AST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 13th April 2021 commencing at 09:30 via MS Teams

AGENDA

			Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 9th February 2021	A		
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback (including written reports from each Committee)	C	Committee Chairs	
6.	Board Assurance Framework	D	DCA	
7.	Chief Executive's Report, including Covid update		CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
8.	Integrated Performance Report Month 11 (February) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	E	CND MD COO CPO CFO	1015 - 1115
9.	Learning from Deaths Quarter 2	Assurance	F	MD	

BREAK

STRATEGY

					Time:
10.	Quality Account Priorities 2020/21	Assurance	G	CND	1130 - 1200
11.	Cardiology and Ophthalmology Update	Information	H	DS	

GOVERNANCE AND ASSURANCE

					Time:
12.	Delegation of approval of Annual Report and Accounts 2018/19	Assurance		DCO	1200 - 1215
13.	Annual Self-Certification	Assurance	I	DCO	

ITEMS FOR INFORMATION

				Time:
14.	Use of Trust Seal	J	Chair	1215 - 1230
15.	Questions from members of the public (15 minutes maximum)		Chair	
16.	Date of Next Meeting: Tuesday 8th June 2021		Chair	

Acting Chair

Jackie Churchward-Cardiff

Key:	
Chair	Trust Chair
CEO	Chief Executive
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
CFO	Chief Financial Officer
CPO	Chief People Officer
MD	Medical Director

16th March 2020

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 9th February 2021 at 09:30 video conference via Microsoft Teams

Present: Mr Steve Phoenix, Chairman
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Tara Argent, Chief Operating Officer
Mrs Vikki Carruth, Chief Nurse & DIPC
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Dr David Walker, Medical Director
Mrs Nicola Webber, Non-Executive Director

Non-Voting Directors:
Mr Steve Aumayer, Chief People Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Mr Richard Milner, Director of Strategy Innovation & Planning
Ms Lynette Wells, Director of Corporate Affairs
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Mrs Emma Chambers, Assistant Director of Midwifery
Mr Dexter Pascall, Clinical Lead, Women & Children's Division
Mr Peter Palmer, Deputy Company Secretary (minutes)

001/2021 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting. He noted that Mrs Kavanagh had been appointed as Non-Executive Wellbeing Guardian, and that Mrs Fadero had been appointed as Non-Executive Maternity Lead for the Trust.

2. Apologies for Absence
Mr Phoenix advised that apologies for absence had been received from:

Mr Chris Hodgson, Director of Estates and Facilities

002/2021 **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.

003/2021 **Minutes**
The minutes of the Trust Board meeting held on 1st December 2020 were considered and were agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

004/2021 **Matters Arising**
There were no matters arising from the previous meeting.

Mrs Churchward-Cardiff noted that feedback on the potential outputs from 111 First had not been circulated. Mrs Argent explained that Phase Two of 111 First would commence on 12th February. She would provide a summary report to the Board as a verbal update at the next Board meeting. **TA**

005/2021 **Board Committee Chair's Feedback**

i. Audit Committee

Mrs Webber reported that the Audit Committee had met on 28th January 2021. She had nothing more to add to the report presented to the Board.

ii. Finance and Investment Committee

Mr Phoenix reported that the Finance and Investment (F&I) Committee had met on 17th December 2020. The Trust was aiming for a breakeven position for a second year in a row, which would be a significant achievement for the organisation. Financial planning for 2021/22 was being undertaken, although the financial regime for the forthcoming year had not yet been finalised.

Mr Reid clarified that the Trust was targeting a £2m deficit for the year, noting that there was an additional risk of around £4-5m to the end of year financial position.

iii. Finance and Investment (Strategy) Committee

Mr Phoenix reported that the Finance and Investment (Strategy) Committee had met on 28th January 2021. Work continued to develop a five year strategy for the organisation. The Committee had received a report on the excellent recent progress made by the frailty team, which was a key service for the organisation.

iv. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 21st January 2021. The Committee had recently refocussed its agenda due to ongoing operational pressures.

v. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met on 21st January 2021. She explained that the Trust was operating in a higher risk environment than normal due to the pandemic, emphasising the importance of being clear about what was expected from staff, and the level of support and protection that they would be given due to the extraordinary circumstances they were working in. She noted that the last few months had been incredibly hard for staff and praised them for their response.

Mrs Carruth explained that, during the second wave of the pandemic, staff had continued to do all they could to provide the best possible care, but it had not always been possible to maintain usual standards. Staff had found this very hard and had voiced concerns about the impact on themselves, patients and colleagues, asking for understanding and recognition of what had taken place. Mr Phoenix explained that the Board fully understood how difficult the last few months had been and were extremely grateful and proud of all the Trust's staff.

Dr Walker reported that the response from nursing and medical staff in the Trust during the second wave had been amazing. He praised respiratory physicians and intensivists, including anaesthetists, who had provided support to critical care. He also praised junior medical staff who had been redeployed

outside of their usual areas and had been incredible.

Mrs Churchward-Cardiff asked whether it might be helpful to review organisational standards in light of the pandemic, reflecting the challenges of the pandemic so that metrics were not all rated as red. Mrs Chadwick-Bell suggested that this could be discussed at the Q&S Committee. She emphasised the importance of retaining the national standards and explained that recovery trajectories could be developed and reported against while the Trust returned to business as usual. .

006/2021 **Board Assurance Framework**

Mrs Wells presented the Board Assurance Framework (BAF), reporting that no new risks had been added to the register during the previous quarter. All the existing risks had been reviewed and progress had been updated. As a result of the significant impact of the second wave of Covid, the risk rating for BAF 2 (restoration and recovery), and BAF 3 (the Trust's performance against access standards) had been increased from 16 to 20. The rating for BAF 1 (safe care) had increased from 9 to 12.

Discussions had taken place at recent Committee meetings about whether risk ratings continued to be correct in light of the second wave of the pandemic. Mrs Wells explained that the Trust was still able to provide evidence that processes for monitoring risks remained in place and continued to operate.

Mrs Wells reported that BAF 5 (protecting staff) had been discussed by the Audit Committee. This had originally been added to the BAF following a visit from the Health and Safety Executive and had been updated during the pandemic to include PPE and risk assessments. The Audit Committee had queried whether this should be further updated to include more detailed information about how the Trust was protecting staff during the pandemic, and she suggested that this should be discussed by POD Committee. Mr Aumayer anticipated that additional risks were likely to emerge as the Trust moved out of the pandemic, including the recruitment and retention of staff.

Mrs Webber noted that the Audit Committee had also discussed whether it was possible to flag controls on the BAF that were not operating on a temporary basis due to the pandemic.

Mrs Churchward-Cardiff asked whether, with regard to BAF 2, milestones for restoration and then recovery of services could be included separately. She noted that no actions for the mitigation of a new risk concerning shortage of staffing in chemistry for BAF4 (sustainable workforce) were included. Mrs Wells explained that the actions were detailed on the Trust's risk register. The BAF captured generic Trust actions rather than actions relating to specific risks.

Mrs Churchward-Cardiff asked whether potential changes to the timetable for Building for our Future (BFF) should be reflected in BAF 8 (Investment required for estate infrastructure). Mrs Wells agreed that this should be reviewed.

Mrs Carruth noted that BAF1 could be updated to capture the challenges that faced the Trust as it emerged from the second wave of the pandemic. This would be discussed by the Q&S Committee.

007/2021 **Chief Executive's Report**

Mrs Chadwick-Bell presented a verbal update. She thanked all of the Trust's staff for their work throughout the pandemic noting that it had been ongoing for more than a year. Staff had gone far over and above their normal duties throughout the pandemic, and in particular during the second wave. She reported that sadly the Trust had recently lost three members of staff; Caroline Moss, a Receptionist in the Trauma and Orthopaedic Outpatient Department; Michael Winchester, Housekeeping Supervisor; and Naomi Gomm, Sister in Critical Care. She offered her condolences to families, friends and colleagues.

Mrs Chadwick-Bell reported that staff from a number of back office teams had been redeployed during the second wave of the pandemic and had been working on the front line. She paid tribute to the Trust's staff who had been extremely flexible in the way in which they had helped the Trust. She reported that the facilities team had worked exceptionally hard to support wards with daily meals and extra cleaning.

The Trust had seen high numbers of admissions during the second wave; during the first wave, the peak of patients, including positive, treat as positive and suspected Covid cases had been 75. The peak in the second wave had been 450 patients in acute hospitals, with an additional 60-70 patients in community hospitals. Bexhill was being utilised as a covid discharge area, and critical care was operating at between 50-80% above normal capacity. Cancer services continued, but there had been some delays due to the unavailability of post-operative critical care beds. Community cases were beginning to reduce and had almost halved during the previous couple of weeks. Mrs Chadwick-Bell reported that the Trust currently had 200 inpatients plus community patients, which was a much improved position.

She reported on estate work that had been completed and was planned included in the opening of Devonshire Ward at EDGH, which would be used as a decant ward for fire compartmentation work. Glynde Ward had also been opened at Eastbourne, with Firwood House temporarily opened to help discharge patients. Work was planned for improvements to A&Es at Eastbourne and Conquest and new buildings for the crèche, switchboard and IT training were in place at Conquest.

Mrs Fadero thanked all staff for the extraordinary job they had been doing. She asked whether Executives had received any feedback which had surprised them during weekly staff briefings, and whether the BAF and risk register were picking up issues within the Trust. Mrs Chadwick-Bell explained that staff queries coming through weekly briefings were mainly around vaccination, PPE and wellbeing. Executive colleagues remained visible in the organisation, speaking to staff and addressing issues as they arose. The Trust had a daily Incident Management meeting, which had its own risk register which fed into the BAF and overarching Trust risk register and was reviewed on a weekly basis by the senior leadership team.

Mr Phoenix explained that he was very encouraged by the reducing number of inpatients, noting surprise at the pace of the reduction. Mrs Argent reported that previous modelling of the second wave showed patient numbers returning to normal in the Trust at the start of April. However, the speed of the reduction meant that remodelling would be undertaken and it was hoped that a return to normal might occur sooner. If this was the case then recovery plans would be brought forward. Dr Walker noted that some of the reduction was due to patients who had been in the hospital for longer than 14 days and no longer

had covid symptoms. These patients were cohorted together in 'blue' areas before moving to care homes, but were no longer counted as actively having Covid.

Mrs Fadero explained that she was keen to understand how the Trust would find the balance between recovering services, and allowing staff the time, energy and focus they would need to recover from the pandemic. Mrs Chadwick-Bell reported that the issue was recognised by the Trust as well as across Sussex, the region and nationally. Conversations had begun about how staff could have a break before work on recovery begun.

Mrs Churchward-Cardiff asked whether a celebration of the end of Covid was being planned. Mrs Argent explained that this would be difficult. The Trust was celebrating everything it could during the pandemic, and recognising the achievements of staff. Mrs Chadwick-Bell agreed that it was important that this should be marked and that staff were appropriately recognised for all they had done during the pandemic.

The Board noted the Chief Executive's Report.

008/2021 **The Ockenden Report**

Mrs Chambers explained that the Ockenden Report had been commissioned in 2018 in response to high level of complaints from families at Shrewsbury and Telford Hospital NHS Trust. 1,862 cases had been reviewed resulting in a number of recommendations both for the Trust concerned and across the NHS. The Trust had been asked to respond to the report, with a short timeframe for submitting the response.

Mrs Chambers explained that the Trust offered a safe, kind and high quality service, and had recently undergone a governance peer review by the Head of Midwifery of another local Trust which had been very positive. There were areas where further improvement could be realised and these were being addressed. The Trust had a motivated maternity workforce, the majority of whom felt well supported by managers. The team were engaged in national safety initiatives and reviewed all national maternity reports when they were issued; fifteen had been published since October 2020. Recommendations were benchmarked and action plans developed for any that were not already in place in the Trust. The maternity team had an open and transparent relationship with senior leaders and the Board and felt very supported.

Issues remained with medical recruitment, which was a national issue, but midwifery recruitment was good. The Trust had fully implemented the Saving Babies' Lives care bundle, and Mrs Chambers noted that Mrs Chadwick-Bell had previously chaired the local maternity system so fully understood the maternity service.

More work was required to provide additional assurance for actions that had been implemented to meet previous recommendations, and it was hoped that recruitment of member of staff to an audit role would address this issue. The physical limitations on the space available for maternity would need to be addressed to further improve the quality of services that could be delivered. Additional work was also being undertaken to improve the team's external website, low level cultural issues and Serious Incident reporting process.

Mr Pascall explained that the team had already implemented many of the recommendations from the report, and were working to ensure that they could

provide assurance that these were embedded and sustainable. There were a low level of adverse outcomes in maternity which were reviewed and escalated as appropriate. He explained that the recruitment of medical colleagues continued to be problematic, as there was a national shortage. The Trust would need to be innovative to address these issues. He praised the relationship the maternity team had with the Board and thanked them for their support.

Mrs Carruth thanked Mrs Chambers, Mr Pascall and the maternity teams for all their hard work, and for how they had responded during the pandemic. She explained that the detailed response provided to the Ockenden report was a credit to the team. She noted that Mrs Fadero had agreed to take on the role of Non-Executive (NED) lead for maternity and thanked her for her support.

Mrs Fadero praised the work that had been undertaken by Mrs Chambers and Mr Pascall in responding to the Ockenden Report in a fast and meaningful way. She hoped that the report would lead to a transformational, sustainable review of maternity services across the country and welcomed the opportunity as a NED to provide scrutiny of maternity at ESHT. She explained that she was absolutely assured that the Trust had responded well to the report, and that work would be undertaken to ensure that governance and escalation processes for maternity were appropriately aligned within the Trust in line with Ockenden requirements. She noted that it was not possible to give assurance that there would never be another maternity safety incident within the Trust, but praised existing reporting mechanisms and grievance processes which helped address any issues that did occur.

Mrs Kavanagh commended the maternity team on the fantastic work they had done in responding to the report, noting that she had found the content to be excellent. She asked whether it was possible to reword the third recommendation for the Board, to remove any ambiguity, and the Board agreed to this.

Mrs Webber praised the response presented to the Board. She asked whether the assessment of risk included in the response could be amended to include experiences of abnormal pregnancy as well as normal pregnancy. She noted that it was not clear from the response how the Trust was addressing the requirement for twice daily, seven day a week, consultant-led labour ward rounds. Mr Pascall explained that a meeting was being held at the end of the week to discuss the issue. Five or six additional PAs of clinical consultant time would need to be found in order for the Trust to meet the recommendation, which equated to an additional consultant. Meeting this requirement would be an issue for all Trusts, due to the national shortage of consultants. The Trust's current arrangements provided consultant cover to the labour ward above the national average, and met the requirement five days a week.

Mrs Webber asked whether the summer implementation of new IT systems would lead to a paperless system, mitigating the risks noted in the report for complex pregnancies. Mrs Chambers confirmed that the new system would be essentially paperless. Appointments and interactions would be managed electronically across both sites, allowing women to access their maternity notes on an app. Hand held notes would be given to anyone without access to an appropriate electronic device.

Mrs Manson thanked Mrs Chambers and Mr Pascall for their work on the Trust's response. She asked how robust the evidence for gathering user feedback was and Mrs Chambers explained that feedback was requested using

Family and Friends Testing; the Trust was working with the Maternity Voices Partnership to identify methods of gathering feedback more proactively. Collecting feedback was a longstanding issue, but there had been an increase during previous months.

Mrs Manson asked whether risk assessments were completed and recorded for each contact, and Mrs Chambers confirmed that this took place, explaining that notes were designed to support this process. Mrs Manson noted that patient information was only available on the Trust's website in English. Mrs Chambers explained that many leaflets were available in other languages, but not all. The Trust was working with the system to address the issue of patient information languages other than English.

Mrs Chadwick-Bell explained that the terms of reference for the Trust's Maternity Board would be reviewed to increase the profile and visibility of maternity in the organisation, ensuring that the team were fully supported in addressing any issues. She noted that responding to the recommendations of fifteen reports over a four month period had taken a huge amount of effort, and support for the leadership team in maternity would be reviewed to help them manage this.

Mr Phoenix thanked the team for all that they had done. He noted that further work would be required, and that the Executive team and Q&S would closely monitor progress. Mrs Fadero would report back to the Board as NED champion on progress in the future.

The Trust Board:

1. Agreed the Perinatal Clinical Quality Surveillance Model for implementation and process for review part of the Quality and Safety Committee agenda.

2. Confirmed that the Ockenden report had been reviewed at Public Board.

3. Confirmed that "the Board is confident that assurance mechanisms are effective to allow for escalation and visibility of incidents involving poor care and avoidable deaths. Confirm that the Board are assured that processes to learn from adverse incidents are effective and embedded."

4. Confirmed that the maternity service have completed the assurance and assessment tool.

5. Formalised the appointment of the Non-Executive Director Maternity Safety Champion.

009/2021 **Integrated Performance Report Month 9 (December)**

i. Quality & Safety

Mrs Carruth reported that the Trust had experienced a significant second wave of Covid since the Board had last met. At its peak, the Trust had had around 450 positive patients with Covid, although the number had recently reduced to just under 250. December and January had been exceptionally difficult for the Trust, with Covid having a significant impact on staffing and on services; over 1,000 members of staff had tested positive in December and January. The Trust had treated more than 2,000 positive Covid cases since the start of

pandemic.

East Sussex had been significantly above the national average for Covid cases during December and January; mutual aid had been requested and had been instigated in January. It was likely that the second wave had impacted on the quality of services, but staff had gone above and beyond to keep services running during extremely difficult circumstances. It had been an unprecedented time, and Mrs Carruth explained how proud and grateful she was to all of the Trust's staff. She thanked them, as well as armed forces colleagues, the CCG and others who had supported ESHT.

Many staff had been redeployed to patient facing areas, including members of the governance and complaints teams. Governance processes and key quality indicators had been maintained as much as possible during the second wave, with continuing weekly patients safety summits which had had excellent clinical engagement. Almost all senior nurses in the Trust had been working clinically to support teams, monitoring standards and the quality of care given.

The Trust had launched its vaccination programme during Christmas week and had now vaccinated almost 20,000 people. Mrs Carruth thanked the staff who had made this possible, and the Trust's NEDs who had supported the programme. She noted that it had been a huge positive during a very challenging period.

Mrs Manson asked about vaccination rates amongst Trust nurses, noting that a newspaper article had reported on a higher national vaccination rate for permanent staff than for agency staff. Mrs Carruth noted that the vaccine was voluntary for staff; some would choose not to be vaccinated, or may not be able to have a particular vaccine. Other members of staff had not been able to have vaccinations due to recently having Covid and others would have received vaccinations outside of the Trust. The Trust was working hard to ensure that all Trust staff and local health and care staff could access the vaccine.

Mr Aumayer noted that 108,000 health and social care workers had been identified as requiring the vaccine across the local system, and the Trust and partner organisations had contacted all of them to ensure that they had prioritised access to the vaccination. Dr Walker noted that all staff had access to twice weekly lateral flow tests; the number of staff testing positive had begun to fall three weeks after the vaccination programme had commenced and continued to reduce.

Mrs Churchward-Cardiff noted that she remained very concerned about fall rates in the Trust, explaining that the issue had been discussed by Q&S. She asked for an update on progress. Mrs Carruth reported that addressing fall rates remained a priority for the organisation, but the second wave of the pandemic had made progress difficult. As the surge receded plans would be reintroduced and she would report back to Q&S on progress.

Mrs Churchward-Cardiff asked about the infection control measures in place to protect staff from Covid. Mrs Carruth explained that there had been a lot of national debate about PPE for staff to ensure that they were protected. The Trust was confident that it was doing all that it could to protect staff. The Infection Control BAF was an effective tool used for monitoring progress and providing assurance.

Mrs Webber noted that it was important to recognise the variability of

performance being reported to the Board as a result of the second wave of Covid. She asked why the staff fill rate at Eastbourne was rising. Mrs Carruth explained that this was a result of opening up additional capacity during the second wave. The fill rate showed the number of staff on duty compared to the planned establishment, and the rising rate demonstrated that the Trust had been far busier than planner. Mr Aumayer noted that the report presented data for December, and reflected the Trust taking a lot of actions to ensure staff availability as the second wave worsened. A clearer picture of the Trust's response would be available when January's data was presented.

Dr Walker reported that as of 8th February the Trust had admitted 2,187 patients because of Covid. 1,800 admissions had taken place since the start of November. 649 patients had sadly died from Covid, an overall mortality rate of 29%. The mortality rate during the second wave had been slightly reduced, reflecting improved knowledge and treatment of covid as the pandemic progressed.

Covid had been the most common cause of death in the Trust during December; Dr Walker noted that the usual measures of mortality, SHMI and RAMI, had not been designed to monitor mortality during a pandemic. Removing Covid from the mortality calculations was complex, as patients who had remained in hospital during the pandemic were generally extremely unwell; elective patients had also reduced. These factors led to an increase in mortality indices, reflected by the RAMI reporting which had been reducing over a number of years in the Trust before the pandemic. The Trust's demography had led to a greater increase in inpatients due to covid; a younger population would likely not have required hospitalisation. Measures to rebalance the SHMI and RAMI moving forward were being explored. The Trust's figures were still below the national average, but Dr Walker anticipated that there would be a period of instability for the mortality measures for some time.

Mrs Churchward-Cardiff acknowledged the progress that had been made to improve mortality in the Trust during recent years, and asked what changes would be made to protect patients coming into hospital moving forward. Dr Walker noted that the best tests available for Covid were only 70-80% successful. The main concern was that patients would come into hospital with no symptoms of Covid, would test negative and would then be put into a non-covid area before subsequently testing positive. He explained that it was likely that annual covid and flu jabs would be given in the future. Infection control measures would lead to some loss of pre-covid productivity, but Dr Walker hoped that this would increase again as the prevalence of covid reduced moving into summer.

Mrs Fadero asked for further information about medical examiner reviews, and Dr Walker explained that the Trust's system had been changed in April 2020. A team of nine medical examiners analysed all deaths that took place to identify if there were any issues which required further assessment. Issues were flagged, and then deaths went through the usual morbidity and mortality (M&M) process. The Trust had assessed 82% of deaths in November, but compliance would be lower for December and January.

ii. Access and Responsiveness

Mrs Argent reported that since last meeting, national cancer targets had been published for November 2020; the Trust had met the standards for 2 week waits, as well as the 31 day standard. It had also met the 62 day standard for the first time since 2014, and had been the eighth best performing Trust in the

country. She thanked staff for all of their hard work in changing the way that the Trust thought about cancer in order to meet the target.

The Trust had been second in the country during November for Referral To Treatment (RTT) performance, which meant that the Trust had had a good understanding of its waiting lists when the second wave of the pandemic arrived. Waiting lists were being clinically prioritised in line with national standards. During December and January the Trust had continued to operate on patients with the most urgent clinical need. However, the second wave would see an understandable dip in performance.

The point of delivery for some services had been changed to allow them to continue. An example of this was the delivery of ophthalmology services away from the acute sites. She thanked staff for their response to the pandemic and flexibility in delivering services in different ways. Patients coming into the hospital through pre-assessment pathways were given a clear understanding of what was expected of them when they came into hospital and how long they would stay in hospital for. Emergency patients were also being given an anticipated date for discharge when they were admitted. The Trust was working with Healthwatch on improving documentation for patients, and would be updating information and terminology including on the website.

The Trust had met the 95% A&E target over the previous month. Capacity issues in Critical Care due to the second wave had impacted on the way other services could be delivered, particularly urology and cancer services. The Trust had worked with the system to arrange for patients who required urgent care to be treated at other hospitals.

Mrs Argent reported that Firwood House had been opened for additional red capacity during the second wave of the pandemic, but that this additional capacity would be closed down imminently as capacity was moved back to acute sites. Additional beds had also been opened in Rye. A review of services being offered away from acute sites was being undertaken to see if they could be resumed on acute sites in a controlled and safe manner.

Mr Phoenix noted that he had joined the Trust two years before; the need to improve cancer performance had been discussed by the Board at one of his first meetings. He thanked Mrs Argent and her team for their work on improving cancer performance, noting the significant achievement in meeting these targets, as well as the excellent RTT performance seen in November.

Mrs Churchward-Cardiff noted that non-elective lengths of stay had increased slightly, and asked what was driving this. Mrs Argent explained that the increase was due to patients being admitted to the Trust who were more unwell, and there had also been issues with discharging patients which were being addressed.

Mrs Churchward-Cardiff asked how the increased number of patients waiting for more than 52 weeks for treatment was likely to impact performance moving forward. Mrs Argent explained that in October 2020, there had been 258 patients waiting for over 52 weeks. There were now 267 patients, and long waiting patients would be addressed as services restarted. Many of the long waits were due to patient choice, and all patients on the waiting list were subject to a harm review by clinicians.

Mrs Chadwick-Bell thanked Mrs Argent for her fantastic work since starting her

role as Chief Operating Office. She noted that the Trust would play a role in supporting patients across the system, and not just in East Sussex, during recovery plans to ensure equity of access to care across the system.

iii. Leadership and Culture

Mr Aumayer noted that the IPR presented data for December; much had changed in the Trust since then. At the end of December, staff sickness had been similar to the first wave of the pandemic with around 500 members of staff unwell or self-isolating. He paid tribute to colleagues from across the Trust for their response to the second wave, and for their efforts in opening the vaccine hub and additional capacity at Firwood House at short notice.

The Trust had been supporting the psychological and physical welfare of staff during the second wave. Measures had included the provision of hot meals to wards, snack boxes, wobble rooms supported by chaplaincy, support for absent staff, psychological support, short- and long-term trauma therapy, a 24 hour time to talk service, care first counselling, vaccinations and support for teams who had experienced loss. Additional ways to support staff were being identified as the Trust moved out of the second wave of the pandemic, and Mrs Kavanagh had been appointed as Wellbeing Guardian for the Trust, a vitally important role.

Activities that would make a big difference had been prioritised. Mandatory training and appraisals had been deprioritised during the second wave, but compliance had not significantly reduced. Inductions for new starters had been tripled during January to allow new staff to begin more quickly. Over 12,800 bank shifts had been filled during December by the Temporary Workforce Team. A significant program to shorten recruitment times had been introduced, with processes simplified and made more efficient. Work to improve the quality of HR and ESR date continued to be undertaken, with the Trust now 26th in the country, and 2nd in the region for the quality of its data.

Mr Aumayer explained that he was very proud to have joined an organisation with such fabulous staff, praising the response of colleagues in rising to the challenges of the second wave of the pandemic. He praised the commitment of staff throughout the organisation. Mr Phoenix reported that he had met a number of new overseas staff at a recent virtual social evening and had been impressed by their enthusiasm for joining the Trust.

Mrs Kavanagh thanked Mr Aumayer and his team for all that they had done. She reported that a recent survey had found that one in five junior doctors' commitment to the NHS had strengthened during the pandemic, while one in three were thinking of leaving to find another job. She asked what was being done to address this issue for doctors, and other staff groups. Mr Aumayer explained that the Trust was aware of the challenges that staff had gone through, during a period of significant pressure and that some would be considering their future. Staff would be supported psychologically, physically and mentally during and after the pandemic, building on the support that was already in place. Retention of staff was a key risk to the organisation, and his team were working hard to engage with staff across the organisation. The issue would be discussed in depth by the POD Committee over the coming months.

Mrs Carruth explained that she felt that the Trust had done as much as possible to support staff during the pandemic. It was inevitable that some staff would consider their future, and whether they could go through another wave of the pandemic, but this would be a universal issue across the NHS. Dr Walker

agreed that the Trust had done an excellent job of supporting staff during an extremely difficult period. However, it was likely that some older clinicians would bring forward their retirement due to the pandemic. The Trust would develop plans to address these potentially significant medical staffing issues moving forward.

Mrs Churchward-Cardiff explained that she had spoken to a member of staff who had used a wobble room and had been very positive about the openness and informality of the facility. She asked what the Trust could do to support staff returning to roles after redeployment and sickness, and how working practices could be changed to increase retention of staff. Mr Aumayer reported that sick patterns had been reviewed, and the number of staff who had been absent due to non-Covid reasons had decreased in comparison to previous year. Work was being undertaken to understand the reasons for this. All aspects of how staff worked would be reviewed in order to address the likely staffing crisis, and he anticipated that there would be a change in the how engagement with staff took place, and how services would be delivered moving forward. There had been a lot of learning that had emerged during the pandemic which could be used to understand how to increase staff retention.

Mr Phoenix noted the important role that leadership behaviours would play, alongside policies, processes and procedures in encouraging staff to remain with the organisation.

Mrs Fadero noted how positive working in the vaccination hub had been and asked if there was a way to allow volunteers to balance work on wards with work in the hub in order to give them a break and reward them. Mr Aumayer agreed that staff had found working in the hub to be extremely rewarding, with some working full shifts in the Trust and then doing additional work in the vaccination hub. It was difficult to offer a balance when services were extremely stretched, but this would be reviewed moving forward. Mrs Carruth agreed, noting that staff had found working in the vaccine hub to be a respite and good for mental health. She reported that some redeployed staff had chosen to remain working in new areas, having been given opportunities that they had never anticipated. She praised the extraordinary teamwork and collaboration seen amongst staff.

Mrs Chadwick-Bell noted that Mr Aumayer had only recently joined the organisation, and thanked him for his tremendous work. She also thanked the HR, workforce, recruitment, wellbeing and occupational health team who had all done amazing work during the pandemic. She also praised the Executive team for their incredible work during the pandemic, noting that without the leadership that had been shown the Trust would not have been able to perform as it had. Mr Phoenix echoed this and thanked the Executive team.

iv. Finance

Mr Reid explained that the payment by results system had been suspended in April 2020 and had been replaced by block contracts. These would remain in place throughout the 2020/21 financial year. All spending by the Trust during its response to the pandemic was subject to retrospective reviews. There were two key financial issues that were being addressed as the Trust approached financial year end:

1. The Trust had £90m of cash reserves, which would be reduced by £30-50m by moving to month end arrears.

2. The capital programme had a likely excess of £7.9m due to the pandemic. Some requests for capital had therefore been cancelled with the centre. This was a national issue. Mr Reid anticipated that similar levels of capital would be available in 2021/22 which would allow capital requirements to be addressed in the following financial year.

The Trust had submitted a £6m deficit plan for the 2020/21 financial year which had been accepted by the ICS but not centrally. Income had been lost from NHS funding routes, including from Trust canteens, due to the pandemic. It was hoped that this lost income would be addressed by a process being introduced during month 12. Another issue was with staff who had been unable to take their leave prior to year-end, due to how busy the Trust had been. Mr Reid was unsure if payments to address this issue would be centrally funded, but this was again a national issue.

Modelling was being undertaken nationally to understand the run rates of individual Trusts; this would be used to set reasonable financial targets for organisations. Trusts would be given elements of financial support and achievable savings targets once block contracts ended and normal financial processes returned.

Mrs Webber explained that she hoped to be able to better understand the value for money position of the Trust from information presented to the Board moving forward. Mr Reid agreed, noting that the IPR provided a retrospective view of Trust finances and explained that the attached commentary would be improved to provide greater understanding. Value for money would be an area of focus for the organisation following the pandemic. The non-covid establishment would be reviewed to provide a starting point for planning for the 2021/22 establishment and cost pressures in the organisation to set a revised base line for the start of financial year. This would be benchmarked against other NHS organisations.

Mrs Churchward-Cardiff asked whether there was a process for identifying additional cost pressures that might occur during 2021/22. Mr Reid reported that the budgeting process for 2021/22 had not begun as this process had been delayed nationally. Mrs Chadwick-Bell noted that the business planning process for 2021/22 was being managed by Mr Milner; she anticipated that any cost pressures would be identified during this work.

Mr Patel explained that he was reassured that the Trust had the space to think clearly about capital spending. He asked when the cash position would be reconciled to achieve a reasonable number, and asked if the £90m was at risk. Mr Reid explained that the Trust's original target was to reduce the cash position to £2.1m by the end of the financial year. The Trust would be paid at the end of each month moving forward, rather than at the start, which would reduce the cash amount by at least £30m. Around £10-15m of the additional cash related to ongoing capital processes. The region had indicated that the original £2.1m target no longer applied and that the level of cash held by the Trust would be helpful in ensuring that suppliers were paid in a timely manner.

The Board noted the IPR Report for Month 9 and actions in place

010/2021 **NHSI Integrating Care response**

Mr Milner reported that the paper presented had been previously been discussed by the F&I Strategy Committee. ESHT fully supported the proposal; the evolution towards collaboration was entirely in line with Trust planning over

the next five years. Relationships with partners, colleagues within the ICP and with the ICS were well developed.

The Board noted the Trust's response to the NHSI Integrating Care Paper.

011/2021 **Review of Corporate Governance Documents**

Mrs Wells reported that a full review of the Trust's Standing Financial Instructions (SFIs), Standing Orders (SOs) and Scheme of Delegation had been undertaken. She explained that these were key governing documents, and that the Audit Committee had supported adoption of the changes. She asked the Board to ratify the changes.

The Board approved the revisions to the Trust's overarching Corporate Governance Documents

012/2021 **Papers for Review and Noting**

i. Charity Annual Report

Mrs Wells presented the East Sussex Healthcare Charitable Fund annual report for the period ending March 2020. She explained that the report had been audited by Grant Thornton. She noted that the report produced for 2020/21 would reflect the high level of contributions received from NHS Charities Together and the Trust's response to the pandemic.

The Board noted the Charity Annual Report.

013/2021 **Use of Trust Seal**

There were five uses of the Trust Seal reported:

Sealing 59 – Willmott Dixon Construction Ltd, 17th December 2020
Service delivery agreement for A&E, Conquest Hospital.

Sealing 60 – Willmott Dixon Construction Ltd, 17th December 2020
Service delivery agreement for A&E, EDGH.

Sealing 61 – Imtech Low Carbon Solutions, 17th December 2020
Lease of land at Conquest Hospital; part of project agreement for energy performance contract.

Sealing 62 – Medica Reporting Limited, 18th January 2021
Three year agreement for radiology reporting, with further two year option.

Sealing 63 – Willmott Dixon Construction Ltd, 20th January 2021
Service delivery agreement for demolition and groundworks at EDGH and Conquest Hospital.

014/2021 **Questions from Members of the Public**

Mr Phoenix noted that a number of written questions had been received from Mr Colin Campbell and Mrs Liz Walke in advance of the meeting. Detailed responses would be sent to them outside the meeting, and would be included within the papers for the next meeting.

015/2021 **Date of Next Meeting**
Tuesday 13th April 2021

Signed ……………………………………………

Position …………………………………………..

Date ………………………………………………

Questions from Members of Public for the Trust Board Meeting, 9th February 2021.

Questions From Mrs Liz Walke

1. Sorry to have missed presentation of Ockenden Report. Disappointed 7 clinical priorities (out of 12, less than half) not met, as although only 4 days' notice, we are led to believe that ESHT Maternity Services, since single-siting obstetric services are very safe and we had no reason to believe otherwise. There is still a shortage of consultants which was stated that single-siting would have addressed. Consultants not complying with twice daily ward rounds is extremely worrying. Although the ESHT report states in the last paragraph (on page 15) that "as a Maternity Team we are proud to provide safe, kind and high quality care and a supportive and fulfilling working environment for our staff etc……." this report appears to show more gaps than compliance. In view of this, suggest the opportunity to think longer term and discuss reconfiguring services which will include obstetrics at both DGH's with networking with BSUH and the Medical School, in particular with Midwife and consultant training, particularly when thinking of building for the future. Please can any building plans include the possibility of having MLU's with alongside obstetric units at both hospitals to enable all East Sussex women to give birth in East Sussex. With state of the art facilities and a new build, it could attract women from outside the County increasing choice and safety etc. The Ockenden report does not identify size of unit as an issue and with recent new build Maternity units for circa 1200 births per annum here is an opportunity for ESHT to explore this.

2. Had a good meeting recently with Emma Chambers and pleased Eastbourne MLU open again. What plans are in place to ensure this doesn't keep happening particularly when relying on the ambulance service so heavily?

   This is outside of the Trust's control. If the ambulance service is unable to guarantee that it can respond in a timely manner then we would close the unit again to ensure the safety of our patients. We hope that we won't have to close the MLU again in the future, but if there is a resurgence of the pandemic then it is a possibility.

3. Building For Our Future. Strategic Outline Business case due date end of March. Very pleased to have a meeting to discuss this in early March. Many thanks.

4. There have been comments about the appalling lighting in the DGH car park. There is no lighting at all on the pavement from the car park payment booth to the exit gate so you cannot see where the pavement ends. A trip or fall hazard? The lighting in the car parking area itself is minimal, if any.

   Thank you for this feedback. This has been passed on to our director of estates.

Questions from the Mr Colin Campbell.

1. Can the Trust confirm that it has had input to the contents of the East Sussex Digital Roadmap?
   Yes the Associate Direct of Digital is a Key member of the East Sussex ICP Digital program and has input into the overall strategy and it is also chaired by the CFO of the Trust

2. A response from the CSU to a recent Freedom of Information request identified a number of Digital Enablers and I would be grateful if the Trust could confirm participation in the following projects:
   a. East Sussex Integrated Digital Team
   Please see above
   b. Shared Care Record
   Yes the Associate Direct of Digital is the Technical Lead on the project and ESHT are the hosts of the infrastructure environment
   c. Personal Health Record
   ESHT has rollout the Patients Knows Best PHR across the Trust and now have 18k patents signed up to it use, all Clinical Letters and Discharge Letters no have the option to be sent via the PHR and not by post. We have an extensive roadmap over the next 12 months to deliver various clinical pathways and Pathology and Radiology result as well as appointments.
   d. Patient Initiated Follow Up process
   PIF is a key part of the outpatient transformation program and also is linked with the PHR above.
   e. Sussex Integrated Dataset
   ESHT are already providing Acute Data into the SID and are currently working on the community Data
   f. Integrated Discharge Solution
   As part of the Shared Care Record and the Digital Aspirant we are working with SCFT/Social Care on the integrated Discharge Solution.

3. What services were provided to the Trust by Liaison Financial Services Ltd in the current financial year?
   Liaison Financial Services LTD provide TempRE which is a temporary workforce management solution designed to help control and reduce temporary staffing costs. The system supports the filling of vacancies through to payment of staff.

4. What services were provided to the Trust by 2020 Delivery Ltd in the current financial year?
   Financial modelling.

5. Where are the payments to NHS Resolution by the Trust expensed in the accounts?
   NHS Resolution is an arm's length body of the Department of Health and Social Care. They are the Trust's insurer for clinical negligence and other liabilities and the payments cover our premium to them. They can be found in Note 7 Operating Expenses: Clinical Negligence.

6. The cash and cash equivalent balance at the end of month 9 was £90m, when did this figure reduce to the average plan balance of £2.1m?
   The cash balance at year end for deficit organisations has historically been £2.1m. In the current year, due to the financial regime changes, the Trust has been moved to a block contract paid in advance which is contributing to the higher than usual cash balance. There is no requirement to meet £2.1m at year-end for the current year.

7. Does the Trust Board have a view on the operational structure proposed for ICS given that the recent CCG Governing Body paper has the ICS being led by Primary Care and Primary Care Networks? Reflecting on the fact that the recent pandemic has clearly identified that the operational pinch point in the NHS is Critical Care provision surely the leadership and therefore the development of the ICS should lie with the Trust supported by an extensive digital highway?
   This appears to ask two questions, the first relating to the recent government White Paper (Integration & Innovation). The Trust fully supported both the ICS and ESCC submission with regard to the consultation ahead of the White Paper (WP). The WP reflects the thrust of the submissions and so we are supportive of the direction set out in the document.

   The second question around critical care is particularly pertinent to ESHT as we have been particularly challenged during COVID with capacity. During the course of COVID, critical care featured as a standing item on the daily operational call across Sussex. We continue to discuss this with our ICS and region.

8. Where do the views of the patients sit within the strategic development of the ICS?
   This is perhaps a question on which the ICS would be better placed to respond. We are aware that our local ICS is particularly keen on involving local residents/patients in its thinking.

9. Can the Trust provide a brief summary of the numbers of staff who participate in the Sussex Health and Care Partnership activities and the meetings that they attend?
   The CEO attends the monthly SHCP meetings. It is much more difficult to estimate those involved in the tasks and activities that flow from this meeting since these are both strategic (planning-related) and tactical (operationally-focused) and so cut across almost all aspects of our day-to-day priorities when managing the Trust.

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust
9th February 2021 Trust Board Meeting

Agenda item	Action	Lead	Progress
004/2021 – Matters Arising	Mrs Argent to provide verbal update on 111 First at April's meeting.	**TA**	Update to be given verbally at the meeting

Item 5Ci - 25th March 2021 Audit Committee Summary

1. Introduction

An Audit Committee was held on 25th March 2021. A summary of the meeting is set out below.

2. Tenders and Waivers

Continued good progress in reducing the number of waivers issued was noted. The Committee praised the significant improvements seen over the previous nine months, thanking finance and procurement colleagues for their hard work.

3. Losses and Special Payments

Reporting to the Committee was enhanced to include the write off of disputed debts with other NHS organisations. The Committee noted and approved the losses and special payments.

4. Integration and Innovation

Two recent HFMA briefings on Integration and Innovation following the publishing of the NHS White Paper were presented to the Committee. It was agreed that these helpful summaries should be included in meeting papers at a forthcoming Board Seminar where the Board would discuss the implications of the White Paper.

5. Board Assurance Framework and Risk Register

Changes to risk ratings in some areas of the BAF were noted. The Committee suggested that longer term actions to address risks on the BAF should be added to the document to help show a path reaching target risk scores. The Committee approved the BAF to be presented to the Board.

6. Draft Annual Governance Statement and Annual Self-Certification

The Committee reviewed the draft annual governance statement, noting that this would be included with the Trust's annual report. The Committee also approved the annual self-certification for presentation to the Trust Board.

7. Changes to Accounting Policies

No significant changes to accounting policies for the financial year-end 2020/21 had been made. It was noted that due to the increase in turnover of the Trust, to over £500m, the Trust would move categories which would impact on materiality. Trust processes had been updated to account for this change. No detrimental impact on the audit process was anticipated by the Trust.

8. Information Governance Update

The annual audit of data security and protection toolkit (DSPT) in the Trust had been completed with substantial assurance received. The Committee praised the work of the team in achieving this benchmark. It was noted that data analytics were being considered to help and understand data breaches in the Trust more effectively.

9. Internal Audit

Four final reports had been issued since the previous meeting. Three were advisory, concerning information governance – patient record access, cyber maturity assessment and CFA Part 2, and the fourth looked at data quality: mixed sex accommodation and received reasonable assurance. Seven draft audit results had been issued. The digital team lead would be invited to a future meeting of the Committee to discuss digital risks in the organisation.

10. External Audit

The year-end audit plan was presented and agreed by the Committee.

11. Local Counterfraud Service

An update was received from LCFS, who noted that in 2021/22 new whole of government fraud standards would be used rather than NHS standards. The LCFS work plan for 2020/21 was agreed.

Nicki Webber
Chair of Audit Committee
01.04.21

East Sussex Healthcare NHS Trust

Finance & Investment Committee

1. Introduction

A Finance & Investment Committee was held on 25 February 2020. A summary of the items discussed is set out below.

2. Month 10 Financial Performance

An update on Month 10 Financial Performance was given including the revised year end forecast position. The current forecast is that the Trust will achieve breakeven following national funding of lost non-NHS income.

3. Month 10 Capital Programme

The 2020/21 capital plan was noted, including the financial performance to the end of January (M10), the financial risks pertaining to the delivery of the capital programme and the revised Capital Resource Limit (CRL). There has been a reduction in the forecast spend to year end which reflects increased pressure on delivering estate projects caused by Covid.

4. Building for the Future (BFF) Draft Strategic Outline Case (SOC) (financial chapters)

The Committee received an update on the Building for our Future programme and Strategic Outline Case, providing assurance of the action being taken following the roundtable discussion with the Department of Health and Social Care's New Hospital Programme team on 29 January 2021. It was noted that timescales had changed following this discussion, however the programme was still on track for submission of the Strategic Outline Business Case by 26 March 2021.

5. Productivity & Efficiency Update

An update was given on the Efficiency Programme. It was noted that deep dives were being undertaken into all of the transformation programmes and stressed that it was important to focus on productivity and benchmarking.

6. 2021/22 Financial Planning

An update was provided on the 2021/22 financial planning process. It was noted that this would be in two parts.

7. Commercial Update

The Committee received an update on Commercial Projects.

8. Construction of a new multi-storey car park at Conquest

The Committee received a paper supporting the request to proceed with the implementation of a Pre-construction services agreement between East Sussex Healthcare Trust and Wilmott Dixon Construction relating to the design and construction of the proposed new multi-storey car park the Conquest hospital. The Committee agreed to sign the agreement and for an order to be raised.

9. **Contract Award Recommendation - Cardiac Defibrillators**

The Committee received a Contract Award Recommendation Report for the purchase of 95 Cardiac defibrillators. This was in the capital plan under minor equipment and was a bid for emergency capital funding which was expected to be received by March 2021.

Damian Reid, Chief Financial officer
on behalf of Steve Phoenix, Chair of Finance & Investment Committee

06 April 2021

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 18 March 2021. A summary of the items discussed at the meeting is set out below.

2. Review of Action Tracker

The outstanding items on the action tracker were reviewed and further updates would be provided at the next meeting.

3. Workforce

Workforce Report

The Chief People Officer provided an overview of the workforce status. Key highlights:

- Total workforce utilisation for February 2021 was 7,505.5 fte
- Workforce expenditure £1390k over budget
- Increase in pay expenditure due to the delay of bank and agency payments; a significant overspend which will decrease over the next few months. The reason for the overspend being double pay (pay for staff off sick as well as pay for bank and agency to cover the roles). This is an unexpected and exceptional experience
- Trust vacancy rate reduced by 0.5% to 0.2%
- Turnover rate remained unchanged at 9.7%
- Monthly sickness decreased by 3.7% to 4.0%. This reflects the reduction in Covid sickness and the impact of the vaccination programme. Lateral flow test results had been 0 for the last 2 weeks
- Annual sickness remained unchanged at 4.8%
- Mandatory training compliance rate had reduced by 1.7% to 87.7% although it was noted that there had been an issue with ESR reporting
- Appraisal compliance rate had reduced by 1.4% to 71.3%
- Staff members had been moved back from redeployment. SA thanked PW and team for the ongoing work involved in this
- Recruitment – significant staff recruited including hard to recruit roles
- Nursing recruitment continues to go well
- Over the period doubled bank staff from 3000 to 6000 — long term positive impact for the Trust
- Job Planning review taking place.

Establishment Review

The Chief People Officer reported that the establishment review had been discussed at the Executive Directors meeting and Terms of Reference were in the process of being agreed.

The Chief People Officer highlighted that the establishment will look specifically at the workforce in areas of nursing, AHPs, HCAs etc. Budgets would need to be correct for next year to include an OD element for creating a baseline of establishment to build for the future.

Employee Relations Report

The Head of Operational HR provided a comprehensive update on the Employee Relations Report and explained that the paper described information relating to the number of formal staff complaints and conduct issues which had been raised, including Employment Tribunal claims, during the period 1 April 2020 and 30 September 2020 (Quarter 1 and Quarter 2). The Covid-19 lockdown had a significant impact on the progress with employee relations casework over the period from March to July 2020.

4. Health and Wellbeing – Staff Survey Summary

The Assistant Director of HR, OD, provided an update of the National Staff Survey. The results were published on Thursday 11 March 2021. The survey was carried out between September and November 2020. The Trust response rate was 50.9% compared to an average of 45.3% for those similar Trusts within our sector.

5. Guardian of Safe Working Hours Report

The Guardian of Safe Working Hours provided a verbal overview of the Report which covered the months November 2020 to January 2021. The purpose of the report is to update and provide assurance to the Board that Doctors in Training (DiT) are safely rostered; a total number of 244. The exception report is the mechanism to report safety concerns in the workplace and junior doctors can receive either financial compensation or time off in lieu validated by their clinical supervisor.

6. Board Assurance Framework

The Director of Corporate Affairs shared the Board Assurance Framework (BAF) and Corporate Risk Register report. This report provides an overview of the status and movement of HR/OD risks qualifying for the corporate (high level) risk register; risks scored at 15 and above. It was noted that there were 12 risks related to HR/OD matters.

The BAF highlights to areas for the POD Committee to focus on:

BAF 4 – Sustainable Workforce – rated 16
BAF 5 – Protecting our Staff – rated 12

The POD Committee were asked to review and note the Corporate Risk Register and BAF and consider the risks identified and appropriate actions.

7. Minutes of the POD Committee 18 February 2021

Approved minutes of the meeting held on 18 February 2021 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee
March 2021

Quality and Safety Committee Report 18th March 2021

- The High Level Risk Register and BAF were reviewed and the number of updates to mitigations noted. This will continue and there are a few items that need to be reworded or removed.

- A post Covid look back/review has commenced and will start to report back against national criteria and lessons specific to ESHT from June onwards. The aim is to have an understanding of the impact and actions taken to maintain safety during the pandemic. The committee will receive a report in June/July.

- The Health and Safety exception report gave assurance on the work of the group and following on, the QSC requested an update on the workplan arriving from an analysis of trust performance.

- The committee noted the increase in service provision for CAMHS but remain concerned over the support available to children in an acute setting. This is a system wide issue to be addressed within our ICS.

- The committee noted progress against the CQC action tracker and the proposed changes to the CQC inspection regime. The change proposed is to move to a risk based approach and the trust would be keen to ensure our improvements were more able to influence the overall rating in future.

- The RTT performance was noted and strong assurance given on maintaining and monitoring patient safety. The advent of 52 week waits as a result of covid was noted but the committee was assured that the Trust is actively managing long waits.

- The IPC BAF was reviewed and good progress maintained with no red items. The addition of new requirements was noted and our ability to respond remains strong at this point.

- The CNST maternity Incentive scheme response is on track for submission with confidence that the Trust will be fully compliant and therefore eligible for a rebate to be allocated for maternity services.

- The paper on patient falls detailed lessons learned by other trusts and a plan for a peer review with another trust. An assessment of current trust performance indicated a number of possible quick wins that can be adopted but further long term cultural change will be required to embed falls management and reduce incidents.

- The committee received a paper on Safer Staffing which underlined the pressure on staff allocations during the second wave. However the committee were assured that basic ward safety was maintained throughout, albeit with a far reduced staffing complement at the height of the pandemic. The report also noted the arrival of the next cohort of international nurses and the measures needed to ensure they were welcomed, supported and inducted into ESHT. Finally the 6 monthly review of staffing is planned to feed into the trust business planning cycle.

Jackie Churchward-Cardiff
Quality and Safety Committee Chair
18th March 2021

East Sussex Healthcare NHS Trust

Item 5Ci - 25th March 2021 Strategy Committee Summary

1. Introduction

The Finance & Investment Strategy Committee met on 25th March 2021; this document summarises items presented to the Committee.

2. Five-Year Strategy Development:

An update on progress in developing the Trust's five year strategy was presented. Following discussions at January's Committee, with the Trust Board, and excellent engagement with staff in virtual ESHT Strategy roadshows in February, a number of changes had been made to the four strategic aims. Engagement sessions had been well attended and each generated good discussion and content. Feedback provided would be incorporated into the next iteration of the strategic aims. The four aims had been revised by Executive colleagues and discussed with ADO's and Chiefs to ensure that they linked up with divisional and business plans.

3. White Paper

A summary paper explaining the key elements of the NHS White Paper was presented, highlighting emerging Acute, Mental Health, Community and Primary Care collaboration. It was noted that the Trust were already undertaking many of the elements of the plan, in partnership with other organisations across the Surrey and Sussex system.

4. ICS Acute Service Review

This service review formed part of the ICS development and required a strategic view on how acute services would develop within Sussex, recovery of elective services following the pandemic, and recognised different ways of working. A single view PTL had been developed around the access waiting list summary across Sussex, to understand the shape and size and the number of patients waiting for treatment across the region. Recovery plans were due to be completed by 6th May 2021, with outline recovery plans completed within the next two weeks.

5. SOC Approval

The Strategic Outline Case (SOC) for Building for our Future had been developed and completed in accordance with all of the requirements of the NHSE/I fundamental criteria, better business case and NHSE/I guidance. The Committee approved the submission of the SOC to the Board for sign off.

6. BAF Approval

The paper provided an overview of the status and movement of the risks overseen by the Strategy Committee which qualified for the corporate (high level) risk register – risks scored at 15 and above and Board Assurance Framework. The programme had extracted 35 risks, mostly related to backlog maintenance.

7. Planning Guidance 21/22

The paper summarised the workforce establishment and includes minimum safety review completed between January / March 2020 to establish a base line. There would be a second stage process which looked at business cases that had been developed during the last year but not actioned, primarily to have a post Covid establishment from month seven onwards. This would help to build up a planning process in May as the starting point.

8. First Draft Capital Plan

Provisional capital allocation for 2021/22 was discussed. Conversations had been held with divisions who had identified priorities for capital expenditure during the year. Discussions about potential additional capital funding were being held with ICS colleagues.

Jacquie Churchward-Cardiff
Acting Chair of Strategy Committee

March 2021

East Sussex Healthcare
NHS Trust

Board Assurance Framework

Meeting information:			
Date of Meeting:	13th April 2021	Agenda Item:	6
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?	

Summary:

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

No new risks have been added to the Board Assurance Framework (BAF) this quarter and all existing risks have been reviewed and progress updated.

The Covid pandemic has had a significant impact on all areas of the Trust including staffing; its impact is highlighted in the BAF and as a result this quarter BAF 2 and BAF 3 remain at 20 and BAF 1 has increased from 12 to 16.

It is anticipated that these risks will reduce as the number of covid admissions reduce and we are able to implement recovery and restoration plans. The Trust's governance framework is also now fully operational.

BAF 6, financial stability, has reduced to a scoring of 4 this is because the financial position for 20/21 is expected to be breakeven with nil or limited risk. Risk will be moderate for Q1 & Q2 next year through an expected block contract but rise in the second half of 21/22

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

- Quality and Safety Committee, 18th March 2021
- People and Organisational Development Committee, 18th March 2021
- Strategy Committee, 25th March 2021
- Audit Committee, 25th March 2021

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

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

Board Assurance Framework (BAF)

Quarter 4 2020/21

Overview

The Board Assurance Framework (BAF) supports the Board in focussing on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of the Objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These assurances have been set out in line with the '3 lines of defence' model (appendix 2), aiding the identification of areas of weakness.

Each principal risk is owned by an Executive Director and rated in accordance with the grading matrix (Appendix 1). The Executive lead ensures the controls, assurance, gaps and risk score reflect the management of the risk. A Board sub-committee is also nominated to have oversight of the risk.

There are no new risks added to the BAF this quarter and all existing risks have been reviewed and progress updated.
The Covid pandemic has had a significant impact on all areas of the Trust including staffing; its impact is highlighted in the BAF and this quarter BAF 2 and BAF 3 remain at 20 and BAF 1 has increased from 12 to 16. It is anticipated that these risks will reduce as the number of covid admissions reduce and we are able to implement recovery and restoration plans. The Trust's governance framework is also now fully operational.

BAF 6, financial stability, has reduced to a scoring of 4 this is because the financial position for 20/21 is expected to be breakeven with nil or limited risk. Risk will be moderate for Q1 & Q2 next year through an expected block contract but rise in the second half of 21/22

Ref	RISK SUMMARY	Monitoring Committee	Objectives Impacted					Inherent risk	Current position (Residual risk)								Change	Risk appetite	Target rating	Target date
									2020/21				2021/22							
									Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
BAF 1	Safe care - sustained and continuous improvement	Q&S	✔					20	9	9	12	16					▲	Low	6	Sep-21
BAF 2	Restoration and Recovery - ongoing impact of Covid19	Q&S	✔	✔	✔	✔	✔	20	16	16	20	20					◄►	Low	6	Sep-21
BAF 3	The Trust's performance against access standards is inconsistent	Q&S	✔	✔				20	12	16	20	20					◄►	Low	6	Sep-21
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16	16	16					◄►	Moderate	9	Sep-21
BAF 5	Protecting our staff	POD			✔				12	12	12	12					◄►	Low	4	Sep-21
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12	12	4					▼	Moderate	8	Mar-21
BAF 7	Investment required for IT, medical equipment and other capital items	F&S	✔				✔	20	16	12	12	12					◄►	Moderate	4	Sep-21
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	12	12	12					◄►	Moderate	8	Sep-21
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	16	16	16					◄►	Low	8	Sep-21

- Inherent - (gross) assessment (before current controls) of the risk
- Residual - (net) assessment (after current controls) of the risk

BAF Action Plans – Key to Progress Ratings		
B	**Complete / Business as Usual**	Completed: Improvement / action delivered with sustainability assured.
G	**On Track or not yet due**	Improvement on trajectory
A	**Problematic**	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
R	**Delayed**	Off track / trajectory – milestone / timescales breached. Recovery plan required.

SO1: Safe Care **SO2: Access** **SO3: Valuing employees** **SO4: Partnership Working** **SO5: Efficient use of resources**

RESIDUAL RISK MATRIX

	Safe and excellent patient care, high quality clinical services	Operate, efficiently and effectively in a timely way	Value, respect and involve employees	Work closely with partners to prevent ill health and deliver services to meet needs	Use resources efficiently and effectively to ensure clinical. operational and financial sustainability
BAF 1 – Safe care - sustained and continuous improvement	**16**				
BAF 2 – Restoration and recovery Ongoing impact of Covid19	**20**	**20**	**20**	**20**	**20**
BAF 3 - The Trust's performance against key access standards is inconsistent	**20**	**20**			
BAF 4 - Sustainable Workforce	**16**	**16**	**16**		**16**
BAF 5 – Protecting our Staff	**12**				
BAF 6 - Financial Sustainability				**4**	**4**
BAF 7 - Investment required for IT, medical equipment and other capital items	**12**				**12**
BAF 8 – Investment required for estate infrastructure – buildings and environment	**12**				**12**
BAF 9 - Cyber Security	**16**	**16**			**16**

SO1: Safe Care

SO2: Access

SO3: Valuing employees

SO4: Partnership Working

SO5: Efficient use of resources

Risk Summary

BAF Reference and Summary Title:	**BAF 1: Safe care – sustained and continuous improvement**					**Strategic Objectives Impacted:** SO1 ✓
Risk Description:	**There is a risk that we will not provide sustained and continuous improvement in patient safety and quality of care**					
Lead Director:	Director of Nursing/ Medical Director	**Lead Committee:**	Quality and Safety Committee		**Date of last Committee review:**	Mar-21
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	25/09/15	1360	Cardiology catheter labs breakdowns	16	16	◄►
	19/02/16	1458	Non-Compliance with NICE guidance NG19 (Diabetic Foot)	20	16	◄►
	03/12/20	1942	Risk of insufficient acute beds during winter	20	16	◄►
	03/12/20	1941	Risk to the delivery of planned/elective activity against Phase 3 recovery	20	16	◄►
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	13/08/20	1907	Insufficient isolation areas and testing kits for Covid-19	16	16	◄►
	24/09/20	1913	Increased waiting times due to cancellations as a result of Covid-19	16	16	◄►

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	4	4	The second wave of the Covid 19 pandemic resulted in some services being suspended and additional pressures including staffing shortages and therefore the consequence increased to major. This risk level is anticipate to improve in quarter one due to the reduction in Covid-19 admissions.	**Likelihood:**	2	Sep-21
Consequence:	3	3	3	4		**Consequence:**	3	
Risk Level:	9	9	12	16		**Risk Level:**	6	

Cause of risk:	• Covid-19 impacting the Trust's ability to provide safe and effective care • Clinical governance systems and systems for learning from incidents and other quality metrics may not be consistently applied and effective	**Impact:**	Failure to provide safe and effective care may result in: • Sub-optimum patient outcomes and experience • impact on our registration and compliance with regulatory bodies

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

Current methods of management (controls)	A. Robust governance process, to support quality improvement and risk management; including undertaking Root Cause Analysis where there are incidents and sharing learning, B. Audit programme in place and reviewed by clinical effectiveness C. Mortality reviews to share learning D. Independent medical examiner scrutinising deaths to identify any quality concerns E. Quality Improvement strategy in place and improvement hub established QSIR improvement utilised and training programme in place F. 'Excellence in Care' audit and reporting programme rolled out to in-patient areas to facilitate clinical areas in assessing themselves against Trust wide standards of care G. Patient tracking lists, use of nerve centre and MDT meetings in place

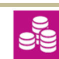
Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	2nd Line of Defence *(specialist support, policy and procedure setting, oversight responsibility)*	3rd Line of Defence *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Oversight of excellence in care at ward and service level (F) • Health Assure being utilised by wards and services as depository for CQC evidence (A) • Divisional management of risk and control framework (A) • Quality improvement champions in place and projects in train (E) • Daily clinical review of patients on waiting list (G) • Nerve centre in use for monitoring real time bed state (G)	• Divisional IPR meetings cover quality and safety (A) • Weekly patient safety summit (A) • Clinical Outcomes and effectiveness group (B) • Integrated Performance Report and incident reporting to Quality and Safety Committee and Trust Board (A) (B) • Improved quality in a number of areas for example sepsis, falls resulting in harm and reduced mortality (A) (C) (D) • Getting it Right First Time (GIRFT) in place has improved learning and actions to improve quality of care (A) (B) • Mortality review group meeting (C) (D) • MDT meetings to manage patient pathways (G)	• CQC inspection regime – Trust rated Good overall and Outstanding at Conquest and Community Services (A) • CCG review of incidents prior to closure (A) • Internal audit conduct annual audit of quality account indictors (A) (B) • External accreditation and quality surveillance such as JAG, audiology (B) • Nationally mandated audits and benchmarking (B)

Gaps in control/assurance:

- CQC identified some "should do" requirements
- Improvements required in discharge particularly around information and communication to care homes
- Refer to BAF 2 for other gaps related to Covid-19 pandemic

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Action plan required and monitoring to address CQC should do requirement	Director of Corporate Affairs	End Mar-21	Action plan in place and majority of actions delivered, Monitoring in place to ensure actions are complete and embedded	**To be closed**
2.	Programme of work in place to improve discharge pathway and quality of discharge	COO/DoN	End Mar-21	Patient Flow – Safe Discharge Workstream in place and multi-disciplinary improvement group focussing on quality being established. However, challenges with discharging patients to care homes due to Covid pandemic.	
	Refer to BAF 2 for additional actions related to Covid-19 pandemic				



Risk Summary						
BAF Reference and Summary Title:	BAF 2: Restoration and Recovery				Strategic Objectives Impacted: SO1 ✓ SO2 ✓ SO3 ✓ SO4 ✓ SO5 ✓	
Risk Description:	There is a risk that the historical and ongoing impact of Covid 19 will be detrimental to the trust's ability to operate effectively, which could impact service delivery, clinical outcomes and patient experience.					
Lead Director:	Chief Operating Officer	Lead Committee:	Quality and Safety Committee Finance and Strategy Committee		Date of last review by Committee:	March -21
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	03/12/20	1941	Risk to the delivery of planned/elective activity against Phase 3 recovery	20	16	◄►
	03/12/20	1942	Insufficient acute beds during winter	20	16	◄►
	24/09/20	1915	Outpatient backlog causing delays	16	16	◄►
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	12/06/20	1888	Staff shortages due to Covid-19	20	16	◄►
	11/06/20	1887	Use of Anaesthetic machines off-label during COVID-19	20	15	**Risk will be closed**
	11/06/20	1885	Insufficient oxygen supplies	20	16	**Risk will be closed**
	01/07/20	1894	COVID-19: Diabetic Eye Screening Restoration	20	20	◄►
	12/06/20	1883	Insufficient critical care trained staff to manage additional capacity	16	16	◄►
	27/11/20	1937	EMU birth centre environment	15	15	◄►

BAF Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5	5	Risk level increased due to the certainty that of the second wave of Covid-19 impacting delivery, restoration and recovery of services. The impact has moved to "certain" and the consequence "major"	Likelihood:	2	Sep-21
Consequence:	4	4	4	4		Consequence:	3	
Risk Level:	16	16	20	20		Risk Level:	6	
Cause of risk:	Due to a significant and sharp increase of Covid-19 admissions, a number of actions have been				Impact:	Failure to effectively manage the pandemic and establish a robust restoration and recovery programme gives rise to risk of		

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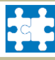
	implemented to support the Trust in being able to effectively respond whilst maintaining patient safety. Measures include cancelling all non-urgent surgery and services, a move to virtual outpatients, relocating services, redeployment of staff and managing reduction in staffing due to self-isolation. Recovery and restoration will be required when admissions reduce.		• patient harm • impaired patient and staff experience • failure to meet constitutional and contractual standards • damage to Trust's stakeholder relationships and reputation
Current methods of management (controls)	A. Workstreams in place aligned to patient, people, process, finance, digital and estates B. Trajectory for restart and recovery to be developed C. Waiting for national guidance on activity requirements D. Estates space utilisation being reviewed taking account of requirements for recovery of safe services whilst maintaining social distancing E. Identifying areas where improvements have been made eg such as virtual out-patient appointments and maximising these opportunities F. Redeployment/Repatriation of staff for restart G. Utilisation of capacity in private providers where available contractually during Q1 H. Elective Care Board oversight of long waiting patients & harm reviews I. Incident declared and controls and actions agreed through daily Incident Management meeting chaired by CEO J. Roll out and support the mass vaccination hubs		

Assurance Framework – 3 Lines of Defence - linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Weekly IMT meeting in place and all decision logged and risks monitored (I)(A) • Workstreams and associated governance arrangements in place (A) (B) (C) (D) (E) (G) (H) (I) (J) • Weekly update report covering concerns/ key actions / positive assurance and decisions presented to Executive Team (A) (B) • Twice weekly Elective Care Board overseeing re-starting of services and interdependencies (H) (G) • Performance against National Standards (B) (C)	• Report on Restoration and Recovery presented to Trust Board and standing item on Board agenda (A) • Linking into system wide recovery approach (B) • Digital infrastructure improved; hardware available to facilitate home working (D) • HR Support for staff related Covid-19 issues including risk assessment and track and trace (F) • Divisional tracking through Elective Care Board against trajectories that are in development (B) (H)	• Internal audit plan will include aspects of the management of Covid-19 (A) • Oversight by NHS Improvement through submission of sitrep information and oversight meetings (B) • ICP/ICS risk and recovery group (B) • Planned Care Board (C)
Gaps in control/assurance:			
• Further controls and assurances will be required to restore and recover services post the current second wave			

SO1: Safe Care

SO2: Access

SO3: Valuing employees

SO4: Partnership Working

SO5: Efficient use of resources

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Maximise opportunities for staff redeployment to support clinical areas	Director of HR	End Jan-20	Redeployment programme in place matching skills to requirements with staff training.	**To be closed**
2.	Ongoing monitoring and review with step down/suspension of services if appropriate and safe to do so	COO	End Jan-20	Routine and non-urgent electives being rescheduled, maternity home births suspended across Sussex. Services for vulnerable patients relocated Additional capacity being opened at Firwood House *Firwood now close, EMU/homebirths recommenced*	**To be closed**
6.	Reset and restart plan and trajectory will need to be developed and refreshed following current wave of pandemic	COO	End Apr-21	Redeployed staff to be returned to substantive roles Reset and restart plan and trajectory being developed	**In progress**

Risk Summary

BAF Reference and Summary Title:	BAF 3: Inconsistent performance against key access standards	Strategic Objectives Impacted: SO1 ✓, SO2 ✓
Risk Description:	There is a risk that we will not fully and consistently meet mandated access standards	

Lead Director:	Chief Operating Officer	Lead Committee:	Quality and Safety Committee	Date of last review by Committee:	Mar-21

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	15/04/13	999	Cancer 62 day compliance	16	12	◄►
	24/09/20	1915	Outpatient follow up backlog – particularly ENT, Ophthalmology and Urology.	20	16	◄►
	10/06/2019	1804	Impact of availability of ward beds on critical care availability	29	16	◄►

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5	5	Risk level increased due to the certainty that the second wave of Covid-19 will impact delivery, restoration and recovery of services. Impact moved to “certain” and consequence “major”	Likelihood:	2	Sep-21
Consequence:	3	4	4	4		Consequence:	3	
Risk Level:	12	16	20	20		Risk Level:	6	

Cause of risk:	Impact:
Increased demand for services and diagnostics year on year. This has been further impacted by the reduction of patient presentations to GPs during the pandemic, leading to a growing unidentified need, and to reluctance on the part of some patients to engage with treatment plans during the pandemic period.	Failure to meet access standards consistently gives rise to risk of • patient harm • impaired patient experience • failure to meet constitutional and contractual standards • damage to Trust’s regulatory and contractual relationships and public reputation

Current methods of management (controls)

A. Urgent care programme of work in place
B. ESHT has been allocated a Cancer Alliance Relationship manager who is working in partnership with the Trust. This work focuses on best practice timed pathways along with partnership working with other providers to learn and share best practice.
C. Pathway improvements and monitoring for A&E, cancer, diagnostics and RTT
- pathway review in line with 28/62 days
- identifying digital opportunities to proactively manage cancer

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

	- Alliance decision to be confirmed re AI digital tracking - Contact with individual patient and agreeing individual approaches to mitigating concerns - Contact with GPs / CCGs / Primary Care Networks etc D. Working closely with the Cancer Alliance on improvement actions such as: - Straight to test pathway - Faster diagnostic standard E. Addressing Histology turnaround times and implementation of the Faster Diagnostic Standard

Assurance Framework – 3 Lines of Defence – mapped to controls A-E			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Clinical oversight and review of RTT and cancer PTL throughout pandemic and recovery period. (B) (C) (D) • Day to day oversight of A&E performance (A) • Ongoing 'Cancer Week' focussed MDT PTL meetings (E) (D) (B)	• Specialist support and feedback from Cancer Alliance (D) • Policy and procedures for MDT reviews strengthened early 2020 (C) • Divisional IPR meetings in place (A) (C) • Cancer Board, Urgent Care and Elective Care Boards with oversight of metrics (A) (C) (D) (E) • Review by Quality & Safety Committee (A) (C) • IPR reports to Trust Board (A) (C) • Flow transformation project in place (A) • Cancer Access Meeting (weekly) (C) (D) (E)	• Oversight by NHS Improvement through submission of sitrep information and oversight meetings (C)
Gaps in control/assurance:			
• Further controls and assurance will be required to restore and recover services post the current second wave			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Revised recovery and restoration of services will be required post current wave	COO	End Sep 2021	Elective care Board and Cancer Access Meetings starting 're-start' trajectory work	
2.	Refresh and implement the revised patient flow programme	COO	End Sep 2021	Project milestones finalised and workstream leads and implementation planning taking place	

Risk Summary

BAF Reference and Summary Title:	BAF 4: Sustainable Workforce					
Strategic Objectives Impacted	SO1	SO2	SO3	SO4	SO5	
	✓	✓	✓		✓	
Risk Description:	**There is a risk that the Trust will be unable to attract, develop and retain its workforce to deliver outstanding services within its financial envelope**					
Lead Director:	Chief People Officer	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	Mar-21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	23/02/12	767	Workforce Plan and Capacity	20	16	◄►
	23/08/16	1537	Medical Staff Recruitment	20	16	◄►
	23/08/16	1538	Nursing Recruitment	20	16	◄►
	23/08/16	1540	AHP/Technical Recruitment	20	16	◄►
	03/05/17	1616	Consultant Vacancies	20	16	◄►
	21/12/18	1772	Insufficient intensive care consultants	20	16	◄►
	21/04/15	1289	Histopathology consultant vacancies	20	16	◄►
	05/10/20	1919	Shortage of staffing in chemistry	15	15	◄►
	15/02/21	2030	Impact of covid-19 pressures on staff retention	20	16	**New**

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4	4	There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention likely to be a risk especially following Covid-19 pressures.	**Likelihood:**	3	Sep-21
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	16	16	16	16		**Risk Level:**	9	

Cause of risk:

- Recognised national shortages in some staff groups
- Geographical location
- Continued pressure in a number of clinical areas
- Lack of opportunity for career development
- Pandemic may have a detrimental impact on staff retention.

Impact:

Failure to maintain workforce stability gives rise to risk of:

- Increased workforce expenditure due to agency requirements
- Detrimental impact on patient care and experience
- Failure to comply with regulatory requirements and constitutional standards
- Detriment to staff health and well-being

SO1: Safe Care **SO2: Access** **SO3: Valuing employees** **SO4: Partnership Working** **SO5: Efficient use of resources**

Current methods of management (controls)	A. Ongoing monitoring of Recruitment and Retention Strategy and developing wide range of recruitment methodologies (events, social media, recruitment consultancies, targeted recruitment activity, including a significant overseas recruitment plan) B. Talent management, appraisals and development programmes C. Developing new roles and "growing our own" D. Workforce metrics in place and monitored E. Quarterly CU Reviews in place to determine workforce planning requirements. F. Review of nursing establishment 6 monthly as per Developing Workforce Safeguards G. Full participation in HEKSS Education commissioning process H. Exit interview programme I. Use of bank and agency if required with authorisation process in place J. Managing impact of EU exit K. Range of wellbeing support available and being further developed

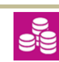
Assurance Framework – 3 Lines of Defence – mapped to controls A-I			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H) (D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas eg consultants in Histopathology, Radiology, Neurology and Acute medicine.(A) (C) • Introduction of Certificate of Eligibility of Specialist Registration (CESR) programme in A&E Sept 2020.Proposed roll out across other areas Qtr 1 2021. (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Direct communication to all EU staff re settled status. Task and finish group established.Direct communication to all EU Nationals (J)	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • 3 year Recruitment Strategy refreshed (A) • Overall Time to hire 75.4 days Jan 2021. (inc advertising/notice period). A slight reduction since last update. Medical and Nurse TTH however remain high due to Covid 19 travel restrictions (D) • Trust net vacancy trending at 0.3% in Jan 2021 due to budget re alignment. (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I) • Wellbeing offering enhance and reviewed by POD (K)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E)
Gaps in control/assurance:			
• Covid travel restrictions have continued to impact on some overseas recruitment/new starters			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers and Sonographers	CPO	Dec 2021	113 international nurses and 9 radiographers recruited to date (Jan 2021).Further 33 to arrive March 2021 with planned 25 every other month during 2021/22. On target to achieve 100 nurses 2021/22	
2.	Establishment of local networks with protected characteristic groups and organisations to increase diversity and talent.	CPO	June 2021	Planned communication in Qtr 1 2021, linked with WRES activities.	

SO1: Safe Care

SO2: Access

SO3: Valuing employees

SO4: Partnership Working

SO5: Efficient use of resources

Risk Summary						
BAF Reference and Summary Title:	BAF 5: Protecting our Staff				Strategic Objectives Impacted: SO3 ✓	
Risk Description:	There is a risk to staff health, welfare and morale if we do not undertake and act upon risk assessments to ensure a safe working environment and effective support for wellbeing					
Lead Director:	Chief People Officer		Lead Committee:	People and Organisational Development	Date of last review by Committee:	Mar-21
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	16/08/20	1908	Protecting our Staff	16	6	▼
	07/07/20	1900	Availability and use of Personal Protective Equipment	16	12	◀▶
	18/12/20	1947	Impact of Violence and Aggression on staff wellbeing	16	12	▼
	15/02/21	2030	Impact of covid-19 pressures on staff retention	20	16	New

BAF Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	Significant work has been undertaken in conducting and acting upon risk assessments for Covid-19. There is also a robust programme of work in place to support wellbeing of staff and manage violence and aggression however there is still more that can be done.	Likelihood:	1	end Sep-21
Consequence:	4	4	4	4		Consequence:	4	
Risk Level:	12	12	12	12		Risk Level:	4	
Cause of risk:	Failure to ensure that we provide a safe working environment for staff where they is adequate protection and support from a number of risks eg Covid-19, violence and aggression and work related stress.				Impact: Adverse impact on staff health and wellbeing. Risk of increased absences and therefore inability to deliver on services; possible closure of services and adverse impact on patient experience and reputational risks.			
Current methods of management (controls)	A. Systems and processes in place to risk assess staff to reduce the risk from infection of COVID 19. Managers are required to complete a risk assessment to identify measures that need to be put in place to enable a member of staff to remain safe at work. If this cannot be achieved managers need to consider deploying their staff member to a different area or working from home if need be. B. Training for managers to have compassionate conversations about risk assessments with vulnerable staff C. Daily compliance reviews take place at the Risk Assessment Task and Finish Group to identify targeted actions							

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

	D. Systems and processes in place both reactive and proactive to manage violence and aggression – including conflict resolution training, OH support, risk assessments and security support. Trialling revised policy and red and yellow letters. E. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. F. Reviewing and implementing best practice from other areas G. Range of wellbeing support available and being further developed

Assurance Framework – 3 Lines of Defence			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Covid risk assessment process implemented to be undertaken by line manager and retained on personnel file. Risk assessment compliance now 98.4% for all staff and 96.9% for BAME staff. (A) (C) • Completion of risk assessments to be recorded on ESR. (A) • Appropriate PPE provided (A) • Promoting wellbeing support available and training to line managers (G)	• Occupational Health and Health and Safety Team support and audit of risk assessments and datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Weekly COVID19 Workforce Group (A) (C) • Local Security Management Specialist advice and support (D) • Oversight and monitoring by Health and Safety Steering Group (D)	• CCG undertaking assurance reviews (A) • Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management (F) • Health and Safety Executive review of violence and aggression (D) • Collaboration with ESCC on lone working (F)
Gaps in control/assurance:			
• The Covid-19 pandemic has impacted some of the progress in supporting staff with incidence of violence and aggression • Need to develop a single software solution to support staff who are lone/community working • Need to ensure that staff have access to appropriate well being support during and following the Covid-19 pandemic			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Managers and staff to review existing covid risk assessments to ensure they reflect latest risk profiles and ensure appropriate mitigations are in place in line with Trust/national guidance.	CPO	End Apr 2021	Good compliance with completion but need to ensure assessments are reviewed and updated, including reviewing and implementing effective mitigation if required. Providing guidance regarding vaccination.	
2.	Progressing introduction of Critical Incident Stress Management (CISM) or Trauma Risk Management (TRiM) within the Trust	CPO	End Apr 2021	Divisions working with HWB team to identify and provide support required. Range of interventions are in place to support psychological wellbeing. Rolling out CISM/TRIM	
3.	Agreed business case for lone worker alert software and this is to be procured and rolled out	CPO	End Jan 2021	Business case approved and exploring options for joint working with ESCC	

Risk Summary

BAF Reference and Summary Title:	**BAF 6: Financial Sustainability**				Strategic Objectives Impacted: SO4 ✓, SO5 ✓	
Risk Description:	**There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run-rate at the end of 20/21 or not complying with Covid financial guidance and audit breaches**					
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Strategy Committee		**Date of last review by Committee:**	Mar-21
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	20/05/20	1878	Delivery of 20/21 Financial Plan	**20**	12	◄►

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	1	Financial position for 20/21 is expected to be breakeven with nil or limited risk. Risk will be moderate for H1 (Q1 & Q2) next year through an expected block contract but rise in the second half of 21/22	**Likelihood:**	2	Mar-21
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	12	12	12	4		**Risk Level:**	8	

Cause of risk:	The trust has agreed a block contract and agreed Covid payments for 20/21. The final month's payments need to be finalised, but not viewed as significant risk	**Impact:**	Failure to maintain financial sustainability gives rise to risk of • Unviable services and increased cost improvement programme • failure to meet contractual standards and possible regulatory action • damage to Trust's stakeholder relationships and reputation

Current methods of management (controls)

A. Risk adjusted CIP programme in place and PID produced for each scheme.
B. Transformation programmes in place to realise benefits of cost effectiveness
C. Reviewing approved business cases for realisations of benefits
D. Restatement of budgets in 2021 issued in September
E. Process in place for setting and managing budgets "grip and control"
   - Developed financial 'solution' for non-recurrent component of CIP delivery driven by delayed investment Agreement to maintain non-covid staffing at 19/20 m8-m10 levels
F. Monthly benchmarking of covid costs within ICS and agreement to only charge excess costs to Covid reclaim system
G. The finance team have combined a forecast update on the budget with the planners producing a revised activity plan as part of recovery. Key areas of focus include:

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

	- A refresh of the efficiency plans working with divisions; - Cost pressures arising from service developments/ recruitment; - How to strengthen the controls and accountability frameworks

Assurance Framework – 3 Lines of Defence - aligned to controls A-F			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Work continues through divisional meetings to both maintain contingency and to strengthen recurrent delivery of the programme. (A) (E) • Covid related costs captured and reimbursed to date (D)	• Oversight by Transformation and Efficiency Committee and Finance and Strategy Committee (A) (B) (C) (G) • Robust leadership of CIP programme, with strong link to Model Hospital and GIRFT established. (B) (C) (F)	• ICS Capital Programme in place in Line with Capital Resource Limit (CRL) (C) • Internal audit reviewing controls and Covid management (A) (D) • External audit programme in place (A) (D) (F)
Gaps in control/assurance:			
• None identified but need to ensure that the system of internal financial control remains robust and that there is effective governance in place to manage the re-establishment of services			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Maintain system of Internal Financial control and due governance as services step back up	DF	End July 2020	TIAA reviewed Covid incident governance and Reasonable Assurance given Project group to validated coding of Covid claim. Now business as usual	Closed
2.	Ensure the emerging financial regime post end of October is fully understood and risks identified	DF	End Jan-21	Confirmation from NHSI on financial enveloped post Covid	Closed
3.	Develop processes to manage the Capital resource limit within the Trust	DF	End July 2020	Tracked within Capital Planning Group	Closed
4.	Update financial reporting pack to support board oversight and scrutiny of financial performance	DF	End Mar-21	Being reviewed as reporting is more difficult during the Covid recovery phase	Closed
5.	A 10% tolerance was allowed against activity performance in month 8. ESHT will ask the ICS to allow a further tolerance in Month 9.	DF	End Mar-21	Reviewed and closed	Closed

Risk Summary

BAF Reference and Summary Title:	**BAF 7: Infrastructure**				**Strategic Objectives Impacted** ✓ (SO5)
Risk Description:	**There is a risk that the Trust will not have the necessary investment required for IT, medical equipment and other capital items**				
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	Mar-2021

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	27/05/20	1879	Capital sustainability	20	12	◄►
	12/02/14	1152	Obsolete medical devices	20	15	◄►
	25/09/15	1360	Cardiac catheter lab breakdowns	16	16	◄►
	01/02/21	2027	Trust Computer Resources for the Virtual infrastructure	20	15	**New**

BAF Risk Scoring

Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	3	3	3	Capital was available through 20/21, but unable to fully utilise due to speed of planning permission issues, limitations of contractors accessing the site and constraints of ensuring Covid requirements were prioritised.	**Likelihood:**	1	Sep-21
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	16	12	12	12		**Risk Level:**	4	

Cause of risk:	Insufficient capital to meet significant backlog maintenance	**Impact:**	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care. clearer reporting of any slippage against plan.
Current methods of management (controls)	A. Significant work was undertaken to deliver the capital plan. However in future there will be clearer reporting of any slippage against plan. B. Essential work prioritised with estates, IT and medical equipment		

Assurance Framework – 3 Lines of Defence - linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (A) (B) • Electronics and Medical Engineering (EME) in close liaison with divisions (B) • Full inventory of medical devices and life cycle maintenance (B)	• Oversight by Finance and Strategy Committee (A) • Estates and Facilities IPR (A) (B) • Digital IPR (A) (B) • Clinical procurement group in place (A) (B)	• Capital business cases reviewed by ICS (A)
Gaps in control/assurance:			
• Longer term capital programme required to identify pressures and requirements			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	10 year capital programme has been developed covering key areas of pressure and investment, aimed at supporting the Trust in delivery of the strategic plan.	Director of Finance	End Mar 2021	Will be utilised to support management of Capital £9m of business cases being progressed to the ICS	
2.	To develop clearing escalation and reporting of slippage of capital plans	Director of Finance	End May 2021		New

Risk Summary

BAF Reference and Summary Title:	BAF 8: Infrastructure				Strategic Objectives Impacted: SO5 ✓
Risk Description:	**There is a risk that the Trust estates infrastructure, buildings and environment, will not be fit for purpose**				
Lead Director:	Director of Estates	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	Mar-21

Links to Corporate Risk Register: Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
09/05/17	1621	Loss of Electrical Services (Power and Lighting) to Critical Clinical Areas	20	16	◄►
26/06/03	79	Limiting asbestos exposure	20	15	◄►
11/11/15	1397	Clinical environment maintenance and refurbishment	20	15	◄►
12/11/15	1410	Inability to manage and control a fire event	20	16	◄►
27/11/20	1937	EMU birth centre environment	15	15	◄►
29/12/20	1949	Insufficient air ventilation could contribute to Covid-19 cross infection	16	16	◄►
10/06/20	1877	Lack of suitable premises for community midwifery service	20	20	◄►
13/01/21	1953	Mortuary capacity across both sites	20	15	**New**

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	3	3	3	The Six facet survey indicates significant backlog maintenance. As our total expected CRL for ESHT is £54.3m, the in-year Capital position is improving significantly which has led to a revised risk scoring.	**Likelihood:**	2	Sep-21
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	16	12	12	12		**Risk Level:**	8	

Cause of risk:		Impact:	
	The Trust's historic financial performance has led to a restricted internally generated capital budget for many years. Despite a successful bid for HIP2 seed funding to develop the Strategic Outline Case there is an immediate need for capital which outstrips availability		Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.

Current methods of management (controls)	A. 2020/21 capital plan reprioritised to ensure that it is fit for purpose post COVID-19. B. Continuous prioritisation of spending and active management of capital resource limit through capital programme work-streams Capital bids being prioritised and prepared for submission to ICS. C. Essential work prioritised with estates, IT and medical equipment D. Maintenance of active fire precautions eg automatic fire detection. emergency lighting and firefighting equipment

Assurance Framework – 3 Lines of Defence- linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	2nd Line of Defence *(specialist support, policy and procedure setting, oversight responsibility)*	3rd Line of Defence *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (B) (C) (D)	• Oversight by Finance and Strategy Committee (A) (B) • Simulated patient safety exercise undertaken on Seaford ward in June 2019 to support refinement of evacuation plans (D) • Estates and Facilities IPR (A) (B) (C)	• Capital business cases reviewed by ICS (A) (C) • The Trust has been named as part of the HIP Programme (Phase 2) and developing strategic outline case to secure significant funding over the next 3-5 years (A) • NHSI funding confirmed in order to facilitate additional fire compartmentation works (D). • Oversight of Fire requirements by East Sussex Fire and Rescue Service (D). • Six Facet Survey (A)
Gaps in control/assurance:			
• Longer term capital programme required to identify pressures and requirements • Need to recommence fire infrastructure work impacted by Covid-19 • Building works delayed to impact of Covid-19 • Some areas inadequately ventilated • Mortuary capacity particularly at CQ due to electrical fault			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Developing "Building for Our Future" full business case and project board being established	Chief Executive	End Mar 2021	Programme Director in place. Governance structure in place. SOC developed for submission April 21	
2.	Aiming to resume fire compartmentation works at DGH in Autumn 2020	Director of Estates	End Mar-2021	Now that the Maternity Day Unit has become available the 1st phase of the refurbishment plan has commenced	
3.	Oxygen – Vacuum Insulated Evaporator (VIE) plant on both sites to be further upgraded	DE	28 Feb-2021	Plant upgraded on both sites – action complete	CLOSE
4.	Electrical infrastructure repairs at CQ following outage in mortuary and adjoining areas	DE	May 2021		New

Risk Summary

BAF Reference and Summary Title:	**BAF 9: Infrastructure**				**Strategic Objectives Impacted:** SO1 ✓, SO2 ✓, SO5 ✓
Risk Description:	A large-scale cyber-attack could shut down the IT network and severely limits the availability of essential information and access to systems for a prolonged period which would impact the Trust's ability to deliver its strategic objectives				
Lead Director:	Director of Finance	**Lead Committee:**	Audit Committee	**Date of last review by Committee**	March-2021

Links to Corporate Risk Register: Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
23/08/17	1660	Cyber Security	20	16	◄►

BAF Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4	4	There are a number of robust controls in place but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda.	**Likelihood:**	4	Mar-21
Consequence:	4	4	4	4		**Consequence:**	2	
Risk Level:	16	16	16	16		**Risk Level:**	8	

Cause of risk:	Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website,	**Impact:**	A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.

Current methods of management (controls)

A. Advanced Threat Protection (ATP) solution implemented to defend against hacking /malware. Regular scanning for vulnerability.
B. Anti-virus and Anti-malware software in place with programme of ongoing monitoring. Client and server patching programme in place and monitored
C. Process in place to review and respond to national NHS Digital CareCert notifications
D. Self-assessment against Cyber Essential Plus Framework to support development of actions for protection against threats
E. Education campaign to raise staff awareness - training ongoing with cyber security awareness campaign commenced October 2019
F. System patching programme in place and upgrade of client and server operating systems
G. Wider engagement including NHS Secure Boundary and signed up to implementing it at ESHT

SO1: Safe Care SO2: Access SO3: Valuing employees SO4: Partnership Working SO5: Efficient use of resources

Assurance Framework – 3 Lines of Defence – linked to controls A-G			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Cyber Essential Plus Framework assessment reviewed by division (D) • Day to day systems in place and support provided by cyber security team with increased capacity (A) (B) (C) (F)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with SESCSG Sussex and East Surrey Cyber Security Group (G) • Regular quarterly security status report to IG Steering Group and Audit Committee (D)	• Cyber security testing and exercises eg senior leaders participated in IT / Cyber exercise delivered by Police South-East Regional Police Organised Crime Unit (Nov-19) (E) • Trust was resilient to WannaCry ransomware attack (May 2017) (A) (B) (C) • Whilst noting the progress made internal audit gave "Limited Assurance" on 19/20 cyber security audit. (D)
Gaps in control/assurance:			
Obtain ISO27001 to provide assurance on reliability and security of systems and information. Continue with patching programme and address points raised by internal audit			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Pursuing ISO27001 as part of the Digital Strategy certification and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework.	Director of Finance	End June 2021	Ongoing - cyber position greatly improved and aiming to achieve Cyber Essentials Plus early in June 2021, Only Two outstanding issues both address with Capital on 20/21	
2.	Further investment in monitoring solutions and to increase compliance with server patching will be addressed as part of digital programme.	Director of Finance	End March 2021	Two additional tools have been implemented providing us a much better understanding of our Cyber posture.	**Complete**
3.	SOP for the network security administration will be created to ensure a standard approach	Director of Finance	End March 2021	SOP developed	**Complete**
4	Implement a Privileged access management (PAM) solution	Director of Finance	Dec 2021	Systems currently under review	
5	New Cyber awareness Campaign	Director of Finance	End June 2021	Campaign is under development	

Appendix One: Risk Matrix

LIKELIHOOD RISK RATING - Likelihood Rating is a matter of collective judgement; the table below provides some structure to aid thinking.

Likelihood	Descriptor	Score
Certain	This type of event will happen or certain to occur in the future, (and frequently)	5
High probability	This type of event may happen or there is a 50/50 chance of it happening again	4
Possible	This type of event may happen again, or it is possible for this event to happen (occasionally)	3
Unlikely	This type of event is unlikely occur or it is unlikely to happen again (remote chance)	2
Rare	Cannot believe this type of event will occur or happen again (in the foreseeable future)	1

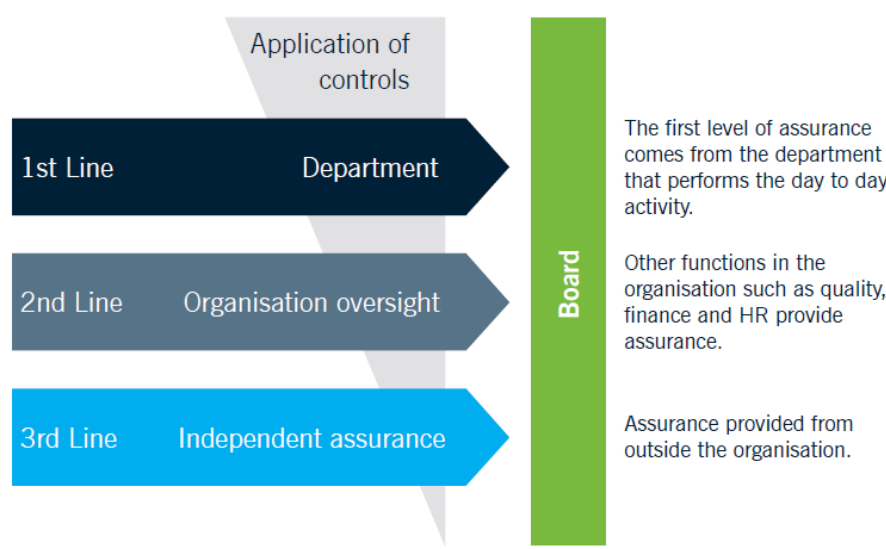
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		CONSEQUENCES / IMPACT				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
LIKELIHOOD	Certain (5)	5	10	15	20	25
	High probability (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Rare (1)	1	2	3	4	5

Low	**Moderate**	**High**	**Extreme**
1 – 3	**4 – 6**	**8 – 12**	**15 – 25**

Appendix Two – Three Lines of Defence Assurance Model

This model helps to provide a clearer picture of where the organisation receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to the Board. It is also important to consider the independence of any assurance provided in terms of how much reliance or comfort can be taken from it. The assurances that an organisation receives can be broken down into the three lines model as illustrated below:



- **1st Line** – provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved However, may lack objectivity but it is valued that it comes from those who know the business, culture and day to day challenges.
- **2nd Line** – provides insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It is distinct from and more objective than the first line of assurance
- **3rd Line** – Independent of the first and second lines of defence. Includes internal and external auditors.

Sources: Baker Tilly: Board Assurance: A toolkit for health sector organisations/BAF University Hospitals of North Midlands

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period February 2021 (Month 11)

Content

1.	About our Integrated Performance Report (IPR)	
2.	Performance at a Glance	
3.	Quality and Safety - Delivering safe care for our patients - What our patients are telling us? - Delivering effective care for our patients	
4.	Our People – Our Staff - Recruitment and retention - Staff turnover/sickness - Our quality workforce - Job Planning	
5.	Access and Responsiveness - Delivering the NHS Constitutional Standards - Urgent Care - Front Door - Urgent Care – Flow - Planned Care - Our Cancer services	
6.	Financial Control and Capital Development - Our Income and Expenditure - Our Income and Activity - Our Expenditure and Workforce, including temporary workforce - Cost Improvement Plans - Divisional Summaries	

About our IPR

- Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2019/20), is being delivered.
- Throughout our work we remain committed to delivering and improving on:
  - Care Quality Commission Standards
    - Are we safe?
    - Are we effective?
    - Are we caring?
    - Are we responsive?
    - Are we well-led?
  - Constitutional Standards
  - Financial Sustainability in the long term plan
- Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.
- Detailed data can be found within the IPR Data Detail (appendix A).

Our AMBITION is to be an outstanding organisation that is always improving
Our VISION is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and well-being of the people of East Sussex

Performance Summary

Key Metrics

Safe	Target	Jan-21	Feb-21	Variation	Assurance
Serious Incidents	<>	3	2	Common Cause	No Target
Never Events	0	0	0	Common Cause	Inconsistent
Falls, per 1000 Beddays	< 5.5	8.7	8.3	Concern	Inconsistent
Pressure Ulcers, grade 3 to 4	0	0	1	Common Cause	Inconsistent

Infection Control	Target	Jan-21	Feb-21	Variation	Assurance
MRSA Cases	0	0	0	Common Cause	Inconsistent
Cdiff cases	< 5	1	4	Common Cause	Inconsistent
MSSA cases	<>	1	3	Common Cause	No Target

Mortality	Target	Prev	Latest	Variation	Assurance
RAMI	<>	86.7	96.4	Concern	No Target
SHMI (NHS Digital monthly)	<>	0.98	0.97	Concern	No Target

Caring	Target	Jan-21	Feb-21	Variation	Assurance
Complaints received	<>	22	33	Common Cause	No Target
A&E FFT Score	> 96%	99.1%	97.5%	Common Cause	Inconsistent
Inpatient FFT Score	> 96%	99.5%	99.3%	Improvement	Consistently Hit
Maternity FFT Score	> 96%	100.0%	100.0%	Common Cause	Inconsistent
Out of Hospital FFT Score	> 96%	95.6%	100.0%	Common Cause	Inconsistent
Outpatient FFT Score	> 96%	97.4%	98.0%	Common Cause	Consistently Hit

Operational Performance (Responsive)	Target	Jan-21	Feb-21	Variation	Assurance
A&E 4 hour target	> 95%	72.9%	91.2%	Common Cause	Consistently Missed
12 Hour DTAs	0	0	0	Common Cause	Consistently Hit
Acute Non Elective LoS	3.6	5.2	4.4	Common Cause	Inconsistent
Community LoS	25	22.5	18.2	Common Cause	Inconsistent
RTT under 18 weeks	> 92%	82.1%	77.6%	Common Cause	Consistently Missed
RTT 52 week wait	0	203	293	Concern	Consistently Missed
Out of Hospital within target wait time	<>	88.4%	86.0%	Common Cause	No Target
Diagnosic under 6 week	< 1%	28.8%	25.6%	Concern	Consistently Missed
Cancer 2 week wait	> 93%	96.3%		Common Cause	Consistently Hit
Cancer 62 day	> 85%	72.1%		Common Cause	Inconsistent

Organisational Health	Target	Jan-21	Feb-21	Variation	Assurance
Trust Level Sickness Rate	<>	4.8%	4.8%	Concern	No Target
Trust Turnover Rate	10.4%	9.7%	9.7%	Improvement	Consistently Hit
Vacancy Rate	9.3%	0.3%	-0.2%	Improvement	Inconsistent
Mandatory Training	90%	89.4%	87.7%	Common Cause	Consistently Missed
Appraisal Rate (%) 12 months	85%	72.7%	71.3%	Concern	Consistently Missed

Exceptions in month	Target	Jan-21	Feb-21	Variation	Assurance
VTE Assessment compliance	95%	89.6%	92.4%	Common Cause	Consistently Missed

Key to variation and assurance flags	
Variation (current month)	Assurance (last seven periods v target)
Improvement	Consistently Hit
Common Cause	Inconsistent
Concern	Consistently Missed

Phase 3 Recovery	Nat. Target	ESHT Target	ESHT Actual
First Outpatient Attendances	100%	100%	78%
FollowUp Outpatient Attendances	100%	100%	76%
Elective DayCase Spells	90%	90%	69%
Elective Ordinary Spells	90%	90%	41%
Diagnostic Tests	100%	99%	84%

Quality and Safety

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is our highest priority
Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

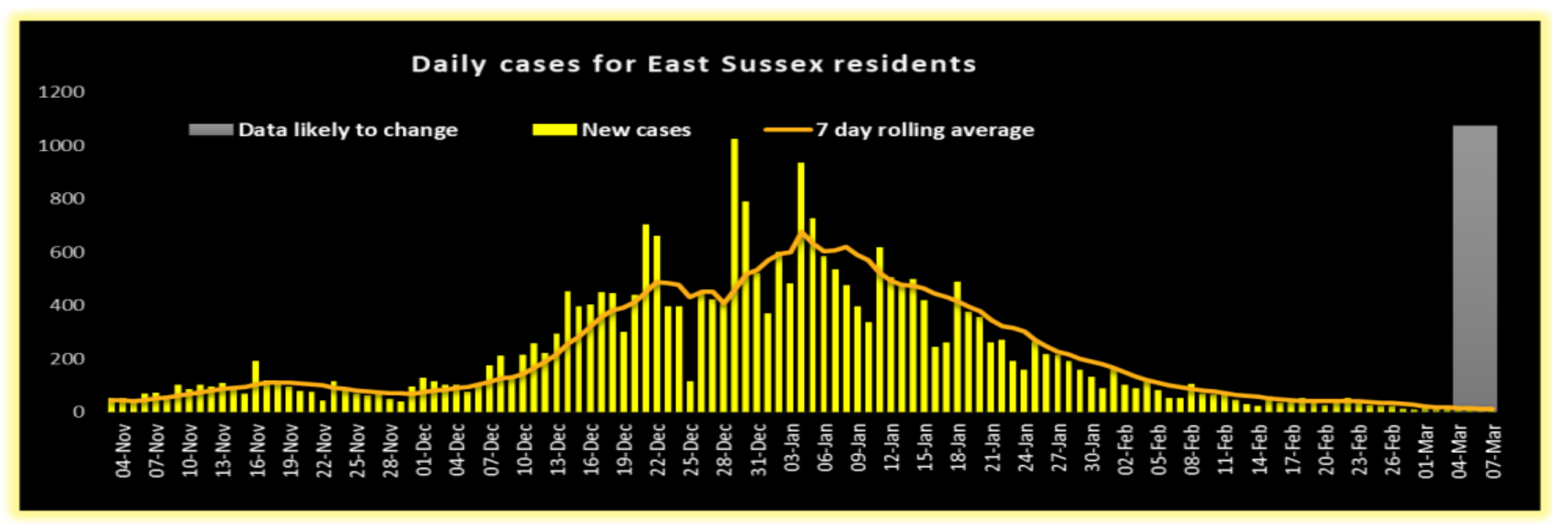
Summary

			Author
Quality and Safety Feb 2021 data	**COVID - 19** Prevalence was reducing in E. Sussex with a reduction in numbers of patients presenting with new COVID. The burden on critical care services was easing and more staff returning to work. **Infection Control** Mandatory reporting of Healthcare Associated Infections has been maintained. ESHT remains within limits set for CDI despite a recent increase in cases. **Safe Care - Incidents** • Total patient safety incidents reported stabilised after a short period of reduction • After a rise in SIs reported near the end of 2020, the number of SI's has reduced • Possible under reporting due to staffing issues **Pressure Ulcers** Rates remained within control limits with common cause variation. There may be some under reporting as all but one of the Tissue Viability Team were redeployed to clinical areas in February so validation is delayed. One Category 3 PU was reported in February and is being investigated via RCA.	**Complaints/FFT** A slight increase in the number of complaints received but remain below the pre-Covid level. FFT was restarted on 1st December 2020 but low numbers submitted as and when clinical teams were able to do so. Although FFT submissions have been lower than pre-Covid the inpatient, A&E and Maternity scores have been 98-99%. **Effective Care – Nursing & Midwifery Workforce** Both fill rates and CHPPD improved during February although staff absence, additional capacity and COVID escalation shifts remained higher than usual. The outcome of this is that overall only 75% of nursing shifts were filled either by substantive or temporary staff. Numbers of patients in Critical Care remained high during February. Some nursing staff remained redeployed however the majority were within their own Divisions. The successful appointment of a SafeCare Lead Nurse will continue to improve compliance and accuracy in the reporting of patient acuity against the levels of staffing available. It will also support the triangulation of quality and safety indicators in relation to nursing levels and skill mix.	 **Vikki Carruth** Chief Nurse and Director of Infection Prevention & Control (DIPC) **David Walker** Medical Director
Actions:	• Safe Care - Incidents. An audit of actions identified in closed SI RCA reports is being undertaken to assess how many actions have been completed with associated evidence • Falls - Complete the benchmarking exercise for falls. A peer review is being commissioned.		

COVID-19

Prevalence

The number of people testing positive in E. Sussex continued to reduce in February. Sussex is currently at a rate lower than the national level with E. Sussex at an even lower rate. Inpatient cases of COVID decreased considerably. Given that we remain in national lockdown it is likely that current rates are as low as we will experience. As social restrictions ease an increase in cases is expected but it is not yet clear how this will affect healthcare as much depends on vaccine efficacy and new variants. The majority of wards at ESHT have been stepped down from high risk (Red) to medium risk (Amber) but not yet low risk (Green), to reflect the need to continue with IPC precautions and PPE at present.



Testing

Due to the low prevalence, rapid testing methods are most useful to detect COVID negative patients but there is increased likelihood of false positives. Additional confirmatory testing is being undertaken and patients should be isolated pending confirmatory results to avoid risk of infection/outbreaks. In-house PCR testing is now in place and further options for testing are being evaluated as there are still challenges with rapid testing.

COVID Vaccination

Vaccination programme is running well and currently focusing on 2nd vaccines.

Safe Care - Infection Control (non COVID)

MRSA cases

Target: zero
Variation: normal
Current Month: 0

CDIFF cases

Target: 5.66
Variation: normal
Current Month: 4

CDIFF per 1000 bed days

Target: monitor
Variation: normal
Current Month: 0.2

MSSA

Target: monitor
Variation: normal
Current Month: 3

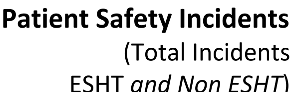
MRSA bacteraemia (MRSA) –
There were no attributable MRSA bacteraemias reported for the month of February.

Clostridium Difficile Infection (CDI) –
For the month of February, 4 hospital attributable cases were reported against a limit of 6. All 4 cases were HOHA (Hospital Onset Healthcare Associated). Post infection reviews are underway.

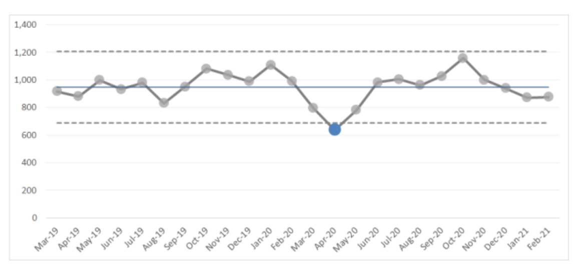
ESHT remains well within annual limit for CDI.

MSSA bacteraemia -
For the month of February, 3 hospital attributable cases were reported. Source of bacteraemia in two cases was respiratory and considered not avoidable. The source was not identified in the remaining patient. All patients were treated for COVID (not Hospital Acquired Infection) and with antibiotics for MSSA and have since been discharged.

Safe Care – Incidents

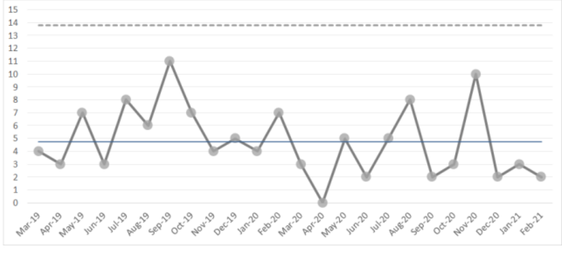


Patient Safety Incidents
(Total Incidents
ESHT *and Non ESHT*)



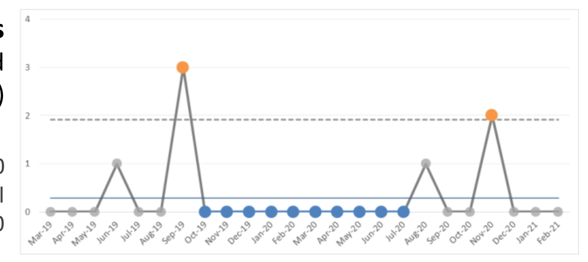
Target: monitor
Variation normal
Current Month: 876

Serious Incidents
(Incidents recorded
on Datix)



Target: monitor
Variation: normal
Current Month: 2

Never Events
(Incidents recorded
on Datix)



Target: 0
Variation: normal
Current Month: 0

Author:	Lisa Forward
Status Report	Following an initial reduction during the second wave of the pandemic, the number of patient safety incidents has stabilised. There may be some under reporting due to the significant staff challenges in relation to ratios and skill mix. Top 3 categories are Slips/Trips/Falls (153), Antenatal, Labour and Post Natal Care and Medication incidents, (both with 75 incidents). The 2 SI's reported in February were both fall to fracture incidents. After a significant rise in SI's towards the end of 2020, the number reported has reduced.
Challenge & Risk:	• Possible under reporting due to significant staffing issues • Falls continues to be the highest category for all patient incidents and for serious incidents.
Actions:	• Divisions are being supported in reporting incidents by their governance leads • A detailed Falls review report taken to the Quality and Safety Committee • An audit of actions identified in closed SI RCA reports is being undertaken to assess how many actions have been completed with associated evidence • Triangulation report provided for Patient, Safety and Quality Group has been amended to include a 12 month review of data as well as monthly to help with monitoring themes and trends

Safe Care - Falls

Total Falls Per 1000 bed days

Target: 5.5
Variation: Concern
Current Month: 8.25

Falls with Harm Per 1000 beddays

Target: monitor
Variation: Normal
Current Month: 2.16

Total Falls

Target: monitor
Variation: normal
Current Month: 153

Major or Catastrophic Falls

Target: monitor
Variation: normal
Current Month: 1

Author: Lisa Forward / Hazel Tonge

Status Report: The very significant impact of wave 2 on workforce did result in a significant increase as expected. Initial benchmarking is being undertaken and results so far indicate ESHT has similar falls rates as other integrated trusts. The only comparable national data is that published by the RCP in 2015 which indicated a falls rate of 6.6. A peer review has been agreed. Quality Improvement work that was being undertaken before the second wave has been recommenced.

Challenge & Risk:

- Significant impact on staffing skill mix and ratios during the second wave which impacted on the quality of care especially falls.
- No current national benchmarking data since 2015 and NHSE/I actively discourage this as the measurement process varies between trusts, is highly complex and inaccurate.
- Quality Improvement work restarted.

Actions:

- Review of current QI work programme and data
- Complete the benchmarking exercise
- Scoping potential for a peer review

Safe Care - Pressure Ulcers

Pressure Ulcers Per 1000 bed days (Grade 2,3,4)

Target: monitor
Variation: normal
Current Month: 3.1

Pressure Ulcers Category 2 (inpatient and community)

Target: monitor
Variation: normal
Current Month: 57

Pressure Ulcers Category 3&4

Target: zero
Variation: normal
Current Month: 1

Pressure Ulcers Assessment Compliance

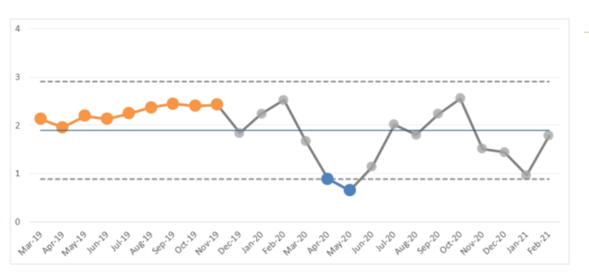
Target: 90%
Variation: normal
Current Month: 95.0%

Author:	Tina Lloyd, Assistant Director of Nursing
Status Report	The overall rate of PUs reported remains within control limits but may increase with TVN validation. Of the 57 Cat 2 PUs reported in Feb 2021; 28 were amongst acute inpatients, 1 was within an integrated care setting and 28 were in the community setting. One Category 3 PU was reported in February 2021 is under investigation by RCA. Of those audited the compliance of patients with completed PU assessments remains at expected levels.
Challenge & Risk:	The staffing challenges on inpatient wards during the second wave of Covid will likely have had an impact on pressure ulcer prevention. All bar one of the Tissue Viability Nurses (TVNs) were redeployed to support front line care services during the second wave of Covid during Jan & Feb. During this time complex wounds and urgent referrals were prioritised. As a result the reporting of pressure ulcers on Datix that is usually validated by the TVNs may not yet reflect the actual PUs during this period.
Actions:	The TVNs were repatriated back to their roles on 1 March. Together with clinical teams the TVNs are undertaking a retrospective look back at the PUs reported from Dec 20– Feb 21 which will be presented to the pressure Ulcer Review Group for shared learning and recommendations, including: • A deep dive into the unstageable PUs reported in Jan 2021 • A review of the clusters of PUs reported in some areas.

What patients are telling us?

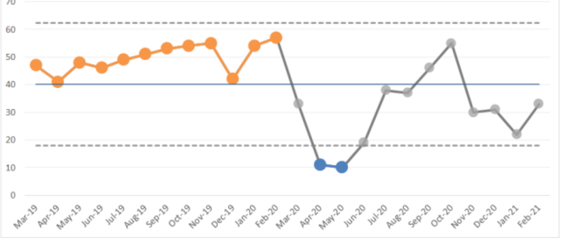
East Sussex Healthcare NHS Trust

Complaints Received per 1000 bed days



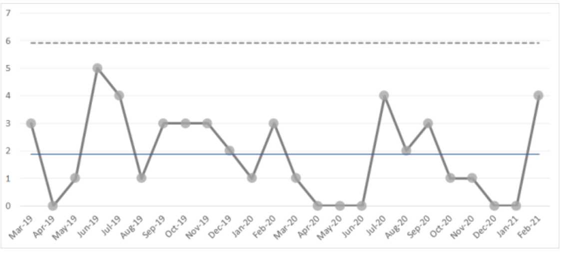
Target: Monitor
Variation: normal
Current Month: 1.8

Complaints Received



Target: Monitor
Variation: normal
Current Month: 33

PHSO contacts

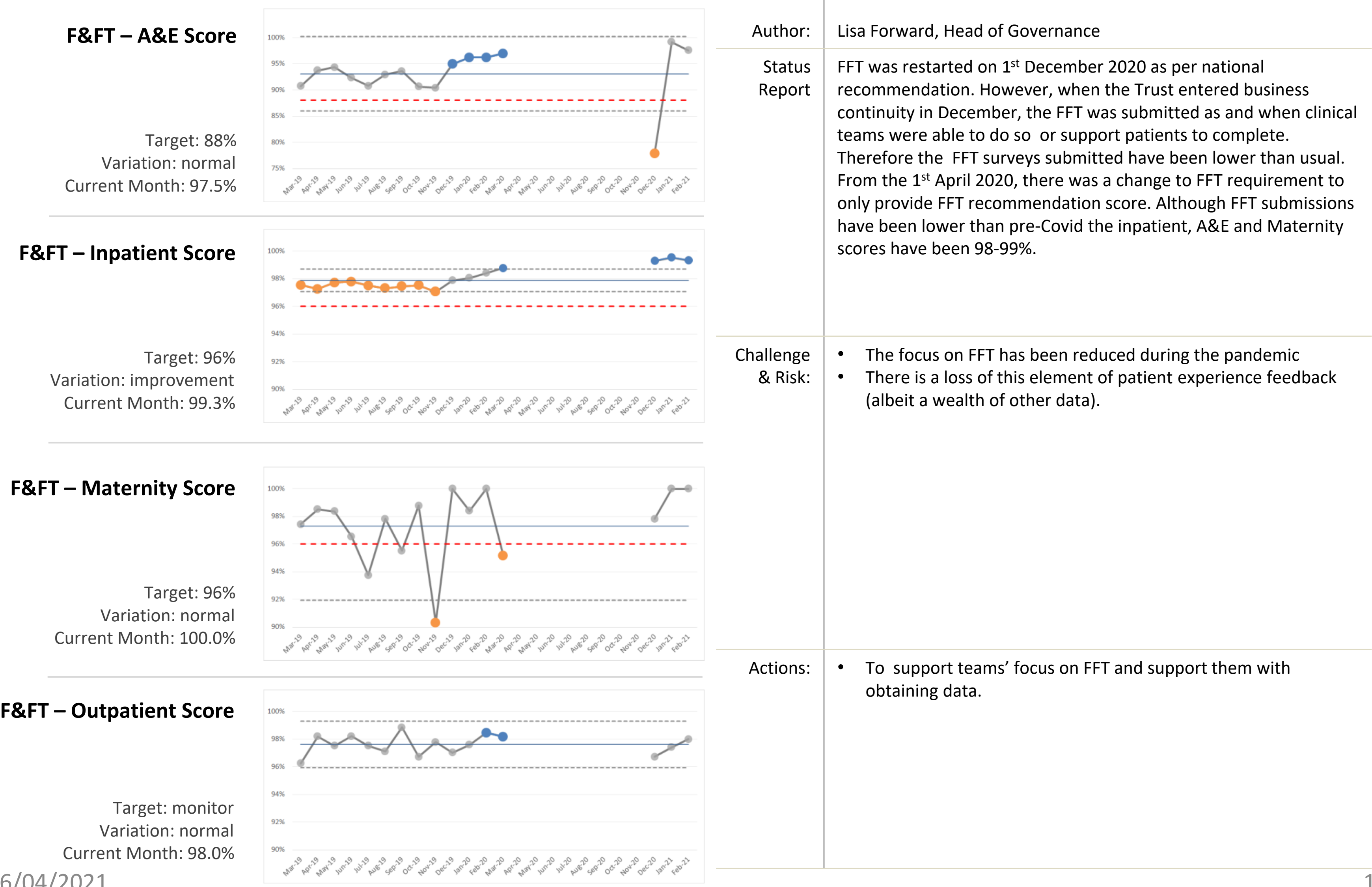


Target: Monitor
Variation: normal
Current Month: 4

Author:	Lisa Forward, Head of Governance
Status Report	There has been a slight increase in the number of complaints received but they remain below pre-Covid levels. The complaint process was restarted following the pause in December . There was 1 re-opened complaint and 4 contacts from the PHSO. The contacts were 2 enquiries and 2 outcomes. Of the 2 outcomes, there was only one recommendation relating to improving record-keeping and documentation of how referrals are prioritised in Community Rehab .
Challenge & Risk:	• Some of the complaints team were redeployed during the second wave of the pandemic to support front line care and other key services. • There is a backlog of complaints to be investigated due to the process being paused. These have been sent to the Divisions who are taking them forward.
Actions:	• Complaints team being re-established • The backlog is being monitored • Divisions aware of the need to focus on the outstanding complaints

What patients are telling us?

East Sussex Healthcare NHS Trust

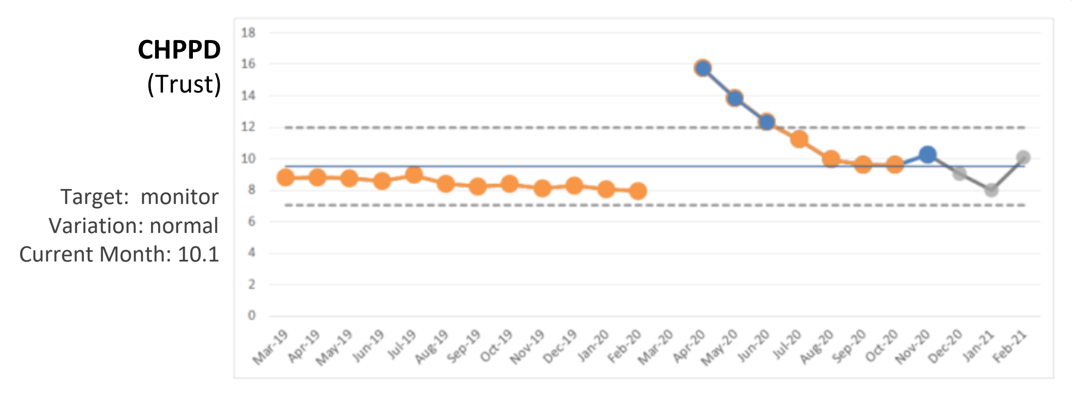


Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

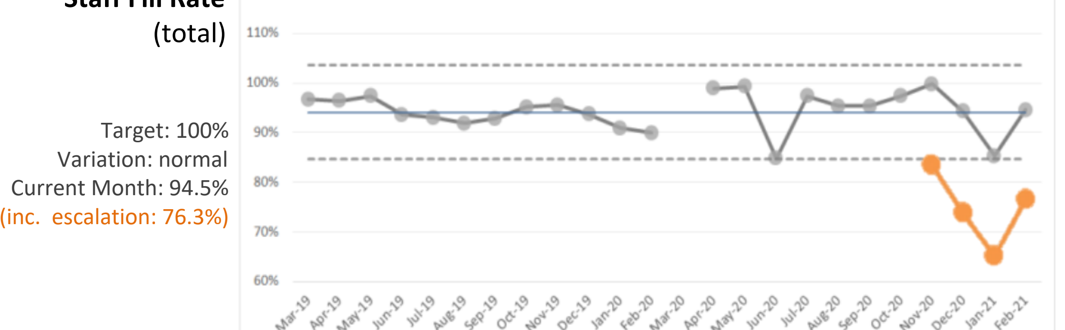
CHPPD (Trust)

Target: monitor
Variation: normal
Current Month: 10.1



Staff Fill Rate (total)

Target: 100%
Variation: normal
Current Month: 94.5%
(inc. escalation: 76.3%)



Author:	Angela Colosi, Assistant Director of Nursing
Status Report	**Care Hours per Patient Day (CHPPD)** Although there has been an increase in February, December's Model Hospital benchmark data shows both peers and national medians at 9.3 with ESHT at 9.0. This reflects the unavailability of staff during the second wave of COVID-19. CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight and is the trust average. A breakdown was provided to QSC in the safe staffing report. **Staff Fill Rate** 94.5% is the fill rate against the agreed nursing template and does not include the nurses required to care for patients in the escalation areas that were open or the additional staff required for Covid escalation when Covid occupancy was high. This was significant even though the bed occupancy started to reduce in February.
Challenge & Risk:	Increase of unplanned admission due to COVID-19 with significant staff sickness absence. In addition the Vaccination Hubs were open which required additional staffing. Community Nursing was also impacted by staff sickness levels and high demand particularly in end of life care provision. Many other teams and services were also affected/depleted.
Actions:	• Twice daily Nurse Staffing meetings held reporting into site meetings held three times a day. • Safer staffing (Nursing) report going to Quality and Safety Committee • Appointment of the SafeCare Lead Nurse who will start in post on 17th May.

Effective Care – Nursing Workforce

Staff Fill Rate
(Bexhill)

Target: 100%
Variation: concern
Current Month: 89.3%

Staff Fill Rate
(Conquest)

Target: 100%
Variation: normal
Current Month 93.2%
(inc. escalation: 75.6%)

Staff Fill Rate
(Eastbourne DGH)

Target: 100%
Variation: normal
Current Month: 96.3%
(inc. escalation: 77.3%)

Staff Fill Rate
(Rye Memorial)

Target: 100%
Variation: normal
Current Month: 102.7%

Author:	Angela Colosi, Assistant Director of Nursing
Status Report	The staff fill rate increased in all areas in February as the numbers of unplanned admissions and sickness absence slowly reduced and wave 2 was subsiding. Bexhill and Rye were unable to open any more additional capacity as already full but the wave 2 impact is still apparent for both.
Challenge & Risk:	The challenge during February was the identification and management of risk across the 4 in-patient areas whilst attempting to plan and start elective activity. Eastbourne was hardest hit as almost all of the additional capacity was opened there. The orange fill rates are the actual rates as they include all additional escalation capacity (5 areas with 78 beds) and the Covid escalation templates due to an almost 50% Covid occupancy.
Actions:	• The majority of staff have been redeployed back to their substantive positions. • Health and Well-being initiatives continue to support staff • Psychological support is available and training continues to teach staff how to assess and recognise trauma in colleagues.

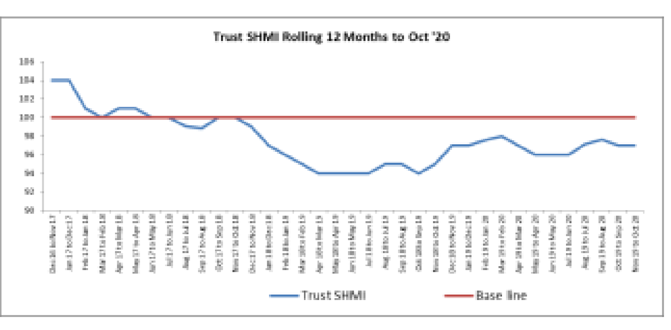
Effective Care - Mortality

East Sussex Healthcare NHS Trust

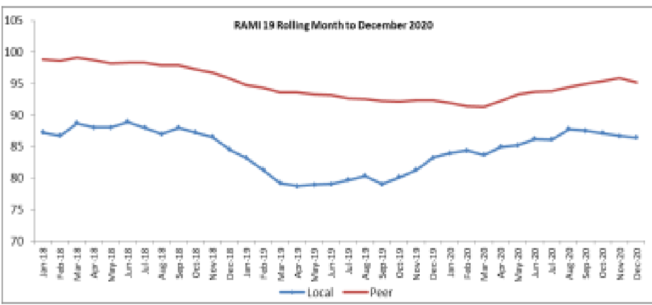
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

Summary Hospital Mortality Indicator (SHMI)

Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures

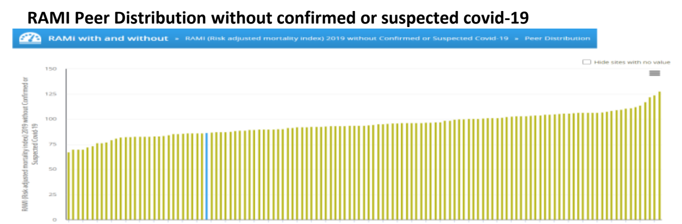


Risk Adjusted Mortality Index (RAMI) – without confirmed or suspected Covid-19



- SHMI – November 2019 to October 2020 is showing an index of 0.97
- RAMI has been rebased and has been updated to RAMI 19
- RAMI 19 without confirmed or suspected Covid-19 – January 2020 to December 2020 (rolling 12 months) is 86 compared to 83 for the same period last year. December 2019 to November 2020 was 87.
- RAMI 19 was 96 for the month of December and 86 for November with a peer position of 102 and 98 respectively. As with SHMI, RAMI is not designed for this type of pandemic activity, so RAMI without Covid-19 has been provided for consistency.
- Crude mortality without confirmed or suspected covid-19 shows January 2020 to December 2020 at 1.62% compared to 1.96% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 51% in December 2020 compared to 64% in November 2020.

RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

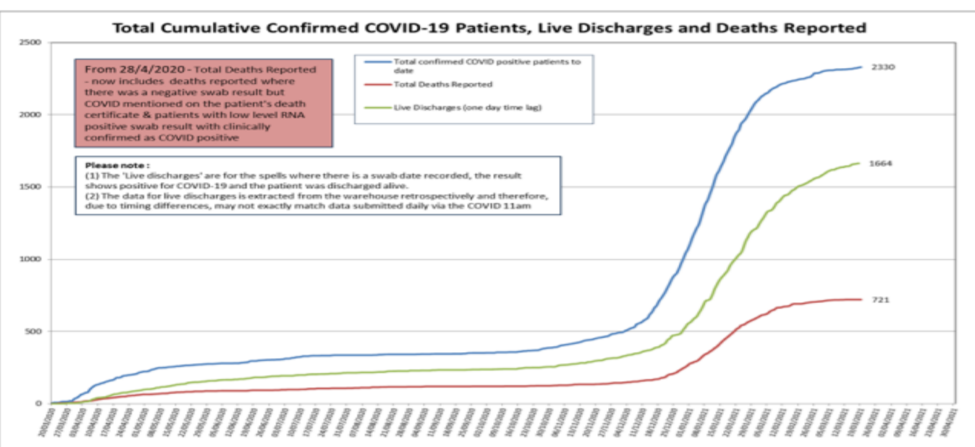
This shows our position nationally against other acute trusts - currently 27/125

February 2021 Main Cause of In-Hospital Death Groups (ESHT)

Cause	Number
COVID-19	83
Pneumonia	19
Sepsis/Septicaemia	15
Cancer	12
Heart Failure	11
Chronic Obstructive Pulmonary Disease (COPD)	4
Community-acquired Pneumonia	3
Myocardial Infarction (MI)	3
Bowel Obstruction	2
Acute Kidney Injury (AKI)	1
Cerebro-vascular Incident	1
Hospital-acquired Pneumonia	1
Liver Disease	1

There were 83 COVID-19 related deaths in February compared to 284 in January.

There are:
26 cases which did not fall into these groups and have been entered as 'Other not specified'.
18 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.



Workforce

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is
our highest priority
Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

	Positives	Challenges & Risks	Author
Responsive	**Annual turnover** is unchanged at 9.7%. reflecting 603.0 fte leavers in the rolling 12 months **Vacancy rate** has reduced by 0.5% to -0.2% . **Current vacancies** are showing as -10.8 ftes **Monthly sickness** has reduced by 3.7% to 4.0%. **Annual sickness** rate is unchanged at 4.8%	**Mandatory Training** rate has reduced by 1.7% to 87.7% **Appraisal** compliance has reduced by 1.4% to 71.3%	**Steve Aumayer** Chief People Officer

Actions:

- The Trust will welcome a further 27 Nurses and 3 Radiographers in March, with a further c.28 Nurses due to arrive by the end of May, with planned cohorts for July, Sept & Nov. This brings the total of international nurses arriving at the Trust since Dec 2017 to 274. The Trust is on target to welcome a total of 185 by the end of the financial year 2002/2021.
- Occupational Health & Wellbeing continue to provide a quick pathway to trauma therapy for individual staff members. The COVID team continues to offer a 7 day service but due to a drop in demand, are starting to scale back with a view to closing off 7 day provision by 1st May.
- A new approach to a team stress survey is being trialled in three areas during Mar and Apr in an attempt to obtain a clearer overview of hot spots, where work related stress is high or consistent
- Each clinical division has met with the Assistant HRD Director – OD, Engagement and Wellbeing to discuss and begin to plan the ongoing Health and Wellbeing support for staff as we move to regroup.
- The Trust has received its embargoed Staff Survey results. Generally the results are very positive and there will be engagement with all staff members about the focus for priorities across the Trust and in all Divisions.
- Continued focus on leadership support during and after the pandemic. Leadership Circles programme of short interventions on specific subjects have been popular and introducing a new programme for "Aspiring Leaders".
- Overall the mandatory training compliance rate has reduced this month by 1.7% to 87.7. Continued efforts have been focused on the compliance rates for Fire, Infection Control both of which have increased by 0.5% and 0.4% respectively.
- Appraisal compliance rate has decreased this month by 1.4%. An action plan is being finalised to set the trajectory to improve Trust compliance. A digital solution has also been identified and is currently going through the procurement process
- Redeployment Office shows reduction from over 400 internal and external staff reduced to 120 currently not returned to their substantive position, however, links with RESTART programme as services come back on line
- Lateral Flow testing continues
- Mass Vaccination modelling refined to show vaccine utilisation against workforce using booking profile/average handling time to plan the successful delivery of the 2nd dose up to mid April
- Business planning discussions continue to agree starting assumptions for 2021/22 and link to BFF strategic longer term planning
- E-Job Planning currently being refreshed for medics in preparation for the new financial year
- Initiated contractual review of all workforce systems in the Trust to provide assurance they are fit for purpose based on the strategic direction of the Trust, user friendly and financially sustainable.

Workforce – Contract type

Agency FTE Usage

Current Month: 192.4

Bank FTE Usage

Current Month: 665.1

Substantive FTE Usage

Current Month: 6,648.1

Vacancy Rate

Current Month: -0.2

- Agency fte usage has increased by 19.4 fte compared to Jan 21. Agency supply has improved following access to vaccinations
- Grip and Control remains a core functionality of TWS with 100% contracting via framework suppliers ; 100% Medical and AHP agency workers contracted via Direct Engagement; Tier 2 HCA supply exited; Tier 1 HCA supply phased reduction with plan to terminate end April
- Bank fte usage shows increase of 53.9 ftes. Bank fte usage reporting is done in arrears, however, reflecting Jan timesheets.
- 77% shifts filled by bank compared 65% bank fill April 2020. Bank pool members increased by 100% in year - now over 6,000 registered
- Temporary supply is now meeting 66% demand (70-75% pre COVID).
- Substantive fte usage increased by 65.8 ftes in Feb following successful recruitment, including an increase in Registered Nursing usage (+46.6 ftes) and Allied Health Profs usage (+14.5 ftes) but a decrease in Medical usage (-10.0 ftes)
- The Trust vacancy rate has reduced by 0.5% to -0.2% (-10.8 fte vacancies). The vacancy rate has been historically low, due to the changes in the budgeted establishment in Sept. Despite the reduction in the budgeted establishment, the Trust is committed to delivering its recruitment plans with continued activity particularly around Nursing and Midwifery in order to address the monthly attrition rates (15 per month). There is also continued activity due to additional funding being available from NHSE/I

Workforce - Churn

Starters FTE

Current Month: 88.5

Leavers FTE

Current Month: 52.0

Annual Turnover Rate

Current Month: 9.7%

Retention Rate

Current Month: 92.0%

- The Trusts starters & leavers monthly net total as at February 2021 is +36.5 with 88.5 starters fte and -52.0 leavers fte

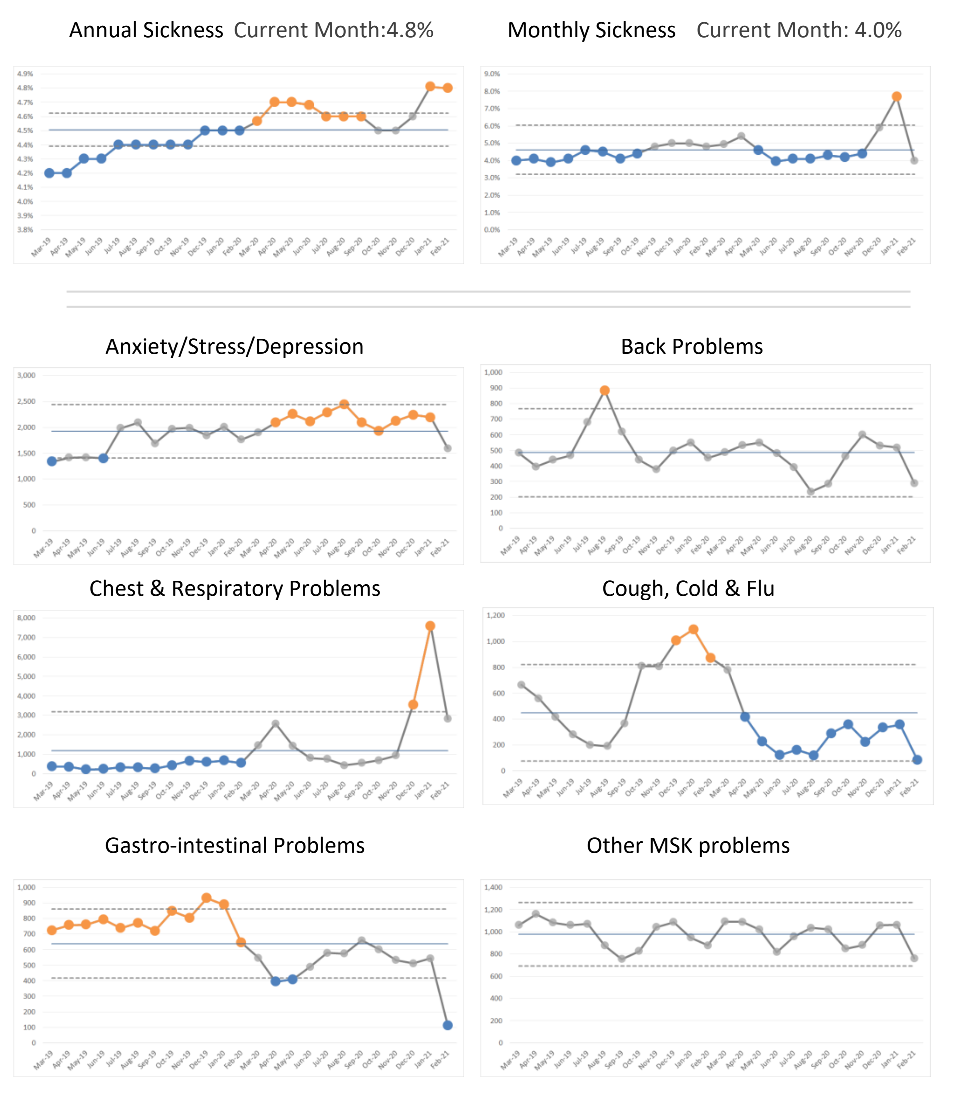
- Vacancies remain historically low due to the budget adjustments but ongoing campaigns continue. Overall applications continue to remain high due to the ongoing economic effects of Covid. Applicants to the Trust for the month of Feb were 2,488 for Agenda for Change (AfC) posts and 270 for Medical posts. Year to date the Trust has seen 31,484 AfC applicants and 10,421 Medical. March numbers remain high. This has resulted in securing candidates for some hard to recruit posts such as Middle Grade in A&E, Consultants in Acute Medicine and Gastroenterology. Recruitment activity has focused on supporting TWS and ensuring candidates start as soon as possible. Medacs, our Recruitment Practice Outsourcing partner, are still continuing to source candidates for difficult to recruit posts. Success in filling Middle Grade Emergency Medicine posts across both sites.

- The Trust Turnover rate has remained low at 9.7%. The Trust Retention rate has also decreased this month by -0.1% to 92.0%.

- Further direct and indirect communication with all of our substantive EU staff (551 in total) is underway to ensure that they apply for settled status before 30th June 2021. EU Nationals on the Bank have also been written to directly. Work is underway with departments who employ a large number of EU Nationals to encourage staff to apply for the scheme.

Workforce - Sickness

East Sussex Healthcare NHS Trust



- Monthly sickness % has reduced this month by 3.7% to 4.0%. Annual sickness % remains unchanged at 4.8%. The reduction in monthly sickness is due to the steep reduction in sickness due to Chest & Respiratory problems, which has decreased this month by 4,783 fte days lost to 2,816 in total in Feb 21, as Covid sickness has fallen.

- Total staff reported as absent due to Covid sickness as at 11th Mar was 43 (compared to a peak of 237 on 22nd Jan). Overall, there were 270 staff absent due to all types of sickness, compared to a peak of 540 (also on 22nd Jan). Staff absent on isolation due to Covid was 191 as at 11th Mar. So far, this figure has peaked on 15th Jan at 378 staff absent.

- As we move forward to a Restart position and COVID related sickness decreases there is a focus on long term sickness and working with managers to ensure staff are supported with their return to work. Staff and managers are directed to the wealth of support services available and managers are advised on identifying potential alternative solutions where the return to work situation is challenging.

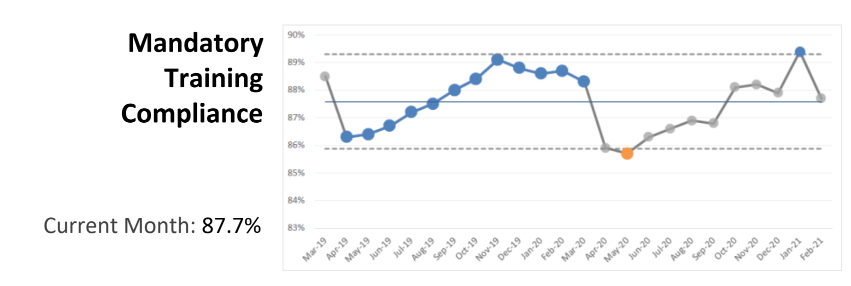
- Operational HR is working closely with Wellbeing colleagues and Divisions to identify those areas that require psychological support to prevent further absences.

Workforce - Compliance

East Sussex Healthcare NHS Trust

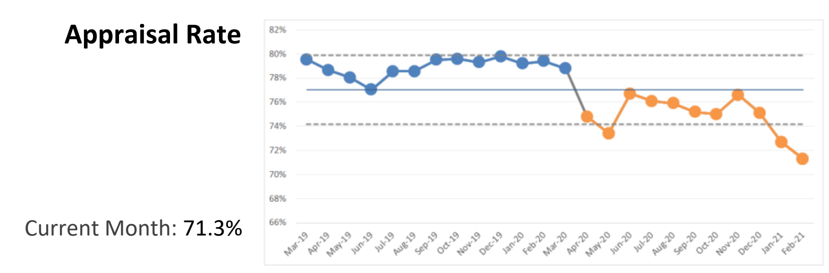
Mandatory Training Compliance

Current Month: 87.7%



Appraisal Rate

Current Month: 71.3%

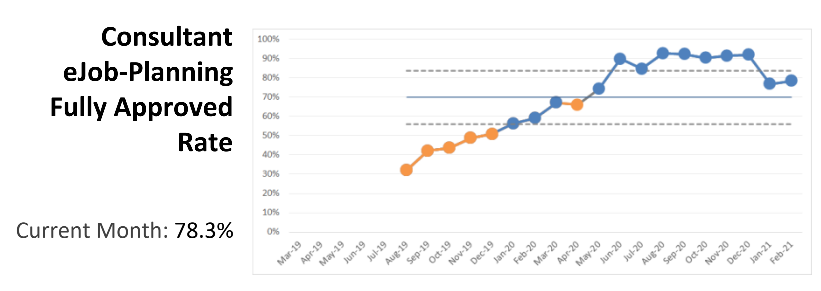


- The Mandatory Training compliance rate has reduced again by 1.7% to 87.7%. That said, an issue with national training reporting in ESR last month did slightly over inflate the compliance percentage in Jan. This has now been corrected. The overall decrease since December 2020 is 0.2%.
- Continued efforts have been focused on the compliance rates for Fire, Infection Control both of which have increased by 0.5% and 0.4%, respectively. Despite continued work with Governance Leads, Information Governance has dropped again this month and this is being prioritised this to meet the Trust's requirement
- The Trust compliance rate has decreased this month by 1.4% to 71.3%. The impact of the COVID 19 pandemic and previous staff sickness continues to impact on compliance.
- An action plan is being finalised to set the trajectory to improve Trust compliance. In addition a digital solution has been sourced and funding identified to support its purchase. The specification includes a electronic appraisal tool and process.

Workforce – Job Planning

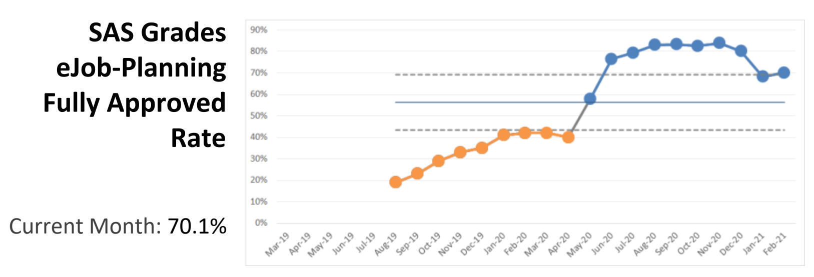
Consultant eJob-Planning Fully Approved Rate

Current Month: 78.3%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 70.1%



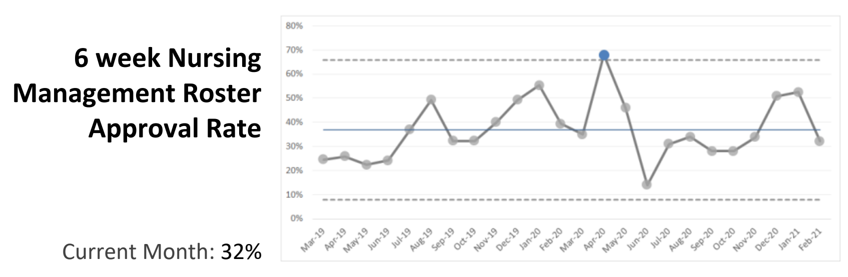
- As of 9th Mar 2021, 202 of 258 consultants (78.3%) and 75 of 107 SAS grades (70.1%) had fully approved job plans.

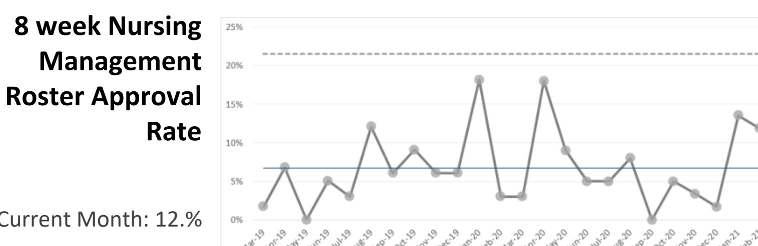
- Overall Trust compliance rate is 75.9%.
- Diagnostics Anaes & Surgery compliance rate is 83.4%
- Medicine compliance rate is 74.7%
- Women & Children compliance rate is 64.5%
- Urgent Care compliance rate is 53.8%.

- The Trust is going through a job plan review period (January to March) and the main focus has been to support Medics, Clinical Leads and Service Managers during this phase in order to get a significant proportion of job plans signed off by 1st April 2021. The current completion rate for Medics job planning is 76%.

- E-Job planning roll out for GPs (Urgent Treatment Care) has commenced.

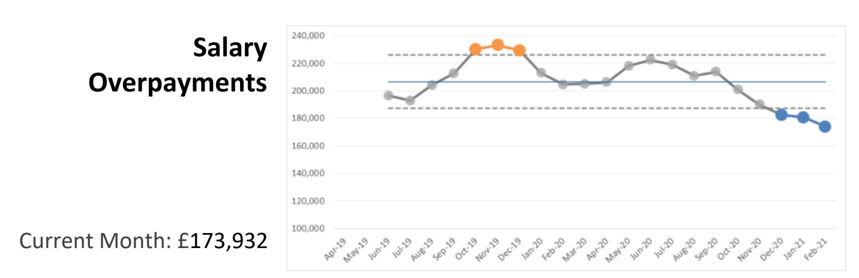
Workforce – Roster Completion





- The following charts show the % of approved rosters as at 6 & 8 weeks prior to commencement.
- For the period commencing 25th Jan ’21, 32% of rosters had been approved at 6 weeks before commencement and 12% had been approved at 8 weeks prior to commencement. This compares to 53% at 6 weeks and 14% at 8 weeks for the previous roster period.
- Monthly reports are produced and sent to Assistant Directors of Nursing and compliance is monitored at the Safer Staffing meeting. During the pandemic, some rostering has been shorter term due to the changing ward footprint.

Workforce – Salary Overpayments



- Outstanding debts as of Feb 21 totalled £173,932, a reduction of £6,741 on the previous month. The 12 month average cost was £204,437.
- New debt added in Feb equated to £18,901 from 35 new cases
- There are currently 263 cases in all; 81 relating to current staff and 182 for leavers
- The most common reason for debts is late notification of leaving (27% of cases) followed by overtaken annual leave (15%)
- Staff leaver and notification of staff changes forms are being reviewed .

Access and Responsiveness

Delivering the NHS Constitutional Standards

Our front door - Urgent Care

How our patients flow through the hospital

Our Cancer Services

Our Out of Hospital Services

We will operate efficiently & effectively
Diagnosing and treating our patients in a timely way that supports their return to health

Summary

	Positives	Challenges & Risks	Author
Responsive	**ED Performance:** Improved by 5.4% from previous month. **RTT:** Trust was placed 9th out of 121 Trusts for RTT performance **Diagnostic Service Provision:** DM01 position has improved by over 3% from previous month. **Restart & Recovery:** Teams have already begun implementing plans to restart services to address elective backlogs **Repatriation of workforce:** As the latest pandemic wave eased, some staff were repatriated to their normal roles and services begun to restart	**Restart & Recovery:** Maintaining safe patient flow and bed capacity while restarting elective services and addressing backlogs with existing capacity **Diagnostics:** Capacity to address backlog while maintaining current demand **Workforce:** Reliance on our staff to aide restart and recovery after second wave. Welfare and safety of our teams. **Roadmap out of lockdown:** Potential for another wave	**Tara Argent** Chief Operating Officer

Actions:

- With the second wave in decline, teams were able to review the need for redeployed staff and repatriate people where appropriate back to their original role to allow some previously halted services to resume. This was reviewed methodically with teams and staff alike and a smooth transition was therefore enabled.

- The Trust is continuously focused on cancer recovery. Achieving the 62 day target back in November but unfortunately, seeing a declining position since with the second wave of the pandemic impacting our ability to deliver. With February currently standing at 66.9% against the 85% 62 day target. There are now dates in the calendar for cancer recovery focus weeks to address the 62 day backlog and we are still aiming to return to a compliant position by July 2021

- RTT performance although still above 80%, did drop in February. This was anticipated with the halting of some services and the standing down of P3 and P4 activity. Weekly Elective Care Board (ECB) meetings in place to address new measures set, to include: P2 patients waiting over 5 weeks for their procedure date, patients waiting over 52, 78 and 104 weeks, waiting list size and overdue follow ups. These metrics are now in place and are monitored weekly through ECB and divisional PTL meetings

- We saw the number of patients waiting over 52 weeks increase slightly in February. This again was anticipated with the standing down of some elective activity. However, we began booking long waiting patients for their procedures in February and the result of this has shown a reduction since.

- Working with the Independent Sector, we have managed to secure additional radiology activity to help address the diagnostic backlog and this will continue through Q1 of 21/22

NHS Constitutional Standards

*NHS England has yet to publish all February 2021 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

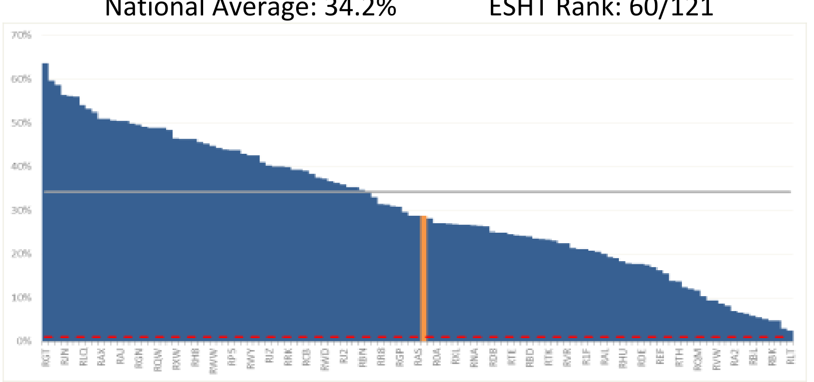
February 2021 Peer Review

National Average: 83.9% ESHT Rank: 17/115

Planned Care – Diagnostic Waiting Times

January 2021 Peer Review*

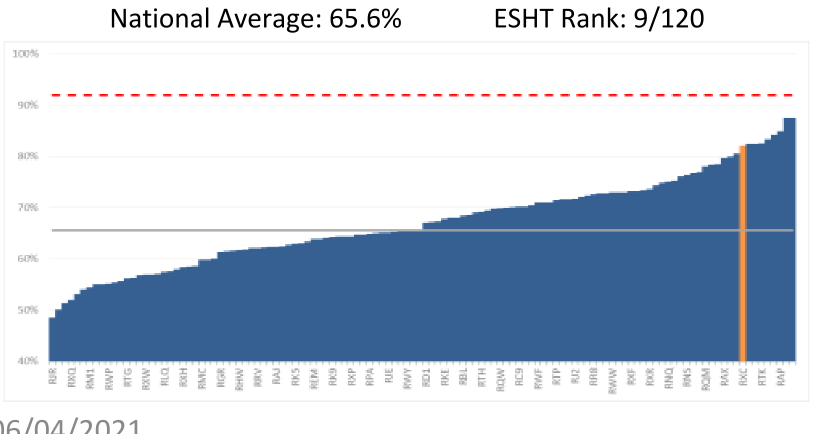
National Average: 34.2% ESHT Rank: 60/121



Planned Care – Referral to Treatment

January 2021 Peer Review*

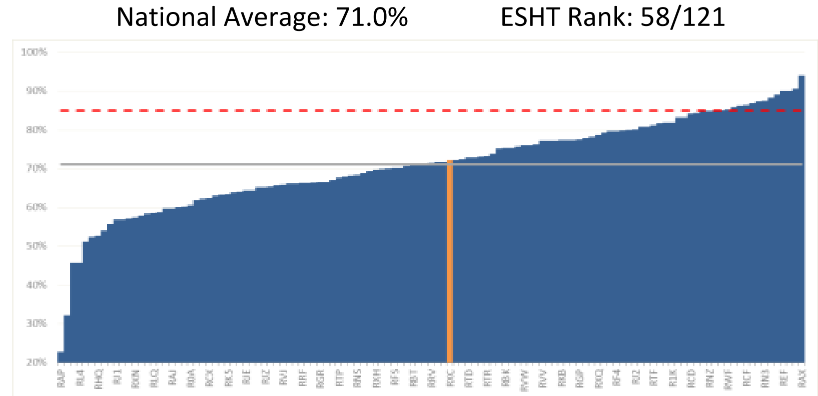
National Average: 65.6% ESHT Rank: 9/120



Cancer Treatment – 62 Day Wait for First Treatment

January 2021 Peer Review*

National Average: 71.0% ESHT Rank: 58/121



Planned Care – Waiting Times

Access and Responsiveness

RTT Incomplete Standard

Target: 92%
Current Month: 77.6%

Status Report

An expected decline against the RTT incomplete standard of 92% as a result of the delays in time to treatment due to the second wave of the pandemic and the standing down of some elective services to support the Trust as it reacted to the second wave and significant rise in covid inpatients. Waiting times for treatment have increased. Although worth noting that ESHT still remains in the top 10 out of 121 Trust against this standard.

RTT Total Waiting List Size

Target: 26,965
Current Month: 29,916

Referrals are starting to increase as GP activity levels rise. This coupled with reduced (stood down) elective activity has seen our waiting list size increase again

RTT 26 Week Waiters

Target: Monitor
Current Month: 2,405

As the average waiting time in specialties has increased with the reduced activity, we see the overall wait time profile increase. 10% of our patients are currently waiting more than 26 weeks for treatment with the majority waiting for routine elective surgery.

Cancellations On The Day (Activity %)

Target: 5%
Current Month: 6.7%

Although fallen from the previous month, we are still above our target measure. The cancellations do appear to be more of a process issue which, after a review with the specialties concerned, will be addressed.

Planned Care – Outpatient Delivery

Outpatient Total Activity
(New and Follow-up)

Target: Monitor
Current Month: 26,861

New

Follow-up

Status Report

Outpatient activity has reduced slightly from previous month due to annual leave reducing the number of clinics running and it being a shorter month. There is an outpatient transformation programme running, which looks to increase the use of Patient Initiated Follow Ups (PIFU), as well as ensuring that clinic capacity is optimised and we should see activity levels increase as a result

Non Face to Face Outpatients Activity
(Activity %)

Target: Monitor
Current Month: 39.9%

A slight decrease in non face to face % activity with the case mix of patients brought through outpatients in February being those that required a face to face consultation (query cancer patients, surgical patients etc)

Outpatient Utilisation
(XX1 and Non XX1 Clinics)

Target: 100%
Current Month: 81.3%

Utilisation has improved from previous month but is not at the levels expected. A lot of clinic template work has gone in to address this as clinicians job plans are updated and this should ensure that clinics are utilised more effectively going forward

Planned Care – Admitted Delivery

Elective Spells
(Day case and Elective IP)

Target: Monitor
Current Month: 3,295

Day case

Elective IP

Status Report

During February, we had 9 of our 19 theatres open across both acute sites. Due to the second wave of the pandemic and the need to redeploy staff to pressured departments and wards. With more complex cases going through our theatres as well, we saw a reduction in elective spells.

Elective Average LoS
(Acute)

Target: 2.7
Current Month: 3.2

As we began to increase the case mix through theatres in an effort to put our long waiting patients through theatres as well as our urgent and cancer patients, this saw a reduction in LoS.

Theatre Utilisation

Target: 90%
Current Month: 68.7%

Improved utilisation from previous month. Turnaround time was still impacting on theatre utilisation in February due to donning and doffing of PPE and other Covid related delays. And this coupled with the complex case mix only going through theatres has resulted in a 70% utilisation rate

Urgent Care – Front Door

A&E Performance
(Local System)

Target: 95%
Current Month: 92.8%

A&E Performance
(ESHT Total Type 1 & 3)

Target: 95%
Current Month: 91.2%

CONQ

EDGH

A&E Attendances
(ESHT Total Type 1 & 3)

Target: Monitor
Current Month: 8,021

Author:	KAIA VITLER
Status Report	From 1st to 28th February 2021, the A&E Performances (including Walk in Centre Numbers) were: Trust 92.8% (National Average: 83.9%) An overall increase of: 15.5% this month. A small increase in attendances in February compared to January from 7989 to 8021. EDGH are consistently seeing higher attendances than CQ.
Challenge & Risk:	Differing issues on each Site. EDGH ED continues to be impacted by patient flow and is seeing higher attendances. Both sites have specialty patients directed to the department for assessment and initial treatment.
Actions:	Ongoing discussions with Specialties to improve streaming and patient pathways

Urgent Care – Front Door

ESHT Total Type 1

ESHT Total Type 3

Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 2,709

Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 6.5%

Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 40.0%

Author:	Kaia Vitler
Status Report	The focus on Ambulance handover times and Pin compliance, working closely with SECAmb has improved the handover times. New SOP has been written, awaiting final sign off with SECAmb. The number of over 30 mins and over 60 mins conveyances has significantly improved.
Challenge & Risk:	Some of the ambulance handover improvements have been related to better patient flow and reduced numbers of COVID patients.
Actions:	Audits undertaken around the conveyances discharged from ED to help inform SECAmb/CCG of some pathways they can look to changing to support reducing conveyances to ED.

Kaia Vitler

Urgent Care – Front Door

A&E Non-Admitted
(ESHT Total Type 1 & 3)

Target: Monitor
Current Month: 97.1%

CONQ

EDGH

A&E 12 Hours From Arrival
(ESHT Total Type 1 & 3)

Target: Monitor
Current Month: 38

Author:	Kaia Vitler
Status Report	Non-admitted performance has improved significantly for both sites. New metric to look at 12 hours from arrival shows an improvement this month.
Challenge & Risk:	The new metric for 12 hours from arrival is directly impacted by patient flow and which site the Specialty beds are on.
Actions:	Will continue to monitor all metrics

Urgent Care – UTC

UTC 2 Hour Standard (Treatment start within 2 hrs)

Target: 98%
Current Month: 84.8%

CONQ

EDGH

UTC 4 hour standard (Visit complete within 4 hours)

Target: 95%
Current Month: 99.7%

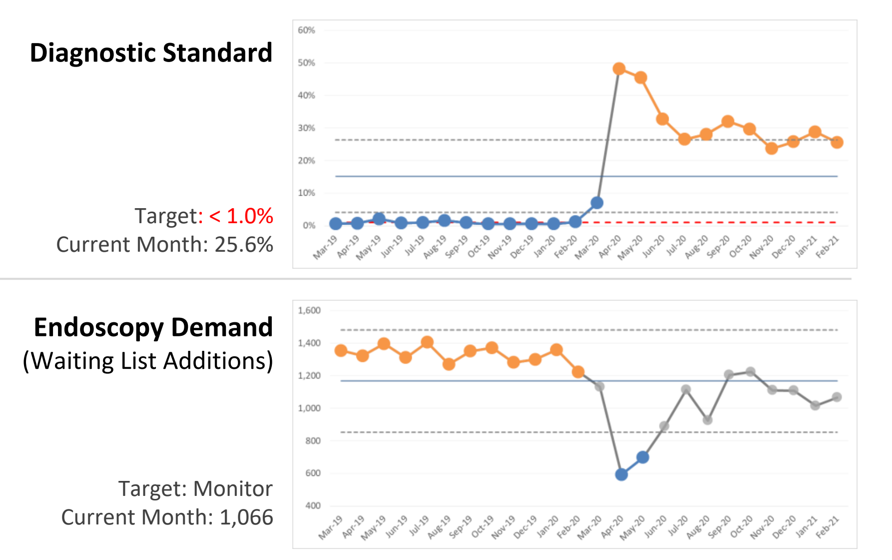
CONQ

EDGH

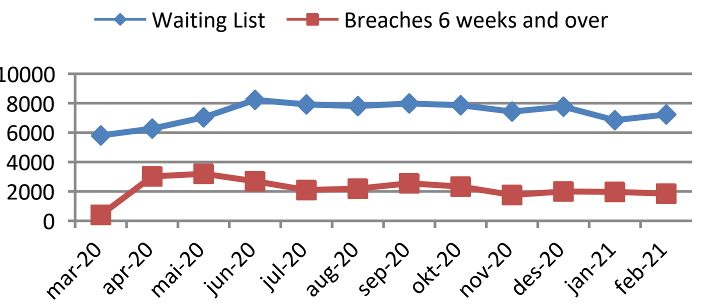
Author:	Kaia Vitler
Status Report	Working with the BI team and Nervecentre team to start to show the booked appointments and difference between 111 booked and walk in patients. As the GP patients are being recorded on EMIS and retrospectively recorded onto Nerve Centre, there may be a requirement for more education for GP's around the importance of correct timings entered. As our non-admitted average is 144m, we are likely to see this metric improve once we have amended how this is input.
Challenge & Risk:	Timely implementation of the metrics to improve data quality and integrity Identify training to inform data quality
Actions:	To move forward the reporting for booked appointments to undertake a comparison

Our People

Planned Care – Diagnostic



The February DM01 position has improved by over 3% and the backlog is slowly but steadily coming down in most areas as additional activity is put on to cope with current demand as well as the back log from the second wave.
Patient cancellations and DNAs were still a challenge and remain a focus but activity levels are restoring and improving as the departments work to improve their DM01 position.



Breach Rates	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Magnetic Resonance Imaging		10.57%	61.58%	48.91%	26.40%	15.14%	16.52%	14.84%	22.96%	22.56%	27.41%	31.53%	24.22%
Computed Tomography		8.49%	48.76%	44.80%	36.44%	32.32%	35.71%	41.41%	37.64%	22.89%	23.39%	24.98%	21.51%
Non-obstetric ultrasound		1.89%	41.25%	28.81%	11.70%	7.76%	11.66%	21.12%	7.70%	3.97%	7.13%	10.98%	12.06%
Barium Enema		--	--	--	--	--	--	--	--	--	--	--	--
DEXA Scan		--	--	--	--	--	--	--	--	--	--	--	--
Audiology - Audiology Assessments		0.00%	33.04%	91.79%	77.48%	97.32%	98.61%	71.43%	100.00%	--	1.67%	2.92%	2.29%
Cardiology - echocardiography		--	0.00%	--	--	--	--	--	--	0.00%	--	--	0.00%
Cardiology - electrophysiology		--	--	--	--	--	--	--	--	--	--	--	--
Neurophysiology - peripheral neurophysiology		--	--	--	--	--	--	--	--	--	--	--	--
Respiratory physiology - sleep studies		0.00%	--	--	0.00%	0.00%	0.00%	--	--	0.00%	--	--	--
Urodynamics - pressures & flows		56.00%	100.00%	87.50%	76.47%	70.83%	54.55%	73.53%	64.29%	84.78%	73.42%	90.00%	100.00%
Colonoscopy		3.08%	35.14%	50.57%	49.22%	47.54%	40.90%	35.18%	32.28%	37.18%	43.60%	41.11%	42.35%
Flexi sigmoidoscopy		4.82%	30.19%	44.65%	57.79%	53.14%	55.21%	57.30%	56.80%	55.28%	59.02%	54.44%	61.96%
Cystoscopy		28.57%	86.96%	57.14%	58.82%	48.72%	46.03%	28.00%	35.71%	20.93%	26.83%	21.05%	14.29%
Gastroscopy		7.10%	38.86%	50.89%	47.50%	54.88%	54.53%	54.93%	56.95%	57.50%	61.81%	61.90%	59.76%
Total		**6.97%**	**48.17%**	**45.48%**	**32.73%**	**26.48%**	**28.08%**	**31.98%**	**29.63%**	**23.68%**	**25.74%**	**28.77%**	**25.59%**

Cancer Pathway

Access and Responsiveness

Two Week Wait Referrals

Target: Monitor
Current Month: 1,826

The Trust saw an increase in referrals in February from previous month and we are already seeing pre-covid referral numbers after the second wave of the pandemic

Cancer 2WW Standard

Target: 93%
Current Month: 97.1%

However, we still managed to deliver the 2ww target with a 97.1% achievement. Patient choice continues to be a challenge as the teams have, and continue to experience a high volume of patient cancellations or declined offers of appointment.

Cancer 31 Day Standard

Target: 96%
Current Month: 96.2%

The Trust achieved against the 31 day measure again despite the covid challenges that specialties were having to deal with.

Cancer 62 Day Standard

Target: 85%
Current Month: 72.1%

January saw us deliver 72.1% placing us at 58 out of 121.
Seasonally, we would expect to see a decline in performance after Christmas and New Year and this has been further impacted by the second wave of the pandemic.
2ww standard: 51 breaches out of 1,370 patients seen
31 day standard: 6 breaches out of 165 treatments
62 day standard: 36 breaches out of 129 treatments (7 of these were patients waiting over 104 days)
February will close @ 66.4% which is a decline from January. This was anticipated with the 2 week pre-procedure isolation requirements, bed availability, diagnostic delays and patient choice.

2WW Referral to First Treatment 62 Days

Breast

Gynaecology

Haematology

Head & Neck

Colorectal

Lung

Skin

Upper GI

Urology

Rolling monthly reported positions by Tumour Site, Target: 85%

Financial Performance

Trust Financial Performance

Statement of Financial Position

Workforce Expenditure

Non Pay Expenditure, Efficiencies & Capital

Receivables, Payables & Cash

Divisional Financial Performance

We will use our resources economically, efficiently and effectively
Ensuring our services are financially sustainable for the benefit of our patients and their care

Finance Report Summary - Month 11

Income YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Contract/Block Income	352,290	368,925	368,735	(190)
Divisional Income	49,489	40,853	27,084	(13,769)
Pre Top-Up Income	401,779	409,777	395,819	(13,959)
FRF/Block Top-up	8,588	39,025	35,597	(3,428)
COVID-19 Expense Claim	0	0	21,661	21,661
COVID-19 Income Claim	0	0	8,822	8,822
Top-up Income	8,588	39,025	66,080	27,055
Total Income	410,367	448,802	461,898	13,096

The Trust's income is above plan £13.1m YTD. This is mainly due to the COVID expense & income claim and funding of £30.5m. Without these element the Trust's income would be £14m adverse due to the NHSE/I planning assumptions. The Elective Incentive Scheme, where income can be withheld should the agreed activity levels not be reached is no longer being applied in accordance with our local ICS guidance.

Operational Deficit YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Permanent	(242,008)	(274,377)	(264,558)	9,819
Temporary	(32,999)	(24,962)	(44,079)	(19,116)
Total Pay	(275,007)	(299,339)	(308,636)	(9,297)
Non Pay Costs	(141,509)	(150,205)	(153,206)	(3,001)
Operating Costs	(416,516)	(449,544)	(461,842)	(12,298)
Operational Deficit	(6,149)	(742)	56	798

The Trust is reporting YTD surplus of £56k against a plan deficit of £742k YTD' this is £798k better than plan. This shift away from deficit is mostly driven reduced spend during the Qtr 4 impact of COVID. Pay expenditure is £9m YTD above plan and non-pay £3m. Both of these variances are due to the Trust's response to and the impact of COVID-19. The previous deficit plan driven by lost nnon-nhs income is no longer current due to £4m funding made available to the Trust as a top-up.

COVID-19 Claim YTD

	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD
Pay	3,285	4,158	3,699	3,576	14,719
Non-pay	2,234	1,190	1,546	1,975	6,944
Planning Assumption	3,589	3,500	0	0	7,089
Loss of Income	135	79	0	0	214
(Loss)/Surplus Adjustment	(229)	1,748	0	0	1,519
Total	9,015	10,674	5,245	5,551	30,485
Amounts Validated	8,768	6,290	8,744	2,211	26,013
Residual Risk	(247)	(4,384)	3,499	(3,340)	(4,472)

The Trust's COVID-19 recovery claim of £30.4m YTD covers increased operating costs due to COVID, a planning assumption gap and non-patient care income losses. The retrospective true-up cost adjustment is no longer applicable. The Trust has been allocated a COVID-19 block fund of £11m for quarters 3 and 4 and a pass through COVID-19 cost of £1.5m.

Workforce

	Pr Year Actual WTE	Plan WTE	Actual WTE	Variance WTE
Permanent	6,949	6,669	6,526	142
Temporary	178	414	472	(58)
Total Pay	7,127	7,083	6,999	84

The Trust has used 84 FTE below plan in M11. The Trust has used 142 substantive FTE below plan and increased temporary workforce by 58 FTE. Despite many of these relating to pre-COVID-19 service developments and the requirement to run red and green areas, FTE's have fallen in line with reduced planned and emergency care activity levels. It is still expected that there will be a rise in recruitment into substantive posts leading up to year-end and through the new financial year to replace some of the temporary staffing arrangements.

Agency Spend YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Medical	3,973	1,645	3,579	(1,933)
Nursing	2,149	980	2,591	(1,611)
AHP's	1,480	1,584	1,702	(118)
Admin	620	418	492	(74)
Other	246	16	80	(64)
Total	8,468	4,643	8,444	(3,801)

Agency spend is above plan by £3.8m YTD, and this overspend is largely driven by Medical and Nursing agency spend. This is mainly due to the Trust's response to delivering the COVID-19 response including having staff for red and green areas and service developments as well as covering vacancies & absence.

Non-Pay Spend YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Drugs	43,831	38,693	43,279	(4,586)
Clinical Supplies	33,528	42,455	29,105	13,350
Purchased Services	10,133	10,046	3,576	6,470
Other	27,052	38,686	50,235	(11,549)
Finance Costs	26,965	20,325	19,069	1,256
Total	141,509	150,205	145,263	4,942

Non-pay spend is better than plan by £5m YTD. This is largely due to reduced spend on clinical suppies and services as planned and emergency care activity is adversely impacted by COVID-19. There is a netting off effect between drug costs and clinical supplies. These ceased rising in M10 and are now in decline with reduced planned & emergency care activity levels.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	95,923	93,823
Year End Forecast	2,100	2,100	2,100	0

The cash balance remains high as the cash has been received in advance of the period it relates to causing a higher than usual cash balance. The income for April 2021 will not be received in advance and therefore reduce the cash balance at year-end,

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	34,004	33,526	478
Year End Forecast	55,791	46,664	9,127

The expected CRL for 2020/21 is £55.791m and includes several successful bids for external funding and capital support. Of this total, £47.856m has been confirmed and £7.935m is awaiting confirmation from NHSE/I on the Trust Limits Report. Against the CRL total of £55.791m the Trust has declared an underspend and is working towards a target of £46.664m.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	59.94%	86.93%	88.25%	89.74%
NHS Invoices	93.66%	99.87%	96.65%	96.19%

60% of trade invoices were paid within 28 days which equates to 87% of the total value paid in month. This is in line with the performance last month in invoices paid within the target of 28 days.

94% of NHS invoices were paid within contract or within 28 days of receipt which was 99% of the total NHS invoices paid.

Divisional Performance

Division	In the Month Plan FTE	In the Month Actual FTE	In the Month Variance FTE	In the Month Plan £k	In the Month Actual £k	In the Month Variance £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Outturn Plan £k	Forecast Outturn Actual £k	Forecast Outturn Variance £k
Diagnostics, Anaesthetics & Surgery	1,714.17	1,717.39	(3.22)	(10,260)	(9,616)	644	(112,157)	(106,276)	5,881	(122,417)	(122,417)	0
Medicine	1,383.38	1,393.97	(10.59)	(6,382)	(6,499)	(117)	(68,684)	(68,251)	433	(75,066)	(75,066)	0
Urgent Care	343.63	347.20	(3.57)	(1,791)	(1,699)	92	(18,829)	(19,622)	(793)	(20,620)	(20,620)	0
Out of Hospital Care	1,089.81	1,080.78	9.03	(4,495)	(4,305)	190	(48,349)	(47,388)	961	(52,844)	(52,844)	0
Women's, Children's & Sexual Health	731.35	695.69	35.66	(3,265)	(3,050)	214	(35,817)	(33,875)	1,942	(39,081)	(39,081)	0
Estates & Facilities	713.60	639.85	73.75	(2,503)	(2,246)	257	(26,827)	(29,155)	(2,329)	(29,329)	(29,329)	0
Corporate	589.85	615.43	(25.58)	(3,527)	(3,226)	301	(37,465)	(36,571)	893	(40,966)	(40,966)	0
Central	516.93	1,015.19	(498.26)	35,120	34,145	(975)	347,385	341,196	(6,189)	374,185	374,185	0
Total	7,082.72	7,505.50	(422.78)	2,897	3,504	607	(742)	56	798	(6,138)	(6,138)	0

Productivity & Efficiency

	Plan £k	Actual £k	Variance £k
YTD	2,195	2,198	3
Full Year	3,001	3,001	-

The Trust has an internal plan that slightly exceeds the plan submitted to regulators to allow for some contingency. The Trust has a YTD over-performance of £3k. This is driven by an overachievement on outpatients, however this is offsetting underperformance in theatres, diagnostics and LoS.

Key Risks

Key Risk 1	The amended financial regime is based on the average income for months 8 to 10 plus a 3.2% inflator. This has the potential to create cost pressures as the block contract is based on a period of time and not on forecast outturn.
Key Risk 2	Continued recruitment to vacant posts and service developments which commenced prior to the amended financial regime could lead to expenditure commitments higher than the funding allows in the block funding for 2020/21.
Key Risk 3	The Trust is required to submit plans to deliver 90% or 100% activity levels. This will incur additional costs. Should we not achieve these activity trajectories then there is a potential for reductions to our block
Key Risk 4	The Trust will receive a revised block value. It is unclear at this stage whether or not this will resolve our block income gap or the income planning gap identified in the current financial regime.

Mitigations

Mitigation 1	An expenditure forecast will be undertaken to understand both the financial opportunities and challenges and put in place early mitigation for the challenges.
Mitigation 2	An update of the Trust's financial plan is being undertaken based on month 1 as a benchmark to monitor pay spend and permanent recruitment
Mitigation 3	The focus will continue to be on productivity and efficiencies to ensure that we meet the required activity trajectories, manage our costs to avoid the risk of a reduced block contract.
Mitigation 4	

20/21 Plan | 20/21 Actuals | 19/20 Actual | 20/21 YTD

Finance Analysis

Year to date financial performance before Top Ups

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Block Income Gap | Income Planning Gap | COVID-19 Costs

FFor month 11, the trust is reporting a deficit pre-top up & True up of £66m. This is currently due to Block Income Gap of £35m, COVID income claim of £9m, and COVID-19 related expenditure additionality of £22m

Monthly financial performance before Top Ups

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Block Income Gap | Income Planning Gap | COVID-19 Costs | 19/20 Actual

In month the trust is reporting a deficit pre-top up & True up of £6.8m. This is currently due to Block Income Gap of £3.6m and COVID-19 related expenditure additionality of £3.2m. The increased deficit run rate is due to higher expenditure related to COVID-19 in M11 and also as a result of restoring 'normal' activity levels. Ideally, the block income gap should track the 19/20 actual trajectory.

Agency expenditure (ceiling basis)

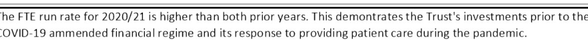
Mthly run rate £000s

20/21 Actuals medical | 20/21 Actuals nursing | 20/21 Actuals other | 20/21 Updated ceiling

The increase in run rate is mainly driven by Nursing agency. This trajectory is being closely monitored in line with the forecast. It is key that the Trust continues to focus on cost control as it has a block contract in place until March with very little opportunity for non-patient care income due to the wider effects of the COVID-19 ammended regime.

2021 FTE RUN RATE OVERLAYED WITH PRIOR YEARS

Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21



The FTE run rate for 2020/21 is higher than both prior years. This demonstrates the Trust's investments prior to the COVID-19 ammended financial regime and its response to providing patient care during the pandemic.

20/21 PAY RUN RATE OVERLAYED WITH PRIOR YEARS

Substantive | Agency | Bank | Pay Spend 2019/20 | Pay Spend 2018/19

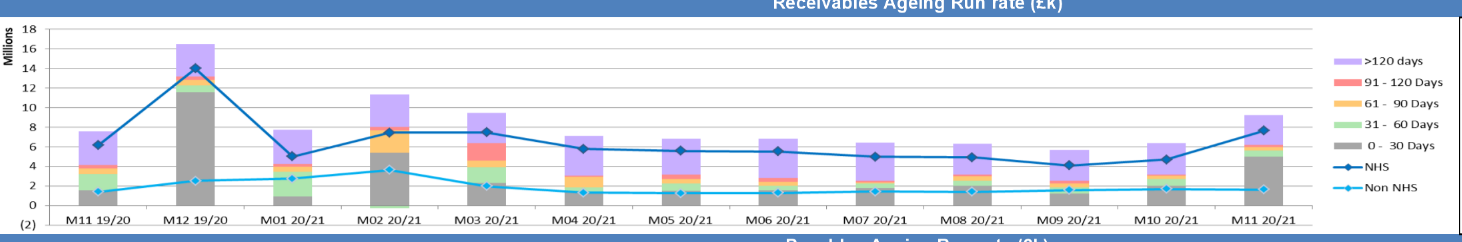
The pay spend is above the run rate of prior years and reflects the increased cost of operating set against the backdrop of COVID-19 (i.e. running 'Red and Green' areas) as well as the impact of service developments which commenced prior to the current financial regime. In addition to this, the increase in run rate relates to the phase 3 restore & recover with the need for additional and backfill of staff in line with planning.

ADMITTED PATIENT CARE ACTIVITY RUN RATE

A&E | NEL | EL | DC

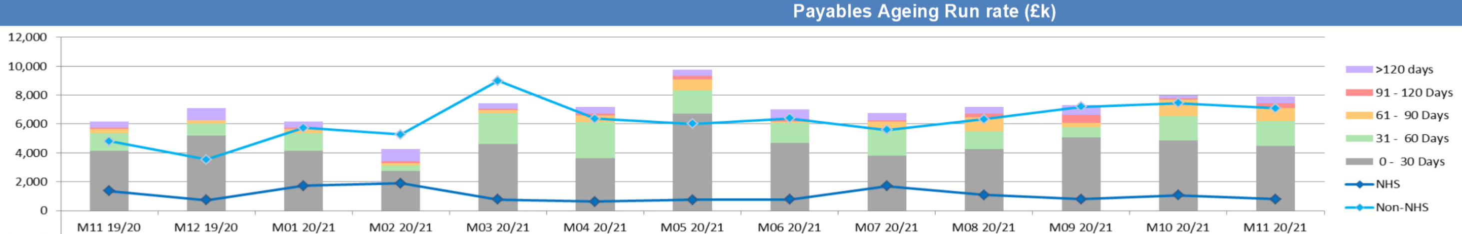
Admitted patient care (excluding Critical care) shows a deep decline in April and consitent recovery thereafter. As at M11, A&E is 77% of prior year activity, NEL at 80%, Elective at 36% and Daycases at 54%. The expectation is that all these would have reached 90% level of activity by now. However, the increased COVID-19 demand is likely to inhibit the Trust's ability to achieve this target.

Receivables Ageing Run rate (£k)



The sales ledger balance at the end of February is £9.2m which is an increase on the previous month of £2.9m. The number of invoices on the sales ledger at the end of the month has reduced by 118 to 1,227. The position reflects a slight improvement in aged debt (invoices > 30 days) of £0.1m. 46% of the total debt owed to the Trust is due and is aged over 30 days. Most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.
There are NHS invoices currently being disputed relating to; prior year market rent recharge from NHSPS £0.955m; SLA year-end settlement 2018/19 £0.281m and delayed discharges £0.092m.

Payables Ageing Run rate (£k)



A decrease in month of £0.1m on the creditor position decreasing the purchase ledger total to £7.9m. This was reflected in a slight increase in the number of invoices on the purchase ledger system. Aligned to the total purchase ledger increase, the value of debt owed to suppliers (aged > 30 days) also increased by £0.3m. Balances that are aged and not ready for payment reflect invoices that are awaiting authorisation or the receipting of the goods/services received.
90% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs which have averaged £3.7m in 2021.
Actual payment runs depend on the level of invoices on the system that are system ready to be paid and due for payment.

M7 to M12 Run Rate

The M11 run rate is £3,519 surplus (£4,550 under the M11 plan)

	M7 Outturn £000	M8 Outturn £000	M9 Outturn £000	M10 Outturn £000	M11 Outturn £000	M12 Plan £000	Total £000
Planned monthly surplus/(deficit)	(833)	(754)	(874)	(1,178)	(1,031)	(1,364)	(6,034)
Acutal monthly surplus/(deficit)	(831)	(750)	(875)	(1,082)	3,519		(19)
Variance from planned monthly deficit	**2**	**4**	**(1)**	**96**	**4,550**		**4,651**
Planned Income pre COVID-19 and top up	35,897	35,854	35,760	35,583	35,715	35,254	214,062
Actual Income pre COVID-19 and top up	36,094	36,301	37,347	35,585	36,469		181,796
Income Variance	**197**	**448**	**1,587**	**2**	**754**		**2,988**
Planned expenditure (pay and non-pay)	(40,352)	(40,352)	(40,432)	(40,530)	(40,535)	(40,404)	(242,605)
Actual expenditure (pay and non-pay)	(40,548)	**(40,674)**	**(41,844)**	**(40,288)**	**(39,729)**		(203,083)
Expenditure Variance	**(196)**	**(322)**	**(1,412)**	**242**	**806**		**(882)**
Planned COVID Income (including pass through)	2,143	2,143	2,143	2,143	2,143	2,143	12,856
Actual COVID Income (including pass through)	1,688	1,409	2,149	2,310	3,240		10,796
COVID Income Variance	**(455)**	**(734)**	**7**	**168**	**1,098**		**83**
Planned COVID Expenditure	(2,142)	(2,142)	(2,142)	(2,142)	(2,142)	(2,145)	(12,855)
Actual COVID Pay Expenditure	(1,246)	(1,032)	(1,421)	(1,370)	(2,207)		(7,276)
Actual COVID Non-Pay Expenditure	(441)	(377)	(728)	(941)	(1,304)		(3,791)
COVID Expenditure Variance	**(455)**	**(733)**	**7**	**169**	**1,369**		**357**
Actual block income top up	3,622	3,622	3,622	3,622	7,050		21,538
Monthly deficit pre income top up	(4,453)	(4,372)	(4,497)	(4,704)	(3,531)		(21,557)
Operational Surplus /(Deficit)	**(831)**	**(750)**	**(875)**	**(1,082)**	**3,519**		**(19)**
Improvement/Deterioration of deficit compared to prior month		**2**	**(5)**	**97**	**4,454**		

Statement of Financial Position - Month 11

	Year to date				Forecast Outturn		
	19/20 Actual (£m)	20/21 Plan (£m)	20/21 Actual (£m)	Variance (£m)	20/21 Plan (£m)	20/21 Outturn (£m)	Variance (£m)
Non Current Assets							
Property, Plant and Equipment	229.5	232.7	249.0	16.3	252.6	275.1	22.6
Intangible Assets	2.4	2.1	2.6	0.5	2.3	2.5	0.2
Other Assets	3.0	9.4	1.9	(7.5)	8.8	3.1	(5.7)
Total Non Current Assets	**234.9**	**244.3**	**253.5**	**9.3**	**263.7**	**280.7**	**17.0**
Current Assets							
Inventories	7.3	6.6	6.5	(0.1)	6.6	6.6	0.0
Trade and Other Receivables	47.3	41.3	24.1	(17.2)	37.6	50.5	12.9
Cash and Cash Equivalents	2.1	10.5	95.9	85.4	2.1	2.1	0.0
Non Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**56.8**	**58.4**	**126.6**	**68.1**	**58.4**	**59.2**	**12.9**
Current Liabilities							
Trade and Other Payables	(28.8)	(32.3)	(63.1)	(30.8)	(32.5)	(47.5)	(15.0)
Borrowings	(234.1)	(4.9)	0.0	4.9	(5.3)	0.0	5.3
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions	(0.4)	(0.4)	(0.3)	0.1	(0.4)	(0.3)	0.1
Other Liabilities	(1.4)	(2.2)	(42.3)	(40.1)	(2.2)	0.0	2.2
Total Current Liabilities	**(264.6)**	**(39.8)**	**(105.7)**	**(65.9)**	**(39.8)**	**(47.8)**	**(7.4)**
Non-Current Liabilities							
Borrowings	(1.8)	(22.4)	0.0	22.4	(27.1)	0.0	27.1
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions	(2.8)	(2.0)	(2.8)	(0.8)	(1.8)	(2.8)	(1.0)
Total Non Current Liabilities	**(4.6)**	**(24.5)**	**(2.8)**	**21.6**	**(28.9)**	**(2.8)**	**26.1**
Total Assets Employed	**22.4**	**238.4**	**271.5**	**33.1**	**253.4**	**289.2**	**48.5**
Financed By							
Public Dividend Capital	162.6	387.5	412.6	25.1	388.6	435.6	46.9
Income & Expenditure Reserve	(230.5)	(246.8)	(231.3)	15.5	(245.6)	(236.6)	9.0
Revaluation Reserve	90.2	97.7	90.2	(7.5)	97.7	90.2	(7.5)
Total Tax Payers Equity	**22.4**	**238.4**	**271.5**	**33.1**	**240.7**	**289.2**	**48.5**

Summary & Next Steps

1. On 2 April 2020, the Department of Health and Social Care (DHSC) announced reforms to the NHS cash regime for the 2020/21 financial year which included that all interim revenue and capital loans as at 31 March 2020 would be extinguished and replaced with the issue of Public Dividend Capital (PDC). In addition, the Trust was moved to block contract payments as part of the NHS response to COVID-19.
2. The effective date for the extinguishing of debt was 30 September 2020; at the time the plan was generated, the assumed debt conversion was April 2020 hence the variance.
3. All outstanding interim loans totalling £234m have been repaid and replaced by Public Dividend Capital.
4. The one remaining normal course of business loan (NCB) was repaid in October, as a result of this transaction the Trust does not have any borrowings.
5. Due to the financial regime changes the Trust has been moved on to block contract payments. Funding is being received in advance causing a higher than usual cash balance at the end of month. The Trust is awaiting guidance from NHSEI with regards to the cash balance in Q4.
6. The block payment paid in advance, is deferred out of the current period and shows as other liabilities on the Statement of Financial Position.

Capital Programme Summary - Month 11

YTD Capital Programme Performance	Original Plan £000	Revised Plan £000	CRG Plan £000	YTD Plan £000	Actual Expenditure £000	Variance to YTD Plan £000
Brought Forward	-	-	-	-	436	436
Estates	3,559	2,429	4,527	2,200	6,311	4,111
Backlog Maintenance	2,783	1,800	2,200	2,005	1,872	(133)
Digital	1,975	3,081	4,036	950	3,001	2,051
Medical Equipment	3,667	2,901	2,917	3,667	3,003	(664)
Finance	1,500	1,500	1,500	1,125	1,375	250
Unplanned urgents	545	350	1,482	545	63	(482)
Fire compartmentalisation	6,020	5,020	2,600	5,520	3,144	(2,376)
Building For Our Future (HIP2)	4,230	10,375	6,000	3,285	3,234	(51)
General Provision	301	-	-	-	-	-
Emergency Capital Funding	9,000	5,250	5,250	6,061	2,284	(3,777)
Local Health Care Record	-	1,452	1,452	-	1,368	1,368
Breast Screening Mobile Units	-	26	26	26	-	(26)
Clinical Ward Internal Courtyards	-	558	587	1,800	228	(1,572)
Energy Centre Conquest	-	350	350	450	897	447
Energy Centre EDGH	-	572	540	720	-	(720)
Helipad area	-	-	-	1,428	-	(1,428)
Temporary Accommodation	-	2,590	2,550	3,107	2,005	(1,102)
COVID-19	-	1,115	1,115	1,115	-	(1,115)
CYBER SIEM Solution	-	220	220	-	97	97
A&E Winter	-	2,700	2,700	-	917	917
Oxygen	-	1,024	1,024	-	998	998
Perkin Elmer	-	323	368	-	368	368
Adopt & Adapt	-	630	530	-	301	301
Hummingbird	-	-	2,000	-	-	-
Digital Aspirant	-	-	950	-	-	-
iPads anytime videoconferencing	-	-	11	-	-	-
HSLI/SID	-	-	1,275	-	-	-
Track and Trace	-	-	149	-	-	-
Shared Records	-	-	300	-	-	-
COVID-19	-	1,374	5	-	1,624	1,624
Total Owned	**33,580**	**45,640**	**46,664**	**34,004**	**33,526**	**(478)**
Donated	1,000	1,000	1,000	1,000	134	(866)
Less donated Income	(1,000)	(1,000)	(1,000)	(1,000)	(134)	866
Total	**33,580**	**45,640**	**46,664**	**34,004**	**33,526**	**(478)**

Capital Resource Limit (CRL)	£k	Notified Underspeds
Planning CRL	**34,580**	
2020/21 Opening CRL	**13,834**	**(1,773)**
Fire Compartmentation	6,020	(1,000)
Building For Our Future (HIP2)	8,375	(775)
Local Health Care Record (LHCRE)	1,452	
Breast Screening Mobile Units	26	
COVID-19 reimbursement (PY)	1,115	
Critical Infrastructure Funds (CIF)	8,270	(3,863)
A&E Winter	3,700	(1,000)
Cyber SIEM solution	220	
Adopt & Adapt	630	(100)
COVID-19 20-21 Approved bids	2,041	(616)
Oxygen (Tranche 2)	1,024	
Perkin Elmer (awaiting MOU)	323	
Digital Pathology (LIMS)	826	
Closing Working CRL	**47,856**	**(9,127)**
Digital Aspirant	950	
iPads anytime videoconferencing	11	
HSLI/SID	1,275	
Track and Trace	149	
Shared Care Records (SHCRS)	300	
Emergency Capital Funding (NHSE/I to be approved)	5,250	
Forecast CRL	**55,791**	**(9,127)**
Target CRL	**46,664**	

Overplanning/(underplanning) margin	-	

Capital Commentary

The expected CRL for 2020/21 is £55.791m and includes several successful bids for external funding and capital support. Of this total, £47.856m has been confirmed and £7.935m is awaiting confirmation from NHSE/I on the Trust Limits Report. Against the CRL total of £55.791m the Trust has declared an underspend and is working towards a target of £46.664m.

Mortality Report – Learning from Deaths 1st April 2017 to 30th September 2020

Meeting information:	
Date of Meeting: 13th April 2021	Agenda Item: 9
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	

Summary:

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

The attached report on "Learning from Deaths" follows the requirements set out in the Care Quality Commission review. The mortality database is designed to reflect this process and has also been updated to incorporate the Medical Examiner review process which commenced at the Trust on September 1st.
Cases referred by the Medical Examiners for further scrutiny, are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.

The current "Learning from Deaths" report details the April 2017 – September 2020 deaths recorded and reviewed on the mortality database. The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme. Trusts are now receiving some feedback from these reviews.
Deaths of patients with learning disabilities are also reviewed internally, in order to mitigate any risk.

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

N/A

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

The Board are requested to note the report. "Learning from Deaths" reports are required on a quarterly basis.

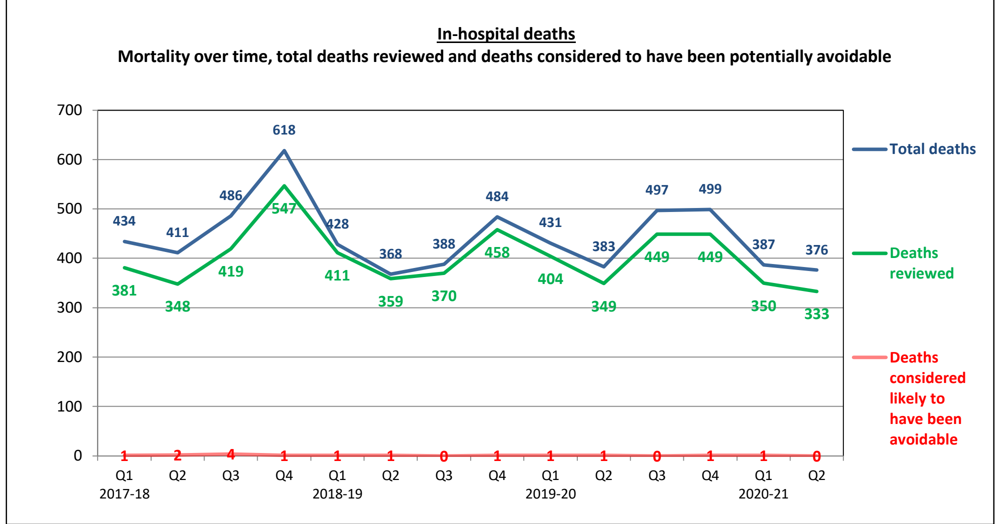
EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard September 2020-21

Description:
This 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 in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 08/03/2021)

Total number of in-hospital deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)

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
128	130	128	105	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
376	387	333	350	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
763	1810	683	1651	1	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 3 Probably avoidable (more than 50:50)		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	14.3%

Score 4 Possibly avoidable but not very likely		
This Month	1	100.0%
This Quarter (QTD)	2	66.7%
This Year (YTD)	4	57.1%

Score 5 Slight evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	14.3%

Score 6 Definitely not avoidable		
This Month	0	0.0%
This Quarter (QTD)	1	33.3%
This Year (YTD)	1	14.3%

Data above is as at 08/03/2021 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 4 care concerns expressed to the Trust Bereavement team relating to Quarter 2 2020/21 deaths. The Complaints department are taking forward complaints received for two of these cases.
Complaints - Of the complaints closed during Quarter 2 2020/21 which were relating to 'bereavement', none have overall care ratings of 'poor care' on the mortality database.
Serious incidents - There was one severity 5 incident reported in Quarter 2 2020/21. This case was discussed at the Mortality Review Audit Group in February 2021 where the avoidability rating of 4 - possibly avoidable but not very likely (less than 50-50), was agreed.
As at 09/03/2021 there are 563 April 2017 - September 2020 deaths still outstanding for review on the Mortality database.(from data on this spreadsheet not mortality database)

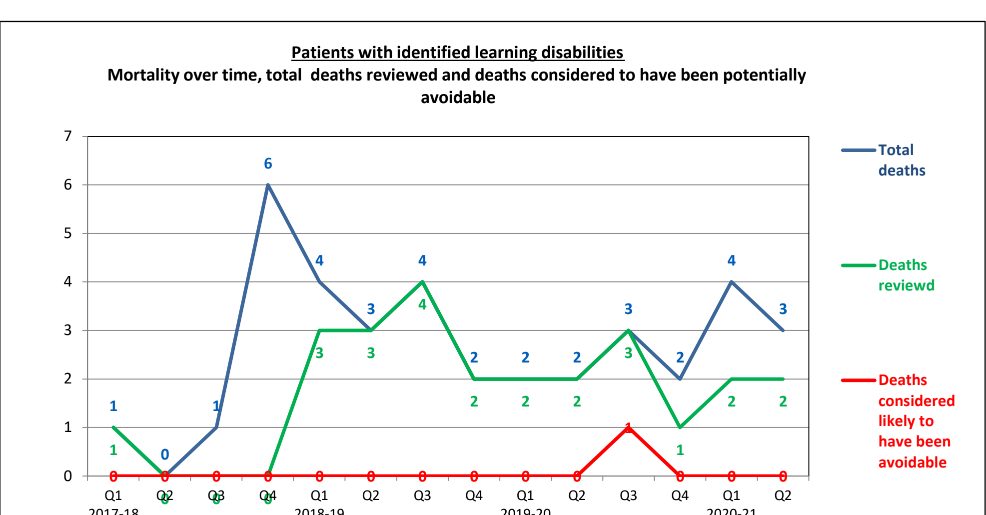
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 08/03/2021)

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities

Time Series:	Start date	2017-18	Q1

End date	2020-21	Q2

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	4	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	9	4	8	0	1



The LeDeR (learning disability mortality review) programme is now in place and the deaths of patients with a learning disability are being reviewed against the new criteria externally. Feedback from these external reviews is now being received by the Trust.
These deaths are also reviewed internally by the Acute Liaison Nurse for Learning Disabilities and Head of Nursing for Safeguarding, who enter their review findings on the mortality database.
As feedback from the wider external LeDeR has not yet been received, the internal reviews are being continued in order to mitigate against any risk.

Quality Account Priorities for 2020/21

Meeting information:			
Date of Meeting:	13th April 2021	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

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?	

Summary:

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

Prior to the Covid-19 pandemic, the Quality Account priorities for 2020/21 had been agreed. However, as the pandemic progressed, it was acknowledged that two of the priorities were not going to be achievable. This was due to the inability to provide training on human factors and also that resource could not be diverted to support the improvement of VTE compliance and treatment.

As part of the 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic' guidance from NHS England, the process for publishing the Quality Account was paused. This pause provided ESHT with the opportunity to consider some further priorities to take forward for the remainder of 20/21. This paper outlines the three priorities now being proposed:

1. Embedding Patient Safety – developing a methodology for evidencing that actions from Root Cause Analysis reports has had an impact on patient safety

2. Infection Control Excellence – to implement the new BAF – IPC and identify areas for improvement

3. Perfecting Discharge – to improve the patient experience of the discharge process and maintain safety by improved communication with healthcare services

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

Quality and Safety Committee

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

For the Board to approve the three priorities identified for the Quality Account 2020/21.

EXECUTIVE SUMMARY

Quality Account Priorities 20/21

Prior to the Covid-19 pandemic, the Trust had identified three priority projects for 2020/21. However, as the pandemic progressed it was acknowledged that two of the projects could not be progressed in 2020/21. Therefore, the Trust identified two new priorities but due to constraints as a result of Covid-19, these could not be consulted upon with the public.

Table 1: Priorities for improvement in 2020/21

Priorities for Improvement 2020/21	Quality Domain
1. Embedding Patient Safety	Patient Safety Clinical Effectiveness Patient Experience
2. Infection Control Excellence	Patient Safety Clinical Effectiveness
3. Perfecting Discharge	Patient Safety Clinical Effectiveness Patient Experience

1. Embedding Patient Safety

Why this has been chosen as priority

The Trust has robust systems in place to report, investigate, identify learning and develop actions to reduce the possibility of the same or similar incidents occurring. However, there remains a challenge to collate evidence that demonstrates, if changes have been made, that they have they led to measureable and sustainable risk reduction. The aim of this priority is to identify methodology that will measure and support the effectiveness of the actions taken forward and their impact on reducing the risk of further incidents.

What we are going to do

- Review the serious incident investigations root cause analysis (RCA) reports and subsequent actions from the previous 12 months
- Identify overdue actions yet to be implemented and identify what barriers are preventing the actions being completed
- Work with clinical teams to develop methodology that will support them in how to evidence the impact of the actions on reducing the risk of further patient safety incidents
- Apply new methodology to 2 areas of patient safety and assess whether methodology is being applied correctly and consistently, and if it is whether it is providing the necessary data from which the Trust can measure the effectiveness of actions and the impact on risk
- From the 12 month RCA report review and utilising guidance in the new draft Patient Safety Incident Response Framework) identify themes to be investigated further
- Identify changes in practice in response to reducing future risk

What will success look like?

- By reviewing the serious incident RCA reports as a whole collection of information rather than individual incidents, new learning will indicate how

actions in the future could be identified to ensure that the risk of further incidents is reduced

- All overdue actions will have been completed with evidence provided
- Methodology for evidencing the effectiveness and impact of actions on improvement (or lack of) in areas of concern for patient safety will have been developed and tested
- Themes for undertaking investigations as part of the new Patient Safety Incident Response Framework will have been identified

How we will monitor progress

- Data on serious incidents, actions and themes and themes is reported to the Quality and Safety Committee bimonthly
- Progress of this priority (particular areas of focus) specifically will be provided to the Quality and Safety Committee bimonthly including presentation on the methodology developed
- Data and information as outputs of this priority will be shared with clinical teams within the appropriate governance and risk meetings.

2. Infection Control Excellence

Why this has been chosen as priority

There has recently been the introduction of a national requirement for Trust to have a Board Assurance Framework for Infection Prevention and Control (BAF- IPC). The purpose of the BAF is to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance and to identify risks. Although the BAF- IPC is not mandatory it is considered to a helpful assurance tool. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can be used to assure trust boards.
The BAF- IPC will be adopted as the key policy for infection prevention and control and implemented in the Trust during 2020/21.

What we are going to do

- Finalise the BAF- IPC template to ensure it is capturing all relevant detail
- Identify key gaps in the BAF- IPC and develop actions plans to address them
- Monitor infection rates and identify and incorporate emerging themes
- Complete serious incident RCA investigation reports into outbreaks and identify learning with appropriate actions

What will success look like?

- The BAF- IPC will be updated and reported on monthly via a number of forums with oversight by the Quality and Safety Committee
- Areas for improvement will have been identified and action plans in place to support improvement
- Learning from outbreak serious incidents will identified on the BAF- IPC and taken forward to ensure high standard of practice is maintained ensuring patient and staff safety
- Trust will be compliant with all national guidance
- The trust will achieve low levels of hospital transmission in relation to national rates.

How we will monitor progress

- The BAF- IPC will be reviewed monthly at the Trust Infection Prevention and Control Group with escalation via the Patient Safety and Quality Group

- There will be oversight on the progress of the priority by the Quality and Safety Committee bimonthly.
- Annual reporting to the Board

3. Perfecting Discharge

Why this has been chosen as priority

Data from the national inpatient survey, our own internal complaints and inpatient questionnaires highlight a number of areas regarding communication and information provided to patients regarding the discharge process as an area where we can make improvements.

Last year as part of the Quality Account Patient Experience Priority 120 patients were surveyed about their experience of involving patients in making decisions about their care, and the information provided to them. The Trust recognises that there are a number of areas in the patient journey where communication could be improved and these surveys identified communication at the point of discharge could be improved.

The changes to the Trust's discharge processes during the Covid-19 pandemic has contributed to an increased focus with short actions being taken and longer term plans being developed. A Multidisciplinary Strategic Discharge Improvement Group has been established to take the plans forward.

A quality improvement approach will be adopted to identify the specific areas to target, test new approaches and ensure improvements are sustained.

What we are going to do

- Provide oversight of themes, trends, lessons learned and areas of best practice that support the divisions to facilitate safe, high quality multidisciplinary and timely planning of discharges and improve the patient experience.
- From data analysis work streams have been identified as areas of focus (communication, process, medication and training and education).
- The strategic group will meet monthly to report back on the work streams progress
- We will gain feedback from those who received the revised process/ communication to identify areas for improvement and develop action plans to implement changes, using a quality improvement approach.
- Seek ongoing feedback from patients/carers/relatives about how well the discharge process is meeting their needs

What will success look like?

- Patients receive high quality (safe, effective, timely, experience) discharge.
- Patients/carers/relatives are comprehensively informed and understand about their care needs and follow-up actions
- Improved satisfaction of patients/relatives/ carers feeling informed during the discharge process.
- Improved the score for each question in section 9 of the National Inpatient Survey by 1 point.
- To obtain the evidence of how the changes made have impacted on patient experience and share this information across the Trust.
- Expected Dates of Discharge are met as planned
- Reduced unplanned admission
- Discharge communication with GP is accurate and complete

How we will monitor progress

- Progress from the discharge workstreams will be reported to the Multidisciplinary Discharge Improvement Group.
- Escalation of issues and barriers will be to the Recovery and Restoration Board
- The Quality and Safety Committee will be provided with a progress report bimonthly.

Cardiology and Ophthalmology Transformation Programme - Update to HOSC

Meeting information:	
Date of Meeting: 13th April 2021	Agenda Item: 11
Meeting: Trust Board	Reporting Officer: Richard Milner, Director of Strategy

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?	

Summary:

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

East Sussex Healthcare NHS Trust (ESHT) in partnership with the East Sussex Clinical Commissioning Group (CCG) are developing proposals to redevelop both Cardiology and Ophthalmology services in East Sussex.

The attached report, which was presented at the Health Overview and Scrutiny Committee (HOSC) on the 4th of March by the CCG and ESHT, provides an overview of the current situation for consideration ahead of further reports later in the year.

The HOSC considered the report and noted the following points;

- The CCG and Trust have undertaken a formal period of 'Pre-Consultation Engagement' with local stakeholders about their experiences of the services.
  - This was completed between December 2020 and February 2021. The feedback informs the process of options development.
- The next step (at the time of the HOSC meeting) was to hold 'Options Development and Appraisal' workshops, involving key stakeholders, patients and the public. Workshops were arranged for between 8th and the 23rd of March 2021.
  - Since the HOSC meeting, the options development workshops have been completed. ESHT and the CCG are awaiting the formal report from the independent facilitators (Opinion Research Services), which is due in draft on the 16th April.
- Following options development, and the selection of options to go forward as proposal, a further report to HOSC would be required to determine if any of the proposals constituted 'substantial variation';
  - Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change that would constitute a 'substantial development or variation' to services for the residents of the HOSC area.
  - There is no national definition of what constitutes a 'substantial' change. Factors such as the number or proportion of patients affected, the nature of the impact and the availability of alternative services are often taken into account in coming to an agreement between the HOSC and the NHS on whether formal consultation is required.
- The CCG reported that they were planning to potentially begin formal consultation with local people in the summer/autumn of 2021. A final decision on timeline is expected during the spring 2021/22, following options development and appraisal, and drafting of a Pre-Consultation Business Case (PCBC).

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

Health Overview and Scrutiny Committee (HOSC), 4th March 2021. The Committee agreed to a further update at its next meeting on the 10th June 2021.

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

This report provides the Board with an update on developments in relation to the Cardiology and Ophthalmology transformation programmes. There are no recommendations that require approval at this point. The Board are asked only to:

1) Consider and note the report; and
2) Agree to consider a further report at a subsequent meeting following the receipt of the options development and appraisal report.

Agenda Item 6.

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**4 March 2021**
By:	**Assistant Chief Executive**
Title:	**Cardiology and Ophthalmology services**
Purpose:	**To update HOSC on the proposed development of Cardiology and Ophthalmology services at East Sussex Healthcare NHS Trust (ESHT)**

RECOMMENDATIONS

The Committee is recommended to:

1) consider and note the report; and

2) agree to consider a further report at its 10th June meeting.

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1. Background

1.1. East Sussex Healthcare NHS Trust (ESHT) provides acute cardiology services from both the Eastbourne District General Hospital (EDGH) and Conquest Hospital in Hastings. The Trust also provides adult and children's ophthalmology (diagnosis and treatment of eye disorders) services from both acute hospital sites and the community hospital in Bexhill.

1.2. East Sussex Clinical Commissioning Group (CCG) in partnership with ESHT is developing proposals to redevelop both services and this report provides an initial overview of the current situation for HOSC to consider ahead of further reports later in the year.

2. Supporting information

2.1. The document attached as **Appendix 1** contains an update from the CCG and ESHT on the progress with developing the new proposals.

2.2. The CCG and Trust have undertaken engagement with local stakeholders about their experiences of the services. The next step will be to develop options for future cardiology and ophthalmology services during March 2021. The CCG is then planning to potentially begin formal consultation with local people beginning in the summer or autumn of 2021. A final decision is expected during winter or spring 2021/22.

HOSC role

2.3. Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change that would constitute a 'substantial development or variation' to services for the residents of the HOSC area. The HOSC

2.4. There is no national definition of what constitutes a 'substantial' change. Factors such as the number or proportion of patients affected, the nature of the impact and the availability of alternative services are often taken into account in coming to an agreement between the HOSC and the NHS on whether formal consultation is required.

2.5. Based on the CCG's timeline, the next step will be for HOSC to consider a report on the proposals at its next meeting on 10th June. At this point, HOSC should be able to agree whether the proposals constitute a substantial variation to services requiring formal consultation with the Committee, which will take place alongside but separate to the public consultation.

3. Conclusion and reasons for recommendations

3.1. This report provides HOSC with an update on developments in relation to cardiology and ophthalmology services at ESHT.

3.2. The Committee is recommended to consider the proposals and agree to a further update at its 10th June meeting.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Harvey Winder, Democratic Services Officer
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Improving local cardiology and ophthalmology services

March 2021

Context for improving services

As part of a continuing drive for excellence, we are always looking for ways to improve local services. This is outlined in our East Sussex Long Term Plan that describes the 'transformation priorities we need to deliver jointly as a health and social care system to meet the future health and care needs of our population… to deliver a "new service model for the 21st century" grounded in the needs of our local population'.

Within this context, we have been talking to people living in East Sussex about their experience of cardiology and ophthalmology services, in particular:

- Ophthalmology services (both adult and children's) provided at The Conquest Hospital, Hastings; Bexhill Hospital; and Eastbourne District General Hospital.
- Acute cardiology services provided at The Conquest Hospital, Hastings and Eastbourne District General Hospital which includes emergency management of heart attacks and interventional cardiology

This is so that we can co-design a set of proposals for the future that improve services for local people, address some of the current challenges and make the most of future opportunities including:

- Being in a position to implement emerging clinical best practice in line with changing population health needs, in particular the ageing population in East Sussex including working together to address health inequalities, improve experiences and outcomes, and ensuring that future proposals support our collective management of Covid 19
- Responding to changing patterns of service delivery, for example specialisation of the workforce, technological advances, and maintain/improve recruitment and retention of staff
- Making the most of opportunities presented by developments in digital service delivery and ensuring that our estates and equipment support service improvements
- Making the best use of our resources

Update and plans for next steps

It is important that local people, patients and members of staff have a say in the development of proposals for improvement including how the service could be delivered in the future.

To ensure this and building on previous engagement (particularly in relation to cardiology), between 4 January and 14 February 2021 we have been talking with local people to understand their current experiences of these services and to find out what's important them. We are now analysing the outputs of this engagement to understand key insights from local people that will inform discussions about future options.

A range of options development workshops are scheduled during March 2021 that will include clinicians, stakeholders and local people. These workshops will follow relevant Covid 19 rules on social distancing, consider how best to ensure inclusive participation including independent facilitation.

The options development workshops will then inform our proposals to improve these Cardiology and Ophthalmology services.

We intend to update HOSC in June with further details about our proposals, with a view to potential formal consultation with local people beginning in the summer/autumn of 2021, and final decision during winter/spring 2021/22.

We will also carry out a separate consultation with the HOSC should the Committee consider that the proposals constitute a significant variation to current services.

NHS Provider Licence Conditions - Annual Self-Certification

Meeting information:			
Date of Meeting:	13th April 2021	Agenda Item:	13
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? No	

Summary:

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

Each year NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence and that they have complied with governance requirements. We need to self-certify the following after the end of each financial year end:

- **That we have taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution (Condition G6(3)).**

  This condition requires NHS trusts to have processes and systems that a) identify risks to compliance and b) take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. We must annually review whether these processes and systems are effective and publish our G6 self-certification by the end of June.

- **That we have complied with required governance arrangements (Condition FT4(8)).**
  We are required to review whether our governance systems achieve the objectives set out in the licence condition. There is no set approach to meeting these standards and objectives but NHSi expect any compliant approach to involve effective board and committee structures, governance framework including performance and risk management systems.

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

Audit Committee 25th March 2021

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD

Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6' Self-Certification is formally signed-off as **"Confirmed".**

Based on the evidence highlighted in Appendix B, it is recommended to the Board that the 'Condition FT4 (8)' Self-Certification is formally signed-off as **"Confirmed".**

The self-certification template (below) will then be signed off and published on the Trust website by the end of June deadline.

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

OK

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

FT4 Annual Corporate Governance Statement

Appendix B

1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	Confirmed	As evidenced in the Annual Governance Statement
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Board reporting cycle and committee structure allow new guidance to be brought to the Boards attention as required
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Governance and accountability framework in place with effective governance structure from "Floor to Board". Annual review of committee structure and effectiveness in place and revisions made if review highlights any requirements.

4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Annual Governance Statement, Quality account along with Annual Report document compliance with regulatory requirements and the Trust's governance and risk framework. Robust external and internal audit processes in place with escalation of any concerns on key internal controls and processes. Regular board and sub-committee meetings include oversight of performance information, financial information, workforce and the corporate risk register. Business planning process in place CQC - Trust rated "Good" overall. The covid-19 pandemic has had a significant impact on elective surgery and increased the number of 52 week waiters. A recovery plan has been developed and the Trust will follow national guidance once published.

APPENDIX ONE

Compliance with the Provider Licence Conditions

SECTION 1: GENERAL CONDITIONS

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G1.	Provision of information	This condition requires licensees to provide NHSI/E with any information they may require for licencing functions.	ESHT has robust data collection and validation processes and the proven ability to submit large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements.	Director Finance Chief Operating Officer
G2.	Publication of information	This condition contains an obligation for all licensees to publish such information as NHSI/E may require, in a manner that is made accessible to the public.	ESHT is committed to operating in an open and transparent manner. The Board holds virtual meeting in public and agendas, minutes and associated papers are published on the Trust website. The website also contains information and referral point details providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a Freedom of Information publication scheme.	Chief Executive Director of Corporate Affairs
G3	Payment of fees to NHSI	The Health & Social Care Act 2012 ("The Act") gives NHSI the ability to charge fees and this condition obliges licence holders to pay fees to NHSI if requested.	NHSI does not currently charge fees. However, the obligation to pay fees is a condition and will be accounted for within the Trust's financial planning as required. ESHT pays fees to other parties such as the Care Quality Commission and NHS Resolution	Chief Finance Officer

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G4	Fit and Proper Persons (FPP)	This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions).	All members of the Board and their deputies who may 'act up' into a Board role have been subject to a Disclosure & Barring Service (DBS) check. FPP checks are made upon appointment and Board members are required to sign an annual declaration that they remain a FPP. The CQC reviewed the Trust's Fit and Proper Persons compliance in December 2019 and found the Trust to be compliant. .	Chief People Officer
G5	NHS Guidance	This condition requires licensees to have regard to any guidance that NHSI issues.	The Trust has had regard to NHSI guidance through submission of required annual and quarterly planning requirements, declarations and exception reporting.	Chief Finance Officer Chief Operating Officer
G6	Systems for compliance with licence conditions and related obligations	This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	The Trust has a robust governance framework in place as outlined in the Annual Governance Statement. The Board and its sub Committees (Audit Committee, Quality and Safety Committee, People and Organisational Development Committee and Finance and Investment and Strategy Committees) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. All Committees undertake a review of their annual work programme and effectiveness and revisions are made as required.	Chief Executive Director of Corporate Affairs

			The Trust has a Risk Management Strategy and processes are in place to enable identification, management and mitigation of current risk and anticipation of future risk. The Risks are identified through incident reporting, risk assessment reviews, clinical audits and other clinical and non- clinical reviews with a clearly defined process of escalation to risk registers. The Board Assurance Framework is reviewed by the Board and its sub committees. The Board has regard to the NHS Constitution, compliance and actions are in place to support delivery and achievement of trajectories.	
G7	Registration with the Care Quality Commission	This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled.	The Trust is registered with the Care Quality Commission without condition.	Chief Executive Director of Corporate Affairs
G8	Patient eligibility and selection criteria	This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.	The Trust publishes descriptions of the services it provides and who the services are for on the Trust website. Eligibility is defined through commissioners' contracts and the choice framework. Assurance is gained through the patient's assessment stages to ensure that the appropriate services are provided.	Chief Operating Officer

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G9	Application of Section 5 (Continuity of Services)	This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. The conditions when Commissioner Requested Services (CRS) shall cease is set out. Licencees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide.	Requested Services are set within the contracts agreed with commissioners. The Trust has effective working relationships with its commissioning partners within the local health economy. The Chief Finance Officer is responsible for leading on contract negotiations and across the Trust there is partnership working to deliver service transformation, efficiency and quality improvement to meet the needs of the local population. The Trust is part of the Sussex Health and Care Partnership integrated care system. Regular meetings take place with NHSI/E and they are notified prior to the expiry of a contractual obligation if no renewal or extension has been agreed.	Chief Executive Chief Finance Officer Chief Operating Officer

SECTION 2 PRICING

	Licence Condition:	Explanation:	Board Assurance	**Lead Director**
P1.	Recording of information	Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with national guidance.	The Trust records all of its information about costs in line with current guidance.	Chief Finance Officer
P2.	Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	The Trust complies with any requirements to submit information to NHSI.	Chief Finance Officer
P3.	Assurance report on submissions to NHSI	When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	The Audit Committee receives and monitors all Internal Audit reports	Chief Finance Officer
P4.	Compliance with the national tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation	The covid-19 pandemic has resulted in a block contract arrangement and this in line with national guidance.	Chief Finance Officer

		on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.		
P5.	Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification.	As above	Chief Finance Officer

SECTION 3: CHOICE AND COMPETITION

	Licence Condition:	Explanation:	Board Assurance	**Lead Director**
C1.	Patient Choice	This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust complies with patient's right to choose and the choice framework	Chief Executive
C2.	Competition Oversight	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	All licensed provider organisations are treated as 'undertakings' under the terms of the Competition Act 1998. This means that as a licensed provider the Trust is deemed to be an organisation engaging in an 'economic activity' and therefore is required to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition.	Chief Executive

SECTION 5: CONTINUITY OF SERVICES

	Licence Condition:	Explanation:	Board Assurance	Lead Director
CoS1.	Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.	As for condition G9 above.	
CoS 2.	Restriction on the disposal of assets	This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI's consent before disposing of these assets when there is concern about the ability of the licensee to carry on as a going concern.	The Finance Department maintains a capital asset register. The Trust complies with requirements regarding disposal of assets.	Chief Finance Officer
CoS 3.	Standards of Corporate Governance and Financial Management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The Risk Assessment Framework will be utilised by NHSI to determine compliance	The Trust has adequate systems and standards of governance, oversight by the Board and establishment and implementation of associated governance systems and processes including those relating to quality and financial management. Refer to the Trust Annual Governance Statement and Annual Report	Chief Executive Chief Finance Officer/Director of Corporate Affairs

CoS 4.	Undertaking from the ultimate controller	This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement. **If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days. Governors, Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'.	The Trust is a Public Benefit Corporation and neither operates or is governed by an Ultimate Controller arrangement so this licence condition would not apply.	Not applicable
CoS 5.	Risk Pool Levy	This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.	The Trust currently contributes to the NHS Resolution pool for clinical negligence, property expenses and public liability schemes. The Trust also submits information in order to benefit from the maternity incentive rebate scheme.	Chief Finance Officer

CoS 6.	Cooperation in the event of financial stress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	The Trust co-operates fully with NHSI in ensuring it meets its licence obligations.	Chief Finance Officer
CoS 7.	Availability of Resources	This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	As with the provision of Mandatory Services, the Trust has well established services in place and currently provides all of the Commissioner Requested Services to a high standard. The Trust has forward plans and agreements in place with commissioners that meet this condition.	Chief Finance Officer

SECTION 6: NHS FOUNDATION TRUST CONDITIONS

	Licence Condition:	Explanation:	Board Assurance	Lead Director
FT1.	Information to update the register of NHS Foundation Trusts.	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with: • a current Constitution; • the most recently published Annual Accounts and Auditor's report; • the most recently published Annual Report; and • a covering statement for submitted documents.	The Trust is not an FT and therefore does not have a constitution. Annual Accounts, Auditors Report and Annual Report are all published.	Director of Corporate Affairs
FT2.	Payment to NHSI in respect of registration and related costs.	If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration.	Not applicable. See G3 above.	Not applicable
FT3.	Provision of information to advisory panel.	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	Not applicable as Trust does not have governors.	Not applicable

Use of Trust Seal

Meeting information:			
Date of Meeting:	13th April 2021	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Chair

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?	

Summary:

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

The purpose of this paper is to provide an overview of the use of the Trust Seal between 9th February 2021 and 30th March 2021.

Sealing 64 – Willmott Dixon Construction Ltd, 25th February 2021
Pre-Construction Services Agreement for alterations to the Conquest Hospital Cardiac Cath Lab.

Sealing 65 – Willmott Dixon Construction Ltd, 25th February 2021
Pre-Construction Services Agreement for multi-storey car-park at Conquest Hospital.

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

Not applicable.

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

The Board is asked to note the use of the Trust Seal since the last Board meeting.