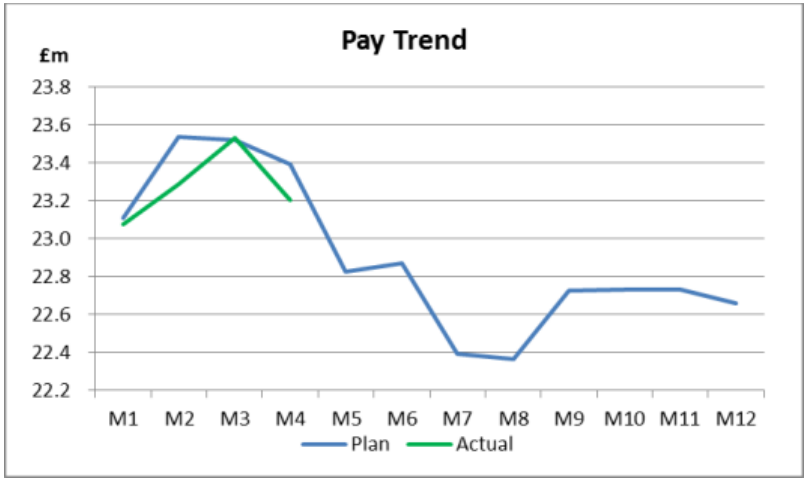
- The graphs below show the trend by category compared to the plan - spend has decreased in month 4 and is forecast to continue to decrease.

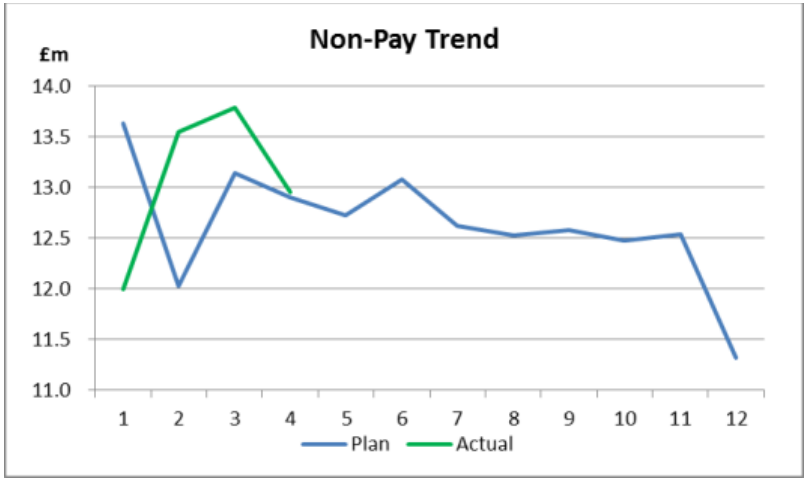
- The average expenditure to M4 is £36.3m and the plan is to achieve £34m in M12.





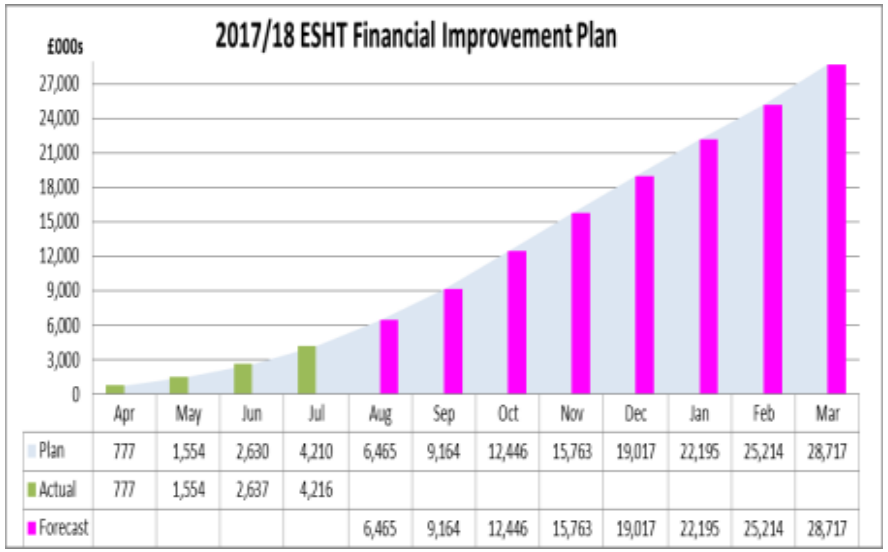
Increased activity levels have had an impact on non-pay spend and pay spend has been controlled





CIP Delivery on Plan – Month 4 YTD

East Sussex Healthcare NHS Trust



	£000's Year To Date		
Workstreams	Approved Projects	Actual	Var.
Clinical Services Review	0	98	98
Data Quality & Clinical Networks	1,222	872	(350)
Elective Pathways	1,716	1,151	(565)
Grip & Control	1,148	1,353	205
Commercial Income	335	287	(48)
Procurement	357	343	(13)
Patient Flow	140	85	(55)
Agency & Premium Pay - Workforce	0	27	27
Approved Projects Total (£34.8m)	**4,917**	**4,216**	**(702)**
Planned Central Risk Adjustment	(708)	0	708
Planned Total (£28.7m)	**4,209**	**4,216**	**6**

Key Messages:
Delivery is on Plan. The Plan is £4.2m YTD underpinned by Projects of £4.9m YTD. Delivery on Plan means no headroom is created to mitigate future risk.

The difference between total Projects and the Plan is £0.7m YTD. It is assessed that £0.2m of this difference will be delivered in future months and £0.5m may not. Further workstream assessment by projects is provided below:

- Elective Pathways (£0.6m) becomes (£0.4m) after timing difference ~ 13 projects, the largest variance of £0.1m is OP Procedures, £80k will be delivered, other timing differences make up the difference. Project actions completed but activity variations in April and July drive adverse delivery. Mitigation sought.
- Data Quality & Clinical Networks (£0.3m) ~ Actions in the T&O Escalations project are behind plan, resource issue addressed for future delivery.
- Patient Flow (£0.1m) ~ LOS improving, closure of beds in addition to the extra capacity beds is challenging.
- Commercial Income (£48k) and Procurement (£13k) become zero after timing difference.
- Clinical Services Review £0.1m/ Grip and Control £0.2m/ Agency & Premium Pay Workforce £27k ~ driven by over-delivery by holding of vacancies, Apprentice Levy and budgetary control, HCA zero agency ahead of plan.

Workforce ~ Encouraging Early Indicators

East Sussex Healthcare NHS
NHS Trust

- Actions to address temporary workforce spend have been effective – CIPs YTD at Month 4 ahead of plan (£0.3m), Trust YTD pay better than plan by £0.5m.

- A new workforce planning lead has been appointed, bringing the workforce planning function up to capacity. Key work around skill-mix and new service models has started to progress.

Medical Staff

- Reduced agency average monthly spend from £0.7m April 17 to £0.5m in July 17
- Reduced agency WTE from 64 to 33
- Reduced weekly cap breaches from average 278 shifts to 158 shifts
- Increased Medical Bank locums from 5 to 25

Nursing

- Reduced agency average monthly spend from £0.4m to £0.2m
- Reduced agency HCA's from 21.54 to Zero WTE
- Reduced agency RGN's from 76.76 to 43.35 WTE
- Increased Bank by 16.85 WTE from September 16 to August 17

Recruitment

- Strengthened offering and process to improve time to hire
- Executive team oversight on VCP and recruitment progress

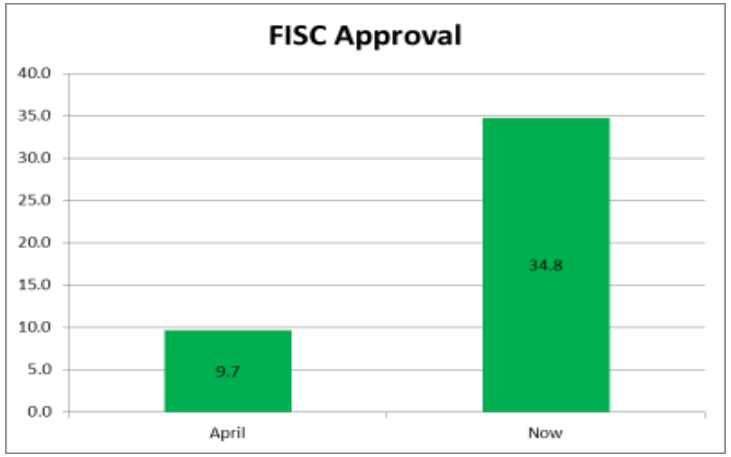
Grip

- CEO, Medical Director and Nursing Director approval for higher rates (All grades) required
- eJob planning and intensive review and scrutiny on all PA's above 12
- MedicOnLine & MedicsOnDuty, (eRostering) implementation gone live in 1:4 divisions (ED)
- Health Roster recommendations being implemented to improve substantive rosters within N&M

East Sussex Healthcare NHS
NHS Trust

Project Status

- The Trust has approved through FISC the full plan of £28.7m required in 2017/18.
- The Trust trajectory was to have £34.8m approved by the end of August. At FISC on 21st August £1.8m of schemes were deferred for strengthening – these have now been approved.
- This is the updated project 'hopper' status.



17/18 Plan

Only green schemes are approved for delivery

£34.8m Approved projects

Deliverability RAG

£28.7m Approved projects

QIA's required for all projects prior to implementation

Pipeline

£3.4m Development projects

75%

£2.6m Development projects

£3.2m Opportunities & Ideas projects

>230 staff savings suggestions and >40 opportunities

33%

Risk Adjusted value reduced

£1.1m Opportunities & Ideas projects

Pipeline will be utilised to develop 18/19 plans, mitigate any risks to 17/18 and where feasible improve the Q4 run rate

The Trust requires £28.7m, and is continually adding opportunities to the list to ensure the £28.7m is delivered.

Securing Resource

- Trust capacity has increased since 2016 by 59, with 34 of these posts being Delivery Support/Project/ Leads / Specialists.
- The Trust has secured additional resources required to deliver the plan as per the last checkpoint meeting.
- Trust has secured resources through secondment, interim and re-deployment. For example, Scan for Safety project delayed to 18/19 and project team now supporting CIPs.
- There is one additional specialist resource required for commercial.
- A seconded individual is providing ad-hoc and technical support to the wider finance team – focusing on cash, capital and workforce.
- We are working with Four Eyes on Theatre Efficiency, they have agreed to re-run our data to incorporate the last 6 months at no cost. Once we have seen the output we will consider how we move forward on this.
- **The Executive team and the Finance and Investment Committee is determining the transition from interims to substantive. For each temporary resource a solution for the medium term is being developed. An update on this will be provided at the October FSM checkpoint review.**
- BDO's (external audit) review of the finance department is underway, working with key stakeholders across the organisation to establish how business needs are being met and what changes are required to ensure the department is fit for the future.

Income Resolution

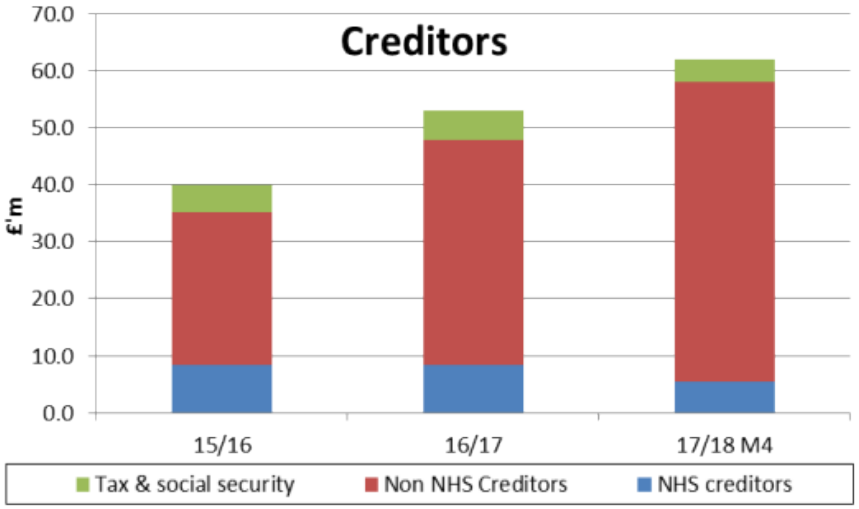
East Sussex Healthcare NHS
NHS Trust

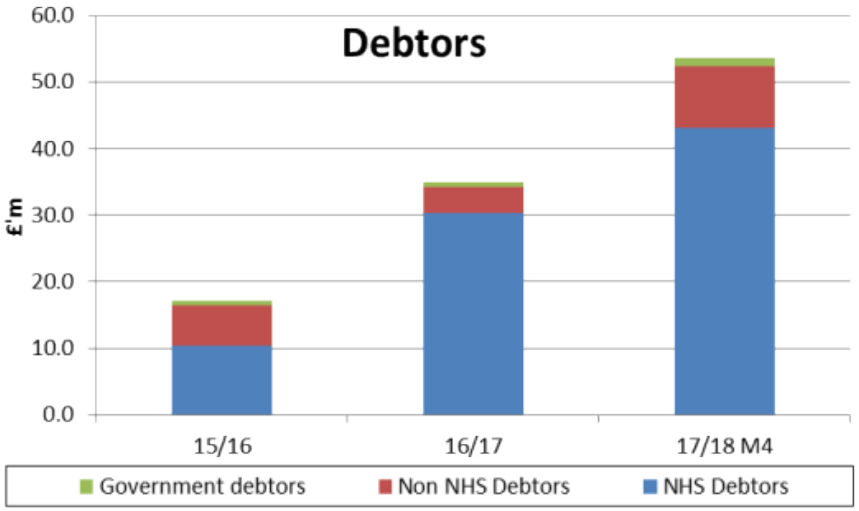
- The 16/17 formally escalated issues within the disputed invoices have now been resolved. Subsequently the CCG have raised additional financial challenges and the Trust is working with the the CCG to agree a finalised position. .

- The system financial position is challenging. The Trust and the CCG have agreed to develop a shared system financial forecast, to understand the drivers of financial pressure for both organisations, and to develop a shared financial recovery plan, working together with local authority colleagues through the ESBT infrastructure.

- Previously the Trust and commissioners would undertake quarterly income reconciliations, this is moving to monthly after September, so this will bring benefits in terms of cash-flow as well as being able to address any challenges in a more timely manner. In addition to this the system meetings with NHSI and NHSE will continue every 6 weeks..

Cash and Creditors





- Creditors have increased significantly in the last 16 months. There are two principal drivers of this;
  - Non cash items in the I&E
  - Increase in Debtors
- During the same period debtors have increased by £36.4m
  - Moving from a cap and collar contract has driven an increase in debtors.
  - Non NHS debtors increase is driven by prepayments.

Actions

- Rapid action on all debts including converting accrued income to invoiced debt.
- New credit controller started 01.09.17
- Expert ad-hoc support seconded to work on cash-flow forecasting and cash management.
- The Trust reports weekly to CEx, COO on those creditors who have placed the Trust on stop or are threatening legal action.

Risks & Mitigations

East Sussex Healthcare NHS
NHS Trust

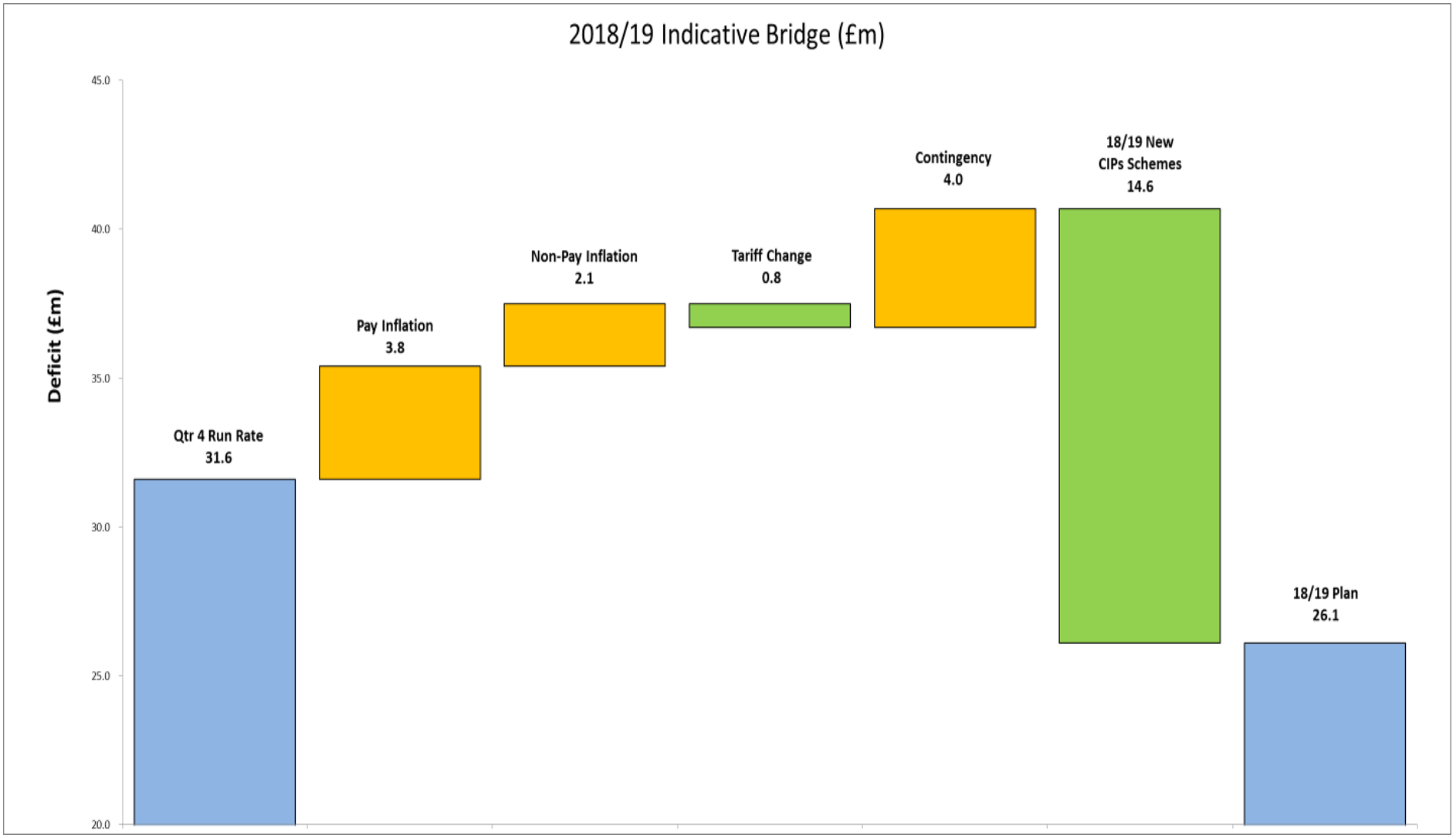
This is the current assessment of risks.

Risk	Commentary	Risk (Opp) £000	Prob %	Est Impact (£000)	Mitigation	Owner
CCG Income Dispute 16/17	Now resolved. Outcome in line with financial plan.	n/a	n/a	n/a	Some residual contract issues, with late CCG challenges, but work in train to resolve.	DoF
New CCG Income Risks 16/17	Impact of subsequent 16/17 challenges	3,400	25%	850	Robust contracting process, early escalation to Chief Officers	DoF
CCG Income Risks 17/18	Impact of 'technical challenges' and coding challenges, including baseline disputes	4,600	50%	2,300	Active management by Contracting, Assurance through FIC	DoF
FISC Delivery Risk 17/18	Non-Delivery of the FISC schemes, over and above the £6.1m contingency.	2,100	20%	420	Robust management of overall FISC programme through Trust PMO	COO
CQUIN for 17/18	Delivery of CQUIN Plans 2017/18	3,400	5%	170	Clarity of CQUIN requirements; Robust project management; New Head of Contracts	DoF
Winter Pressures	Risk of Inadequate Winter Funding	1,500	20%	300	Executive Team scrutiny; clearer monthly review of spend; baseline-v-escalation plans agreed	COO/DoF
New MSK Contract	Risk of adverse impact on financial plan	1,200	40%	480	Trust has now agreed a revised Heads of Terms	DoF
			Total	**4,520**		

The pipeline of schemes remains healthy and the Trust will use this pipeline to mitigate risks to delivering the control total and in planning for 18/19.

2018/19 Indicative Bridge

East Sussex Healthcare NHS Trust



Next Steps

- The Trust remains focused on delivering the 17/18 control total. Adverse performance at Month 5 suggests a need to ensure continued focus on delivery of all components of financial performance, including the CIP and trading performance in month.

- The Trust will need to work closely with NHSI and local partners in managing the system affordability challenge, and in developing a system financial recovery plan. .

- Cash remains a challenge for the Trust and the Trust has agreed a detailed review of creditor movements to support an application for supplier payments and is implementing more active debtor management.

- The Trust's financial plan for 2018/19 is taking shape, but the arrangements for the development of the detailed plan will need further review by the Finance and Investment Committee in September and October 2017.

- For FSM specifically, the Trust is preparing for an October FSM review, at which checkpoint the FSM team will feed back further on progress through the FSM regime.

Annual Safeguarding Report – 2016/2017

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	13.1
Meeting:	Trust Board	Reporting Officer:	Hazel Tonge

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The Annual Safeguarding Report provides discussion around key points that arise from National & Local Safeguarding guidance and incidence. The report provides an update of progress of these key points and Safeguarding responsiveness. There are some risks that have been identified:

- Mental Capacity Assessment recording inaccuracies and knowledge.
- Mental Health Act compliance requires addressing.
- Professional Curiosity when women are pregnant in regards to potential Domestic Abuse
- Actions from Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) must be implemented.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

TNMAG – 21 July 2017
SAB Board
LSCB Board
Patient Safety and Quality Group – 26 July 2017
Quality and Safety Committee – 19 July 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD)

The Trust Board is asked for support with implementation and delivery of the safeguarding agenda.

East Sussex Healthcare NHS
NHS Trust

Annual Safeguarding Report

2016 - 2017

Contents

Executive Summary

This is the April 2016 - 2017 annual report for corporate safeguarding children and adults for the East Sussex NHS Healthcare Trust (ESHT). The report provides information about national changes and influences, local developments and activity including how statutory requirements are being assured, and how challenges to business continuity relating to safeguarding children are being managed.

The Trust has agreed governance and accountability arrangements which include regular reporting to the Trust Board via the Patient Quality and Safety Group, The Safeguarding Strategic Group and The Safeguarding Operational Group. Information is shared via the Director of Nursing who attends the East Sussex Local Safeguarding Children Board (LSCB) and the East Sussex Local Safeguarding Adults Board (SAB) along with Head of Safeguarding. There is excellent representation at steering and operational meetings which enables the East Sussex NHS Healthcare to make a significant contribution to the work of the East Sussex LSCB and SAB. As a result Safeguarding is fully engaged in the East Sussex Better Together programme.

In this reporting period (2016/2017), there has been the publication of the NHS England Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework, Mandatory reporting of FGM, FGM Enhanced dataset and the initiation of the Goddard Inquiry. The report will give an overview of ESHT's Safeguarding responsibilities and progress of embedding these areas into practice and policy.

There is on-going quality assurance work which includes multi-agency self-assessments as required under Section 11 of the Children Act 2004, performance monitoring of serious case review action plans, domestic homicide reviews, and engagement with multi-agency audits undertaken by the LSCB and SAB and ESHT audit programmes.

A CQC inspection in September 2016, which included a review of adult and child safeguarding within ESHT, reported reasonable assurance other than inconsistencies in the documentation and understanding of Mental Capacity Assessments.

Local Serious Case Reviews (SCRs), Domestic Homicide Reviews and multi-agency learning reviews have highlighted: the risks to children and the vulnerability of babies, risks to children and young people with mental health needs, as well as the risks to adults associated with domestic abuse, self-neglect and mental health problems. A separate report to the ESHT Board will focus on meeting the health needs of Looked after Children (LAC) and Maternity.

1.0 – Introduction

1.1 The aim and purpose of the ESHT Safeguarding annual report is to inform and provide assurances to the ESHT Board of the current key progress and developments in accordance with the national and local safeguarding agenda.

1.2 East Sussex Health care is committed to the East Sussex Better Together programme aimed at transforming health and social care. It is a shared vision which aims by 2018 to have a fully integrated health and social care economy. ESHT Safeguarding professionals have a long and established working relationship with social care and have already integrated part of the service this year.

1.3 The report aims to provide evidence to the Clinical Commissioning Groups (CCG) as our commissioners, and responsible for safeguarding quality assurance through contractual arrangements, that as a provider ESHT adheres to the guidance as set out within Working Together to Safeguard Children 2015, and the Care Act 2015 (updated 2016).

1.4 Existing statute underpins the work of ESHT health professionals and social care and as such delivers children's services in line with Section 11 of the Children Act (1989, 2004), the Children and Young Person Act (2008), Working Together to Safeguard Children (2013, 2015) and the Intercollegiate document (2014, RCPCH) and the Promoting the health and wellbeing of looked after children (2015).

1.5 The Care Act came out in April 2015 (updated in 2016) which has impacted upon safeguarding adults practice and policy, therefore the report aims to demonstrate how this has been disseminated throughout the organisation and influenced local training, supervision and policy.

2.0 - Key Developments

2.1. The Trust Board is asked to note the following key developments:

- ✓ Introduction of a Head of Safeguarding post that aims to progress the Trusts local safeguarding strategy, board and trust's work plans, Case Review action plans as well as the national safeguarding agenda at a local level.
- ✓ Development of Key Performance Indicators for Safeguarding.
- ✓ The involvement ESHT in both the Child S Serious Case Reviews (SCRs) has led to recommendations that impact upon ESHT services and the annual work plans.
- ✓ Domestic Homicide Reviews (DHR) has recommendations which have influenced the Emergency Department and Maternity Unit in regards to their management of pregnant women who are vulnerable to domestic abuse.
- ✓ Adult A (SCR) recommendations have informed the Trust regarding patients who self-neglect which is reflected in the forward workplan.

- ✓ The LSCB has undertaken audits on the effectiveness of management of concerns related to fabricated and induced illness, strategy discussions, sexual abuse and child sexual exploitation (CSE) which has influenced the work undertaken by the Safeguarding Team.
- ✓ The SAB has undertaken an audit of Domestic Violence cases and the recommendations will inform Safeguarding practice.
- ✓ Introduction of the Independent Domestic Violence Advisor role, funded externally, has raised awareness of domestic violence at the Conquest Site. Working within our most vulnerable areas such as the Emergency Department, Special Care Baby Unit and Maternity Unit.
- ✓ Delivery of Safeguarding Children's training has been reviewed, now includes the maternity services, staffs have been identified who will deliver the training.
- ✓ Integration of 2 members of the community safeguarding team into the Health Visiting Integrated service to ensure that there are safer risk assessment of level 3 and level 4 (high risk) child protection cases.
- ✓ Signed up to and gradually embedding a mandatory national child protection information system (CP-IS) as a result we are leading ahead of other providers and local authorities nationally.
- ✓ Thorough review of the Mental Capacity Assessments through audit, training review and modern accessible means of information gathering such as apps and podcasts are being promoted.

3.0 - Governance Arrangements

3.1 ESHT holds a statutory responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children and adults is carried out effectively. There is a requirement for a Trust Board Lead for safeguarding children and adults which this position is held by the Director of Nursing.

3.2 The Intercollegiate Document states that as a provider there is clinical and strategic expertise of Named Doctors and Named Nurses for Acute, Community and Looked after Children. ESHT Safeguarding has a team of specialist nurses with expertise in nursing, midwifery, health visiting, paediatrics and education (appendix 1). The CCG has a designated doctor and nurse for safeguarding children, as well as a designated nurse for adults who act as a vital source of advice to ESHT as a provider.

3.3 ESHT Adult Safeguarding has a Lead Nurse (Designated Adult Safeguarding Manager) and a specialist nurse for adult safeguarding. Adult safeguarding does not have a Named Doctor within acute, as this post is not currently statute. However it is widely felt that the Adult Safeguarding team would benefit form a leading clinician with an interest in this area. A Named Doctor for Adult Safeguarding has been recruited by one of the CCG's to work with GPs in the community. The aim is to extend the Named GP role across all CCGs in time.

3.4 The ESHT Safeguarding Policies for Adults and Children set out the key arrangements for safeguarding and promoting the welfare of children across the organisation. The Safeguarding Children's policy was reviewed in 2017; the Safeguarding Adults is pending new legislation. All

policies relating to Safeguarding are actively managed via the Safeguarding Policy Matrix (Appendix 2)

3.5 The Director of Nursing or newly appointed Deputy Director of Nursing chair the ESHT Strategic Safeguarding Group Meeting. There has been good representation at these meetings throughout 2016/17. On occasions the Head of Nursing has chaired the meetings and it has been acknowledged that this has been a challenge as they chair the Operational Group Meetings for Adults and Children separately. Attendance at the Children's Operational Group has been high with all meetings being 100% quorate. This has been more of a challenge for the Adults Operational Group due to being a smaller team and difficulty in being quorate. There is no medical representation at Adult Safeguarding meetings. As a result a decision has been made to combine both which reduces time spent in meetings.

3.6 The Designated Nurse for Children's Safeguarding chairs a Health Forum which is an opportunity to focus upon the local and national agenda, as well as work towards future inspections. This year we anticipate a Joint Targeted Assessment Inspection across which will focus upon children who present with neglect as well as a potential CQC inspection in the autumn

3.7 Following changes in the Health Visiting Service structure as part of the service being integrated within local authority children's social care. It was identified that now that line-managers supervise Health Visitors in the management of complex high risk cases that the work previously undertaken by the ESHT Safeguarding Team had altered. As a result 2 FTE posts within the Community Safeguarding team were transferred to the Integrated Service.

3.8 The Looked after Children (LAC) contract was reviewed in September 2016 and the contract returned to ESHT's portfolio. An ISEND (Inspection of Special Educational Needs and Disability) Report following an inspection into LAC services (Under Kent at the time of inspection), was undertaken in April 2016 identified the potential conflict of the Designated nurse role being combined with the Named Nurse role for LAC. There was a lack of definition and clarity. This WTE post is now 2 roles which are separated into 0.5 WTE Designated Nurse (CCG) and 0.5 Named Nurse (ESHT) for LAC which continues to be monitored. The LAC annual report will be submitted separately from this Annual Report.

4.0 National Guidance/Inquiries

5.0

4.1. Multi-Agency Guidance Female Genital Mutilation (FGM)

ESHT response to the consultation on Multi-Agency Guidance Female Genital Mutilation (FGM) which followed the Home Office public consultation on Multi-Agency Guidance Female Genital Mutilation (FGM) has been positive. Safeguarding professionals have attended specialist training based upon the publication of the statutory guidance during 2015 which concluded in September 2015. The guidance includes the new mandatory reporting duty of regulated professionals in health, social care and education where a 'known' case of FGM in under 18's has been identified. ESHT has delivered training throughout ESHT in order to support professionals and reported into the Health and Social care Information centre (HSCIC). This duty came into effect at the end of October 2015. The numbers and type of referrals for the last 1 year are as follows:

4.1.1 Female Genital Mutilation Data for 2016/2017

Female Genital Mutilation Data from Euroking 01/04/2016 to 31/03/2017					
	Type not known	Type 1	Type 2	Type 4 **	Total
2016	3	5	0	0	8
2017	4	0	1	1 **	6
Total	**7**	**5**	**1**	**1**	**14**

** Obstetric Referral FGM Plan

4.2 NHS England Safeguarding Vulnerable People on the NHS - Accountability and Assurance Framework

This is the second NHS Accountability and Assurance Safeguarding Framework, this builds on the previous version and reaffirms and strengthens NHS England's commitment to safeguarding vulnerable individuals. NHS England together with Clinical Commissioning Groups (CCGs) has developed capability at individual and system level and delivered significant improvements including:

- The establishment of the National Safeguarding Steering Group
- Delivery of the executive leaders programme
- Development of a national Designated Professionals' network for children
- Significant contribution to the House of Lords inquiry into the Mental Capacity Act (MCA) 2005, subsequently investing 14 million pounds into the system to support commissioners, providers and partners.

ESHT Safeguarding has focused upon improving professional's knowledge of the MCA and how to apply it to their practice. The CQC in 2016 identified that improvements were required in the record keeping of MCA assessments and that there were inconsistencies in staff understanding.

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4.3 Independent Inquiry into Child Sexual Abuse (Goddard Inquiry)

In September 2015, NHS England received correspondence regarding the Independent Inquiry into Child Sexual Abuse. The correspondence sets out the requirements of the Goddard Inquiry with regard to retention of records. As part of the Inquiry letters have been sent to many organisations. In March 2016, NHS England produced a Goddard Inquiry checklist to be sent to Provider trusts. Awareness of Child Sexual Exploitation (CSE) and abuse has improved within ESHT following the introduction of a dedicated CSE Specialist Nurse by the CCG. Specific cases were flagged and taken to the Missing and Child Sexual Exploitation Group (MACSE) by the CSE Nurse which was a tremendous support to ESHT. However funding, 2017 onwards, was not

secured. This is vital work is now identified as of high importance by the ESHT Safeguarding team who represent the organisation at the MACSE Meetings.

4.4 Operation Dunhill

Although ESHT involvement in Operation Dunhill was minimal there are always lessons which can inform the organisation. In summary during a hearing at the Central Criminal Court on September 8th 2015 the accused pleaded guilty to two charges of indecent assault and one charge of misconduct in public office following the work of Sussex police as part of Operation Dunhill.

He was sentenced to 32 months imprisonment at a subsequent hearing on 7th October 2015. The accused became the Bishop of Gloucester in April 1992 and it was during his time of office there or previously as the Bishop of Lewes that the offences occurred. He had been cautioned for an offence of gross indecency in 1993 and resigned though he was allowed to officiate in various ways in the intervening years. Operation Dunhill was initiated after a review of closed cases undertaken by the Church raised concerns about this case and the earlier caution. Significant questions have been raised about the Church's handling of this case at the time of the caution and thereafter. As a result the Archbishop of Canterbury commissioned an independent review of the way the Church responded which helps the Church to learn lessons and improve safeguarding practice. This learning from the review is to be shared through the local SAB and LSCB Boards to support practice and learning at a local level.

As an organisation we must be seen to manage any allegation of abuse responsibly, working closely with Police, Social Care and our Human Resources department to ensure that we are open and transparent and that all professionals are treated equally no matter the position of authority that they hold within ESHT.

4.5. The Woods Report: A Review of the Local Safeguarding Children's Boards 2016

4.5.1 This is a national report which reviews the Local Safeguarding Children's Board roles and functions. The report sets out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. It contains recommendations for government to consider with regard to Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). It is thought within the LSB that locally there will not be any major changes locally. The Woods Report recommendations are:

- To replace the existing statutory arrangements for LSCBs and introduce a new statutory framework for multi-agency arrangements for child protection within a prescribed period. The three key agencies are health, police and local authorities. Local areas/regions would need to establish a plan which would describe how services would meet the new statutory framework, the existing legislative framework underpinning LSCBs should cease to operate as new arrangements come into being. Where an LSCB has been functioning effectively (as in East Sussex) there is an option to retain existing ways of working.

- To discontinue Serious Case Reviews, and to establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. Providing new guidance to cover best

practice in undertaking single and multi-agency inquiries, including the importance of a rapid response and transparency in publicising how an area has learned for the event and what has changed in local practice; and advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

- CDOPs to move from the Department for Education to the Department of Health who should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS. If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction.

4.5.2 The CDOP Specialist Nurse is funded by ESHT Safeguarding. In recent years there have been SCR's where there has been the death of a child and as a result it has remained within ESHT Safeguarding. During 2016/17 there were a total of 21 unexpected deaths. This figure is the lower than recent years and the reasons for this have been discussed at the CDOP meeting. West Sussex and Brighton have mirrored our numbers for 2016/17 in relation to population. Panel member's opinion about the lower numbers is that this cannot be explained. The trend this year already indicates an increase.

4.5.3 The ESHT CDOP specialist nurse is a member of the panel. A review is held into each death to determine whether there are modifiable factors which may have contributed to the death. The most common modifiable factor continues to be inappropriate sleeping position for babies. East Sussex healthcare Trust (ESHT) have undertaken a review of the work regarding safe sleep advice/strategies and have shared this with all health colleagues within ESHT and external partners such as children's centres.

4.5.4 Between 2014 /15 there was concern regarding the number of hangings which correlated with national statistics around the leading causes of death for the 14 to 17 year age group-being unintentional injuries, suicide and homicide. The CDOP year goes 01/04 to 31/03 figures for the last 3 years are as follows:
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14-15 there were x3 hanging and 1x12 rapid response.
15-16 there were x1 hanging and x8 rapid response.
16-17 there were x1 hanging and x2 rapid response.

4.5.5 The Mental Health and Resilience of young people is an issue which has been raised nationally and locally through the East Sussex Children and Young People's Mental Health and Wellbeing Transformation Plan (2015-2020). The Safeguarding team intends to undertake an audit to look at the impact of M.H. admissions within our organisation.

5.0 - Local National Guidance/Inquiries

5.1 Serious Case Reviews

In May 2016 an ESHT Internal Management Review (IMR) was requested by the LSCB regarding a case where two young children had been exposed to significant issues of Neglect which contributed towards a Serious Case Review (SCR) Child S. The East Sussex LSCB has yet to publish the SCR report however ESHT Safeguarding has developed an action plan in response to their recommendations from the IMR. The SCR was predominantly a health focussed case with recommendations made for primary care, midwifery services, health visiting and school nursing. Progress on recommendations and resulting actions has been closely monitored by the Trust Strategic Group, CCG and the LSCB.

5.2 Domestic Homicide Review
The ESHT Safeguarding team have contributed towards the request from LSCB and SAB requests for IMR's for two Domestic Homicide Review's. The final reports are awaiting publication.

5.3 Adult Case Review
The ESHT Adult Safeguarding team have contributed towards the request for an IMR for Adult A Case Review. The final report is awaiting publication.

6.0 - Safeguarding Audits

6.1 Safeguarding Adult Board Assurance Audit Report
ESHT contributed to the SAB Safeguarding Assurance Audit Report which is yet to be correlated and published by the SAB .

6.2 Children Act 2004 Section 11 Audit Report and Action Plan
The East Sussex Local Safeguarding Children Board is responsible for coordinating and ensuring the effectiveness of the work undertaken by its members. Section 11 audits are one method of monitoring compliance. In January 2016, the CCGs, ESHT, SPFT, SECAmb and IC24 were required to complete the audit; these were due for submission at the beginning of March 2016. The submissions and progress of resulting action plans are be monitored by both the LSCB and CCGs. This is the 4th S11 audit and 24 agencies took part with improved compliance rates.

7.0 - The Safeguarding Annual Workplans 2017/2018

7.1 ESHT Safeguarding Annual Workplans

The forward looking Work plans for 2017/2018 are informed largely by SCR and DHR actions as well as the LSCB and SAB work plans for 2016/2017. The work plans are regarded as vital in that they inform the strategic vision for the Safeguarding Team and enable this to be communicated effectively.

LSCB Work plan 2016/2017

LSCB Priorities 2016/2017

- Tackling Child Sexual Exploitation
- Improving Safeguarding in Education
- Online safety
- Mental health service provision to those who need it
- Tackling the impact of domestic abuse on children

SAB Work Plan 2016/2017

The SAB 2016/2017 work plan, based on the same 5 strategic aims as overall strategic plan covers 2015-18. Additions and amendments to last year's plan were highlighted in the document for ease. There are 2 key points in particular:

- Consider threat of cyber-crime, and online safety: It has been agreed that this could be an area combined with the Partnership protocol, linking with other Boards/Partnerships where work is ongoing, rather than a separate action for the SAB

- National Mental Capacity Act Competency framework – The SAB has agreed to have this as an action for SAB members to consider adopting with their staff. This is on the SAB website and can be accessed on the following link: http://www.eastsussexsab.org.uk/information-resources/national-mental-capacity-act-competency-framework. ESHT Safeguarding are addressing Mental Capacity Act within the Workplan.

8.0 - Safeguarding Children and Adults Activity

8.1. The Safeguarding Team is responsible for ensuring that all safeguards and risk to adults and children are reported to the local authority. The number of safeguarding concerns is recorded per month by ESHT Safeguarding Team. The Key performance indicator is that 100% of known safeguards within our organisation are alerted to the local authority. In part this does not represent the total safeguarding activity but does demonstrate the risk for our organisation if this responsibility is not supported within ESHT. It is important to note that the raising of a safeguarding concern is different between children's and adults, this is not only in what constitutes a safeguarding concern, the process of making a referral, but also the Safeguarding Team responsibility and accountabilities.

8.2 Children who have a Child Protection Plan (CPP) are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns, by whom, and how it will be known progress is being made. The numbers of Children on a CPP has been consistent in March 2016 was 448 and March 2017 was 476.

8.2.1 In regards to Safeguarding Children Training the CQC requires that ESHT as a provider train a minimum of 80% of their staff in safeguarding children and training is expected to be at the appropriate level as set out in the Intercollegiate Document, Roles and Responsibilities of Health Care Staff 2014. This now includes Prevent, FGM and CSE. There has been a sustained improvement in compliance of Safeguarding Training since 2012. Level 2 has steadily risen across

the organisation and level 3 compliance is high. A specific area of concern regarding compliance has been Urgent Care; this was a result of widening the attendance criteria which did result in a dramatic fall in compliance. This was acknowledged and is currently on the Trust Risk Register.

8.2.2 Training Compliance Safeguarding Children Levels 1 to 3 Chart

Overall Trust % Trained KPI 85%	Level 1 leaflet	Level 2 Safeguarding Children Clinical staff	Level 3 Safeguarding Children Staff working directly with children
March 2017	100%	84.44	85.48%
March 2016	100%	82.12%	85.89%
March 2015	100%	78.12%	87.42%
March 2014	100%	56.41%	78.56%
March 2013	100%	39.04%	42.74%
March 2012	100%	65.0% (Combined level 2 & 3)	N/A

8.3 Progress of the introduction of the Care Act since it was passed through Parliament in May 2014. In relation to safeguarding, the Care Act has influenced the work of the Adult Safeguarding Team in establishing the following:

- ESHT has a statutory requirement to provide Director representation upon the Safeguarding Adult Board.
- ESHT has a corporate duty to make safeguarding enquiries to local authorities
- ESHT Safeguarding has contributed to SCRs which is mandatory.
- The Safeguarding team has cooperated in the supply of information when there is a safeguarding enquiry.
- Supported the local authority to find advocacy for people who do not have anyone else to speak up for them
- Re-enact existing duties to protect people's property when in hospital
- Supported the duty of candour responsibility upon ESHT as a provider when there has been a failing within the hospitals and care settings. This is vital to the organisation as it is now an offence for providers if found to be supplying false or misleading information

The Act provides sets of regulations and new statutory guidance and regulation was originally published in October 2014 and the legal framework came into effect on 1 April 2015. The Safeguarding Team ensures that the Care Act is adhered to by supporting the guidance on sections 42 – 46. An updated statutory guidance was published in March 2016 which included;

- Clarification of Enquiries under section 42 in relation to those who self-neglect.
- New definition of Domestic Violence to reflect new legislation
- Additional information about financial abuse
- Clarified the need for a strategic and accountable lead for safeguarding at senior level

8.4 The Deprivation of Liberty Safeguards DoLS Authorisations

The Law Commission published a consultation paper initially in July 2015, which set out a comprehensive replacement scheme for The Deprivation of Liberty Safeguards DoLS. An interim statement was issued in May 2016, recommending a more streamlined, straightforward and flexible scheme for managing DoLS authorisations. ESHT records the numbers of DoLS issued and these have been consistent across each quarter. The table below (8.4.1) demonstrates the authorisations for the last 3 years are as follows:

8.4.1 The Deprivation of Liberty Safeguards DoLS Authorisations Chart.

Authorisations by Quarter 2014/15	**2014/15**	**2015/16**	**2016/17**
1 Urgent	13	26	22
1Standard	6	5	0
2 Urgent	17	24	17
2 Standard	4	3	1
3 Urgent	29	19	21
3 Standard	11	1	0
4 Urgent	15	16	18
4 Standard	3	0	1
Total **Urgent** **Standard**	 **74** **24**	 **85** **9**	 **78** **2**

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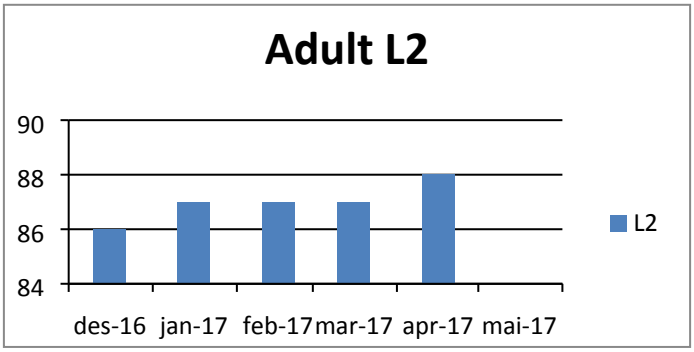
8.5 Training

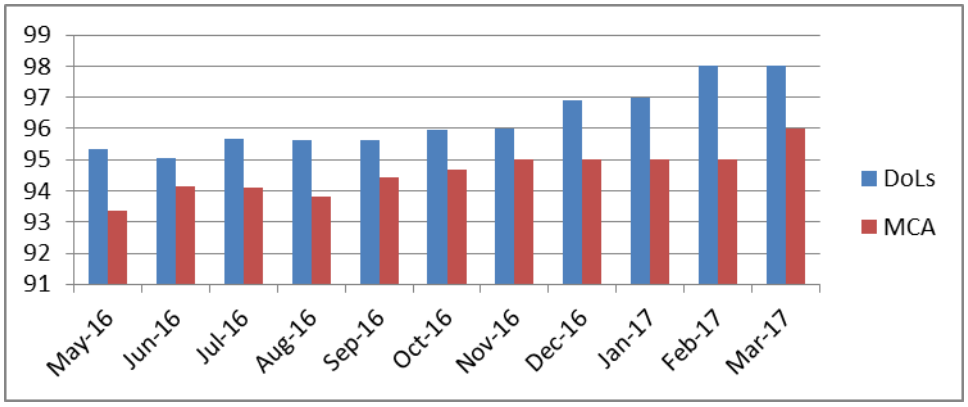
8.5.1 Safeguarding Adults level 2 training KPI Measure: 85% compliance with safeguarding training. Adult Safeguarding level 2 training has significantly improved in compliance as has level 3 training this year.

8.5.2 Level 2 Safeguarding Adults Compliance Chart.



8.6 Staff receive Mental Capacity (MCA) and Deprivation of Liberties (DOLs) training to ensure understanding of processes to follow in practice. A KPI of 90% compliance of staff trained in MCA and DOLs is set and there has been significant improvements over the last year. This should enable ESHT to demonstrate that its training programme is aimed at addressing issues raised by the CQC regarding inconsistencies in the recording of mental capacity. This is a national challenge which is well documented.

8.6.1 Staff receive Mental Capacity (MCA) and Deprivation of Liberties (DOLs) training Chart.



8.7 A DoLS and mental capacity audit was completed last summer on five wards in the two main hospitals. There were two sets of questionnaires, one for patients on wards and one for staff on the same wards. The outcomes/results were disappointing. The first comment from the CQC with regards safeguarding investigations was that mental capacity assessments were inconsistent. There will be monthly audits set up to review and help make documentation more consistent. There will be second mandatory e-learning refresher training given and face to face training sessions with matrons. The care plan and management of DoLS need to be reviewed. Work books are very popular with staff too.

8.8 ESHT adults safeguarding training is influenced by SAB working and following the addition of financial abuse there has been a focus during the last 12 months upon scams awareness. It is vital that staff within ESHT are alert to our vulnerable patients falling victim to scamming. District nurses are visiting patients in the community and are able to alert Social Care when they are concerned. A tremendous amount of work is being carried out by community services and trading standards as well as Public Health England and Operation Signature.

8.9 Mental Health Act Assessment and Training

Safeguarding acknowledges that there is a need to address MHA understanding and application. Areas for development are as follows:

- Develop a ratified Trust Policy or operational procedures for MHA to be available electronically
- The existing SLA needs to be reviewed and set out in the policy to ensure anyone with a role has the training and understanding to perform that role and be competent
- The site team (out of hours) and ward matrons (in hours) have the responsibility under the SLA for receiving papers and conducting a number of tasks that protect patients' rights whilst detained. They are not trained at present
- The liability that ESHT holds, whilst a detained patient is with us (on our sites) and the exact risks to patients, public, staff and the Trust arising from any failure of ESHT staff to properly manage the MHA in line with legislation are not fully known and appreciated – this is a risk which needs putting on the risk register
- Mitigations put in place and a plan to close risk in safeguarding report at next meeting
- Mitigations prior to training which are to liaise with the current liaison service for psychiatry (out of hours) to support staff.

9.0 - Prevent Action Plan 2016/17

Each year Sussex Police have a statutory requirement to produce a Counter Terrorism Local Profile (CTLP) which outlines the threat and vulnerability from terrorism-related activity within their policing area. This year partners on the Prevent Board contributed to the CTLP with additional feedback as one of the aims of the CTLP is to support the mainstreaming of Prevent activity into day-to-day policing, local government and partnership work. The Prevent Action Plan 2016/17 identifies a number of areas partners agreed to prioritise. They include:

- Encourage partners and other agencies across Sussex in the identification of those who have returned from war zones so that appropriate support can be provided when required.
- Partners to be proactive in providing positive messaging in relation to the refugee resettlement crisis across East Sussex.
- Actively promote and encourage the reporting of hate crime when engaging with local communities.
- Continue to embed Prevent within the ongoing development of Multi-agency Safeguarding Hubs (MASH) and within key partner agencies such as Adult and Children's services where a lack of awareness has been identified.
- To encourage staff to make referrals referrals and explore existing pathways/emerging trends (e.g. mental health, autism, and young people) following increased referrals in 2015/16.
- To support the LSCB and SAB to develop and deliver appropriate Prevent provision/activities/intervention targeted at vulnerable age groups, most notably those aged 18 and under.
- Ensure continued compliance with the Counter Terrorism Security Act 2015 Channel Duty.

10.0 - CQC Inspection Report Comments in regards to ESHT Safeguarding.

The CQC inspected ESHT in 2015 and again in September 2016. The report was published in January 2017 and in regards to safeguarding found the following:

•The trust has clear and up to date policies for both adult and child safeguarding. Policies and procedures are linked to county safeguarding boards.
• Safeguarding is led at board level by a named director and the board receives regular updates and an annual report ensuring that it is sighted and receiving assurance on safeguarding issues.
• The trust has teams that support the management of safeguarding within the trust. Staff are clear about responsibilities and understand who to access to report or take advice on safeguarding issues. This team shares information with the organisation via a newsletter.
• The trust provides comprehensive training in safeguarding and this is largely taken up by staff. However, in some services medical staff attendance at training is below target and below that of other groups within the workforce.
Consent processes were generally controlled and well documented, including processes for children, although audit results suggested that this was less consistent in the emergency care departments.
• Review of documentation indicated that whilst processes for application of do not resuscitate (DNACPR) had improved since our last inspection, staff understanding of the application of MCA remained inconsistent despite enhanced training.

11.0 - ESHT Learning Disability

11.1 The ESHT Learning Disability (LD) lead is a member of the safeguarding team acting to support and facilitate equality of health care for adult patients with learning disabilities; improving patient experience and outcomes. Central to the care delivery for this vulnerable group of patients is adherence to the Mental Capacity Act 2005 and the provision of reasonable adjustments as required by the Equality Act 2010. The lead supports delivery of training with an emphasis on vulnerabilities and reasonable adjustments.

11.2 The Trust has LD champions who work across all sites, from a clinical or non-clinical background, in order to promote of best practice in the context of the care and treatment of patients with learning disabilities. ESHT LD champions meet at network events co-ordinated quarterly and receive role updates and education around specific topics.

11.3 The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) was published in 2013. All LD deaths are reviewed and recorded on a database and are subject to an internal review by the Learning Disability Lead and Head of Safeguarding. Cases are reviewed to ensure that there is no evidence of discrimination, diagnostic overshadowing, comprehensive multi-disciplinary input and reasonable adjustments were made. There has been a request that a member of the team is involved in the LeDeR programme:

• The Learning Disability Mortality Review Programme (LeDeR programme) is a national 'must do' with no additional funding which will be implemented by the end of 2017. This will result in the deaths of all patients with LD in hospital being reviewed against standard and robust criteria. Appropriate staff members with expertise in LD (serious incident / safeguarding investigations at

complex level) are required to train as reviewers. A network or peer reviews will occur with reviewers expected to conduct reviews independent of the Trust in which they work
• All deaths of people with LD aged four years and older are subject to review using LeDeR methodology.
• If there is a death of person with LD in an acute setting in an area that is not yet covered by LeDeR programme Trusts are recommended to use structured judgement review (SJR) process or methodology of equivalent quality that meets requirements for the data that must be collected as an interim measure. Once reviews are completed they will be notified to the LeDeR web based platform and to the relevant governance body at the Trust where the death has occurred. The Learning Disability Nurse will train as reviewer

11.4 In regards to discharge planning the LD Lead Nurse supports requirements to review of the efficacy and timeliness of proactive discharge planning. This can involve individual adjusted care pathways for patients identified as having increased health needs, behaviour which challenges and for those who require major adjustments to their care pathway.

12.0 - Safeguarding Record Keeping

The Safeguarding team are required to work with more than one IT system in order to communicate effectively and share information, (Working Together 2015). There have been some changes as follows:

12.1 SystmOne online recording system has been implemented within ESHT community health visiting and safeguarding services. However, there has been difficulty in accessing up to date information from Children's Services. Traditionally the Children's Index was a reliable resource, it is being phased out and the Liquid Logic system is to be introduced in the autumn 2017. It is essential that this is inclusive of Healthcare professionals working in Safeguarding Children roles.

12.2 The CP-IS (Child Protection Information System) CP-IS programme is a NHS England led child protection register which is being developed nationally. It is an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings. It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in unscheduled care settings. The implementation of this project has now been delegated to the CCGs to implement through the designated professionals. Child Protection Information Systems (CP-IS) has been rolled out within ESHT (Senior reception staff access in the Emergency Departments and acute Paediatric Liaison Service). It is still in its infancy but in time it will be possible to share information nationally regarding the most vulnerable children from out of area via the Child Protection Information System (CP-IS).

12.3 An area of concern has been that the ESHT safeguarding systems which are owned by the local authority are outdated/unreliable as local authority is no longer using/updating the Children's Index. The risk is that for ESHT checking children's child protection history and entering alerts onto our systems is essential along with the use of clinical expertise. There is a solution with CP-IS/Liquid logic hopefully in the autumn and participating in working groups. Information sharing remains an issue for the children's safeguarding team, social care have an out of date system (Children's Index) access to Liquid logic would be essential to ESHT Safeguarding work planned for September 2017. By not having access to up to date information means that information

regarding children attending ESHT acute areas is potentially out of date or not updated at all. This issue has been raised with local authority and CCG. The Safeguarding team have been included in the changes to information systems as part of the Sussex Better Together initiative.

13.0 - Safeguarding Policy

Safeguarding and related policies are readily available to staff working within ESHT, which are reviewed when required. The KPI is 100% and in regards to ESHT specific policies 100% has been achieved this quarter. The policy matrix attached (Appendix 2) enables the Safeguarding team leads to monitor the dates for review and to ensure that the most up to date versions are available to staff. The Domestic Abuse Policy has recently been updated to reflect findings from a recent Domestic Homicide Review Report which reflects changes required in midwifery practice All ESHT policies are up to date; however policies which are shared with Adult Social Care require updating. These policies are to be reviewed by Adult Social Care this year.

14.0 – Priorities for 2017/18

Safeguarding priorities are outlined in the annual work plans. To summarise:

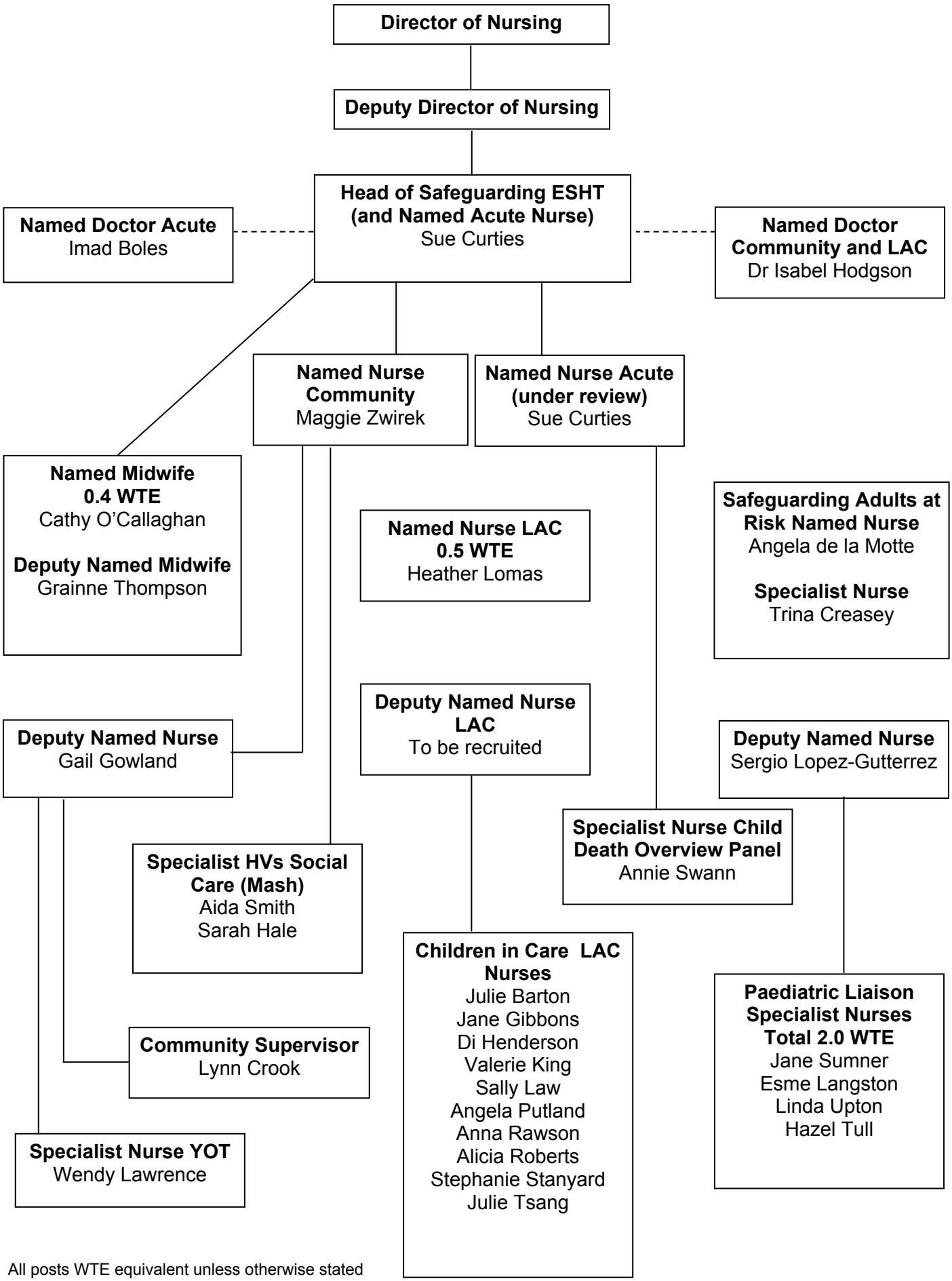
- Implementation of CP-IS across the healthcare setting across the Healthcare setting and ensure that up to date information sharing improves between local authority and health.
- Evaluation and monitoring of Section 11 audit and update progress to the LSCB
- Mental Capacity inconsistencies understanding and recording in clinical areas must be addressed.
- Maternity – recording of Domestic Violence on E3 (Maternity IT system).
- Mother & Baby Adoption Forms are failing to be completed and turned around in a timely manner.
- Mental Health Act roles and responsibilities for healthcare professionals are not clearly understood within the organisation - to be entered on the Trust Risk Register and following a training needs analysis the implementation of a training programme.

15.0 - Conclusion

In conclusion, the safeguarding agenda within ESHT is well led by the Director of Nursing. ESHT has given Safeguarding a higher profile; it now sits within the Deputy Director of Nursing portfolio and a Head of Safeguarding has been recruited in March. The Safeguarding team are empowered to be responsive to local and national issues such as Child Sexual Exploitation (CSE), Prevent (Terrorism and Extremism) and FGM (Female Genital Mutilation). The Safeguarding team is fully established with a shared vision of working towards improving patient safety and quality.

Name: Sue Curties
Role: Head of Safeguarding
Date: 29/06/2017

Appendix 1 – East Sussex Safeguarding Children/Adults Personnel



All posts WTE equivalent unless otherwise stated

Appendix 2 - Safeguarding Policy Matrix

East Sussex Healthcare NHS
NHS Trust

Issue No	Directorate/ Clinical Unit	Dept ID	DOC TYPE	Title	NEXT REVIEW DATE	Responsible Person	Upload Date	Comments
2014278	Women and Children Clinical Unit	38	Policy	Policy for the Management of Faltering Growth in Infants and Children Under 18	19 Dec 2017	Safeguarding Children Strategic Group	19/12/2014	Under review by SC and EL. Presenting to Policy Group July 2017
2015082	Clinical Practice		Policy	Policy for the Management of Domestic Abuse	01 Feb 2018	Safeguarding Adult services	16/04/2015	Merged with Maternity into one Policy For Policy Group July 2017
2015155	Clinical Practice	53	Policy	Safeguarding Adults at Risk Policy	02 Aug 2019	Sue Curties, Head of Safeguarding	02/08/2016	
2016124	Clinical Practice	64	Policy	Safeguarding Children & Young People Supervision Policy	01 Dec 2019	Sue Curties, Head of Safeguarding	01/12/2016	
2016263	Women and Children Clinical Unit	38	Guideline	Guideline for requesting/arranging medicals	06 Dec 2019	Named Doctors	06/12/2016	
2013138	Women and Children Clinical Unit	38	Policy	Did Not Attend (DNA) Policy for Children/Young People Under 18	10 Jan 2020	Safeguarding Children Strategic Group	30/01/2017	Check
2017009	Clinical Practice	64	Policy	Child Safeguarding Policy and Procedures	13 Jan 2020	Sue Curties, Head of Safeguarding	13/01/2017	
2017010	Women and Children Clinical Unit	38	Guideline	Guideline for Vulnerable Young People aged 16–18 years and Vulnerable Adults with Dependent Children under the age of 16	13 Jan 2020	Assistant Director of Nursing for Safeguarding Named Nurse for Child Protection (Acute)	13/01/2017	
2017017	Clinical Practice	64	Policy	Procedure for Allegations of Child Abuse against Staff	20 Jan 2020	Sue Curties, Monica Green, Director of Human Resources	20/01/2017	
2016084	Clinical Practice	53	Procedure	Chaperone Procedure	03 Jun 2020	Assistant Director of Nursing for Safeguarding Named Nurse for Child Protection (Acute)	03/06/2016	

Equality Delivery System (EDS2) 2016/17

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	13.2
Meeting:	Trust Board	Reporting Officer:	Kim Novis

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)

Key stakeholders:		Compliance with:	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒

Compliance with Public Sector Equality Duty, S149 Equality Act 2010

Other stakeholders please state: Patients & Staff

Have any risks been identified ☐ *(Please highlight these in the narrative below)*	On the risk register?

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

EDS2 is 4 goals that lead to 18 outcomes. 2 goals focus on patient access to services, experience and communication. The further 2 goals focus on staff experience, fair recruitment, access and leadership. The report supports the Trust in meeting its statutory obligations

Workforce data is separated into protected groups.

Patient data highlights access to A&E and access to communication support during the reporting period.

The report also contains the Trust Equality objectives and summarises progress to date.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality & Safety Committee
Organisational Development Group
People & Organisational Development

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD)

That the Board is suitably assured that the Trust is meeting its obligations under the Public Sector Equality Duty

The Equality Delivery System (EDS2)

Equalities Analysis Report 2016/17

Contents

Summary

Introduction
This is the Trust annual Equality Report (RAG rating is reviewed bi-annually). The report uses the Refreshed Equality Delivery System (EDS2), to guide the Trust in reporting and complying with the legal obligations set out in the Public Sector Equality Duties. This report seeks to provide assurance for patients, carers, the public and staff, that the Trust is inclusive of the needs of all people. Whether people are accessing services, visiting or working for the Trust, no matter where they live within the organisation's geographical reach, they can be confident that the Trust is continually seeking to improve the services it offers as a healthcare provider and employer.

2016/17 has been another year of building on existing good work, progressing the equality objectives and as always rising to new challenges. The report uses the EDS2 outcomes to guide and measure the Trust in the progress in delivering good practice along with identifying areas for further development.

Achievements
The Trust has devised many initiatives throughout the organisation to ensure patients, carers, visitors, service users and staff have equal access to services. This was recognised through achieving finalist nominations for awards recognising leadership and innovation in equality and inclusion categories.

The Trust Annual Staff Awards and the Unsung Heroes awards provided the opportunity to recognise the great work ESHT staff do. Trust Awards were given out to staff for a variety of achievements such as exemplary leadership, commitment and dedication to improving access to healthcare for those who may otherwise find it difficult. Unsung Heroes awards were awarded for recognition of the tremendous work of those who work behind the scenes.

ESHT welcomed the third cohort of interns on Project Search, a programme that supports young adults with learning difficulties and enables them to widen their employment opportunities.

Areas of focus from 2015/16 report:
Increasing communication with the organisations service users to assist the Trust in reaching its target of being a Trust rated by CQC as 'Outstanding' by 2020, commenced with the appointment of the Associate Director of Communications. Through the development of the communication and engagement strategy along with the staff networks the Trust provides an open and transparent approach to present topics that cause concern, listen to peoples' views and act on innovation wherever possible.

Implementing the new Accessible Information Standard across the Trust to ensure patients, service users and carers have access to healthcare information in a format that is suitable to them commenced in July 2016. The

Standard aims to Identify, record, highlight, share information and support the communication needs of all those that require communication support due to a disability, sensory or cognitive impairment. This is an ongoing piece of work through 2017/18.

The Trust CQC inspection report in October 2016 highlighted that the Trust was no longer rated 'Inadequate' and is now rated as 'Requires Improvement' and rated as 'Good' for care. Fifteen areas of 'outstanding practice' were also highlighted.

Areas of focus for 2017/18:
2017/18 will see the EDS2 outcomes regraded to reflect the ongoing work within the Trust. The outcomes will also be reviewed and aligned with the Trust's 2020 objectives to support the organisation in becoming "outstanding" by 2020.

During 2017/18 the Trust will further review the disability access audit and identify areas requiring improvements. The actions will be managed through the disability staff network, the Equality Steering Group and the Estates department. Local audits will be completed annually thereafter.

An area for disabled changing and public toilets with a hoist is to be developed as part of the 5 year 2016-2021 estates strategy.

A scoping exercise will be carried out to identify possibilities of developing and utilising bilingual staff to support delivering excellent patient care to those who do not use spoken English as their primary method of communication.

EDS2 Outcomes and Grading 2015/16 – 2016/17

Goal 1: Better health outcomes		
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**ACHIEVING**
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**DEVELOPING**
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**DEVELOPING**
1.4	When people use the NHS their safety is prioritised and they are free from mistakes, mistreatment and abuse	**ACHIEVING**
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**ACHIEVING**
Goal 2: Improved patient access and experience		
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**DEVELOPING**
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	**DEVELOPING**
2.3	People report positive experiences of the NHS	**DEVELOPING**
2.4	People's complaints about services are handled respectfully and efficiently	**UNDEVELOPED**
Goal 3: A representative and supported workforce		
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**ACHIEVING**
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**UNDEVELOPED**
3.3	Training and development opportunities are taken up and positively evaluated by all staff	**DEVELOPING**
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	**DEVELOPING**
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**DEVELOPING**
3.6	Staff report positive experiences of their membership of the workforce	**DEVELOPING**
Goal 4: Inclusive leadership:		
4.1	Boards and other senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**DEVELOPING**
4.2	Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed	**ACHIEVING**
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**DEVELOPING**

1. Introduction to the refreshed Equality Delivery System (EDS2)

The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a toolkit that assists NHS organisations in improving their services, both as service providers to their local communities, and also as employers. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Based on this evaluation and subsequent engagement with the NHS and key stakeholders, a refreshed EDS – known as EDS2 – was made available in November 2013.

The main purpose of the EDS2 is to help NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. Engagement for EDS2 grading will take place bi-annually. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

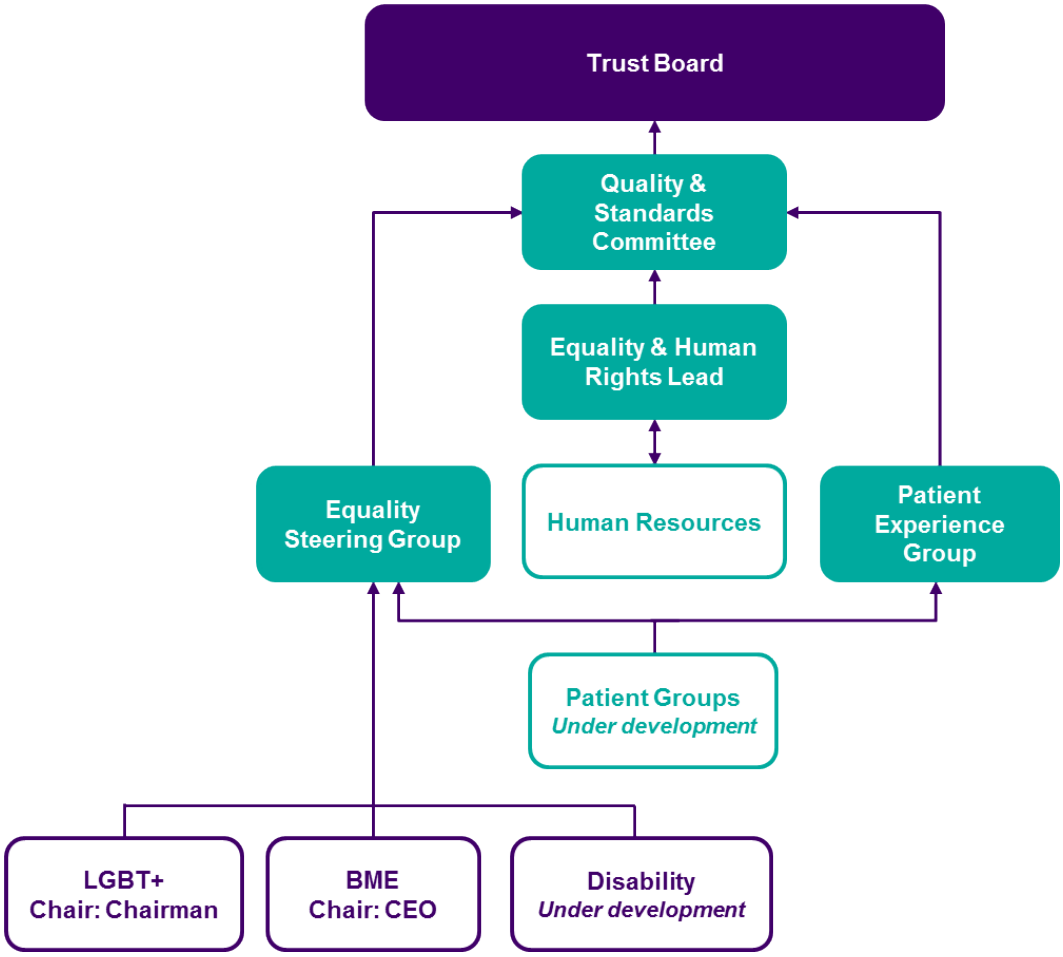
East Sussex NHS Healthcare Trust has embedded the EDS2 into everyday practice which assists the Trust to deliver a report that is understandable and transparent. Complying with EDS2 assists East Sussex Healthcare Trust in:

- Ensuring staff and service users are free from unlawful discrimination
- Identifying barriers to healthcare enabling the Trust to improve access to services
- ensuring staff and service users are provided with equality of opportunity and are fostering good relations
- Improving patient experiences of the organisation which will deliver better health outcomes
- Deliver a well-led, supported workforce that is representative of the communities it serves.

Equality sits with the highest level of leadership at ESHT with a robust governance framework to support monitoring and delivery. There are 2 sub-groups that feed into the Quality and Safety Committee; The Equality steering group which is made up of for directors, managers, EDS2 and Workforce Race Equality Standard (WRES) leads. The aim of the Equality Steering Group is to ensure that there are robust reporting mechanisms in place and to constantly review data that ensures objectives are being met and progress reported. The group will also manage Equality Impact Assessment outcomes and the local annual disability audits.

Patient groups, staff groups and networks will discuss and address concerns and capture innovative ideas that will assist the Trust in becoming the Healthcare provider of choice for local people and an employer where staff are happy and proud of their membership.

1.1 Equality & Human Rights Governance Structure



1.2 The four Goals that lead to the 18 outcomes:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

1.3 EDS2 Grading

For each EDS2 outcome, there are four grades, and a RAG “plus” rating, to choose from:

Excelling **Purple**
Achieving **Green**
Developing **Amber**
Undeveloped **Red**

For most outcomes the key question is: how well do people from protected groups fare compared to people overall?

Each grade is dependent on evidence of the protected characteristics including; gender, race and ethnicity, age, disability, religion or belief, sexual orientation, pregnancy/maternity/adoption and paternity, transgender and marital status.

Undeveloped	Developing	Achieving	Excelling
			
People from all protected groups fare poorly compared with people overall OR evidence is not available	**People from only some protected groups fare as well as people overall**	**People from most protected groups fare as well as people overall**	**People from all protected groups fare as well as people overall**

2. Trust Performance

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.1
Outcome: Services are commissioned, procured, designed and delivered to meet the health needs of local communities	

Summary of Activity:

ESHT 2020 is a major programme of work consisting of 5 key strategic priorities to ensure the Trust consistently deliver safe patient care, through valued and respected staff, by working closely with commissioners, local authorities, and other partners whilst operating efficiently and effectively utilising our resources. .ESHT aim to achieve a CQC rating of 'Good' by 2017 and 'Outstanding' by 2020.

To support the Trust's compliance with current equality legislation and ensure it meets the needs of all its users, the EDHR Lead continues to be a panel member for relevant tendering processes alongside dedicated procurement leads when out-sourcing its services.

ESHT was successful in obtaining the contract to provide Hastings and Rother Integrated Musculoskeletal (iMSK) care. The service will provide care for patients in Hastings and Rother with muscles, bones and joint conditions. Clinics delivering the service include Battle Health Centre, Bexhill Hospital, Conquest Hospital, Station Plaza, Rye, Winchelsea and District Memorial Hospital.

Language and communication
Language and communication needs were previously supplied under the East Sussex County Council's SUSTI framework which translates foreign community languages, through telephone, face to face, written, audio, braille and sensory interpreters. Following a scoping exercise with internal stakeholders and service users, opportunities to improve the service were explored. Potential suppliers from an existing framework provided by NHS Commercial Solutions were invited to submit a bid for a sole contract for interpreting services at ESHT. A successful bidder was identified and mobilisation of a new and improved service was rolled out across the Trust in September 2016. The new supplier has also assisted the Trust in implementing the Accessible Information Standard which supports patients with communication needs arising from a disability or impairment.

Grade:	ACHIEVING

Evidence for grading:
- Quality Accounts
- CQC Report
- Healthwatch
- FFT
- Tender processes / contracts
- Internal scoping exercises

Areas of focus from 2015/16 Report for 2016/17

Develop a full action plan to successfully implement the Accessible Information Standard across the Trust.

Identify innovative ways to meet the communication needs of all service users with Learning Disabilities, sensory and cognitive impairments and other disabilities.

Ensure a robust SLA for Interpreting Services meets the needs of all service users who do not communicate using spoken English.

Many initiatives for improving communication for all service users with Learning Disabilities; sensory impairments; cognitive impairments and other disabilities have been rolled out and included in the Accessible Information Standard action plan.

A robust SLA that considers the needs of all people requiring communication support was awarded to Capita Translation and Interpreting.

Areas of focus for 2016/17

- Identify resources to support ongoing implementation of the Accessible Information Standard
- Identify further resources to support patients with foreign spoken languages

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.2
Outcome: Individual people's health needs are assessed and met in appropriate and effective ways	

Summary of Activity:

Learning Disabilities (LD)
Patients ae supported with use of this is me - my care passport and DisDAT to assist staff in understanding communication including atypical presentations.

Provision of hospital communication books assist staff and patients with communication needs

Provision of easy read materials to explain procedures - on occasion including Drs drawing simple diagrams to explain procedures and / or treatment

Use of any individual patient communication aid including computers, pocket photo albums and laminated alphabet charts with pictorial drawings are utilised wherever required.

For patients who present with complex behavioural presentations - assessment of non-verbal communication styles and inclusion of these indicators in individual care plans.

Equality & Human Rights Analysis (EHRA)
The refreshed EHRA form continues to be embedded into relevant documents ensuring inequalities are identified and removed wherever possible. The Trust Policy Group reviews all Trust policies every 3 years. The group continues to ensure 100% of all relevant Trust policies are appropriately assessed by 2019.

Healthwatch engagement and feedback
Healthwatch continues to contribute with engaging with local communities. In November 2016 Healthwatch covered a 24 hour period in the acute hospitals including the A&E departments. Several recommendations were made to support meeting the needs of local communities. The full report can be found at http://www.healthwatcheastsussex.co.uk/wp-content/uploads/2015/01/Round-the-Clock-Care-Report-2017.pdf

Healthwatch also been involved in ESHT Maternity departments to support the Trust in improving the areas highlighted in the Trust CQC report. Healthwatch published their findings in April 2016. The report highlights what worked well for women and what did not work so well. It included the experiences of partners, wider family members, and where appropriate, members of staff. The full report can be found at http://www.healthwatcheastsussex.co.uk/wp-content/uploads/2015/01/From-special-measures-to-special-moments-April-2016.vfinal.pdf

Language and communication
Language and communication needs continue to be assessed and met in a variety of ways using a simplified system following the successful award of a Service Level

Agreement (SLA) for face to face interpreters, telephone interpreters, and bilingual advocates are provided for patients who do not have spoken English as their first language.

Grade:	DEVELOPING

Evidence for grading:

- Healthwatch
- Patient Experience Surveys
- Language and Communication policy
- Interpreter data
- LD initiatives

Areas of focus from 2015/16 Report for 2016/17

Patient engagement groups are currently being developed to identify champions for protected characteristics.

Collecting, recording and analysing feedback from bilingual patient FFT is currently being developed with Capita TI.

Links have been created for public access to information on LD nurse's and documents such as passport and DisDAT toolkits. These will be available on the Trust website.

Areas of focus for 2016/17

- Patients, service users, carers, parents will be invited to attend an engagement group to review the 'Disability Access Audit' to identify further barriers and share their experiences. Feedback will be considered at the Equality Steering Group.
- Pilot bilingual FFT.

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.3
Outcome: Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	

Summary of Activity:

Engagement
As an integrated health provider, the Trust continues to work closely with commissioners and partner organisations, including other trusts, GPs and adult social care to support an effective transition for people on care pathways. All clinical units have clear pathways to other specialities such as Orthoptics have a direct referral pathway with the Stroke team. Podiatry have pathways for high and low risk diabetic patients, Nail surgery, Musculoskeletal and home visiting for high risk patients. Information leaflets are available to patients on cancer pathways which are made available in alternative formats when requested or where needs are identified.

We have a full time learning disability nurse specialist who supports patients with learning disabilities, their family, carers and hospital staff, to identify the additional needs experienced by individuals and to plan reasonably adjusted pathways.

Waiting Times
A&E waiting times suggest as age increases so does the time spent waiting. There were minor variations in waiting times when separated by ethnicity. White British/white other and unknown had the longest waiting times with those identifying as mixed ethnicity waiting the least time. This was the same with breaching the 4 hour target. Females waited an average of under 6 minutes longer than Males. There were over 1000 more breaches than Males.

Grade:	DEVELOPING

Evidence for grading:
- Annual data collection
- Pathways information and guidelines

Areas of focus from 2015/16 Report for 2016/17
Use of existing data collection methods has been used to identify further breakdown of A&E.

Data is now collected on interpreter usage for each speciality to ensure all patients who do not have spoken English as their first language are well informed and supported through their care pathways. Details are in the Equalities Analysis.

Methods for collecting and reporting equalities data on delayed transfers will continue through 2017/18.

Areas of focus for 2017/18
- Continue to improve data collection methods for equalities data

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.4
Outcome: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	

Summary of Activity:

There is an extensive system for reviewing and reporting on patient experience, clinical effectiveness and patient safety. At clinical quality review meetings pressure ulcers, falls and medication incidents are reviewed and actions and learning outcomes continue to be agreed. Indicators such as infection control, incidents and safeguarding are monitored at the Quality and Safety Committee. This process also identifies themes and trends, along with actions and learning.

Serious Incidents
Serious Incidents are subject to root cause analysis and are discussed and reviewed by the Serious Incident Review Group (SIRG) prior to being submitted to commissioners for closure. Any issues regarding equality are highlighted at the meetings. There have been no SI reports in relation to equalities issues for the past 3 reporting periods. The Trust continues to recognise that a large number of serious incidents relate to falls and pressure ulcers which are prevalent in older people which are monitored at the SIRG.

Equality & Human Rights Analysis (EHRA)
EHRA's provides patients and staff with confidence that potential equalities related mistakes, incidents and risks are identified, managed, mitigated or eliminated wherever possible. Any risks identified are reviewed at the SIRG and Equality Steering Group.

Grade:	ACHIEVING

Evidence for grading:

- Privacy and Dignity policy
- Equality & Human Rights Analysis for policy and strategic developments
- SI Reporting

Areas of focus from 2015/16 Report for 2016/17
Data related to incidents and infection control cases is regularly reviewed to ensure that no person with a protected characteristic is affected less favourable than any other person. All SI's are triangulated to record actions taken and learning outcomes.

Areas of focus for 2017/18

- Continue to promote EHRA training to ensure equalities related mistakes, incidents and risks are identified, managed, mitigated and eliminated wherever possible.

EDS2 Goal 1: Better health outcomes	EDS2 Reference Number: 1.5
Outcome: Screening, vaccination and other health promotion services reach and benefit all local communities	

Summary of Activity:

Health Promotion

'Making Every Contact Count' (MECC) is a project that provides training for Conquest staff to identify, when in contact with patients, opportunities to talk about their patients' wellbeing and to empower those individuals to make healthier lifestyle choices. The emphasis is on prevention of problems and early intervention by providing information and signposting to other services. 100 staff had received training up to 31st March 2016. In April 2016 further funding was awarded to implement the project in Eastbourne. MECC training is now included in the clinical induction training for all new staff and 1000 staff are expected to have completed MECC training by March 2017.

Sexual Health

The Sexual Health teams continue to build relationships with LGBT patient groups and the local communities. Promoting Sexual Health and testing will include attending both Hastings and Eastbourne Gay Pride events.

Male access to Sexual Health Services has increased from 22% to nearly 31%. 5.03% of people reported being gay or bi-sexual.

Grade:	ACHIEVING

Evidence for grading:

- Sexual health data
- Service accessibility (online)
- MECC Project Plans
- MECC Newsletter

Areas of focus from 2015/16 Report for 2016/17

Key projects aimed to reach a 10% increase in male attendances within the sexual health service - the clinics reached an increase of over 22%.

Areas of focus for 2017/18

- MECC will continue to develop across Eastbourne.
- Promote ESHT Sexual Health Services at local events such as local Gay Pride.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.1
Outcome: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	

Summary of Activity:

Engagement
The Trust is committed to ensuring all of its sites are accessible to all who may use them. Many provisions already exist including lifts, ramps, induction loops, disabled toilets and free of charge disabled parking. Provisions are in place to ensure all communication needs are met. Toolkits to support people with learning disabilities are constantly reviewed to ensure they are meeting individual needs.

Accessibility
Reasonable adjustments to improve accessibility are continually sought throughout the Trust. During 2017/18 a further review of the disability access audit will provide the initial focus point for the disability user group. The audit and outcomes will be used by the group to inform the Trust on where improvements and changes are needed. The Trust has a 'changing places' initiative - as part of the Trust 5 year 2016-2021 estates strategy. As part of this strategy an area for disabled changing/public disabled toilets with hoist is to be identified at both acute sites.

It is anticipated that at least one ward on each acute site will be upgraded per financial year. Upgrades will include appropriate signage and colour schemes as well as fixtures and fittings, to enhance the environment for patients with a disability and dementia.

Language and communication
The Trust provides a wide range of interpretation services for patients, carers and service users through the use of a new Service Level Agreement (SLA) with Capita Translation & Interpreting (TI). Capita TI provide the Trust with all methods of translation which can be booked by staff using an online portal, email or telephone. Service include:

- Face to face interpreters
- Immediate telephone interpreters
- Sensory losses (BSL, Lip Speakers, Deaf-blind manual)
- Advocacy & Bilingual Advocacy
- Written & Audio Translation (including Braille)

During 2015/16 telephone interpreting was rarely used (7.6% of interpreting used) and staff relied on unnecessary face to face interpreters for short appointments. This often resulted in staff rearranging or delaying appointments to ensure an interpreter was available. It was identified that a large proportion of appointments would be suitable for telephone interpreting. The Equality & Human Rights department have delivered training packages to staff to increase the use of telephone interpreting for patients, service users and their carers to ensure healthcare and information about it is accessible without delay. 28.7% of all interpreting was carried out by telephone

interpreting during 2016/17. Further details of the languages requested are found in 2015/16 Equalities Analysis.

Accident and Emergency Waiting times
The national target for A&E waiting times in acute hospitals remains at 4 hours. Data suggests that waiting time in A&E is longer for those aged over 65 years. Analysis of A&E data by age, ethnicity and gender can be found in the Equalities Analysis.

Grade:	**DEVELOPING**

Evidence for grading:

- SUSTI data
- Capita TI data
- A&E metrics
- Estates strategy 2016-2021

Areas of focus from 2015/16 Report for 2016/17
The Trust entered into a Service Level Agreement for interpretation services ensuring; easy access to interpreters and translation materials, robust data, and staff training. KPI's include improving BSL interpreter availability.

Monitoring A&E metrics is now included in daily communication to all staff.

Areas of focus for 2017/18

- Funding has been allocated to commission an external company to carry out an access audit on Conquest, Eastbourne and Bexhill Hospital sites.
- Commence annual departmental Access Audits to include Accessible Information in January 2018.

ESD2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.2
Outcome: People are informed and supported to be as involved as they wish to be in decisions about their care	

Summary of Activity:

Engagement
Through engagement with Healthwatch and the CQC reports, the Trust has good evidence and insight into potential areas of concern. Further engagement with Healthwatch through 2016/17 will enable the Trust to address any further areas of concern. During 2016/17 Healthwatch independently reviewed services over a 24hr period at both acute sites making recommendations which have been considered in Trust action plans. Healthwatch reports can be found at http://www.healthwatcheastsussex.co.uk/our-work/our-reports/

Support
The Trust is committed to ensuring patients, as well as their families and carers, are involved, informed and consulted on all decisions about their care and treatment. All patients continue to have a personalised care plan which is developed with them

The Trust has in place the following policies aimed at supporting patients. All policies are reviewed every 3 years as a minimum.

- Consent Policy
- Privacy & Dignity Policy
- Equality & Human Rights Policy
- Language and Communication Policy
- Guidance for Staff on the Implementation of the Mental Capacity Act (MCA)
- Policy for the use of the Mental Health Act 1983

An EHRA is completed for each policy to ensure due regard and reasonable adjustments are applied accordingly.

Patients, service users and their carers identified as not speaking English are provided with interpreters or bilingual advocacy to support decision making. All patient leaflets are made available, upon request, in alternative formats and languages. Documents that are translated into alternative formats are kept and uploaded onto the Trust website for further future use.

The trust Patient Advice and Liaison Service (PALS) support patients in accessing support and signposting should they require help. If people report that they do not feel informed after speaking to PALS then this is investigated as a concern and/or are advised about the formal complaint procedure. Where relevant concerns are raised, the Equality & Human Rights Lead directly liaises with services and the service user and / or carer to resolve concerns effectively and quickly.

The Learning Disabilities Liaison Team (LDLT) ensure reasonable adjustments are continually made with information provided in alternative formats. LD patients have the same access to, and information about, their treatment and care as those without LD. This ensures LD patients are involved and supported in decisions about their

care and that their wishes are taken into account. ‘This is Me - My Care Passport’ or Disability Distress Assessment Tool (DISDAT), continue to be carried out and remain on the patient’s record through an electronic flagging system which highlights any additional needs the patient may have.

Grade:	DEVELOPING

Evidence for grading:

- Language & Communication Policy
- Consent Policy and Process
- Individualised care plans
- Patient Administration Systems
- Communication & Engagement Strategy

Areas of focus from 2015/16 Report for 2016/17

The Trust has implemented the Communication & Engagement Strategy to deliver the Trust principles so people feel confident that are involved in decisions about their care.

Areas of focus for 2017/18

- Review the new system for interpretation services to ensure the SLA is meeting demands and value for the Trust.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.3
Outcome: People report positive experience of the NHS	

Summary of Activity:

Staff pride themselves on providing patients with the best possible experience of the Trust. Many initiatives are rolled out to capture patient feedback and to make improvements to enhance patient experience.

The CQC Survey of Adult Inpatients conducted in 2015 was made available during 2016. The report highlights there is an overall improvement (5%) of patient experience. 47% identified as male and 53% female. 66% of respondents identified as over the age of 66 years, 21% aged 51-65, 8% 36-50 and 4% aged 16-35. Only 1% identified as being from a minority ethnic group and again only 1% identified as lesbian or gay. It is not possible to draw conclusions of experience based on protected groups due to small numbers and therefore a deep dive into equalities data from the Trust Friends and Family Test results of 2015/16 and 2016/17 will be published.

NHS Choices website continues to provide a place for patients and service users to leave their feedback. All feedback is responded to by the Patient Experience Manager. The Trust currently has a 4 out of 5 star rating.

Grade:	DEVELOPING

Evidence for grading:

- Friends and Family Test
- NHS Choices
- CQC Survey of Adult Inpatients 2015
- Patient Experience Steering Group minutes

Areas of focus from 2015/16 Report for 2016/17
Customer care apprenticeships, up to degree level, are now being offered to staff
Options for Bilingual FFT questionnaires are currently being explored.

The Trust website was reviewed and updated and will soon include a patient engagement page with a ‘you said, we did’ approach. Results to surveys and feedback are now available.

Bilingual FFT is being developed as part of the new Interpreter services contract.

Areas of focus for 2017/18

- Continue to develop the new improved Trust website to provide a place for people to report their experiences of the Trust.
- Ensure people accessing Trust services, and do not use spoken English as their first language, are included in the FFT.
- Publish equalities breakdown of FFT for 2015/16 - 2016/17.

- Commence objectives to relaunch Patient Experience Champion Programme to along with planning for a combined strategy with public engagement.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.4
Outcome: People's complaints about services are handled respectfully and efficiently	

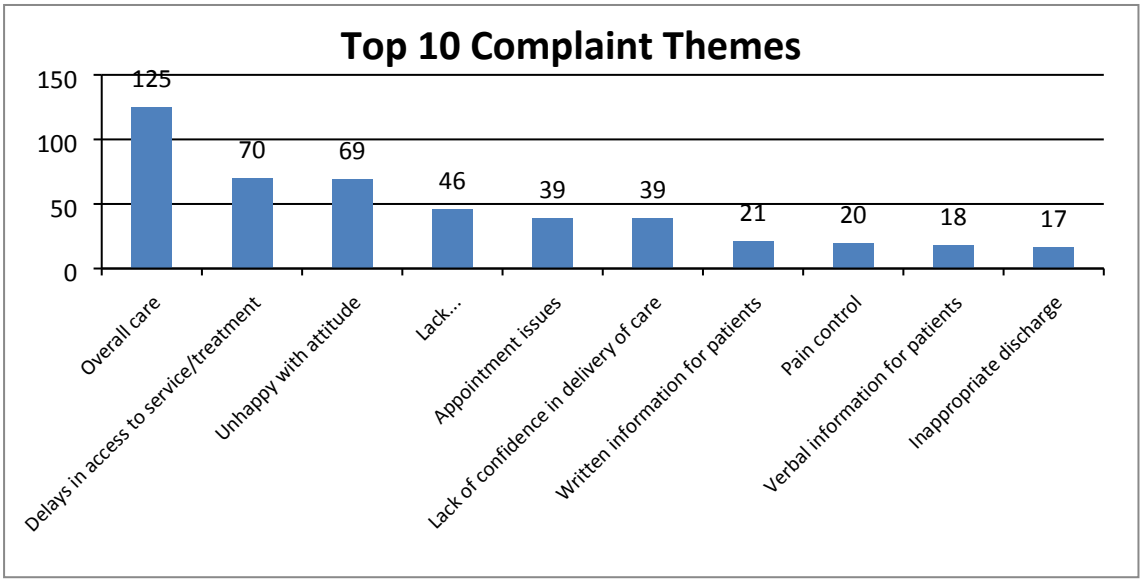
Summary of Activity:

The Trust is committed to continuously improving the outcomes for patients and achieving excellence in patient care and patient experience. The Trust actively encourages staff closest to the point of care to deal with concerns and problems quickly as they arise, ensuring a professionalised response with consideration of individual needs and circumstances. The Trust recognises that at times some peoples' experience of the Trust and its services may not reach individual expectations.

Improvement work in the complaints department has taken place over the last reporting period including the first "Complaints Deep Dive" .This involved randomly selecting twenty complaints files relating to the Division, reviewing the process, looking at themes and considering how we can address these. This process enabled some rich data to be identified and shared with the Division. Attendees at the "Deep Dive" included, senior nurses from the Division, Complaints and PALS Manager, Head of Governance, Healthwatch representatives and our Patient Experience Volunteers. Two further "Deep Dives" have been planned for Urgent Care (April) and Diagnostics Anesthetics and Surgery (May). Further reviews surrounding the information provided to patients on admission with the aim to design a standard document across the trust. It is anticipated that this will assist in improving some of the communication issues.

The number of formal complaints received by the Trust has reduced in 2016/17 (664) compared to 2015/16 (680) which is a 2.5% reduction. The top 10 themes can be seen in the table below.

Healthwatch report on 'making complaints personal' is available at http://www.healthwatcheastsussex.co.uk/wp-content/uploads/2016/06/Making-complaints-personal-March-2016.vfinal.pdf



Data is not always available to identify the protected characteristics of complainants. However, any equality and diversity concerns identified in the complaints process automatically alerts the Trust Equality & Human Rights Lead for monitoring to ensure equality related concerns are investigated to the highest possible standard.

Grade:	**UNDEVELOPED**

Evidence for grading:

- Complaints Report 2016/17
- Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)
- Complaints Process
- Healthwatch 'Making Complaints Personal' report
- CQC reports

Areas of focus from 2015/16 Report for 2016/17
Post complaint surveys commenced in October 2016. This is sent to all complainants for completion. The survey includes monitoring protected characteristics to ensure all complaints are dealt with fairly.

A complaints training package was developed and is currently being delivered to all staff. This training includes customer care and the complaints handling process.

Datix Risk Management Software has enabled us to capture and report on the appropriate information to ensure all complaints are handled in a culturally competent way. Actions are tracked and subsequently completed. However further work is required to ensure these actions are robust, completed and embedded into practice.

Areas of focus for 2017/18

- Carry out further deep dives to ensure
- Ensure actions are robust, completed and embedded into everyday practice

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.1
Outcome: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	

Summary of Activity:

The Director of Human Resources continues to oversee the operational delivery of recruitment and selection to support the Trust's strategic aims

Recruitment
The Trust has a robust Recruitment and Selection Policy which adheres to the mandate for employment checks in the NHS (in England). The policy requires managers to complete recruitment and selection training, including equality and diversity training prior to becoming involved in recruitment processes. This aims to equip all staff involved in recruitment and selection, with the skills, knowledge and understanding of their roles and responsibilities and to ensure that they recruit the best possible candidate into a post. Staff are encouraged to consider the Workforce Race Equality Standard (WRES) and advertise using known groups such as BME networks when senior positions are being recruited for. Data of ESHT workforce and recruitment are found in the workforce analysis.

The Recruitment and Selection Policy used in conjunction with the Equality Policy provides a solid framework for managing recruitment and selection in an efficient, effective and fair manner. The Trust aims to ensure that no unlawful discrimination occurs during the recruitment and selection process, that equality of opportunity is an integral part of the procedure.

The Trust has continued to review policies governing recruitment and selection to ensure compliance with best practice. There is a dedicated recruitment team, based within HR providing ongoing guidance, advice, support and administration throughout the recruitment process. Recruiting mangers are also supported through an online training portal and ad-hoc face to face training sessions.

All activity is monitored to ensure consistency and compliance with the recruitment standards.

Data presented in the 2015/16 WRES indicated that despite the representation of BME applicants increasing at interview stage (up to 30%), BME representation at offer stage reduces by 5% for total Trust recruitment assignments and by 20% for Band 8a and above. The white representation at the offer stage for Band 8a and above is over 90%. Data does suggest that the percentage of BME applicants and those attending interview is within the expected norms for East Sussex however the percentage reduction at offer stage is reduced. Recruitment teams and the BME Staff Network will devise actions to explore further.

A large project saw an increase of Healthcare Assistants move from agencies to the Trust Bank (Temporary Workforce Services) reducing the agency expenditure.

The Trust now advertises key vacancies using Twitter and other online social media platforms to reach target audiences.

Grade:	ACHIEVING

Evidence for grading:

- Trust policies and training on recruitment & selection
- Raising awareness of opportunities to disadvantage groups
- Retention of two ticks symbol status
- Recruitment processes
- BME Recruitment Paper for Pod Committee
- The Workforce Race Equality Standard (WRES)

Areas of focus from 2015/16 Report for 2016/17

Policy reviews ensured all policies governing recruitment and selection continue to comply with best practice.

Improved monitoring of staff recruitment and selection training to demonstrate compliance.

Recruitment System training for managers and recruiters continued to be rolled out across the Trust.

An action plan was developed to increase BME representation of underrepresented groups at all levels. Details of the action plan are contained in the WRES Report 2016/17.

Areas of focus for 2017/18

- Implement the WRES action plan through the BME Staff Network
- Develop the Disability Staff Network to support implementation of the Workforce Disability Standard (WDES)

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.2
Outcome: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil legal obligations	

Summary of Activity:

The Trust follows national established pay scales for all staff:
Agenda for Change – All non-medical staff
Medical & Dental Pay Scales
VSM Pay Scales – For very senior staff where AfC is not applicable.

Equal Pay Audit 2017
The Trust commenced the first equal pay audit in 2016 to identify discrepancies of pay between male and female employees. The figures highlighted a varying degree of salary and earnings differences. Band 3 and 4 remain the only grades where females' salary was higher than their male equivalent. These had increased from 0.59% to 1.77% for band 3 and 1.49% to 1.67 for band 4. However, the total earnings gap changed for males in band 4 from earning 4.32% to 4.56% higher more than females.

The biggest male : female gap in salary is medical career grades at 18.41%, followed by junior doctors at 17.92% (audit only covers staff who have been employed a full financial year so there are reduced no. of Jr Drs and therefore caution must be used when forming judgements using these data). When total earnings are factored in (such as on call allowances) the gap increases to 26.97% for medical career grade staff and increases to 20.45% for junior doctors.

The pay gap between male : female consultants' average salary has reduced since 2016 audit, from 5.98% to 2.24%. Average earnings had remained fairly static at 13.27%. Further details can be found in the Workforce Equalities Analysis 2016/17.

Further exploration is planned for 2017/18 to gain a deeper understanding of why differences exist across pay scales.

Grade:	UNDEVELOPED

Evidence for grading:
- Established national guidance and local policies
- ESHT Equal Pay Audit 2016
- ESHT Equal Pay Audit 2017

Areas of focus from 2015/16 Report for 2016/17
- A full equal pay audit commenced to reach national targets for 2018 reporting.

Areas of focus for 2017/18
- Conduct detailed analysis of pay differences

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.3
Outcome: Training and development opportunities are taken up and positively evaluated by all staff	

Summary of Activity:

Commissioned and funded training courses continued to be evaluated through Higher Education Institutes which is then fed back to the organisation. Internal Trust courses are evaluated by participants at the end of each course. Poor evaluations are fed back to the lead trainers for action.

NHS Staff Survey

88% of White respondents and 75% of BME respondents believed they were provided with equal opportunities for career progression or promotion. BME reporting is a significant increase on 2015. The overall average for the Trust in 2016 was 86% (4% increase from 2015) and the median for all national scores for combined acute and community trusts remained at 87%.Each characteristic group reports an increase in believing the Trust provides equal opportunities for career progression or promotion from 2015. KF 13. Quality of non-mandatory training, learning or development was reported as 4.03 (maximum score is 5) this is a 0.7 increase from 2015. Combined national average was 4.07.

Ethnicity	2016	2015	Average (median) for combined & community Trusts
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion			
White	88%	85%	88%
BME	75%	64%	75%

2016

NHS Staff Survey KF21. % of staff believing the organisation provides equal opportunities for career progression / promotion									
Gender		Disability		Ethnic Background		Age			
Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
79	88	79	88	88	75	93	88	84	84

2015

NHS Staff Survey KF21. % of staff believing the organisation provides equal opportunities for career progression / promotion									
Gender		Disability		Ethnic Background		Age			
Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
77	84	72	85	85	64	92	83	82	80

Staff engagement and improving staff experience of the workforce remains a key priority of ESHT Trust Board and Managers. Pulse surveys continue to be carried out regularly to identify successful initiatives and to gain an insight into where further improvements can be made to ensure staff are supported and provided with opportunities to progress and reach their full potential.

Many clinical units and departments organise their own local non-mandatory training such as writing classes, cultural workshops which are not recorded centrally. This can prove challenging when reporting. Communication to managers reminding them to record all completed staff training staff will be issued as a theme of the week newsletter.

Project SEARCH

Project SEARCH is a collaborative approach to a supported internship programme for young people with learning difficulties/ disabilities, run from the Eastbourne DGH site. With many departments participating, this is a rewarding programme for the interns and the departments involved. The programme has continued to grow and attract positive media attention and recognition. The benefits to the interns include increased confidence, self-esteem and aspirations, giving them an opportunity to acquire new skills, receive tailored support, gain interview skills and apply for employment. In addition, their internship continues to create a wider social network with work colleagues.

Grade:	**DEVELOPING**

Evidence for grading:

- Established policies and processes.
- Staff training records
- Staff Survey
- Project SEARCH

Areas of focus from 2015/16 Report for 2016/17

Career progression is a key agenda item at the BME Staff Network meetings. Career development opportunities have been identified and will be implemented through 2017/18

Career development workshops are planned for 2017/18

Areas of focus for 2017/18

- Identify ways to monitor local training sessions not organised through learning and development to ensure equal opportunities to training and development is disseminated

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.4
Outcome: When at work, staff are free from abuse, harassment, bullying and violence from any source	

Summary of Activity:

Engagement

The Trust continues to recognise the need to do more still to ensure staff are free from abuse, harassment, bullying and violence from any source. Managers recognise that more needs to be done locally to prevent this, from any source. The staff survey highlights this further. If staff do experience unwelcomed behaviour from any source, they will be supported to speak up. Senior Managers have implemented and continue to identify further ways to prevent Harassment & Bullying (H&B) or violence across the Trust. The 'Speak up Guardian' supports staff in ensuring issues that have been raised are addressed.. Senior managers are committed to ensuring that the culture of the organisation empowers staff to speak up and work in an environment which is free from harassment, bullying, and victimisation or violence.

The Trust has a Staff Health and Well-being Board, whose membership includes the Equality & Human Rights Lead and the Speak Up Guardian.

NHS Staff Survey Feedback

	Gender		Disability		Ethnic background	
NHS Staff Survey Question	*Male*	*Female*	*Yes*	*No*	*White*	*BME*
KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths	13	16	17	15	14	22
KF23. % experiencing physical violence from staff in last 12 mths	4	2	2	2	2	5
KF24. % reporting most recent experience of violence	71	70	71	69	68	81
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths	25	31	39	28	29	34
KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths	27	27	37	25	27	29
KF27. % reporting most recent experience of harassment, bullying or abuse	45	50	56	46	48	53

Grade:	DEVELOPING

Evidence for grading:

- Dignity at work policy. Raising Concerns policy, Independent Board member
- Staff survey Results 2016
- Local security management service which investigates reports of violence against staff by patients or other employees
- Reports to Quality and Standards committee

Areas of focus from 2015/16 Report for 2016/17

Harassment & Bullying (H&B) action plan was developed and implemented to include receiving feedback at Staff Operational Engagement Development Group

Areas of focus for 2017/18

- Continue to implement H&B initiatives and empower staff to speak out.
- EDHR training to continue providing H&B - channels for reporting

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.5
Outcome: Flexible working options are available to all staff consistent with the needs of the service and the way that people lead their lives	

Summary of Activity:

Offering flexible working opportunities, attract skilled potential employees that may otherwise struggle to seek employment, in particular those with parental or caring responsibilities. The Trust supports staff to remain in employment and retain skills within the Trust by exploring suitable flexible working opportunities with employees. This approach also supports the Health and Well-Being agenda, as supporting staff in maintaining a good work-life balance reduces stress amongst the workforce.

The Trust Child and Family Care Manager offers drop-in sessions for all staff returning from maternity or adoption leave. 4.54% of Staff took maternity, paternity or adoption leave during 2016/17 (further breakdowns are available in the workforce analysis) Flexible working options are reviewed annually as part of each member of staff's Personal Development Review. Any member of staff can request flexible working and wherever their service permits, managers will always endeavour to accommodate such requests. Many staff request temporary flexible working arrangement, such as during school holidays when childcare can become difficult. Flexible working requests are often agreed locally and may not result in a change to working hours. For example a nurse on a ward may still do the same number of overall hours but may change to fixed days/nights each week due to caring needs or something similar. Equally a member of staff may agree a 9 day fortnight with their manager but still doing full-time hours. The E-rostering system allows for an element of self-rostering. Setting up a system centrally to capture every occasion of flexible working would be very resource intensive therefore this will be explored at a future Equality steering group with a view to identifying potential reporting methods.

51% (an increase of 4% in 2015) of respondents to the NHS Staff Survey felt 'satisfied with the opportunities for flexible working patterns'. The median for national scores for combined acute and community trusts was 51%

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KF15. % satisfied with the opportunities for flexible working patterns									
Gender		Disability		Ethnic background		Age (years)			
Male	*Female*	*Yes*	*No*	*White*	*BME*	*16-30*	*31-40*	*41-50*	*50+*
47	53	48	52	51	57	49	55	53	50

Grade:	DEVELOPING

Evidence for grading:

- Flexible Working Policy
- Recruitment and Retention Strategy
- Organisational Change Policy
- Special Leave Policy

- Attendance Management Policy
- Work-Life Balance Policy

Areas of focus from 2015/16 Report for 2016/17

- Following a review the effectiveness of policies further engagement and promotion of staff benefits including flexible working options was promoted through various engagement events facilitated by the Trust Child and Family Care Manager.

Areas of focus for 2017/18

- Explore options to increase flexible working monitoring.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.6
Outcome: Staff report positive experiences of their membership of the workforce	

Summary of Activity:

The Trust has been very proactive in promoting 'Health and Well Being' to support staff in feeling motivated and engaged. Staff have reported in the NHS Staff Survey improvements to all 6 questions relating to job satisfaction. A score of 3.64 (max is 5, combined acute and community score is 3.71) for staff recommendation of the organisation as a place to work or receive treatment. Following the CQC Report it was identified that this was not always the case and that the 2014 NHS Staff Survey's corroborated this. 2015 NHS Staff Survey reported staff experience in some areas had improved with further increases this year. BME staff reported increased job satisfaction in all questions relating to job satisfaction compared to White staff.

It is accepted that there is still much work to do however this further increase is a demonstration of the Trust's and individual commitment to improving equality, staff experience and wellbeing.

Staff survey questions on job satisfaction (the higher the score the better)										
Staff Survey Question	Gender		Disability		Ethnic background		Age (years)			
	Male	*Female*	*Yes*	*No*	*White*	*BME*	*16-30*	*31-40*	*41-50*	*50+*
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.64	3.64	3.45	3.67	3.6	3.9	3.8	3.66	3.61	3.6
KF4. Staff motivation at work	3.8	3.92	3.76	3.92	3.86	4.19	3.9	3.83	3.93	3.9
KF7. % able to contribute towards improvements at work	65	70	61	71	68	73	76	71	70	65
KF8. Staff satisfaction with level of responsibility and involvement	3.84	3.89	3.73	3.91	3.86	4.03	3.91	3.9	3.87	3.86
KF9. Effective team working	3.7	3.81	3.68	3.81	3.78	3.89	3.89	3.8	3.81	3.74
KF14. Staff satisfaction with resourcing and support	3.22	3.26	3.1	3.28	3.22	3.51	3.44	3.2	3.25	3.23

Grade:	DEVELOPING

Evidence for grading:

- Staff Health & Well-Being Policy
- Staff feedback

- Operational Development and Staff Engagement Group Action Plan
- Staff Conversations
- NHS Staff Survey 2016

Areas of focus from 2015/16 Report for 2016/17
Identify further opportunities to engage with seldom heard staff groups on their experiences of the Trust.

The LGBT Staff Network commenced at the end of summer 2016, led by the Chairman, along with a BME Staff Network led by the Chief Executive. Both Networks are managed by the Equality & Human Rights Lead.

Areas of focus for 2017/18

- Deliver training to provide staff with the knowledge and understanding of trans and gender non-conforming individuals,
- Identify further training opportunities to support BME Staff through the BME Staff Network
- Following a a review of access audit of the Trust sites, commence an engagement and disability access improvements for staff through a Disability Staff Network.

EDS2 Goal 4: Inclusive leadership	**EDS2 Reference Number: 4.1**
Outcome: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	

Summary of Activity:

Leadership
Following many changes at senior level through the previous year, there is now a feeling of stability which can be felt throughout the Trust. The new directors have formed a major part in supporting staff from protected groups, raising awareness of the Trust's equality agenda.

Chairman – David Clayton-Smith chairs the LGBT+ Staff Network and has been a huge support in getting the Network up and running. David has supported plans to represent the Trust at local Gay Pride events have been key to promoting the LGBT+ Staff Network.

Chief Executive – Dr Adrian Bull chairs the BME Network with passion and dedication to improving equality for this group of staff. The Network has welcomed the leadership that Dr Bull has provided.

Director of Estates & Facilities – Chris Hodgson will chair the Disability Staff Network which is currently being developed. The first meeting will take place following a a review of the disability access audit of the Trust's main sites.

The Equality & Human Rights Lead is encouraged and supported by senior leaders to share the Trust's good practice and processes with other organisations and NHS Trusts, recognising that engagement with wider communities is key to delivering equality in healthcare and employment.

Equality initiatives such as promoting Equality Week and small lapel badges to show support to our LGBT+ staff are supported and attended by senior leaders. Funding for such events have been kindly provided by charitable funds.

Declaring personal equality information is not always welcomed by individuals in the workplace. Even though this information can really help organisations provide positive working environments and enhance opportunities. This is evident in our workforce equality analysis. 43.41% of staff did not declare their religion; 11.31% did not declare their ethnicity; over 50% did not declare whether they had a disability; and 40.21% did not declare their sexual orientation. To encourage staff to provide their personal equalities data, to help improve working environments and meet the needs of staff, the Trust Board declared some of their personal equality information to identify how representative the Trust Board is. It is hoped that staff will see this as a positive step to highlighting how an open, diverse Trust is one to be proud of.

The Trust Board is underrepresented for ethnicity as all members identify as White British. The Board is representative of other protected characteristics; 11% identified as LGBT+; 36% identified as having beliefs other than Christianity (including no belief); 22% identified as having a disability as defined by The Equality Act 2010.

Grade:	DEVELOPING

Evidence for grading:

- EDHR Steering Group minutes
- Equality Action plans
- LGBT+ Staff Network meetings
- BME Staff Network Terms of Reference
- BME Staff Network meetings
- Equality questionnaires

Areas of focus from 2015/16 Report for 2016/17

Board members and senior leaders have to engaged in equality initiatives promoting equality when conducting quality walks

Areas of focus for 2017/18

- The Chairman will continue to provide leadership to the LGBT Staff Network
- The Chief Executive will continue to provide leadership to the BME Staff Network
- The Trust Board will continue to engage regularly with the EDHR Lead to ensure equality remains at the most senior level within, and beyond, the organisation.

EDS2 Goal 4: Inclusive leadership	**Reference Number: 4.2**
Outcome: Papers that come before the Board and other major committees identify equality related impacts including risks, and say how these risks are to be managed	

Summary of Activity:

The Trust Equality Objectives 2015 – 2019 include: "all strategies, business plans and annual reports that come before the Board or other major committees will include the Trust's standard Due Regard, Equality & Human Rights Analysis (EHRA), including how any inequalities will be managed". This form is an integral part of the policy writing template and therefore no strategy, business plan or procedural document will be considered by the Board or other major committee without this information being completed. A summary of the Trust Equality Objectives can be found at the end of this report.

The Trust has an established Equality, Diversity and Human Rights (EDHR) Lead who is line managed by the Director of Corporate Affairs. The EDHR Lead meets regularly with the Chairman, Chief Executive, Director of Nursing and other Medical and Non-Medical Executives. The Equality Steering Group is linked with Patient Experience, the People & Organisational Development Group and feeds into the Quality & Safety Committee.

Completion of EHRA's is embedded in the Equality, Diversity & Human Rights Policy and the Policy & Procedure for the Development and Management of Procedural Documents.

The Trust Policy group manages and ratifies policies that are to be used with the Trust. Since the implementation of the Trust Equality Objectives there have been no policies ratified without a completed EHRA. All Trust policies should have an updated EHRA by 2019.

Grade:	**ACHIEVING**

Evidence for grading:

- Trust Quality Objectives 2015- 2019
- EHRA Database
- EHRA training sessions
- Equality, Diversity & Human Rights Policy
- Policy & Procedure for the Development and Management of Procedural Documents

Areas of focus from 2015/16 Report for 2016/17
Policy writers continued to be supported with training and decision making processes when considering equality.

All relevant documents that came before the Board and major committees continued to include the Trust's standard Due Regard, Equality & Human Rights Analysis

Translation & Interpreting services continued to be led and managed by the EDHR Lead with a revised Language and Communication Policy to support processes for communication support, circulated for comment from stakeholders.

Areas of focus for 2017/18

- Continue to support staff with EHRA's when developing procedural documents.

EDS2 Goal 4: Inclusive leadership	EDS2 Reference Number: 4.3
Outcome: Middle managers and other line mangers support their staff to work in culturally competent ways within a work environment free from discrimination	

Summary of Activity:

Staff Annual Awards
The Annual Staff Awards are an opportunity for the Trust to recognise great Leadership demonstrated by many members of staff who continue to consistently go above and beyond their everyday roles to ensure that patients and staff feel supported.

Mentoring
Mentoring opportunities are available to staff who wish to gain skills and knowledge from other managers. Shadowing opportunities are open to all staff wishing to gain an insight into other roles within the Trust.

Training
All staff are required to undertake mandatory Equality and Diversity (E&D) training every 3 years, either face to face or via E-learning. E&D training forms part of the Trust induction programme. Line managers are offered additional training for cultural awareness and also training for completing Equality & Human Rights analysis when developing policies, procedural documents, guidance, strategies etc. These are offered on a one to one basis and group sessions including telephone support.

The number of Equality, Diversity & Human Rights face to face training sessions for all staff have continued to increase.to ensure equality, diversity and inclusion is embedded into everyday practices.

Training packages were developed to equip managers with the skills to tackle prejudice arising from communication needs. Sessions have been included as part of the Trust induction programme and staff from all clinical units have received training on processes and procedures for supporting patients with communication needs, which can be disseminated amongst teams.

Further training is planned during 2017/18 including Transgender awareness, providing managers with the knowledge to meet transgender patient needs, support initiatives, best practice and support colleagues transitioning at work. Identify funding sources for basic BSL lessons to support basic social communication with deaf patients.

Grade:	DEVELOPING

Evidence for grading:

- Equality & Human Rights Policy
- Equality and diversity training evaluations
- NHS Staff Survey results

Areas of focus from 2015/16 Report for 2016/17
Mentoring schemes will equip managers with the skills to promote positive cultural change
Mangers continue to be offered developmental master classes to ensure they are equipped to support their teams. The master classes include coaching and mentoring skills.

Uptake of mentoring opportunities will be analysed and reported in the next EDS2 report.

Areas of focus for 2016/17

- Identify sources of funding to support basic BSL lessons for staff.
- Communicate dates for Transgender awareness training.

Patient Equalities Analysis to Support EDS2 Report 2016/17

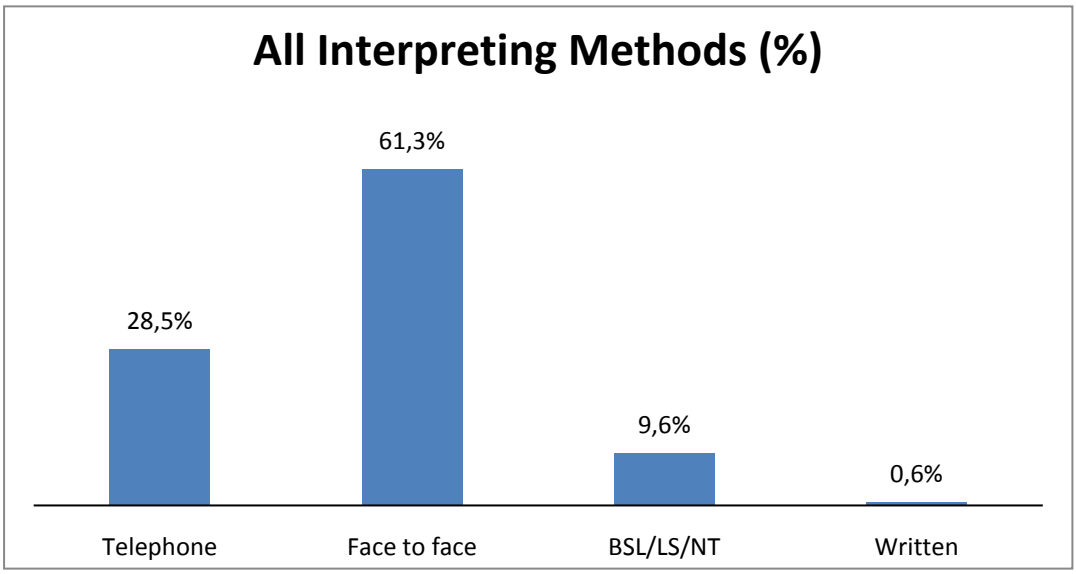
Interpreters provided for Sensory Support 2016/17

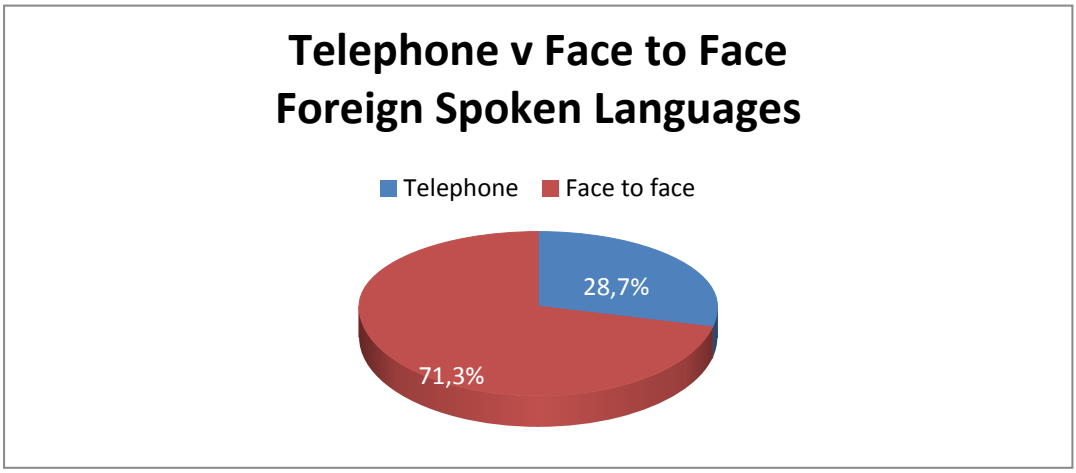
Language Requested	Total	St Leonards	Eastbourne	Surrounding
BSL	140	59	61	20
Lipspeaker	0	0	0	0
Note Taker	1	0	1	0
Total	**141**	**59**	**62**	**20**

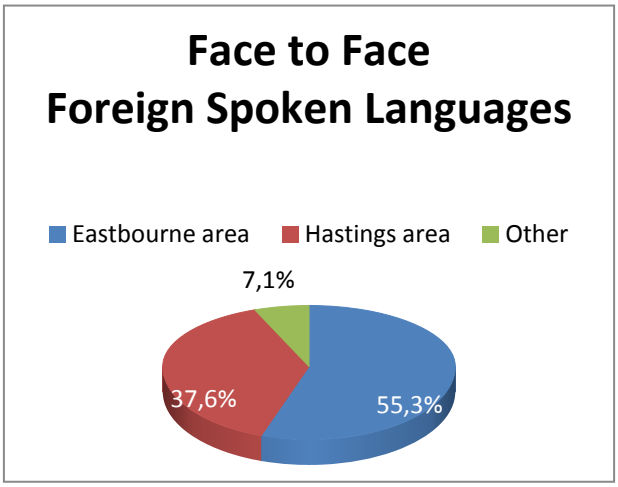
All interpreters supplied to patients, service users or carers during 2016/17 in order of most requested

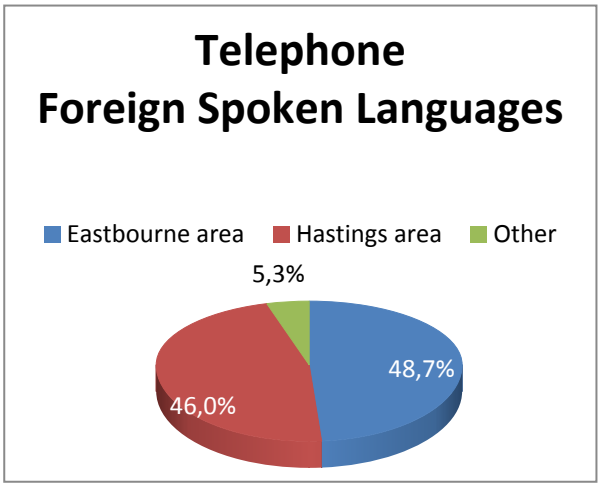
Language Requested	Total	St Leonards	Eastbourne	Surrounding
Polish	197	33	144	20
Mandarin	184	130	39	15
BSL	140	59	61	20
Portuguese	128	7	117	4
Russian	93	36	55	2
Farsi	84	30	54	0
Arabic	84	33	43	8
Bengali	77	19	51	7
Bulgarian	69	15	54	0
Albanian	53	31	22	0
Spanish	46	17	23	6
Cantonese	37	15	12	10
Turkish	33	13	18	2
Czech	30	28	2	0
Kurdish (Sorani)	30	27	3	0
Romanian	29	19	8	2
Tamil	25	7	15	3
French	18	7	11	0
Italian	17	3	12	2
Lithuanian	17	6	10	1
Vietnamese	16	11	5	0
Hungarian	12	7	5	0
Slovak	13	13	0	0
Amharic	10	10	0	0
Pashto	7	7	0	0
Latvian	5	5	0	0
Urdu	4	0	4	0
Dari	2	2	0	0
Sylhetti	2	0	2	0
Tagalog	1	0	1	0
Note Taker	1	0	1	0
Dutch	1	0	1	0
Punjabi	1	1	0	0
Total	**1466**	**591**	**773**	**102**

ESHT Interpreting Methods (%) 2016/17

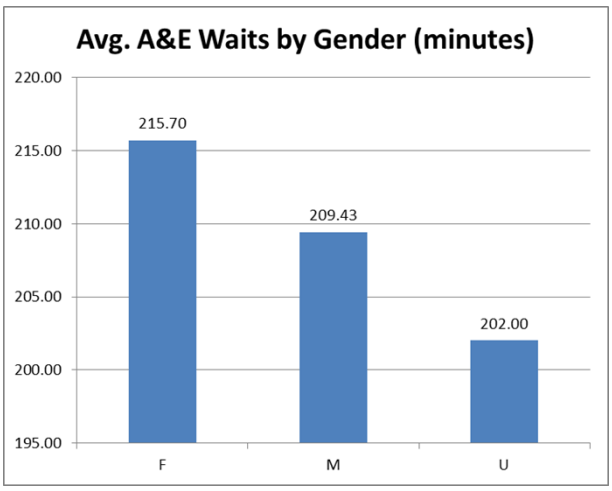


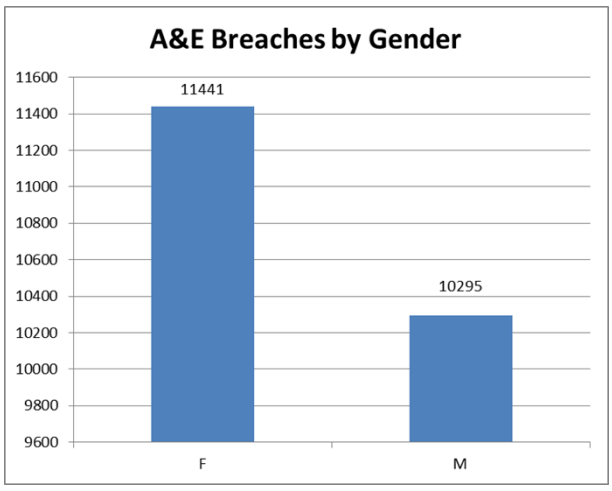


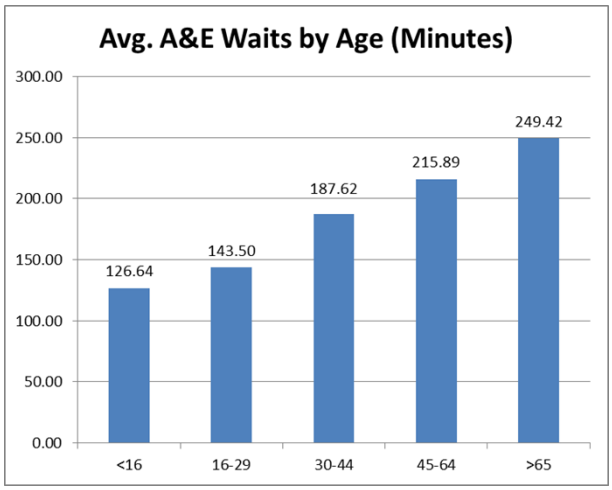


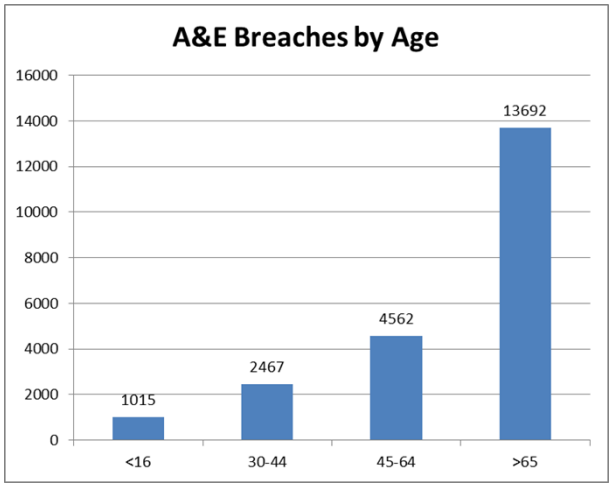


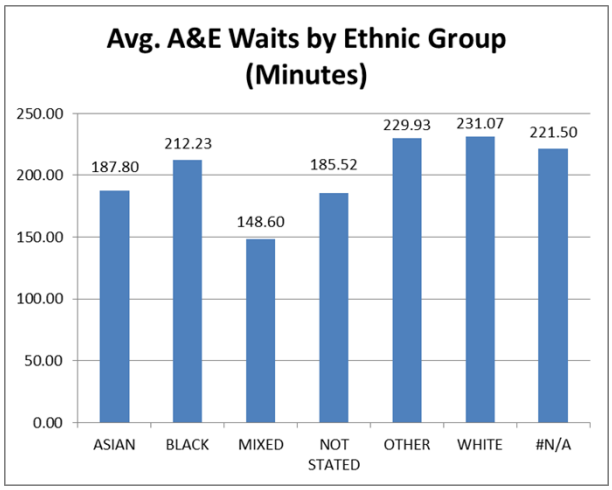
Accident & Emergency waiting times 2016/17

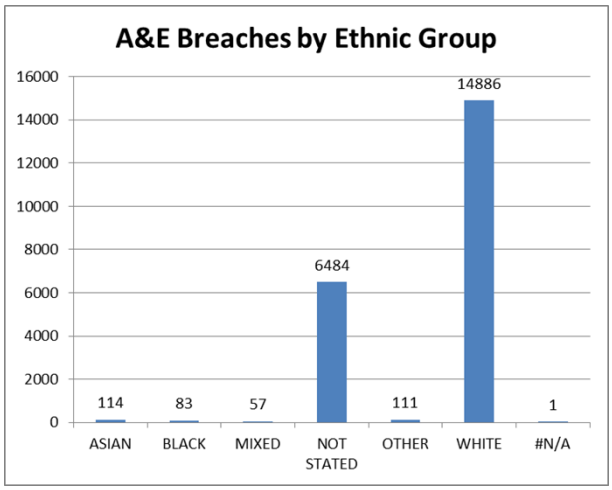










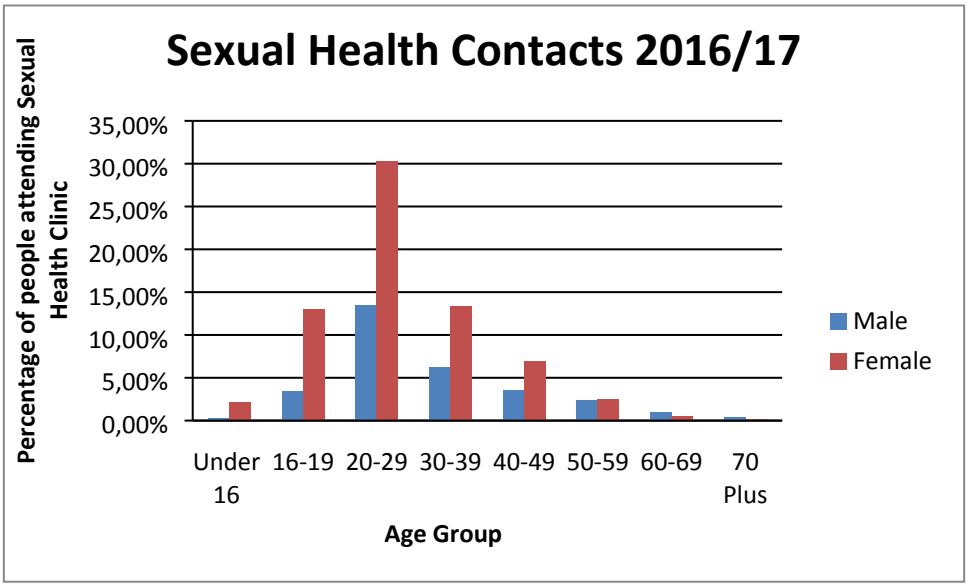


ESHT Risk Adjusted Mortality 2016 (RAMI) April 2016 to March 2017 35 Years and Over by Age Band

	Male		Female		Total	
Age band	Observed deaths	RAMI Index	Observed deaths	RAMI Index	Observed deaths	RAMI Index
35-39	1	107	1	71	**2**	**85**
40-44	6	129	2	115	**8**	**125**
45-49	12	146	4	73	**16**	**117**
50-54	18	132	6	89	**24**	**118**
55-59	21	103	13	90	**34**	**98**
60-64	27	89	25	137	**52**	**107**
65-69	46	84	36	93	**82**	**87**
70-74	83	108	61	109	**144**	**109**
75-79	98	90	83	86	**181**	**88**
80-84	142	100	125	110	**267**	**104**
85-89	126	78	175	87	**301**	**83**
90+	165	116	208	104	**373**	**109**
Total	**745**	**1282**	**739**	**1164**	**1484**	**1230**

Access to Sexual Health by Age, Gender and Sexual Orientation 2016/17

	Male	Female	Total
Sexual Orientation			
Heterosexual	26.52%	68.12%	94.64%
Gay/Lesbian	3.44%	0.19%	3.62%
Bi-sexual	0.75%	0.65%	1.41%
Not Known	0.13%	0.19%	0.33%
Total	**30.85%**	**69.15%**	**100.00%**
Age Group			
Under 16	0.28%	2.19%	2.47%
16-19	3.41%	13.07%	16.48%
20-29	13.53%	30.29%	43.82%
30-39	6.29%	13.36%	19.65%
40-49	3.52%	7.01%	10.52%
50-59	2.40%	2.52%	4.92%
60-69	1.05%	0.56%	1.61%
70 Plus	0.37%	0.15%	0.52%
Total	**30.85%**	**69.15%**	**100.00%**



Workforce Profile broken down by protected characteristics

East Sussex Healthcare NHS Trust employed 6867 people as of 31st March 2017

Workforce breakdown by protected characteristics.

Ethnic Origin	Percentage of Employees (%)
White	76.37%
BME	12.32%
Unknown	11.31%

Age Group	Percentage of Employees (%)
<=29 yrs old	14.11%
30-44	33.86%
45-59	42.64%
60-78	9.39%

Sexual Orientation	Percentage of Employees (%)
Bisexual	0.42%
Gay	0.41%
Heterosexual	58.63%
Lesbian	0.33%
Unknown	40.21%

Religion	Percentage of Employees (%)
Atheism	10.38%
Buddhism	0.51%
Christianity	37.09%
Hinduism	1.31%
Islam	1.21%
Other	6.09%
Unknown	43.41%

Disability	Percentage of Employees (%)
Yes	2.34%
No	46.24%
Unknown	51.42%

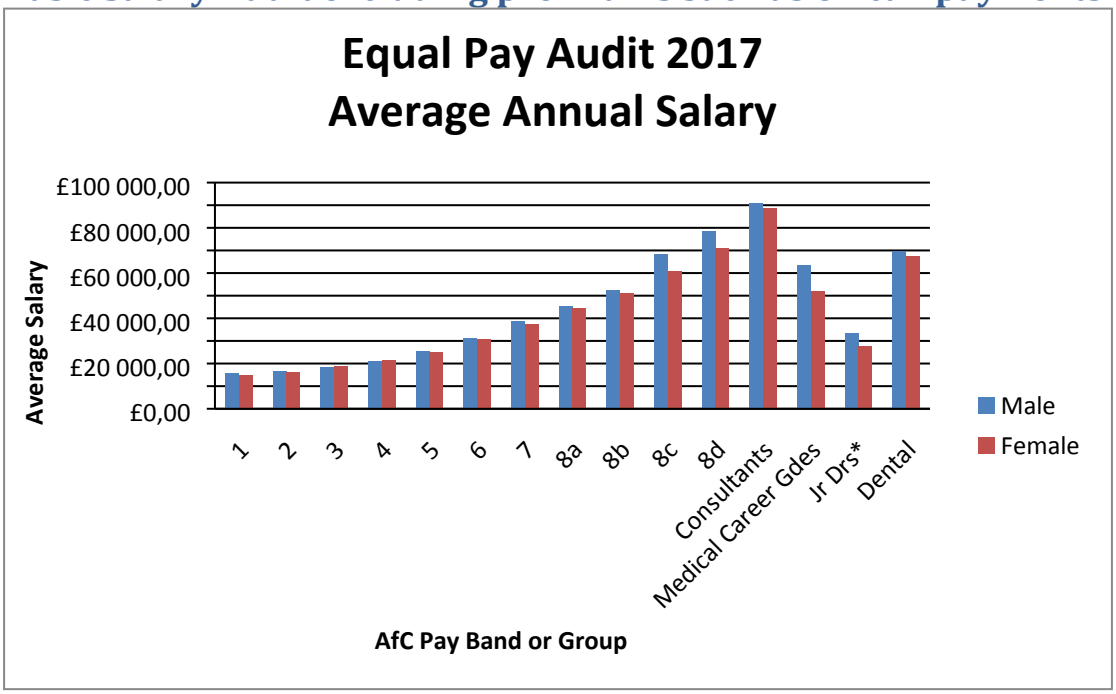
Gender	Percentage of Employees (%)
Female	77.52%
Male	22.48%

2015/16 Recruitment Annual Monitoring

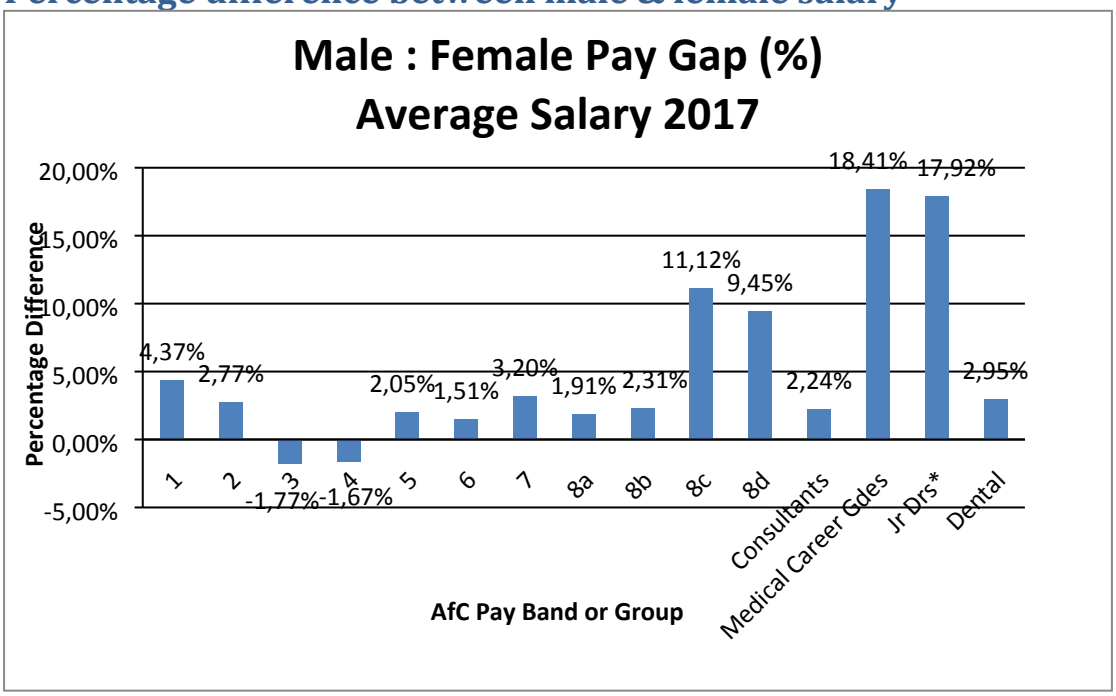
Percentage of application, shortlisting and appointment across the protected characteristics:

Characteristic	Applied	Shortlisted	Appointed
Gender			
Male	27.8	28.4	26.4
Female	72.1	71.4	73.6
Not stated	0.1	0.2	0
Ethnicity			
White	78.6	80	72.5
BME	17.7	19	17
Undisclosed	3.7	1	10.5
Disability			
No	32.8	29.6	37.6
Yes	5.5	4.9	5.3
Not stated	61.7	65.5	57.1

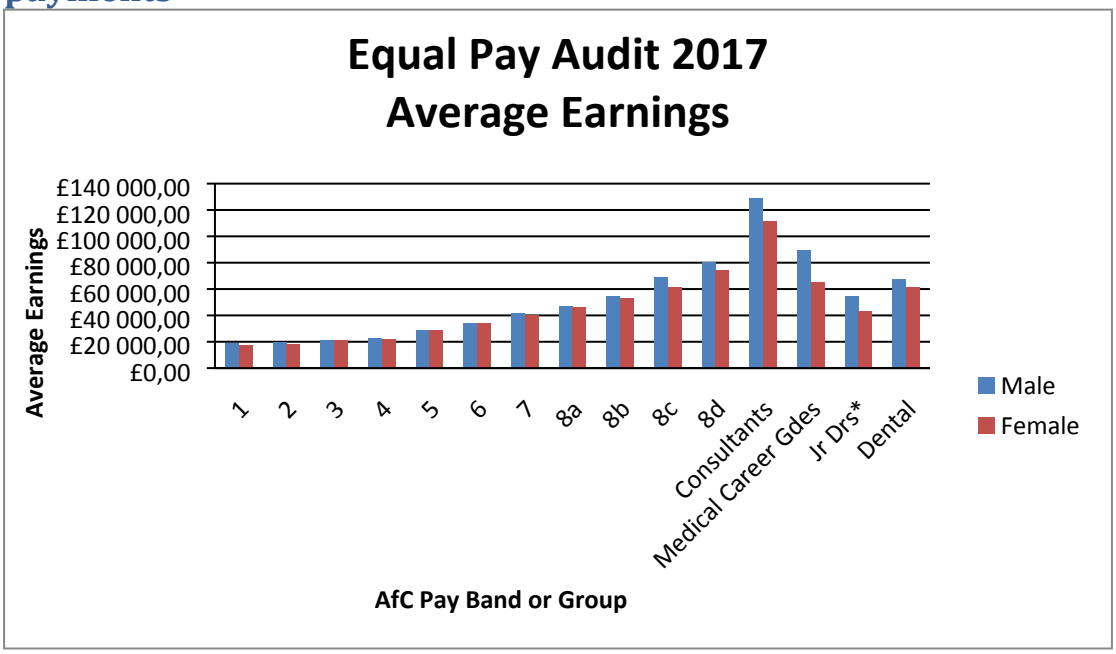
Basic Salary Audit excluding premiums such as on call payments



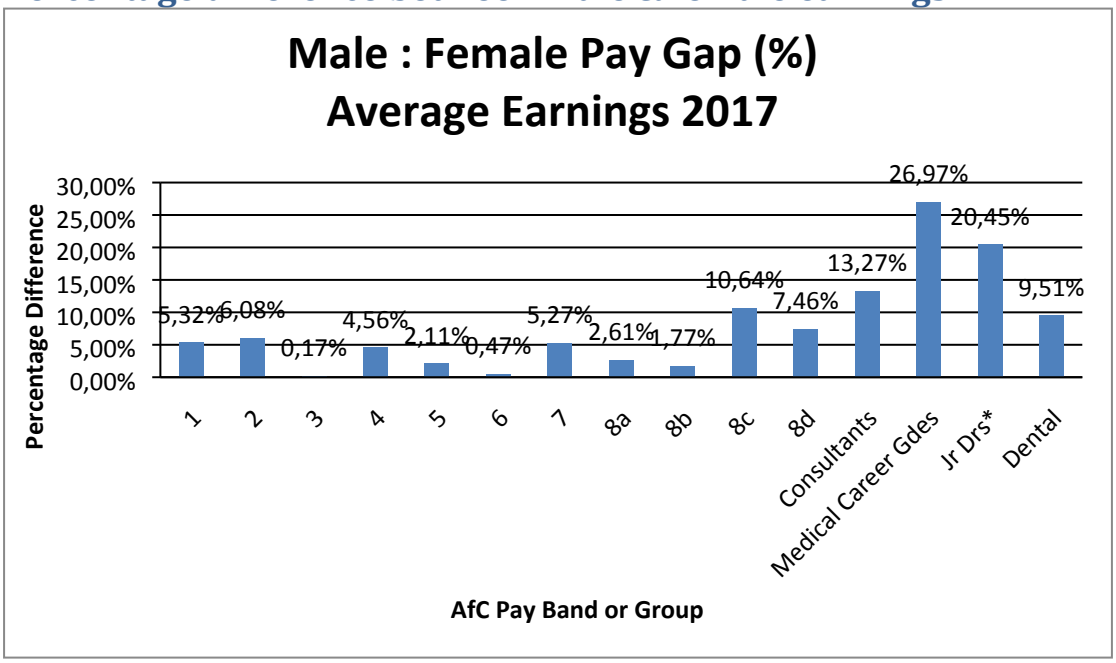
Percentage difference between male & female salary



Total earnings audit including premiums such as on-call payments



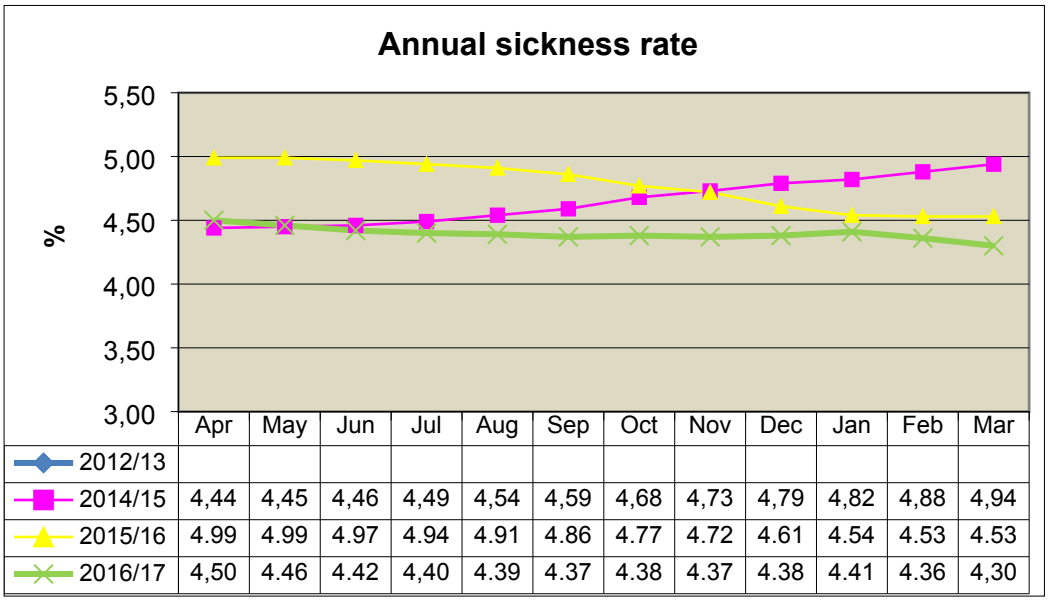
Percentage difference between male & female earnings



Maternity, adoption, paternity and paternity adoption leave taken during 2016/17

Staff taking Maternity, Paternity Adoption or Paternity Adoption Leave during 2016/17		
Protected group	**Maternity/Adoption Leave**	**Paternity/Paternity adoption Leave**
Ethnic Group		
White	79.93%	59.26%
BME	14.44%	29.63%
Not Stated	5.63%	11.11%
Total	100.00%	100.00%
Sexual Orientation		
Straight	70.07%	74.07%
LGBT	1.76%	0.00%
Not Stated	28.17%	25.93%
Total	100.00%	100.00%

Sickness absence rate. Three year trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13												
2014/15	4,44	4,45	4,46	4,49	4,54	4,59	4,68	4,73	4,79	4,82	4,88	4,94
2015/16	4.99	4.99	4.97	4.94	4.91	4.86	4.77	4.72	4.61	4.54	4.53	4.53
2016/17	4,50	4.46	4.42	4,40	4.39	4.37	4.38	4.37	4.38	4.41	4.36	4,30

ESHT 2015 – 2019 Equality Objectives

EDS2 Goal	EDS2 Goal	Method	Actions	EDS2 Outcome	EDS2 Outcome	Lead	Monitored / Reviewed
1	Better Health Outcomes	Review SI action points	Review learning from incidents to ensure we are not treating anyone less favourably and implement actions appropriately	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	1.4	Director of Nursing/ Patient Safety Lead	TNMAG EDS2/WRES SG
2	Improved Patient Access and Experience	Evaluate arrangements and awareness of existing interpreting and translation services	Enter a Service Level Agreement to implement a robust streamlined system providing easy access to interpreters. A post interpretation survey will be conducted by the interpreter. Raise staff awareness of access to interpreting service	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds People are informed and supported to be involved as they wish to be in decisions about their care People report positive experiences of the NHS	2.1 2.2 2.3	Company Secretary / EDHR Lead	EDS2/WRES SG
3	A Representative and Supported Workforce	Analyse percentage of BME staff at all levels of the organisation and ensure that the recruitment process is reflective of best practice.	Conduct analysis of BME staff at all levels and develop actions such as encouraging BME staff to participate in training and development opportunities Band 8+ recruitment panel will consist of a BME member or the EDHR Lead.	Fair NHS recruitment and selection process lead to a more representative workforce at all levels	3.1 WRES metric 1 & 2	Director of HR / Assistant Director Workforce Development	EDS2/WRES SG
4	Inclusive Leadership	Strategies, business plans and annual reports will require EHRA.	Approval of all strategies, business plans and annual reports that come before the Board, will be subject to completion of Due Regard, Equality & Human Rights Analysis, which includes how inequalities will be managed.	Papers that come before the board and other major committees identify equality –related impacts including risks, and say how these risks will be managed.	4.2	EDHR Lead / Assistant Director of Nursing (Safeguarding)	EDS2/WRES SG

ESHT 2015 – 2019 Equality Objectives Progress 2016/17

EDS2 Goal	Method	Actions	Completion/ target date	Risk	Lead
1	Review SI action points	Review how learning outcomes link to incidents Triangulate SI, Learning outcomes Review outcomes	May 15 Dec 16 Dec 17	Complete Complete On target	DATIX Team SI Lead EDHR Lead
2	Evaluate arrangements and awareness of existing interpreting and translation services	Service Level Agreement implemented with robust streamlined system providing easy access to interpreters. KPI's agreed Training to raise awareness of access to interpreting service A post interpretation survey will be conducted by the interpreter. Review post interpretation survey feedback	Jun 16 Jul 16 Jul 16 Jan 18 Jan 19	Complete Complete Ongoing On target. Financial impact may be risk	Procurement Director, Corp Affairs EDHR Lead Capita EDHR Lead EDHR Ass Capita Capita Service users EDHR Lead Patient Experience team
3	Analyse percentage of BME staff at all levels of the organisation and ensure that the recruitment process is reflective of best practice.	Band 8+ recruitment panel will consist of a BME member or the EDHR Lead. Conduct analysis of BME staff at all levels and develop actions Deep dive into BME recruitment (application – offer stage Develop action plan to support BME recruitment embed into WRES	May 15 May 16 May 17 July 17	Ongoing. Risk of no BME staff at interview Complete Complete Complete	Director of HR / Assistant Director Workforce Development
4	Strategies, business plans and annual reports will require EHRA.	Policy Group to embed new EHRA into Policy for Policies New EHRA mandatory Audit Policies for EHRA uptake Audit Policies for EHRA uptake	May 15 Jun15 Jun 16 Jun 16	Complete Complete 100% uptake 100% uptake	EDHR Lead / Assistant Director of Nursing (Safeguarding)

Further breakdowns of data contained in this report are available upon request by contacting the Equality & Human Rights department.

This document is available, upon request, in alternative languages and formats, such as large print, Braille, Audio and electronic. Please contact the Equality and Human Rights Department for further information on: 01424 755255 ext 8353

Annual Fire Report

Meeting information:			
Date of Meeting:	26th September 2017	Agenda Item:	13.3
Meeting:	Trust Board	Reporting Officer:	Norman (Jan) Ingram, Senior Fire Advisor

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:	.....		
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? Yes	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This annual report covers the period of 1st April 2016 to 31st March 2017.

It is noted that the Trust has in place the appropriately qualified and experienced fire safety advisors, systems, training and fire safety risk assessments according to the requirements of HTM 05-01 (2013). Clinical units continue to attend the mandatory training sessions for fire safety and the attendance has been steadily increasing post April 2016.

The level and number of risks should decrease over the next 5 years through investment arising from the 2016-2021 Capital Plans, albeit the Trust will have in place a degree of risk related to fire safety during this period.

Given the report is retrospective in nature then ordinarily it would not look forward. However given the Grenfell Tower tragedy an addendum has been added to the report to consider its potential impact upon ESHT.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

None.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

To note the contents of the report.
To consider the requirement for year on year increases in both capital and revenue investment for at least the next four years until existing risks are reduced to an acceptable level/ achieve statutory compliance.
To undertake a “balanced” risk assessment to consider the impact of the identified compartmentation issues against those resulting in ward closures to undertake the remedial work.

East Sussex Healthcare NHS
NHS Trust

Annual Fire Safety Report

1st April 2016 – 31st March 2017

FINAL - V1.3 9th July 2017

In accordance with HTM 05-01 2013 “Managing Health Care Fire Safety”, the role of Fire Safety Manager is undertaken by Chris Hodgson, Associate Director of Estates and Facilities

Compiled and completed by
Norman (Jan) Ingram
Senior Fire Advisor
Property Management

July 2017

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

CONTENTS

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

EXECUTIVE SUMMARY

The Annual Fire Safety Report (AFSR) has been prepared by the Senior Fire Safety Advisor to provide underpinning information to the Trust Board, to report all relevant risks and where necessary make recommendations for compliance purposes.

Policy:

The 2013 Fire Policy reviewed in 2016 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2015 second edition. However following learning outcomes of the chiller incident in October 2016 at EDGH, a further review of fire incident management is required and is underway. The agreement to strengthen the on-site clinical teams will assist in future management of any out of hours incidents.

Fire **Safety Protocols** are being developed to assist staff with reference material for all aspects of Fire Safety Management identified in HTM 05-01. With 80% now complete, it is the intention to complete the remaining documentation by the 31st July 2017.

Risks:

The Trust is currently carrying a **Major risk** in relation Patient and Staff Safety, Statutory Duty (enforcement) and service interruption. The previous Extreme risk was reduced to major following amalgamation of Trusts risks during 2016/17. Premises do not comply with the regulatory reform (Fire Safety) Order 2005 (RRO) in certain respects as noted within this report. Please refer to section 5 for further information on these non-conformances.
Details of these deficiencies are contained in Appendix A and B.
Considerable capital investment is required within the next 1-3 years to achieve statutory compliance.

Training:

Mandatory Fire Training is at **85%** of Trust Staff trained. There is a variation of 1-2% attendance each month depending on seasonal issues and other Trust pressures.
Fire Drills - 537 Staff have been trained.
Fire Wardens- 83 Staff have been trained.

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

Fire Risk Assessments:

The (RRO) includes requirement for all premises and areas within Trust premises to have a suitable and sufficient current Fire Risk Assessment and for a safe means of escape for all relevant persons to be maintained.

- 100% of the 170 **Acute** Hospital areas have been subject to risk assessments in the past 12 months.
- 100% of **Community sites** have been subject to risk assessments in the past 12 months.

Operational Maintenance:

The outcomes of the planned preventative maintenance of fire related equipment is increasing in nature as systems expand and national guidance is changed. Therefore the additional operational maintenance issues will require additional revenue funding year on year e.g. fire dampers.

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

1.0 PURPOSE

To provide underpinning information to the Trust Board, to report all relevant risks and where necessary make recommendations for compliance purposes.

1.1 Context

The key challenge for the Trust is to ensure a safe healthcare environment for all relevant persons, compliant with fire safety legislation.

Effective Management of Fire Safety is essential to preserve life, lower the impact of any fire on business continuity and care and is a legal requirement under the auspices of the RRO and the suite of HTMs

To ensure identification and appreciation of Fire Safety risks, monthly fire reports are forwarded to the Fire Safety Manager and quarterly fire reports forwarded into the Health and Safety Steering Group (HSSG). Risk register entries are compiled to highlight statutory deficiencies.

1.2 Legal background

The Regulatory Reform (Fire Safety Order) 2005 came into effect on 1 October 2006 and applies to England and Wales. The Fire Safety Order replaces previous fire safety legislation.

2.0 FIRE SAFETY POLICY & PROTOCOLS

2.1 Fire Policy

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

The 2013 Fire Policy reviewed in 2016 reflects the new national guidelines included in Hospital Technical Memorandum (HTM) 05-01 2015 second edition. However following learning outcomes of the October 2016 at EDGH, fire a further review of fire incident management is required and is underway.

2.2 Fire Safety Protocols

Fire Safety Protocols are being developed to assist staff with reference material for all aspects of Fire Safety Management identified in HTM 05-01.

Personal Emergency Evacuation Plan (PEEP)	Ratified
Risk Assessments	Reviewed
Fire Safety Training	Reviewed
Normal Operating Procedures	Reviewed
Emergency Action Plans	Reviewed
Fire Prevention	Ratified
Fire Extinguishers	Reviewed
Fire Strategies	Complete
Construction and refurbishment	Complete
False Alarms and unwanted fire signals	Complete
Fire Extinguishers	Complete
Security	Complete
Arson	Complete
Hot Works	Complete
Maintenance of Fire Equipment	Complete

With 80% now complete, it is the intention to complete the remaining documentation by the 31st July 2017.

3.0 FIRE TRAINING:

Annual Fire Safety Report

April 1st 2016 – 31st March 2017

The current level of mandatory Fire Training is at 85%, which has increased from its lowest level of 62% in February 2012.There is a variation of 1-2% attendance each month depending on seasonal issues and other Trust pressures.

Spaces have been allocated to accommodate 120% of Trust Staff for 2016/17 to maintain and improve on this level of compliance.

The annual training needs analysis has been completed and the training presentation content amended accordingly.

The training figures for the past three years are shown below for comparison.

Year	2014/15	2015/16	2016/17
Number of ESHT Staff	6285	6146	6476
Number of ESHT Staff in date	5342	5224	5504
Percentage	86%	85%	85%
Non ESHT Staff trained Volunteers, Sussex University and Doctors Surgery Staff)	701	565	504

3.1 Fire Warden Training and Fire Team Training

83 Fire wardens have received specific training by the Fire Department.

3.2 Practical Evacuation Exercises and Fire Drills

537 Staff have received specific training on their local emergency procedures by the Fire Department.

4.0 INCIDENT REPORTS

4.1 False Alarm Activations

Fire Alarm activations are now available to be recorded on the Datix Web Report system.
Alarm activations are within National guide Lines.

4.2 Fires

There were two fires during 2016/17 with no injuries reported.

23/10/16 Fire in plant room via a chiller unit and smoke bought into ED by air intake – learning outcomes –improvement to fire management systems required.

25/12/16 Baird Ward –Patient lit a small piece of paper. Investigation carried out at the time by Clinical Site Manager.

A table and analysis of Fire Calls is attached at **Appendix C.**

5.0 RISKS

5.1 Risk Assessment

The Regulatory Reform (Fire Safety) Order 2005 (RRO) requires all premises to have suitable and sufficient current Fire Safety Risk Assessments in place. The suitability being assessed against a series of guidance notes specific to the accommodation type and the annual external audit from the Authorising Engineer. The fire risk assessment template has been revised during 2016/17 to include additional control measures to assist in continuous improvement.

- DDA Requirements
- Fire Door operation
- Compartmentation

Combined building and staff FRAs are carried out for Trust premises and Staff only FRAs for buildings not owned by the Trust.

5.1.1 100% of the 170 Acute Hospital areas have been subject to risk assessments in the past 12 months.

100% of the Community sites have been subject to risk assessments in the past 12 months.

5.1.2 Infrastructure Risks

The Trust is currently carrying a Major risk in relation Patient and Staff Safety, Statutory Duty (enforcement) and service interruption. The previous Extreme risk was reduced to major following amalgamation of Trusts risks during 2016/17. Premises do not comply with the regulatory reform (Fire Safety) Order 2005 (RRO).
Details of these deficiencies are contained in Appendix A and B.
Considerable capital investment is required within the next 5 years to achieve statutory compliance.

A list of infrastructure risks has been identified from the outcome of Fire Risk Assessment findings and the requirements of East Sussex Fire and Rescue Service Audits. The Trust has non -compliance issues in the areas of Compartmentation, Emergency lighting and Residency fire alarms. A summary is provided in Appendix A and details in Appendix B.

It is essential that capital investment to resolve those risks is actioned and continued annually to demonstrate a responsible and proactive approach to dealing with fire safety issues and compliance requirements.

The risks identified have yet to be progressed with the exception of the EDGH Compartmentation Project, which has had only relatively limited effect on our overall fire compliance positon to date.

5.1.3 Operational Maintenance

Operational maintenance includes the day to day maintenance of the both active and passive fire related equipment; including fire alarms, fire dampers, fire extinguishers, fire doors and emergency lighting systems.

The outcomes of that planned preventative maintenance of fire related equipment is increasing in nature as systems expand and national guidance is changed. Annual inspections are now required to fire dampers (Conquest has approximately 500 and EDGH 700). The replacement of Conquest's fire alarm increased the number of devices (detectors and call points) from 1500 to approximately 5000.
Therefore the additional operational maintenance issues require additional revenue funding to be completed.
Revenue budgets should be reviewed to meet these challenging statutory requirements.

A summary is provided in **Appendix A**

6.0 AUDIT AND REVIEW

6.1 An Audit of Trust Fire Safety Management systems has been undertaken by the Authorised Engineer and a report received, the recommendations of which are highlighted in **Appendix D**.

6.2 Compliance with legal requirements will be reviewed each Month by the Estates Department to provide Independent assurance and advice.

7.0 LEGISLATION UPDATES SINCE THE PREVIOUS REPORT

7.1 Any new guidance and amendments from Hospital Technical Memorandums has been considered and department processes amended.

8.0 LIASION WITH EAST SUSSEX FIRE AND RESCUE SERVICE.

EDGH:

24th March 2016 –Compartmentation issues EDGH.

17th August 2016 - Compartmentation issues EDGH.

17th October 2016 –Large Fire Exercise Endoscopy Building –Ground Floor.

2nd February 2017 Compartmentation Meeting at ESFRS HQ.

Conquest:

28th April 2016 –Local Crews –Update risk information

15th July 2016 Automatic Fire Detection issues-letter.

16th December 2016- Automatic Fire Detection issues-letter.

N Ingram

Senior Fire Safety Advisor

3rd July 2017

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Appendix A – Infrastructure Risk Summary

ITEM	Reference Number	RISK ASSESSMENT					ACTION required Insert actions required to reduce/eliminate risk	COST					COMMENTS
		Domain	C	L	RR	Risk Phrase		Year					
								2014/15	2015/16	2016/17	2017/18	2018/19	
Fire- Physical Environment – Buildings and Services	**1410**	Safety	4	3	**12**	Major	**Compartmentation EDGH :** Annual funding required for upgrading compartment walls and doors. Project planning only. No physical investment 2016/17 due to project timings. **Emergency Lighting Conquest:** Maternity and Central System. Project planning only. No physical investment in 2016/17.Works planned for 2017/18 **Compartmentation Conquest:** £6K invested breaches in-filled. Now a low risk **Fire Dampers EDGH/CQ, Bexhill and Irvine Unit:** No physical investment 2016/17 **EDGH Residencies:** Fire alarm remedial requirements identified since 2011. Scoping Group to be formed. **CQ Residencies:** £60k forthcoming. Upgrade of all remedial fire alarm works to be complete July 2017.			£165K	£750K	£750K TBC	
		Statutory Duty / Inspections	4	3	**12**	Major							
		Service Interruption	4	3	**12**	Major							
		Statutory Duty / Inspections	4	3	**12**	Major							
		Service Interruption	4	3	**12**	Major							
		Statutory Duty / Inspections	4	3	**12**	Major							
		Service Interruption	4	3	**12**	Major							
		Statutory Duty / Inspections	4	3	**12**	Major				£60K			
		Service Interruption	4	3	**12**	Major							

Appendix B Infrastructure Risk details

B1.0 Fire Damper Testing and Maintenance

B1.1 EDGH:

Following an Estates and Facilities request to comply with national damper testing requirements, sample testing of Fire Dampers at EDGH was carried out. 40% of the sample were defective .Damper maintenance was not being carried out due previous removal of that revenue funding.
Recommendation- A programme of maintenance and testing should be introduced and supported through revenue. Initially the site would need to be redrawn and then the dampers identified for testing on a risk basis. Drawings progressed however no completed. In addition damper testing would mean disruption to patients as ceiling tiles would have to be removed to gain access and this would also lead to potential asbestos exposure. No progress since 2015/16 report.

B1.2 Conquest:

Following an Estates and Facilities request to comply with national damper testing it was found that fire dampers were tested every 3 years, however the legal requirements is now annually. This additional testing would require additional revenue support. No progress since 2015/16 report.

B1.3 Bexhill and the Irvine Unit:

Initial testing in 2015. No progress since 2015/16 report.

B2.0 Fire Compartmentation EDGH:

Parts of the EDGH were built with “crown immunity” and not covered by the Fire Precautions Act 1971. Sixty minute Fire Compartments were not properly established also alterations over time have caused breaches in the established fire compartments.

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East Sussex Fire and Rescue visited in 2010 and 2012 regarding this issue. Their instruction dated 10/2/2012 on the "Record of Inspection SF21" was a requirement to plan, identify and upgrade all identified 60 minute fire compartments.

A comprehensive compartmentation report was commissioned on the 3rd of July 2013 and the report received from the Fire Protection Association on the 1st November 2013.Subsequently a full intrusive survey of the EDGH has been carried out. The original 4 year programme of remedial works identified may well extend to 7 years.

We have met with East Sussex Fire and Rescue Service and as of our last meeting in February 2017 and recognised the Trust case that the continued full occupation of Phase 1 and asbestos issues meant that they were in broad agreement with the Trusts commitment of £250K per year to resolve the issue. Regular meetings are scheduled in order to maintain relationships and update progress of the Project.

Year 1 (2014/2015)

Progress with the upgrade to the buildings Phase 2 fire 60 minute fire resisting doors:

- £250K Committed
- Orders issued for 74 single and double 60 minute door sets
- Accredited installers instructed to supply and install door sets.
- Installation of hour door sets on a rolling programme from October 2014 to 31st March 2015.
- Each door set will receive a certificate of conformity.

Year 2 (2015/2016)

- £250K Committed
- During installation unexpected issues have occurred regarding the structure.
- Suspended ceilings will have to be replaced after their removal as will general emergency lighting.

Year 3 (2016/2017)

- Tenders sent out and scoping carried out (budget £165K).

- No work started. Delayed till 2017/18

B3.0 Fire Compartmentation Conquest:

Conquest Hospital breaches have been in-filled. Replacement of main theatre doors remain the last compartmentation issue. Now a low risk.

B4.0 Emergency Lighting Conquest:

The Building currently does not comply with British Standard 5266 - Emergency Lighting provision in the Maternity area.

B4.1 Central communal area system:

Five separate central systems linked together by a central controller cover the communal areas.

Due to the age of the system replacement parts cannot be sourced either new or second hand. No other maintenance support is available, system test reports cannot be accessed and there is a risk of whole or part failure of the system at any time.

B4.2 Maternity Area:

The maternity area does not have sufficient emergency lighting cover and is there is no emergency lighting provision in some areas. The system has been planned and tenders have been issued in 2016 and again in 2017.The issue should be resolved during 2017/18.

B5.0 Residency Fire Alarms:

B5.1 Conquest Residencies:

£60K invested in 2016/17 in a new fire alarm system and on completion in July 2017 risks will be reduced to an acceptable level.

B5.2 EDGH Residencies:

Apart from Fleming House and single family dwellings the fire alarm systems are not suitable and sufficient. Highlighted on FRA action plans since 2011.

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Existing systems apart from Fleming House are no longer supported by the contractor. Operational maintenance are trying to keep the systems “live” by using equipment taken from Harvey House the empty block.

Appendix C Analysis of Fire Calls

Call Type	Conquest	Conquest Residencies	EDGH	EDGH Residencies	Bexhill& ABC
Fires.	1**	0	1*	0	0
False Alarms –Fire Service called.	10	0	6	0	7
False Alarms –Fire Service not required.	22	2	51	93	0

*23/10/16 Fire in plant room and smoke bought into ED by air intake – learning outcomes – improvement to management systems

**25/12/16 Baird Ward –Patient lit a small piece of paper. Investigation carried out at the time by CSM

Appendix D - Recommendations of the Fire Engineers (AE) Audit 2016.

D1.0 It is recommended that the role of Fire Safety Manager (FSM) be devolved from the current deputy Chief Executive to the Associate Director of Estates and Facilities. **Complete.**

D2.0 It is recommended that the production of outstanding fire safety protocols be completed as soon as is reasonably convenient. Priority should be given to those for hot works and medical gases. **By end July 2017.**

D3.0 Practical Training in the use of vertical evacuation equipment, including evacuation mats and chairs needs to be introduced and formalised as soon as practicable. This training needs to be available to those members of staff (and volunteers where necessary) who can be expected to use this equipment. **On-going on a risk basis.**

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D4.0 It is recommended that a facility is introduced into the CAFM system that allows for automatic generation of actions following the discovery of defects during routine PPM activity. This process should include a reporting and monitoring facility to all levels of management using the system. **To be arranged.**

D5.0 It is recommended that all fire safety related defects and remedial work is reported through the CAFM system, so that a clear overview of fire related remedial (capital and revenue) is retained. **To be arranged.**

D6.0 It is recommended that arrangements are made to ensure the timely release of funds for the compartmentation Project, so as to allow for detailed planning, along with a robust tendering process, in order to ensure the satisfactory delivery of this project. **No funds allocated in 2016/17.**

D7.0 It is strongly recommended that the compartmentation remedial work is extended to include separation issues in concealed areas as soon as is practicable. **No funds allocated in 2016/17.**

D8.0 It is strongly recommended that the preparation of ventilation and fire damper drawings for the EDGH site be completed as soon as possible. This needs to be followed by the introduction of a programme of testing of fire dampers at the EDGH site as soon as practicable. Dampers at the Conquest site should be tested annually. **No progress in 2016/2017.**

D9.0 It is recommended that staff accommodation at the Conquest site be included into the Trust's fire safety management system as soon as is practicable. **Complete.**

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April 1st 2016– 31st March 2017

Addendum Grenfell Tower Potential Implications

Following the tragic events at Grenfell Tower, we have carried out a high level review and identified potential issues that arise from this tragedy, Points of particular note are:

- There is no Aluminum Composite Material (ACM) cladding as implicated in the fire spread at Grenfell installed at any Trust owned accommodation. We have confirmed with NHSi that we do not have ACM's,
- There is cladding installed throughout the main Trust buildings at 3 of its 4 main inpatient services sites; Conquest, Eastbourne and Bexhill Irvine Unit (none at Rye) ,
    - In the main the claddings are of the original construction type installed at construction and we understand that they were approved materials at the time of construction
    - The most recent cladding installed in 2012/3 at the 2 storey Endoscopy building at Eastbourne is a rain screen type and we understand that the rain screen cladding is certified as Class O fire retardant material,
    - We have carried out our own rudimentary in-house combustibility tests on samples of cladding materials, panels etc. from the 3 main inpatient sites and following these tests, 1)we have replaced six cladding panels with material of another fire retardant type material at Bexhill Irvine Unit (the majority of panels at Bexhill were found to be suitable) and 2)it was noted that although the internal courtyard cladding panels within Phase 1 at Eastbourne did not combust, we did note smoke was given off during the test.
- Height of buildings is considered to be a risk factor (usually buildings over 8 storeys are of concern due to pump ladder/pump access issues)
    - At the two main inpatient hospitals, Conquest and Eastbourne is 3/4 storey inpatient accommodation,
    - Our residential accommodation at Eastbourne and Conquest is mainly of 2/3 storey brick/concrete construction type with the exception of Fleming House at Eastbourne which is 8 storey and in itself has emergency lighting, fire alarm and dry risers in full operation.
- We have been in dialogue with East Sussex Fire and Rescue Services (ESFRS) and NHSi and at the writing of this report we are expecting imminent visits by ESFRS to

review our cladding and fire systems arrangements at Conquest, Bexhill and Eastbourne hospitals.

- Phase 1 of Eastbourne was designed and built in the early 1970's to a particular South East hospital model and given its age was not subject to Health Technical Memorandums (Phase 1 is considered to be Seaford, Halisham wards, etc., but excludes the medical wards within Phase 2 such as Folkington, Pevensey etc)
    - The Compartmentation area within Phase 1 is horizontal per floor in nature and are considered to be large compared to modern standards. For example one compartment is for the whole of Seaford Wards 1-4 inclusive.
    - As per the main report we have an ongoing dialogue with ESFRS over time on upgrading this compartmentation to reduce the risk. Given the difficulty of being able to access the wards and asbestos being found in the structure around the works area, our focus to date has been on achieving 30/60 minute fire resistant structure as appropriate on corridors, stairwells etc. Works within the ward due to access and construction issues has not been considered to be a priority up until this point.
    - We are anticipating that the position around regulatory inspection will change and indeed having carried out an internal review, we have now started to re-plan our strategy by planning to introduce sub-compartmentation within Phase 1.
- At all four main inpatient sites are within the main, subject to some exceptions as noted within the body of this main report, have in place fully operational and maintained fire alarm, emergency lighting systems and where appropriate, dry risers are installed and maintained as required. We do not have any sprinklers systems installed at any of our sites.

Issues to be revisited/reviewed;

- Review of desktop emergency evacuation processes and live test - to be undertaken with Fire Advisors, Emergency Planning Office and Hospital Director with the initial emphasis on Eastbourne by the end of FY17/18 Q3 at the very latest
- Bring forward plan to address and complete the EDGH compartmentation within Phase 1 in the next 2 years and replace internal courtyard cladding. The review will be completed during FY17/18 Q2, and we will need to confer with clinical colleagues

on the impact of this accelerated works and ESFRS on its acceptability. It will likely have an impact upon clinical activity as some areas will require to be moved out whilst the works takes place (asbestos will need to be removed prior to works taking place). We will need to review the capital works program as it will likely increase the funding from the anticipated £250K to £750K per annum.

Winter Preparedness

Meeting information:			
Date of Meeting: 26th September 2017		Agenda Item:	14

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐
Meeting: Trust Board		Reporting Officer: Joe Chadwick-Bell	

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

An East Sussex Winter Plan has been developed under NHS England guidance in order to ensure that there is sufficient capacity to meet the pressures of winter in the East Sussex Health and Social Economy (LHE). This includes, where appropriate, reforming, improving and redesigning the wider Urgent and Emergency Care system, reductions in delayed transfers of care, bed capacity modelling and capacity planning.

The system plan has been submitted to NHS Improvement and NHS England via the CCG for assurance. The plan covers not just the actions of the Trust but all other health and social care partners.

The plan reflects learning from winter 2016/17, changes to services, newly identified pressures and known forthcoming developments, such as the introduction of Primary Care Streaming at the front door of A&E, which will become operational from October 2017. It will ensure the organisation is able to provide seamless, safe timely care despite variations in demand.

The Winter Plan is supported by the Surge & Capacity plan which describes the way in which the East Sussex Local Health Economy will respond to the additional demands of pressures throughout the year.

At this time the additional capacity required outside of the Trust remains subject to funding confirmation and will be discussed further at the Alliance Executive Group on 25th September 2017. .

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality & Safety Committee on 27th September 2017

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Trust has detailed and robust plans to address activity surges over winter, which have been developed in the context of the wider East Sussex system. The Board is asked to receive assurance that the Trust's winter capacity plans will be reviewed in full by the Quality & Safety Committee on 27th September 2017.

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Tuesday 31st May 2017 at 12.00am in Committee Room, Conquest

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

In attendance Dr Adrian Bull, Chief Executive
Ms Janine Combrink, Director, BDO
Lydia Crouch, Deputy Head of Financial Services
Mr Stephen Hoaen, Head of Financial Services
Mr Jonathan Reid, Director of Finance
Mr Mike Townsend, Regional Managing Director, TIAA
Mrs Lynette Wells, Director of Corporate Affairs

Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

029/17 Welcome and Apologies for Absence

Mr Stevens opened the meeting and introductions were made.

Apologies for absence were received from:

Mr Jody Etherington, Audit Manager, BDO
Mr Chris Lovegrove, Counterfraud Manager, TIAA
Mr Adrian Mills, Audit Manager, TIAA
Dr David Walker, Medical Director
Mrs Alice Webster, Director of Nursing

030/17 Minutes of the meeting held on 23rd March 2017

i) The minutes of the meeting held on 23rd March 2017 were reviewed and approved as an accurate record.

ii) Matters Arising

It was noted that the meeting had been convened to review and sign off the accounts. Therefore, with one exception, matters arising were deferred to the next Audit meeting scheduled for Wednesday 26th July 2017.

National Adult Diabetes Audit
Mr Reid reported that a proposal had been received to appoint 0.5wte of a Band 4 member of staff as an administrator for the National Diabetes Audit. This had been approved and there was an expectation that the Trust would participate on a partial basis in the National Diabetes Audit during 2017/18 and on a full basis in following years.

Mrs Bernhauser asked why there had been such a delay in identifying that the issue could be resolved by employing a member of staff rather than by buying an electronic system. Mr Reid explained that funding for the electronic system had been considered but there were mixed reviews from other Trust's utilising the sysem. It had been decided that employing an administrator would be the best approach.

031/17 Quality Account 2016/17 Update
Mrs Wells reported that she was presenting the update on behalf of Mrs Webster. The update had previously been reviewed by the Quality and Safety Committee. External Audit had undertaken a review of a number of the metrics within the report, and this process was continuing. The date for publication and submission of the Quality Account was 30th June and Mrs Wells asked the Audit Committee to delegate authority to the Trust Chairman to sign off the Quality Account and this was agreed.

She asked that any comments be sent to her following the meeting. Mr Stevens highlighted a number of areas where he felt that improvements could be made.

Mrs Wells noted that the Quality Account would be formally received by the Board at the AGM in September.

The Committee noted the Quality Account 2016/17 Update.

032/17 Annual Accounts and Report 2016/17

i) ISA260 BDO Annual Governance Report on the Annual Accounts 2016/17
Mr Hoaen circulated updated annual report and accounts documents. Ms Combrink explained that audit work had not yet been completed, and that the deadline for submission of the Annual Accounts and Report was 1700 on 1st June.

She explained that there was a possibility that the ISA260 would not be signed off before the deadline. Significant differences existed between Trust and CCG income assumptions, due to the change in contract for 2016/17and the ISA260 could not be issued until BDO

had ensured that assumptions about expected income were correct.

Ms Combrink reported that an error had been identified in the Trust's Property, Plant and Equipment (PPE) valuation leading to an improvement in the final deficit reported for 2016/17 by £108k to £43.792million. Mr Reid reported that a thorough review of the Trust's asset management processes would be undertaken during 2017/18.

Materiality of £6.35million had been identified within the Trust's financial statements including £4.5million of unadjusted audit differences, largely relating to differences between CCG payables and ESHT receivables. Ms Combrink explained that this was above the performance materiality level for auditors and that work was being undertaken to reduce this figure prior to issuing the ISA260.

Ms Combrink highlighted the following key risks to the Trust which had been identified within BDO's audit report:

Management Override of Controls
No evidence of material misstatements as a result of management override of controls were identified.

Revenue Recognition
Significant mismatches between Trust receivables and CCG payables were recorded. The Trust remained in dispute with the CCGs in respect of income totalling £6.086million and there was the possibility that the dispute would have to be resolved by arbitration.

Remuneration and Staff Report
Due to the large numbers of changes at Board level within the Trust during 2016/17, minor errors had been identified within the remuneration and staff report. These errors had subsequently been corrected.

Valuation of Land and Buildings
Two errors in accounting had been identified. One of these related to the presentation of a revised valuation of the Trust's land and buildings within the accounts, and had been addressed.

Payroll Verification
Ms Combrink explained an area of deficiency had been identified within the Trust's payroll verification processes. Mr Reid reported that verification testing of all staff on the Trust's payroll would be undertaken during 2017/18.

Use of Resources
An adverse conclusion had been reached regarding use of resources

due to the Trust's significant deficit. Areas of improvement had been recognised but the Trust's lack of a medium term financial plan remained a concern.

Going Concern
Ms Combrink reported that NHSI would no longer offer letters of support to Trusts regarding going concern status as they had done previously. The going concern statement within the accounts and annual report had been amended to reflect this change.

Testing of Assets
BDO had been unable to verify two assets on the Trust's register. One of these had been reported as being disposed and the other could not be located, leading to a £24,000 difference. Mr Hoaen confirmed that both assets had recently been located, enabling valuation to take place. He explained that this would lead to a reduction in the auditors' concerns about materiality.

Employee Benefits
Ms Combrink reported that employee benefits had not been accrued for bank staff following year end, and were shown within the accounts partially as open reserves and partially as in-year accrual. Increased testing was taking place, especially around payroll accruals and she noted that the Trust was likely to be audited on employee benefits within the National Audit Office sample during the year.

Mr Reid reported that the CCG had given the Trust an additional £3million in cash and had been asked to provide acknowledgement that they would be willing to negotiate additional money to help resolve the differences between CCG payables and ESHT receivables. Dr Bull explained that negotiations with the CCG to resolve the difference had been ongoing for 3-4 months, and that Trust Executives were confident that the Trust's position was correct.

Mr Reid recognised the additional work that the auditors had needed to undertake in order to receive appropriate assurances and thanked them for this. Ms Combrink thanked the finance team for their help and patience during the process.

Dr Bull reported that a review would be undertaken at the end of the process to share learning from the audit process to make it easier the following year. Ms Combrink offered to co-ordinate a debrief meeting for the Trust and the new auditors, Grant Thornton.

ii) Annual Report including the Annual Governance Statement

The Committee approved the Annual Report and Annual

Governance Statement, noting that they would be updated prior to submission.

iii) Annual Accounts and Associated Certificates 2016/17

Mr Hoaen reported that the final deficit reported in the circulated accounts had been updated from £43.9million to £43.792million due to the reduction in the PPE dividend payable.

Increases in receivables and payables were reported. The increase in payables was driven by a shortage of cash within the Trust. The increase in receivables was driven by the year end catch up with accruals and the team would look to learn lessons from this in the future.

Mr Hoaen highlighted that the Trust's loan from the Department of Health now amounted to almost £90million, which would need to be repaid in the future. He noted that due to being in financial special measures the Trust would be charged interest at 6% on any additional loans.

Mr Nealon noted that the NHS had a different definition of going concern to other organisations. Mr Reid explained that it was assumed that the Secretary of State would continue to ensure the provision of services. Ms Combrink noted that even if the Trust merged or demised then accounts would still be prepared on a going concern basis as services would continue to be offered.

In response to a question from Mr Nealon, Mr Reid explained that depreciation within the Trust was valued at £11-12million. Mr Hoaen explained that capital investment was carefully maintained by the organisation.

iv) Internal Audit Annual Report and Head of Internal Audit Opinion for 2016/17

Mr Townsend explained that the paper contained TIAA's annual report and opinion and provided limited assurance as it had for the previous year, largely due to the Trust's financial position.

He reported that the audit team had made around 200 recommendations during 2016/17 with less high priority and slightly more routine recommendations than the previous year. The previous year had seen a large amount of directed audit work while 2016/17 had seen a more normal approach with most areas reviewed compliant. He explained that this was a positive sign that the Trust had a basic policy framework in place, and that significant improvements were seen throughout the year. He hoped that continued progress could lead to a conclusion of reasonable assurance for 2017/18.

Mr Townsend reported that two areas had received substantial assurance during the year.

Mr Stevens asked how often tiaa checked that audit recommendations had been undertaken. Mr Townsend explained that the Audit Committee received regular reports on progress and that these were checked using an online action tracker.

v) Section 30 referral letter

Mr Reid reported that a minor amendment had been made to the previously circulated Section 30 referral letter, and that it had subsequently been submitted to the Department of Health.

033/17 Audit Committee Annual Report 2016/17

Mr Stevens reported that the Audit Committee Annual Report had been written following a self-assessment exercise which had included responses from auditors. Very positive comments had been received about the Committee and the Annual Report would be presented at August's Trust Board meeting.

034/17 Date of Next Meeting

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

Wednesday 26th July 2017 at 1130 in the Committee Room, Conquest.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

FINANCE & INVESTMENT COMMITTEE

Minutes of the Finance & Investment Committee held on
Wednesday 26th July 2017 at 9am – 11.30am
In the Committee Room, Conquest

Present:
Mr Barry Nealon, No-Executive Director, Chair
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mr Mike Stevens, Non-Executive Director
Mrs Joe Chadwick-Bell, Chief Operating Officer
Mr David Clayton-Smith, Trust Chairman
Dr Adrian Bull, Chief Executive
Mr Jonathan Reid, Director of Finance
Mr Ian Miller, Director of Financial Improvement
Mrs Lynette Wells, Director of Corporate Affairs
Mr Dan Bourdon, Interim Deputy Director of Finance

In attendance:
Ms Jane Farrow, Deputy General Manager, DAS (for Michele Elphick)
Mrs Jenny Darwood, General Manager, Transformation
Mr Chris Hodgson, Associate Director for Estates & Facilities
Mrs Michelle Clements, General Manager, Facilities Services
Mr Mark Paice, General Manager, Estates Services
Miss Chris Kyprianou, PA to Director of Finance (minutes)

111/17	**Welcome and Apologies for Absence** Mr Nealon welcomed members to the Finance & Investment Committee meeting. Apologies were received from Miss Tracey Rose.	**Action**
112/17	**Minutes of the Meeting of 28 June 2017** The minutes of the meeting held on 28 June were agreed as an accurate record.	
113/17	**Action Log** (i) Financial Recovery Plan/FSM Update An update on the Clinical Services Review was discussed under minute item 121/17 below. (ii) Divisional Assurance Divisions were being invited to attend the Finance & Investment Committee meetings to present their plans and provide assurance, starting with DAS at today's meeting.	

	(iii) Cashflow – Monthly Report A more detailed update on cash was presented under minute item 117/17 below. (iv) Capital – Monthly Report A more detailed update on Capital was presented under minute item 118/17 below. (v) Refreshed Financial Plan A summary of the disputed items had been circulated to the Committee. (vi) Market Developments It was noted that the date beside the Clinical Site Safety Team (Hospital at night/OOH) business case had been updated to read 2017. The Committee noted that the analysis of the health visiting service was in progress. Once clarity was received regarding potential procurement a paper will be developed for the Executive Team for consideration and presentation at a board seminar. (vii) Annual Review of Committee Effectiveness This item was on the agenda for the Trust Board. (viii) Work Programme Mr Reid was discussing the alignment between agendas for the Finance & Investment Committee and People and Organisational Development with Ms Green.	
114/17	**Divisional Assurance – Diagnostics, Anaesthetic & Surgery (DAS)** At the June Finance & Investment Committee meeting, it was agreed that each Division would be invited to a meeting to present their plans and to explain the actions being taken to achieve their year end forecast, starting with DAS. Mr Nealon welcomed Ms Farrow to the meeting and explained that part of the role of the Committee to seek assurance, where it sees variances from the agreed plan, and to ensure that there are proper mitigating plans in place. The DAS report showed the following YTD financial position and variance to budget: • Variance of £691k overspent ytd (excluding contract income)	

and FOT of £1,308k overspent (also excluding contract income).

- Pay overspend of £306k is due to nursing & medical agency within surgical specialties, continued waiting list payments, Theatre agency staff and agency Radiographers backfilling vacancies, partly offset by vacancies within Critical Care, Pathology & HSDU. Planned recruitment to reduce pay costs and forecast variance by year end of £435k.
- Non Pay overspend of £185k due to increased Theatre activity in June, Radiology non-pay activity pressures and Contracted out Healthcare. Forecast assumes procurement savings and cease of all outsourcing to bring back in line with budget.
- Divisional Income -£199k – due to low Michelham Private Patient activity, HSDU (external contracts) & Cervical Cytology activity (Pathology). Forecast shows a challenging position but work being undertaken to review all income generation possibilities in the division
- Contract Income £1,700k, new Head of Contract income is reviewing variance to establish activity/ price variance against plan.

Ms Farrow reported that one of the major problems within the DAS Division was recruitment of medical staff in senior positions which has added to the locum agency spend along with ad hoc sessions to ensure that patients are treated and seen in appropriate time frames. Ms Farrow explained actions being taken to try and address this issue. The Committee noted that this was a national problem across the board.

Mr Bourdon reported that there was an impact on income from the HRG4+ but there was also lower than anticipated activity levels.

Ms Farrow gave an update on the type of activity that was coming through and explained how the balance of activity was being managed.

It was stated that the Division was doing as much activity as it could. 18 weeks was currently achieving and there were plans in place to meet the 62 day target in September. However there was a lot of demand coming through and Ms Farrow explained the mitigating actions in place to bring spend back in line with budget, including a proposal to stop waiting list initiatives by November.

Mr Reid explained that one of the things that the Trust was putting in place for this year was a weekly activity tracker that Ms Goldsack, Associate Director for Knowledge Management, had developed over the last few weeks.

Mr Nealon raised a query on Radiology which was an area that was not quite meeting the RTT. Ms Farrow reported that there was an equipment issue which will be resolved by the end of the year with the CT scanners, and also the Trust was one Radiologist down which was having an impact.

	Mr Reid drew the attention of the Committee to the slide showing the DAS mitigation actions as per early draft FOT which highlighted the actions being taken and how they will impact on the underlying run rate. Mr Reid reported that a detailed review was going on within the team to mitigate any variances from forecast outturn and said he would be happy to share the weekly activity report that is beginning to come through if this would be helpful. The Committee noted that the Division had plans in place to reduce its overall spend. The Division sought approval to undertake an initial scoping exercise and then action the outcomes of radical actions, to be presented to the IPR for approval to proceed. The Committee noted that DAS was working with all internal and external agencies to achieve FRP and CIP schemes. **Action** **The Committee noted update from the DAS division and the actions in place to bring the Trust closer to plan.**	
115/17	**Integrated Performance Report/Finance Report – Month 3** Mr Reid presented the refreshed Trust financial report at month 3 and highlighted the key messages. It was noted that the Trust continues to deliver on plan excluding a component of Q1 STF. 15% of the £9.9m STF funding is contingent on the Trust hitting the required trajectory on A&E performance. In Q1 the target was 90% and actual delivery was 83.2% and therefore the Trust has missed out on £223k income in quarter one. The Committee noted that the Trust had submitted an appeal to NHSI to recover the income. Mrs Chadwick-Bell reported that she would try and find out the timetable for this during her call with NHSI later today. The Committee noted that the Trust had delivered the plan in Q1. However the five operational divisions were in total £0.8m (£0.7m M2) adrift from plan YTD. Work is in train with divisions to ensure both that their baseline plans are right, and that actions to return to plan are in train The Trust has a £28.7m CIP target for 2017/18 which is phased towards the latter part of the year - at Month 3, the full £28.7m of schemes has been developed, and discussions are in train with budget-holders to ensure delivery and alignment within financial plans. In the YTD, the CIP number has been delivered – but continued focus is required to ensure delivery. The Trust continues to draw down loan funding to support operational	

	deficits, in line with the financial plan. Cashflow remains challenging resulting in increased creditor values and poor performance against the Better Payment Practice Code. The Trust has drawn cash equivalent to the income and expenditure deficit to date. The overall capital programme has a significant level of over-commitment as a result of demand for infrastructure and equipment requirements. The Capital Review Group (CRG) is closely monitoring capital spend and is forecasting delivery. Mr Reid reported that in total the contact income was on plan as a result of significantly increased activity levels. However, increased income in the Medicine division had been offset by reduced income in DAS, arising from increased non-elective activity. Mr Reid explained that the Trust had an improved relationship with the CCG and was strengthening the contractual review process. It was noted that there was currently a quarterly reconciliation process in place. It was agreed that an update on the reconciliation up to the end of June will be given at the August meeting. Mr Reid highlighted the trend graph for workforce pay costs which showed that the overall temporary staffing spend had increased year on year. It was anticipated that there would be an overall increase in expenditure. However there had been an improvement in some of the underlying factors such as agency, and a transfer of agency staff to bank. Mr Nealon queried what level of confidence the Trust had in delivering the CIPs for the remainder of the year. Dr Bull reported that work was ongoing within each of the workstreams which was being reviewed at the Financial Improvement & Sustainability Committee (FISC) and explained that the Trust was broadly on plan. Mr Miller updated the Committee on the position and explained that the task of FISC was to find where to make the additional £1.6m which was a gap in delivery, against the over planning target of £6.1m. The Committee noted the key financial risks and the actions in place to mitigate these risks. **Action** **The Committee noted the performance for Month 3 and noted the current and projected risks associated with the current projected financial position and the steps being taken to mitigate the risks as far as possible.**	**JR**
116/17	**Contracts – Monthly Review** The Committee received an update on the month 3 2017/18 contract	

	income position identifying any risks in the reported year end position and describing the steps being taken to mitigate the risks. The Trust set an income plan for 2017-18 based on 2016-17 levels of activity, and a prudent 1% growth assumption – amended for known service changes. This plan contains increases in income for a number of Trust initiatives, including those detailed in the FRP. It was noted that at Q1, the plan was delivering, but emergency and urgent care work was reducing the ability to deliver elective work. For 2017/18, the reporting of income and activity was more granular, and weekly activity reviews against plan were now being undertaken alongside the PTL (waiting list) meetings with Clinical Units. It was noted that the impact of HRG4+ was still being worked through, but initial indicators were that overall it was in line with Trust plans. Mr Reid gave a brief update on where the Trust was with regard to iMSK. It was noted that the tender process was on the basis of a fixed value contract over the period with a fixed monthly payment. Provisional agreement on the contract has been reached. It was agreed that Mr Reid would bring back an update on the position to the September Finance & Investment Committee. Further work is required to review underperformance in the Sussex MSK contract (which relates to the Eastbourne area) – although initial indicators are that this is consistent with the pressures on elective activity across the Trust. **Action** **The Committee notes the update on the income position of the Trust.**	**JR**
117/17	**Cashflow – Monthly Review** Mr Bourdon presented the monthly cashflow report which detailed the cash, borrowings, creditor and debtor positions as at month 3. It was noted that cashflow remains challenging resulting in increased creditor values and poor performance against the Better Payment Practice Code. At the end of month 3, the Trust had £2.1m in the bank which was aligned with plan. However, creditor balances were still very high driven by the fact that the Trust has been unable to collect all its debts. Mr Bourdon explained that a large amount of this was tied up with year end negotiations. Mr Bourdon explained that the target was to have less than 5% of the debts over 90 days at the end of the month. This was currently running at 58%. The Committee reviewed the analysis of receivables and payables broken down by NHS and non NHS debts.	

	Mr Bourdon reported that the Finance Department was focussing on cash collection and the raising invoices and there is a now monthly review of all the accrued income with a view to raising the invoices. It was noted that the level of creditors had slightly reduced at month 3. **Action** **The Committee noted the ongoing management of cash within the Trust.**	
118/17	**Capital Programme Quarterly Review** Mr Reid presented the Committee with an update on the position of the capital programme at month 3. The Committee noted that the Trust Capital Resource Limit (CRL) for 17/18 is £12.7m. This includes donated purchases of £1.0m. At the end of Q1, the cumulative capital expenditure amounted to £1.8m. This excluded £0.2m related to donated assets. The plan includes £4.3m of estates schemes that were committed to in the previous financial year and an additional £0.2m of items carried forward from 17/18 that were not provided for and result in a pressure on the plan and increase the over-planning margin. The year-end forecast position shows a £4.4m pressure. The Capital Resource Group (CRG) will monitor and control expenditure to ensure the Trust does not exceed its CRL at year end. The plan excludes the A&E streaming schemes awarded at £1.7m whilst confirmation from NHSi is sought as to whether our additional PDC can increase the CRL to reflect the capital costs associated with the works. Funding can only be drawn down on receipt of invoices relating to these schemes and this is included in the cash forecast between August and October. The CRG hold regular discussions, reviews of the position and consideration of requests for capital expenditure which alternate between conference calls and meetings. The CRG have developed a forecasting process for capital expenditure which will be reviewed and monitored from month 4. Schemes approved during the past month include the following which total £0.4m: • Wireless Community • Accommodation Wi-Fi • Server Refresh • Enterprise Printing	

	• File Migration • Theatre Trolleys (Uckfield/EDGH) • Urodynamics • Wolf Stack System The Committee received a table showing the current capital investment programme position at month 3 and cumulatively, subject to finalisation and review through the CRG. **Action** **The Committee noted the current performance of the capital programme.**	
119/17	**Refreshed Financial Plan 17/18** This item did not require further discussion as this was discussed in detail at the Trust Board the previous day. **Action** **The refreshed financial plan was noted.**	
120/17	**Securing Additional Capacity** Mr Reid updated the Committee on the position of securing additional resource to deliver the refreshed financial plan. It was noted that a number of staff have already been secured or are in the process of being secured by individual interims, redeployed staff and temporary backfills. The Committee reviewed the latest assessment of the financial position for 2018/19 and the new CIPS of £14m required to deliver the 18/19 control total of £26.1m. The following indicative timeline for the 18/19 financial plan was noted: • August – F&I Committee to agree 18/19 timetable • September – FISC to commence review of 18/19 savings • October – FISC to continue to review 18/19 savings • November – Draft 18/19 Financial Plan to be presented to F&I • December – Final 18/19 Financial Plan to be agreed by F&I It was intended to have a firm plan for next year by December 2017 as the Trust has for this year at July. Mr Miller felt there was a risk to delivery as the Trust fulfils the above timetable to ensure that it has the 18/19 plans, the same level by December that the Trust now has in place in July which will have a lot of calls on people's time. Mrs Wells suggested that this risk be added to the finance Risk Register.	**JR**

	Mr Miller asked for Capacity and Capability to be added to the FISC agenda as a standing item. **Action** **The Committee noted the update on securing additional capacity and the indicative timetable for the 18/19 plan.**	**JR**
121/17	**Progress on Clinical Services Review (CSR)** Mrs Darwood presented the Committee with an update on the Clinical Services Review. The Trust has been reviewing several workstreams that had been identified from the Lord Carter work. Mrs Darwood reported that the governance principles had been strengthened over the last few weeks and there was now a very firm governance structure in place with very clear aims. It was reported that weekly CSR meetings were taking place with the Executive Lead where the risks to workstreams are discussed. The Committee reviewed the Delivery Governance structure which showed how CSR fits within the Financial Recovery Plan. Mr Nealon asked Mrs Darwood if she was comfortable that the financial delivery was appropriately phased. Mrs Darwood said that she meets regularly with the Head of Financial Management and the divisions around the phasing and at present she was happy with the way this was phased. There was some early delivery of some schemes around grip and control. However there are some risks to some of the phasing which Mrs Darwood will raise with the Executive Directors as they arise. Mrs Darwood reported that the main tranche of the schemes are starting to come in in September/October. It was noted that it was a very tight timeframe. Mrs Darwood gave a brief overview of the workstreams within each of the 3 different traches. It was noted that: • Tranche 1 relates to workstreams where efficiencies have been identified with deliverable efficiencies opportunities within 17/18 • Tranche 2 relates to relates to workstreams who have had potential saving efficiencies identified but have not completed the operational; diagnostic phase. Still to be approved at FISC & QIA • Tranche 3 relates to workstreams who efficiencies are not clearly defined and may need significant review and development. Efficiency savings not anticipated to deliver in	

	year. Mrs Chadwick-Bell asked if Mrs Darwood would be prepared to attend one of the General Managers meetings to talk through the workstreams. Mrs Darwood said she would be happy to attend. The Committee reviewed the slide showing the risk of delivery assessment and Mrs Darwood explained how the risks would be managed and assessed. It was noted that the risk is reviewed on a weekly basis. Mrs Chadwick-Bell reported that she would go through this to ensure that there is no double counting. Mrs Churchward-Cardiff asked if they could have that re-conciliation. **Action** **The Committee noted the update on the Clinical Services Review.**	**JC-B**
122/17	**Alliance Executive Financial Plan 2017-18** This item was discussed and signed off at the Trust Board meeting the previous day, and therefore discussion on this item was not required. **Action.** **No discussion required.**	
123/17	**Sussex and East Surrey STP Financial Plans** This item was also discussed and signed off at the Trust Board meeting the previous day. **Action** **No discussion required.**	
124/17	**Costing Transformation Programme (CTP) Update** The Committee received an overview of the costing transformation programme (CTP), and a progress update on the 2016/17 acute patient-level costing submission. The Trust was accepted by NHSI, along with 80 other NHS Trusts, to be an early implementer in the new national Costing Transformation Programme, to undertake a voluntary submission of 2016/17 Acute cost data by August 2017. The Trust, subject to advice from NHSI, plans to submit a reconciled cost collection by the 8th of August 2017. This will not be a complete submission but will cover the majority of material costs/activity for the Trust. Work will continue, to mitigate the risks highlighted in the report,	

	ensuring that when the annual Patient Level Costing submission becomes mandated by NHSI that the submission stands up to external audit scrutiny. The Trust is committed to continue to improve the quality of the costing data to improve decision making and to deliver efficiencies, at the same time ensuring that we improve the quality of care to our patients. **Action** **The Committee noted the CTP update.**	
125/17	**Laundry and Residential Options** Mr Hodgson attended the meeting with Mr Paice and Mrs Clements to provide an update on the Laundry and Residential options. ***(i) Laundry*** At the Finance and Investment Committee in March 2017, the direction of travel for the Laundry was noted. Since then there has been ongoing work with Salisbury to develop a partnership. Mr Hodgson gave a brief update of the main commercial terms and timescales. Procurement and legal advice has been sought. Timescales are ambitious but should be achievable. Mrs Clements would carry this forward following the departure of Mr Hodgson. Mr Nealon said that the Committee were comfortable with the direction of travel and felt that the approach was correct. ***(ii) Residential and St Anne's property portfolio*** Mr Hodgson presented a brief update on Residential accommodation options at EDGH and Conquest. It was noted that a Strategic Outline Case (SOC) was presented to the Estates & Facilities IPR in December 2016. The SOC noted that existing accommodation stock continues to make a valuable contribution in the recruitment and retention of staff. The Trust residential estate is in poor condition having been deprived of investment. An independent assessment in 2016 identified £9m to address current maintenance need. The majority of accommodation is on a shared kitchen and bathroom model with ratios of from 1:3 to 1:6 which is not considered to be a good standard. The SOC suggested that the significant investment required was not likely to come from capital where there is a greater need to prioritise in patient areas which have also suffered from a	

	historic lack of investment. Mr Hodgson reported that there were numerous examples within the NHS of successful partnering with the private sector to address this type of challenge. It was noted that the Estates and Facilities team were beginning to explore options, and Mr Paice would take the lead on this project following the departure of Mr Hodgson. The Committee said they encouraged this research and looked forward to a more detailed submission in due course. It was noted that this was Mr Hodgson's last attendance at the Finance & Investment Committee. The Committee thanked him for all his work and was wished well for the future. **Action** **The Committee noted the update on the Laundry and Residential options.**	
126/17	**Revised 2017/18 Work Programme** The Committee reviewed the 2017/18 work programme. The changes to the programme were highlighted. It was noted that Medicine would be invited to attend the August meeting. **Action** **The Work Programme and revised changes were noted**	
127/17	**Minutes to note – for information only** The Committee received the minutes of the following meetings for assurance and information: • Financial Improvement & Sustainability Committee – 27.6.17 • Capital Resources Group - 16.6.17 **Action** **The Committee noted the above minutes.**	
128/17	**Any Other Business** (i) ***Estates Plan*** Mrs Churchward-Cardiff reported that she would like the Committee to review the minor works issues that are not being done, as part of the Estates Plan, which is on the agenda for the September meeting.	

129/17	**Date of Next Meeting** The next meeting will take place on Wednesday 30 August 2017 at 8:30am – 11.30am in St Mary's Board Room, Eastbourne DGH. The Committee asked if future meetings could start at 8.30am to allow more time for discussion whilst the Divisions are invited.	**CK**