East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 13th February 2024

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, Eastbourne District General Hospital, Kings Drive, Eastbourne BN21 2UD

	Item	Lead	Action	Time
1	**Welcome and apologies**	Chair	Information	09:30
2	**Staff Recognition**	Chair	Information	
3	**Frailty Early Discharge Scheme (FEDS)**	Dr Aktham Nathhas	Information	09:30
4	**Declarations of Interest**	Chair	Information	
5	**Minutes of Trust Board Meeting in public 12.12.23**	Chair	Approval	09:45
6	**Matters Arising**	Chair	Approval	
7	**Chief Executive's Report**	CEO	Information	09:50
	Quality, Safety and Performance			
8	**Integrated Performance Report, Month 9 (December)** 1. Chief Executive Summary 2. Quality & Safety 3. Our People 4. Access and Responsiveness 5. Financial Control and Capital Development	 CEO CNO/DCMD CPO DCOO CFO	Assurance	10.05
9	**Learning From Deaths Q1**	DCMD	Assurance	10:50
10	**NHS National Patient Surveys**	COS	Information	10:55
11	**2023/24 Financial Forecast**	CFO	Decision	11:05
	Break – 15 minutes			
	Strategy			
12	**Estates Development**	CEO	Information	11:35
13	**Shared Delivery Plan and Transformation Workstreams**	CEO	Assurance	11:40
	Governance and Assurance			
14	**Mortuary Security**	DCMD	Information / Assurance	11:50
15	**Annual Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation**	CFO/COS	Approval	12:00
16	**Board Assurance Framework Q3**	COS	Assurance	12:05

17	**Board Committee Summaries**	Committee Chairs	Assurance	12:10
	For Information			
18	**ESHT Charity Annual Report and Accounts**	Charity Chair	Information	12:15
19	**Safeguarding Annual Report**	CNO	Information	12:20
20	**EPRR Annual Report**	DCOO	Information	12:25
21	**Use of Trust Seal**	Chair	Information	
22	**Questions from Members of the Public**	Chair		12:30
23	**Date of Next Meeting** Tuesday 9th April 2024	Chair	Information	
	Close	Chair		

Steve Phoenix
Chairman

Key:	
Chair	Trust Chair
CEO	Chief Executive
CNO	Chief Nurse and DIPC
DCOO	Deputy Chief Operating Officer
CFO	Chief Finance Officer
COS	Chief of Staff
CPO	Chief People Officer
DCMD	Deputy Chief Medical Director
DOM	Director of Midwifery

Board Meetings in public: Etiquette

Please be aware that there are a number of things that we know contribute to productive meetings and show respect to all members in the room. If you are attending the meeting then we would be grateful if you would consider the following:

- Mobile devices that are not used solely for the purpose of following the meeting ought not to be brought into the meeting
- If you are required to have a mobile device about your person, please keep the use to a minimum, and ensure that it is on silent mode. If you are required to take a call, please do so outside the meeting
- All members of the public are asked to sign in
- Recording devices should not be used in the meeting
- The Trust Board is a meeting in public, not a public meeting. As such, the Chair leads and directs the meeting. Papers are presented to the chair (not to the public) so where points are raised/responses are made these should be directed to the Chair
- Questions from members of the public may only relate to items on the agenda, and these will be considered in the time set aside on the agenda
- If several members of the public wish to raise questions, the Chair will seek to ensure a fair allocation of time among questioners

Board Meetings in public: 2024

Month	Location	Timing	Any other information
9th April	St Mark's Church Hall, Green Lane, Bexhill	09.30 – 12.30	
11th June	Conquest – Lecture Theatre, Education Centre	09.30 – 12.30	
13th August	St Mary's Boardroom, Eastbourne District General Hospital	09.30 – 12.30	
10th September – Annual General Meeting	Bexhill – The Relais Cooden Beach	14.30 – 16.00	
8th October	St Mark's Church Hall, Green Lane, Bexhill	09.30 – 12.30	
10th December	Conquest – Lecture Theatre, Education Centre	09.30 – 12.30	

East Sussex Healthcare NHS Trust

Staff Recognition

Purpose of the paper	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort, and loyalty of its people. As such, this is an opportunity for the Trust to demonstrate and acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Jacquie Fuller, Assistant Director of HR – Engagement & Wellbeing Melanie Adams, People Experience Manager						
Governance overview	Trust Board						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x	x	

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	N/A

Executive Summary

Hero of the Month

<u>October 2023</u>

Joint Winner – Hannah Kennedy, Urgent Community Response – CHIC Division

'Hannah attended a care call where the patient was concerned about her husband. Hannah was asked to check on the husband and she went into another room in the patients house where she found a gentleman collapsed on some furniture not moving or breathing. She immediately called 999 and began CPR. Hannah is a new ISW and she continued giving CPR until the ambulance arrived sometime later.

This was a very brave and heroic effort from Hannah who knew almost immediately that the gentleman was deceased but followed her training and stuck with the resuscitation attempt until the ambulance crew arrived. Hannah then went on to complete the care call and supported the patient before leaving this visit. I believe Hannah went above and beyond and showed true bravery in her attempt to bring the gentleman back . I believe I have never heard of a person more deserving of this award than Hannah.'

Hannah receiving her certificate from Steve Phoenix, Chairman

Joint Winner – Sammi Foy, Occupational Health – Corporate Division

'Sammi has shown exceptional levels of resilience, perseverance and leadership with her meticulous planning and implementation of the staff seasonal flu vaccination programme. She has managed challenges and unexpected issues with high levels of integrity and professionalism, always adapting and considering how to overcome obstacles so that the programme can proceed. This is against a backdrop of ongoing high demand for the Occupational Health service and staffing challenges. She constantly rethinks and reprioritises in order to keep offering a safe, effective and responsive service for the trust and our people.

Sammi really has gone above and beyond over the past month and as such, I feel deserves this nomination. Thank you.'

November 2023

Winner – Hastings Community Nursing Team, Plaza Health Centre – CHIC Division

'The Hastings and St Leonards community nursing team have been working over and above and support each other on a daily basis. They never complain and always go the extra mile to cover the visits and ensure patient safety.

The team are also being moved area (their base) and have agreed to this with grace and support. I am proud to be a part of this team.'

Long Service Awards

Nov-23						
10 Years Service			**25 Years Service**			**40 Years Service**
Marta	Alonso-Bermudez		Mandy	Davey		
Amanda	Brown		Audrey	Davies		
Clare	Calcott-James		Claire	Faulkes		
Pantelis	Ioannidis		Janet	Mulvey		
Eanna	McKnight		Hemant	Thakral		
Suhal	Miah		Carina	Warrington		
Michelle	Moorton					
Rodah	Mvula					**50 Years Service**
Holly	Pope					
Kirsty	Reed					
Nooreena	Rummun					
Julie	Ward					
Yao	Yao					
Kirsty	Yates					

Next steps	Not applicable

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Minutes

Date: Tuesday 12th December 2023

Time: 09:30 – 12:30

Venue: Horntye Park Sports Complex, Bohemia Road, Hastings TN34 1EX

		Actions
	Attendance: Mr Steve Phoenix, Chairman Mrs Joe Chadwick-Bell, Chief Executive Mrs Vikki Carruth, Chief Nurse & Director of Infection Prevention and Control Mrs Jackie Churchward-Cardiff, Vice Chair Mrs Karen Manson, Non-Executive Director Dr Simon Merritt, Chief Medical Officer Mrs Charlotte O'Brien, Chief Operating Officer Mr Damian Reid, Chief Finance Officer Mrs Nicola Webber, Non-Executive Director Non-Voting Directors Ms Ama Agbeze, Associate Non-Executive Director Mr Steve Aumayer, Deputy Chief Executive and Chief People Officer Mrs Amanda Fadero, Associate Non-Executive Director Mr Richard Milner, Chief of Staff Mr Frank Sims, Associate Non-Executive Director In Attendance Ms Brenda Lynes, Director of Midwifery Mr Peter Palmer Deputy Company Secretary (minutes)	
	Apologies: Mr Paresh Patel, Non-Executive Director Ms Carys Williams, Non-Executive Director	
86/ 2023	**Chair's Opening Remarks** Mr Phoenix welcomed everyone to the meeting. Staff Recognition Mr Phoenix reported that Neil Maskell, a Waste Porter in the Estates and Facilities team, had won the Trust's Hero of the Month Award for August. He explained that giving out the awards was one of the greatest joys of his job, and the team spirit shown by the Facilities team when Neil had been presented with his award had been fantastic to see. September's winner had Melanie Southwood, a Midwife in the Buchanan Delivery Suite, who had been extremely modest about the help that she had given to an asylum seeker during her labour and birth.	

87/ 2023	**Declarations of Interest** In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chair noted that no potential conflicts of interest had been declared.	
88/ 2023	**Minutes** The minutes of the Trust Board meeting held on 10th October 2023 were considered. A number of amendments to the minutes had been received from Ms Williams prior to the meeting which would be actioned, but they were otherwise agreed as an accurate record, and were signed by the Chair and would be lodged in the Register of Minutes.	
89/ 2023	**Matters Arising** There were four formal matters arising from the meeting on 10th October 2023, all of which had actions assigned to them.	
90/ 2023	**Chief Executive's Report** Mrs Chadwick-Bell reported that the environment that the Trust was operating in continued to be extremely challenging and thanked staff for their continued hard work. She reported that the Trust had originally set out a financial plan for 2023/24 which would enable a breakeven position to be reached at the end of the year. However, continued industrial action during the year had led to a reduction in activity and additional staffing costs which meant that the Trust was heading towards a £12m deficit by the end of the financial year. An improvement plan had therefore been developed in order to return to a breakeven position, which included a recruitment freeze on non-clinical roles. All potential recruitment was subject to review and would continue for any positions where there was a potential impact on patient care. The Trust was aiming to deliver 76% performance against the four hour A&E target by March 2024, with no patients waiting for over 65 weeks for elective care. There were risks associated with the plan, particularly as it did not include mitigation for any further doctors' strikes, and it would be a challenging few months for the organisation. Mrs Chadwick-Bell reported that she had been delighted to have recently signed the Armed Forces Covenant, which was a pledge by the Trust to ensure that past and currently serving armed forces personnel and their loved ones were not in any way disadvantaged because of their service. The Trust had received an Employer Recognition Scheme (ERS) bronze award. Staff throughout the organisation had completed the annual staff survey, with increased compliance rates being seen in comparison 2022/23. Board members continued to ensure visible leadership in the Trust by visiting different areas to provide support to wards and department in the lead up to Christmas. There had been a recent feature on the BBC featuring the Trust's Director of Estates and Facilities which highlighted that Eastbourne DGH had installed the first solar car park in any UK hospital, which was a key component in enabling the Trust to reach its goal of zero emissions by 2050. She thanked the estates team for their hard work in completing this project. Mrs Webber noted the fantastic achievement in securing funding for net zero projects in the Trust. She asked for further information about the armed forces covenant. Mr Aumayer explained that the Trust would work to identify veterans or currently serving members of the armed forces and their families to ensure that they were not disadvantaged. Identification of these patients would be improved by the introduction of electronic patient records in the Trust, enabling ESHT to go further in providing support than was currently possible. Mrs Churchward-Cardiff asked about the implications of the upcoming junior doctors strikes for finances, activity and staff morale. Mrs O'Brien explained that work to protect as much elective activity as possible during the strikes was being completed. Mr Reid explained that plans to reach a breakeven target were based on the assumption that there would be no further strikes. The financial impact of the strikes would be identified and would be considered to be a reasonable variance. Mrs Chadwick-Bell noted that national conversations would take place about any losses incurred due to further strike actions.	

	Mrs Churchward-Cardiff asked about the continued appetite for strike actions. Mr Aumayer explained that due to the timing of the upcoming strikes, a significant amount of leave had already been booked by staff which would add to the challenge maintaining safe services. It was important to strike the correct balance in keeping non-elective services safe and continuing to undertake as much activity as possible. Doctors were concerned about the longevity of strike actions and the challenges of covering services. Mrs Churchward-Cardiff asked if more could be done by the Trust to provide morale support for staff. Mr Aumayer explained that during strike actions doctors preferred to be allowed to focus on caring for patients. Dr Merritt noted that thanking doctors, particularly junior doctors, for their support during strike actions, and remaining visible was key for Trust leaders.	
91/ 2023	**Integrated Performance Report for Month 7 (October)** <u>Quality and Safety</u> Mrs Carruth reported that a deep dive into clostridium difficile (c.diff) infections would be presented to the Quality and Safety (Q&S) Committee later on in the week, along with a review of infection control in the Trust during quarters one and two of the year. A national increase in c.diff cases had been seen since the pandemic, and the infection control team work working with the Integrated Care System (ICS) and Trust teams to mitigate risks. October had seen an increase in MSSA bacteraemia cases reported, but the Trust remained below the national average. A paper would be presented to Q&S about the improvement work that was being undertaken concerning reconditioning and quality initiatives related to length of stay and discharge. There were eight patients who had stayed in the Trust for over 100 days and their care was subject to weekly discussions between Mrs Carruth and Dr Merritt. Mrs Carruth paid tribute to the work of the Trust's security teams in helping to address violence and aggression (V&A) in the organisation. November had seen four arrests and multiple incidents reported, with the security team completing 35 incident reports and nine crime reports during the month. Three yellow card sanctions had been issued. 36 incidents of verbal abuse of staff had been reported with almost half of these committed by people considered to have capacity. A new two hour personal safety training session had been develop which had received positive feedback. She thanked the security team for their professional and supportive approach in very challenging circumstances, noting that a paper on V&A would be presented later in the meeting. Mr Phoenix agreed, recognising the amazing work that the security teams did. Mrs Churchward-Cardiff asked what was driving the increase in V&A. Mrs Carruth explained that the issue was being seen nationally across all sectors, and that she was attending a summit to discuss mental health later on in the week with Mrs Chadwick-Bell. The pandemic had taken a toll on mental health, along with the challenging economy, and people were less patient and more aggressive than before the pandemic. The level of violence was also of concern, as weapons were occasionally being seen. Mr Sims asked what more could be done outside of the acute setting to support the emotional wellbeing of the public. Mrs Carruth noted that in some parts of the country early interventions for isolated or deprived people were taking place; discussions about what more could be done in Sussex would take place with the ICS. The training offered to staff in high risk areas was being reviewed to understand if more expert training was required, and staff were supported by a mental health outreach team and a cohorted gateway area. Mental health first aiders continued to be trained to equip them with the skills required to de-escalate incidents. Mr Aumayer noted that the system had a V&A prevention and reduction lead. A national programme had recently been launched to address the issue at a national level, with actions being given to organisations. He anticipated that the programme would mature over time and would offer different interventions to help address increased V&A. Mr Sims asked why infection control levels had increased and what was being done to address the issue. Mrs Carruth explained that during the previous year, only one c.diff infection had been due to cross infection. More could be done around anti-microbial stewardship where a balance needed to be found in providing the best support possible	

frailty areas, as the risk of infection increased exponentially for over 75s. Robust monitoring of patients from the start of their pathways through the Trust, with antibiotics stepped down when appropriate would lead to improvements, with colleagues passionate and supportive about driving these improvements in the Trust. Dr Merritt explained that there had been a big focus on the treatment of sepsis during the previous 3-4 years, with antibiotics given in suspected cases within an hour of admission. This resulted in a significant improvement in mortality but also led to an increase in infections. In addition, reporting no longer separated community and trust acquired infections, and some of the increase being seen was possible due to primary care prescriptions.

Mrs Fadero reported that there had been detailed discussions in November about V&A at both the Q&S and People and Organisational Development Committees. She suggested that the root causes of the increase in V&A needed to be understood in order for targeted interventions could be made. She thanked Mrs Carruth and her team for their work in maintaining quality figures at a good level, noting the challenge of doing this in a pressured environment. Mrs Chadwick-Bell noted that there had been an increase in the number of patients with mental health issues in the Trust which changed the dynamics on wards and in other areas. The mental health summit taking place later on in the week would discuss how to provide better support to patients who were not necessarily in the right place. However, there was no quick solution to the issue and therefore mitigations and specialist support were being looked at. Mrs Fadero noted the importance of ensuring that care for children and young people with mental health issues was also considered; Mrs O'Brien explained that the Trust took part in a weekly system escalation call where young people were discussed.

Mrs Churchward-Cardiff noted that there urgency was required in addressing the issue as almost 70 patients were awaiting beds for treatment of mental health issues in Sussex. Mrs Chadwick-Bell agreed, noting that action plans had been developed by the whole system to address the issue. Mrs Webber reported that the Audit Committee was presented with an annual security report which had set out that additional security had been put in place in the Trust during the previous year to protect patients and staff even though this was unfunded. The security provision would be subject to review in 2024/25.

Dr Merritt reported that both the Summary Hospital-level Mortality Indicator (SHMI) and the Risk-Adjusted Mortality Index (RAMI) remained within expected ranges, with neither changing much since October's Board meeting. The Trust was ranked as 36th out of 122 trusts for RAM. The observed versus expected death rates showed that sepsis and COPD were the areas where the Trust had statistically more observed deaths than expected and deep dives into both these areas would be undertaken. No areas of particular concern had been identified. Mrs Chadwick-Bell noted that the Board had discussed mortality during a recent seminar session. A lot of good work was being undertaken to improve the quality of coding by focussing on the quality of patients notes. She praised the clinical coding team and hoped that the work would lead to further improvements in mortality metrics.

<u>Our People – Our Staff</u>
Mr Aumayer reported that there had been positive progress during October with turnover 25% lower than it had been the previous year. Mandatory training and appraisal rates continued to improve and were now the best ever reported. Rostering compliance was also the best it had been in recent years, and job planning had increased to 85%, with an excellent quality of plans produced. Sickness had increased over the previous few months, in line with national trends, and workforce costs remained challenging.

Mr Aumayer noted that the IPR data did not show how much the Trust scale of operational challenge faced by the Trust and the impact that this had on colleagues. Papers on V&A and on the Freedom to Speak Up Guardians (FTSUGs) would be presented later in the meeting, which highlighted the pressure felt by colleagues. The annual staff survey had closed a couple of weeks before, with 49% of staff repsnding against a target of 48%. This represented an increase of 14% mor epeople responding than in 2021/22 which was an outstanding achievement. New Trust values were being finalised and would be presented to the Board in 2024. October had been national Speak Up month, with a lot of activities taking

place in the Trust promoting speaking up. Workforce controls had been reviewed and strengthened during the month to support the revised Trust financial plans.

Mrs Chadwick-Bell noted that the 85% rate of completed job planning was a significant achievement; the plans could be used to drive discussions that would ensure that colleagues were undertaking agreed levels of activity. She thanked the Deputy Medical Director, Dr Gould, for his outstanding work in realising this increase.

Mr Phoenix noted that when organisations were under operational pressure it was normal for training rates to deteriorate. He praised the continued increase in mandatory training rates in the Trust noting that this was a huge credit to all colleagues. Mrs Churchward-Cardiff echoed this praise and asked about the increase in reported musculoskeletal (MSK) conditions, noting that the rate was at its highest for four years. Mr Aumayer explained that a deep dive into this had been undertaken the previous year and most of the reporting was due to incidents outside of work, with a national increase being seen. He agreed to provide a more detailed response into the increase in MSK reporting to February's Board. **SA**

Mrs Fadero asked about progress with flu vaccinations in the Trust. Mr Aumayer explained that 50% of staff had received a vaccination, with rates at 46% for frontline staff. This was the same rate that had been seen the previous year, against a national trend of vaccination fatigue. He noted that vaccinations given in the community to members of staff were not included within the vaccination rates as the Trust was unable to access this external information. Mr Phoenix noted that he was given his flu jab while handing out a hero of the month award and praised the proactive vaccination team.

Mrs Webber noted that medical turnover at the Trust had increased and asked what was being done to address this. Mr Aumayer explained that a deep dive into the reasons behind this would be undertaken, and would be presented to the People and Organisational Development Committee. **SA**

<u>Access and Responsiveness</u>
Mrs O'Brien reported that performance against the 4 hour Emergency Access Clinical standard had been particularly challenging for both the Trust and regionally during October and November. October's performance had been 70.01%, falling to 68.4% in November. The Trust hoped to deliver consistent 70% performance, and while close to achieving this had more work to do. Two patients had waited for more than 12 hours for admission due to issues with patient flow, and the Trust had ranked as 43rd out of 123 in England for Emergency Department (ED) performance in October. A 'preset' was taking place in the run-up to Christmas, which would focus on key areas for improving performance such as admission avoidance, treating patients in same day emergency services (SDEC) and getting patients into the correct place for their treatment as soon as possible. The Trust had also undertaken work with SECAmb to improve ambulance handover times and had seen a reduction in the number of delays of over 60 minutes as a result.

The average length of stay for patients had reduced in October; patient pathways were subject to daily reviews with system partners. Eight patients had been in hospital for over 100 days, three of whom met the criteria to reside. Work was being undertaken to improve the number of patients discharged on the day when they no longer met the criteria to reside.

Reducing the number of patients waiting for more than 65 weeks for elective treatment continued to be an area of focus and was ahead of trajectory. One patient had waited for more than 78 weeks in October, with processes introduced to prevent any recurrence. The Trust was performing in excess of 2019/20 activity levels for outpatient and elective activity. A focussed piece of validation work had taken place on the Trust's Patient Tracking List (PTL) which had allowed 2,000 patients to be removed.

Large number of cancer referrals continued to be received with a 20% increase seen since the previous year. 50 patients had waited for over 104 days against a trajectory of 30 in October, and reducing this number was an area of focus. Diagnostic performance increased to 90.66% against the 95% target during the month with a reduction in the overall waiting

list seen. A positive impact had been seen from the outsourcing of community paediatric services with a reduction in the number of long waiting patients.

Mrs Churchward-Cardiff asked whether the Trust fully understood the reasons for increased patient attendance at EDs. Mrs O'Brien explained that access to primary care was a recognised factor, with work taking place across the system to ensure patients attended the most appropriate place for their treatment.

Mrs Churchward-Cardiff noted that the Trust's elective waiting list had doubled since 2019/20 and asked what was being done to manage this. Mrs O'Brien explained that validation work that had been undertaken had helped to reduce the list, and work continued to fully understand the waiting lists.

Mrs Manson asked when improvements in ED performance were anticipated. Mrs Manson explained that the Trust aimed to deliver 76% performance against the 4 hour standard. Work was taking place to improve flow prior to Christmas, reducing waiting times in A&E and improving the management of non-admitted patients.

Mrs Manson asked whether the waiting times in EDs were contributing to the increased V&A being reported. Mrs O'Brien that the Trust was looking at ways to improve communication with in order to recue frustrations. Mrs Carruth accepted that delays could cause frustration for patients, but noted that V&A often came from repeat offenders who were already known to the Trust, police and social services.

Mr Sims recognised the good work that was taking place in preparing for winter pressures and asked whether plans included addressing issues with primary and social care. Mrs O'Brien explained that while primary and social care where outside of the Trust's control, there were a lot of areas that it controlled where improvements could be realised. Mrs Carruth noted that Associate Directors of Nursing were overseeing weekly length of stay review meetings, and that she also attended a weekly review meeting. Issues were escalated to the Transfer of Care Hub where they were managed both internally and as a system to improve discharge processes. Senior leaders attended board rounds with clinical teams in order to help resolve any issues as they occurred.

Mrs Agbeze asked whether there had been an increase in confirmed cancer cases in correlation to the increase in referrals that was being seen. Mrs O'Brien explained that during the pandemic a lot of people had sought treatment, which had led to the increase in referrals and diagnoses now being seen. The Trust worked with the cancer alliance to review referrals, but preferred GPs to err on the side of caution by referring patients if they had concerns.

Mrs Webber asked whether High Intensity Theatre (HIT) lists were being considered by the Trust having being successful in other organisations. Mrs O'Brien reported that the operating model was being considered for the new elective care hub as it offered increased productivity. It was vital that the configuration of theatres and appropriate supporting staff were in place to allow the model to operate as effectively as possible.

<u>Financial Control and Capital Development</u>
Mr Reid reported that the Trust had set a challenging Cost Improvement Programme (CIP) target for the year of £32m. Significant industrial actions, challenges with discharging patients had led to reduced income with CIPs now anticipated to be around £24.5m for the year. Additional inflationary pressures and an increase in drug costs had added around £3m of further costs, leading to a deficit position against targets of £5m by month seven, which was anticipated to be a £10-12m deficit by the end of the financial year.

A national reduction in the amount of elective activity required of trusts, from 107% to 103% of 2019/20 activity levels, had taken place during month seven, with trusts being asked to achieve a breakeven financial position for the year. Activity at ESHT would need to increase by £3m to reach a breakeven position, which was a substantial challenge for the Trust. Controls had been introduced to reach a breakeven position; however the initial controls had not delivered anticipated savings so further measures would be put in place. Costs

	associated with winter pressures would also need to be closely managed in order to reach breakeven position for the year. The Trust had received additional capital during the financial year, but had faced delays in completing building work in line with challenges seen nationally. A £2.5m capital underspend for the year was anticipated; mitigating actions would be developed along with clear plans to manage the Trust's capital spend until the end of the financial year. Mr Phoenix noted the importance of reaching the end of the financial year in a good financial position, as well as the continued work taking place to reduce the run rate in the Trust which would have long term financial benefits for the organisation. Mrs Chadwick-Bell noted that a number of workforce controls that had been introduced had not had the anticipated benefits and deep dives were being undertaken to fully understand why this was the case. Mr Reid explained that additional workforce controls would ensure clarity about the Trust's establishment, supporting planning for future years and driving efficiencies within the current financial year. A paper showing the benefits realised from pausing non-clinical recruitment would be presented to a future Finance and Productivity (F&P) Committee. Mrs Manson asked why the Trauma and Orthopaedic service were £2.2m behind their planned income against Emergency Recovery Fund (ERF) targets for the year. Dr Merritt explained that elective activity had been effected by industrial actions and issues with discharging patients had led to emergency patients having to utilise elective beds. Mr Reid explained that the Trust was focussing on ensuring that elective beds were better protected as this would drive improved income. Mrs O'Brien reported that work had been undertaken to protect elective activity, and to improve productivity of elective and outpatient operating lists. Plans to further increase activity were being developed, and increased trauma activity was being supported across the organisation. Mrs Churchward-Cardiff noted the importance of ensuring that the system could afford to pay for any additional activity that was undertaken, and asked whether more could be done to support divisions in meeting CIP targets. Mrs Chadwick-Bell explained that the Trust was paid for elective activity through payment by results, and that no limits on activity had been set by the system. She reported that a recent session had taken place with clinical leaders where efficiencies had been discussed. It was recognised that the Trust needed to operate differently to meet financial targets, and divisions had been asked to develop transformational plans which would be reflected in business planning for 2024/25. Mrs Fadero asked whether the Trust was doing all that was within its power to meet its financial targets. Mrs Chadwick-Bell explained that work was being undertaken to fully understand additional savings that could be achieved through productivity and workforce measures and looking at different ways of working. The Trust and system were also identifying measures that could lead to further savings.	
92/ 2023	**Maternity Overview Q2** Mrs Lynes presented the Q2 maternity overview report. She confirmed that the Trust had met all of the criteria for maternity safety actions for the CNST Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). Compliance had been assessed by the Trust's internal auditors and review by the Q&S Committee, and she thanked the maternity team for their contribution. She reported that the workforce and culture of the maternity team continued to be areas of focus. Vacancy rates continued to improve, with work being undertaken to address areas where recruitment was challenging. An increased complexity of patients was being seen, with proactive measures being taken to address this including additional training for staff. A review of staffing levels using the national birth rate plus tool was being undertaken. Two referrals to Maternity and Newborn Safety Investigation programme (MNSI) had been closed during the quarter. Completed actions arising from the referrals had included the introduction of a more robust maternity triage system and an escalation process for staff.	

The Trust continued to work towards full implementation of the Saving Babies Care Bundle 3 by March 2024, in line with CNST requirements.

Work was being undertaken to review admissions to the Special Care Baby Unit (SCBU) as 38 term babies had been admitted during Q2, which was a 76% increase on Q1. Of these admissions, three could have been avoided with enhanced transitional care on neonate wards. Actions to reduce admissions included continued work on transitional care pathways, ensuring babies received steroids in utero where indicated and ensuring escalation of clinical concerns to medical teams in a timely manner.

Maternity staffing levels remained stable, with mandatory training at above 95% and appraisal rates at over 80%. Feedback was received from service users through a number of routes, with resulting improvements made including the introduction of a pilot scheme for 24 hour visiting; improvements to the feeding room on the postnatal ward; a new maternity website; the development of a new process for the induction of labour; and improved discharge co-ordination support.

Mrs Fadero congratulated the maternity team on their compliance with all ten areas of CNST, noting that this was underpinned by the cultural improvement work that had been undertaken by the maternity leadership team. She noted that staff openly recognised the improved culture where their concerns were listened to and acted upon. Mr Aumayer noted that the role that maternity leaders had played in improving vacancy rates, reducing staff turnover and improving workforce measures was significant and he recognised and thanked the maternity leadership team for their achievements.

Mr Sims praised the maternity leadership and asked about the increase in highly complex patients. Ms Lynes reported that patients with mental health and safeguarding issues had increased by 30%, with the number of service users doubling in the last three years. Other issues included increased co-morbidities. These complexities meant that more time was required to care for patients; increased ITU and HDU admissions were also seen along with an increase in cardiological issues.

Mrs Manson recognised the phenomenal work that had been carried out by the maternity leadership team. She asked whether increased complexity was a national issue, and whether it should now be considered to be normal. Mrs Carruth explained that the lasting effects of the pandemic had led to a number of challenges which needed to be fully understood. Services needed to be planned differently as the cohort and needs of patients had changed. She noted that work was being undertaken to look at improving accessibility for patients by allowing them to access services outside of traditional models of care, including in shopping centres and meeting people where they were.

Mrs Churchward-Cardiff asked how the outcomes of the staffing review would be reflected in business planning for 2024/25. Ms Lynes reported that a team would be commissioned to undertake the review; it had been three years since the last review. Mrs Carruth anticipated that the review would reflect the changes to the provision of maternity services over the previous three years. It was possible that different ways of staffing would be recommended rather than an increase.

Mrs Churchward-Cardiff asked how the increased complexity of patients affected health visiting colleagues. Mrs Carruth reported that there had been successful recruitment of newly qualified staff to health visiting teams in recent years, but national conversations about the pay grade for these staff continues. Mr Phoenix reported that he had spoken to health visiting leadership teams recently, who had complimented the support that they received from the Trust and the improvements to the service that were being made.

Mrs Chadwick-Bell asked for an update on progress against actions that had arisen from the CQC's inspection in January 2023 and Ms Lynes explained that one outstanding action, concerning mandatory training rates, remained. This was currently at 82% against a 90% target. She agreed to include an update on progress against this action in the next report to the Board. **BL**

	Mrs Webber asked what the top priorities were for the maternity service that would have the most impact. Ms Lynes explained that improving the culture of community maternity services was a priority, as recruitment to this team was currently challenging. Mrs Carruth noted that she had recently met two newly recruited midwives who had cited the culture within the maternity team as one of the reasons for joining the Trust. The improved culture within the service had led to increased recruitment and it was crucial that this was maintained. Ms Lynes agreed to include an update on community maternity services in her next report to the Board.	**BL**
93/ 2023	**Winter Preparedness 2023/24: Update** Mr Phoenix noted that the Board had previously discussed the draft winter plan. Mrs O'Brien explained that the update highlighted refreshed bed modelling for the winter period, with the greatest challenges anticipated during December and January. She believed that there would be sufficient capacity at EDGH, but that capacity at the Conquest remained concerning. Work was being undertaken with Minerva to deliver additional community capacity, and had been included in revised financial planning for the year. Plans to manage during periods of industrial action were being finalised. Mrs Webber noted that the plan was predicated on reducing lengths of stay for patients and asked what provision had been made if this could not be achieved. Mrs O'Brien agreed to share a detailed summary of the bed modelling which underpinned winter planning with Mrs Webber outside of the meeting.	**COB**
94/ 2023	**Mortuary Security** Dr Merritt explained that he was reporting to the Board on mortuary security as he was the tissue authority licence holder for the Trust. He explained that a number of recommendations had been by Sir Jonathan Michael following the independent inquiry into the issues raised by the David Fuller case. A full paper would be presented to the Board in February, but he wanted to provide assurance to the Board ahead of this. The mortuaries at ESHT could not be accessed without a swipe card, and the access report was subject to a monthly review to check for any unauthorised access or suspicious activity. CCTV was in place in the mortuaries and employees working in the mortuaries were subject to DBS checks. Details standard operating procedures were in place which were regularly reviewed, with compliance monitored. Any contractors or visitors were signed in to the mortuaries and supervised; out of hours access was not available to individuals and had to be undertaken with a colleague. The Trust would be working collaboratively with other trusts to undertake audits to ensure that mortuary services were as safe as possible. Mrs Fadero asked how the Trust was assured about processes when additional mortuary capacity was required. Dr Merritt explained that the Trust was operating at about 50% of capacity at present so did not anticipate needing any additional capacity. However, when this was required the Trust operated within a local network so other mortuaries with similar processes would help when required. Mrs Webber asked whether the curiosity of staff to question and speak up could be included within the report presented to the Board in February. Mr Phoenix explained that whenever issued of security and access arose, there tended to be an assumption that people were acting with good intentions. He noted that it was important not to be complacent about the intentions of others and felt that colleagues were more conscious about the possibility of wrongdoing than they had been 20 years before. Mrs Carruth agreed, explaining that she felt that colleagues were good at challenging when appropriate, particularly following the events of Letby and the ongoing Thirlwall Inquiry.	
95/ 2023	**Establishment of Inequalities Committee** Mr Milner reported that the first meeting of the Inequalities Committee had recently taken place. The formation of the Committee was a positive statement for the organisation emphasising the importance for colleagues that a good culture was fostered. The Committee would focus on internal and external aspects, including health inequalities across the wider population and diversity within the Trust.	

	Mrs Churchward-Cardiff noted that the membership set out in the Terms of Reference did not include any community or business intelligence representation, which could help to increase understanding of the population served by the Trust. Mr Milner reported that the Director of Public Health had been invited to sit on the Committee, which would provide a wider perspective for discussions. Mr Phoenix explained that it was important that the work of the Committee did not duplicate work already being undertaken as a system. The Committee's work would focus on what only ESHT could do as an organisation, including work that had been agreed as part of system partnerships. He emphasised the importance of the formation of the Committee and was pleased that inequalities would now be subject to organisational focus at the highest level.	
96/ 2023	**Speak Up Guardian Update** Mr Aumayer noted that following the previous presentation of the Freedom to Speak Up Guardian's (FTSUG) report to the Board, a management response was now included. The report also included the National Guardian's response to the Letby case.one of request from last time report was presented was a management response. ESHT was passionate about supporting a positive speak up culture, and previous staff surveys had highlighted that colleagues felt able to speak up when they had concerns. The FTSUG played a pivotal role in ensuring that people felt confident about escalating concerns, and worked proactively to ensure that managers managed concerns themselves rather than escalating issues when appropriate. Less than 1% of reports were made anonymously within the Trust, compared to a national rate of 9%. The Trust also saw more staff raising concerns than other organisations, demonstrating the positive speak up culture that existed. Mr Aumayer reported that the previous bullying and harassment category had been split into two categories of bullying and attitude and behaviour. This had been helpful in better understanding trends, with only 6% of reports relating to bullying. Reports in all categories, apart from work and safety, had reduced over the previous two years. No particular staff group was raising concerns more than others. The requirement for speak up training continued to be promoted amongst Trust leaders. Increased security staffing was put in place where it was known that aggressive behaviour was more likely to provide support to colleagues. The FTSUG were now line managed by Mr Aumayer, providing them with direct access to executives when they needed support or to escalate issues. A new poster and online campaign promoting the FTSUGs was due to be launched shortly. Alongside this, a refresh of the Trust values would take place which focussed on the behaviours of colleagues and service users and their families. He thanked Ms Agg and Ms Holliman for their hard work in supporting staff. Mrs Churchward-Cardiff asked what was done when areas of concern were identified, and Mr Aumayer reported that focussed interventions were undertaken in departments where particular concerns had been raised. Mr Sims was pleased to see the progress that was being made and asked whether colleagues were bypassing their line managers and raising concerns directly with the FTSUGs. Mrs Agbeze asked how managers were being supported to ensure that they were comfortable addressing concerns when they were raised. Mr Aumayer explained that in comparison to other organisations that Trust had a positive reporting culture; however, only 50 out of 8,000 had raised a concern in the previous quarter. Recent changes to policies meant that there was a focus on resolving issues without using formal processes, and the FTSUGs sought assurance that line managers had been appropriately involved with concerns before they would accept a case. On occasions where line managers encouraged staff to contact the FTSUGs, conversations took place to ensure managers were aware of the correct process to follow for raising concerns. Multi-disciplinary HR meetings had been introduced where cases were reviewed to ensure that correct processes had.	

	Mrs Chadwick-Bell asked whether a category could be added to reporting to highlight where staff had discussed concerns with their line managers and had been unhappy with the resolution they had received. Mr Aumayer explained that these issues were picked up via HR reviews; FTSUGs would provide support for colleagues but wouldn't represent them in these instances. Mr Aumayer noted that the FTSUGs would be attending the private Board meeting that afternoon and would be happy to discuss the report further with the Board.	
97/ 2023	**Violence and Aggression SBAR report** Mr Aumayer explained that the report was being presented to the Board following discussions about increased Violence and Aggression at the People and Organisational Development (POD) and Quality and Safety Committees. A full report on the issue would be presented to the Board in February, and the issue had already been discussed at some length during the Board meeting. Mrs Webber asked that the report presented to the Board in February also considered a recent report on Trust security to the Audit Committee.	
98/ 2023	**Delivering Improving Lives Together: Partnership Working Update** Mrs Chadwick-Bell explained that conversations about the delivery of the Sussex five year strategy 'Improving Lives Together' (ILT) had taken place at a recent Trust Board Seminar and with the wider organisation. She explained that the paper presented had been written to provide an update on the delivery of ILT to the Integrated Care Board (ICB). A new committee in common and two collaboratives would be established; additionally, the 11 workstreams that underpinned the Sussex Shared Delivery Plan (SDP) would be reviewed to ensure that there was no duplication of work between them. An additional Health Committee would be formed by April 2024 for the Chief Executives and Chairs of each organisation to consider the sustainability of the system and measures to ensure that financial balance was achieved. The organisations within the Sussex system were already working well together and the plans presented to the Board would drive further collaboration. Mr Phoenix noted that the benefits of sharing burdens of effort and focus through collaboration for organisations were clear, but asked how the system would ensure that the governance structure delivered change and maintained transparency for both colleagues and the public. Mrs Chadwick-Bell explained that it was vital that the system identified key workstreams and targets and worked towards achieving these while being supported by an appropriate governance structure. The Health Committee would not remove any responsibilities from individual organisations, and any significant changes that would affect organisations would require approval from respective boards. Further updates would be made to the Board as work to deliver ILT progressed. Any significant proposed service changes would be subject to public consultation. Mrs Churchward-Cardiff noted concern about the top heavy nature of the governance structure that was being proposed, and about the resource that would be required form the Trust to support it. Mrs Chadwick-Bell explained that the intention was not to have a top heavy structure; infrastructure that already existed at place would be redirected to supporting the delivery of ILT. Mr Phoenix noted that the governance structure should support focussed, targeted actions and less bureaucracy. Mrs Fadero noted that she had previously asked the ICB's Chief of Staff about how the culture of the ICB would change as it transitioned from being a CCG to a new form of organisation. She asked about progress with this. Mrs Chadwick-Bell explained that she was unable to comment on the culture at the ICB, but noted that the ICB had been through a process of continuous development for a couple of years. Structures were adjusted to better support commissioning, regulatory and strategic outcomes. Wider organisational development work would be required as organisations within the system collaborated in different ways.	

	Mrs Fadero asked about the impact that had been seen to date from the eleven workstreams. Mrs Chadwick-Bell explained that collaborative had been set up to enable provider colleagues to identify three or four priorities for 2024/25. The elven workstreams would be reviewed to identify if any of these should come under a collaborative, and some may not continue as a result. It was important to set priorities as it was not possible to do everything at the same time. Mrs Manson asked whether the collaboratives were meant to be transformational, noting concern that priorities might become lost while dealing with day to day issues. Mrs Chadwick-Bell explained that the collaboratives aimed to be strategic and transformational in nature and would not become involved in day to day operational matters. They would allow multiple organisations to work together to find solutions to system wide issues.	
99/ 2023	**Reports from Board Committees** *Audit Committee* Mr Reid reported that the increasing issues around V&A had been discussed at the recent Committee meeting. *The Board noted the report.* *Finance and Productivity Committee* Updated Terms of Reference for the Committee were approved. *The Board noted the report.* *Inequalities Committee* The Terms of Reference for the Committee were approved. *People and Organisational Development Committee* *The Board noted the report.* *Quality and Safety Committee* Updated Terms of Reference for the Committee were approved. *The Board noted the report.* *Strategy and Transformation Committee* Updated Terms of Reference for the Committee were approved. *The Board noted the report.*	
100/ 2023	**Infection Control Annual Report** Mrs Carruth explained that the full infection control was included as an appendix to the Board papers, and had been discussed in detail by the Q&S Committee. A deep dive into infection control at the Trust was due to be presented to Q&S later on in the week to provide additional assurance to the Committee. Mrs Churchward-Cardiff asked whether, due to the current pressures on the Trust, there was sufficient capacity to manage the threat of infections and compliance with infection control processes. Mrs Carruth explained that the management of infection control was a constant challenge, but that the Trust was supported by an expert and diligent infection control team. Discussions about capacity and capability took place with divisions, and colleagues were supported to ensure that they knew the correct infection control processes to follow.	

101/ 2023	**Use of Trust Seal** Five uses of the Trust Seal were noted since the previous meeting of the Board.	
102/ 2023	**Questions from members of the public** Mr Hardwick reported that there had been an incident a few weeks before which had seen a patient conveyed to Conquest hospital by ambulance before being discharged four days later. They were subsequently readmitted to Conquest, and discharged again four days later. The patient lived very close to EDGH and he was unsure why they had been taken to Conquest. Mrs Chadwick-Bell noted that she did not know the details of the case, but that the services provided at Conquest and EDGH were not identical. Ambulances conveyed patients to the appropriate A&E for a patient's condition: those with surgical or trauma conditions were taken to Conquest, while those with ENT or stroke conditions were taken to EDGH. Patients with general medical conditions were taken to the closest A&E. Mr Hardwick passed on the best wishes of his wife, Eileen, to the Board. Mr Campbell explained that he had submitted a Freedom of Information request to the Trust for the contents of a transport survey, which had been refused. He asked what information the survey contained that prevented it from being published. Mr Milner explained that he believed the Trust's intention was to publish the report in the future. He agreed to ask the Trust's Director of Estates and Facilities for further information. Mr Campbell noted the continued pressure on staff in the Trust and asked what was being done to ensure that staff burnout was monitored and minimised. Mrs Carruth explained that the welfare of staff, and protecting them against burnout, had been the subject of numerous conversations. Restorative supervision training was being rolled out to support staff alongside a range of wellbeing support measures and practical, emotional and psychological support for all staff. Mr Aumayer reported that colleagues in the Trust had received mental health first aid training to enable them to identify and support those who needed help. In addition, occupational health services and reach out services provided confidential support and access to counselling and guidance when required. Sickness levels and attendances were monitored to identify any areas of concern and trauma support through TRiM was offered when necessary. Organisational development and cultural interventions had taken place in areas where particular concerns had been identified. Mr Phoenix noted that throughout his years of working in healthcare he had never seen an organisation that offered as much health and wellbeing support to staff as ESHT. Staff throughout the organisation looked out for each other, from the wards to the most senior leaders. The Trust was the most caring organisation that he had ever encountered. Mr Campbell asked whether it would be possible to include the anticipated year end position on the run rate page of the IPR so that variability could be more easily measured. He noted that the potential year-end financial deficit was not reflected in reporting and it would be helpful to be able to see the magnitude of the challenge faced by the Trust. Mr Reid noted that the run rate page was an indicator of the underlying financial position of the Trust, so was not the best place to show the anticipated year-end position. However, he accepted that this could be more clearly set out within the IPR.	**RM**
103/ 2023	**Date of Next Trust Board Public Meeting** The next meeting of the Trust Board would be taking place on Tuesday 13th February 2024 at 0930 at Eastbourne District General Hospital.	

Matters Arising from the Board meeting of 12th December 2023

Agenda Item	Action	Lead	Progress
91/2023 – Integrated Performance Report, Month 7 (October)	Detailed response on increase in colleagues with musculoskeletal (MSK) reporting to be presented to the Board.	Steve Aumayer	Update attached to Matters Arising
	Deep dive on medical turnover to be presented to POD Committee.	Steve Aumayer	A deep dive into medical turnover was undertaken, reviewing data from the past three years; no concerns were identified. This is a small group of staff so any changes to turnover rates can show up as a relatively high deviation. As nothing of concern was discovered during the deep dive there is no plan to present the findings to POD.
92/2023	Update on progress with improving mandatory training rates in the maternity team to be included in Q3 update to the Board.	Brenda Lynes	To be included within Q3 Maternity update which will be presented to the Trust Board in April 2024
	Update on Community Maternity services to be included in Q3 update to the Board.	Brenda Lynes	To be included within Q3 Maternity update which will be presented to the Trust Board in April 2024
93/2023	Data that underpins bed modelling assumptions to be shared with Mrs Webber following the meeting	Charlotte O'Brien	Bed modelling data shared with Mrs Webber on 22nd December 2023
102/2023	Further information about the Trust's response to an FOI request for the contents of a transport survey to be sought.	Richard Milner	It has been agreed that the transport survey can be publicly released and a copy will be provided to Mr Campbell.

East Sussex Healthcare NHS Trust

MSK Absence Assurance Report

Purpose of the paper	To provide the Board with an update about the increase in absences amongst staff due to musculoskeletal (MSK) issues.
	For Decision: ; For Assurance: x ; For Information: x
Sponsor/Author	Sponsor: Steve Aumayer, Deputy Chief Executive and Chief People Officer Author: Samantha Foy, Occupational Health Manager
Governance overview	N/A

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		x

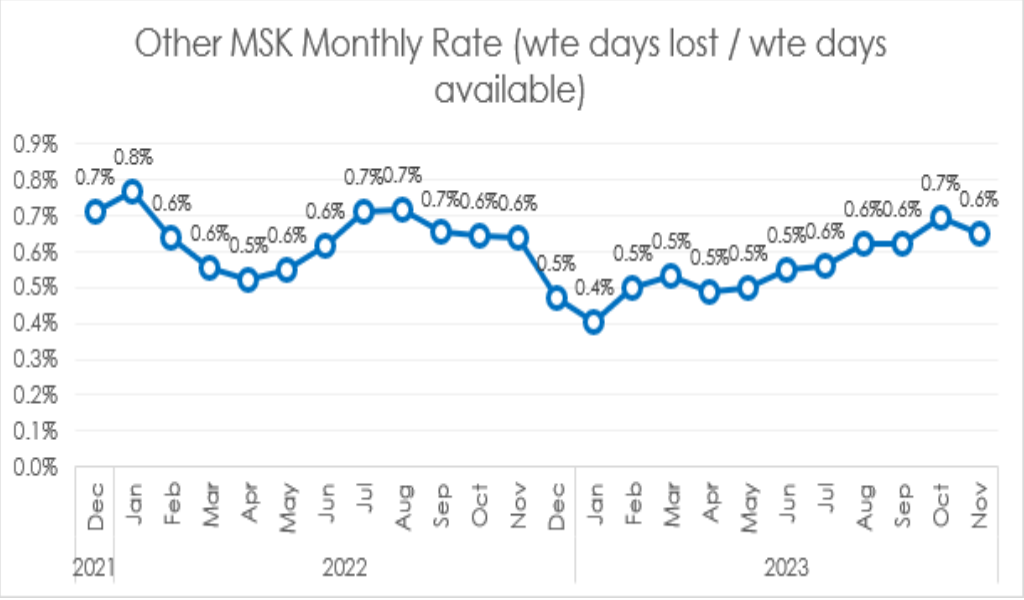
Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x		x	

Recommendation	This report is for assurance, and for information.

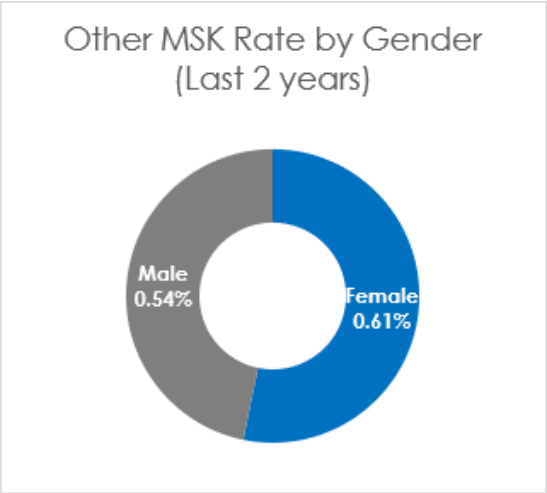
Executive Summary

Statistical data within this report had been taken from Workforce Analytics.

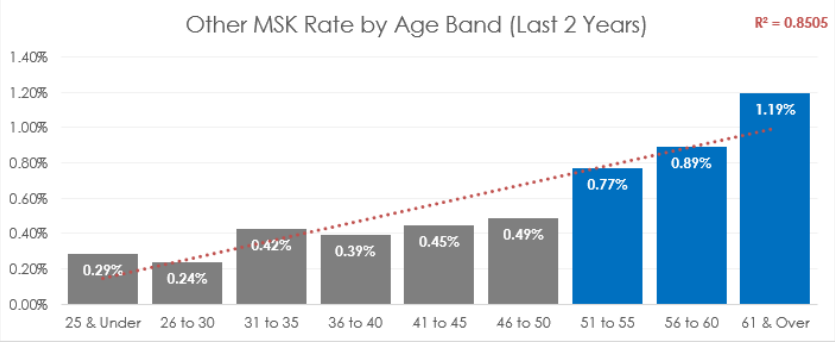
The table below shows the percentage of whole time equivalent (WTE) days lost within the Trust on a month by month basis over the last two years. The highest rate was 0.8% in January 2022, with a low of 0.4% in January 2023. An increasing trend was seen during 2023, peaking at 0.7% in October 2023.



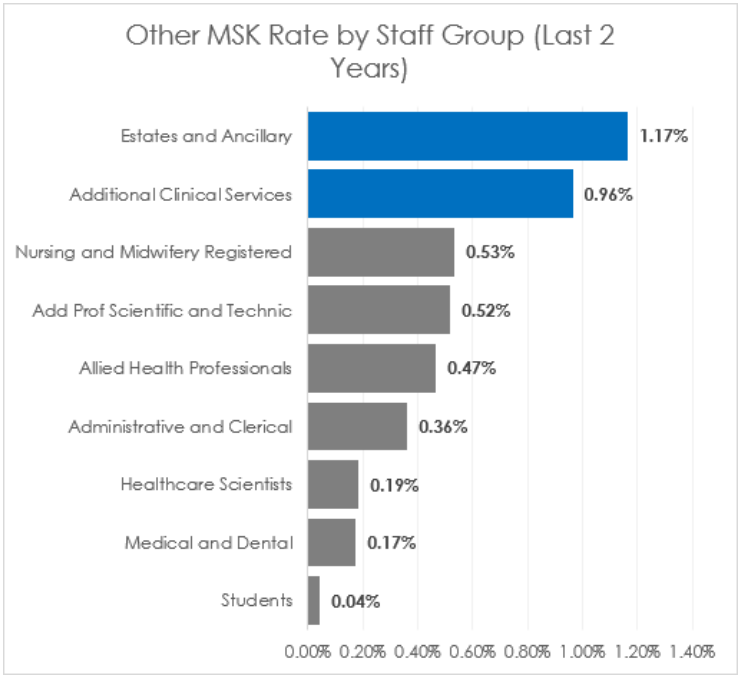
MSK absence is slightly more prevalent in our female population (gender identity as per ESR).



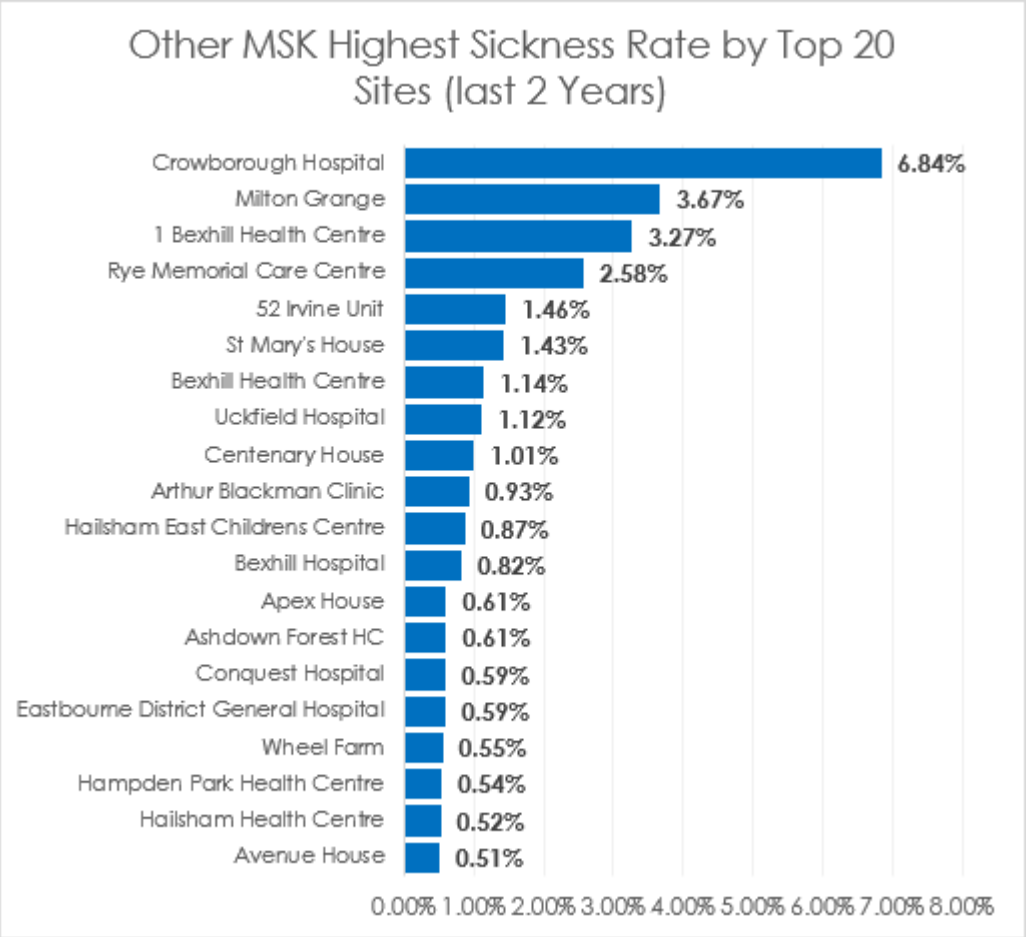
MSK absence shows significant increases in older members of staff, in line with clinically expectations.



Estates & Ancillary and Additional Clinical Services (HCAs etc) are the staff groups most affected by MSK issues.



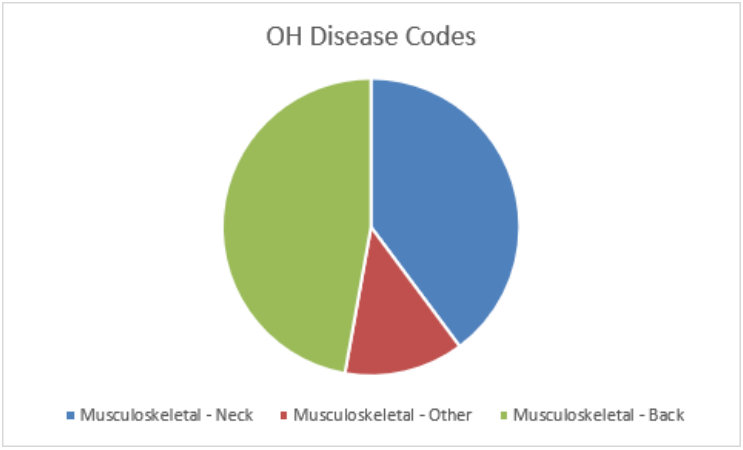
Our acute sites are far down the list of work locations reporting MSK issues, but this is likely to be a reflection of MSK issues reported by members of staff in smaller teams, resulting in disproportionately higher percentage sickness rate.



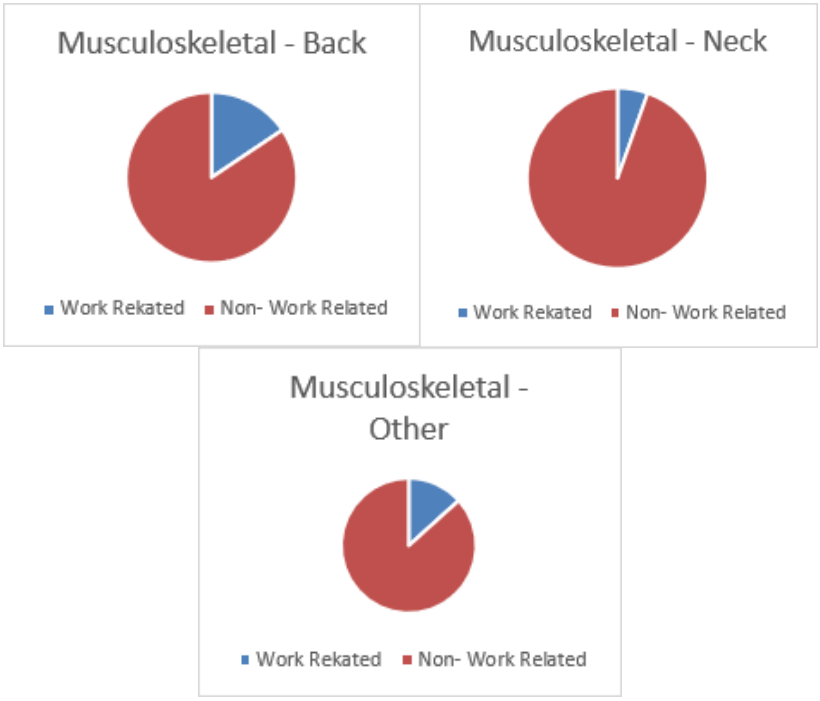
Using data held within Occupational Health (OH), which is gathered from staff who have been reported to OH during 2023, 167 employees were referred for MSK related issues. Of these, following OH assessment, 11 were identified as work related issues, a further 17 were identified as a combination of work/non-work related. The majority, 139, were not work related.

Of these there were 5 fractures reported, all of which were not work related.

MSK related referrals are subcategorised as follows:



This data can be further broken down to identify if the MSK condition was related to work or not.



These graphs demonstrate that though some reported incidences of MSK symptoms are work related, the majority are not linked to a work-related cause.

Despite not having the highest MSK related absence, it is prudent to note that the MSK absence is an increasing trend.

Next steps

- Actions which OH have started in December 2023 are:
  - Improving the Display Screen Equipment (DSE) assessment process (internal OH processes)
    - Improving the speed with which employees receive DSE equipment by OH working with procurement on the existing process and introducing a Procurement Certificate.
    - Improving referral to OH assessment time.
    - Working with the OH physio provider – Physiomed.
- Physiomed management information reports have identified that there can be a delay in referral for physiotherapy (which increases length of symptom experience +/- increase in symptoms).
  - OH Manager to meet with Physiomed to discuss improving awareness of available physiotherapy services.
- OH Manager to commence Bitesize manager drop-ins to support awareness of the offerings within OH. Topics to include:
  - Physiomed access.
  - Fast track MSK appointments.
  - DSE awareness.
- Actions which OH plan to commence in 2024 in conjunction with work being conducted and undertaken by the Absence Management group:
  - MSK Awareness Month; engaging with managers and employees regarding self-care, especially desk-based exercises, as many staff are sat at a computer for a lengthy period (highlighted by neck issues).
- Planning has already commenced for:
  - DSE awareness for managers, reminding managers to prompt employees to complete assessments, especially for those working from home or agile workers.
  - Targeted support for staff groups and divisions most impacted by MSK absences.

East Sussex Healthcare NHS Trust

Chief Executive Report

Purpose of the paper	To update on key items of information which are relevant but not covered in the performance report or other papers						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Joe Chadwick-Bell						
Governance overview	Not applicable						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x	x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the updates and assurances provided by the CEO

Executive Summary

I'd like to start by wishing everyone a Happy New Year, although that feels like a long time ago. Despite the many challenges face staff worked extremely hard over the early winter months to ensure that we were there for our patients and our communities and I would like to recognise the hard work and dedication in the lead up to what is always a challenging time for the NHS.

Patient flow remains a challenge for us as we return from both the festive break and the impact of industrial action. There were two planned junior doctor strikes in the lead up to the Christmas period and post New Year. Whilst as usual we prioritised urgent care, we also continued to undertake elective work; there was however an inevitable reduction in elective activity which in turn impacts on waiting times and the waiting list.

Paediatrics at EDGH

The Trust has been developing plans over the past nine months to change where children will be seen at Eastbourne when they have an urgent care need and this has been discussed with Board members and through the Executive Committee on a regular basis. In summary children can still attend the emergency department at Eastbourne DGH as they do now. There are four key differences to the current service model:

1. An Advanced Paediatric Nurse Practitioner or Paediatric Registrar is now working within the emergency department at least five days a week, although the plan is to establish this to seven days a week, enabling children to be seen sooner and negating the need to move to another department within the hospital;
2. The existing SSPAU (Paediatric Assessment Unit) will no longer run as a separate service;
3. Planned care services will move to an out-patient setting;
4. The SSPAU consultant shift will no longer support urgent care and capacity will be re-job planned to support reduction in wait times.

The service plans have been shared by the Health and Overview Scrutiny Committee (HOSC), who are conducting a separate service review. In addition, I am commissioning

a further independent review as part of the implementation to provide further professional scrutiny as there remain some internal concerns within the paediatric team, as is often the case with differences in opinion within the consultant body. There has also been some external concern raised through various channels, although we understand this to be on the basis that people are concerned about losing a service at EDGH, which is not the case. It's important that the public continue to access care via their GP, through the Urgent Treatment Centre and emergency department, recognising that in-patient services are already based at Conquest.

Business Planning

The Trust continues with its business planning process, although the NHS Operating Guidance has been delayed, and therefore is subject to change. The draft annual objectives will be shared with the organisation shortly and will align with our three strategic priority areas:

1. Quality
2. People
3. Sustainability

As we move into the new financial year and once plans are finalised, the Board scorecard will be adapted to track the objectives and intended outcomes as well as maintaining and focus on key 'watch' metrics to ensure compliance with core standards.

HSJ partnership award for Patient Safety Collaboration of the Year

I'm delighted that we have been nominated for the Patient Safety Collaboration of the Year award. Our partnership with Oakhouse Kitchens has enabled us to develop and deliver a robust programme which is now a core part of the training suite available to our colleagues. This enables us to deliver the very best care for patients with dysphagia in East Sussex.

Conquest Hospital - Gold-level National Joint Register Data Quality Award

Our Conquest site has been awarded as a National Joint Registry (NJR) Data Provider for 2023. The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall cost-effectiveness in joint replacement surgery. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met registry targets.

It was incredible to hear that hospitals are required to have a minimum baseline compliance of 95% to qualify for an award, I know we will continue to strive to achieve the most excellent data quality standard.

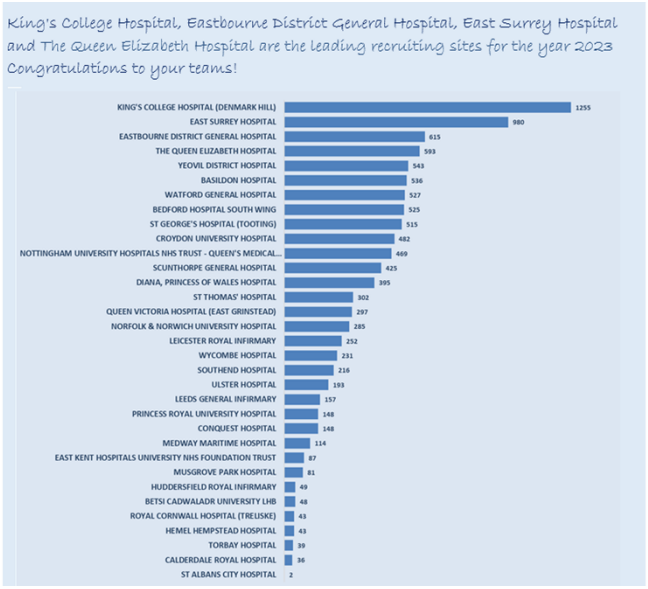
CQC update

The Trust received a fixed penalty notice following notification – Failure to comply with Regulation 12(1) and 22(2)(b) Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – following a previously reported serious incident. The Trust was fined £4,000 which has been paid with in the 28 day period. Further details will be covered in part 2 as this relates to an individual case and as such may be patient identifiable.

National Institute Health and Care Research Recruitment Success

We are proud to announce that ESHT are one of the leading sites for recruitment in 2023. For the year 2023-2024 ESHT pledged to recruit 722 patients into NIHR clinical trials. To date we have exceeded our pledge and recruited 935 into NIHR trials and a total of 944 patients into a combination of NIHR and non-NIHR trials. We are on track to recruit more than 1,000 patients by the close of the financial year. Our current successes include:

- MIDI Study: we have recruited our 2,000th patient in the total time open for the study and are the 3rd highest recruiting site nationally this year to date.
- TIPPS Study: 3rd Place Nationally
- ZODIAC Study: we were the first hospital to recruit to the trial nationally and the first hospital to recruit to target (33 patients) nationally.
- After Ankle Fracture Study: 2nd highest recruiter in KSS



Visible Leadership

The Executive team have enjoyed being out and about visiting wards over Christmas; our wonderful staff made so much effort to spread festive cheer to patients, visitors, and colleagues. Hot meals, buffets and sweet treats were provided by our Trust Charity to staff who were working over Christmas in appreciation of their hard work.

At this time of year, it is important to remember that some of us are not able to be with our loved ones. In support of this remembrance cards were made available for staff to write and hang on the Christmas trees in the chapels on both sites. The wellbeing team organised festive refreshments which were held across our acute and community sites. As well as this, the voices of our amazing, talented staff were heard singing carols around the wards at EDGH on Friday 22nd December and at Conquest on Christmas Eve.

The Chairman had the honour of presenting December's hero of the month award to our fantastic, hardworking community nursing teams.

A particular highlight were the areas I visited over Christmas. I am always blown away by our Emergency Departments' ability to provide outstanding care and support to our patients, even in the busiest of times. What really stuck with me were the smiles and positivity from our front-line staff, this continued as I visited other areas.

	Electronic Patient Records formal approval As you may already be aware, the EPR Programme has been running within the Trust for well over 12 months now following processes and gateways overseen by the national Frontline Digitisation programme. We now have formal approval and will be going out to Tender on Monday 5th February. The procurement phase will run from 5th February to 7th June upon which a Procurement Outcome Report will be produced for review and approval by the Trust. In parallel the Full Business Case (FBC) will be in production, with a plan to present the draft FBC to the EPR Board in early July, following which it will progress through the Trust approvals route while separately also following the Regional and National approvals routes as part of the Frontline Digitisation governance process. It is expected that an EPR will increase uptake in the use of ePMA (electronic prescribing) across all clinical areas and greater Live Bed State visibility with the potential integration of an AI-based solution into existing clinical systems.

Next steps	*N/A*

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period December 2023 (Month 9)

Content

East Sussex Healthcare NHS Trust

Content

About our IPR

East Sussex Healthcare NHS Trust

- 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 (2023/24), 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.

Our vision describes our ambition for the organisation over the five years of this plan:

- **To develop outstanding services, building a reputation for excellence in care, becoming "the best DGH and community care provider"**
- **To lead a modern organisation for our people, enabled by technology, agile working and a light environmental footprint**
- **To harness existing strong relationships to forge a vanguard collaborative tackling the social and health challenges that face our coastal towns**
- **To make a demonstrable economic and social impact through our partnership commitments; on health, employment, education, training and skills development across Sussex**
- **To develop as a financially sustainable and innovation-led organisation**

Chief Executive Summary

East Sussex Healthcare NHS Trust

Executive Summary

Our priorities over the past month, in line with our annual objectives have been to focus on elective recovery including cancer; delivering safe and sustainable urgent care; reducing the number of inpatients who do not meet the criteria to reside; financial break even and the wellbeing of the workforce. Whilst we are pleased with the progress made across a number of key metrics, we continue to focus on improving performance in all areas and are committed to maintaining high standards in our quality of care.

Urgent and Emergency Care performance remains a key focus point as delivering the 4 hour target has been a challenge for the Trust in recent months. Our Urgent and Emergency Care 4 hour performance is multi-factorial; the high bed occupancy in our hospitals; our growing length of stay with higher acuity patients and our limited ability to discharge to onward care beds are challenges that we are working collaboratively to address.

Key Areas of Success

- The number of patients waiting >65weeks for first definitive treatment continues to be ahead of agreed trajectory for our year-end target of zero and the Trust is expecting to deliver zero >78 week waits for the remainder of 23/34.
- The Trust has seen improvement in 18-week RTT compliance, with the Trust ranked 90 out of 119 Trusts, up from 112 in September.
- Staff turnover and vacancy rates reduced further in December. Turnover has reduced to 10.3%, previously peaking at 13.9% in Nov 2022.
- Our Urgent Care Response continues to be an area of success with the standard of 70% having been consistently achieved year to date. In December >86% of patients were seen within the 2-hour response window.
- Our Friends and Family Tests (FFT) recommendation rates for December, when compared to the most recent data released by NHS England (October), show that ESHT continues to be higher than the national average.
- RAMI indices of mortality remain better than our peers. With the Trust positioned at 37 out of 122 Acute Peer Trusts.

Key Areas of Focus

- Urgent and Emergency Care performance is below trajectory and delivering the actions from our Urgent and Emergency care improvement plan to support recovery of the 4 hour performance continues to be a priority for the Trust.
- Our key area of focus in the coming months is to address the average length of stay in our acute and community beds and overall bed occupancy rates, building on the improvements that we have seen in December.
- The Trust is focused on reducing first outpatient appointment waiting times to a maximum of seven days for patients referred with suspected cancer, supporting delivery of both the FDS and 62 day standards.
- Continued focus at both Trust and Divisional level to improve productivity and ERF performance against plan; mitigating the impact of Industrial Action on elective activity where possible.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Patient Safety Incidents Causing Harm	0	3	2	4	Common Cause	Inconsistent
Serious Incidents	0	2	0	5	Common Cause	Inconsistent
Never Events	0	0	0	0	Common Cause	Inconsistent
Inpatient Falls per 1,000 Bed days		5.42	5.49	4.30	Common Cause	Target required
Pressure Ulcers, category 3 to 4	0	3	2	1	Common Cause	Inconsistent
MRSA Cases	0	0	1	0	Common Cause	Inconsistent
Cdiff Cases	5	6	5	4	Common Cause	Inconsistent
MSSA Cases	0	4	7	1	Concern	Inconsistent
RAMI	100	91.0	89.8	80.1	Concern	Achieving
SHMI (NHS Digital monthly)	100	99.6	99.5	94.7	Concern	Achieving
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	91.9%	91.6%	93.7%	Common Cause	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		38	27	42	Common Cause	Target required
Complaints Response Compliance		47.2%	50%		Common Cause	Target required
Reopened Complaints		5	3	5	Common Cause	Target required
A&E FFT Score	85%	64.4%	55.6%	94.9%	Concern	Inconsistent
A&E FFT Response Rate		0.695%	0.334%	6.13%	Common Cause	Target required
Inpatient FFT Score	95%	98.9%	98.6%	97.9%	Common Cause	Achieving
Maternity FFT Score	95%	96.5%	100%	100%	Common Cause	Inconsistent
Outpatient FFT Score	95%	98.6%	96.1%	97.0%	Common Cause	Achieving
Post Covid19 Assessment FFT Score	95%	100%	100%		Common Cause	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,172	8,172	7,228	Improvement	Target required
Agency Rate	3.6%	1.60%	1.35%	1.34%	Improvement	Achieving
Vacancy Rate	7.5%	6.7%	6.5%	10.5%	Improvement	Inconsistent
Staff Turnover	11.6%	10.3%	10.3%	10.0%	Improvement	Inconsistent
Retention Rate	90%	92.3%	92.3%	91.9%	Improvement	Achieving
Monthly Sickness - Absence %	4.7%	5.8%	6%	5%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	18.9	18.8	16.3	Improvement	Not Met
Staff Appraisals	85%	81.9%	81.2%	79.8%	Improvement	Not Met
Statutory & Mandatory Training	90%	89.1%	89.7%	88.8%	Improvement	Not Met

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	76%	68.4%	69.7%	78.0%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	708	807	223	Concern	Not Met
A&E waits over 12 hours from DTA	0	2	0		Common Cause	Inconsistent
Conveyance handover >60 mins	0%	0.879%	1.48%	2.11%	Improvement	Inconsistent
Non Elective Length of Stay	4.48	4.55	4.57	3.97	Common Cause	Inconsistent
Average daily NCTR	95	214	188		Improvement	Not Met
104 day Backlog	35	27	27	27	Concern	Achieving
Elective Activity (ELIP,DC,OPFA, OPFUP P...	108%	106%	105%		Common Cause	Inconsistent
RTT under 18 weeks	92%	52.9%	51.4%	91.1%	Concern	Not Met
RTT 65 week wait	280	193	220	0	Concern	Achieving
RTT Total Waiting List Size	58968	54561	55384	29019	Common Cause	Inconsistent
Diagnostic <6 weeks	1%	9.97%	13.3%	0.597%	Improvement	Not Met
Urgent Community Response within 2 h...	70%	88.6%	86.2%		Improvement	Inconsistent
CHIC wait times < 13 weeks	75%	81.9%	80.0%	85.9%	Concern	Achieving
Intermediate Care Length of Stay	30	37.4	32.5	22.9	Common Cause	Inconsistent
% Discharges delayed 1+ days		22.1%	21.7%		Common Cause	Target required
Total delay days from monthly Discharges		4091	4350		Common Cause	Target required
Cancer 2WW	93%	81.1%	66.3%	96.8%	Concern	Inconsistent
Cancer 62 Day	85%	57.0%	58.0%	77.8%	Concern	Not Met
28 Day General FDS	75%	74.2%	72.4%	69.4%	Improvement	Inconsistent

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(46)	5,292	(2,881)	n/a	n/a	Not Met
Surplus/(deficit) (£'000) - YTD	28	439	(2,515)	n/a	n/a	Not Met
ERF (£'000) - in month	7,540	9,429	7,701	n/a	n/a	Inconsistent
ERF (£'000) - YTD	76,456	66,158	73,859	n/a	n/a	Not Met
Efficiency (£'000) - in month	3,142	2,632	2,396	n/a	n/a	Inconsistent
Efficiency (£'000) - YTD	22,301	17,564	19,960	n/a	n/a	Not Met
Capital (£'000) - YTD	29,411	13,615	16,836	n/a	n/a	Not Met
Capital (£'000) - FOT	64,664	62,531	61,740	n/a	n/a	Not Met

Constitutional Standards | Benchmarking

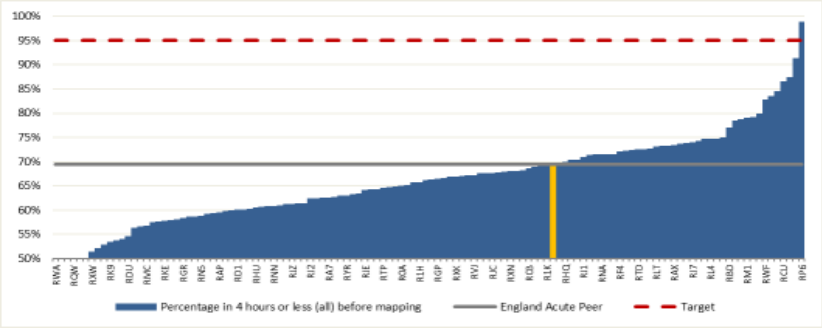
East Sussex Healthcare NHS Trust

*NHS England has yet to publish all December 2023 Provider based waiting time comparator statistics

Urgent Care – A&E Performance

December 2023 Peer Review

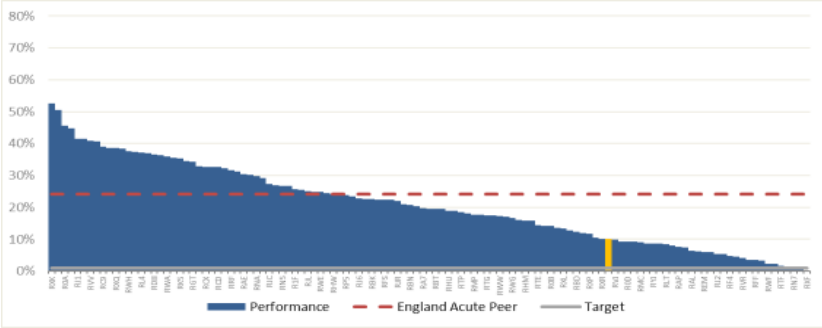
National Average: 69.40% ESHT Rank: 42/124



Planned Care – Diagnostic Waiting Times

November 2023 Peer Review*

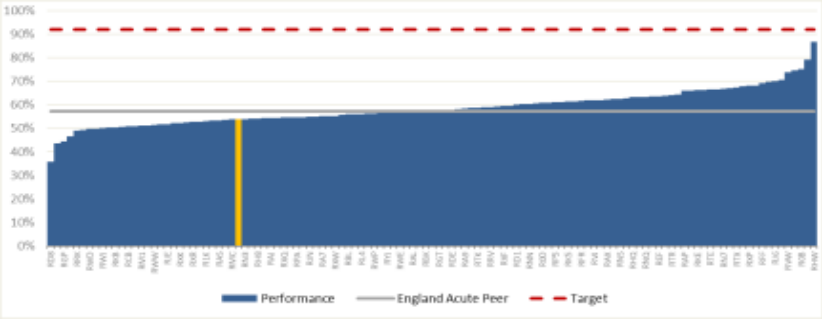
National Average: 24.2% ESHT Rank: 32/119



Planned Care – Referral to Treatment

November 2023 Peer Review*

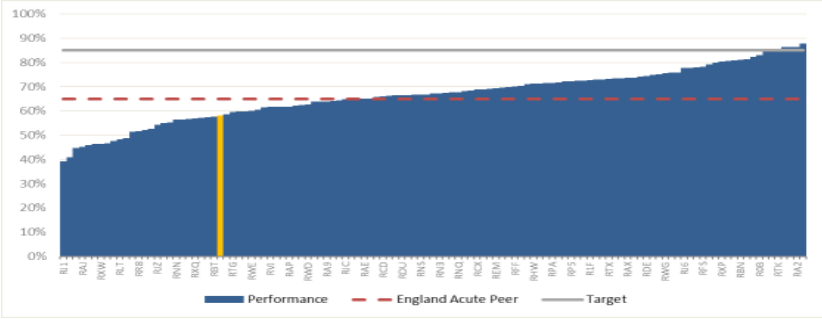
National Average: 57.1% ESHT Rank: 90/119



Cancer Treatment – 62 Day Wait for First Treatment

November 2023 Peer Review*

National Average: 65.0% ESHT Rank: 94/119



ESHT denoted in orange, leading rankings to the right

East Sussex Healthcare NHS Trust

Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

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

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Quality and Safety

COVID 19
The Trust continued to experience some COVID outbreaks with prevalence increasing and declining in a wave like pattern. Most patients do not require additional treatment. The outbreaks were mainly confined to bays and the IPC and Ops/clinical teams work closely to ensure zero void beds.

Infection Control
There was an outbreak of influenza A confined to one bay involving 4 patients on one ward. All patients received Treatment (Oseltamivir) and recovered from this. A confirmed outbreak of Norovirus was well managed by Rye affecting 8 patients.
5 cases of CDI were reported with two Hospital Onset Healthcare Associated (HOHA) and three Community Onset Healthcare Associated (COHA). None of the cases were found to be due to cross infection.
One MRSA bacteraemia occurred in December in a patient with renal cell carcinoma. The infection was assessed as unavoidable. 7 MSSA infections were reported in December, 2 HOHA and 5 COHA. Hospital onset cases related to patients with cellulitis and infective spondylosis that occurred prior to admission. One COHA case was assessed as a probable contaminant. A report on contaminated blood cultures is being prepared to see what improvements can be made.

Safety Events
For the month of December 23 there were a total of 778 patient safety events attributed to ESHT, 97% of which were no harm/near miss. There have been no PSII's to date, and qualitative data collection continues to facilitate determining themes and trends that are emerging with the transition to PSIRF.

Harms
Of the overall 161 Slips, Trips and Falls, 118 at severity 1 and 40 at severity 2 with 3 SWARM reviews being undertaken. There were 92 Medication related incidents, a slight reduction. The third highest category was Clinical Treatment and Care Pathways which was an increase from November.

Mortality
RAMI indices of mortality rolling 12 months remains better than peers positioned at 37 out of 122 Acute Peer Trusts. SHMI has reduced slightly again this month at 99.49 and is within the expected range. EDGH is showing an index of 99.5 and Conquest 100. Barring Congestive Cardiac Failure (marginal) our SHMI for individual diagnoses does not show any areas of significant excess deaths, this does represent improvements in fracture neck of femur, stroke and cardiac failure mortality vs expected.

Patient Experience
In December, formal complaints represented 1.3% of all patient experience feedback received. The Trust received 27 new complaints, a reduction from November. There were 9 complaints overdue at the end of December (the longest being 36 working days over), 3 complaints were reopened (unhappy with Trust response). The Trust received 3 contacts from the PHSO in December, all 3 were initial enquiries, i) podiatry care in 2020, ii) management of a patient's chest symptoms during and after her pregnancy in 2021, and iii) failure to follow pre-assessment procedures

The positive FFT recommendation rates for December, when compared to the most recent data released by NHS England (October), show that ESHT continues to be higher than the national average, (excluding Emergency Departments). There was an overall reduction in the number of FFT surveys completed in December, this is in line with previous years.

Workforce
The number of additional beds for inpatient capacity increased during December with the use of super surge beds, despite a continuing focus on discharge and our discharge ready/ long stay patients. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas requiring specialist MH skills. Some patients present with extremely challenging behaviour and are resistant to care and are often aggressive and/or violent. Ward staffing in December remained stretched to cover the additional requirements with community teams also under continued pressure. In all areas this is likely to have had an impact on key quality KPIs, access to training and at times staff wellbeing with sustained pressures. Focus continues regarding Healthroster compliance, use of temporary workforce, authorisation of additional shifts and supernumerary time with significant improvements noted regarding the use of additional shifts and roster effectiveness.

Safeguarding
Work has been completed to update and refresh the e-learning component of the Think Family level 3 training which is being launched. Staff will also be required to access a 3-hour safeguarding workshop which will be live in February. Work has been undertaken to scrutinise and validate the data for initial health assessments pertaining to children in care, this is showing some improvement. The team are working alongside the Women's' and Childrens division to enable clinics for unaccompanied asylum seekers. A plan is progressing to develop safeguarding forums to offer a supervision space for adult facing practitioners.

Author(s)

Vikki Carruth Chief Nurse and Director of Infection Prevention & Control (DIPC)

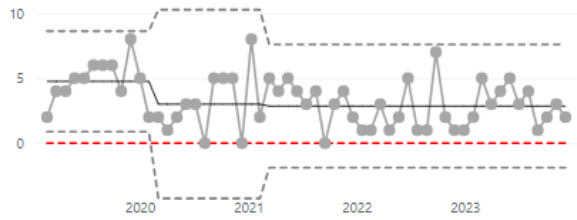
Simon Merritt Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

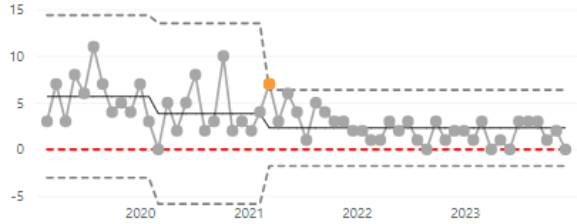
Patient Safety Incidents Causing Harm: Total, Safety

Inconsistent	Common Cause	2



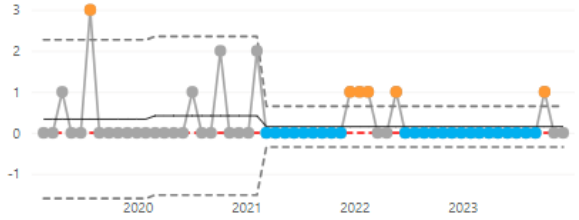
Serious Incidents: Total, Safety

Inconsistent	Common Cause	0



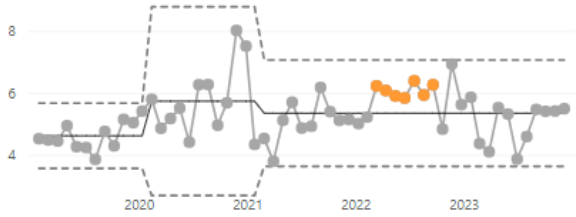
Never Events: Total, Safety

Inconsistent	Common Cause	0



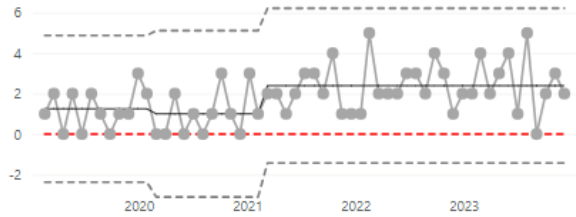
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	5.49



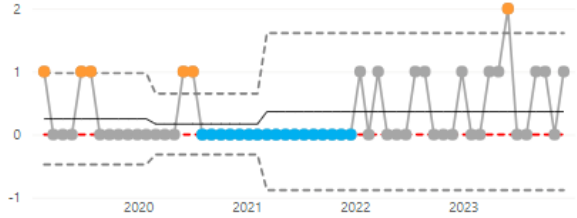
Pressure Ulcers, grade 3 to 4: Total, Safety

Inconsistent	Common Cause	2



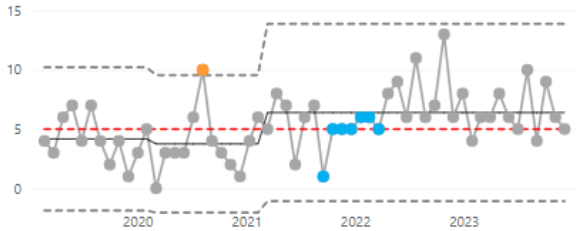
MRSA Cases: Total, Safety

Inconsistent	Common Cause	1



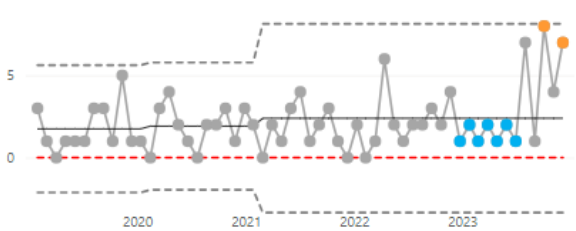
Cdiff Cases: Total, Safety

Inconsistent	Common Cause	5



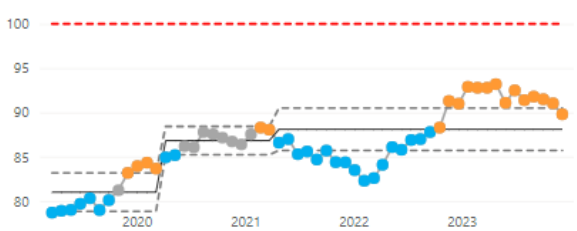
MSSA Cases: Total, Safety

Inconsistent	Concern	7



RAMI: Total, Safety

Achieving	Concern	89.8

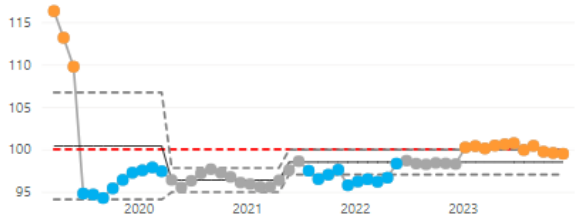


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

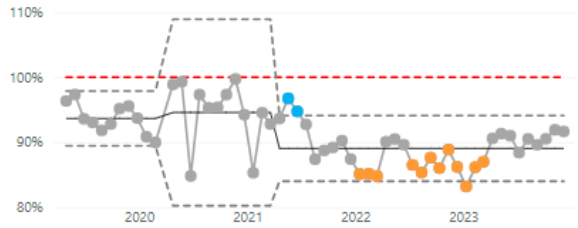
SHMI (NHS Digital monthly): Total, Safety

Achieving	Concern	99.5



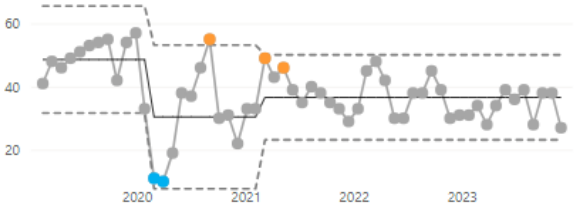
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Common Cause	91.6%



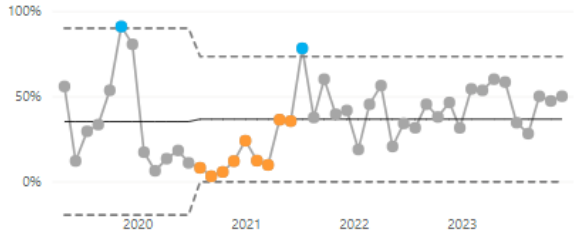
Complaints received: Total, Patient Experience

Target required	Common Cause	27



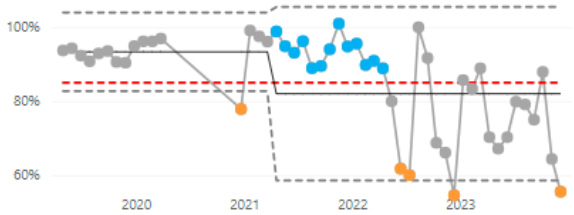
Complaints Response Compliance: Total, Patient Experience

Target required	Common Cause	50%



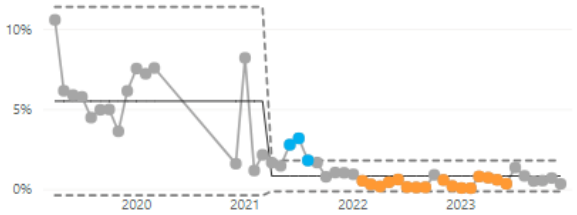
A&E FFT Score: Total, Patient Experience

Inconsistent	Concern	55.6%



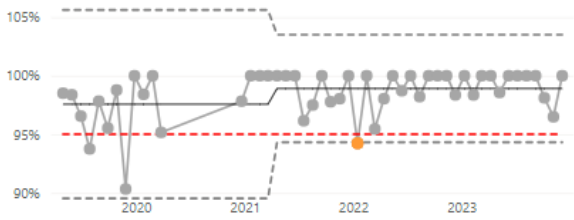
A&E FFT Response Rate: Total, Patient Experience

Target required	Common Cause	0.334%



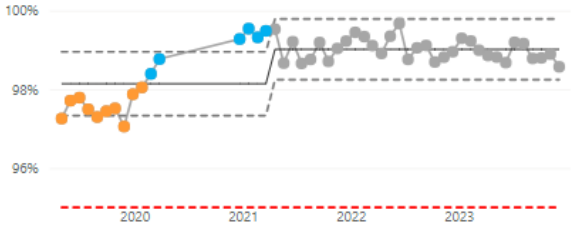
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	100%



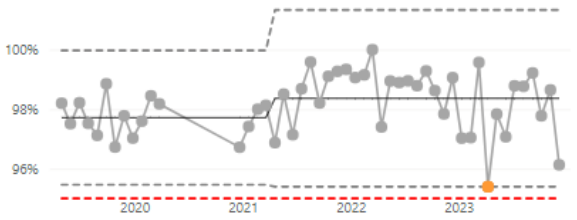
Inpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	98.6%



Outpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	96.1%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	• The transition to the Patient Safety Incident Response Framework (PSIRF) continues and there is ongoing engagement with clinical teams. Response templates and information leaflets for staff and patients are available. Learning from Patient Safety Events (LFPSE which replaces NRLS) reporting on Datix videos are now available to support staff with reporting. There is a focus, in collaboration with the ICB, on metrics that will be reported on for the region, nationally and our own internal reporting metrics as PSIRF develops. All events continue to be reviewed at the Weekly Patient Safety Summit with escalation to the new Fortnightly Patient Safety Panel.	• To continue to support learning around PSIRF templates and their application with clinical teams. • Monitoring of the use of the various PSIRF templates is ongoing to identify learning, and areas for focus. • Duty of Candour is still a requirement for Severity 3+ events. • Monitoring of training uptake continues, and bespoke sessions are being delivered.
Nursing & Midwifery Workforce	• Additional super surge beds and significant numbers of patients requiring enhanced observation for cognitive impairment, high risk of falls or patients with challenging/violent behaviour during December resulted in ongoing additional staffing requirements via TWS. Ward nursing CHPPD overall was 8.9 for December (noting distortion by specialist areas) with 13 areas less than 8 which is an improving position. Nursing fill rates for day shifts RN 89% and HCSW 87% and night shifts 99% for RN and 94% for HCSW, similar to last month.	• The Nursing Establishment Review (NER) for wards and community is complete and in the data analysis/financial review stage. • Nursing/Midwifery Roster compliance sessions continue with evidence of good controls and work in progress to support enhanced observations and requests for additional staff. • Work on improving the education and career progression framework continues including restorative supervision and the reviewing the role of practice educators.
Inpatient Falls	• Rates have remained relatively static since September 2023 and very low numbers of patients with repeat falls.	• Work on reconditioning continues supporting the focus on LoS and discharge planning with the numbers of patients who are Discharge Ready (Not Meeting Criteria to Reside) still high albeit improvements in their overall LoS and LoS from when NCTR. • SWARM forms are now being undertaken for all falls to determine learning from each events and build themes. This will inform the development of quality improvement initiatives to support reduction/prevention.
Patient Experience	On reviewing the monthly risk rating of all complaints, most were moderate in common with the general pattern (27 complaints in total); • 2 high risk where the action/omission by the Trust has placed a patient at risk of harm/or patient has suffered harm • 19 moderate risk where aspects of clinical care appear suboptimal • 6 low risk where clinical quality does not form part of the complaint. 67% of December complaints covered 3 categories: Patient Care=8, Communication=5, Values and Behaviours=5	• The Patient Experience Team continue to work with divisions to help identify learning and actions from complaints, trends, and themes from all experience feedback received. • Due to the digital change freeze, the planning for implementing Healthcare Communications providing Friends and Family Test service has been delayed by 3 weeks and the preliminary meeting has been arranged for the 25 January 2024.
Pressure Damage	• One Category 3 PU was reported in December in a patient residing in their own home. The second was also in a patient's home and deterioration form a 2 to a 3 in a high-risk patient. • New national guidance related to pressure ulcers including their categorisation has now published and implementation of any changes is being reviewed by the PUSG and discussed with NHS Sussex.	• The Pressure Ulcer Steering Group (PUSG) are working with the Trust Patient Safety Lead, to implement PSIRF going forward. • An action plan is underway to improve compliance to meet CQUIN 12 – Pressure Ulcer Prevention in line with NICE Guidance

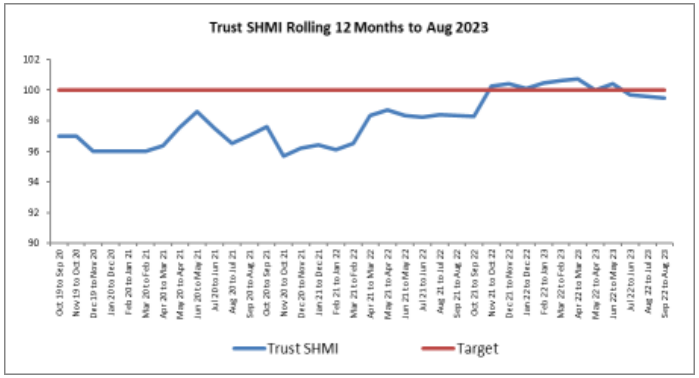
Effective Care - Mortality

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.

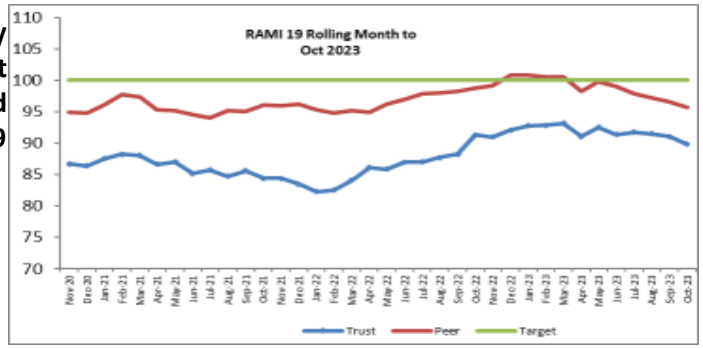
Summary Hospital Mortality Indicator (SHMI)

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

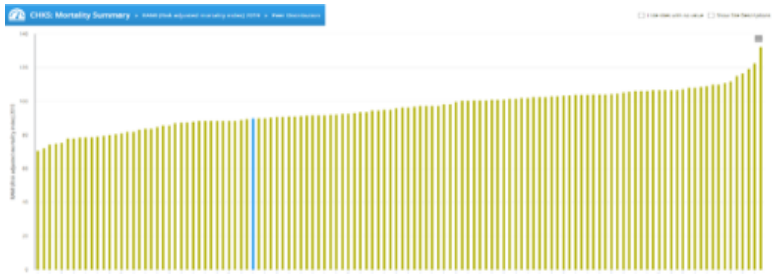


- SHMI – Sep 2022 to Aug 2023 is showing an index of 99.49 and is within the expected range. EDGH is showing 99.5 and Conquest is 100.
- RAMI 19 – Nov 2022 to Oct 2023 (rolling 12 months) is 90 compared to 91 for the same period last year. Oct 2022 to Sep 2023 was 91.
- RAMI 19 was 92 for the month of October and 86 for September. Peer value was 92 for October.
- Crude mortality without confirmed or suspected covid-19 shows Nov 2022 to Oct 2023 at 1.57% compared to 1.64% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 80% for October 2023 deaths compared to 57% for September 2023 deaths.

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



RAMI Peer Distribution without confirmed or suspected covid-19



This shows our position nationally against other acute trusts – currently 37/122

Effective Care – Mortality (continued)

East Sussex Healthcare NHS Trust

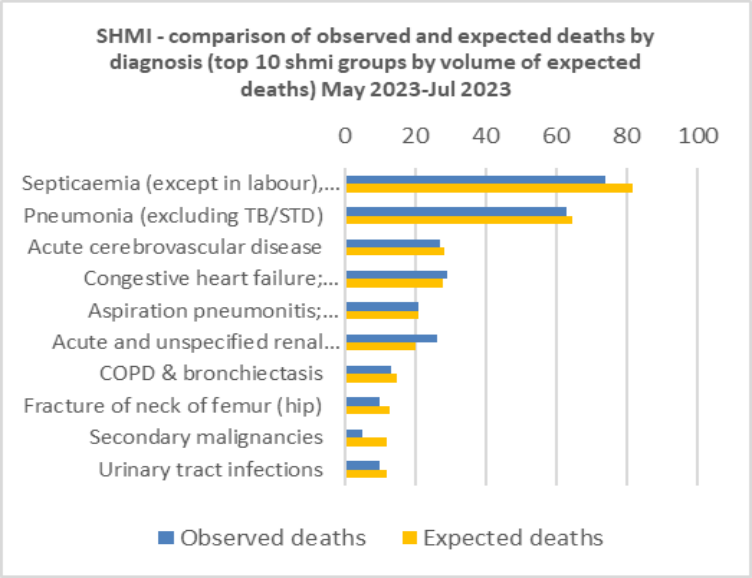
December 2023 Main Cause of In-Hospital Death Groups (ESHT)

Description	Deaths
Cancer	16
Sepsis/Septicaemia	15
Pneumonia	13
Stroke	12
Heart Failure	10
Chronic Obstructive Pulmonary Disease (COPD)	8
Aspiration Pneumonia	6
Community-acquired Pneumonia	6
Frailty of old age	6
Hospital-acquired Pneumonia	6
Urosepsis	4
Atrial Fibrillation (AF)	3
COVID-19	3
Dementia	3
Myocardial Infarction (MI)	2
Bowel Obstruction	1
Liver Disease	1

There are:
23 cases which did not fall into these groups and have been entered as 'Other not specified'.

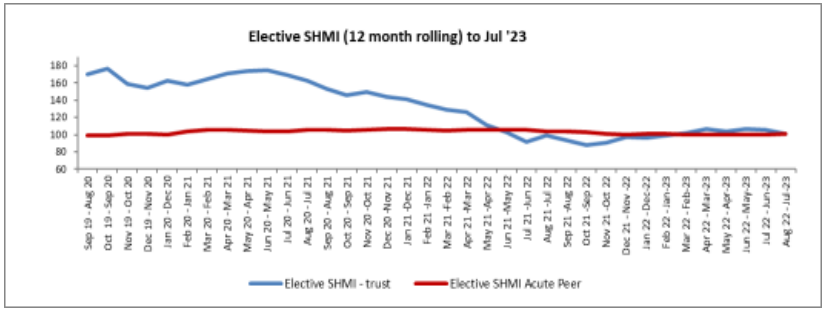
57 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

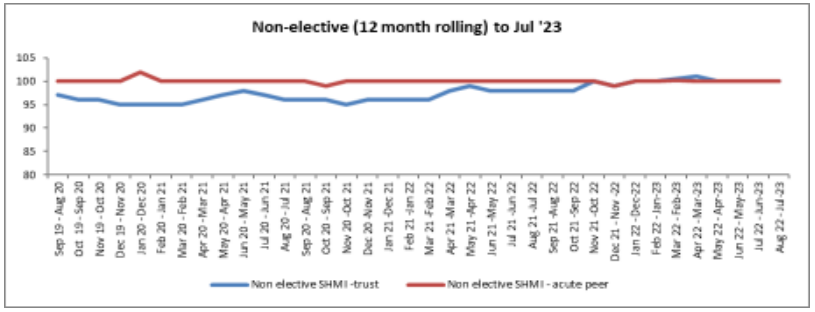
SHMI Diagnosis Main Groups



Summary Hospital Mortality Indicator (SHMI)

Elective and Non elective Inpatient Trends





East Sussex Healthcare NHS Trust

Our People

Recruitment and retention
Staff turnover / sickness
Our quality workforce
What our staff are telling us?

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

Our People | Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	Turnover is unchanged at 10.3% (719.9 wte leavers in the last 12 months) Vacancy rate reduced by 0.2% to 6.5% (521.8 wtes) Annual sickness reduced by 0.1% to 5.1% Mandatory Training rate increased by 0.6% to 89.7% Appraisal compliance increased by 0.7% to 81.9%.	Monthly sickness increased by 0.2% to 6.0% however this is lower compared to last year (Dec 22) rate of 6.4%. Worth noting that whilst monthly sickness changes from month to month, the 12 month sickness is expected to reduce Covid peaks and troughs still in that time period.	 **Steve Aumayer** Chief People Officer

Overview:

The Turnover rate is unchanged this month at 10.3% (719.9 wte leavers in the last 12 months) following consecutive reductions over the past nine months. This is well within the ICB target of 11.6%. The Trust has experienced reductions in Allied Health Professionals (AHPs) turnover by 0.2% to 6.5% (36 wte leavers) and Additional Clinical Services (ACS) turnover by 0.2% to 11.9% (192.1 wte leavers). These were offset by increases in Medical & Dental turnover by 0.7% to 13.0% (41.3 wte leavers) and Estates & Ancillary by 0.3% to 8.9% (57.1 wte leavers). Both Registered Nursing & Midwifery (198.8 wte leavers) and Admin & Clerical (169.9 wte leavers) marginally increased their turnover rates by 0.1%.

The Trust vacancy rate continues to reduce, by a further 0.2% to 6.5% (521.8 wte vacancies). This is due to some small reductions in the substantive budgeted establishment, in line with cost improvement programmes and the transfer of some HCA substantive budget to bank for CDC and Michelham. Vacancies fell for AHPs by 0.1% (down by 0.7 wtes to 66.5) for ACS staff by 0.8% (down by 15.4 to 238.6) and for Healthcare Scientists by 0.4% (down by 0.6 to 4.7) but vacancies increased for Medical & Dental staff by 0.7% (up by 5.1 wte to 158.2), for Registered Nursing & Midwifery staff by 0.1% (up by 0.6 wte to 150.8) and for Admin & Clerical staff by 0.4% (up by 5.5 wte to 118.0).

The monthly sickness rate increased by 0.2% to 6.0%. This is consistent with previous seasonal trends. It is worth noting, the monthly rate for Dec 22 was 6.4%. Overall, the annual sickness rate has reduced by 0.1% to 5.1%. Seasonal illnesses increased with wte days lost for Cold, Cough, and Flu, up by 322 and Chest & Respiratory illnesses, up by 619. The number of staff absent due to sickness with Covid averaged 33 across the month, an increase of 5 from Nov. Thus far in Jan the numbers are averaging 34 (to 11 Jan). Anxiety, Stress & Depression illnesses have increased again by 203 wte days lost to 2,449 in month. These illnesses usually rise in tandem with Covid (though last month bucked this trend).

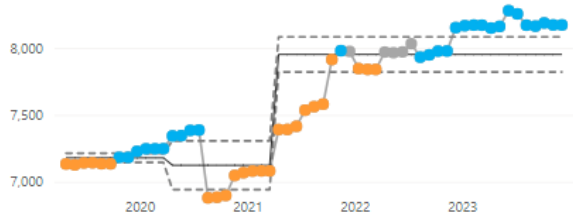
The monthly training rate increased by 0.6% to 89.7%. All modules increased, compared to Nov (though Induction was already at 100% compliance). Despite the junior doctors' industrial action on 20 – 23 Dec, even the medical staff compliance rate increased, by 0.8%, though remains relatively low at 74.8%, compared to other staff groups. The largest monthly increases in compliance were for Safeguarding Level 2 training, up by 1.2% to 86.0% and Mental Capacity Act and Deprivation of Liberties training, up by 1.0% to 87.2%. These both bounced back following reductions last month. The appraisal rate increased by 0.7% to 81.9%, after last month's fall. Last month the report was run a few days earlier, due to shorter reporting periods, and this month's increase reflects that the report was run a little later, picking up more delayed input. Registered Nursing & Midwifery compliance increased by 1.3% to 81.8%, Estates & Ancillary increased by 3.9% to 88.1% and AHPs increased by 1.2% to 84.0%. Medical & Dental compliance, however, reduced by 6.5% to 82.9%.

Our People Core Metrics

East Sussex Healthcare NHS Trust

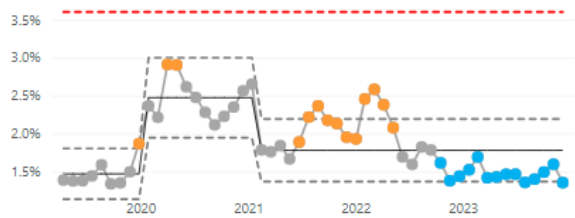
Establishment (WTE) All: Total, Our People

Target required	Improvement	8,172



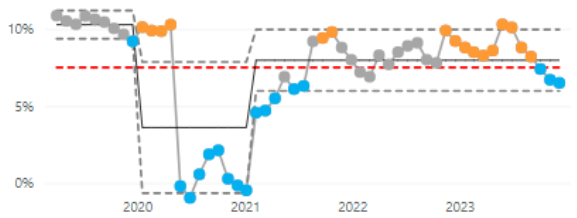
Agency Rate: Total, Our People

Achieving	Improvement	1.35%



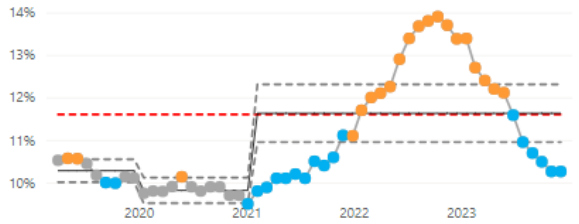
Vacancy Rate: Total, Our People

Inconsistent	Improvement	6.5%



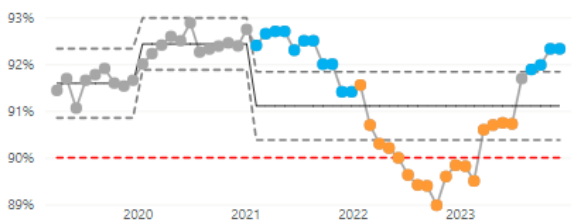
Staff Turnover: Total, Our People

Inconsistent	Improvement	10.3%



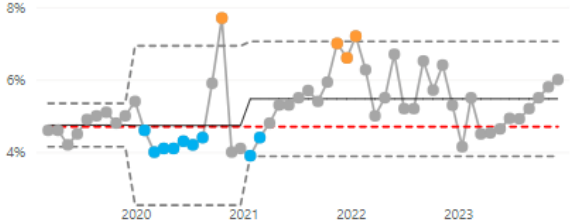
Retention Rate: Total, Our People

Achieving	Improvement	92.3%



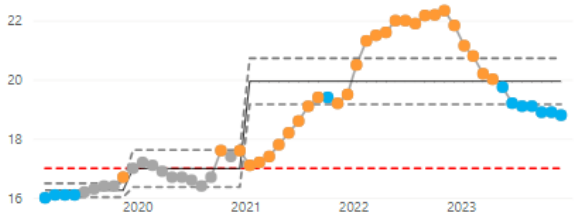
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	6%



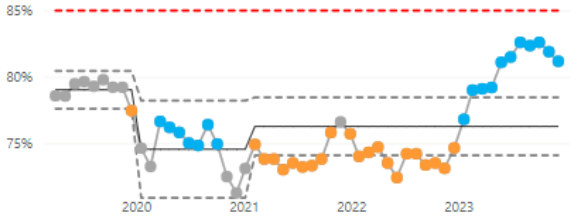
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Improvement	18.8



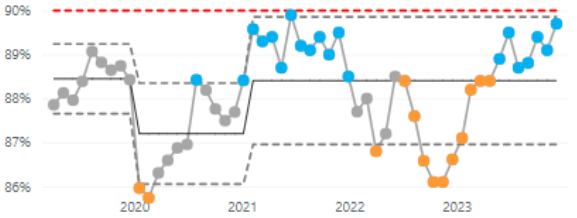
Staff Appraisals: Total, Our People

Not Met	Improvement	81.2%



Statutory & Mandatory Training: Total, Our People

Not Met	Improvement	89.7%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate is unchanged at 10.3%, following nine months of reducing trend. It is well within the ICB target of 11.6%. Turnover is now at the level seen pre-pandemic (turnover averaged 10.4% in second half of 2019).	First drafts of the Retention & Wellbeing Promises for ESHT completed which set out priorities and objectives for 2024/25. This has been developed through extensive engagement with our people and aligns with national and regional direction for NHS workforce. The Trust was successful in its submission to NHSE to be a People Promise Exemplar site during this second wave of funding. Full details currently being confirmed but the priorities will build upon workstreams already started within the People Engagement & Wellbeing team, contributing to retention. Recruitment of a Project Support Manager, in late December, who will initially focus on the violence prevention and reduction work, facilitating effective progress, before moving onto other priorities impacting on the retention of our people. Restorative Supervision pilot continues with delivery of two bespoke sessions for Practice Educators within Health Visiting. Restorative supervision will not only bolster the psychological wellbeing and safety of staff but has been shown to also reduce staff absence.
Vacancy Rate	Vacancy rate reduced by 0.2% to 6.5% (521.8 wte vacancies). Remains below target. This month, this is due to some small reductions in the substantive budgeted establishment, in line with cost improvement programmes and the transfer of some HCA substantive budget to bank for CDC and Michelham.	Continued recruitment activity around Medics, AHPs and Estates & Facilities. Some success with difficult to recruit medical posts e.g. 4 Specialty Drs for Emergency Medicine, Consultant Anaesthetics and Locum Consultant Urology. Collaborative working with local DWP to promote posts, as well as with the ICS on International Nurses to plan for 2024/25. Virtual Recruitment site on track for launch March 2024. Continued activity to support AHP recruitment, 4 Dieticians due to start in March 2024. Trust is the main sponsor for the Bexhill recruitment event. . .

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased again by 0.2% to 6.0% but annual sickness reduced by 0.1% to 5.1%. The annual sickness rate has reduced as the monthly rate is below that for Dec 22, when it was 6.4%. Average sickness days per fte have reduced by 0.1 to 18.8, which is the lowest it has been since Sep 21 Seasonal illnesses have continued to increase, with Chest & Respiratory illnesses increasing by 619 wte days lost and Cold, Cough & Flu sickness increasing by 322 wte days lost. The number of staff off sick with Covid averaged 33 across the month, an increase of 5 from Nov. Anxiety & Stress absence has continued to increased, for the third month in a row by a further 203 wte days lost to 2,449 wte days lost in month. Other MSK absences, however, continued to reduce, down by a further 83 wte days lost.	We continue to see a fluctuation in the reported Covid cases, although it must be noted that, where there is no longer the requirement to test, these figures can only be indicative. Seasonal colds and flu remains high and notably longer periods of absence have been reported as recovery takes longer. In other long term sickness cases Operational HR are working with managers to ensure the most appropriate support is being offered to colleagues, acknowledging in some cases this may involve IHR or dismissal on the grounds of capability due to ill health. Reviewing the monthly Workforce Summary Information, HRBPs are identifying those areas that are reported as hotspots and planning for the relevant support from operational HR and Staff Engagement in a bid to understand themes or working practices that may be impacting on colleagues' health and wellbeing. To ensure effective management of sickness within teams, managers are being asked to ensure they review trigger reports and/or monitoring long-term cases to ensure that they are in the appropriate stage of the sickness process with the support of HR where necessary.
Statutory & Mandatory Training	Trust compliance increased by 0.6% to 89.7%.	Increase in compliance achieved, despite the festive holiday period, rises in Trust sickness and Industrial action by Junior Doctors. Rate is now just 0.3% short of the CQC set target of 90%. Focus remains on Junior doctor compliance particularly across DAS and Medicine Division.
Appraisal	Compliance increased by 0.7% to 81.9%.	Again, increase in compliance achieved despite the factors mentioned above. Focus of support for several services including Urgent Care, Neurology, Contracting, Legal Services, SPH Admin staff and Medicine Division.

East Sussex Healthcare NHS Trust

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

Diagnosing and treating our patients in a timely way that supports their return to health

Access and Responsiveness| Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Urgent Community Response (UCR)** The UCR standard of 70% has been consistently achieved year to date, with >86% of patients seen within the 2-hour response window in December. **Elective waiting list:** Validation and increasing activity levels has supported a 12.5% decrease in the overall PTL size since July 2023, despite increasing referral numbers. The Trust has also observed improvement in 18-week RTT compliance, with the Trust ranked 90 out of 119 Trusts (99 the previous month and 112 the month before). **Elective Activity** The Trust is beginning to see significant improvements in Theatre productivity as part of the productivity improvement work being undertaken to support both daycases and Elective IP. ESHT is currently ranked first in the region for capped theatre utilisation.	**4 Hour Emergency Access Clinical Standard** Performance against the Emergency Access Clinical standard in December was 69.7%. This was 3.3% percent away from our H2 planning trajectory of 73%. The Trust needed to reduce breaches by 433 in December to have achieved against trajectory. In preparation for Christmas the Trust undertook an operational reset aimed at reducing the LOS for our patients and reducing the number of patients who did not meet the criteria to reside. This had a positive impact. We continue to work with system partners to address these issues to focus on implementing the actions contained within the Urgent and Emergency Care improvement plan. **Elective waiting list:** In December, the trust submitted a plan to NHSE which supports no patient wating greater than 65 weeks for treatment at the end of March 2024. It should be noted that the ongoing industrial action may impact on the deliverability of this plan. In December, the trust reported 1 78ww and 220 65ww. **Cancer** Performance remained challenged in month with the Trust achieving 72.4% against the Faster Diagnosis Standard (FDS. There is an ongoing focus on reducing the waiting time to first appointment to 7 days and on reducing diagnostic delays. Robust PTL meetings continue with a focus on expediting patient pathways. In addition, the Trust are planning a “Focus on Cancer Week”.	 **Charlotte O’Brien** Chief Operating Officer

Actions:

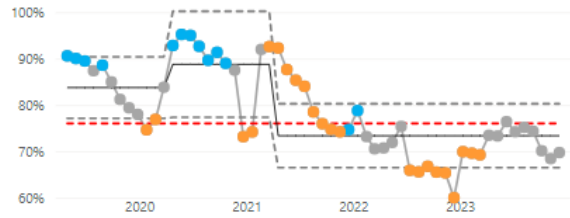
- Delivering on the agreed actions from the Urgent Care Improvement Plan to support delivery of the 76% Emergency Access Clinical Standard in March 2024.
- Focus on 28 day FDS achievement across all departments, reducing the 62-day backlog and eliminating 104 day waits.
- Delivering the revised trajectories for performance against the 4 hour clinical ED standard, number of 65 week waits, 62day Cancer backlog, and delivery against the Faster Diagnosis Standard that were reprofiled as part of the H2 planning response.

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

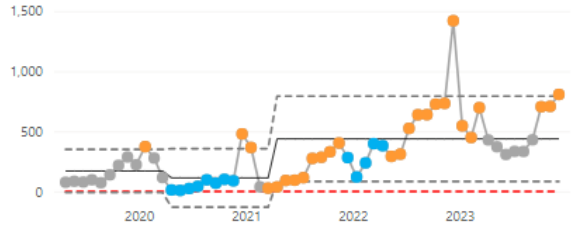
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	69.7%



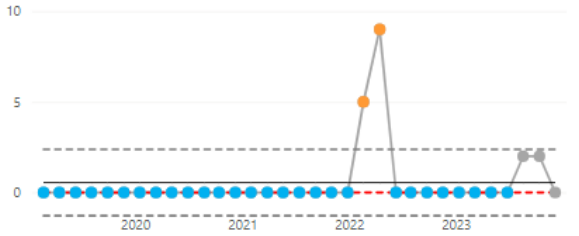
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	807



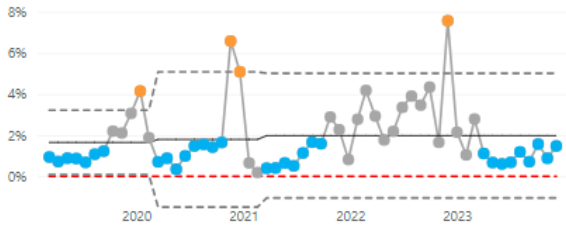
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Common Cause	0



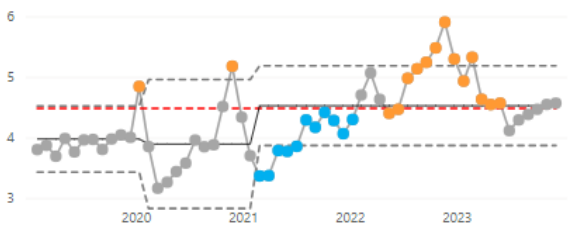
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Improvement	1.48%



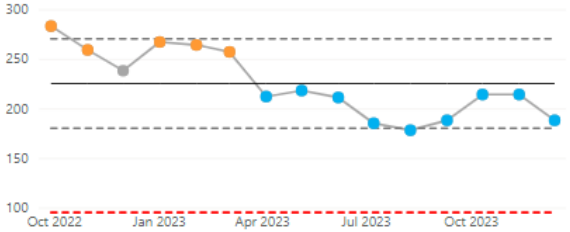
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	4.57



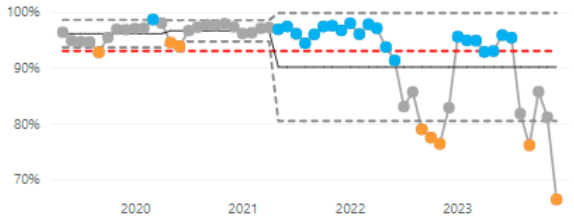
Average daily NCTR: Total, Our Performance

Not Met	Improvement	188



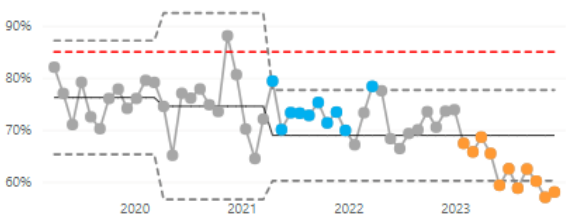
Cancer 2WW: Total, Our Performance

Inconsistent	Concern	66.3%



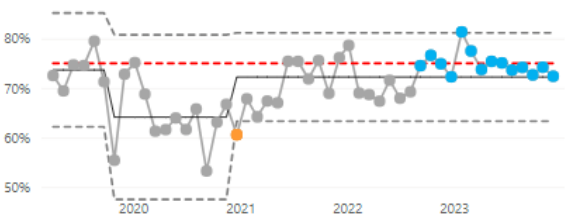
Cancer 62 Day: Total, Our Performance

Not Met	Concern	58.0%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	72.4%

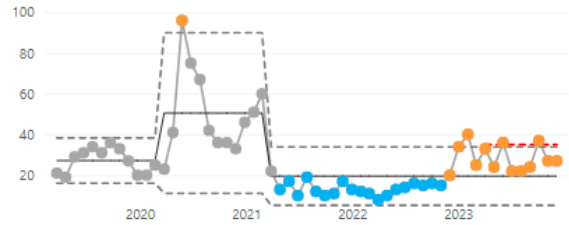


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

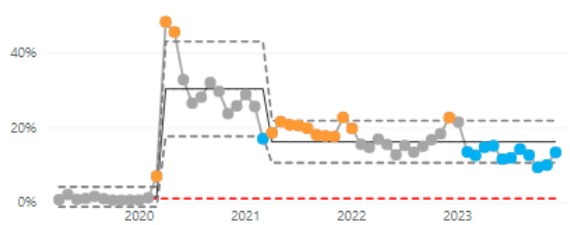
104 day Backlog: Total, Our Performance

Achieving	Concern	27



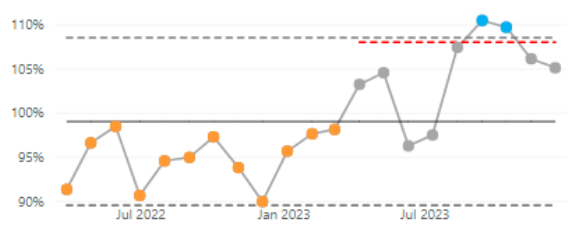
Diagnostic <6 weeks: Total, Our Performance

Not Met	Improvement	13.3%



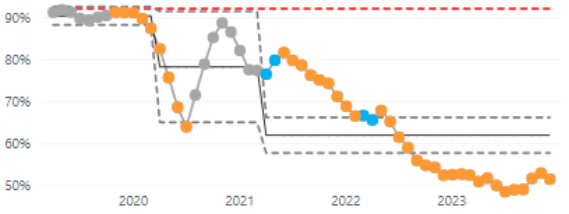
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Inconsistent	Common Cause	105%



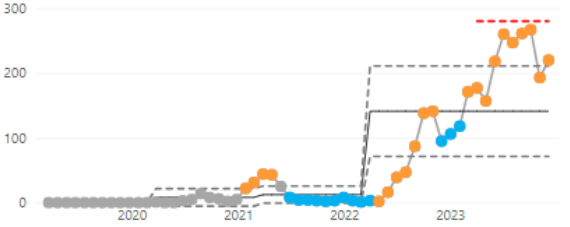
RTT under 18 weeks: Total, Our Performance

Not Met	Concern	51.4%



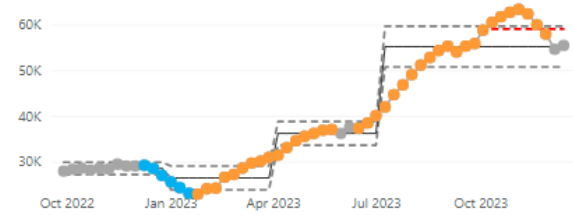
RTT 65 week wait: Total, Our Performance

Achieving	Concern	220



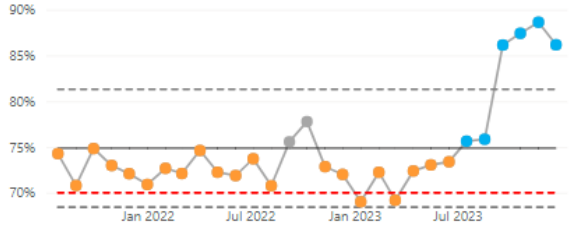
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Common Cause	55384



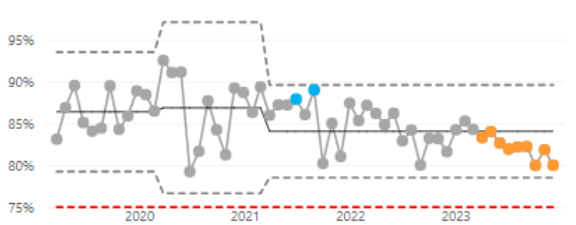
Urgent Community Response within 2 hours: Total, Our Perf...

Inconsistent	Improvement	86.2%



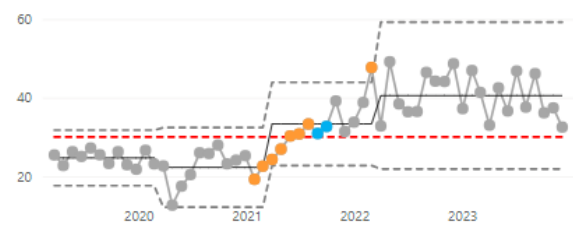
CHIC wait times < 13 weeks: Total, Our Performance

Achieving	Concern	80.0%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	32.5



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	76% patients should be seen and discharged, treated or admitted within 4 hours, the Trust achieved 69.7% against the standard in December 2023.	• Protecting CDU capacity for ED patients, increasing streaming to Specialty SDEC areas • Clinical leadership training to reduce waiting times overnight. • Medical workforce review- ensuring rotas are aligned to known patterns • Establishing Minor Clinics
Patients in department over 12 hours from arrival to discharge	There was an increase in November for the number of patients waiting over 12 hours from arrival to discharge from 708 in November to 807 in December.	• Continued work with system partners around timely support for patients awaiting mental health review / assessment and or mental health bed. • Ongoing focus on maintaining reductions in LOS and the number of NCTR patients in both the acute and community bed base to support flow out of ED for patients who require admission • Early escalation and actions to reduce risk
Conveyance Handover >60 mins	The percentage of conveyed patients handed over >60 mins was 1.48%	• Continue to work on key actions that will improve the efficiency of the handover process including optimising the Rapid Assessment and Triage model.
Non elective Length of Stay	In December the Trusts non-elective LOS was 4.57 days versus a target of 4.48 days	• At the end of December 2023 – the number of patients not meeting the criteria to reside reduced to 177. • Over 21 days LOS – At the end of December 2023 the number of patients with a LOS >21 days reduced to 122. 6 patients were >100 days. • Divisional teams continue to undertake length of stay reviews for patients over 7, 14 and 21 days • CNO led daily P0 patient reviews with the divisional ADNs • Daily P1-3 reviews led by the TOCH for all patients not meeting the criteria to reside.
Elective Activity	In December the Trust delivered 105% of 2019/20 baseline activity levels. First Outpatient Appointment activity continues to exceed 108%, with a further focus required to increase admitted activity (both day case and Elective inpatients) and reduce non-value weighted FU activity.	• Outpatient productivity programme underway • Theatre productivity programme in place. • Review of pre-assessment capacity to support theatre utilisation. • Continued and improved utilisation of the Care Coordination Service to support more efficient waiting list management and improve utilisation. • Review of counting and coding to ensure accurate capture of activity.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The number of patients waiting more than 62 days on a Cancer pathway was 169 patients (versus a trajectory of 175) as at the end of December. The Trust reported 46 >104 waits at the end of December against a trajectory of 27. Long waiting patient delays are caused by complex pathways, diagnostic delays and tertiary centre delays. The Cancer Waiting Time Standards remained challenged in November (FDS 72.4%, 31 Day 92.2% and 62 Day 58%.). This includes referrals from all routes i.e. GP, Screening, Upgrades, Breast Symptomatic in line with the new Cancer Waiting Times Guidance introduced in October 2023.	• Twice weekly PTLs in place to focus on reducing the number of patients in the >62 day backlog and to expedite key pathway milestones. • Weekly focus on patients waiting >104 days and patients approaching >104 days. • For patients who have been transferred, ongoing partnership work with key providers (e.g. GSST), to ensure delivery of diagnostics or treatment in a timely way. • "Cancer Week" in February to focus on patient treatments and support recovery. • Additional nursing resource in place following successful bid to SSCA • Regular Breach Analysis Reports circulated to identify bottlenecks in pathways. • Bids to the Surrey and Sussex Cancer Alliance prepared for submission for 24/25 to support improvement of pathways.
RTT long wait position (78 and 65 weeks)	In December, the trust submitted a trajectory to NHSE which delivers zero 65ww by the end of March 2024. This remains the aim of the trust but may significantly impacted by Industrial Action. In December, the trust reported 220 65ww. Although December's 65ww position represents an increase of 17 from November it was significantly below the trajectory of 355. There is high confidence that January's trajectory target of 298 65ww will be achieved, and that there will be zero 78ww.	• Current 65ww cohort and actual volumes have been reviewed at specialty level. • Trajectories have been calculated at specialty level based on existing demand and capacity assumptions. • Weekly DCOO led review of all >78 week risks • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Utilisation of SPH where possible to support long wait position. • Exploring mutual aid, both via the ICS and the Digital Mutual Aid System, including PIDMAS. • Targeted validation. • Increasing FOPA attendances. • Specific challenge in Neurology, Urology, ENT and Gynaecology. • Below/at tariff insourcing options being reviewed across all specialties. • The trust is being asked to work with system partners to support a reduction in 65-week waits in other key specialties including Cardiology.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT Total Waiting List Size	The overall waiting list for elective care has decreased by 12.5% since reaching its peak in July 2023 when there were 63301 patients on the RTR PTL. In December, the Trust had 55384 patients on the PTL, a reduction of 342 from the previous month. Whilst the volume of patients on a referral-to-treatment (RTT) pathway continues to be significantly higher than 19/20, the impact of the targeted technical validation; increased activity and pathway changes have all contributed to the waiting list reduction	• Review of insourcing in a range of specialities to support a reduction in waiting times for patients on a RTT pathway. • Continued focus on validation and pathway management to ensure a more accurate PTL, and support the development of modernised pathways, training and better use of digital technology. • RTT refresher training to support pathway management
Diagnostic DMO1	DMO1 compliance was reported at 86.69% in December, a reduction of 3.34% on the November position. In month improvements seen in Echocardiography and Audiology, with challenges in Endoscopy and Radiology (particularly MRI). The Trust anticipates achieving 95% at the end of March 24. Overall, the waiting list reduced by 679 during December with the total waiting list standing at 6986.	• Review of booking arrangements to ensure all lists are fully utilised. • Cardiac Echo- plans to reduce the overdue surveillance backlog by 100 per month, being implemented (decrease of approximately 350 patients to date). Insourcing to continue until end of March 24.
Community Waiting Times	The Trust's most challenged community service in terms of waiting times continues to be Paediatrics, with demand continually outstripping capacity. Outsourcing to Psicon continues and this has supported a decrease in the waiting list for New appointments over the last 12 months (from 2580 to 2175). The number of children waiting over 3 years has also decreased from 82 in Dec 22 to 1 in Dec 23. The number of children waiting over 18m has reduced from 663 in Dec 22 to 179 in Dec 23.	• Outsourcing to Psicon ongoing • Ongoing recruitment initiatives to support the service. • Pathway redesign work continues for Sleep/melatonin, supported by the ICB. • Ongoing validation of the community waiting list for NEW and FU patients. • Work continues with system partners to develop a sustainable plan to address the growing backlog.

East Sussex Healthcare NHS Trust

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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| Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	• In month deteriorated from a £5,292k surplus to a £2,881k deficit, this was driven by significant one of movements accounting for the difference plus additional IA costs in M8. Some small underlying improvement • ERF outperformed in month with actual of £7,701k compared to plan of £7,540k. • Efficiency deteriorated from £2,632k to £2,396k • Capital spend is £12,575k behind plan	Risk analysis shows a potential range from £10.2m deficit position for the downside to a £5.4m deficit against the base case, this is a material change since M8. The M8 forecast was predicated on the assumption that further industrial action did not occur (£3.9m impact) and a baseline adjustment to ERF was honoured (£1.5m), this have not proven the case which has resulted in this change.	 **Damian Reid** Chief Financial Officer

Overview:

I&E: M9 is a deficit of £2.9m taking the YTD to a deficit of £2.5m. This is driven by a change in the ERF baseline where we had expected a 2% reduction for Sussex activity, the YTD impact recorded in month was £1.1m (£1.5m FOT) and cost accounted for against the industrial action of £1.4m in month.

Run rate: The underlying run rate has improved from the prior month at £1.3m deficit in month (up from £1.8m). To Breakeven run rate needs to reduce by £2.1m per month, a straight-line forecast would therefore suggest a forecast deficit of £5.3m.

Efficiency: The Divisions have delivered £20.0m efficiency YTD against the plan of £22.3m resulting in £2.3m adverse position. This is largely associated with the ERF delivery and LoS this is offset by vacancy slippage and the CNST maternity rebate. The RAG is amber due to 50% of the YTD actual being non-recurrent and there is slippage in ERF delivery of £2.5m (£0.3m less than M8), which is being offset by vacancy slippage.

Capital: Total plan for 2023/24 is £64.7m. The capital plan is backloaded and expenditure is behind plan at M9 by £12.6m. FOT is a £2.9m underspend however mitigations to address this are being investigated.

Exec summary

East Sussex Healthcare NHS Trust

£m	RAG	YTD Plan	YTD actual	Var F/(A)	Commentary
Surplus/deficit	A	0.0	(2.5)	(2.5)	• M9 is a deficit of £2.9m taking the YTD to a deficit of £2.5m. This is driven by a change in the ERF baseline where we had expected a 2% reduction for Sussex activity, the YTD impact recorded in month was £1.1m (£1.5m FOT) and cost accounted for against the industrial action of £1.4m in month. Pressures on Non Pay continued for the third month in a row of £1.8m (up to £6.4m now M6-9). Pay run rate did decrease in month by £0.9m but there was still a budget variance of (£1.0m).
Income	G	486.5	493.6	7.1	• Income is £7.1m surplus to plan YTD driven by underperformance against elective activity targets of £0.3m and Pay award shortfall of £1.8m, offset by the IA and deficit funding received in month of £7.5m and cost and volume Drugs/Devices £1.3m.
ERF activity	G	76.4	73.9	(2.6)	• ERF is under plan by £2.6m YTD. With National adjustments to plan this reduces the gap to £0.6m. Catch up from prior months happening each month. • We have noted material movements in the data for Freeze so the underlying position may improve (but this will not affect the bottom line due to clawback mechanism)
Pay	A	(327.5)	(330.4)	(2.9)	• Pay cost is (£2.9m) overspent ytd driven by Industrial Action cover costs at £2.1m ytd alongside premium costs in Urgent Care/Med/DAS, offset by vacancies ytd and reserves released of £1.0m. M9 saw a run rate decrease of £0.9m across Permanent/Agency/Bank. • The Trust is using 5% more contracted staff than in 22/23 month 9.
Non-pay	R	(159.0)	(165.7)	(6.7)	• Non-pay costs adverse to plan ytd, with LA supported funding partly offsetting high non pay spend across most Divisions in month, a continuing trend M6-9. Overall LA funding support ytd of £1.9m offsetting pressures in Med/UC/Theatres alongside inflationary pressures Trust Wide of £4.5m and Drugs £2.2m.
Efficiency	A	22.3	20.0	(2.3)	• The Divisions have delivered £20.0m efficiency YTD against the plan of £22.3m resulting in £2.3m adverse position. This is largely associated with the ERF delivery and LoS this is offset by vacancy slippage and the CNST maternity rebate. The RAG is amber due to 50% of the YTD actual being non-recurrent and there is slippage in ERF delivery of £2.5m (£0.3m less than M8), which is being offset by vacancy slippage.
Capital	A	29.4	16.8	12.6	• Total plan for 2023/24 is £64.7m. The capital plan is backloaded and expenditure is behind plan at M9 by £12.6m. FOT is a £2.9m underspend however mitigations to address this are being investigated.
Risk	R	n/a	n/a	n/a	• Risk analysis shows a potential range from £10.2m deficit position for the downside to a £5.4m deficit against the base case, this is a material change since M8. The M8 forecast was predicated on the assumption that further industrial action did not occur (£3.9m impact) and a baseline adjustment to ERF was honoured (£1.5m), this have not proven the case which has resulted in this change. • We are seeking approval to amend the official forecast to a £5.4m deficit

Income and Expenditure

East Sussex Healthcare NHS Trust

Finance

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	46,134	46,419	*286*	419,546	426,264	*6,717*
Divisional	6,713	6,656	*(56)*	61,581	60,494	*(1,088)*
ERF	578	500	*(78)*	5,196	6,650	*1,454*
Covid - variable	20	33	*13*	177	184	*7*
Total Income	**53,444**	**53,609**	***165***	**486,501**	**493,592**	***7,091***
Operating Expense						
Pay						
Permanent	(35,424)	(32,487)	*2,936*	(321,993)	(288,621)	*33,373*
Temporary	(684)	(4,603)	*(3,919)*	(5,355)	(41,671)	*(36,316)*
Total pay	**(36,108)**	**(37,090)**	***(983)***	**(327,349)**	**(330,292)**	***(2,943)***
Non-pay						
Drugs	(1,128)	(1,349)	*(221)*	(10,083)	(12,253)	*(2,170)*
TEDD	(3,477)	(3,607)	*(130)*	(31,315)	(34,580)	*(3,265)*
Clinical supplies	(4,683)	(5,322)	*(640)*	(39,093)	(39,754)	*(661)*
Purchased services	(1,155)	(1,177)	*(22)*	(10,523)	(11,460)	*(937)*
Finance costs	(2,498)	(2,517)	*(19)*	(22,482)	(22,461)	*21*
Other	(4,425)	(5,418)	*(993)*	(45,479)	(44,983)	*495*
Total non-pay	**(17,366)**	**(19,390)**	***(2,025)***	**(158,975)**	**(165,491)**	***(6,516)***
Covid exp - block	-	(24)	*(24)*	-	(132)	*(132)*
Covid exp - variable	(17)	(31)	*(14)*	(149)	(164)	*(14)*
Total Expense	**(53,490)**	**(56,535)**	***(3,045)***	**(486,473)**	**(496,078)**	***(9,605)***
Surplus/(Deficit)	**(46)**	**(2,926)**	***(2,881)***	**28**	**(2,487)**	***(2,515)***

I&E position

- M9 is a deficit of £2.9m taking the YTD to a deficit of £2.5m. This is driven by a change in the ERF baseline where we had expected a 2% reduction for Sussex activity, the YTD impact recorded in month was £1.1m (£1.5m FOT) and cost accounted for against the industrial action of £1.4m in month. Pay and non-pay both materially overspent in month, however did reduce on an underlying level. ERF performance was good despite industrial action.

Income

- The position is surplus by (£7.1m) ytd, the main drivers being;
  - Industrial Action and deficit funding of £5.5m received in Month 9.
  - Lower than planned elective activity against target by £0.6m (partially offset by lower associated costs), this is after the 2% baseline adjustment, underlying position is £2.6m shortfall.
  - Note that the Doctors' strike days would have contributed in part to this in April (15% of working days impacted) ,June (16%), July (16% Junior plus Consultant days) Aug (16%) Sept (15%) Oct (15%) and Dec (13%).
  - Pay Award income shortfall (offsetting pay variance) of £1.8m for M1-9.

Expense

- The Trust has a (£2.9m) adverse pay position YTD. In December Permanent/Agency/Bank costs reduced by £0.9m across all Divisions, however budget variance was still (£1.0m). Temporary and premium staffing costs in Urgent Care and DAS plus Industrial Action cover costs of £2.1m ytd. Offset by CDC and VW vacancies alongside reserves release of £1.0m.
- All pay awards now processed for 23-24. An overall shortfall of commissioner income of £2.3m FYE, but partly offset by vacancy .
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget but still overspent.
- Month 9 Non pay was £2.0m overspent of which continuing pressures against Theatres, Core and Medicine plus other pressures, so four months of higher spend. IA costs of £0.7m also reflected in NP for M9. Overall overspend M1-9 of £6.7m is supported by reserves of £1.7m, so net non-pay is actually pressured ytd due to inflationary pressures and Drugs activity.

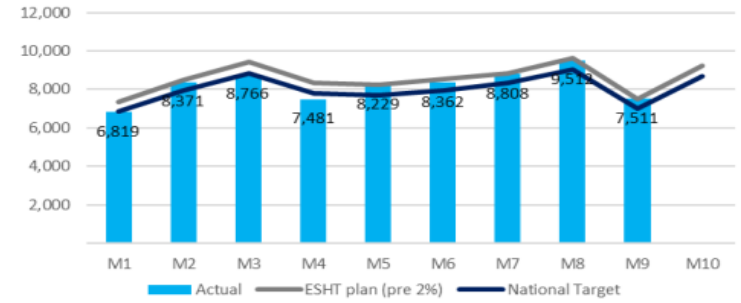
ERF - Trust

East Sussex Healthcare NHS Trust

ERF performance

- Prior to adjustments, the Trust underperformed its internal plan by £0.03m in month, taking the total underperformance to £2.6m.
- Post adjustments the Trust overperformed against its plan by £2.0m in month and £1.5m YTD based on initial data. The includes the 4% national reduction to the ERF target and the recording of SPH against ERF income.
- T&O represents the majority of the underperformance, with Cardiology also exhibiting a material adverse variance.

ERF performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	2,772	2,796	24	0.9%	27,158	26,452	(705)	(2.6%)
Elective	1,685	1,723	37	2.2%	19,016	15,744	(3,272)	(17.2%)
New OP	1,451	1,393	(58)	(4.0%)	14,509	14,242	(267)	(1.8%)
OP Procedures	1,562	1,395	(167)	(10.7%)	15,137	15,297	160	1.1%
Ward Attenders	70	121	51	73.1%	637	1,375	739	116.0%
ERS	-	83	83		-	749	749	
Internal plan	**7,540**	**7,511**	**(29)**	**(0.4%)**	**76,456**	**73,859**	**(2,597)**	**(3.4%)**
Baseline Adj	(47)	-	47		(1,964)	-	1,964	
Prior period catch-up	-	(175)	(175)		-	-	-	
SPH	-	234	234		-	2,095	2,095	
I&E impact	**7,493**	**7,570**	**77**	**1.0%**	**74,492**	**75,954**	**1,462**	**2.0%**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Haematology Service	207	140	(67)	2,111	1,992	(119)
Gynaecology Service	500	434	(67)	4,855	4,860	5
Cardiology Service	631	568	(63)	6,275	5,197	(1,078)
Interventional Radiology Servi	62	0	(62)	599	228	(371)
Maxillofacial Surgery Service	164	107	(57)	1,454	1,171	(283)
Clinical Oncology Service	146	91	(56)	1,552	1,066	(486)
Respiratory Medicine Service	160	109	(51)	1,638	1,155	(483)
Orthodontic Service	64	18	(46)	496	247	(249)
Neurology Service	133	91	(42)	1,076	1,047	(29)
Ear Nose and Throat Service	333	295	(38)	3,444	2,880	(564)
Vascular Surgery Service	61	48	(13)	524	361	(163)
Transient Ischaemic Attack Se	41	30	(11)	416	346	(70)
Paediatric Service	137	129	(8)	1,280	1,411	131
Trust	7	-	(7)	63	-	(63)
Stroke Medicine Service	5	2	(3)	57	33	(24)
Paediatric Epilepsy Service	5	4	(1)	28	42	15
Paediatric Trauma and Orthop	-	-	-	-	-	-
Plastic Surgery Service	-	-	-	-	6	6
Paediatric Dermatology Servic	-	-	-	-	-	-
Chemical Pathology Service	12	12	0	132	114	(18)
Hepatology Service	-	0	0	-	3	3
Palliative Medicine Service	0	1	1	2	7	5
BCSP	23	25	2	192	305	113
Endocrinology Service	37	39	2	431	471	41
Anaesthetic Service	5	8	3	86	88	1
Diabetes Service	7	11	4	70	109	39
Respiratory Physiology Service	34	39	5	445	348	(97)
Breast Surgery Service	184	189	5	1,830	1,819	(12)
Elderly Medicine Service	18	29	11	250	239	(11)
Rheumatology Service	196	221	25	1,992	2,023	31
General Internal Medicine Ser	10	45	34	163	226	63
Trauma and Orthopaedic Servi	1,413	1,459	46	14,629	12,593	(2,036)
Urology Service	661	709	48	6,835	7,269	435
Acute Internal Medicine Servic	-	58	58	-	456	456
Gastroenterology Service	445	505	60	4,621	4,490	(131)
General Surgery Service	778	849	71	8,016	8,236	221
Dermatology Service	172	247	75	1,780	2,069	289
Ophthalmology Service	880	982	102	9,030	10,780	1,750
Sub total	**7,540**	**7,511**	**(29)**	**76,456**	**73,859**	**(2,597)**

Pay costs

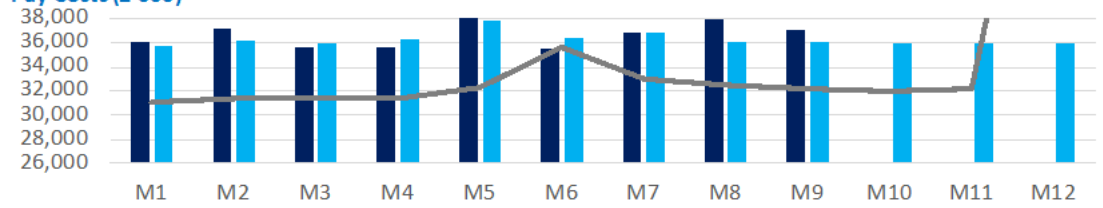
East Sussex Healthcare NHS Trust

Pay analysis

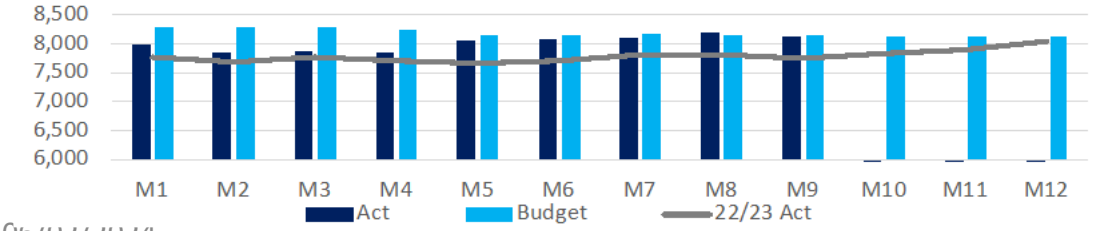
All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(8,774)	(657)	(8,155)	(4,713)	(8,565)	907	41	841	8	872
Nursing	(14,664)	211	(13,838)	(399)	(14,636)	3,760	(98)	3,630	(103)	3,729
AHP	(4,984)	444	(4,302)	4,219	(4,889)	1,252	(104)	1,121	(120)	1,216
Admin	(4,299)	162	(3,821)	1,870	(4,197)	1,377	(74)	1,294	(85)	1,360
Other	(4,369)	(1,143)	(2,818)	(3,919)	(4,413)	836	212	817	100	843
Total	**(37,090)**	**(983)**	**(32,935)**	**(2,943)**	**(36,699)**	**8,132**	**(23)**	**7,703**	**(200)**	**8,020**

Temporary	Pay costs (£'000)					WTE				
	Oct	Nov	Dec	PY	YTD	Oct	Nov	Dec	PY	YTD Ave
Bank	**(1,731)**	**(2,182)**	**(1,921)**	**(1,907)**	**(17,548)**	**535**	**554**	**448**	**483**	**491**
Medical	(328)	(505)	(323)	(361)	(3,064)	22	28	25	29	25
Nursing	(312)	(363)	(395)	(332)	(3,422)	69	73	63	63	61
AHP	(156)	(170)	(111)	(53)	(1,455)	22	22	16	12	23
Admin	(102)	(174)	(102)	(14)	(1,014)	8	8	7	2	6
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(898)**	**(1,212)**	**(930)**	**(761)**	**(8,955)**	**121**	**131**	**110**	**106**	**116**
Locum	**(1,370)**	**(1,212)**	**(1,282)**	**(1,113)**	**(11,946)**	**107**	**99**	**102**	**69**	**105**
WLI	**(429)**	**(452)**	**(470)**	**(322)**	**(3,194)**	**43**	**45**	**42**	**38**	**40**
Total Temp	**(4,428)**	**(5,057)**	**(4,603)**	**(4,102)**	**(41,644)**	**806**	**829**	**703**	**696**	**752**

Pay Costs (£'000)



WTEs



Pay analysis

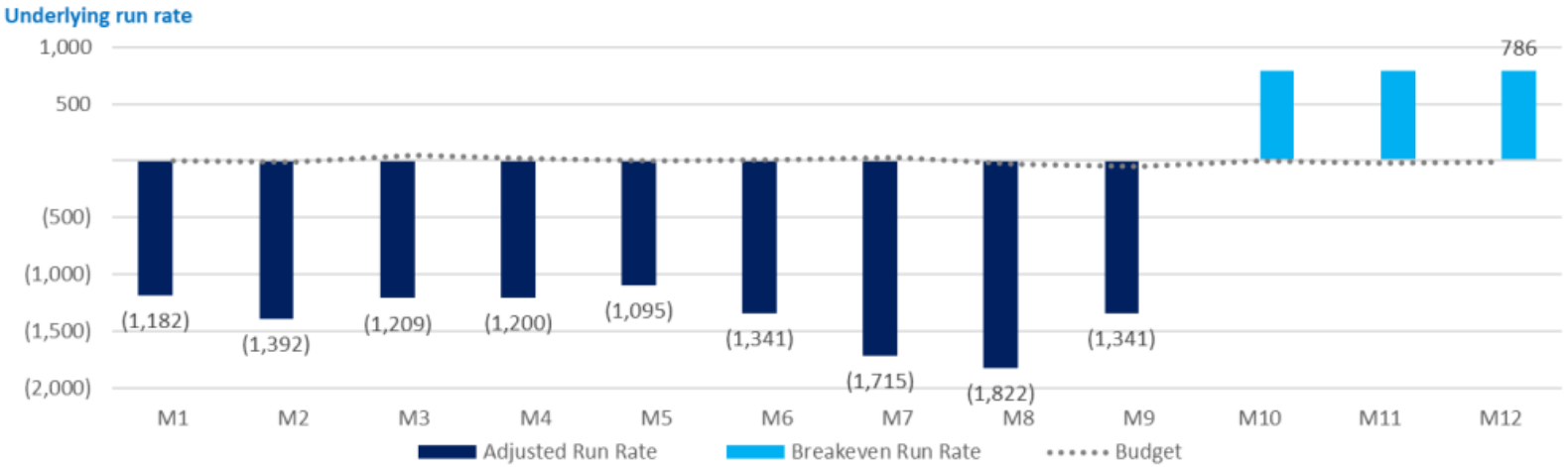
- M9 pay costs are higher than budget due to increased perm/Agency and Bank across the Trust. Partially offset by released reserves, vacancies within CDC and VW (income funded schemes). IA £0.7m in month.
- Overall the in month spend of £37.1m is £4.2m higher than 22-23 comparator due to investment in Urgent Care, CDC and Virtual Ward, aligned with material central changes being smoothed over the 23-24 year.
- AFC Pay Award for 23-24 was processed in month 3. Overall increase in budget of £17.2m. Potential income shortfall of approx. £2m fye.
- M&D Pay Award processed M7, increase to budget of £6m. Income shortfall approx. £0.3m fye.
- Nursing & Medical staffing groups are over spending, mainly linked to Medicine/UC/DAS.
- Nursing spending is impacted by the continuation of escalation wards (extra beds above funded) and supernumerary double running costs.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive, especially in Urgent Care for Senior Medical posts.
- YTD Industrial action cover costs of £2.1m in spend.

PY comparison

- Pay (£) is overall is above the 22/23 comparator as described above.
- Pay WTE is higher than the prior year comparator aligned to the investments above.
- Pay WTE is 429 fte higher.

Run Rate

East Sussex Healthcare NHS Trust



Methodology

- Adjustments have been made to show underlying run rate. These account for one off/non-recurrent items unrelated to the activities in month (e.g. credit note received from prior year) and for catch up where cost or income relating to multiple periods in reflected in one months ledger.
- One-off items - whilst removed from the run rate - will impact the required run rate to achieve breakeven and this has been accounted for.

Run rate

- The graphs shows a run rate of (£1.5m). The analysis has removed net £9.5m of one-off items which whilst don't impact the run rate will still impact the in year financial position, including IA funding received in M9 of £5.5m. Driven by:
  - £1.8m of ERF non-clawback, depending on further guidance received this may be considered a non-adjusting item (as a result of compensating for strike actions);
  - £1.5m of contract income phasing which will reverse over the course of the year. Contract income has been phased to deliver a balanced plan each month meaning as a result of CIP phasing, additional amounts are recognised early in the year compared to a flat line profile.
- M9 underlying run rate is a (£1.3m deficit), this is in £0.6m lower than the previous month (£1.8m deficit), with the pay run rate lowering this month compared to M8. Taking the current average months run rate and extrapolating gives an overall deficit of £15.8m. Decrease in month due to high non pay costs for third month in a row but a decrease on Pay run rate of £0.9m. Funding has been received for M8 for Industrial Action but this is not seen as part of the regular spend/income so for this reporting has been removed.
- Further mitigations will be required from divisional management to ensure progress is made to reduce run rate to the required level by Mar-24, currently around a £2.1m reduction per month compared to M9.

Divisional Summary

East Sussex Healthcare NHS Trust

Finance

Divisional position

Division	Variance to budget - M9							YTD overall Variance	Underlying Run Rate			
	Contract Income	Divisional income	Pay	Non pay	Overall Variance	M8 Variance	WTE		Oct	Nov	Dec	
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000	
CHIC	-	(60)	63	(67)	(64)	(53)	(10)	(447)	(4,147)	(4,102)	(4,196)	q
Core Services	(54)	133	266	(555)	(211)	(319)	(41)	(847)	(6,637)	(6,714)	(6,587)	p
Estates & Facilities	-	(20)	7	(75)	(88)	(242)	(21)	318	(3,114)	(3,270)	(3,370)	q
Medicine	141	(81)	(438)	22	(356)	(189)	+70	(3,716)	(4,048)	(4,384)	(4,594)	q
DAS	74	4	(484)	(390)	(797)	(559)	+49	(5,228)	(3,555)	(2,714)	(4,088)	q
Urgent Care	70	45	(441)	46	(281)	(353)	+57	(2,742)	(4,957)	(5,294)	(4,995)	p
WCSH	(64)	(28)	191	(168)	(69)	95	(38)	330	(2,393)	(2,577)	(2,872)	q
Corporate Services	-	137	61	300	498	(118)	(34)	1,859	(5,272)	(5,315)	(5,063)	p
SPH	-	154	(0)	(60)	94	236	(13)	221	216	431	(72)	q
Central/Trust wide	41	(327)	(207)	(1,114)	(1,606)	6,820	(232)	7,738	32,111	32,037	34,309	p
ESHT	**208**	**(43)**	**(983)**	**(2,063)**	**(2,881)**	**5,318**	(214)	**(2,515)**	**(1,795)**	**(1,902)**	**(1,526)**	p

- **CHIC** – headroom has gradually been reducing as recruitment is catching up to investments and we have now seen in M1-9 overspends in the division for the first time in a number of years. Pay pressures due to Minerva contract supporting Urgent Community response now above budgeted levels, although recent contract held centrally. VW position now showing in Pay and Income.
- **Core Services** – Underspend on pay driven by below budget spend on Pathology cost and CDC underspend, this is matched in income. Non pay pressures M6-M9 attributed to activity aligned to outsourcing in Radiology.
- **E&F** – Overspend driven on pay by Covid legacy costs (eg housekeeping) which are no longer funded. Utilities inflation/usage pressure on non pay M9 due to actual consumption/tariff higher than budgeted, plus Facilities non pay in catering due to Xmas. Tariff element £0.5m underspent ytd.
- **Medicine** – Overspend driven Escalation beds above funded ytd, this is exacerbated by significant service overspends in Gastro, haematology and Cardiology. IA costs £0.5m ytd moved to Central. Supernumerary staffing and premium staffing continues to be a driver of these variances. ERF income underachieved ytd by £1.9m.
- **DAS** – Electivity activity lower than plan ytd with under performance of £0.9m with improvement in T&O in the month. Urology and General & Breast pressures in pay due to premium costs. DAS is also using more staff than budget in some areas (Urology & T&O). IA costs approx. £0.4m ytd moved to Central. Excluding CIP target the division is overall below establishment (also true for Urgent Care). DAS overall is the worst performing division with Medicine and Urgent second and third on the list respectively.
- **UC** – Premium costs for Medical staffing continuing to cause pressures alongside supernumerary staffing. IA costs £0.4m ytd move to Central now.
- **Corporate services** – underspend driven by external training funding, some of which of the costs will be in the divisions, this is reconciled later in the year when schedules received from HEE.
- **SPH** – SPH income for M9 higher resulting in better performance than forecast ytd. Compucare system now being utilised.
- **Central** – Pay costs high in month as IA costs M1-9 moved away from Divisions into one place. Non pay showing £0.8m of IA costs assumed.

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd – M9			Full Year				
	Plan	Actual	Var	Plan	Actual	Var	Rec	NR	Total	Target	Gap
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medicine	975	489	(486)	6,308	3,760	(2,548)	3,190	1,409	4,599	9,247	(4,649)
Urgent Care	248	76	(172)	1,164	1,345	181	865	759	1,624	1,919	(295)
DAS	867	576	(291)	6,629	4,476	(2,153)	4,896	1,083	5,979	9,235	(3,255)
Core Services	428	455	27	2,158	2,601	443	1,494	1,847	3,341	3,504	(163)
CHIC	74	104	30	630	1,383	753	139	1,618	1,757	844	912
WCSH	118	(0)	(118)	1,109	1,781	673	678	1,364	2,043	1,980	62
Estates & Facilities	164	137	(28)	1,406	1,148	(258)	22	1,270	1,292	1,697	(404)
Corporate	308	564	256	2,622	3,492	871	2,618	2,079	4,696	3,538	1,159
Sussex Premier Health	89	(4)	(93)	276	(27)	(303)	(36)	-	(36)	543	(579)
Total	**3,270**	**2,396**	**(875)**	**22,301**	**19,960**	**(2,341)**	**13,866**	**11,429**	**25,295**	**32,507**	**(7,212)**

Overview

- The divisions have delivered £2.4m of efficiencies in the month, this is £0.9m less than the planned value of £3.3m.
- The in-month variance is largely due to Length of Stay, Workforce Controls and Demand Management not achieving the targets, this is offset by over-achievement on Theatres and Improving Patient Data Capture.
- The target for the year is £32.5m, this is made up of the original £25m target plus the stretch target of £7.5m that was needed for the system to deliver a breakeven plan. The full £32.5m has been allocated out to the Divisions based on the Programme opportunities. We are behind plan by £2.3m YTD, this is largely driven by £2.5m under-delivery on ERF (£0.3m less than M8) and LoS not delivering to plan, this is partially offset by vacancy slippage and the CNST rebate (received earlier than planned).
- The current forecast gap has reduced by £0.4m to £7.2m, however the risk adjusted forecast is £23.5m, so the gap is higher at £9m, this is better than last month by £0.5m, this is due to the in-month delivery on Theatres and Workforce Controls being greater than expected.
- Currently 45% of the £25.3m forecast is non-recurrent, of this £10m is vacancy slippage, however the proportion of non-recurrent is 50% on the year-to-date position.

Capital

Trust Lead	Capital Scheme	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Full Year Variance £'000
	Original									
DIG	Digital Programmes	328	972	644	1,782	3,287	1,505	3,500	4,296	796
DIG	Our Care Connected	-	-	-	-	-	-	900	900	-
	Total Digital	**328**	**972**	**644**	**1,782**	**3,287**	**1,505**	**4,400**	**5,196**	**796**
EME	Diagnostic Equipment	350	51	(299)	1,488	327	(1,160)	1,750	1,150	(600)
EME	Medical Equipment	450	354	(96)	1,913	1,338	(574)	2,250	2,300	50
	Total Medical Equipment	**800**	**404**	**(396)**	**3,400**	**1,665**	**(1,735)**	**4,000**	**3,450**	**(550)**
EST	Fire	160	156	(4)	560	944	384	1,600	1,600	-
EST	Backlog	1,233	346	(886)	3,596	2,675	(921)	10,575	8,200	(2,375)
EST	Cath Lab Replacement	-	66	66	1,650	1,649	(1)	1,650	1,650	-
EST	Cardiology Business Case	-	336	336	2,000	856	(1,144)	2,000	2,000	-
EST	Clinical - Prior Year	-	47	47	-	122	122	-	90	90
EST	Decant Ward	50	(7)	(57)	175	519	344	500	600	100
EST	Discharge Lounge	-	-	-	500	453	(47)	500	500	-
EST	Elective Hub	745	10	(735)	2,980	247	(2,734)	7,451	7,451	-
EST	Friston Paeds	-	11	11	375	175	(200)	375	230	(145)
EST	ICU adaptations Conq	-	3	3	50	14	(36)	50	135	85
EST	Ophthalmology Business Case	-	5	5	2,000	589	(1,411)	2,000	1,300	(700)
EST	Ward Refurbishment	125	221	96	625	748	123	1,250	1,250	-
	Total Estates	**2,313**	**1,194**	**(1,118)**	**14,512**	**8,992**	**(5,519)**	**27,951**	**25,006**	**(2,945)**
FIN	Business Case Development	-	-	-	-	26	26	-	-	-
FIN	Divisional Small Works	40	18	(22)	360	104	(256)	500	190	(310)
FIN	Minor Capital	72	242	170	648	578	(70)	900	750	(150)
FIN	Planned slippage/prioritisation	(54)	-	54	(270)	-	270	(521)	-	521
	Total Finance	**58**	**260**	**203**	**738**	**708**	**(30)**	**879**	**940**	**61**
	System Capital	**3,498**	**2,831**	**(667)**	**20,431**	**14,653**	**(5,779)**	**37,230**	**34,592**	**(2,638)**
	New									
EST	Building For Our Future	92	57	(35)	824	579	(246)	1,145	1,145	-
EST/EME	Community Diagnostic Centre	-	145	145	1,000	562	(438)	1,000	715	(285)
EST	Elective Hub EDGH	896	30	(866)	3,582	169	(3,413)	8,956	8,956	-
DIG	Diagnostics Digital Capability (LIMS)	229	49	(179)	229	155	(74)	914	914	-
DIG	Diagnostics Digital Capability (OCS)	113	-	(113)	113	-	(113)	451	451	-
DIG	Diagnostics Digital Capability (Image Sharing)	250	-	(250)	250	197	(53)	1,000	1,000	-
DIG	Frontline Digitalisation (EPR)	-	-	-	-	-	-	4,200	4,200	-
EST	NHP Enabling Fees	994	264	(730)	2,982	521	(2,461)	4,734	4,734	-
EST	Endoscopy	-	1	1	-	1	1	5,000	5,000	-
DIG	Cyber Improvement Programme	-	-	-	-	-	-	34	34	-
	Total Additional Capital	**2,572**	**545**	**(2,027)**	**8,980**	**2,184**	**(6,797)**	**27,434**	**27,149**	**(285)**
	Total Capital	**6,071**	**3,376**	**(2,694)**	**29,411**	**16,836**	**(12,575)**	**64,664**	**61,740**	**(2,923)**
EST	PSDS3	-	-	-	-	2,454	2,454	165	165	-
EST	PSDS3 Income	-	-	-	-	(2,454)	(2,454)	(165)	(165)	-
	Total Grant Capital	**-**	**-**	**-**	**-**	**0**	**0**	**-**	**-**	**-**
FIN	Donated Expenditure	120	(104)	(224)	1,080	65	(1,015)	1,500	1,500	-
FIN	Donated Income	(120)	(12)	108	(1,080)	(65)	1,015	(1,500)	(1,500)	-
	Total Donated Capital	**-**	**(115)**	**(115)**	**-**	**-**	**-**	**-**	**-**	**-**
	Total Capital	**6,071**	**3,261**	**(2,810)**	**29,411**	**16,836**	**(12,575)**	**64,664**	**61,740**	**(2,923)**

East Sussex Healthcare NHS Trust

Capital

- The planned capital allocation for 2023/24 is £64.7m and is made up of the core ICS allocation of £37.2m plus national programmes expected in year of £27.4m.
- The capital expenditure incurred totals £16.8m compared to a plan of £29.4m. The current position is therefore behind plan by £12.6m. The plan is back loaded in-line with trends from previous years and the major national schemes that are scheduled to deliver in Q4.
- Capital expenditure was largely driven by the following schemes:
  - Digital equipment, clinical systems, infrastructure and EPR £3.3m.
  - Medical and diagnostic equipment £1.7m.
  - Estates works of £9.0m, the main schemes being fire compartmentalisation (£944k), backlog maintenance (£2,675k), cath lab replacement (£1,649k), decant ward (£519k), discharge lounge (£453k), ophthalmology business case (£589k), and ward refurbishments (£748k).
  - Community Diagnostics Centre £562k which combines costs for both equipment and works.
  - Building for Our Future £579k.
  - NHP Enabling Fees £521k.
- The Elective Care Hub is split funded partly from system funding (£7.5m) and national PDC schemes (£9m). The scheme is behind plan with expenditure of £416k ytd.
- The national schemes total a possible £27.4m of additional capital funding to be drawn. However, cash cannot be drawn in advance of capital commitment and cannot be carried over. £1.0m has been drawn to date and a further £1.0m has been requested.
- A forecast has been worked through and indicates a projected underspend of £2.9m at year-end. However, the Trust is working through a range of options and monitoring the situation closely to try and mitigate the risk of under delivery.

Assets and Liabilities

East Sussex Healthcare NHS Trust

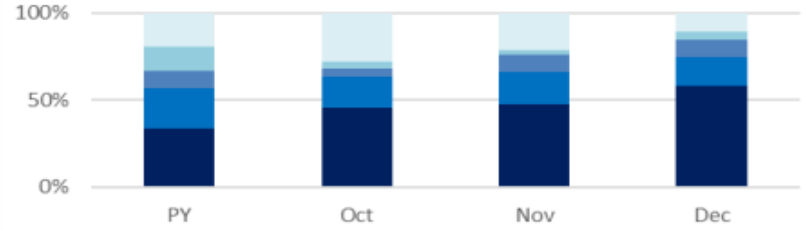
Trust Assets and Liabilities

	Oct £'000	Nov £'000	Dec £'000	Change £'000
Non-current assets	**348,453**	**349,363**	**349,282**	**(81)**
Inventories	9,006	8,810	9,429	619
Trade and other receivables	37,246	50,503	56,411	5,908
Cash and Cash equivalents	43,756	42,603	39,954	(2,649)
Current Assets	**90,008**	**101,915**	**105,794**	**3,879**
Trade and other payables	(56,210)	(61,509)	(63,217)	(1,708)
Other liabilities	(14,590)	(15,908)	(21,941)	(6,032)
Current Liabilities	**(70,800)**	**(77,417)**	**(85,157)**	**(7,740)**
Non-current liabilities	**(11,371)**	**(11,371)**	**(10,411)**	**960**
Total assets employed	**356,291**	**362,491**	**359,508**	**(2,982)**

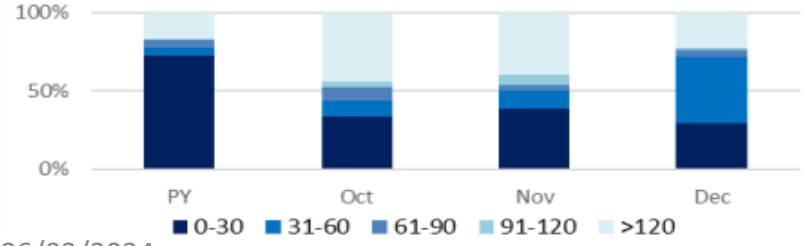
BPPC (Based on invoice count)

Trade	85.3%	86.4%	87.2%	0.8%
NHS	95.6%	95.4%	95.3%	-0.1%

Trade Payables Ageing



Trade receivables Ageing



Balance sheet

- There has been a slight decrease in non-current assets in month 9.
- Current assets has increased in month by £3.9m, this is due to an increase in Trade and Other Receivables of £5.9m relating to income accruals, offset by a decrease in cash of £2.6m. Inventories has increased by £0.6m.
- There were 4 weekly payment runs in December. The average payment run value was £4.3m.
- Current liabilities has increased in month by £7.7m due to an increase in expenditure accruals and an increase in the level of deferred income.
- The Trust continues to hold significant cash balances at £40.0m.

Better Payment Practice Code (BPPC)

- An increase in BPPC for Trade and a slight decrease for NHS in month. Where possible, the Financial Services team continue to prioritise performance, with non-NHS payables a particular focus. Poor performance is largely due to issues with no purchase orders quoted on invoices or raised, or delays to receipting of goods and services.

Trade and Other Payables

- An increase in month of £0.8m on the creditor position increasing the purchase ledger total to £11.8m. The number of invoices registered on the system is 5,053, a decrease of 537 in month.
- 87% of the outstanding invoices are payable to trade (Non-NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.
- Most aged invoices are stuck in the system due to issues relating to the 'No PO, No Pay' policy.

Trade and Other Receivables

- The sales ledger balance increased by £4.2m in month to a total of £9.9m.
- The invoice count on the sales ledger is 1,995, a decrease of 172 in month.
- The ageing profile of debt due has increased by £3.5m in month and now totals £7.0m.

Risk adjusted forecast outturn (1 of 2)

East Sussex Healthcare NHS Trust

- The base case now includes the funding given in M9 for IA and deficit funding.
- Risk analysis shows a potential range from £10.2m deficit position for the downside to a £5.4m deficit against the base case, this is a material change since M8. The M8 forecast was predicated on the assumption that further industrial action did not occur and a baseline adjustment to ERF was honoured, this have not proven the case which has resulted in this change – see next slide.
- We are seeking finance committee approval to adjust the official Trust forecast for M10 reporting in conjunction with the ICB and UHSx to a £5.4m deficit

	Downside £'000	Base £'000	Upside £'000	Commentary
M9 YTD	**(2,514)**	**(2,514)**	**(2,514)**	
Underlying Runrate	(7,317)	(4,878)	(3,969)	**Base/Upside**: Extrapolation of Month 9 run rate average of last 3 months shows net pressures once risk accounted for elsewhere. **Downside** assumption of current runrate extrapolated with no improvement.
Runrate Extrapolation	**(9,831)**	**(7,392)**	**(6,483)**	
Recovery Actions	1,463	1,950	2,600	**Base/Upside**: Current recovery plan assumes £2.6m of improvements from M9-12 with robust challenge on recruitment/non pay and maximising income, this has been adjusted for now being in M10. **Downside** assumption that 75% of this improvement found.
Balance Sheet Adjustments	1,125	1,500	2,000	**Base/Upside**: Current recovery plan assumes £2.0m of improvements from M10-12 of accounting treatments and review of all methods of accruals and assumptions, £1.5m remains available. **Downside** assumption that 75% of this improvement found.
Efficiency Improvement	-	700	1,050	*Overall target of £32.5m in 23.24* **.** **Base/Upside**: Assumes M10-12 improvement will impact upon current CIP delivery and FOT and give improved outcomes. **Downside** assumption no extra CIP found on top of FOT.
January IA costs	(1,420)	(1,420)	-	*Increasing expenditure based on additional operational demand over winter* **Base: No** Additional funding from ICB for Winter pressures, therefore set at zero for base case with moderate forecast pressure. **Downside**: £1.250m included for potential risk against funding such as increased Escalation beds or Covid.
Winter Pressures	(938)	(300)	-	*Increasing expenditure based on additional operational demand over winter* **Base: No** Additional funding from ICB for Winter pressures, therefore set at zero for base case with moderate forecast pressure. **Downside**: £1.250m included for potential risk against funding such as increased Escalation beds or Covid.
Non Pay Inflation	(625)	(420)	-	*Non pay Inflation assigned to known contract price changes such as Utilities. Generic price increases not funded in baseline* , **Downside:** assumes 2% increase on remaining non pay budget for 23-24 across the remainder of the year. **Base:** assumes some additional costs materialising, currently set at £0.6m. **Upside**: no additional non-pay inflation costs
FOT Position	**(10,226)**	**(5,382)**	**(833)**	
Prior month	**(5,413)**	**-**	**2,535**	

Finance

06/

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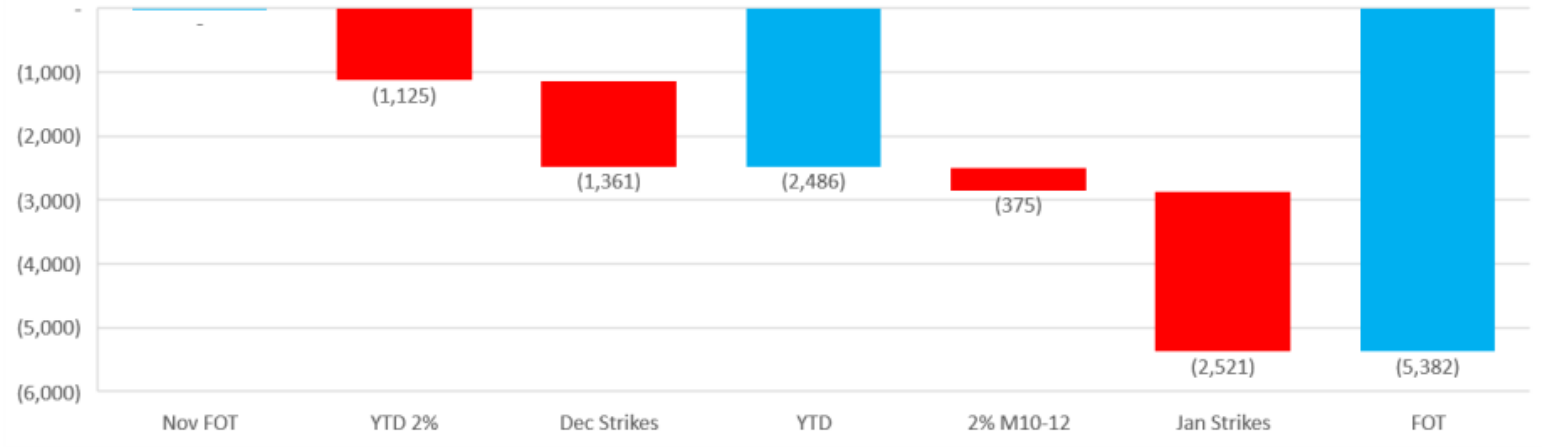
Risk adjusted forecast outturn (2 of 2)

East Sussex Healthcare NHS Trust

Background

- As part of the November reforecast activity the Trust committed to a breakeven plan with central support of £5.5m and a 2% reduction in the National ERF baseline. This forecast was predicated on three assumptions which may no longer hold true:
  - **No industrial action**: all providers and commissioners were asked to forecast on the basis of no further strikes, we have now had three in December and six in January with further potential.
  - **2% reduction in Sussex ERF baseline**: this is different from (either of) the national 2% reductions, at the time of the initial plan submissions Sussex submitted a breakeven plan on the basis that the ERF baseline for overall Sussex activity would reduce by 2%. We were assured by the ICB leadership both at the time and post the November resubmission that this was being honoured – it is now clear this is not the case.

Impact (Inc. estimates for Jan)



- 2% baseline: Total impact of £1.5m, which is £1.1m YTD (all recognised in M9 and £0.4m M10-12)
- Industrial action: based on historical costs, and benchmarked to UHSx as per discussions with the ICB, we have estimated (which is inherently subjective) that the cost of industrial action in December was £1.4m and is likely to be £2.5m for January – a total of £3.9m across the two months.
- Overall: this presents a £2.5m explainable deficit at M9 equating to a £5.4m FOT. We are seeking finance committee approval to adjust the official Trust forecast for M10 reporting in conjunction with the ICB and UHSx.

East Sussex Healthcare NHS Trust

Mortality Report: Learning from Deaths 1 April 2017 to 30th June 2023

Purpose of the paper	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review. All deaths in hospital are reviewed by our team of Medical Examiners and any cases requiring further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Dr Simon Merritt					
Governance overview	N/A					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
		x	x	

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

Executive Summary	The current "Learning from Deaths" report details the April 2017 – June 2023 deaths, recorded and reviewed on the mortality database. Learning disability deaths are subject to external review against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process in order to mitigate any risk.

Next steps	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. Deaths going to inquest, SIs, Amber reports, complaints and "low risk" deaths are all reviewed for completeness.

Learning from Deaths Dashboard April 2017-June 2023 (Data as at 24/01/2024)

Department of Health

Organisation	**EAST SUSSEX HEALTHCARE TRUST**
Financial Year	**2023-24**
Month	**June**

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard June 2023-24

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 24/01/2024)

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

Time Series:	Start date	2017-18	Q1	End date	2023-24	Q1

Total number of deaths recorded in the mortality database - excluding Learning Disability

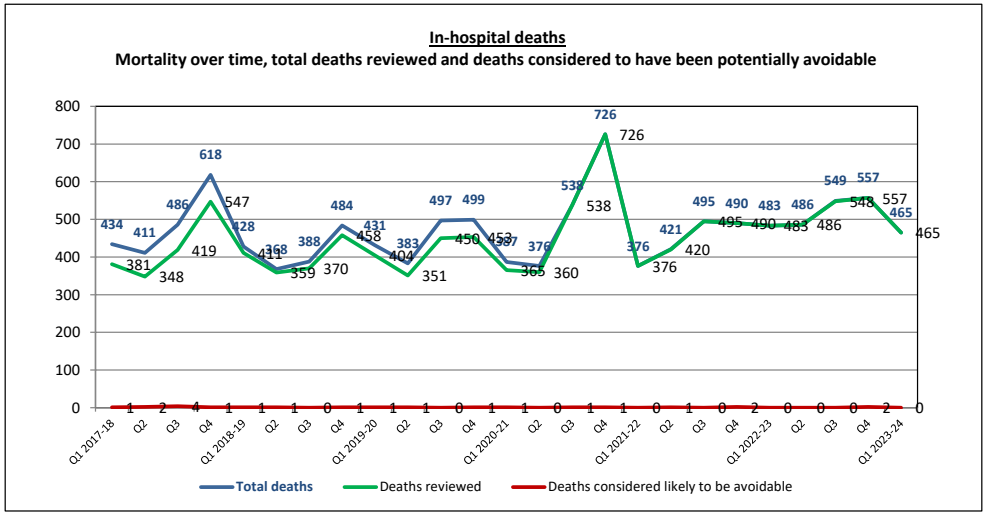
This Month	Last Month
136	185
This Quarter (QTD)	**Last Quarter**
465	557
This Year (YTD)	**Last Year**
465	2075

Total deaths reviewed by Medical Examiner

This Month	Last Month
136	185
This Quarter (QTD)	**Last Quarter**
465	557
This Year (YTD)	**Last Year**
465	2074

Total number of deaths considered to have been potentially avoidable (RCP Score <=3)

This Month	Last Month
0	0
This Quarter (QTD)	**Last Quarter**
0	2
This Year (YTD)	**Last Year**
0	2



Total deaths reviewed by RCP methodology score. Historically avoidability was recorded when the overall care was judged to be poor or very poor. From April 2023 all deaths reviewed and given an avoidability rating have been included.

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)	0	0.0%

Score 4 Possibly avoidable but not very likely		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 5 Slight evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	2	11.8%
This Year (YTD)	2	11.8%

Score 6 Definitely not avoidable		
This Month	3	100.0%
This Quarter (QTD)	15	88.2%
This Year (YTD)	15	88.2%

Data above is as at 24/01/2024 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were four care concerns expressed to the Trust Bereavement team relating to Quarter 1 2023/24 deaths. None were taken forward as complaints.
Complaints - Of the complaints closed during Quarter 1 2023/24 which related to to 'bereavement in hospital', all had an overall care rating of 'good care', .
Serious incidents - There was one severity 5 serious incident raised in Q1 2023/2024, relating to an out of hospital death in June 2022.
As at 24/01/2024 there are 516 April 2017 - June 2023 deaths, still outstanding for review on the Mortality database.

Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 24/01/2024)

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

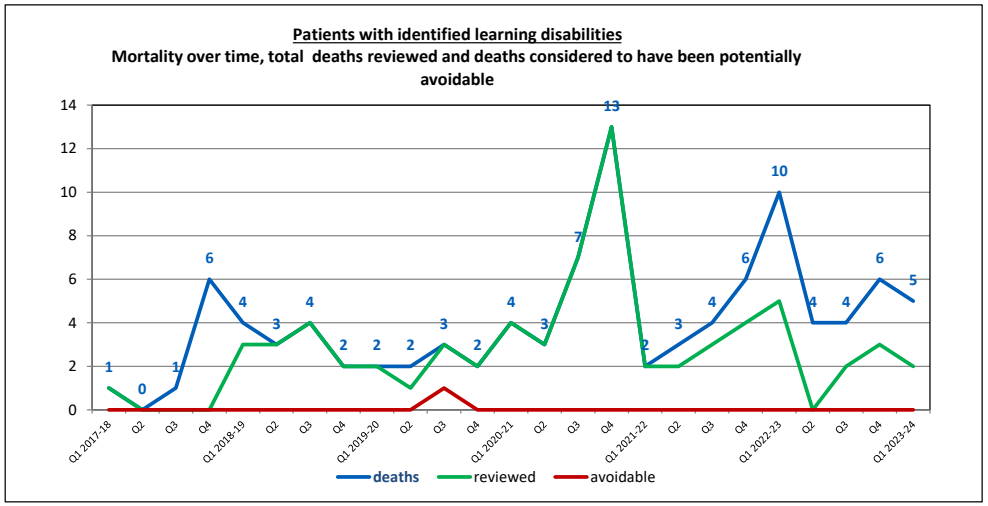
Time Series:	Start date	2017-18	Q1

End date	2023-24	Q1

Total number of deaths recorded in the mortality database - Learning Disability	
This Month	Last Month
3	1
This Quarter (QTD)	Last Quarter
5	6
This Year (YTD)	Last Year
5	24

Total deaths reviewed through the LeDeR methodology (or equivalent)	
This Month	Last Month
1	1
This Quarter (QTD)	Last Quarter
2	3
This Year (YTD)	Last Year
2	10

Total number of deaths considered to have been potentially avoidable	
This Month	Last Month
0	0
This Quarter (QTD)	Last Quarter
0	0
This Year (YTD)	Last Year
0	0



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. There can be a significant delay in this process.
These deaths are also reviewed internally by the Acute Liaison Nurse for Learning Disabilities, who enters the review findings on the mortality database.

East Sussex Healthcare NHS Trust

NHS National Patient Surveys

Purpose of the paper	The purpose of this paper is to share the results and action plans of the published NHS National Patient Surveys; Adult Inpatient survey 2022 and Urgent and Emergency Care survey 2022.						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Richard Milner, Chief of Staff Amy Pain, Head of Patient Experience						
Governance overview	Executive Leadership Team Meeting Patient Safety and Quality Group Urgent Care Governance Meeting						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x			

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the contents of this report.

Executive Summary

The CQC use a rolling programme of national surveys to gain service user feedback which helps to assess the performance of NHS providers. National survey reports are Trust specific but within the report provide national benchmarks.

This report and action plans are being shared at Board for the first time (for information) and next year the suggestion is that there will be a collective report produced to address all published surveys during 2024/25.

Surveys published during 2023/24 were:

- Adult Inpatient survey 2022 (published September 2023); and
- Urgent and Emergency Care survey 2022 (published July 2023).

<u>Adult Inpatient Survey 2022</u>
Overall, this report is positive, each Trust is assigned one of five bands according to their overall performance across the survey: ESHT is “middle 60%”, with fewer questions scoring worse by 5% or more and in the bottom 20% of Trusts.

Themes of the questions which featured in the top 20% of Trusts (2022) were:

- Food (assistance with meals and availability)
- Privacy when being treated
- Staff availability to meet patient needs
- Staff asked about additional equipment needed when leaving hospital
- Patients were asked to give their view on the quality of care.

The seven questions which scored in the bottom 20% of Trusts (2022) were not subjects which were of surprise, these have featured in local feedback received (via complaints, PALS and Friends and Family Test).

Patient feedback and performance against standards continue to be monitored and reported on through divisional Integrated Performance Reviews, such as communication, discharge and waiting times (against standards and themes of complaints/ concerns).

	The Inpatient survey is a Trust wide survey, we are not able to identify areas where responses came from; this action plan will be shared with operational leads and there will be shared ownership for completion and themes arising from patient feedback will be monitored. National Urgent and Emergency Care (UEC) Survey 2022 Two separate questionnaires were used, one for Type 1 (major ED) and one Type 3 (Urgent and Emergency Care (UEC)). Both surveys were reported to be in the "middle 60%" of Trust responses. Overall, the results for Type 1 and Type 3 surveys have decreased when compared to previous years. Both surveys provide similar themes, which can be attributed to delayed waiting times during September 2022 when the survey was completed: • The 4-hour performance during September 2022 was between 60%-70% throughout the month • Attendances were on a normal trajectory – although length of stay in the department was high • Ambulance delays increased over the month of September 2022 • Bed occupancy was above 98% Both reports were discussed at Patient Safety and Quality Group and Urgent and Emergency Care Survey has been discussed widely with the Emergency Department and continues to be monitored through governance meetings.

Next steps	1. The action plan to address National Adult Inpatient Survey 2022, will be shared widely with clinical divisions and the survey question/ theme will be monitored against trends and themes from complaints 2. The action plan to address National Urgent and Emergency Care (UEC) Survey 2022 will be monitored at the Urgent Care governance meetings 3. At the end of 2024/25 all published national surveys will be presented to the Board for information.

NHS National Patient Surveys

The CQC use a rolling programme of national surveys to find out what service users think of the NHS healthcare services that they use; this helps to assess the performance of NHS providers.

Surveys published during 2023/24 were, the Adult Inpatient survey 2022 (published September 2023) and Urgent and Emergency Care survey 2022 (published July 2023). Both reports were discussed at Patient Safety and Quality Group and Urgent and Emergency Care Survey has been discussed widely with the Emergency Department and continues to be monitored through governance meetings.

This report and action plans are being shared at Board for the first time and next year the suggestion is that there will be a collective report produced to address all surveys published during 2024/25, as listed below:

- 2023 Maternity: fieldwork April – June 2023, publication 9 February 2024 (this will be picked up in the Maternity updates)
- 2023 Adult inpatients: fieldwork January – April 2024, publication August 2024 (TBC)
- 2024 Children and young people: fieldwork July – October 2024, publication March 2025 (TBC)
- 2024 Urgent and emergency care: fieldwork April – July 2024, publication October 2024 (TBC)
- 2024 Maternity: fieldwork April – June 2024, publication December 2024 (TBC)

National survey reports are Trust specific but within the report provide national benchmarks.

Patient Experience and operational teams monitor performance and feedback received throughout the year at Integrated Performance Reviews.

Adult Inpatient Survey 2022

This survey is comparable with previous surveys as the questions remained the same. Eligibility to take part in the survey was if the patient stayed in hospital for at least one night during November 2021 and were aged 16 years or over at the time of their stay.

The ESHT response rate for this survey was 43%, an increase of 1% vs. ESHT 2021 Adult Inpatient Survey.

<u>Change since 2021</u>

Average score: 75.1% (decrease of 0.5% from 2021).

When comparing ESHT results, there is a reduction in 10 questions scoring worse by 5% in 2022.

	2021	**2022**
Better by 5% or more	2 questions	0 questions
Less than 5% change	40 questions	49 questions
Worse by 5% or more	12 questions	2 questions

The two questions which scored worse by 5% or more when compared with the 2021 survey were (both questions featured in the bottom 20% of Trusts in the national comparison):

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital? (2021 score= 81.4%, 2022 score=67.5%)
- Q34. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital? (2021 score = 71.7%, 2022 score= 58.3%)

National Comparisons

Each Trust is assigned one of five bands according to their overall performance across the survey: ESHT is "middle 60%".

The table below categorises the number of questions which scored in the top 20%, middle 60% and bottom 20% of Trusts. When comparing ESHT results nationally, there is an increase of five questions that feature in the top 20% of Trusts and a reduction in 12 questions that feature in the bottom 20% of Trusts.

	2021	**2022**
Top 20% of Trusts	2 questions	7 questions
Middle 60% of Trusts	26 questions	39 questions
Bottom 20% of Trusts	19 questions	7 questions

Themes of the questions which featured in the top 20% of Trusts (2022) were:

- Food (assistance with meals and availability)
- Privacy when being treated
- Staff availability to meet patient needs
- Staff asked about additional equipment needed when leaving hospital
- Patients were asked to give their view on the quality of care

Seven questions which scored in the bottom 20% of Trusts (2022) were:

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?
- Q18. When doctors spoke about your care in front of you, were you included in the conversation?
- Q25. How much information about your condition or treatment was given to you?
- Q31. Beforehand, how well did hospital staff answer your questions about the operation or procedure?
- Q32. After the operation or procedure, how well did hospital staff explain how the operation or procedure had gone?
- Q34. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?
- Q46. Thinking about any medicine you were to take at home, were you given any of the following: I was given medicine but no information

Overall, this report is positive with fewer questions scoring worse by 5% or more and in the bottom 20% of Trusts.

Patient feedback and performance against standards are monitored and reported on through divisional Integrated Performance Reviews, such as communication, discharge and waiting times (against standards and themes of complaints/ concerns).

There are still areas for improvements with the questions which scored in the bottom 20% of Trusts (this includes the two questions which scored worse by 5%). The Trust's Head of Patient Experience has created an action plan to address these questions (Appendix A).

The Inpatient survey is a Trust wide survey, we are not able to identify areas where responses came from; this action plan will be shared with operational leads and there will be shared ownership for completion and themes arising from patient feedback will be monitored.

National Urgent and Emergency Care (UEC) Survey 2022
This survey is comparable with previous surveys, as the questions remained the same. Eligibility for the survey was if the patient was aged 16 years or older and had attended UEC services during September 2022. This survey is run every two years.

Two separate questionnaires were used, one for Type 1 (major ED) and one Type 3 (Urgent and Emergency Care (UEC)).

The ESHT response rate for the Type 1 survey was 29% (268 responders, national average response rate =23%), a decrease of 11% vs. ESHT 2020 UEC Type 1 survey.

The ESHT response rate for the Type 3 survey was 24% (135 responders, national average response rate =22%), a decrease of 10% vs. ESHT 2020 UEC Type 3 survey.

Changes since 2020- Type 1 attendances
Average score: 68.7% (decrease of 8.2% from 2020).

When comparing ESHT results, there is a reduction by two questions scoring better by 5% or more and an increase of 18 questions scoring worse by 5% or more when compared to the 2020 survey. Four questions have been changed/ amended and five questions have been added to this survey.

	2020	**2022**
Better by 5% or more	3 questions	1 question
Less than 5% change	27 questions	9 questions
Worse by 5% or more	1 question	19 questions

One question which scored better by 5% or more when compared with the 2020 survey was (this question did feature in the bottom 20% of Trusts):

- Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapists or community nurse or assistance from social services or the voluntary sector)? (2020 score= 60.4% vs. 2022 score=67.5%)

Themes of the questions which featured worse by 5% or more were:

- Privacy at reception areas
- Waiting times (to be seen/ triage/ time spent in ED)
- Help or assistance provided whilst waiting to be seen
- Communication about clinical condition/ test results/ medication/ who to contact if condition deteriorates/ follow up arrangements
- Confidence in staff treating you
- Pain control
- Cleanliness of department
- Food and drink available
- Discharge
- Overall experience

National Comparisons
Each Trust is assigned one of five bands according to their overall performance across the survey: ESHT is “middle 60%”.

When comparing ESHT results nationally, there are now zero questions that feature in the top 20% of Trusts and an increase of 11 questions that feature in the bottom 20% of Trusts. Four questions have changed/ amended and five questions have been added to this survey, these questions account for five questions scoring in the middle 60% of Trusts and three questions account for questions scored in the bottom 20% of Trusts.

	2020	**2022**
Top 20% of Trusts	2 questions	0 questions
Middle 60% of Trusts	27 questions	24 questions
Bottom 20% of Trusts	3 questions	14 questions

Eight of the 14 questions which feature in the bottom 20% Trusts also featured in the worse by 5% or more category.

Themes of the questions which featured in the bottom 20% of Trusts:

- Waiting times (time to be seen, assistance whilst waiting)
- Communication about clinical condition/ test results/ medication/ who to contact if condition deteriorates/ follow up arrangements
- Confidence in staff treating you
- Pain control
- Food and drink available in ED
- Overall experience in ED (2020=82.9% vs. 2022= 71.4%)

Changes since 2020- Type 3 attendances

Average score: 76.4% (decrease of 5.8% from 2020)

It is not possible to compare ESHT 2022 with 2020 as the measure in 2020 for better, less or worse than 10% and now the measure is 5%. Three questions have been changed/ amended and five questions have been added to this survey.

	2020	**2022**
Better by 5% or more	N/A	2 questions
Less than 5% change	N/A	7 questions
Worse by 5% or more	N/A	16 questions

Two question which scored better by 5% or more when compared with the 2020 survey were:

- Q18. Did Health professional talk to each other about you as if you weren't there? (2020 score= 91.7% vs. 2022 score=96.8%)
- Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapists or community nurse or assistance from social services or the voluntary sector)? (2020 score= 76% vs. 2022 score=82%)

Themes of the questions which featured worse by 5% or more were:

- Privacy at reception areas
- Waiting times (to be seen/ triage/ time spent in UTC)
- Communication about clinical condition/ test results/ medication/ who to contact if condition deteriorates/ follow up arrangements/ decisions about care
- Confidence in staff treating you
- Pain control

- Cleanliness of UTC
- Transport arrangements
- Overall experience in ED (2020=87.9% vs. 2022= 79.8%)

National Comparisons

Each Trust is assigned one of five bands according to their overall performance across the survey: ESHT is "middle 60%".

When comparing ESHT results nationally, there remains one question which features in the top 20% of Trusts and an increase of six questions that feature in the bottom 20% of Trusts.

	2020	**2022**
Top 20% of Trusts	1 question	1 question
Middle 60% of Trusts	18 questions	18 questions
Bottom 20% of Trusts	8 questions	14 questions

The one question (this is a new question and not comparable) which featured in the top 20% of Trusts was (this is a different question to the one which featured in the top 20% in 2020):

- Q39. If you had contact with care and support services after leaving UTC, did the health and social care staff have information about your visit? (2022= 70.8%).

Themes of the questions which featured in the bottom 20% of Trusts:

- Communication about clinical condition/ test results/ medication/ who to contact if condition deteriorates/ follow up arrangements/ decisions about care/ with relatives
- Confidence in staff treating you
- Privacy when being treated
- Cleanliness of UTC

Overall, both the type 1 and type 3 survey results provide similar themes, the results have decreased when compared to previous years, which is probably attributed to delayed waiting times during September 2022:

- The 4-hour performance during September 2022 was between 60%-70% throughout the month
- Attendances were on a normal trajectory – although length of stay in the department was high
- Ambulance delays increased over the month of September 2022
- Bed occupancy was above 98%

Amy Collis, Assistant Director of Nursing has created an action plan to address low scoring questions/themes (Appendix B), this action plan will be owned and monitored via the Emergency Department governance meeting.

Appendix A- Action plan to address National Adult Inpatient Survey 2022

Survey Question	Recommendation	Action	Lead	Status
Q2.* How did you feel about the length of time you were on the waiting list before your admission to hospital?	To improve this score in future surveys.			
Q18. When doctors spoke about your care in front of you, were you included in the conversation?	All interactions about a patient, should include patient, carers, and their relatives.	Care for The Carers training is being rolled out, which emphasises the need to include carers in decisions about care and treatment. This theme will be monitored through all patient feedback and where locations or staff groups are identified they will be addressed.	Medical Staff.	Ongoing.
Q25. How much information about your condition or treatment was given to you?	To improve this score in future surveys.	To monitor this question through the monthly patient feedback received. Patient Information Group to liaise with clinicians about the availability of written information (paper, weblinks).	Patient Experience and all staff.	Ongoing.
Q31. Beforehand, how well did hospital staff answer your questions about the operation or procedure?	To improve this score in future surveys.	To monitor this question through the monthly patient feedback received. Patient Information Group to liaise with clinicians about the availability of written information (paper, weblinks).	Patient Experience and all Staff.	Ongoing.

Q32. After the operation or procedure, how well did hospital staff explain how the operation or procedure had gone?	To improve this score in future surveys.	To monitor this question through the monthly patient feedback received. Patient Information Group to liaise with clinicians about the availability of written information (paper, weblinks).	Patient Experience and all Staff.	Ongoing.
Q34.* To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	Staff involved in discharge planning to talk to the patient/family and carers re discharge planning.	Ward support simple patient discharges; our Transfer of Care Hub provides support to ward for any complex discharges, supported by Discharge Co-ordinators and Discharge Sisters/Charge Nurses.	Ward staff and Transfer of Care Hub.	Ongoing.
Q46. Thinking about any medicine you were to take at home, were you given any of the following: I was given medicine but no information.	New Medications to patients should be discussed with you with a doctor or pharmacist.	On discharge the ward staff will go through your medications with you, so you know what you are being discharged with. All medications dispensed will have an information leaflet around dosage and potential side effects.	Nurses, doctors or pharmacists.	Ongoing.

*worse by 5% or more and scored in the bottom 20% of Trusts

Appendix B- National Urgent and Emergency Care (UEC) Survey 2022

Type 1 Attendances

Survey Question (theme)	Recommendation	Action	Lead	Status
Waiting times*	Improve communication- keep patients updated on expected waiting time.	Update the waiting rooms screens in real time, consider how signposting to alternative pathways could be displayed. Increase the number of screens (not all waiting area seats face the same way).	ED staff.	Ongoing.
Help or assistance whilst waiting to be seen	Consider what staffing resource could be made available to support patients in the waiting area.	UTC navigators in post to support patients in the waiting areas.	ED management team.	Completed.
Privacy in reception areas	Due to the physical layout of the reception area, privacy is limited.			
Food and drink available*	Vending machines in the department to provide a greater choice of healthy food available, meeting dietary requirements.	The provision of food and drink available from vending machines has been reviewed with the provider and the machine will be changed for one that can accommodate refrigerated food to include healthier options. Improve signage to the vending machines within the department.	Trust Facilities Manager- Hotel services.	Ongoing- with the vending machine providers.
Overall experience*	Monitor all patient experience feedback received to help measure the patients experience in ED.	Increase the Friends and Family response rate, Patient Experience Team to provide monthly feedback to the department including trends and themes.	ED staff and Patient Experience Team.	Ongoing.

Pain control*	Decrease triage times, enabling patients to access pain relief earlier.	To review whether there is scope to increase triage workforce. ADN is leading with ED HoN's and UTC managers cross site improvement plan specifically for triage. Monitor pain audit.	Assistant Director of Nursing and Head of Nursing.	Ongoing.
Confidence in staff treating you*	To improve this score in future surveys.	This theme will be monitored through all patient feedback and where locations or staff groups are identified they will be addressed.	Patient Experience.	Ongoing.
Communication* with Trust staff and discussions about clinical care and treatment	Share this report widely with current ED staff and new staff.	Share with new staff as part of their induction to the department the importance of communication with our patients/ carers/ relatives. Review visibility of QR codes which shares information on conditions.	ED staff.	Ongoing.
Discharge process	Implement a discharge checklist on NerveCentre.	Commence a discharge audit monitoring compliance against discharge checklist on NerveCentre.	ED staff.	Ongoing.

*worse by 5% or more and scored in the bottom 20% of Trusts

Type 3 Attendances

Survey Question (theme)	Recommendation	Action	Lead	Status
Waiting times	Improve communication- keep patients updated on expected waiting time.	Update the waiting rooms screens in real time, consider how signposting to alternative pathways could be displayed.	ED staff.	Ongoing.
Privacy in reception areas		Due to the physical layout of the reception area, privacy is limited.		
Privacy when being treated	Ensure at all times the patient's privacy and dignity is being maintained.	Due to the physical layout of the department, ensuring privacy and dignity can be challenging at times. All staff to ensure that every effort is made to ensure patients privacy in maintained when being treated.	ED staff.	Ongoing.
Overall experience	Monitor all patient experience feedback received to help measure the patients experience in ED.	Increase the Friends and Family response rate, Patient Experience Team to provide monthly feedback to the department including trends and themes.	ED staff and Patient Experience Team.	Ongoing.
Pain control*	Decrease triage times, enabling patients to access pain relief earlier.	To review whether there is scope to increase triage workforce. ADN is leading with ED HoN's and UTC managers cross site improvement plan specifically for triage. Monitor pain audit.	Assistant Director of Nursing and Head of Nursing.	Ongoing
Confidence in staff treating you*	To improve this score in future surveys.	This theme will be monitored through all patient feedback and where locations or staff groups are identified they will be addressed.	Patient Experience.	Ongoing.

Communication* with Trust staff and discussions about clinical care and treatment	Share this report widely with current ED staff and new staff.	Share with new staff as part of their induction to the department the importance of communication with our patients/ carers/ relatives. Review visibility of QR codes which shares information on conditions.	ED staff.	Ongoing.
Cleanliness of UTC*	Monitor cleaning audit compliance.	ED have increased the number of clinical orderly roles in the department. Monitor compliance against cleaning audit. Cleaning schedules to be displayed.	ED staff.	Ongoing.
Transport arrangements	Consider ways in which the department can support transport needs for patients attending the UTC.	UTC matron now in post and public transport times are publicised.	UTC matron.	Ongoing.

*worse by 5% or more and scored in the bottom 20% of Trusts

M10 Trust Financial Forecast

Purpose of the paper	This paper, which is based on M9 financial information, sets a revised forecast for the Trust's financial position for approval for submission as part of the M10 formal regulatory return. The ICB has been consulted on this approach and value.					
	For Decision	x	For Assurance		For Information	
Sponsor/Author	**Sponsor**: Damian Reid (damian.reid1@nhs.net) **Authors**: Matt Backler (matt.backler1@nhs.net),					
Governance overview	The Trust financial plan and recommitment during November have previously been approved by the Board. The Board receives monthly updates on the financial position. The proposal set out in this paper has been reviewed and discussed in detail at the January Finance and Productivity Committee.					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x	x	X

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	X

Recommendation	The Finance and Productivity Committee recommended that the Board approve an adjusted forecast for M10 reporting of a £5.4m deficit, this adjustment will be in conjunction with the ICB and UHSx.
Executive Summary	As part of the November reforecast activity the Trust committed to a breakeven plan; however a number of underpinning assumptions have changed since then, namely that there would be no further strikes and the 2% ERF baseline reduction in Sussex would be honoured. The total impact of these is estimated at £5.3m forecast outturn (£2.5m as at M9). We are also expecting the ICB and UHSx to move their forecast as part of M10 reporting.
Next steps	Submission to ICB and NHSE Close monitoring of financial position

M10 Trust Financial Forecast

1. Purpose

This paper, which is based on M9 financial information, sets a revised forecast for the Trust's financial position for approval for submission as part of the M10 formal regulatory return. The ICB has been consulted on this approach and value.

2. Background

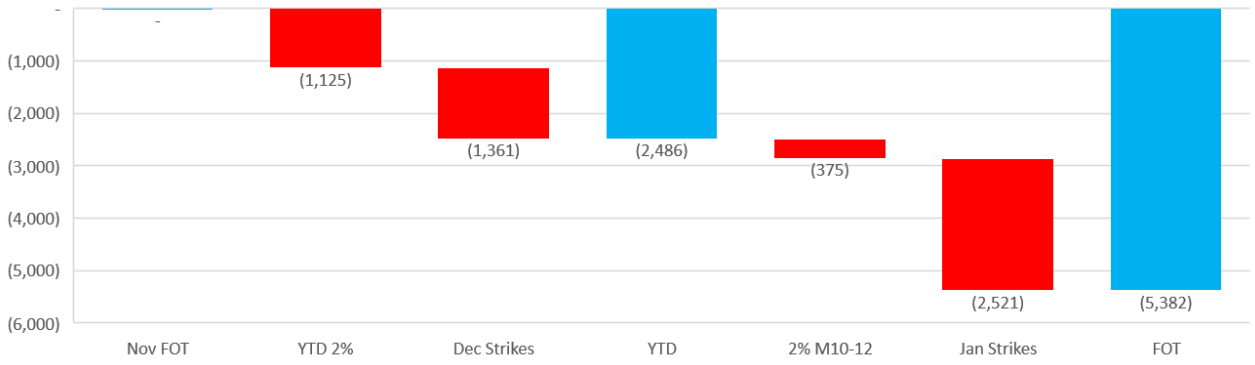
As part of the November reforecast activity the Trust committed to a breakeven plan with central support of £5.5m and a 2% reduction in the National ERF baseline. This forecast was predicated on three assumptions which, some of which may no longer hold true:

- **No industrial action**: all providers and commissioners were asked to forecast on the basis of no further strikes, we have now had three in December and six in January with further potential.
- **2% reduction in Sussex ERF baseline**: this is different from (either of) the national 2% reductions, at the time of the initial plan submissions Sussex submitted a breakeven plan on the basis that the ERF baseline for overall Sussex activity would reduce by 2%. We were assured both at the time and post the November resubmission that this was being honoured – it is now clear this is not the case.
- **Other assumptions**: no further changes to national rules, funding allocations or other material assumptions. At the time of writing this has held true in the majority of cases, however we are currently seeking to get further clarity on national depreciation funding which may be lower than expected.

The Trust committed to a number of actions which have either been delivered or are in progress (such as vacancy reviews, tighter controls on non-pay such as minor improvement works). As such we remain committed to deliver the "breakeven" position outside of any impact of key assumptions changing as set out above.

3. Impact

The bridge below sets out the position as of M9, which was a £2.5m deficit and a full year forecast (FOT) of £5.4m deficit.



2% baseline: Total impact of £1.5m, which is £1.1m YTD (all recognised in M9 reporting position and £0.4m M10-12). The effect is limited to the Sussex ICB element of the ERF as this was not applied to other commissioners.

Industrial action: based on historical costs, and benchmarked to UHSx, we have estimated (which is inherently subjective but represents management's best estimate with the information available at the time) that the cost of industrial action in December was £1.4m and is likely to be £2.5m for January – a total of £3.9m across the two months. This includes costs for:

- Direct pay costs (additional cost of covering shifts at premium rates less amounts not paid to those striking),
- Some indirect staff costs relating to management time in preparing for and managing the strikes;
- Lost activity for which tariff would have been paid (i.e. under-utilised clinics or theatre sessions), actual performance is compared to run rate on non-strike days triangulated with booking information. This is partially offset by reduced non-pay costs.

Other assumptions: at the time of writing, no further amendments are being made but this may change pending further clarity on the depreciation funding quantum and how this compares to planned levels.

4. Conclusion

Overall: this presents a £2.5m explainable deficit at M9 equating to a £5.4m FOT. Finance Committee recommend that the Board approve an adjusted forecast for M10 reporting of a £5.4m deficit, this adjustment will be in conjunction with the ICB and UHSx.

M10 performance: as noted this paper is based on the M9 financial information as we have not yet closed M10, however an early view of the position is that there is nothing that would change the conclusion or recommendations made in this paper. A further verbal update will be provided at the meeting.

East Sussex Healthcare NHS Trust

Development of the Sussex Surgical Centre at Eastbourne District General Hospital

Purpose of the paper	Provide an update on the development of the Sussex Surgical Centre at Eastbourne District General Hospital.					
	For Decision		For Assurance		For Information	X
Sponsor/Author	Chris Hodgson – Director of Estates and Facilities					
Governance overview	Public Trust Board – 13th February 2024					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x		x	

The Sussex Surgical Centre will create a dedicated High Volume Low Complexity (HVLC) day surgery unit at Eastbourne District General to:

1. Maximise capacity focusing primarily on the delivery of high-volume pathways (day cases) across 6 days, potentially extending to 7 days.
2. Pandemic Resilience within the current theatre footprint, service configuration and internal flows became a significant challenge during COVID, and a clear 'green' day surgery operating space is needed to prevent that reoccurring.
3. Protect dedicated elective capacity to ensure that activity is maintained, reduces the risk of cancellations, and will support the system to achieve the 30% increase in elective activity as per planning guidance.
4. Provide an enabler for a future build to be added to allow flexibility for future expansion and support the deliverability of the Trust's *Building for our Future Hospital Redevelopment* Programme which is part of the national New Hospital Programme (NHP).

The activity model for the Elective Hub, as presented in the final business case (FBC), that was first approved by the Trust Board, ICB and NHSE, indicates that there will be a total of 8,453 day surgery cases delivered through the four operating theatres in the unit per annum.

The Elective Hub operational/ clinical team are working with each surgical speciality to identify the day case procedures and pathways that could be managed within the Elective Hub, which will be supported by published Get It Right First Time (GIRFT) guidance and best practice.

The two storey building, which includes plant space, contains four operating theatres, dedicated admission, recovery and discharge space and associated support facilities on the ground floor. There is expansion space on the 1st floor for future clinical facilities.

The facility is being built a high standard and in accordance with the Trust Green Plan (2021); we are aiming to achieve a low net carbon impact by utilising capacity from our new low carbon heat pump source to provide heating and hot water to the facility. The Trust is committed to maximising the use of modern methods of construction (MMC) in the construction of the unit. Furthermore, we are aiming for the highest score range possible, i.e. Excellent under the Building Research Establishment Environmental Assessment Method (BREEAM) assessment process.

Construction commenced in July 2023 and is due to complete in early 2025, with an aim to commence surgical procedures in early Spring 2025.

Good progress is being made by our construction partner, IHP: on the site we currently have a large tower crane and this has helped construct all of the main piling foundations, below ground drainage and ground floor slab works. We have now moved on with the erection of the main supporting columns with the ground and 1st floor main supporting columns currently being casted, with the 1st and 2nd floor plant room floor slabs to follow in the next few weeks.

East Sussex Healthcare NHS Trust

Shared Deliver Plan and Transformation Programmes

Purpose of the paper	To summarise for the Board how the Trust's transformation programmes contribute to the ICS Shared Delivery Plan						
	For Decision		For Assurance	x	For Information		
Sponsor/Author	Sponsor – Joe Chadwick-Bell Author – Simon Dowse						
Governance overview	Elements of this paper have been to Strategy & Transformation Committee but not the table covering specific transformation programmes and their contribution						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x		x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

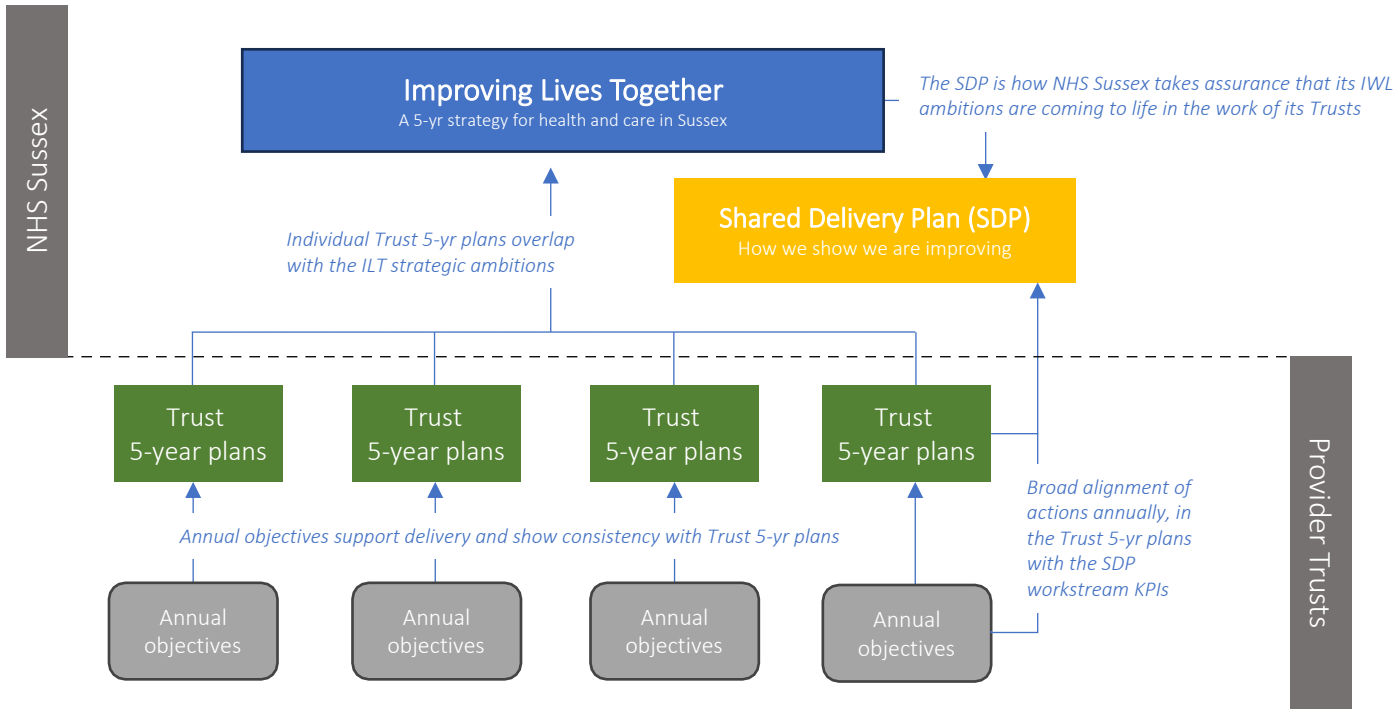
Recommendation	The Board is asked to note the content of this report.

Executive Summary	The Shared Delivery Plan (SDP) describes the approach that the Sussex Integrated Care System (ICS) will take in delivering our shared strategy. It includes 11 delivery boards covering the key objectives in the strategy; one board for each work area (although that structure may still evolve further as the system forms 'collaboratives'). Those are all set out in the paper along with which of our Executives and senior leaders represent the Trust at each board. The Trust contributes in multiple ways and this paper shows how our 10 priority Transformation programmes contribute (and notes that two of our key improvement programmes – Planned Care and Urgent and Emergency Care – also link to the SDP boards). The 10 priority programmes predate the development of the SDP but, as we would have expected because we have been working as a system and supported the development of the SDP, are all well aligned and our aims and objectives ultimately all aim to improve access to care, the quality of care, patient experience and the sustainability of our system.

Next steps	We will update periodically via Strategy and Transformation committee on progress and any changes in the system.

The Sussex ICS Share Delivery Plan describes how 'Improving Lives Together' will be delivered and overseen by the ICS (both NHS Sussex and the Local Authorities)

Simplified planning structure: Alignment and Collaborative Aims



- There are 11 workstreams within the SDP, chaired by Trust CEOs and/or NHS Sussex executives, with a series of KPIs to deliver – they all report into the Single Oversight Board (SOB)
- These workstreams meet monthly and attendees are drawn from clinical and non-clinical leaders of Trusts, NHS Sussex and Local Authorities
- The aim is that, by working together to track progress and collectively resolve roadblocks to delivery, the SDP is owned and delivered collaboratively
- The following pages outline how we engage with the SDP and how our transformation (and major improvement) programmes contribute to the SDP

We have senior management presence in each SDP board

Single Oversight Board (Joe Chadwick-Bell)

Long term improvement priorities		Immediate improvement priorities		Continuous improvement priorities	
Integrated Community/ Neighbourhood Teams	Abi Turner	Urgent & Emergency Care	Garry East	Mental Health, LD and Autism	Charlotte O'Brian
People & Development	Steve Aumayer	Social care & discharge	Vikki Carruth	Health Inequalities	Richard Milner
Digital & Data	Hilary Kirchner	Planned Care, Cancer & Diagnostics	Andy Bailey	Finance, Sustainability and Productivity	Damian Reid
Clinical Leadership	Simon Merritt	Primary Care	Simon Dowse		

- Updates from the eleven boards are provided to the System Oversight Board, chaired by NHS Sussex Chief Officer and attended by provider CEOs and NHS Sussex executives
- We ensure an appropriate rep from ESHT is on each SDP Board (typically they meet bi-monthly)
- Not shown here are the subgroups and clinical reference groups supporting the boards key workstreams. We are drawing from a wider group of senior leaders to enable us to support these
- Our representatives at each board provide feedback to the Trust and Trust governance
- NOTE – As the ICS governance evolves and the 'collaboratives' form the precise arrangements for the 11 board may change – but the underlying ambition of the SDP will not

Our transformation (and priority improvement) programmes contribute to the 11 SDP Boards

Long term improvement priorities	
Integrated Community/ Neighbourhood Teams	• ESHT's new ICT programme • 'Frailty' and 'Community - Art of the Possible' programmes
People & Development	• Our people strategy (reporting to POD and Place Executive Delivery Group) is wholly aligned • We are closely engaged with NHS Sussex
Digital & Data	• EPR • Key digital enablers for Radiology and Pathology • Our Care Connect, Sussex Integrated Dataset, Plexus are enablers for us
Clinical Leadership	• We engage with SDP • It will link to our CQI programme in due course (as appropriate)

Immediate improvement priorities	
Urgent & Emergency Care	• Frailty & Community 'art of the possible' programmes contribute • UEC improvement programme contributes (not under the transformation heading - reporting via UCOG to ExComm)
Social care & discharge	• Community 'art of the possible' contributes (e.g. HomeFirst, rehab, virtual wards) • UEC improvement programme contributes
Planned Care, Cancer & Diagnostics	• Our Planned Care programme (reporting to Planned Care Group) and CDC • Transformational programmes Elective Hub, Endoscopy, Radiology (reporting to StratCom) and Pathology
Primary Care	• Potential links are still being explored • Clearly connected to the ICT programme • Exploring the link into Frailty programme

Continuous improvement priorities	
Mental Health, LD and Autism	• Implications for our UEC improvement programme and enhancing Community Paediatrics
Health Inequalities	• This is a factor to be considered in any service change or improvement • It is tested in Transformations rather than a programme itself
Finance, Sustainability and Productivity	• All the transformation programmes aim to support long term sustainability

- The Trust's Transformation Programme and priorities will be reviewed, as usual, during business planning for 24/25 and as we look at the priorities for the next 3 years

The aims of our priority transformation programmes align both to SDP objectives and the Trust's strategic priorities (1 of 3)

Transformation programme*	What is it?	What are its aims?	Which elements of the SDP does it contribute to?
Frailty	Improving the management of frailty within the hospital (e.g. FEDs for acute frailty, POPs for surgical pathways) Transforming to an integrated pathway to proactively manage urgent health need and risk in people with frailty before ED or admission **Status:** Successful FEDs pilot, POPs due in 24/25 and new integrated model being agreed – pilots with primary, community and acute teams using Sussex integrated dataset and 'Frailty Falls Risk Model' due to initiate	To improve patient experience and timely support in the right locations such that people with frailty need acute hospital care less often and for less time	Supports the objectives several SDP boards: • Urgent and Emergency Care • Finance, sustainability and productivity • Integrated Community Teams Enabled by Digital & Data, People & Development, Clinical Leadership, Health Inequalities
Community – 'Art of the Possible'	Several projects that collectively aim to optimise the balance of resources we use between acute hospital and out of hospital services – including – Virtual Wards (including for children), HomeFirst, Intermediate Care (& rehab), Admission & ED attendance avoidance – with better alternatives (e.g. our UCR team working directly with ambulance services to identify who they can help much earlier and at home) **Status:** Virtual wards up and running – expansion plan in development, HomeFirst piloted and successful – expansion plan in development, UCR & SECAMB piloting 1st phase admission avoidance, System Single Point of Access model initiated	To improve the provision of healthcare outside the hospital for: • More timely, more appropriate & useful response (e.g. a home visit rather than an ambulance journey to ED) • A more personalised response to patient needs and a better experience • A lower risk of deconditioning or newly acquired illness due to unnecessary or extended hospital stays • Reduced onward need to social support • Improving access to acute emergency departments and beds when they really are necessary	Supports the objectives several SDP boards: • Urgent and Emergency Care • Social care and Discharge • Finance, sustainability and productivity • Link to Integrated Community Teams • Potential to support Primary Care Enabled by Digital & Data, People & Development, Clinical Leadership, Health Inequalities
Community – 'ICTs'	Very early stages – the system plans to develop an "Integrated Community/Neighbourhood Teams". The Trust has an ICT programme to respond and contribute to that. Thus far this is primarily responding to and informing the system process AND within East Sussex Place we are jointly leading ICT development with colleagues in 'frontrunner' locations – Hastings at present **Status:** ICS has produced data packs for each ICT footprint (5 in East Sussex), drafted a 'core offer' and in East Sussex we have had the first Hastings 'ICT' workshop	To make it easier for multiple agencies in the system to plan and deliver together taking account of local resources, determinants of health and care needs, community preferences and challenges To therefore improve the type of care, access to it, proactive support and deliver joined up, holistic responses.	• Directly supporting the SDP ICT Board • Expected to support Health Inequalities Board • Likely to link to Primary Care Board • In the future may support objectives of UEC, Social Care and Discharge, Health Inequalities Enabled by Digital & Data

**For clarity – these are the priority programmes scrutinised at Strategy and Transformation Committee and Executive Committee – they do not represent every single project or programme within the Trust. In particular, our Planned Care programme and Urgent and Emergency Care programme (reporting to PCG and UCOG respectively and then to Executive Committee) are not managed as 'transformation' programmes as their primary focus is on getting business as usual right. Clearly though there are interdependencies*

The aims of our priority transformation programmes align both to SDP objectives and the Trust's strategic priorities (2 of 3)

Transformation programme*	What is it?	Aims	SDP Contribution
Cardiology	Implementing the agreed transformation following public consultation to consolidating elements of the service onto one site to enable us to deliver best practice and meet 'GIRFT' recommendations. **Status –** currently critical estates developments needed to implement the plan, 1 new cath lab opened	To improve the quality of planned and emergency cardiology services, meet best practice in a sustainable way and increase productivity	• Contributes to the Urgent and Emergency Care and Planned Care objectives • Benefits Sustainability
Ophthalmology	Implementing the agreed transformation following public consultation to consolidate the service onto two sites to enable us to increase capacity and productivity **Status –** currently in phase 1 (of 3) of necessary estates developments	To improve capacity, productivity and therefore access, waiting times and patient experience. May also enable service enhancements because supervised models now become possible	• Contributes to the Planned Care objectives • Benefits finance, sustainability and productivity
Elective Hub	Building a £40m new surgical centre at Eastbourne for modern, highly productive, day surgical case delivery and implementing modern day surgical pathways **Status –** Building underway – target opening in beginning 25/26	To increase capacity, reduce waits, implement modern day surgical pathways and improve productivity	• Contributes to Planned Care, Cancer and Diagnostics Board objectives
Bexhill Endoscopy Unit	Planning stages for £20m 4 room Endoscopy unit for diagnostic activity and screening – off the acute site to increase pandemic resilience and focus on high-throughput work	To increase endoscopy 'room' capacity for East Sussex toward national benchmarks, productivity, reduced waits, diagnostic pathways, attract endoscopist clinicians, increase training capacity. May also enable the acute hospitals to increase therapeutic endoscopy capacity	• Contributes to Planned Care, Cancer and Diagnostic Board objectives • Enabled by People and Development

**For clarity – these are the priority programmes scrutinised at Strategy and Transformation Committee and Executive Committee – they do not represent every single project or programme within the Trust. In particular, our Planned Care programme and Urgent and Emergency Care programme (reporting to PCG and UCOG respectively and then to Executive Committee) are not managed as 'transformation' programmes as their primary focus is on getting business as usual right. Clearly though there are interdependencies*

The aims of our priority transformation programmes align both to SDP objectives and the Trust's strategic priorities (3 of 3)

Transformation programme*	What is it?	What are its aims?	Which elements of the SDP does it contribute to?
Pathology	4 key components – 1. Network implementation of 'LIMS' (Lab Info Mgmt System) and 'DAP' (Digital Histopathology), 2. Target Sussex Operating Model and Managed Equipment Service Contract procurement, 3. Workforce development and 4. Commercial structures for the network **Status –** LIMS procured, implementation timeline under review, DAP going live, TOM progressing toward agreed, quantified view, MSC delayed (HM Treasury), Collaborative MOU agreed for Network – long term structure in discussions	To create a mature pathology network across Sussex that: • Minimises variation in equipment, standards and governance • Maximises benefit of joint procurement • Realises a more productive operating model and capacity sharing • Allows for easy transfer of data (across providers and to users) • Enables workforce recruitment, development and retention Such that patients get more from Sussex pathology	Long term programme but contributes to: • Urgent and Emergency Board • Planned Care, Cancer and Diagnostics Board • Finance, Sustainability and Productivity Board • Digital and Data Board • Workforce Board
Radiology	Similar to Pathology but less mature as a programme – it is about forming a sub-regional network (including Frimley's system) to improve capacity and create a more sustainable operating model. Includes digital enablers and joint procurement/implementation - Ordercomms, SectraPACS, iRefer and Network developments **Status –** Digital elements are progressing – Ordercomms is live, SectraPACS is implemented and Phase 2 started, iRefer is a network plan – live in Primary Care. The network itself is developing a little more slowly – but has picked up pace and new governance was proposed and initiated.	To create a mature radiology sub-regional network that: • Maximises benefits from joint procurement • Standardises digital, referral and data sharing/image sharing platforms • Enables network wide use of capacity – improving productivity and speed of diagnostic pathways across the network • Enables sustainable capacity planning	Long term but contributes to: • Planned Care, Cancer and Diagnostics Board • Finance, Sustainability and Productivity Board • Digital and Data Board • Links to Primary care • Potentially support Health Inequalities objectives (i.e. reducing variation in diagnostic pathways)
EPR	Major digital programme to transform our patient record system in East Sussex. Enabler for multiple programmes and projects. Currently the programme is structured in 4 workstreams – Developing the Outline Business Case, Running the procurement, agreeing investment and funding and clinical engagement. Once a provider is agreed – the key step will be how users will transform the way they work. **Status –** After a bit of challenge by NHSE, we have approval of the OBC for East Sussex – with NHS Sussex/SDP support. Clinical and user engagement work has started.	• To enable a secure, paperless mechanism for recording patient information, management and clinical information and sharing it (as appropriate) far more easily across services and agencies – within the bounds of information governance • To enable multiple improvement and transformation projects (e.g. record sharing to support ICTs or the integrated Frailty pathway)	Long term but contributes to all SDP programmes in some way

Appendix

Aims of the Long-Term Improvement Priority areas

Long term improvement priorities

Integrated Community/Neighbourhood Teams (ESHT rep: Abi Turner, Deputy COO)

Oversee and support development of ICTs at Place, with increased focus on collaborative pathway design via joined up services

- Develop ICT framework to set out accountabilities
- Agree and formalise a 5-yr delivery plan, with Place and stakeholders at Place
- Serve as 'incubator' for ICTs, sharing ideas, knowledge, influencing co-design
- Oversee the alignment of transformation programmes that that support/enable ICTs

People & Development (ESHT rep: Steve Aumayer, Deputy CEO & Chief People Officer)

There are four actions/achievements:

- Action: Launch guaranteed employment scheme. Achievement: SPFT will have reduced MH nurse vacancy rate
- Action: Develop 5-yr people plan with an inclusive culture. Achievement: Agree one approach to workforce across system
- Action: Agree model for single workforce support package. Achievement: Have it in place
- Action: Identify communities to test 'one workforce' approach. Achievement: Begin roll out

Digital & Data (ESHT rep: Andy Bissenden, Associate Director of Digital)

Agree a delivery plan to outline end-state, and delivery goals. There are 9 goals listed in the TOR, including:

- Agree a digital charter all providers will work to
- Develop and use data derived from engagement
- Develop a single target operating model to streamline processes & approaches
- Develop and maintain a shared risk/security position re: data/cyber protection

Clinical Leadership (ESHT Rep: Simon Merritt, Chief Medical Officer)

Five objectives in-year:

- Appoint a clinical leader for each of the 3 ICTs by June 23
- Establish CRGs for each of the 11 workstreams by June 23
- Set out benchmarks for improvements in clinical outcomes by Sept 23
- Agree an approach to improvement (QI) by Sept 23
- Establish a clinical leadership academy by Mar 24

Aims of the immediate improvement priority areas

Immediate improvement priorities

Urgent & Emergency Care (ESHT rep: Garry East, Deputy COO)

Oversee delivery of NHS Sussex UEC strategy & ensure alignment across ICB partners/Place re: "patients waiting too long for UEC not always able to access right care/place/time"

Objectives are to oversee development/delivery of strategies/plans that will:

- Improve access to UEC, patients get timely care, place appropriate to their needs
- Minimise inpatients (working with community transformation teams)
- Improve inpatient flow to decongest EDs
- Improve ambulance response times

Social care & discharge (ESHT rep: Joe Chadwick-Bell, (Committee Chair) and Vikki Carruth, Chief Nursing Officer)

Aim: develop, design & test new approaches to Dx. Objective: more people are discharged from all settings, with right support

Actions:

- Reduce waits for dx – across all pathways
- Reduce time spent in dx – assess capacity, optimise flow, support patients
- Increase opportunities for w/e dx
- Impact acute bed occupancy – reducing it to 92%

Planned Care, Cancer & Diagnostics (ESHT rep: Andy Bailey, Deputy COO)

Overall remit/goals:

- Agree delivery plan, deliverables and workstreams

Primary Care (ESHT rep: Simon Dowse, Director of Strategy & Transformation)

Oversee a programme of work covering:

- Access to GPs – diagnose issues in accessing GPs, set out desired outcomes, support access issues around demand/capacity, use of tech, workforce & estate, interaction with UC services, approaches to popln health management
- 1ary Care integration - support/develop GP and pharmacy collaboration, including networks and capacity/capability building

Aims of the continuous improvement priority areas

Continuous improvement priorities

Mental Health, LD and Autism (ESHT rep: Vikki Carruth, Charlotte O'Brien)

Delivery board shall:
- Oversee deliverables as per the SDP
- Oversee the financial framework associated with delivery & ensure sustainability of MHLDA services
- Ensure services address the needs to make reasonable adjustments for our population
- Support clinical models that reduce unwarranted variation
- Ensure co-design/co-production in planning MHLDA services
- Support the Place-based MH oversight boards
- Ensure alignment with provider collaboratives for MH issues

Health Inequalities (ESHT rep: Richard Milner)

First year priorities are:
- Assure delivery against health inequalities & prevention priorities (Schedule N)
- Improve position against 22/23 baseline on hypertension and LLT therapy prescription
- Continue roll out of tobacco treatment services in inpt, maternity & MH
- Continue to address inequalities and improve outcomes for deprived/vulnerable patients as per CORE20PLUS5
- Develop defined work programme around CYP CORE20PLUS5

Finance, sustainability & productivity (ESHT rep: Damian Reid, Joe Chadwick-Bell)

Oversee delivery of the breakeven plan and drive a rolling productivity programme:
- Deliver b/e and oversee operational plan delivery
- Set b/e for 24/5
- Efficiency and productivity plans of providers and NHSS are delivered
- Develop a clinically-led process for optimising delivery models/services by YE 2023
- Produce comprehensive productivity plan by Sept 24
- Deliver initiatives to improve productivity by 7% cf 19/20 by Mar 24

East Sussex Healthcare NHS Trust

Response to Independent Inquiry into issues raised by the David Fuller case by Sir Jonathan Michael November 2023

Purpose of the paper	This paper sets out the Trust's response to the 17 recommendations from the Phase 1 report into the Maidstone & Tunbridge Wells (MTW) NHS Trust David Fuller mortuary inquiry of November 2023, setting out further actions where necessary.					
	For Decision		For Assurance	X	For Information	X
Sponsor/Author	Sponsor Dr Simon Merritt CMO Author David Garrett, Divisional Director of Operations, Core Services Division					
Governance overview	Quality & Safety Committee 18.01.24					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Trust Board is asked to note how the Trust's response to the 17 recommendations coming from the Jackson inquiry relating specifically to the MTW. This is ahead of a Phase 2 report due later in 2024 which will make recommendations to all trusts providing mortuary services.
Executive Summary	The Phase 1 inquiry report into the MTW David Fuller case, published November 2023, identified "*where governance, systems and processes…failed*" setting out 17 recommendations for MTW to immediately follow. Although these were specifically written for MTW to address, it is expected that the Phase 2 report, due later in 2024, will draw on these themes and ask all trusts to respond. This has provided the ESHT mortuary service with an opportunity to self-assess compliance. Sussex ICB have already asked ESHT to respond to the 17 recommendations which was done by Dr Merritt on 5th January 2024. The following table sets out the 17 recommendations and shows the ESHT mortuary response to these with actions and proposed timelines for completion where necessary.

Next steps	• Updates on progress will be provided 6 monthly to Trust Board and quarterly to Q&S Committee thereafter.

	Recommendation Detail	Trust Response	Further Actions	Due Date (calendar yr)
1	The trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.	**In core hours:** • Procedure is that in core hours all non-mortuary staff must ring the call bell even if they have swipe access. • Internal & external maintenance in core hours requires sign-in and sign-out in visitors log and mortuary staff are present or nearby. • All routine maintenance conducted in hours only. • EDGH Housekeeper works alone in core hours, has to ring the call bell and sign in and out (no swipe access granted), only scheduled to clean non-clinical areas • Any visitors that require access to the mortuary have to sign in on a visitors log and are thereafter supervised by a member of the mortuary team. • Contractors will only attend during core hours and will need to sign in. Thereafter mortuary staff will be present or nearby. **Out of Hours:** • Out of hours maintenance staff are required to sign in and out on visitor's log, procedure does not currently state that they must attend in pairs. Out of hours attendance would be access to the electrical cupboards within the mortuaries in both corridors or fridge alarms which Anatomical pathology technicians (APTs) are on call for as well so would be contacted should the need arise to attend. • Conquest housekeepers clean outside of core hours, with swipe access. Required to attend in pairs at all times. • Out of hours policy states that porters will accompany non-ESHT staff requiring access to the mortuary out of hours, they	Mortuary Access Policy to be written (combining current out of hours policy with the mortuary security procedure). Including a review of the following: Need to understand the process for OOHs maintenance: whether in pairs, how work is allocated (Estates) Review out of hours policy for maintenance staff. Change policy so that porters attend in pairs for collection of concealment trolley and body bags Review of collection and transfer of paediatric/neonatal patients by porters Review access for coroner's crew.	Q3 2024

		will return and secure the mortuary afterwards. • On-call APTs will attend in pairs. • Coroners crew also attend in pairs, without the assistance of mortuary staff. Access via swipe card individually provided. **In General:** • Porters may attend the mortuary on their own to collect equipment or transfer of paediatric/neonatal patients. • CCTV present in all areas of Mortuary (other than PM room). Swipe access recorded and monitored.		
2	The trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.	• Regular audit schedule covering HTA and ISO15189 Standards, including security audits. • No deceased patients are left outside of the refrigerated storage units overnight, the area in which patients are stored is covered by CCTV.	No action required	
3	The trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements	• Current Trust policy is that only those working in the Trust in frontline care roles are eligible for enhanced DBS checks. • For high-risk roles enhanced DBS should be repeated every 5 years or if someone changes job within the Trust. • All Mortuary Staff have had an enhanced DBS check in the last 5 years and will be subject to repeated checks every 5 years (arranged with HR)	Understand what level of checks non-mortuary staff and non-ESHT staff have including maintenance staff, coroner's crews etc.	Q2 2024
4	The trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.	• The mortuary team are supported by a well-defined management structure and quality management system accredited to ISO15189. • Very experienced mortuary lead, more than 20 years' experience working in the mortuary, certificate of APT completed 2003, Vtech 2005, Diploma (APT) 2006. Became senior APT in 2020, Deputy mortuary manager in 2021. • Structures defined in the Pathology quality management system.	Work towards uplift in role for the Deputy Mortuary Manager to become Mortuary Manager.	Q3 2024

5	The role of Mortuary Manager at the trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.	• Currently the Deputy Mortuary Manager fulfils most of this role with support from the principal BMS (Pathology Lead). Deputy Mortuary Manager to become Mortuary Manager once sufficient experience gained in managerial aspects of the role. • The Deputy Mortuary Manager regularly takes on hands on tasks and is the mentor for one trainee and one part qualified team member on all aspects of the training and the overseer of the third trainee and the mortuary assistant and the one bank staff. • Currently Deputy Mortuary Manager operates approx. 50% of the time as a dedicated role.	Complete training of current staff (over the next 4 years) Backfill to Deputy Manager role	2028 Q4 2024
6	The trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	• Only named individuals who require swipe access are granted this. • Swipe access applies to main mortuary access points. • Internal doors are locked with keys outside of core hours, to prevent access to PM room. • EDGH and Conquest porters have keys. • CCTV coverage across the mortuary	Mortuary Access Policy to be written (combining current Out of Hours policy with the mortuary security procedure). Need to establish security of porters keys at EDGH and Conquest Look at the feasibility of the mortuary being a 24/7 staffed service.	Q3 2024 Q1 2024 Q4 2024
7	The trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	• All policies and procedures are audited as part of a full audit schedule within the Pathology quality management system covering all aspects of the HTA and ISO15189 requirements. • Swipe access records and CCTV images are reviewed monthly by the mortuary team to ensure that there is no suspicious activity e.g. denial of access.	Annual audit to be set up to review who has swipe access and whether this is still appropriate. Further support required from the trust security team for reviewing swipe access patterns particularly out of hours. Consider how to enhance CCTV audit. Implement a reciprocal auditing programme with	Q3 2024 Q3 2024 Q4 2024 Q3 2024

			other mortuaries in the region	
8	The trust should treat security as a corporate not a local departmental responsibility.	• Currently security of the mortuary is treated as a departmental issue rather than a corporate concern. • Mortuary hold a record of those with authorised access, working together with both Trust security offices. Trust Security offices request authorisation from Deputy Mortuary Manager before allowing access to the mortuary on a swipe card. • Risk assessment for security is in place.	ESHT to further consider how security can be treated as a corporate concern. To include mortuary representation at Trust security forums Ensure that all security procedures are adequately recorded in the new policy. Risk assess the possibility of the Trust security team being involved in CCTV audits.	Q1 2024 Q1 2024 Q3 2024 Q4 2024
9	The trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.	• CCTV coverage of all areas of the mortuary including patient storage areas and entrances to the facility • There is no CCTV coverage in the PM room due to the nature of the work that takes place (privacy and dignity), however no access to patients is possible in this room (no “through fridges” – such as those at Maidstone and Tunbridge Wells) with the exception of when PMs are being conducted. • Refrigerator doors have key locks on MOST of the fridge doors at both sites but not all. Doors are not locked due to the need for access for Porters.	Review current CCTV governance e.g. DPIA Risk assessment of CCTV coverage in the PM room. Need to balance extra security with privacy and dignity of the patient. Consider the feasibility of installing swipe access to all doors, including fridge doors	Q2 2024 Q3 2024 Q4 2024
10	The trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.	• Swipe access records and CCTV images are reviewed monthly by the mortuary team. • Mortuary are not trained in CCTV handling.	See actions in 7 and 8 ESHT require further guidance on the meaning of “appropriately trained” staff	Q2 2024
11	The trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.	• HTA and UKAS inspections supported by management and escalated where necessary. • Other organisations may be NHSBT or retrieval teams, third parties that use our facilities for licensed activities. Donations for research on behalf of Parkinson/London brain bank.	Include HTA reports during contract review meetings. Check that retrieval and donation teams	From now on Q3 2024

		• All HTA inspection reports are public on HTA website as well as HTARIs. • Licence numbers displayed for visitors. • Trust given HTA report update via HTA governance meeting and external organisation reports.	have auditing in place. Include council and coroner's representation at HTA Governance meeting.	Q2 2024
12	The trust should ensure that the Local Authority has examined contractual arrangements with the trust to ensure that they are effective in protecting the safety and dignity of the deceased.	• East Sussex County Council (ESCC)contract is in place and is due for renewal in March 2024 process initiated in October.	During contract renewal ensure that the contract is reviewed to ESCC's as well as ESHT's satisfaction that the safety and dignity of the deceased is included.	Q1 2024
13	The Trust Board must ensure that the trust reviews it governance and monitoring processes in light of this report.	• Process underway, first report to be delivered to the Trust board in February.	Report regarding the response to this enquiry to be submitted to the Trust board in Feb	Q1 2024
14	The trust board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.	• It is necessary to ensure a clear line of governance to provide assurance to the board regarding any Mortuary/HTA activities: HTA governance meetings take place at which the Designated Individual (Divisional Director of Operations) attends along with the HTA Licence holder (Chief Medical Officer).	Agreed for DI at ESHT to report 6 monthly to Board from February 2024 onwards and quarterly to Trust Quality & Safety Committee. Review HTA governance membership e.g. consider additional divisional representation	Q1 2024 Q2 2024
15	The trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.	• HTA governance meetings held, chaired by the HTA Designated Individual (Divisional Director of Operations) at which all HTA matters including HTA reportable incidents are discussed. • HTA licence held, regularly take part in self audit submissions and inspections.	No further action at this stage. Further action may be required in Phase 2.	
16	The executive should be made explicitly responsible for assuring the trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.	• HTA licence holder (Chief Medical Officer) attends HTA governance meetings and can escalate any matters to the Board. • Corporate nursing briefed where required.	Ensure ongoing attendance of all personnel with HTA responsibilities at the HTA governance meeting.	Ongoing

17	The trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.	• Mortuary involved in the development of the Trust End of Life Care Policy • There are detailed SOPs which are regularly reviewed and acknowledged by the mortuary team. • Mortuary staff engaged and recording CPD over and above mandatory training. • Mortuary Staff competencies are in place providing assurance that procedures and standards are followed.	Trust to ensure that the Mortuary team and those with HTA responsibilities are involved in the ongoing review of the End of Life Care Policy.	Q1 2025 (review date of policy)

East Sussex Healthcare NHS Trust

Annual Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation

Purpose of the paper	An annual review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation has been undertaken and proposed revisions are set out below.						
	For Decision	x	For Assurance		For Information		
Sponsor/Author	Sponsor: Damian Reid Author: Pete Palmer						
Governance overview	This paper was presented to the Audit Committee on 25th January 2024, who endorsed the updated Trust governing documents for approval by the Trust Board.						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x	x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x		x	

Recommendation	The Trust Board is asked to endorse the proposed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Executive Summary

The Trust Board is required to review and update the Trust's governing documents on an annual basis. The documents reviewed are:

- Standing Orders: cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities.
- Standing Financial Instructions: detail the financial conduct and governance of the Trust and requirements therein.
- Scheme of Delegation: lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated.

The annual review is undertaken jointly by the Director of Finance and Board Secretary, with input from the Deputy Director of Finance and the Head of Procurement.

All of the documents were subject to a full review and as a result a number of non-material changes, to improve clarity and consistency, were made throughout the documents to bring them up to date. In addition, a number of material changes are proposed to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation and these are detailed below.

A full set of the updated governing documents can be found in the appendix to the Board papers. The proposed changes to these documents are highlighted in red text within that document for the Board's convenience.

Standing Orders

Page Number and Reference	Detail	New wording (in bold)
P20 4.8.7	Added information about the Inequalities Committee	**Inequalities Committee** **The Trust Board will establish an Inequalities Committee to provide a Board level focus on the Trust's broad approach to equality, both in staffing and service delivery.** **The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least three non-executive directors, one of whom will be the Chair of the People and Organisational Development Committee.**
P20 4.8.8	Added information about the Executive Committee	**Executive Committee** **The Trust Board delegates power to the Executive Team to oversee the management of an effective system of governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. They exercise this function in collaboration with senior operational colleagues through the Executive Committee.**
P23 7.1.1 (i)	Added clarification that Board members should declare any interests they hold on an annual basis	The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests **on an annual basis**. Any Board members appointed subsequently should do so on appointment **and thereafter on an annual basis**.

Standing Financial Instructions

Page Number and Reference	Detail	New wording (in bold)
P37 2.4.2	Added information about the Trust's policy for the purchase of non-audit services from the appointed external auditor.	**The Trust will not purchase any non-audit services from its appointed external auditor unless required to do so by NHS England or the Department of Health.**
P50 7.5.5	Update inconsistency in wording relating to process for ensuring fair and adequate competition	Where the exceptions set out in SFI Nos. 7.1, 7.5.3 and 7.5.4 **don't** apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate
P55, 7.6.10	Clarified process for reinvolvement of staff in repeat tendering process. Original wording did not allow for any staff reinvolvement, which can be restrictive when dealing with very small teams.	Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced, **the reinvolvement of** any staff member involved in the original process **should be reviewed** before any involvement in the new process.
P56 7.8	Updated UK Public Procurement Threshold to £139.688 + VAT	-
P56 7.8	Updated approvals process for authorisation of tenders and competitive quotations both for spend within current budget and new spend. These changes mean that document now more accurately reflects the process that is in place.	
P84, 22.4.2	Updated waiver authorisation levels to provide consistency with authorisation levels updated throughout the SFIs in the 2022/23 update.	
P 87-92	Updated waiver form added	

Scheme of Delegation

	Page Number and Reference	**Detail**	**Replaced with**
	P119-121 Section 2, 4	Updated approval thresholds for quotations, tendering and contract procedures to provide consistency with authorisation levels updated throughout the SFIs in the 2022/23 update.	-
	P127 Section 2, 8a ii	Updated approval thresholds for Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods and Services to provide consistency with authorisation levels updated throughout the SFIs in the 2022/23 update.	-
Next steps	If endorsed by the Trust Board the Governing Documents will be updated on the Trust's intranet.		

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF) Update

Purpose of the paper	This paper updates the Trust Board as to the progress in managing the Board Assurance Framework's (BAF) Q3 2023/24 position.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Chief of Staff/Board Secretary					
Governance overview	All BAF risks were refreshed for 23/24 at the May Seminar and drafted initially by sub-committee Chairs and relevant EDs. They were reviewed by the Board and amendments were made and shared with the Board Secretary. Each BAF risk has been reviewed by the Chief of Staff and Executive Risk Owner. Collectively the full BAF is reviewed at Executive Directors and shared quarterly with the Audit Committee before going to the next scheduled Trust Board. Each Board sub-Committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter.					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x		x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
		x		

Recommendation	The Trust Board is asked to note the completed summary position for BAF risks and Q3 positions of each risk, having been reviewed by each Board sub-Committee
Executive Summary	This paper comes to Trust Board via Audit Committee provides an overview of the Q3 risk position for each of the twelve BAF risks, following discussions with executive risk owners and interrogation at the relevant Board sub-Committees. Each sub-Committee has reviewed the risk descriptions, mitigations and positions contained within the Q3 update. Against the anticipated YE risks, nine of the twelve are shown as being at the YE levels, with the remaining three being above the anticipated YE level. The reasons for this are contained within the relevant BAF risks and have been shared with the relevant sub-Committees. In terms of risk assessment changes between Q2 and Q3: • The Q3 rating and anticipated year-end rating for BAF 4 have risen from 12 to 20, due to the significantly increased risk of a deficit forecast for 2023/24. While, at month eight, there was an expectation of delivering a breakeven position this was on the basis of no further strikes after November 2023. Ongoing strike actions, and a lower than anticipated ERF settlement, mean that the Trust will need to review its forecast in month ten. • The Q3 rating for BAF 9 has dropped from 16 to 12 on the basis that the further discussions around how we will build capacity in QI in both the short and medium term has now meant that we have a clearer plan as to our ambitions for 24/25 and how this will support both our objectives and the transformation programme. It is therefore anticipated that this risk will achieve its YE anticipated position. • The anticipated year end rating for BAF 3 has dropped from 16 to 12 due to the ongoing and sustained improvement seen across workforce metrics (for example turnover and vacancy rate) and despite the expectation that industrial action will continue.
Next steps	Mitigating actions as detailed in each BAF risk summary remain under review by the Board sub-Committees and will be reported in the Q4 (YE) update to the next Board.

Board Assurance Framework (BAF)

East Sussex Healthcare NHS Trust

Quarter 3 Update 2023/24 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 Five), 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 Four). 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.

The Trust Board discussed an updated BAF In April and May 2023, agreeing updated BAF risks and the organisation's risk appetite for each. The Trust's Corporate Risk register contains all of the risks in the Trust that are rated as 15 or more. The majority of risks included on the BAF are included on the Corporate Risk Register, which is presented in full to the Audit Committee alongside the BAF.

Links between each BAF risk and the risks on the Trust's Corporate Risk Register can be found in Appendix One.

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

East Sussex Healthcare NHS Trust

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Anticipated YE Risk	Target date
								2023/24							
								Q1	Q2	Q3	Q4				
1	Capacity constraints associated with supporting the collaborative infrastructure	Strat	X			X	9	6	6	6		◄►	Seek/ Significant	6	Review every two months
2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD		X	X	X	15	15	15	15		◄►	Open	15	Ongoing
3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD		X	X	X	20	16	16	16		◄►	Cautious/ Open	12	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	12	12	20		▲	Cautious	20	31/01/23
5	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff	F&P		X	X	X	20	16	16	16		◄►	Cautious	16	Ongoing
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	16	16	12	12		◄►	Minimal	12	Ongoing
7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	16	16	16	16		◄►	Open	12	Ongoing
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	16	12	12	12		◄►	Significant	8	31/03/26
9	Failure to maintain focus on improvement	Strat		X		X	16	16	16	12		▼	Open	12	Review every two months
10	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay	Q&S	X	X	X	X	20	16	16	16		◄►	Open/Seek	12	Ongoing
11	Failure to demonstrate fair and equal access to our services	Strat	X			X	15	9	9	9		◄►	Cautious/ Open	9	Review every two months
12	Failure to meet the four-hour standard	Q&S	X	X	X	X	20	16	16	16		◄►	Cautious	16	Ongoing

Strategic Aim 1: Collaborating to deliver care better | Strategic Aim 2 : Empowering our People | Strategic Aim 3: Ensure Innovative & Sustainable Care | Strategic Aim 4: Improving the health of our communities

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.

Key to Risk Appetite Ratings		
0	None	Avoidance of risk is a key organisational objective
1	Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
2	Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
3	Open	Willing to consider all potential deliver option and choose while also providing an acceptable level of reward
4	Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
5	Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Key to Risk Rating Types	
Inherent Risk Rating	The amount of risk that exists in the absence of controls
Residual Risk Rating	The amount of risk that remains after controls are accounted for.
Target Risk Rating	The desired optimal level of risk.

RESIDUAL RISK MATRIX (Risk assessment post-controls/mitigation)

		Collaborating to deliver care better	Empowering our People	Ensure Innovative & Sustainable Care	Improving the health of our communities
BAF 1	Capacity constraints associated with supporting the collaborative infrastructure	6			6
BAF 2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.		15	15	15
BAF 3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.		16	16	16
BAF 4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery			20	20
BAF 5	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff		16	16	16
BAF 6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	12	12	12	12
BAF 7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions			16	16
BAF 8	Failure to transform digitally and deliver associated improvements to patient care			12	12
BAF 9	Failure to maintain focus on improvement		12		12
BAF 10	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that no longer meet the criteria to reside	16	16	16	16
BAF 11	Failure to demonstrate fair and equal access to our services	9			9
BAF 12	Failure to meet the four hour standard	16	16	16	16

Risk Summary							
BAF Reference and Summary Title:	BAF 1: Capacity constraints associated with supporting the collaborative infrastructure			Strategic Aims Impacted			
				x			x
Risk Description:	Resourcing pressure arising from support/presence at partnership initiatives diverts leadership resource from internal ESHT priorities						
Lead Director:	Chief of Staff	Lead Committee:	Strategy & Transformation Committee		Date of last Committee review:	07/12/2023	

BAF Risk Scoring									
Inherent Risk	Residual Risk	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Review
	Likelihood:	2	2	2		The synergy between System-level success and organisation-led delivery to achieve this aligns Sussex-wide goals with what Trusts are doing.	Likelihood:	2	
	Consequence:	3	3	3			Consequence:	3	
(3x3)	Risk Level:	6	6	6		However, this risk reflects the potential disadvantage of this tie-up; namely that key senior leaders' capacity is stretched across external meetings as well as internal ones.	Risk Level:	6	Every two months via Strat Com
9						To date, the Trust has managed within its existing resources and we intend to do so (hence the risk score for Q1) but – especially in certain areas – there is a recognition that ICB resource is well-provided for and, with this, comes a commensurate range of ambitions and scale of workload.			

Cause of risk:	• New/evolving governance forums leading to the time commitment of ESHT senior leaders being compromised	Impact:	• Internal priorities focused on delivery of ESHT 23/24 objectives may be compromised by relevant senior leaders being at other meetings
Current methods of management (controls)	A. Robust monitoring process via EDs, IPRs enabling teams to flag where pressures arise – either on external commitments or internal presence being compromised to the point where senior leaders' grip on internal priorities is suboptimal		

Assurance Framework – 3 Lines of Defence – linked to control (above)			
	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:	• Teams to consider alternative options/resources to ensure ESHT collaboration is maintained at an appropriate level	• Teams able to escalate to EDs for review/support/mitigation options • EDs to consider alternative resource and appropriateness to the responsibility levels	• EDs to raise with external partners as required where no alternative resource is available

Gaps in control/assurance:
• None seen currently

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**

There is no change from the Q2 position. Current proactive management and ongoing ICB review of meeting commitments means that we are confident of reaching the anticipated YE risk score of 6. We maintain good, open relations with ICB colleagues and are comfortable escalating where we feel requirements stretch internal resource in order to support ongoing ICB areas. Attendance issues are flagged via Executive Directors meeting and/or Divisional IPRs and our discussions with the relevant partners to seek to manage expectations on attendance have so far been extremely positive.

Risk Summary						
BAF Reference and Summary Title:	BAF 2: Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time				Strategic Aims Impacted	
					x	x	x
Risk Description:	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term					
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	21/09/2023	

	BAF Risk Scoring								
Inherent Risk	Residual Risk	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x3) 15	Likelihood:	5	5	5		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 is a clear risk given the ongoing operational pressures being experienced locally and across the NHS. The Trust's age profile presents a specific risk to longer term retention with around 20% of our workforce are at a point where they are technically able to retire. Industrial action relating to the BMA continues to present short term workforce issues and disquiet in the workforce. The risk rating remains as for Q2 2023/24 based on the nature of the industrial action. The anticipated year end risk reflects the ongoing threat of industrial action.	Likelihood:	5	Ongoing
	Consequence:	3	3	3			Consequence:	3	
	Risk Level:	15	15	15			Risk Level:	15	

Cause of risk:	• Industrial action • Recognised national shortages in some staff groups • Geographical location, demographics and age profile of workforce • Continued operational pressure in a number of clinical areas • Lack of opportunity for career development • Working pressures over the last three years have had a detrimental impact on staff retention (although turnover rates for the last nine months have been reducing) • Withdrawal of Brighton University from East Sussex may impact on the number of trainees choosing to base themselves in East Sussex during their training, which may reduce the number of potential employees seeing the Trust as a natural first choice for post training employment	Impact:	Failure to maintain workforce stability gives rise to risk of: • Not being able to deliver activity in line with operational needs • Detrimental impact on patient care and experience • Detriment to staff health and well-being • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas • Failure to comply with regulatory requirements and constitutional standards • Detriment to performance and productivity • Increased workforce expenditure due to agency requirements

	• Withdrawal of funding for registered nurses associates to undertake two year degree to become fully registered nurses		• Inability to ensure 'great place to work' culture and climate thus frustrating strategies and efforts to attract, recruit, retain, deploy, and develop staff

Current methods of management (controls)	A. Ongoing monitoring of Attraction, 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, succession planning, appraisals and development programmes C. Developing new roles and "growing our own" e.g. New to Care D. Workforce efficiency metrics in place and monitored E. Quarterly 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 and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Stay interview and exit interview programmes I. Use of bank and agency where required J. Focus on retention particularly on understanding why people may want to leave the Trust. K. Use of government initiatives e.g. Kickstart L. Flexible working M. More flexible use of retire and return N. Proactively building our positive reputation as an employer O. Implementation of an industrial action project to mitigate the impact of colleagues taking industrial action P. Assurance is being provided re industrial action preparedness to system and region via self-assessment checklist Q. Ongoing responses to key themes from staff survey

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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 e.g. consultants in Histopathology, Radiology, Neurology, Orthopaedics and Acute medicine.(A) (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Workforce efficiency metrics (D) • New AHP /HCSW initiatives (C) • Continued International Nurse recruitment. c70 in total for 2023/24 (A)	• 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) • Three-year Attraction and Recruitment Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Temporary workforce costs scrutinised by Finance and Productivity Committee (I)	• 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) • NHS Staff Surveys and Pulse Surveys and benchmarking data (A) (B) (C)

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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)*
	• Additional Headhunter Agencies engaged for hard to recruit Medical Posts (A) • Regular meetings with Regional Post Graduate Deans for Acute and Primary care (C)(J)(N) • Job plans in place for all doctors (B) • Industrial Action working group and daily resource meetings attached to site meetings (O)(P) • In the event of industrial action, reduction in services to ensure all urgent and derogated services are delivered (O)(P)	• Wellbeing offering enhance (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy is being delivered (A)(B)(C)(D)(E)(F)(I)(K) • Ongoing recruitment campaigns for hard to fill roles (A) • Delivery of an employee value proposition (EVP) in 2023/24 • NHS Workforce long term plan implementation	
Gaps in control/assurance:			
• None identified			

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.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers, Gastro and Endoscopy	Chief People Officer	Ongoing	• Continued recruitment campaigns with both Medacs and MSI agencies to source International Nurses, AHPs and Medics. Target of 70 International nurses this financial year(2023/24) achieved. 9 International Radiographers recruited year to date. • Additional Recruitment agencies engaged to support with hard to recruit posts. • Local and UK recruitment campaigns continue. Trust main sponsor for recruitment event in Bexhill. • Trust continues to work with external recruitment agencies to assist with recruiting 'hard to fill posts'. Number of initiatives in place to support recruitment e.g. assistance with relocation/onboarding of new colleagues • Increased number of direct applicants to hard to recruit posts i.e., Consultant Neurology/Respiratory and Anaesthetics.	G

2.	Local outreach initiatives	Chief People Officer	Ongoing	• Trust working with DWP and Princes Trust. To date c60 young adults supported with Prince Trust initiative. Recruitment events attended in conjunction with DWP. Planned events for 2024/25 • Trust working with other ICB organisations with regards local recruitment activities and initiatives e.g. 'Recruitment Hub' which is due to go live Feb/March 2024 • Trust involved with both Little Gate Farm and Project Search initiatives. • Campaign to increase volunteer numbers across the Trust.	G
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	Chief People Officer	Ongoing	• SCP :We continue to have two SCP on programme at Anglia Ruskin University the course is for 2 years part time. Meeting scheduled to discuss future SCP development for 23/24 to 27/28 for the NHS England Workforce Training and Education commissioning process. • PA Role : Conversations to formalise the lead PA appointment. There is a one off payment of 20k funding from the ICB to support this role, with additional funding for a Band 7/8a to support the. A meeting, in collaboration with UHSx is scheduled to discuss support to take the role forward in light of new NHS Workforce Plan released this week. • Education Steering Group: ToRs are currently being reviewed. The new Deputy Chief Medical Office – Workforce will co-chair the group. • Anaesthetic Associates: Recent meetings held with clinical lead and division, as well as with the GMC's lead for anaesthetic associates. NHS England announced pump prime funding to support development of the role in Trusts. Business case to be written for development of x2 anaesthetic associate roles in the service with funding from NHS England.	G

Risk Summary							
BAF Reference and Summary Title:	BAF 3: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.				Strategic Aims Impacted		
						x	x	x
Risk Description:	There is a risk that any decline in staff motivation negatively impacts on our ability to deliver the required levels of activity to the standards we require.						
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	21/09/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4	4		Data is showing that engagement levels across the NHS and locally have reduced over the past three years Elongated industrial action without resolution may further impact on the motivation and morale of colleagues taking industrial action and those directly impacted by it, and our ability to deliver services in a timely and efficient way. The anticipated year end risk is based on industrial action continuing, but an ongoing improvement in other metrics (e.g. turnover, vacancy rate)	Likelihood:	3	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	16	16			Risk Level:	12	

Cause of risk:	Ongoing operational instability and pressures, alongside workforce availability and industrial action.	Impact:	Adverse impact on staff engagement, health and wellbeing could lead to increased absences and turnover, and an associated inability to deliver services, possible closure of services and adverse impact on patient experience and reputational risk.

Current methods of management (controls)

A. Training for managers to have compassionate conversations about risk assessments with vulnerable staff
B. 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.
C. Working with the ICS to develop a system wide strategy and policy on violence prevention
D. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work.
E. Reviewing and implementing best practice from other areas (e.g. TRiM, MHFA)
F. Targeted support for implementing TRiM in ED departments through a dedicated resource for a period of three months
G. Range of wellbeing/pastoral support available and being further developed across all professional groups
H. Development of Health and Wellbeing Conversations for all colleagues
I. Ongoing focus on Violence and Aggression with ambition to become upper quartile organisation
J. Ongoing National vaccination programmes
K. Workforce Efficiency and Availability Reviews

	L. Workforce Strategy M. Admission avoidance and discharge activity through operational teams N. Working with the entire system, third sector and independent health and social care organisations to assist them with recruitment and training. O. Effective rostering and leave management P. Undertaking deep dive cultural reviews in areas where there is particular concern regarding colleague engagement and morale

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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:	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • Completion of risk assessments to be recorded on ESR. (A) • Promoting wellbeing support available and training to line managers (G) • DME monitor/reviews confidential trainees in difficulty register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs (I) • Appropriate PPE provided (A) • Ongoing reviews of effectiveness and efficiency of rostering to deliver the required staffing levels	• 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) (H) (I) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Local Security Management Specialist advice and support (D) • Oversight and monitoring by Health and Safety Steering Group (D) • Deep dive cultural Reviews (P) • Implementation of NHS Long term workforce plan	• ICS 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) • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust (H)(L)
Gaps in control/assurance:			
• *None identified*			

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.	People Strategy	Chief People Officer	Ongoing	• People Strategy has undergone year 2 refresh and this established programme of works and has reported to POD. • Further updates will continue on a quarterly basis	G

Risk Summary							
BAF Reference and Summary Title:	BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery			Strategic Aims Impacted			
						x	x
Risk Description:	At month nine the Trust has been asked to deliver a breakeven position, However given current industrial action and a lower than expected ERF settlement this will be reviewed at the month ten submission.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	28/09/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	3	3	5		**Likelihood**: There is an expectation to deliver breakeven, although this had been on the basis of no ongoing strikes after November 2023. The Trust will need to review its forecast at month ten given the position on industrial action and lower than expected ERF settlement. **Consequences**: There is a significantly increased risk of a deficit forecast. Whilst the consequences are potentially severe, we are cognisant that the challenges faced by the Trust are common with many NHS providers and therefore the regulatory response will likely be proportionate in that context. Therefore, the consequence has been capped at a 4. There has an adjustment for industrial action up to month eight. However, the forecast at month ten will be to allow for the additional current pressures.	Likelihood:	5	31/03/2024
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	12	12	20			Risk Level:	20	

Cause of risk:	• ERF activity is being delivered to plan; however, pay and non-pay costs have also risen. • Increased operational pressures and in particular patients not meeting the criteria to reside meaning that we face additional operational flow pressures. • Failure to deliver sufficient recurrent efficiencies • Ongoing lack of resolution of strike actions • Inflation pressures resulting from recent contract awards	Impact:	Failure to maintain financial sustainability gives rise to risk of: • Unviable services and increased cost improvement programme; • Additional controls will be imposed by the national team. Controls are being increased across NHS England. • Damage to Trust's stakeholder relationships and reputation.
Current methods of management (controls)	A. Efficiency programme is in place with targets set and monitored at divisional level; B. Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive; C. Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay; D. Staffing controls through establishment control, including vacancy panel; E. Productivity Director has implemented project controls on CIP plans		

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:	• Work continues through divisional meetings, at IPRs and joint COO/CFO additional reviews to both maintain contingency and to strengthen recurrent delivery of overall financial position and the efficiency programme. (A) (B) (D) • Procurement, Temporary Workforce Services and vacancy panel all monitor compliance as appropriate with scheme of delegation and SFIs (C) (D)	• Oversight by Efficiency Committee and Finance & Productivity Committee (A) • Revised SFIs and SoD (C)	• Internal audit reviews (A) (B) (D) • External audit programme in place (A) (B) (C)
Gaps in control/assurance:			
None identified but need to ensure that the system of internal financial control remains robust.			

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.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	31/03/2024	• At M9 there are plans in place for the full £32.5m CIP, with £20m delivered to date. However, industrial action, temporary staffing costs and some elements of waiting list initiatives has resulted in a delivery shortfall of £2.3m. • The latest forecast is £25.3m delivery, resulting in a shortfall of £7.2m, this is primarily due to non-delivery of ERF in Theatres £3m (this position improved in M9), Length of Stay £3.2m (additional beds have opened in December). • Additional control measures were agreed in November, including ensuring we are following national rules on agency/bank/consultancy to reduce the gap to deliver the Trust break-even plan. • However, with the impact of industrial action and winter there is still a significant risk to overall delivery.	R
2.	Establish a finance and activity focused accountability session chaired by COO and CFO with each division covering financial performance, activity and efficiency to increase scrutiny, grip and control above the existing IPR process	Chief Financial Officer	31/03/2024	• Finance and Assurance meetings have been taking place for a number of months. • Service level recovery plans have been developed and an update will be provided to the Finance and Efficiency on 15th January.	A

Risk Summary							
BAF Reference and Summary Title:	BAF 5: The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff				Strategic Aims Impacted		
						x	x	x
Risk Description:	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	28/09/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4	4		The Trust's capital budget for 2023/24 is £23.3m (excluding capital for strategic projects from ICB, national and NHP), comprising £3.5m on diagnostic and medical equipment, £3m on digital, £7.3m on estates backlog and other schemes. Given the overall level of backlog for the estate, medical equipment and digital, the planned annual expenditure is not enough to meet the significant backlog that exists. Following completion of the options appraisal for Building for our Future (BFF) we will have a greater understanding of the residual backlog which will be left post the BFF works. We anticipate that this work will be completed in early 2024. We are working with a consultancy to undertake a review of critical infrastructure and clinical activity/risk which should be available in March 2024. This should clarify the level of capital backlog and how that will affect future capital spend and may result in a risk rating on the BAF. An interim report on backlog will be presented to the F&P Committee in December 2023, with a full report to follow in March 2024.	Likelihood:	4	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	16	16			Risk Level:	16	

Cause of risk:	Insufficient capital to meet significant backlog	Impact:	Lack of capital for investing in the future sustainability of the Trust 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. Significant work is always undertaken to deliver the capital plan B. Essential work prioritised with estates, IT and medical equipment

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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 Productivity and Strategy Committees (A) • Estates and Facilities IPR (A) (B) • Clinical procurement group in place (A) (B)	• Capital business cases reviewed by ICS (A) • Review of critical infrastructure (A) (B)

Gaps in control/assurance:

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed and not clear at present
- Availability of project managers to deliver the backlog programme

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.	ICS will undertake a medium term financial plan	Chief Finance Officer	Ongoing	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	A
2.	Through New Hospital Programme business case process and associated enabling business cases, Trust will be addressing solutions for backlog maintenance	Chief Finance Officer	March 2024	• Priorities to be developed into the New Hospital Programme Case	A
3.	Options appraisal for Building for our Future (BFF) to be undertaken	Programme Director BFF	March 2024	• We anticipate that this work will be completed in early 2024.	A
4.	Work to be undertaken with consultancy to review critical infrastructure and clinical activity/risk in order to clarify the level of capital backlog and how this will affect future capital spend.	Director of Estates and Facilities	March 2024	• Work with consultancy commenced in December 2023.	G

Risk Summary							
BAF Reference and Summary Title:	BAF 6: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	Current mitigations include rollout of MFA to key users, plan to minimise non-supported software and contain software that cannot currently be removed, and ensure offsite backup.						
Lead Director:	Chief Financial Officer	Lead Committee:	Audit Committee	Date of last Committee review:	28/09/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	4	3	3		A number of elements of the cyber action plan have been delivered, reducing our cyber exposure. 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. A significant amount of work has been done to increase the robustness of the Trust Cyber security posture. The current security risk status has reduced to which has been a great achievement. But the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations. We have created a Cyber Action Plan, which has got the Trust to medium risk status, which has resulted in the risk rating being reduced to 12. We continue to work towards receiving Cyber Essentials Plus accreditation. The action plan has four elements: 1. Internal Audit recommendation 2. Cyber Essentials Self-assessment recommendations 3. External Penetration Test recommendations 4. 12 Risks on the trust risk register	Likelihood:	3	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	12	12			Risk Level:	12	

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.

	• Infrastructure Hardware failure, due to unsupported systems or lack of Capital Refresh.		
Current methods of management (controls)	A. Network Monitoring 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. Ongoing Education campaign to raise staff awareness. F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary H. Continual Network monitoring for abnormal activity / behaviour I. Vulnerability scanning, to identify vulnerabilities and remediate J. Migration of Clinical Systems to the Cloud K. Strategy of Cloud first, so Software as a service or platform as a service on any new procurements L. Rolling refresh of infrastructure Hardware, LAN, Wi-Fi, Servers, and Client Devices.		

Assurance Framework – 3 Lines of Defence – linked to controls (A-L)			
	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) (H) (I)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with organisations within the Sussex ICS (G) • Regular quarterly security status report to IG Steering Group and every six months to Audit Committee (D) • Monthly reporting via NHS Digital on Cyber Exposure score (D)	• Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex, and two internal events at ESHT with senior leaders (E) • Trust to date has had no ransomware attack (A) (B) (C)(H)(I) • RSM internal audits throughout 2023/24 (D) • Final submission of DSPT for assurance to internal auditors took place in June 23 (D)
Gaps in control/assurance:			
• Obtain Cyber Essentials Plus to provide assurance on reliability and security of systems and information. Continue with patching programme and address points raised by internal audit • Cyber Action plan developed which sets out all of the actions that would need to be taken to mitigate cyber risks			

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.	Cyber Essentials framework.	Chief Finance Officer	Ongoing	• Internal Cyber Essentials self-assessment completed with identifies gaps in compliance • Gaps have been used to create the cyber action plan • Next step is to mitigate gaps in compliance	*G*
2.	Medical devices with network connectivity asset list	Chief Finance Officer	2024	• Celera, an auditing tool, has been installed and is now running network audit. Further work required to enable greater visibility • Anticipate that full visibility will be delivered at EDGH by October 2023 • Conquest delivery anticipated in 2024	*G*
3.	LAN Refresh EDGH	Chief Finance Officer	February 2024	• Replace the Core Network and Fibre connections to the Edge Switches anticipated to be complete by December 2023, this was delayed, but all prep work complete and Jan / Feb for final migration	*A*
4.	LAN Refresh Conquest	Chief Finance Officer	March 2024	• Replace the Core Network and Fibre connections to the Edge Switches • Suitable locations identified with estates and design has now been completed • Orders are being placed. • Estates work started on Core Network location	*A*
5.	24/7 Cyber Operations Centre	Chief Finance Officer	Complete	• In place and Complete	*G*
6.	Active directory migration	Chief Finance Officer	December 2024	• New domain has been built • Migration of users December 2023 • Migration of devices January 2024 • Migration of services December 2024	*G*

Risk Summary							
BAF Reference and Summary Title:	BAF 7: Failure to develop business intelligence weakens insightful and timely analysis to support decisions				Strategic Aims Impacted		
							x	x
Risk Description:	Currently developing daily, weekly and monthly dashboard. Aim to develop self-serve as a second stage.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	28/09/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	4	4	4		A large number of clinical systems and complex data structures, along with a variety of reporting methods and a lack of controls around the data quality leads to a lack of confidence in the data that we produce.	Likelihood:	3	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	16	16			Risk Level:	12	

Cause of risk:	• There are a large number of complex clinical systems used across the Trust. • Variable quality of data input into systems • Number of systems can lead to duplication of data entry • Limited assurance available about the data reported outside of the organisation	Impact:	• Inability to make clinical decisions. • Impact of potentially incorrect data on business planning • Impact of using potentially incorrect data when reporting nationally.
Current methods of management (controls)	A. Local data management policy which includes clear reference to performance data collection, collation and reporting processes; offers a localised point of reference that can provide more clarity to Trust officers than relying solely on national guidance. B. Standard Operating Procedures which assist in ensuring a consistent approach in line with policy by all involved in processes. C. Awareness Training D. Process Mapping E. Responsibilities of all staff groups involved in the process are clearly defined and documented. F. Manual Validation of collected data prior to reporting. G. System Validation – automated checking (such as reasonableness, completeness) of data prior to reporting.		

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:	• Incidents – there have been incidents (or no incidents) relating to the accuracy of data in this metric. (A)(B)(C)(D)(E) • Process Improvement – processes relating to the collection/collation/reporting of data have been subject to improvement. (A)(B)(C)(D)(E)(G) • Recruitment of Data Quality lead (A)(B)	• Observation/Feels Right – the executive and/or operational lead considers that the reported figures feel correct and are consistent with observations and frontline feedback. (F) • Benchmarking – reported figures for the Trust are comparable with similar organisations. (F) • Business Intelligence Team View – Business Intelligence/Knowledge Management opinion on the accuracy of the data being reported. (F)	• External Review – external organisations (e.g. CQC) have recently reviewed the data and/or data collection processes. (F) • Internal Audit/Granularity – Internal Audit (or another assurance function) has conducted a recent, detailed review of the current process. (A)(B)(F)

Gaps in control/assurance:

- Clear national guidance reduces the risk of inaccurate data being reported and is not available for all metrics.
- Level of automation. Significant manual intervention increases the risk of human input errors.
- Complexity of rules, where the rules set out in national guidance are highly complicated and risk misinterpretation.
- System set-up. Nationally validated systems tend to assist in providing consistency in application of rules and reported data across multiple organisations, providing a greater source of confidence than locally developed systems.
- Weakest link, where there may be a single point in the process where data quality could be compromised, such as an individual making a process error that impacts on reportable figures.
- Sensitivity, where small reportable numbers mean any error is exacerbated.
- Dependency on external bodies to validate data prior to reporting.
- Opportunity for manipulation if there is any point within the process whereby any individual (or group) can alter reportable figures so that the data is no longer true or accurate.

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.	Recruitment of replacement Data Quality and Assurance Lead	Chief Finance Officer	January 2024	• Data Quality and Assurance Lead being recruited. • Continue data quality steering group and further development of framework	A
2.	Electronic Patient Record (EPR) procurement	Chief Finance Officer	March 2024	• Outline business case and specification completed, and review of invitation to tender being completed. • OBC has been signed off by the national EPRIB Board • Procurement will start in March 2024 • A large number of posts have been recruited to support procurement and implementation.	G
3.	Development of Power Business Intelligence (BI) Reporting	Chief Finance Officer	Ongoing	• Daily, weekly, and monthly dashboards have been completed • Development of divisional reporting • Development of updated Board IPR	G
4.	Upskilling the Business Intelligence team	Chief Finance Officer	Ongoing	• Provision of suitable training in the development of Power BI	A
5.	Development of new data warehouse	Chief Finance Officer	December 2024	• Move Systm One to Azure Modern Data Platform (MDP) • Move NerveCentre to MDP • Integration of new EPR into MDP	A

Risk Summary							
BAF Reference and Summary Title:	BAF 8: Failure to transform digitally and deliver associated improvements to patient care				Strategic Aims Impacted		
							x	x
Risk Description:	Currently targeted investment in LIMS Pathology, Sectra Radiology, and virtual wards. Full Business Case for Electronic Patient Records to be developed in 23/24.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	28/09/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	3	3	3		**Likelihood**: To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources however, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles. **Consequence**: Long term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions The progress on Electronic Patient Record (EPR) procurement has increased the level of engagement across the organisation and the need for digital and structured data.	Likelihood:	2	31.03.26
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	12	12	12			Risk Level:	8	

Cause of risk:	• Lack of capital and digital funding to deliver improved digital maturity. • Lack of staff and capability to deliver, support and manage transformative digital solutions. • Lack of time, Business as Usual activity and operational pressures reduce the time required and available to support the change required for digital transformation. • Inconsistent processes in relation to be purchase & implementation of new systems, which results in additional steps and handoffs in the process for patient care. • Potential organisational unwillingness to embrace change. • Trust-wide digital transformation programme requires significantly enhanced capacity and capability to manage change	Impact:	• Acceptance of change needed to support new and innovative solutions is disparate across the Trust • Lack of capital for investing in the future sustainability of the Trust • Loss of key staff • Digital solutions developed in silos and unsupported by the Digital team, impacting on the management of patient pathways due to increase in process steps

Current methods of management (controls)	A. Digital Steering Group setup and established to monitor, support, and approve any Trust wide digital initiative and alignment to digital strategy B. Project Prioritisation Matrix to track and manage priorities for digital C. Working with the ICS to develop a system wide strategy for digital innovation D. Digital Benefit lead role established and currently embedding benefits into all digital activity E. Process Mapping to facilitate change acceptance and benefits management F. Transformation programmes to be put place to realise benefits of cost effectiveness G. Longer term capital plan to support delivery of sustainable services

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:	• Digital Steering Group to continue to management and approve any digital activity (A) • Process Improvement - process relating to the prioritisation of project / programmes with digital (C) (E) (F) (G) • Benefits Strategy approved (D)	• Oversight by Finance and Productivity and Strategy and Transformation Committees (G) • Digital IPR (A) (B) (F) (G) • Transformation Board (monthly) (F) (G)	• Capital Business cases reviewed by ICS (G) • Internal RSM audits (A) (B) (D)

Gaps in control/assurance:
• Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust • Complexity and changes to national guidance retain to the patient pathways

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.	EPR procurement	Chief Medical Officer	March 2024	• Outline business case and specification completed, and review of invitation to tender being completed • OBC was signed off by the national EPRIB Board with some conditions; these are being reviewed by the regional team • Procurement anticipated to start in October 2023 • A large number of posts have been recruited to support procurement and implementation.	G
2.	Digital transformation roadmap based on supporting the digital strategy	Chief Finance Officer	March 2024	• Review of progress on the digital strategy and development of the next 12–24-month road map	A
3.	Digital Literacy Assessment	Chief Finance Officer	March 2024	• Evaluate the current level of digital literacy across the staff groups. • Development of a plan to increase digital literacy	A
4.	Increase digital culture	Chief Finance Officer	March 2024	• Communications strategy and engagement	A

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Failure to maintain focus on improvement**			**Strategic Aims Impacted**		
					X	X
Risk Description:	**Insufficient focus leads to a failure to embed a QI culture as "the ESHT way" of securing change and the expected improvement outcomes/benefits are therefore not realised**					
Lead Director:	**Director of Transformation Strategy and Improvement**	**Lead Committee:**	**Strategy and Transformation Committee**	**Date of last Committee review:**	**07/12/2023**	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**23/24 Q1**	**23/24 Q2**	**23/24 Q3**	**23/24 Q4**	**Rationale for Risk Level**	**Anticipated Year End Risk**		**Review**
(4x4) 16	**Likelihood:**	**4**	**4**	**3**		The current risk position recognises the challenge of delivering the improvements. The improvement in the Q3 scoring is driven by greater confidence in our revised approach, which prioritises skills development internally, supplemented by additional resources in the interim. Over the medium term we are confident that additional resources will be made available to continue the support for our CQI programme. The associated actions are set out in the 'further actions' section.	**Likelihood:**	**3**	Every 2 months at Strat Com
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
	Risk Level:	**16**	**16**	**12**			**Risk Level:**	**12**	

Cause of risk:	• People trained under previous model have been inactive • Need to build capacity & training infrastructure of new model • Challenge of delivering improvement aims in an operationally/ financially challenged environment	**Impact:**	• No current systemic approach to delivering improvements • Persistence of training gaps esp. with senior leaders across the Trust
Current methods of management (controls)	A. Stocktake via the creation of ED Transformation Improvement B. Provide regular reporting via EDs/StratCom as regards the current transformation programme		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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:	• Through reporting to EDs	• Engage strategic partners to capacity build within our teams and clarify approach	• Potential for peer review, especially with strategic partner and their experiences elsewhere

Gaps in control/assurance:
• None seen currently

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	Recruit to clear CQI lead within TSI team	Dir of TSI	Apr 24	• On track	G
2	Relaunch Exec CQI steering group		Dec 23	• Began on time	B
3	Reprioritise TSI team work programme to increase CQI support		Dec 23	• Began in Dec 23 but not yet complete	A
4	Drive first phase of 'Management System' component through Business Planning Round using internal resource		Apr 24	• On track	A
5	Develop 'Plan B' to continue programme through internal team development and expansion (jointly with HR)		Mar 25	• Not yet due. Will be a key action over 24/25	A
6	Identify and launch with strategic partner (pending financial commitment)		During 24/25	• Not yet due. Remains an intended action over 24/25. High risk relates to the expectation of a challenged resource environment over 24/25	R

Risk Summary							
BAF Reference and Summary Title:	BAF 10: Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	The Trust has very large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition there is a negative impact on patient experience as a result.						
Lead Director:	Chief Operating Officer / Chief Nursing Officer / Chief Medical Officer	Lead Committee:	Quality and Safety Committee	Date of last Committee review:	21/09/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4	4		Evidence on a daily basis of the impact of greater than 50 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff. Situation continues with very large numbers of patients who are discharge ready and significant extra bedded capacity open including "supersurge" capacity. In addition in times of extremis it has been necessary to pre-emptively place (board) additional patients on wards until a bed space is available.	Likelihood:	4	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	16	16			Risk Level:	16	

Cause of risk:	Impact:
• Sustained pressure on care home sector resulting in reduced staffing, capacity and acceptance criteria • Closure of care homes across Sussex • Pressures on primary care • Lack of sufficient suitable alternative pathways for patients • Lack of sufficient assessment and treatment capacity in mental health • Recent sustained increase in patients whose primary need is mental health and/or housing • Increase in assaults and aggressive behaviour from patients and/or members of the public • Lack of sufficient capacity for urgent placement of children at risk	• Delays for some patients in being able to access care • Delays to assessment and treatment • Patients in inappropriate locations • Poor experience for patients and staff • Delays with discharge planning and process given the significant numbers of additional and/or complex patients • Risk of harm to patients, e.g. self-harm, harm to others, risk of absconding, violence and aggression • Patients are deteriorating and deconditioning due to length of stay once discharge ready

	• Lack of sufficient suitably trained staff for all capacity that is in use • National removal of discharge to assess funding • Insufficient Discharge to Assess capacity • Increased length of stay in the acute and onward care settings • Ongoing negative impact of the pandemic e.g. elective backlog of patients, impact on non-elective patients who have not accessed healthcare as a result of the pandemic • Ongoing industrial action by various staff groups		• Increase in safeguarding concerns given the huge numbers of vulnerable patients, many of whom are resistant to care and have a very considerable length of stay • Increasing incidents of violence and aggression
Current methods of management (controls)	A. Significant variable additional capacity remains open B. Significant attempts to safely staff all capacity C. Systems in place to identify and escalate NCTR/discharge ready patients D. Ongoing collaborative system working to identify solutions, with discussion at ICB level E. Audit of stranded patients undertaken to investigate risks and/or harms F. Weekly long length of stay panel meeting to support expediting discharge of patients with the longest length of stay G. Full capacity protocol, and escalation actions being updated. H. Ongoing workshops to ensure whole Trust approach in supporting this work. Future work required with plans underway.		

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:	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Assurance through Urgent Care improvement plan overseen by Urgent Care Oversight Group • Daily capture and monitoring of escalation and supersurge capacity	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P0-P3 patients with system partners • Clear oversight and responsibility for operational delivery, and of quality and safety • Work being undertaken with Nervecentre to develop capture and monitor patients who are pre-emptively placed	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board • Provider assurance meetings and system clinical quality review meetings

Gaps in control/assurance:
• Workforce demand outstripping supply due to significant additional capacity required • Lack of suitable physical space for surge capacity • Lack of sufficient equipment for surge capacity • Overcrowding due to additional beds and equipment • Unable to completely avoid all inappropriate attendances/admissions • Lack of Adult Social Care capacity • Currently unable to easily/accurately describe the impact or harm from reconditioning • Accuracy and timeliness of data on NerveCentre albeit improving • Stranded patients requiring mental health support or housing (the housing challenge is increasing) • Work ongoing regarding more detailed quality dashboard

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.	Ensure clinical areas are staffed as safely as possible	COO/CNO/CMO	Ongoing	• Still have significant additional capacity open • Workforce pressures remain • Escalation process in place • Escalation capacity forms part of the main financial risk for 2023/24	A
2.	Ensure as far as possible that patients are placed as safely and appropriately as conditions permit	COO/CNO/CMO	Ongoing	• All escalation areas remain open with additional supersurge capacity remaining open and pre-emptive placement of patients when in extremis.	A
3.	Ensure high risk patients are assessed and flagged appropriately	COO/CNO/CMO	Ongoing	• Divisional long length of stay meetings • Interim Head of Discharge and Flow in post • Weekly high risk patient meeting introduced by CNO • Scoping work underway regarding ESHT mental health outreach team and possible dedicated bay for patients in mental health crisis	G
4.	Need to design process for capturing and reporting on the impact of deconditioning	COO/CNO/CMO	Ongoing	• Reconditioning group to be established with clear process for monitoring and reporting	A

Risk Summary							
BAF Reference and Summary Title:	BAF 11: Failure to demonstrate fair and equal access to our services				Strategic Aims Impacted		
					X		X
Risk Description:	Combined operational and financial pressures means that the additional analysis and support is not prioritised in-year						
Lead Director:	Chief of Staff	Lead Committee:	Strategy Committee	Date of last Committee review:	07/12/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x3) 15	Likelihood:	3	3	3		This risk has evolved from the previous BAF risk 12, around public health priorities. Challenges for 23/24 are prioritising the data collection and reporting as part of Trust BAU business intelligence. Additionally, we recognise the need to share this information and work with Divisions where it is identified that access issues persist for sections of our population.	Likelihood:	3	Review every two months
	Consequence:	3	3	3			Consequence:	3	
	Risk Level:	9	9	9			Risk Level:	9	

Cause of risk:	• Capacity within existing BI team • Health inequality requirements via contract for 23/24	Impact:	• BI team making prioritised choices over aspects of reporting/analysis that it can cover in this financial year
Current methods of management (controls)	A. Routine information gathering as part of report collation B. Where significant transformation is taking place (e.g. cardiology, ophthalmology) members of the team have been trained or have experience in establishing meaningful engagement (in line with statutory/legal obligations)		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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:	• Through reporting documentation (basic stakeholder analysis) to show engagement approaches	• Teams engage relevant corporate support (health inequalities, communications) to advise and support where engagement is required	• EDs to support prioritisation of team resources to ensure appropriate support is given to most pressing risk areas (e.g. where corporate reputation may be at risk)

Gaps in control/assurance:
• The BI team previously had noted their capacity challenge in supporting the data requirement around this risk. This is now resolved.

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.	Audit current levels of relevant information (e.g. ethnicity, protected characteristics) available within ESHT	Chief of Staff	Mar-24	This work is being supported by a system role, hosted by ESHT, that is reviewing processes across ESCC, SCFT and ESHT to support services with approaches to drive up the quality of protected characteristics data that we hold	A
2.	Engage with BI team and ICB data leads re: supporting data analysis re: health inequalities		Mar 24	The ESHT BI team now produce this data	B
3.	Share Health Inequalities data with teams to raise awareness of issues that can then be worked through with Divisions		Mar-24	A session is planned with the Divisional leadership teams in Q4 to review the findings and the actions that Divisions can take	A

Risk Summary							
BAF Reference and Summary Title:	BAF 12: Failure to meet the four-hour standard				Strategic Aims Impacted		
					X	X	X	X
Risk Description:	Due to ongoing challenges with patient flow, there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.						
Lead Directors:	Chief Nurse and DIPC, Chief Medical Officer & Chief Operating Officer	Lead Committee:	Quality and Safety Committee		Date of last Committee review:	21/09/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4	4		There is robust data/evidence on a daily basis that describes the length of time patients stay in the department and that the standard/ambition is not being met.	Likelihood:	4	Ongoing
	Consequence:	4	4	4			Consequence:	4	
	Risk Level:	16	16	16			Risk Level:	16	

Cause of risk:	• Bed occupancy in excess of 92% • Lengthy times to assessment in ED, leading to high numbers of non-admitted breaches. • High numbers of patients who do not meet CTR and are Discharge Ready • Insufficient bedded capacity (flow) immediately available • Insufficient community capacity (ESHT, care homes and discharge to assess)	Impact:	• Patients spending longer than they need to in the emergency department • Delays for patients being able to access the emergency department in a timely way • At times increased handover times for ambulance crews • Overcrowding of the emergency departments effecting the experience of patients and staff
Current methods of management (controls)	A. Live bed state provides accurate information regarding occupancy and available bedded capacity B. Urgent Care improvement plan C. Review and refresh of length of stay programme and reporting D. Weekly highlight meetings regarding improvement plan and related KPIs		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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:	• Urgent Care improvement plan overseen by Urgent Care Oversight Group • Eliminate reliance on escalation and super surge areas • Focus on non-admitted breaches • Back to basics training for staff on discharge processes • Review and refresh of length of stay programme, governance and reporting	• Discharge Front runner support across Sussex to reduce Discharge Ready numbers • Breach compliance assurance across divisions • Long length of stay reviews across divisions • High risk patient reviews by CNO and CMO	• Increase in discharge to assess capacity across Sussex • Virtual ward increase in capacity • Discharge lounges usage • Focus on improving weekend discharges via Urgent and Emergency Care Improvement Plan
Gaps in control/assurance:			
• Vacancies in Transfer of Care Hub • Still embedding processes at ward level e.g. board rounds, referral to Transfer of Care Hub, accurate update of information on NerveCentre • Lack of a clear agreed process at system level to escalate and manage delays for temporary accommodation/housing			

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.	Ongoing recruitment for Transfer of Care Hub	COO	March 2024	Successfully recruited to leadership role but still trying to recruit to clinical roles	A
2.	Review of CHC process	COO	Oct 2023	Part of discharge front runner workplan	A
3.	Development of ward staff further	COO	Autumn 2023	Q1 Train the trainer programme delivered, Q3 training plan developed for delivery in Autumn	B

Appendix One – Links to Corporate Risk Register (only risks rated 15 and above appear on the Corporate Risk Register)

BAF 1 - Capacity constraints associated with supporting the collaborative infrastructure						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply			
BAF 2 - Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	14/11/2017	1680	Wait times for routine Child Development clinic referrals >36 months	12	16	◀▶
	17/05/2018	1721	Insufficient physiotherapy staffing for neurological outpatient service	15	15	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	1772	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	01/07/2020	1896	Unchaperoned ultrasound examinations	16	16	◀▶
	23/10/2020	1931	Health Visitor Vacancies	9	20	◀▶
	12/08/2021	2066	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	25/11/2021	2079	Construction project manager vacancies	25	16	◀▶
	25/11/2021	2080	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	28/06/2022	2114	Delays in out of hours patient assessment times	20	16	◀▶
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	17/08/2022	2135	Vacancies in radiology and histopathology increasing diagnostic service waiting times	12	15	◀▶
	22/03/2023	2182	Integrated Support Worker staffing in Urgent Community Response team	20	16	◀▶
	01/06/2023	2192	Radiology Physics Service Staffing	20	15	◀▶
	28/06/2023	2200	Subject Access Requests / Redaction Software	15	15	◀▶
	18/08/2023	2213	Delays to Paediatric Dietetic Appointments	20	20	◀▶
	18/08/2023	2214	Physiotherapy provision for paediatric patients with cystic fibrosis	20	20	**NEW**
	22/08/2023	2218	Acute and community physiotherapy staffing vacancies	16	16	**NEW**
	25/09/2023	2232	Histopathology consultant vacancies	20	16	**NEW**

BAF 3 - Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	02/10/2017	1669	Risk to community staff from lone working	12	16	▲
	14/12/2017	1686	Violence and Aggression in Emergency Departments	9	15	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	1772	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	29/04/2020	1867	Violence and Aggression Trust wide	16	20	▲
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	01/06/2023	2192	Radiology Physics Service Staffing	20	15	◀▶
	06/09/2023	2227	Risk to all staff from lone working	15	15	NEW

BAF 4 - Failure to deliver income levels/manage cost/expenditure impacts savings delivery						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	13/04/2023	2183	Delivery of the 2023/24 financial plan	20	20	◀▶

BAF 5 - The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	25/02/2002	19	Risk of Legionella	6	15	◀▶
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	10/12/2013	1118	Aging Building Management System (BMS)	15	15	◀▶
	11/11/2015	1397	Clinical Environment Maintenance & Refurbishment	20	15	◀▶
	12/11/2015	1398	External Cladding/Façade at EDGH	20	15	◀▶
	12/11/2015	1410	Potential non-compliance with Fire Safety Legislation	16	16	◀▶
	12/11/2015	1425	Failure of lifts	16	16	◀▶
	09/05/2017	1621	Loss of Electrical Services to Critical Clinical Areas	16	16	◀▶
	09/05/2017	1622	Working at Height	15	15	◀▶
	03/08/2017	1655	Containment Level 3 Laboratory	15	20	◀▶
	01/03/2018	1703	Fire Detection System	16	16	◀▶
	27/06/2019	1806	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	1807	Insufficient isolation facilities to meet demand	12	16	◀▶
	21/04/2020	1866	Aseptic Unit	20	15	◀▶
	27/05/2020	1879	Capital - Sustainability	12	20	◀▶
	27/11/2020	1937	Eastbourne maternity environment	15	15	◀▶
	29/12/2020	1949	Insufficient air ventilation	16	16	◀▶
	02/07/2021	2053	Clinical Space on Frank Shaw Ward	20	15	◀▶
	03/08/2021	2065	Lack of availability of community obstetric venues/hubs	15	15	◀▶
	25/11/2021	2079	Construction project manager vacancies	25	16	◀▶

	25/11/2021	2080	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	31/10/2022	2154	Conquest Radiology Imaging Equipment	20	16	◀▶
	30/05/2023	2190	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	19/07/2023	2210	Obsolescence of software and equipment for Emergency Dental Services	25	15	◀▶
	18/08/2023	2216	Scott Unit environment	20	16	◀▶
	22/08/2023	2217	Urgent Community Response and Virtual Ward team environment	15	15	**NEW**
	22/08/2023	2219	Conquest CT Scanner installation	25	20	**NEW**
	02/10/2023	2230	Environment for children and young people with complex psycho-social challenges	20	16	**NEW**
	06/11/2023	2233	Mortuary freezer capacity	16	16	**NEW**

BAF 6 - Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	23/08/2017	1660	Cyber Security	20	16	◀▶
	21/03/2022	2092	Unmitigated Software Vulnerabilities	16	16	◀▶
	21/03/2022	2099	ESHT data centre segregation	20	16	◀▶
	21/03/2022	2100	3rd party and supplier remote access controls	20	16	◀▶
	04/11/2022	2158	Multi Factor Authentication	16	16	◀▶
	30/05/2023	2190	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	06/06/2023	2196	Network infrastructure devices	16	16	◀▶
	19/07/2023	2210	Obsolescence of software and equipment for Emergency Dental Services	25	15	◀▶
	18/08/2023	2215	Digital booking management for paediatrics	16	16	◀▶

BAF 7 - Failure to develop business intelligence weakens insightful and timely analysis to support decisions

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply			

BAF 8 - Failure to transform digitally and deliver associated improvements to patient care

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	31/10/2022	2154	Conquest Radiology Imaging Equipment	20	16	◀▶
	28/06/2023	2200	Subject Access Requests / Redaction Software	15	15	◀▶

BAF 9 - Failure to maintain focus on improvement						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply	-	-	-

BAF 10 - Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that no longer meet the criteria to reside.						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	06/06/2016	1496	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/08/2017	1655	Containment Level 3 Laboratory	15	20	◀▶
	03/12/2018	1764	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	18/04/2019	1792	Risk of delayed treatment due to overdue follow up appointments	16	16	◀▶
	27/06/2019	1806	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	1807	Insufficient isolation facilities to meet demand	12	16	◀▶
	03/12/2020	1942	Risk of insufficient beds during winter	16	16	◀▶
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶
	22/03/2023	2182	Integrated Support Worker staffing in Urgent Community Response team	20	16	◀▶
	16/05/2023	2186	Delays in surgical treatments	16	16	◀▶

BAF 11 - Failure to demonstrate fair and equal access to our services						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶

BAF 12 – Failure to meet the four hour standard						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	06/06/2016	1496	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/12/2018	1764	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	23/10/2020	1931	Health Visitor Vacancies	9	20	◀▶
	03/12/2020	1942	Risk of insufficient beds during winter	16	16	◀▶
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶
	28/06/2022	2114	Delays in out of hours patient assessment times	20	16	◀▶
	16/05/2023	2186	Delays in surgical treatments	16	16	◀▶

Appendix Two – BAF Summary 2022/23

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Target Risk	Target date
								2022/23							
								Q1	Q2	Q3	Q4				
1	Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture	Strat	X			X	12	9	6	6	6	◄►	Seek / Significant	6	Review every two months
2	Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time	POD		X	X	X	15	12	12	12	20	▲	Open	9	Ongoing
3	Decline in staff welfare, morale and engagement that impacts standards of care in 22/23	POD		X	X	X	20	16	16	16	16	◄►	Cautious / Open	12	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	20	16	8	4	◄►	Cautious	8	31/01/23
5	Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23	F&P			X	X	15	10	10	16	16	◄►	Seek	10	31/03/23
6	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff	F&P		X	X	X	20	16	16	16	16	◄►	Cautious	8	Ongoing
7	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	20	16	16	16	16	◄►	Minimal	12	Ongoing
8	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	20	16	16	16	16	◄►	Open	12	Ongoing
9	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	20	16	16	16	12	▼	Significant	12	31/03/25
10	Failure to maintain focus on improving care	Strat				X	12	12	12	9	9	◄►	Cautious / Open	9	Review every two months
11	Risk of not being able to maintain delivery of safe, high quality effective care due to huge numbers of patients that no longer meet the criteria to reside.	Q&S	X	X	X	X	20	16	16	16	16	◄►	Open / Seek	12	Ongoing
12	Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas	Strat	X			X	12	9	6	9	6	▼	Cautious / Open	4	Review every two months
13	Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services	Strat	X			X	15	12	12	12	9	◄►	Open	6	31/03/23

Appendix Three: 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

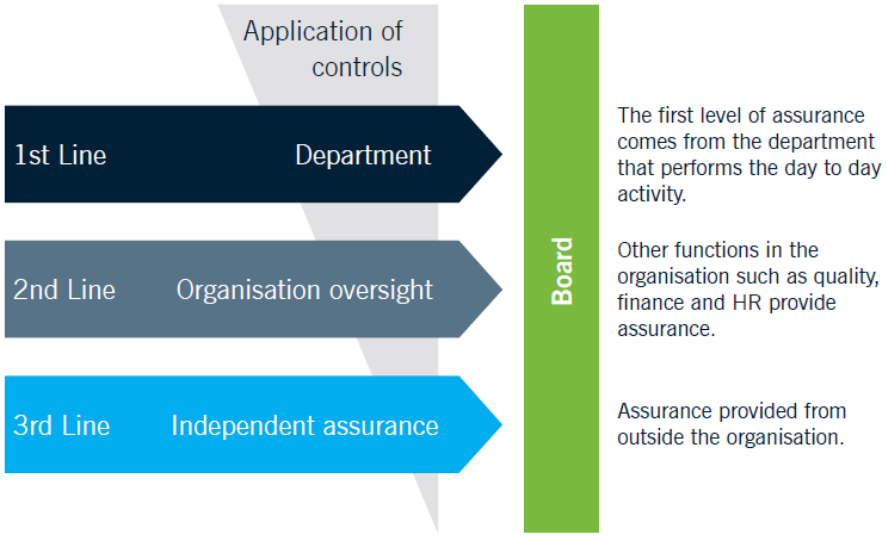
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		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 Five – 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

East Sussex Healthcare NHS Trust

Audit Committee
25 January 2024

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
005/24	EPRR Annual Update	• The Trust continued to recognise & comply with its duties as a 'Category 1 responder' under the Civil Contingencies Act 2004, and the requirements of the NHS EPRR Framework • ESHT maintained a record of commitment to both internal & external EPRR exercises, whilst accepting that the current continuation of industrial action had continued to largely reduce both exercising and training. However more recently there had been increased activity regarding exercises. • The EPRR Team had completed the 2023 assurance process and can report the Trust maintained 'Substantial Compliance'. The number of non-compliant standards had reduced from 4 out of 62 in 2022 to just 2 out of 62 in 2023.	
006/24	Digital Cyber Security Update	• The Cyber risk level remained at Amber (Medium) • End of life operating systems use continued to reduce • Good progress on the introduction of the NHS Mail multifactor authentication • Number of Servers without an automated patching schedule had reduced.	
007/24	Q3 Board Assurance Framework	• The Committee noted the updates to the Board Assurance Framework	• Discussion to also be held between Execs around reconciling the different areas encompassed within BAF 3 or amending its wording to reflect focus on aspects which the Trust could directly influence.
008/24	Corporate Risk Register	• Of the 262 risks overall, 66 qualified for the Corporate Risk register • Only one risk had been added to the Risk Register (regarding the storage of research documentation)	• Chief Nurse and Interim Assistant Director of Clinical Governance to consider how future reporting could best provide additional context, narrative, or justification around closed risks. Mrs Carruth also to investigate why risks linked to pressure ulcers and harm on discharge had been removed from the register.
009/24	Information Governance (IG) Toolkit Update	• Evidence providers were reviewing and updating evidence for the Data Security & Protection Toolkit 23/24 • The IG team ran a data protection awareness campaign at the end of January • There remained a good culture of reporting IG and Information Security incidents within ESHT • ESHT did not have any Information Governance breaches open with the ICO (Information Commissioner's Office)	• Information Governance Lead and Data Protection Officer to arrange a brief in-person session training session in support of IG compliance for junior doctors with support from the Clinical Education team.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
010/24	Tenders and Waivers	• The single tender waivers awarded by value for the period 1st November and 31st December 2023 were Core Services £192k (36.3%), Medicine £180k (34%), Commercial Facilities & Estates £87k (16.4%), Women Children & Sexual Health £52k (9.9%) and Corporate Services £18k (3.4%) • Waivers for Microbiology Testing Services (£192k) and Estates Maintenance for Fire Alarms at EDGH (£87k) were reviewed by the Audit Committee Chair.	
011/24	Annual Review of Trust Governing Documents	• The was is undertaken jointly by the Director of Finance and Board Secretary, with input from the Deputy Director of Finance and the Head of Procurement • The Committee noted and approved amendments to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation	
012/24	Review of Losses and Special Payments	• A total of 71 losses and special payments equating to £371,284 were incurred during this period. In comparison to the same period in the previous financial year, the cost incurred by the Trust increased by £210,396 despite a reduction in the number of cases by 27 • 97% of this increase (£203,147) related to an increase in loss and write off of stock.	• Deputy Director of Finance to request details of mitigations in place to prevent large pharmaceutical stock write-offs, including consideration of Electronic Prescribing and Medicines Administration rollout and its impact.
013/24	External Audit Report (Verbal Update)	• It was noted that the next annual External Audit Plan would be presented to the Committee in March	
014/24	Internal Audit Report	The following Final Reports had been issued: - Clinical Negligence Scheme for Trusts (7.23.24)- Advisory/Compliance - CQUINs (8.23.24) – Reasonable Assurance • Of the 38 management actions on the tracker, six actions (five medium and one low) were implemented in the period. One low priority action was overdue but being implemented	• Chief Finance Officer to provide an updated plan around the Finance recommendations from Internal Audit with a response deadline of 31st March 2024. To include clear narrative around any deferred actions.
015/24	Counter Fraud	• A fraud awareness session was delivered to 70 of the members of the Finance Team and a session to the Board was scheduled to take place on 14 May 2024 • Two new referrals had been received in the period, four were closed and three were pending closure.	
016/24	Policies & Procedural Documents Report	• 23% of all policies were overdue for review. This was a reduction of 8% compared to October 2023 • 10.8% of all procedural documents were overdue for review. This was a reduction of 14.2% since the October 2023 report	

East Sussex Healthcare NHS Trust

Finance and Productivity Committee 25 January 2024

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
005/24	**Board Assurance Framework**: Presentation of BAF Risk Assessment for Q3 23/24	• The Q3 risk rating for BAF 4 (Failure to deliver income levels/manage cost/expenditure impacts savings delivery) had increased from 12 to 20 since Q2, due to the significantly increased risk of a deficit forecast for 2023/24 • The anticipated end of year risk rating for BAF 4 had also increased from 12 to 20.	
006/24	**M9 Financial Performance**: Presentation of Trust's financial position both with key issues highlighted	• £2.9m deficit at Month 9 taking the YTD to a deficit of £2.5m • Improving elective performance within the context of winter pressures • Impact on financial performance from recent industrial action and the change in the ERF baseline • Recommendation to Board that Trust change the forecast outturn position, to £5.4m deficit	
007/24	**System Update** Presentation of System financial performance including analysis of all providers.	• System year to date deficit at month 9 of £45.4m, £35.5m over plan and £10.7m over the forecast position agreed in November, primarily driven by the December industrial action and the YTD impact of the revised ERF target • Other key drivers for the deficit were being investigated and would be linked to efficiency planning	
008/24	**Productivity Portfolio update/KPI Dashboard/Elective Recovery update** Presentation on productivity portfolio and efficiency position and programme risks noted	• £2.4m Efficiencies in month which is £0.9m behind plan • YTD delivery £2.3m behind the planned value of £22.3m • M9 activity on the days that were not affected by industrial action better than anticipated due to an improvement in theatre productivity and improving patient data capture	

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
009/24	**M9 Capital Position** Update on Capital Position	• The capital expenditure ytd position at month 9 was £16.8m, which was £12.6m behind the year-to-date plan of £29.4m • The trust is prioritising projects to mitigate delays in procurement and reduce the risk of underspend • The Trusts overall CRL is expected to be £64.7m for the year	• Ongoing monitoring of capital position • Mitigation projects underway
010/24	**24/25 Planning Outline** Overview of the approach and current status of planning for 24/25,	• Limited planning guidance received – working assumption that an minimum of 4% efficiency required in 24/25 • Allocations at System level has not been published, but initial planning based on “flat cash” • The Committee approved the principle of using the Medium Term financial plan as the basis for planning (noting this may change in discussion with NHSE and ICB) and support the approach of using available resource to anchor planning	• Additional information to be provided as planning round progresses
011/24	**National Cost Collection** Overview of the National Cost Collection process and assurance the submission has been completed in line with Approved Costing Guidance.	• This is an annual mandated submission of costs. • The Trust’s submission was made to NHS England on 9th January 2024.	

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
012/24	**Items for Escalation from CRG** summarise schemes requiring F&P approval	• None for escalation this month	
013/24	**Enterprise Order Comms update** Update on the latest financial implications of the Sussex enterprise order comms development.	• Additional funding had been received by NHS England to bridge the gap and proceed with this project	

East Sussex Healthcare NHS Trust

Inequalities Board Sub Committee Meeting Held 21st November 2023

Summary of meeting for Trust Board

Steve Phoenix – Chair of Inequalities Board Sub Committee

Agenda item number	Title and function of agenda item	Key points made	Actions
2	Introduction	• The Chairman welcomed everyone to the inaugural meeting of the Committee and invited members to introduce themselves. • The Chairman talked about the importance of the sub-committee, its overarching purpose and his own commitment and experience of work in the equality field over the preceding 40 years. • Mr Aumayer and Mr Milner, as senior leads in employment equalities and health inequalities, respectively, expressed their support for the committee. Mr Aumayer looked forward to exploring innovative approaches given the current challenges in the NHS, while Mr Milner emphasised the potential for the committee to drive meaningful service-level conversations	
3	Terms of Reference	• Phased Approach: Explicitly outline a phased approach in the terms of reference, focusing on system commitments in the first year and broadening scope in the second year. • Avoid Duplication: Acknowledge existing system-wide efforts in primary care and avoid duplicating work. • Proactive Approach: Clarify the committee's ambition as a proactive force, addressing both system-driven mandates and creatively approaching internal processes for better patient outcomes.	Terms of reference to be updated
5	Equality, Diversity and Inclusion (EDI) High Impact Actions	• Reporting Structure: Seek clarification on the reporting structure to NHS England and provide updates as soon as information is available without preventing the committee from moving forward.	Feedback on reporting structure to be presented to Committee when available
6	Health Inequalities	• Address the need for improved ethnicity data coverage. • Recognise the need for a standardised approach in evaluating patient treatment lists. • It was agreed to ask the DPH of ESCC to join the meeting • A discussion would take place about priorities at the next meeting	Collaboration with network chairs on language to support PC data collection
7	Key Performance Indicators (KPIs) /Measuring Success/Health Impact Assessments (HIA)	• Proposed the development of a scorecard or key data pack to focus discussions and prevent overwhelming detail. • Enhance external data presentation for both workforce and patient information. • Address concerns about the interpretation of deprivation, emphasising financial aspects and the broader impact, including social isolation and loneliness.	Propose a briefing session with Director of Public Health, Darrell Gale, or his team to understand the nuances of the Index of Multiple Deprivation (IMD) and how it is compiled.

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee
18 January 2024

Summary of meeting for Trust Board

Carys Williams – Chair of POD Committee

Agenda item number	Title and function of the paper	Key points made in the paper	Actions
3.1	POD Workforce Insight Report	• The Trust vacancy rate continued to reduce, by a further 0.2% to 6.57% • The monthly mandatory training rate increased by 0.6% to 89.7% • The appraisal rate increased by 0.7% to 81.9% • The Turnover rate was unchanged this month at 10.3% • The monthly sickness rate increased by 0.2% to 6.0% (not including Covid as not being reported). Not an outlier with other organisations. Support being provided to managers and individuals for a deeper understand of the key reasons. • Vaccination rates: Covid 20% / Flu 53.55% • The Trust remained safe during the Junior Doctor industrial action. There had been some disadvantages in terms of the impact on patients around electives, which led to an increased length of stay • An increase had been seen in appropriate behaviours and attitudes of "staff on staff"- continually monitored.	
4.1	Partnership Forum	• Verbal update provided on the Partnership Forum; discussions had taken place: - Review of the Trust Values - Career progression - Increasing morale - Communicating with People • Challenges remain around embedding the Partnership Forum across the Trust and increasing engagement from divisional leads. • Branding being discussed for members to be recognised.	
4.2	Schwartz Round	• Annual Report shared • Schwartz Rounds had been running since May 2015 and ESHT had celebrated their 100th round in Autumn 2023.	

Agenda item number	Title and function of the paper	Key points made in the paper	Actions
4.3	Violence & Aggression Reduction (VAR)	• Project Support Manager role created • Communication plan launched – to include external • Trauma Informed focus had been introduced • Training Needs Analysis – looking at gaps in training for staff	External Communications: Update to be provided on how we are publicly supporting our people and what messages we are putting out as a Trust about what our people deserve
4.4	Veteran Aware	• The Committee was reassured that the Trust was still meeting the due regard requirements around the equality impact assessment process of the Armed Forces Act 2021; aiming to be veteran aware by the end of March 2024.	
5.	Board Assurance Framework (BAF)	• BAF 2, attracting and retaining our workforce remained rated at 15 due to national recruitment challenges for some roles and continuing industrial action • BAF 3, staff welfare, morale and engagement remained unchanged at 16. • The full BAF to be presented to the Audit Committee followed by Trust Board in February 2024.	
6.	Guardian of Safe Working Hours Report	• A discussion took place regarding the ongoing lack of engagement from some Consultants regarding the Exception Reporting process. Thought to be historic as some consultants had been appointed many years ago and it was an expectation at the time for them to complete work on wards before leaving. Therefore, exception reporting was possibly less accurate than it should be. Ongoing support was being offered to the Junior Doctors and Locally Employed Doctors (LEDs).	

East Sussex Healthcare NHS Trust

Quality & Safety Committee
18 January 2024

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
003/2024	Patient Safety & Quality Group - Escalation and Assurance	• ESHT had chosen to work towards the UNICEF Baby Friendly Initiative as a framework to maintain and improve standards. In the 2023 re-accreditation report, 8/10 of the requirements were met. For the two not met, there are action plans in place • The newly incepted ESHT PSIRF Review Group would collate data around Severity 1 & 2 Treatment Delays, Diagnostics and Maternity and produce quarterly reports	
004/2024	Excellence in Care (EIC) Review Quality Metrics	• A revised set of 38 EIC metrics were approved for integration into a new data dashboard, which would go live in March 2024	• Head of Information Management to update the Committee in February on Power BI integration for the New Quality Dashboard (expected by March 2024) key metrics, following discussion with the Chief Nurse
005/2024	Monthly - Governance Quality Report and areas of concern identified from the Balance Scorecard (Dec 23 data)	• Of the 778 patient safety incidents reported attributed to ESHT, 73% were no harm/near miss; this is slightly lower than the percentage for November 2023 (76%)	• Interim Assistant Director of Clinical Governance to provide further insight and context about why most administration errors were at the end of treatment pathways, in terms of both the national perspective and internal reasons/processes.
006/2024	High Level Risk Register	• Of the 66 risks which qualified as Corporate Risks, 2 risks had been reviewed in the last month and 61 risks had been reviewed in the last 2 months. This was is in accordance with the Risk Management Policy and Procedure	
007/2024	Maternity Clinical Quality Surveillance Report	• The Eastbourne community midwifery workload (particularly bookings for antenatal care) and staff wellbeing were affected by vacancy and sickness absence. Immediate support had been provided to the team through the temporary suspension of Eastbourne Midwifery Unit intrapartum care provision, with the midwives redeployed to provide antenatal and postnatal care to Eastbourne community. This suspension will affect an average of 4 births a week, women and people will all receive a supportive discussion to consider birth options which include a homebirth or a low-risk birth at the Conquest Hospital. A full review of Maternity services will commence with a Birthrate Plus review in early 2024. Recruitment is currently underway within this area.	• Director of Maternity Services and Head of Midwifery to produce a Deep Dive report on trends around preterm births (inequalities, smoking, alcohol consumption etc.) and risk factors within the local population.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
008/2024	Board Assurance Framework (Q3)	• BAF 10: This was unchanged from Q2 and remained rated as 16. This is due to the continuing daily impact of the number of patients who are discharge ready, and the impact that this has on flow and increasing risk to patients and staff. Significant extra bedded capacity remains open, and it has been necessary at times to pre-emptively place additional patients on wards until a bed space is available. • BAF 12: This continues to be assessed as being 16. This is due to the daily evidence that describes the length of time patients stay in the Emergency Department and that the four-hour standard/ambition is not being attained.	
009/2024	Occupational Safety and Health (OSH) Improvement Plan	Progress against all five OSH priorities had improved. Highlights included: • The establishment of a Sharps Safety group, • Improved risk triangulation and reporting to Trust HSSG supported by effective dashboards, • A hierarchical approach to managing risk supported by targeted training, the establishment of specific Excellence in Care metrics, • The approval by the Institute of Occupational Safety and Health (IOSH) as the only Trust currently within the UK as an approved training centre.	
010/2024	ESHT Mortuary Compliance Against Sir Jonathan Michael Inquiry Report Recommendations, November 2023	• ESHT had completed a self-assessment and response plan for each of the 17 recommendations made in the Phase 1 report into the Maidstone & Tunbridge Wells NHS Trust David Fuller mortuary inquiry of November 2023 • •Updates on progress would be provided 6 monthly to Trust Board and quarterly to Q&S Committee thereafter.	

East Sussex Healthcare NHS Trust

Strategy & Transformation Committee 7 December 23

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
045/23	**Mapping ESHT programmes to the SDP** – illustrating how we plan to align our plans with the aims of the Sussex system and ensure we ensure the Board is kept aware of the progress made and how ESHT plays its part	• There is a clear, traceable line between the SDP governance meetings and the performance and assurance committees of the Trust • The 11 workstreams are likely to evolve further with some potential for consolidation • The development of provider collaboratives may offer an alternative approach for tracking the SDP workstreams	• Bring to StratCom following further clarification of relationship with Provider Collaboratives
046/2023	**Transformation Updates** Function is to provide assurance relating to delivery of Trust priority transformation programmes, realised benefits and / or critical risks and issues	• **Frailty –** improving engagement, still working to pull strands together. Working with ICB team and workshop in January specifically for VW/Community/Acute alignment. • **Community –** Projects progressing. Will quantify 2 year view of 'art of the possible' & benefits for business planning. More work needed on transformation metrics • **Elective Hub –** Day surgery rates benefiting from pathway work. Deep dive to come in February • **Radiology –** Network ToR & Governance under review. SECTRAPACS deployed – early view of benefits. Update on Capex to come to F&P • **Pathology –** TOM2 agreed in principle; MSC procurement and Network 'commercial' solution protracted. Currently risk to ESHT is low however. • **EPR –** procurement timetable at risk due to NHSE challenge on ICS convergence. Mitigation underway by Trust and ICS colleagues supporting.	• Deep Dives for next committee on Elective Hub and 'Digital' programmes

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
046/2023	**Transformation Updates cont.** Function is to provide assurance relating to delivery of Trust priority transformation programmes, realised benefits and / or critical risks and issues	• **Cardiology –** Project on Track. 'Deep Dive' due at Executive Committee in January# • **Ophthalmology** – Phase 1 building work has begun, phase 2 completing June. Phase 3 solution still to be identified • **Endoscopy** – Programme forming up. Noted significant risk to capital expenditure in 23/24 (partially mitigated) which could impact 24/25 and challenge to meet regional deadlines (i.e. open by Apr '25)	• Deep Dives for next committee on Elective Hub and 'Digital' programmes
047/2023	**Green Plan Highlight Report** Summary of plan and assurance of progress from Mr Knight	• Several successes highlighted - installing heat pumps, new waste contract. Not quite on carbon footprint trajectory – need to complete PSDS3 scheme. • Trust is benefiting from positive exposure due to 'green' plan progress (e.g. solar farm on BBC Sussex, other Trusts want to visit, first in UK)	
048/23	**ICT Follow Up Discussion** Verbal update for the committee – ongoing monitoring of an evolving new 'concept' within the ICS	• ICS developed 'ICT' Data packs had arrived. Lots of data on each of the 5 'footprints' in E. Sussex, or data on E. Sussex overall. • Multi-agency meeting/workshop held in Hastings, resulting in an action for an 'operational' level workshop which may identify problems they would work together to fix. • Still unclear what form or function the ICT (which may become INT) will take. Views across the ICS appear to vary.	• Update regularly throughout the year

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Charity Annual Report and Accounts 2022/23

Purpose of the paper	This paper provides assurance to the Trust Board about the business of East Sussex Healthcare NHS Charity, the Trust's charity.						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Sponsor: Karen Manson Author: Pete Palmer						
Governance overview	Meeting of the Corporate Trustees, 30th January 2024						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x	x	

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the Charity's Annual report and Accounts for 2022/23

Executive Summary	East Sussex Healthcare NHS Charity is the Charity of East Sussex Healthcare NHS Trust. The Charity's aims are to: 1. Enhance the patient experience throughout their time with the Trust 2. Expand East Sussex Healthcare NHS Trust's capacity to provide care and improve health outcomes 3. Support staff wellbeing in our hospitals and community services We rely on the generosity of our donors to be able to enhance the care that is provided by the Trust and everything that the Charity does is only possible due to the generosity and support of the public. Every donation we receive helps to support our incredible NHS staff and enhance the level of care we provide to thousands of patients and their families every year. More information about the Charity can be found on its recently launched website: https://eastsussexhealthcarenhs.charity/ The annual report and accounts attached as an appendix to the Board papers were approved at the meeting of the Charity's Corporate Trustee on 30th January 2024 and submitted to the Charity Commission on 31st January 2024. The Charity's income for 2022/23 was £108,000; £229,000 was spent funding charitable activities during the year.

Next steps	• The Charity will continue to raise money to provide support the Trust in delivering the highest quality care to patients.

East Sussex Healthcare NHS Trust

Annual Safeguarding Report - 2022/2023

Purpose of the paper	The 2022/2023 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the Safeguarding work undertaken during the year, the work planned to further transform Safeguarding practice in 2022/2023 and take assurance regarding the Trust's compliance with the legislative and regulatory framework.						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Sponsor _ Vikki Carruth, Chief Nurse - Executive Lead for Safeguarding. Author – Gail Gowland, Head of Safeguarding.						
Governance overview	Discussed at the Quality & Safety Committee.						
Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable			
	x	x	x	x			
Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement			
	x	x	x	x			
Recommendation	The Board is asked to note the full report which is included within the appendix to the Board papers and take assurance from the information contained within. It is also asked to continue to support the work of the Safeguarding Team and the service that it provides to some of our most vulnerable patients and the guidance, support and specialist advice provided to our colleagues whilst working in partnership with patients, service users and external agencies locally and beyond. Board members are encouraged to consider service visits with our Safeguarding and Health Visiting teams as part of it's commitment to visible leadership.						
Executive Summary	Over the course of 2022/23, the Trust has continued to see and care for increasing numbers of very vulnerable people, many of whom have particularly complex physical and psychosocial needs. This has been true across all of our services in ambulatory, bedded and domiciliary care, affecting all age groups including maternity. There has been an increasing number of people/patients (children, young people and adults) presenting with complex and enduring mental health needs, some of whom who are especially high risk; to themselves and those around them. Some patients have remained in an acute bed whilst waiting on a more appropriate bed elsewhere, with last year seeing a particular surge in numbers (and ultimately risk) during the closure of some SPFT facilities which took place						

	for refurbishment. The impact on our EDs and gateway areas was especially challenging especially at EDGH with considerable support required from our dedicated and professional security teams. The numbers of young people and adults with complex eating disorders and significant associated behavioural challenges has increased, often resulting in a very extended length of stay with work required at system level with regard to more robust pathways and more holistic long-term care especially with partners in Mental Health and Children's Services. The year saw a further increase in the numbers and complexity of cases of abuse and neglect (including domestic and child abuse and child and self-neglect) across the whole population. Cases referred to respective child and adult social care teams have seen a year-on-year increase, with the effects of years of the Covid pandemic and the impact on the economy, apparent and ongoing. As well as the lack of immediate appropriate in-patient/specialist mental health beds, a lack of emergency foster placements for children and young people is sadly a growing local, regional and national issue. The Safeguarding team have continued to provide specialist support, supervision and training for large numbers of colleagues across a range of roles and services with overwhelmingly positive feedback albeit some challenges with attendance due to ongoing operational pressures and challenges. I would like to thank all of our colleagues for their continued support with this complex agenda and recognise the challenges it presents, both personally and professionally.
Next steps	The Quality & Safety Committee will continue to receive reports with regards to all aspects of Safeguarding and members of the board are encouraged to consider spending time with the Safeguarding and Health Visiting teams as part of its commitment to service visits and visible leadership.

East Sussex Healthcare NHS Trust

EPRR Annual Update

Purpose of the paper	The report is submitted to the Trust Board, as required by the NHS Emergency Preparedness, Resilience & Response (EPRR) framework, and as set out in the Trust EPRR policy. The report details the current EPRR agenda on key issues of Trust performance over the period October 2022 to date, on behalf of the Chief Operating Officer (COO) as 'Accountable Emergency Officer'. Guidance requires that this report includes an overview of the following: 1. The organisation's compliance position in relation to the latest NHS England EPRR assurance process. 2. EPRR training and exercises undertaken by the organisation. 3. Summary of any business continuity, critical and major incidents experienced by the organisation.					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Authors: Luke Blackwell – Acting Head of EPRR & Garry East – Deputy Chief Operating Officer Sponsor: Charlotte O'Brien - Chief Operating Officer / Trust Accountable Emergency Officer					
Governance overview	The NHS EPRR Core Standards for assurance require that: "The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements". 1. This report is submitted on behalf of the Trust's Audit Committee who reviewed the EPRR annual update on 25th January 2024 2. EPRR performance also feeds into the Deputy COO's 'IPR' performance monitoring arrangements.					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x			x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x		x	

Recommendation	1. Acknowledgement of the importance in delivering the EPRR programme of work (as detailed within this report). 2. Acknowledgement of the Trust's level of compliance with the NHS E/I Core Standards for EPRR.
Next steps	The EPRR Team will be working to comply with the two outstanding core standards, improving service level Business Continuity Plan compliance and delivering a variety of EPRR training across the Trust.

Introduction

The Trust continues to recognise & comply with its duties as a 'Category 1 responder' under the Civil Contingencies Act 2004, and the requirements of the NHS EPRR Framework.

Core tasks within the CCA2004 are:

- Assess the risk of emergencies occurring and use the assessments to inform planning.
- Confirm emergency plans for external incidents.
- Implement further Business Continuity Management arrangements (for internal incidents).
- Embed arrangements to warn / inform the public about civil protection matters.
- Share information and co-operate with other local responders.

1. Compliance: NHS England EPRR Core Standards Assurance Framework

The EPRR Team has completed the 2023 assurance process and can report the Trust maintained 'Substantial Compliance'. The Trust board is asked to note that the Trust has reduced the number of non-compliant standards from 4 out of 62 in 2022 to just 2 out of 62 in 2023.

Core Standards not achieved:

- Core Standard 12 – Infectious Diseases Plan.
  Although the Trust has a ratified plan in place, it has not yet been exercised. To achieve this standard, an exercise must have taken place. The Trust aim to have carried this out by September 2024.

- Core Standard 29 – Trained Loggists.
  This became non-compliant during 2023, as the Trust does not currently have enough trained loggists for 24/7 cover during an incident. This is being addressed across the Sussex Integrated Care Board and wider system, and the Trust is committed to increasing the number of Trained Loggists and return to being fully compliant in 2024.

2. EPRR training and exercises undertaken by the organisation.

ESHT has a record of commitment to both internal & external EPRR exercises, accepting that the current continuation of Industrial Action has continued to largely reduce both exercising and training. However more recently there has been increased activity regarding exercises:

- Evacuation & Shelter Exercise: The Trust participated in this regional exercise on 29th June 2023. This was a Southeast regional tabletop exercise which focused on the full evacuation of a hospital. This brought together all NHS organisations including ambulance providers.
- Exercise Flamingo: A 'no notice' communication cascade test facilitated by the ICB.
- Exercise Sakari: Facilitated by the EPRR team, this was an internal 'no notice' communications exercise held on 14 September 2023 to test the new EPRR Communications Plan and the processes for Incident alerting both in and out of hours.
- The EPRR team have also developed a new training programme with the vision to bring more in-depth and meaningful training at a service level.
- Major Incident and CBRN Emergency Department Study Days: The EPRR team held several of these events during 2023 with the focused on providing a greater level of training for Major Incidents.

The 'Practical EPRR for On-Call Staff' is currently under review with the aim to introduce a new and improved training package for our On-Call teams. The new package will provide greater detail and support which incorporates the operational elements and objectives of our On-Call Teams and EPRR team members.

For the year ahead, the Trust will continue to work closely with the Sussex Local Health Resilience Partnership (LHRP) & the Sussex Resilience Forum (SRF) with the aim to engage in a full multi-agency live exercise is being planned for later in 2024.

Risks

The Trust EPRR risk register is linked to ESHT risk systems, links to the LHRP and the SRF Community Risk registers and is reviewed monthly. The EPRR Team have completed a full review of the risk register and worked closely with our ICB Resilience colleagues to align to their EPRR risk register model. As a result, we have reduced from 12 risks down to just 3 overarching risks. These are:

- Risk 2190 (score 16) Effect on ESHT from Business Continuity, Critical or Major Incidents. We are addressing our service level Business Continuity plans with the aim of this being completed by the end of 2024. Across the Integrated Care Board there is ongoing work to agree system wide Business Continuity and Critical Incident triggers to further support the work being completed at provider level.

- Risk 2189 (score 12) Ability to respond to Mass Casualty Event.
  The Trust is working with several key services to develop bespoke service level Major Incident Training packages which are aligned to the NHS England Clinical Guidelines for Major Incidents and Mass Casualty Events. These will then be delivered on a frequent basis to ensure staff are confident in their roles and understand the expectations of them during a Mass Casualty Event.

- Risk 2191 (score 8) Complexity of Helicopter Emergency Medical Services (HEMS) patient transfers at Conquest Hospital. This is under continuous monitoring and review.

Notable Successes

Successes include:

- The EPRR Team supporting the continued to response to ongoing Industrial Action.
- The development of new Business Continuity Templates.
- The work to support services to continue to develop their Business Continuity Plans.
- The development of new Training Needs Analysis, EPRR Personal Development Portfolios for Operational, Tactical and Strategical Commanders.
- New Training proposals.
- The work on the annual EPRR core standards with improvements made since 2022.
- The improved working relationships between the EPRR Team and both internal services and external organisations.
- The continual management of the Trust TOC
- EPRR Team now managing the Trust Weekend Plan.
- On-going discussions regarding planning for the future.

East Sussex Healthcare NHS Trust

Use of Trust Seal

Purpose of the paper	To inform the Board of the use of the Trust Seal						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Chief of Staff						
Governance overview	Not applicable						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement

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

Executive Summary	The Trust Seal was used to seal two documents between 5th December 2023 and 30th January 2024: **Sealing 103 – Resmed (UK) Ltd, 9th January 2024** Agreement for provision of respiratory therapy equipment and consumables for five years. **Sealing 104 – Hamish and Angela Monro, 19th January 2024** Agreement for lease of ground floor of Unit 10, Wheel Farm for six years.

Next steps	Not applicable

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Governing Documents, incorporating: Standing Orders, Standing Financial Instructions, Scheme of Delegation

Document ID Number	
Version:	V1.2
Ratified by:	Trust Board
Date ratified:	
Name of author and title:	Chief Financial Officer & Chief of Staff
Date originally written:	January 2023
Date current version was completed	January 2024
Name of responsible committee/individual:	Trust Board / Chief Financial Officer & Chief of Staff
Date issued:	
Review date:	January 2025
Target audience:	All Staff
Compliance with CQC Fundamental Standard	N/A.
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	N/A

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1	January 2023	Pete Palmer	New Document	New Document
V1.1	May 2023	Pete Palmer	Internal Consistency	Changes made to values to ensure internal consistency within documents
V1.2	January 2024	Pete Palmer	Annual Review	

Consultation Table

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

Name of Individual or group	Title	Date
ESHT Trust Board		13 February 2024
Audit Committee		25 January 2024

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

Table of Contents

Foreword to Standing Orders

1. The Code of Accountability requires the Boards of NHS Trusts adopt:

   - Standing Orders (SOs);
   - Reservation of Powers to the Board and Delegation of Powers;
   - Standing Financial Instructions (SFIs)

2. These documents provide a framework for the regulation of proceedings and the business of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

3. The Standing Orders incorporate provisions of the National Health Service Trusts (Membership and Procedure) Regulations.

4. These Standing Orders have been adopted by the Board and are therefore mandatory for all directors and employees of the organisation.

5. Where reference is made to other documents, these are available from the Chief of Staff

.

1. Introduction

Statutory Framework

The East Sussex Healthcare NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2011 under The East Sussex Healthcare NHS Trust (Establishment) Order 2011 No. 1185 (the Establishment Order).

The Trust provides NHS acute and community services throughout East Sussex at two district general hospitals, Conquest Hospital and Eastbourne District General Hospital, community hospitals in Bexhill, Rye and Uckfield and a number of clinics and health centres, GP surgeries and in people's homes.

NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999, the Health and Social Care Act 2001, the NHS Act 2006, Health Act 2009 and Health and Social Care Act 2012. The functions of the Trust are conferred by this legislation.

As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee.

The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
The Trust takes into account the rights and pledges set out in the NHS Constitution which has the force of law

NHS Framework

In addition to the statutory requirements, the Secretary of State through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

The NHS Codes of Conduct and Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct outlines requirements concerning possible conflicts of interest of Board members.

The Freedom of Information Act (2000) sets out the requirements for public access to information on the NHS.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements.

Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO.5) the Trust is given powers to 'make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct'. Delegated Powers are covered in a separate document 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. Interpretation

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive or Associate Director of Corporate Governance in consultation with the Chief of Staff).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in this interpretation and in addition:

'Accountable Officer' means the NHS Officer responsible and accountable for funds entrusted to the Trust. He/She shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

'Associate Member' means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

'Board' means the Chairman, Officer and non-officer members of the Trust collectively as a body.

'Budget' means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

'Budget Holder' means the director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

'Chairman of the Board (or Trust)' is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'the Chairman of the Trust' shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

'Chief Executive' means the chief officer of the Trust.

'Chief Financial Officer ' means the chief financial officer of the Trust.

'Commissioning' means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

'Committee' means a committee or sub-committee created and appointed by the Trust.

'Committee members' means persons formally appointed by the Board to sit on or to chair specific committees.

'Contracting and procuring' means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

'Funds held on trust' shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

'Member' means executive or non-executive director of the Board, as the context permits. 'Member' in relation to the Board does not include its Chairman.

'Membership, Procedure and Administration Arrangements Regulations' means NHS

Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

'Nominated officer' means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

'Non-officer Member' means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

'Officer' means employee of the Trust or any other person holding a paid appointment or office with the Trust.

'Officer Member' means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

'Associate Director of Corporate Governance in consultation with the Chief of Staff' means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

'SFIs' means Standing Financial Instructions.

'SOs' means Standing Orders.

'Trust' means the East Sussex Healthcare NHS Trust.

'Vice-Chairman' means the non-officer member appointed by the Chairman to take on the Chairman's duties if the Chairman is absent for any reason.

'Senior Independent Director' means the non-officer member appointed by the Chairman to be available to members of the Board if they have concerns which contact through the normal channels of Chairman, Chief Executive or Chief Financial Officer has failed to resolve or for which such contact is inappropriate.

The 'Regulator' means NHS England or successor body.

Standing Orders for the regulation of the proceedings of East Sussex Healthcare NHS Trust

Part 2 – The Trust Board: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership**,** Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chairman of the Trust (Appointed by the Regulator);

(2) Up to 5 non-officer members (Appointed by the Regulator);

(3) Up to 5 officer members (but not exceeding the number of non-officer members) including:

- The Chief Executive
- The Chief Financial Officer
- The Chief Medical Officer
- The Chief Nurse

The Board shall have not more than 11 and not less than 8 voting members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of the Chair and directors

Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chairman and Members

2.3.1 The regulations setting out the period of term of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Section 2 to 4 of the Membership, Procedures and Administration Arrangements Regulations.

2.4 Appointment and powers of Vice-Chairman

2.4.1 Subject to SO 2.4.2 below, the Chairman may appoint any Member of the Board, who is also a Non-Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him/her. If, in exceptional circumstances due to illness or any other cause, the Chairman is unable to appoint a Vice-Chairman, then another non-executive director will assume the office of Vice-Chairman.

2.4.2 Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.4(1).

2.4.3 Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties.

2.5 Appointment and powers of Senior Independent Director

2.5.1 Subject to SO 2.5.2 below, the Chairman may appoint any Member of the Board, who is also a Non-Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a Member of the Board, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board.

2.5.2 Any Non-Executive Member of the Board so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Board of Directors may thereupon appoint another Non-Executive Member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.5.1.

2.6 Appointment and powers of Associate Non-Executive Directors

The Board may appoint Associate Non-Executive Directors on terms and conditions to be specified by the Board to provide additional advice and expertise to the Board. Associate Non-Executive Directors will be non-voting appointees without executive or delegated executive functions but will be accountable to the Board for the responsibilities detailed in their terms and conditions of employment, which shall never exceed 4 years but may be renewed by the Board.

2.7 Joint Members

2.7.1 Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

2.7.2 Where the office of a member of the Board is shared jointly by more than one person;

i. either or both of those persons may attend or take part in meetings of the Board;

ii. if both are present at a meeting they should cast one vote if they agree,

iii. in the case of disagreements no vote should be cast.

iv. the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.10 Quorum.

2.8 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.8.1 **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.8.2 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.8.3 **Chief Financial Officer**

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.8.4 **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.8.5 **Chairman**

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with the Trust's Standing Orders.

The Chairman shall liaise with the Regulator over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.9 Corporate Role of Board

2.9.1 All business shall be conducted in the name of the Trust.

2.9.2 All funds received in trust (charitable funds) shall be held in the name of the Trust as corporate trustee.

2.9.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

2.9.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.10 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.11 Lead Roles for Board Members

The Chairman shall ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc).

3. Meetings

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Board shall be held at such times and places as the Board may determine and may be held using an online platform

3.1.2 The Chairman of the Trust may call a meeting of the Board at any time.

3.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.1.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.1.5 Agendas will be sent to members 6 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. Failure to serve such a notice on more than three members will invalidate the meeting. A notice shall be presumed to have been served one day after posting

3.1.6 Before each public meeting of the Board a public notice of the time and place of the meeting, or details of the online meeting, and the public part of the agenda, shall be displayed either at the Trust's principal office or to be published electronically at least three clear days before the meeting. If the meeting is convened at shorter notice, then as soon as reasonably practicable. (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a)).

3.2 Notice of Meetings and the Business to be transacted

3.2.1 Before each meeting of the Board a notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to him/her at least three clear days before the meeting. The notice shall be signed by the Chairman, or by an officer authorised by the Chairman to sign on their behalf. Want of service of the notice on any member shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by members is default of the Chairman calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6

3.3 Agenda and Supporting Papers

The Agenda will be sent to members 6 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 clear days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notices of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 and 3.8, a member of the Board wishing to move a motion shall send a written notice to the Chief of Staff who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 5 clear days before the meeting. The Chief of Staff shall include in the agenda for the meeting all notices received that are in order and permissible under governing regulations. This Standing Order shall not present any motion being withdrawn or moved without notice on any business mentions on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions': Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

3.7.1 **Who may propose?**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

3.7.2 **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

3.7.3 **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 **Rights of reply to motions**

a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 **Withdrawing a motion**
A motion, or an amendment to a motion, may be withdrawn.

3.7.6 **Motions once under debate**
When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 An officer in attendance for an executive director (officer member) but without having been formally appointed on an acting up basis may not count towards the quorum.

3.9 Chairman's Ruling
The decision of the Chairman of the meeting on questions of order, relevancy and (regularity including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial instructions at the meeting shall be final.

3.10 Quorum

310.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is an officer member and one who is not is present.

3.10.2 An officer in attendance for an executive director (officer member) but without formal acting up status may not count towards the quorum.

3.10.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.11 Voting

3.11.1 Save as provided in Standing Orders 3.12 – Suspension of Standing Orders and 3.13 Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding, (i.e. Chairman of the meeting) shall have a second and casting vote.

3.11.2 At the discretion of the Chairman, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.11.3 If at least one third of the members present so request, the voting on any question may be recorded to show how each member present voted or did not vote (except when conducted by paper ballot).

3.11.4 If a member so requests, their vote shall be recorded by name.

3.11.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.11.6 A manager who has been formally appointed to act up for an officer member during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the officer.

A manager attending the Board to represent an officer member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the officer member. An officer's status when attending a meeting shall be recorded in the minutes.

3.12 Suspension of Standing Orders

3.12.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.10), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two thirds of the whole number of the members of the Board are present, (including at least one member who is an officer member of the Trust and one member who is not) and that at least two thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

3.12.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Board.

3.12.3 No formal business may be transacted while Standing Orders are suspended.

3.12.4 The Audit Committee shall review every decision to suspend Standing Orders.

3.13 Variation and Amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
- upon a notice of motion under Standing Order 3.5 that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed and that at least
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.14 Record of Attendance

The names of the Chairman and members present at the meeting shall be recorded in the minutes.

3.15 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.16 Admission

3.16.1 The public and representatives of the press may attend all public meetings of the Trust (Board) but shall be required to withdraw upon the Trust (Board) resolving as follows:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

3.16.2 **General Disturbances**

The Chairman (or Vice Chairman, if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

'That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public' (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

3.16.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.16.4 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.17 Observers at Trust Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions at it deems fit.

Part 4 – Appointment of Committees and Sub Committees

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State, the Board may appoint committees of the Trust.

The Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Suspension of Standing Orders

4.2.1 Joint committees may be appointed by the Trust by joining together with one or more other Commissioners, or other Trusts consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of a committee also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

4.4 Terms of Reference

Each such committee shall have terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Chairman shall make the appointments to each of the committees that the Board has formally constituted. Where the Chairman determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees within the terms of reference of the committee and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State

4.8 Committees established by the Trust Board

The committees, sub committees, and joint committees established by the Board are:-

4.8.1 Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, an audit committee will be established and constituted to provide the Trust Board with an independent and objective review of its financial systems, financial information, system of internal control and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on at least an annual basis.

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One member should also be a member of the Quality and Safety Committee and one member a member of the Finance and Investment Committee. At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee. Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4.8.2 Remuneration and Appointments Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, a Remuneration and Appointments Committee will be established and constituted.

The overall purpose of the committee is to ensure that the process of appointing, and if necessary dismissing, the executive directors are robust, fit for purpose and have been followed. The committee shall oversee the system for all executive director appointments and agree the parameters for the senior appointments process. The process of all senior executive appointments will be reported back to the committee in order that the committee can provide the Board with assurance. Additionally, the committee will agree and review the Trust's policies on the reward, performance, retention and pension matters for the executive directors of the Trust. The terms of reference will be approved by the Trust Board and reviewed on an annual basis.

4.8.3 Quality and Safety Committee

The Trust Board will establish a Quality and Safety Committee to provide assurance to the Trust Board that the Trust is providing safe and high quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care. It will review whether local and national targets are met and that lessons learned from incidents, complaints and claims. The terms of reference will be approved by the Trust Board and reviewed on at least an annual basis.

The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors.

4.8.4 Finance and Productivity Committee

The Trust Board will establish a Finance and Productivity Committee to assure itself that responsibilities in regard to fiscal issues, value for money, financial risk and investment decisions are being discharged. It will review in more detail the financial performance of the Trust and the investment systems, options for future investment and investment performance. The Terms of Reference will be approved by the Trust Board and reviewed on at least an annual basis.

The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors, one of whom should be a member of the Audit Committee.

4.8.4.1 Capital Sub Committee

The Finance and Productivity Committee may establish a capital subcommittee to provide a forum for detailed review of the Trust's capital programme, underlying capital processes and longer term capital planning, ensuring that capital plans are delivered in a timely manner and in line with Trust governance processes.

The committee and committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors, one of whom should be a member of the Finance and Productivity Committee.

4.8.5 **People and Organisational Development Committee**

The Trust Board will establish a People and Organisational Development Committee to assure itself that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success. The Terms of Reference will be approved by the Trust Board and reviewed on at least an annual basis.

The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors.

4.8.6 **Strategy and Transformation Committee**

The Trust Board will establish a Strategy and Transformation Committee to oversee and scrutinise the formulation, direction and delivery of strategy and related performance matters at the Trust, thus giving assurance to the board on the delivery of its strategy.

The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least two non-executive directors.

4.8.7 **Inequalities Committee**

The Trust Board will establish an Inequalities Committee to provide a Board level focus on the Trust's broad approach to equality, both in staffing and service delivery.

The Committee and Committee Chairman shall be appointed by the Chairman of the Board and should comprise of at least three non-executive directors, one of whom will be the Chair of the People and Organisational Development Committee.

4.8.8 **Executive Committee**

The Trust Board delegates power to the Executive Team to oversee the management of an effective system of governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. They exercise this function in collaboration with senior operational colleagues through the Executive Committee.

4.8.9 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

4.9 The arrangements made by the Board as set out in the Reservation of Powers to the Board and Delegation of Powers document shall have effect as if incorporated in these Standing Orders.

Part 5 – Arrangements for the exercise of Trust functions by delegation

5.1 Delegation of Functions to Committees and Officers

Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-Executive members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.2 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with the requirements of statute and guidance from the Department of Health and the Regulator. Outside of these requirements the role of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason the Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with the Standing Orders to the Chief Executive as soon as possible.

Part 6 – Overlap with other Trust policy statements, regulations and the Standing Financial Instructions

6.1 Policy Statements General Principals

The Trust Board will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by East Sussex Healthcare NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Legislation, Policy and Guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements and any amendment thereto:

- the Standards of Business Conduct for NHS staff (HSG(93)5) and the Trust's Interests, Gifts, Hospitality and Sponsorship Policy
- the Trust's Counter Fraud and Bribery Policy
- the Disciplinary Procedure, both of which shall have effect as if incorporated in these Standing Orders.
- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000;
- NHS Constitution Health Act 2009;
- Bribery Act 2010
- Fit and Proper persons regulations

And any other legislation, policy or guidance that impacts the regulation of proceedings and the business of the Trust

Part 7 – Duties and obligations of Board members/directors and senior managers under these standing orders

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

(i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests on an annual basis. Any Board members appointed subsequently should do so on appointment and thereafter on an annual basis.

7.1.2 Interests which should be regarded as relevant and material are:

i) Directorships, including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).
ii) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
iii) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
iv) A position of authority in a charity or voluntary organisation in the field of health and social care.
v) Any connection with a voluntary or other organisation contracting for NHS services.
vi) Research funding/grants that may be received by an individual or their department:
vii) Interests in pooled funds that are under separate management.

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 **Conflicts of interest which arise during the course of a meeting**
During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 6.3)

7.2 Register of Interests

The Associate Director of Corporate Governance in consultation with the Chief of Staff will ensure that a Register of Interests is established to formally record declarations of interests of Board or committee members. In particular the Register will include details of all directorships and other relevant and material interests as defined in SO 6.1.2) which have been declared by both executive and non-executive Board members, as defined in Standing Order 5.5.

7.2.1 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.2 The Register will be available to the public and the Associate Director of Corporate Governance in consultation with the Chief of Staff will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in proceedings on account of pecuniary interest.

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) **"spouse"** shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) **"contract"** shall include any proposed contract or other course of dealing.

(iii) **"Pecuniary interest"**. Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) **Exception to Pecuniary interests**
A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the Trust Board

(i) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Trust Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) **Power of the Secretary of State to make waivers:**

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) **Definition of 'Chairman' for the purpose of interpreting this waiver**
For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is –

(a) at a meeting of the Trust, the Chairman of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;

(ii) in the case of any other member, the Chairman of that Committee.

(3) **Application of waiver**
A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) **Conditions which apply to the waiver and the removal of having a pecuniary interest**

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
(ii) may vote on any question with respect to it; but
(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of business conduct policy

7.4.1 **Trust Policy & National Guidance**

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will retain accountability to the Trust.

7.4.2 **Interest of Officers in Contracts**

i. Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 6.5/7.5) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Associate Director of Corporate Governance as soon as practicable.

ii. An officer should also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii. The Trust requires interests, employment or relationships declared, to be entered in the register of interests.

7.4.3 **Canvassing of, and Recommendations by, Members in Relation to Appointments**

i. Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii. A member of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i. Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

ii The Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive, to ensure that the appointing officer/panel are informed of the relationship prior to appointment being made and report to the Trust Board any such disclosure made.

Part 8 – Custody of Trust Seal, sealing and signature of documents

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Associate Director of Corporate Governance or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them. Also refer to 7.8 of the standing financial instructions.

8.3 Register of Sealing

The Associate Director of Corporate Governance shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Custody of Seal

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director. The Associate Director of Corporate Governance may act as a counter signatory if required.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

Part 9 – Miscellaneous

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

Appendix A – Schedule of decisions reserved to the Trust Board

Introduction

Standing Order 1.5 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, , which may include members participating by video or telephone." These powers and decisions are set out in this Schedule.

1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1. Approve, including variations to:

- 1.1.1. Standing Orders for the regulation of its proceedings and business.
- 1.1.2. this Schedule of matters reserved to the Trust Board.
- 1.1.3. Standing Financial Instructions
- 1.1.4. Scheme of Delegation, including financial limits in delegations, from the Trust Board to officers of the Trust.
- 1.1.5. suspension of Standing Orders

1.2. Determine the frequency and function of Trust Board meetings, including:

- 1.2.1. administration of public and private agendas of Board meetings
- 1.2.2. calling extra-ordinary meetings of the Board

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation ; and:

- 1.4.1. delegate functions from the Board to the committees
- 1.4.2. delegate functions from the Board to a director or officer of the Trust
- 1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies
- 1.4.4. receive reports from Board committees and take appropriate action in response to those reports
- 1.4.5. confirm the recommendations of the committees which do not have executive decision making powers
- 1.4.6. approve terms of reference and reporting arrangements of committees
- 1.4.7. approve delegation of powers from Board committees to sub- committees

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- 1.5.1. Appoint the Chief Executive
- 1.5.2. Appoint the Executive Directors

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests

1.7. Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.

1.9. Approve arrangements for dealing with and responding to complaints.

1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on Trust

1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. *Determination of strategy and policy*

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans
2.2.2. definition of the strategic aims and objectives of the Trust.
2.2.3. clinical and service development strategy
2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3. *Direct operational decisions*

3.1. Approve capital investment plans:

3.1.1. the annual capital programme
3.1.2. all variations to approved capital plans over £1 million
3.1.3. to acquire, dispose of, or change of use of land and/or buildings
3.1.4. capital investment over £2.5 million in value, supported by a business case and in line with the approval guidance issued by NHS England & Improvement.
3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k).

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5 million:

3.3.1. Tenders and quotations over the lifetime of the contract
3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement
3.3.3. Orders processed through approved supply arrangements
3.3.4. Orders processed through non-approved supply arrangements
3.3.5. Receipt of loans and trials equipment and materials
3.3.6. Prepayment agreements for services received

3.4. Decide the need to subject services to market testing

4. *Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

4.2.1. The Care Quality Commission
4.2.2. NHS Improvement

4.3. Consider and approve of the Trust's Annual Report including the annual accounts.

4.4. Approve the Annual report(s) and accounts for funds held on trust.

4.5. Approve the Quality Account

5. Audit arrangements

5.1. Approve audit arrangements recommended by the Audit & Risk Committee (including arrangements for the separate audit of funds held on trust).
5.2. Receive reports of the Audit & Risk Committee meetings and take appropriate action.
5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.
5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit & Risk Committee, where appropriate.
5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

ENDS

Appendix B – Standing Financial Instructions

1. Introduction

1.1 General

1.1.1 The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs). There will be a training and communication programme administered by the Chief Financial Officer to affect these SFIs.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.
All financial procedures must be approved by the Chief Financial Officer .

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 **FAILURE TO COMPLY WITH SFIs and SOs IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 **Overriding Standing Financial Instructions**
If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non- compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Trust's Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

a) '**Accountable Officer'** means the NHS Officer responsible and accountable for funds entrusted to the Trust. He/She shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive;

b) '**Board**' means the Board of the Trust;

c) '**Budget**' means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

d) '**Budget Holder'** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

e) '**Chief Executive**' means the chief officer of the Trust;

f) '**Chief Financial Officer**' means the chief financial officer of the Trust;

g) '**Executive Director**' means a member of the Trust who is an officer;

h) '**Funds held on trust**' shall mean those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the National Health Service Act 2006 and the Health and Social Care Act 2012. Such funds may or may not be charitable;

i) '**Legal Adviser**' means the properly qualified person appointed by the Trust to provide legal advice;

j) '**Officer**' means employee of the Trust or any other person holding a paid appointment or office with the Trust;

k) '**Non-Executive Director**' means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of the Membership and Procedure Regulations;

l) '**Trust**' means the East Sussex Healthcare NHS Trust;

m) Any reference to an act should be taken to include any subsequent legislation.

1.2.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term 'employee' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Any employee of the Trust who solicits or accepts any gift or consideration of any kind from contractors or their agents or from any organisation, firms or individual, as an inducement or reward for doing or refraining from doing anything in his official capacity, or for showing favour or disfavour to any person in his official capacity shall be liable to dismissal and to prosecution. All dealings shall be in accordance with "Standards of Business Conduct for NHS Staff."

1.2.5 Powers not defined by Standing Orders or these SFIs shall be exercised on behalf of the Trust by such officers as the Chief Executive designates, within such limits and subject to such conditions as the Chief Executive shall prescribe.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of Matters Reserved to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as Accountable Officer to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board and employees and all new appointees are notified of and understand their responsibilities within these instructions.

1.3.7 The Chief Financial Officer is responsible for:

a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

d) the provision of financial advice to other members of the Board and the wider organisation;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding unplanned financial losses;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer .

2. Audit

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Trust's Board shall establish an Audit Committee which will provide an independent and objective view of internal control by:

(a) concluding upon the adequacy and effective operation of the organisation's overall internal control system. In particular it is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust;

(b) reviewing the establishment and maintenance of effective systems of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives;

(c) ensuring that there is an effective internal audit function, including the Counter Fraud function, establishment by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;

(d) reviewing the work and findings of the external auditor and consider the implications of management's responses to their work.

(e) receive a report on tenders and waivers and framework direct awards that exceed £250k (cumulative if a supplier is awarded more than one contract for the same project);

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care. (via the Chief Financial Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.2 Chief Financial Officer

2.2.1 The Chief Financial Officer is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities not involving fraud or corruption (for cases involving suspected fraud or corruption see paragraph 15.2.3);

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

i. a clear opinion on the effectiveness of internal control;
ii. major internal (financial) control weaknesses discovered; progress on the implementation of internal audit recommendations;
iii. progress against plan over the previous year;
iv. strategic audit plan covering the coming three years;
v. a detailed plan for the coming year.

2.2.2 The Chief Financial Officer and designated auditors are entitled without necessarily giving prior notice to require and receive;

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case they shall have a duty to safeguard that confidentiality);

b) access at all reasonable times to any land, premises, members of the Board or employees of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of the Board and employee's control; and

d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. fraud and other offences,

ii. waste, extravagance, inefficient administration,

iii. poor value for money or other causes.

e) Internal Audit shall also independently verify the Assurance Framework in accordance with guidance from the Department of Health.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning; cash, stores, other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

2.3.3 The Audit Manager/Director of Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Audit Manager/Director of Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years.

2.3.5 The Audit Manager shall report direct to the Chief Financial Officer who shall refer audit reports, under agreed reporting arrangements, to the appropriate designated officers. Recipients of an audit report shall send a written response within two weeks stating the action to be taken in response to the audit recommendations. Failure to take any necessary action within a reasonable period shall be reported to the relevant Executive Director.

2.4 External Audit

2.4.1 The external auditor is appointed and paid for by the Trust. The Audit Committee must ensure that the Trust receives a cost efficient service. Should there be a problem which cannot be resolved by the Audit Committee, then this should be discussed with the external auditor and if appropriate referred to the Board for resolution. In exceptional circumstances the issue may be referred to NHSI if it cannot be resolved.

2.4.2 The Trust will not purchase any non-audit services from its appointed external auditor unless required to do so by NHS England or the Department of Health.

2.5 Fraud and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the Secretary of State's Directions on fraud and bribery.

2.5.2 In line with their responsibilities, the Board shall monitor and ensure compliance with the provisions of the Bribery Act 2010. Senior officers (including non-board level managers) can be individually held criminally liable for the Trust's bribery offences.

2.5.3 All suspicions of bribery should be reported to the Trust's Local Counter Fraud Specialist. Detailed guidance can be found in the Trust's Counter Fraud & Bribery Policy.

2.5.4 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.5 The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work with staff in the Directorate of Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.5.6 The Local Counter Fraud Specialist will provide a written report, at least annually to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. Business planning, budgets, budgetary control and monitoring

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources and is in accordance with the guidance issued by NHSI.

The annual plan content and the number of submissions are defined by NHSI. The plans usually contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

c) detailed financial templates, accompanying finance narrative and operational/strategic narrative.

3.1.2 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and the delivery of a balanced budget.

3.1.3 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the annual business plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared as far as is reasonably practicable within the limits of available funds; and

e) identify potential risks and the means of mitigating such risks.

3.1.4 The Chief Financial Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Board. As a consequence the Chief Financial Officer shall have the right of access to all budget holders on budgetary related matters.

3.1.5 All budget holders must provide information as required by the Chief Financial Officer to enable budgets and annual plans to be compiled.

3.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.7 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement;

e) achievement of planned levels of service; and

f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by Executives.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year end position (Income Statement);
(ii) movements in working capital (Statement of Financial Position);
(iii) movements in cash and capital;
(iv) capital project spend and projected outturn against plan;
(v) explanations of any material variances from plan;
(vi) Cost Improvement Programme Report;
(vii) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, activity and workforce budgets;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer ;

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 Contract Income

3.4.1 The Chief Financial Officer of the Trust will:

a) periodically review the bases and assumptions used for compiling budgets and ensure that these are reasonable and realistic;

b) periodically review contract income and all other sources of income to ensure the Trust is obtaining all the funds due;

c) prior to the start of each financial year submit to the Trust's Board of Directors for approval a report showing the total expected contract income received and the proposed allocation including any sums to be held in reserve; and

d) regularly update the Trust's Board of Directors on significant changes to contract income and the uses of such funds.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 13)

3.6 Monitoring Returns

3.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSI within agreed timescales.

3.7 Business cases and service changes

3.7.1 For any service change which requires an increase to the cost base of the Trust even if there is offsetting income, it is the responsibility of the Executive lead for the respective area to ensure the following process is followed:

a) A service change proposal should be developed and submitted to the relevant Integrated Performance Review (IPR) for approval;

b) For cases over £50,000 per annum increase in costs a business case should be submitted to Business Development Group (BDG) for recommendation to Executive Directors which is required to approve the case

c) For cases over £500,000 per annum approval is also required from Finance and Productivity Committee.

d) For cases over £2,500,000 per annum approval is also required from the Board

3.7.2 A case may require approval from a more senior committee than the financial values alone may dictate due to the nature of the change being proposed, this is beyond the scope of this document but the relevant committee will advise on an ad hoc basis and accountability for seeking appropriate approval will sit with the Executive Director lead.

4. Annual Accounts and Reports

4.1 The Chief Financial Officer, on behalf of the Trust, will:

a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

b) prepare and submit annual financial reports to the Secretary of State certified in accordance with current guidelines; and

c) submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care (DHSC).

4.2 The Trust's annual accounts must be audited by the appointed auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting, (see 1.3.2). The document will comply with the DHSC group accounting manual (GAM) .

5. Bank and Office of Paymaster general accounts

5.1 General

5.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account DHSC guidance/directions. In line with 'Cash Management in the NHS', Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and Government Banking Service (GBS) Accounts

5.2.1 The Chief Financial Officer is responsible for:

a) GBS and bank accounts;

b) establishing separate bank accounts for the Trust's non exchequer funds;

c) ensuring payments made from GBS or bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken); and

e) monitoring compliance with DHSC guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of GBS and bank accounts which must include:

a) the conditions under which each GBS and other bank account is to be operated;

b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No bank account may be opened for official monies without the approval of the Chief Financial Officer.

5.4 Tendering and Review

5.4.1 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. Income, fees and charges and security of cash, cheques and other negotiable instruments

6.1 Income Systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The Chief Financial Officer is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow NHSI's and the Department of Health's guidance in setting prices for NHS contracts e.g. "National Tariff Payments System."

6.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the DHSC Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures (See Section 15).

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Chief Financial Officer is responsible for:

a) approving the form of all receipting books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such records;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Cash income may be exchanged for Payable Orders for Petty Cash and Patients Money. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. Tendering and contracting procedure

7.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No 3.12 Suspension of Standing Orders is applied).

7.2 The Public Contracts Regulations 2015 Legislation Governing Public Procurement

The Public Contracts Regulations 2015 Legislation promulgated by the DHSC prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reserve eAuctions.

7.4 Other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the NHSI 'Capital Regime, Investment and Property Business Case Guidance' and 'Estatecode' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with relevant Department of Health guidance

7.5 Formal Competitive Tendering

7.5.1 General Applicability

All competitive tendering must be undertaken in conjunction with the Procurement team.

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services, Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to tendering procedures.

7.5.3 Exceptions and Instances where Formal Tendering need not be applied

Formal tendering procedures need not be applied where:

a) the estimated expenditure or income is, or is reasonably expected to be, less than £70,000 (excluding VAT) over the life of the contract;

b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

c) regarding disposals as set out in SFI 15;

d) where the requirement is covered by an existing valid contract;

e) where supply of goods or services is through NHS Supply Chain unless the Chief Executive or nominated officers deem it inappropriate for reasons of cost or availability. The decision to use alternative sources must be documented;

f) where the Trust can utilise framework agreements through a direct award or further competition to achieve Value for Money. These may include but not be limited to Crown Commercial Services, NHS Commercial Solutions and the other NHS Hubs, NHS Shared Business Services, Health Trust Europe, Pro5;

g) for construction works under the provision of the DoH ProCure21+/P22/P23 framework;

h) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members where the Head of Procurement and Chief Financial Officer is satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

i) where a statutory payment can only be made to a specific statutory body (eg rates), authorisation of the bodies considered in this category will be determined by the Chief Financial Officer and Head of Procurement.

j) where payment is to another NHS body and the Head of Procurement and Chief Financial Officer is satisfied that the procurement arrangements conform to current statute and deliver value for money;

k) where payment is less than the current Public Procurement Threshold for Goods & Services and is for the renewal of maintenance services under an original supplier contract to provide equipment or IT and the Chief Financial Officer and Head of Procurement is satisfied that the procurement arrangements conform to current statute and deliver value for money;

l) where payment is less than the current Public Procurement Threshold for Goods & Services and is for the renewal of software license agreements under an original supplier contract to provide software licenses and the Chief Financial Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money;

m) where payment is less than the current Public Procurement Threshold for Goods & Services and is for the purchase of replacement equipment parts under an original supplier contract to provide medical equipment and the Chief Finance Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money

7.5.4 Formal tendering procedures may be waived in the following circumstances:

a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

b) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

c) where specialist expertise is required and is available from only one source;

d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and evidence of the decision making process and cost / benefit analysis documented;

f) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society of England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

g) where allowed and provided for in the Capital Regime, Investment and Property Business Case Approval Guidance.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure (except in circumstances outlined in 7.5.3 (d) above)

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.5 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 7.1, 7.5.3 and 7.5.4 don't apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than **three** firms/individuals (unless demonstrated to be a restricted market), having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.6 Building and Engineering Construction Works

Competitive Tendering should not be waived for building and engineering construction works and maintenance (other than in accordance with relevant guidance) without DHSC approval.

7.5.7 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in Standing Financial Instructions for which formal tendering procedures are not used and which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to Tender

i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

ii) All invitations to tender shall state that no tender will be accepted unless:

a) accompanied by a statement from the prospective supplier / contractor that provides assurance that they are compliant with the Bribery Act 2010.

iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

iv) Every tender for building or engineering works (except for maintenance work, when the Estatecode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with the Estatecode guidance. When the content of the work is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institution of Mechanical Engineers and the Association of Consulting Engineers, (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to

cover special features of individual projects.

v) All individuals involved in the evaluation of tenders will make a formal declaration of any interests they have along with any gift or hospitality received regardless of the provider.

7.6.2 Receipt, Safe Custody and Record of Formal Tenders

(i) Formal competitive tenders shall be returned electronically via the Trust's nominated e-portal provider;

(ii) When tenders are received in electronic format the e-portal will automatically record the date and time of receipt of each tender. This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

7.6.3 Opening Formal tenders (Electronic Format)

(i) The e-tendering portal will automatically close at the date and time stated as being the latest time for the receipt of tenders, the e-tendering portal shall be closed to further tender submissions, and the project will be locked for evaluation.

(ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iii) A designated procurement officer shall electronically open the submitted tenders through the e-tendering portal.

(iv) The e-tendering portal will record the date and time the tender submissions are opened.

(v) A tendering register shall be maintained on the e-tendering portal, to show for each set of competitive tender invitations dispatched:

a) The name of all firms' individuals invited;

b) The names of firms individuals from which tenders have been received;

c) The date the tenders were opened;

d) The person opening the tender;

(vi) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing, should be dealt with in the same way as late tenders (paragraph 7.6.5 below).

7.6.4 Admissibility

i) If for any reason the Procurement officer is of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 Late Tenders

i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. uploaded in good time but delayed through no fault of the tenderer.

ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the process of evaluation and adjudication has not started.

iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

7.6.6 Acceptance of Formal Tenders (See Overlap with SFI No. 7.7)

i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

ii) The most economically advantageous tender (MEAT), the lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons (for example, evaluation criteria) shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time;
e) result of the "quality" aspect of any mini-competition in conjunction with the tender price

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive

iv) The use of these procedures must demonstrate that the award contract was:

a) not in excess of the going market rate/price current at the time the contract was awarded;
b) the best value for money was achieved; and

v) All tenders should be treated as confidential and should be

retained for inspection.

7.6.7 Tender Reports to the Trust Board

Reports to the Trust Board will be made in exceptional circumstance basis only.

7.6.8 List of Approved Firms

a) Responsibility for Maintaining List

Tender lists for building and engineering works will be compiled by the Director of Estates & Facilities from "Constructionline" the Trust's approved list of Contractors.

b) Building and Engineering Construction Works

i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Tender documentation will require confirmation that companies on the tender list confirm that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not unlawfully discriminate, harass or victimise any person because of colour, nationality, ethnic or national origins, religion or belief, sex, gender reassignment, age, disability, sexual orientation, pregnancy or maternity, civil partnership or marital status and will comply with the provisions of the Equality Act 2010 and the Gender Recognition Act 2004 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.6.9 Exceptions to Using Approved Contractors

a) If in the opinion of the Chief Executive and Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the "constructionline" list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on "constructionline"), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those

firms that are invited to tender or quote. The Trust should also seek written confirmation from the potential contractor that they are compliant with the Bribery Act 2010.

b) An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.6.10 Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced, the reinvolvement of any staff member involved in the original process should be reviewed before any involvement in the new process.

7.7 Quotations: Competitive and Non-Competitive

7.7.1 General Position on Quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income is reasonably expected to exceed £25,000 but not exceed £70,000, excluding VAT.

7.7.2 Competitive Quotes

(i) Where possible requests for Quotations over £25,000 excluding VAT shall be logged using an e-tendering portal
(ii) Quotations should be invited from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
(iii) Where possible, quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
(iv) All quotations should be treated as confidential and should be retained for inspection.
(v) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) Where the goods or services are purchased through charitable funds /donations from Leagues of Friends, provided that they are below the UK Public Procurement Threshold and a value for money evaluation has been undertaken.

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer.

7.8 *Authorisation of Tenders and Competitive Quotations*

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

(Please note that the UK Public Procurement Threshold (for supplies and services – £139,688 inc VAT)

Within Current Budget (within the budget approved by the Board for the appropriate financial year)

Value of the Public Procurement Threshold	• Individual responsible for the Budget as per scheme of delegation
From The Public Procurement Threshold to £500,000 excluding VAT	• Individual responsible for the Budget as per scheme of delegation
From £500,000 to £2,500,000 excluding VAT	• Individual responsible for the Budget as per scheme of delegation • Chief Financial Officer and Chief Executive
Value of £2,500,000 or above excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget as per scheme of delegation • Chief Financial Officer and Chief Executive

New Spend (not included within a budget approved by the Board for the appropriate financial year)

Value of the Public Procurement Threshold	• Individual responsible for the Budget as per scheme of delegation
From the Public Procurement Threshold to £500,000 excluding VAT	• Individual responsible for the Budget as per scheme of delegation • Executive Directors and Director responsible for the Budget
From £500,000 to £2,500,000 excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget as per scheme of delegation; and • Chief Financial Officer and Chief Executive; and • Finance & Productivity Committee
Value of £2,500,000 or above excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget as per scheme of delegation; and • Chief Financial Officer and Chief Executive; and Finance & Productivity Committee; and • Trust Board and Common Seal of the Trust

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

If there is any doubt about whether proposed expenditure falls outside of the £139,688 inc VAT then please seek advice from the Procurement team.

The Executive Team is authorised to respond to short notice national capital bids. For any elements over £5m the Chief Executive will have consulted the Chair of the Board before preparing a bid. For the avoidance of doubt the Finance & Productivity Committee and the Board retain control over final authorisation of business cases.

7.9 Instances where Formal Competitive Tendering or Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a) the Trust shall use the NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented;
b) if the Trust does not use the NHS Supply Chain the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

7.10 Private Finance for Capital Procurement (See Overlap with SFI No. 13.2)

The Trust should normally market-test for PFI (Private Finance Initiative Funding) when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
b) Where the sum exceeds delegated limits, a business case must be referred to NHSI for approval or treated as per current guidelines.
c) The proposal must be specifically agreed by the Board of the Trust.
d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance Requirements for all Contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) The Trust's Standing Orders and Standing Financial Instructions;
b) The Public Contracts Regulations 2015 and other statutory provisions;
c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;
d) Such of the NHS Standard Contract Conditions as are applicable;
e) Contracts with Foundation Trusts must be in a form compliant with

appropriate NHS guidance;

f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations are invited.

g) In all contracts made by the Trust, the Board shall endeavor to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Healthcare Services Agreements (See Overlap with SFI No. 8)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 2014 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts.

However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable by law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.14 Disposals (See Overlap with SFI No 15)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

d) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
c) Evaluation team, comprising normally a specialist officer, a purchasing officer and a Chief Financial Officer representative.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15.6 Applicability of SFIs on Tendering and Contracting to Charitable Funds
(See also SFI section 8)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's Charitable funds.

8. NHS Service Agreements for provision of services

8.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services. All contracts should aim to implement the agreed priorities contained within the Trust Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- NHS Standard Contract;
- the provision of reliable information on cost and volume of services;
- the NHS Service and Financial Framework (SaFF);
- the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing partnership arrangements;
- that contracts are based on integrated care pathways; and
- The NHS Constitution which has the force of law.

8.2 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast contractual income. This will be supplemented by reports on profitability of individual services based on the costing activity in line with latest guidance.

9. Terms of service, allowances and payment of members of the Board and employees

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting, (see NHS guidance contained in the Higgs report).

9.1.2 The Committee will:

a) provide assurance to the Board around the process for appointing and dismissing all executive directors of the Board, including the chief executive;

b) agree the remuneration package, including performance related pay and other terms of service of the Chief Executive, including the scheme for performance related pay and any other benefits;

c) with the Chief Executive, agree the remuneration packages, including the scheme for performance related pay and other terms of service (including severance terms of applicable) of the executive directors and very senior managers;

d) review and agree the grading and remuneration package of any Director post that falls vacant, prior to the vacancy being advertised; and

e) monitor the system to evaluate the performance of the Chief Executive, the Executive Directors and other senior employees.

9.1.3 The Committee shall report in writing to the Board on an annual basis.

9.1.4 The Trust will remunerate and pay allowances to the Chairman and Non-Executive Directors in accordance with instructions issued by the Secretary of State for Health.

9.1.5 All employees are required as part of their conditions of service to comply with the Trust's and national guidance notes on 'Standards of Business Conduct for NHS Staff'.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or a nominated officer .

9.3 Staff Appointments

9.3.1 Employees may only be engaged, re-engage, or regraded, whether on a permanent or temporary basis, and agency staff may only be hired and changes in any aspect of remuneration can only be made:

a) within agreed policies and procedures; and

b) within the limit of approved budgets and the funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief Financial Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

9.4.2 The Chief Financial Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee and officers;

h) procedures for payment by cheque, bank credit, or cash to employees and officers;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash;

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust; and

n) premature retirement proposals.

9.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Chief Financial Officer 's instructions and in the form prescribed by the Chief Financial Officer ; and

c) notifying termination of employment in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

10. Non-pay expenditure

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer .

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

10.2.2 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Chief Financial Officer will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of Board members/employees (including specimens of their signatures) authorised to certify invoices.

ii) Certification that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

c) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account The Public Contracts Regulations 2015 rules where the contract is above a stipulated financial threshold); and

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Financial Officer;

c) state the Trust's terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Financial Officer.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made. All leases must be assessed prior to entry and classified as either operating or finance leases under IFRS. Authority to enter into finance leases requires written approval from the Chief Financial Officer .

b) contracts above specified thresholds are advertised and awarded in accordance with The Public Contracts Regulations 2015;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the DHSC;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii) conventional hospitality, such as lunches in the course of working visits;

   iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable, and also notify the details of all such hospitality offered or received, for entry in a register maintained for that purpose by the Chief Executive.

The national guidance contained in HSG 1993/5 'Standards of Business Conduct for NHS Staff' is shown as to Standing Orders 6.2.

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order except for those specifically excepted by the Chief Financial Officer in financial procedures, and purchases from petty cash or on purchase cards;

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order';

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Chief Financial Officer and;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer ; and

l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

10.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained with ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

Payments to local authorities and voluntary organisations made under the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

11. External borrowing

11.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the DHSC. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer .

11.3 The Chief Financial Officer must prepare detail procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the DHSC.

11.5 Any applications for short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer . The Board must be made aware of all short term borrowings at the next Board meeting.

11.6 All applications for long-term borrowing must be consistent with the plans outlined in the current Trust business plan and be approved by the Trust Board.

11.7 Investments

11.7.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

11.7.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.7.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. Planning Framework

12.1 The Chief Financial Officer shall ensure that members of the Board are aware of the operational planning and contracting guidance issued by the regulator. The Chief Financial Officer should also ensure that the guidance is followed by the Trust.

13. Capital investment, private financing, fixed asset registers and security of assets

13.1 Capital Investment

13.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation, where applicable of commissioner support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 Capital for the purpose of approval should be differentiated between:

a) **Replacement assets**; this is where an asset has reached the end of its useful economic life and requires a like for like replacement with no change to the delivery of the service (outside of incremental benefits from a new asset) – for example replacing an x-ray machine that is no longer fit for purpose or has ceased working or refurbishing a clinical area under the same footprint and layout. These should also have no material impact on revenue costs

b) **Investment assets**; where the asset is not a like for like replacement or results in a non-trivial impact on a service model or material impact on revenue costs – for example re-modelling and expansion of the day surgery unit. This could include increasing the number of assets (e.g. moving from two to three CT scanners).

Capital Review Group will be responsible for final determination of asset type.

13.1.3 For **replacement assets**, as long as the total expenditure falls within the capital allocated to that category (eg Digital or medical equipment) as part of the capital plan approved by the Board, the Chief executive will ensure:

a) that there is a completed Capital Expenditure Approvals Form (CAPEX) approved by the Capital Resource Group (CRG);

b) Replacement assets with capital expenditure proposal above £1,000,000 excluding recoverable VAT are approved by Executive Directors and should have a business case;

c) Replacement assets with capital expenditure proposal above £2,500,000 excluding recoverable VAT are also approved by Finance and Productivity Committee; and

d) Replacement assets with capital expenditure proposal above £5,000,000 excluding recoverable VAT are also approved the Board.

13.1.4 For every **investment asset** capital expenditure proposal in excess of £250,000 excluding recoverable VAT the Chief Executive shall ensure:

a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the combined Business Development Group (BDG) and Capital Resource Group (CRG). The submission can be to CRG only if there are no material revenue implications other than depreciation and public dividend capital.

b) for investment assets every capital expenditure proposal in excess of £250,000 excluding recoverable VAT the business case is also required to be submitted to the Executive Director's meeting for approval.

c) for all investment asset projects over £500,000 excluding recoverable VAT a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Productivity Committee for approval.

d) for all investment asset projects over £500,000 excluding recoverable VAT the Project Director will be required to co-ordinate and complete a monthly capital monitoring return to Capital Resource Group (CRG) showing performance against budget.

f) for all investment asset projects over £2,500,000 excluding recoverable VAT the business case will be submitted to the Trust Board for approval

13.1.5 The table below summarises the approval requirements for capital cases:

Asset Type	Documentation		Approval			
	Capex	Business case	CRG	Executive Directors	F&P	Board
Replacement	⚐	<£1,000k	All	<£1,000k	<£5,000k	>£5,000k
Investment	⚐	<£250k	All	<£500k	<£2,500k	>£2,500k

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of 'Estatecode'.

The Director of Estates and Facilities shall assess on an annual basis the requirement for the operation of the construction industry scheme in accordance with Her Majesty's Revenue and Customs guidance.

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender;

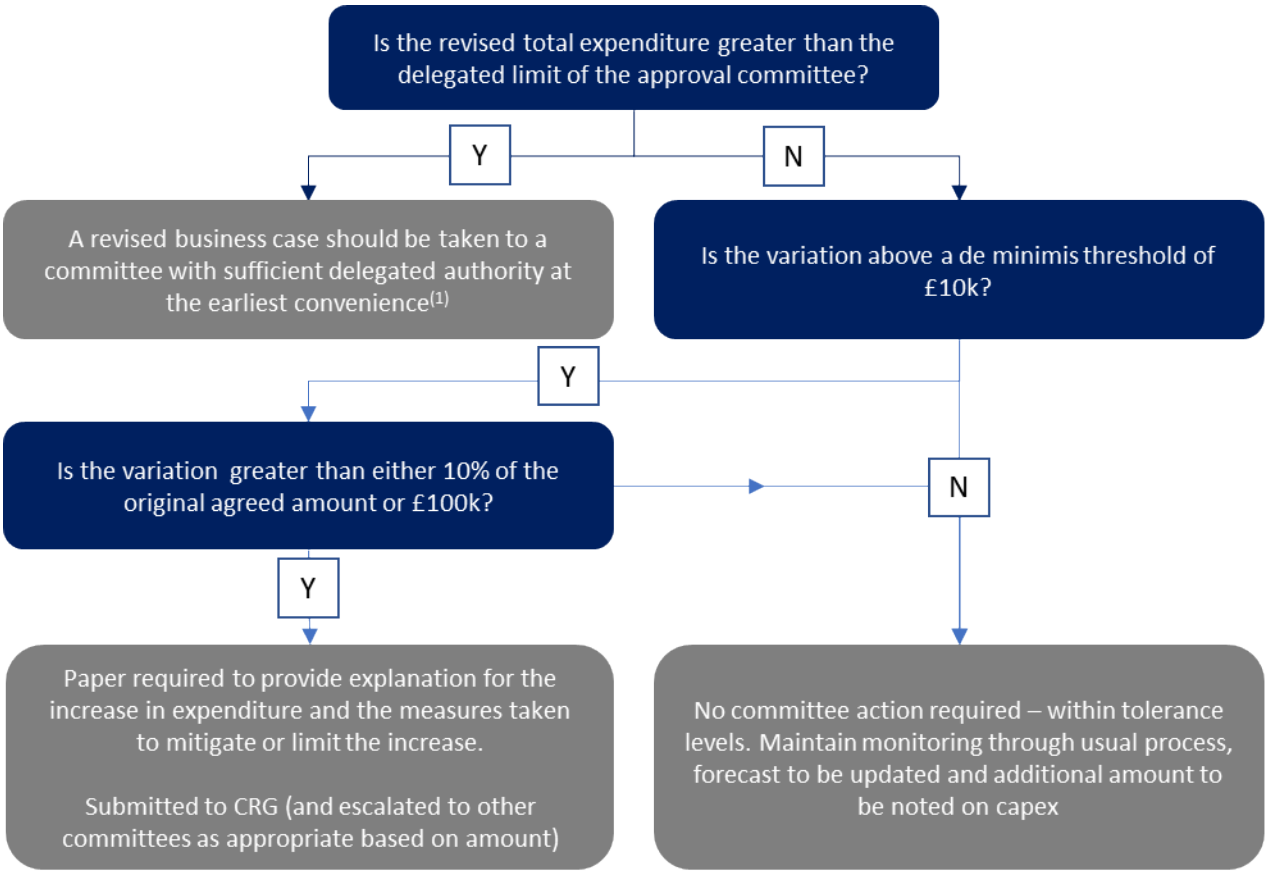
c) approval to accept a successful tender.

The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with 'Estatecode' guidance and the Trust Standing Orders.

13.1.8 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Regulator.

13.1.9 Capital schemes will be monitored through local and Committee review processes. Variances to capital schemes should be discussed and approved at the CRG and the Finance & Productivity Committee as appropriate at the earliest opportunity following awareness that it is likely that a scheme will overspend.

The flowchart below sets out the process that should be followed for any expected overspend of capital schemes:



(1) At this point this triggers the project should be considered unapproved and where possible expenditure should not be committed until approval is received. If the project is live or timing is critical and delay until a meeting cycle is not possible this should be brought to the attention of the Deputy Director of Finance and the Head of Financial Services immediately and an appropriate action plan will be developed (for example chair's action or extraordinary meeting of appropriate committee).

13.2 Private Finance

13.2.1 When the Trust proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) The proposal must be specifically agreed by the Board.

c) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DHSC body and/or treated as per current guidelines.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Regime, Investment and Property Business Case Approval Guidance as issued by the DHSC.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of land and buildings will be at "fair value" on the balance sheet date. Under the requirements of IFRS, the Modern Equivalent Asset valuation method will be adopted.

13.3.7 The value of each asset shall be depreciated according to the useful economic life of the asset. The Trust will use commonly available and appropriate indices for the revaluation of assets or take advice from independent experts. The Chief Financial Officer will ensure that a review of all asset lives will be undertaken annually.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

13.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

13.4.6 Where practical, assets should be clearly and securely marked as Trust property.

13.4.7 Trust assets and facilities are to be used for official Trust purposes only, unless approval for private use has been given by the Chief Executive.

14. Stores

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stocktake; and

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to the Head of Procurement by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of estates stock, fuel oil and coal of a designated Estates Manager.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Director of Estates and Facilities. Wherever practicable, stocks should be marked as health service property.

14.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Procurement shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 15 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt of the goods against the delivery note.

15. Disposals and condemnations, losses and special payments

15.1 Disposals and Condemnations

15.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations (Disposal of Surplus Goods/Equipment Procedure) and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer ;

b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.1.5 Land and buildings formally planned for closure and/or disposal shall be valued and referred to the Chief Financial Officer prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The Chief Financial Officer shall prepare a report at least annually to the Audit Committee detailing all losses reported by number and amount with detail for those over £1,000

15.2.3 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive.

Where a criminal offence is suspected, the Executive Directors must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Directors must inform the DHSC Counter Fraud Services in accordance with the Secretary of State's directions and the Local Counter Fraud Service.

15.2.4 The Chief Financial Officer must notify the External Auditor of all frauds and suspected frauds.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, at an estimated value in excess of £10,000, the Chief Financial Officer must immediately notify:

a) the Board, and

b) the External Auditor.

15.2.6 The Audit Committee shall approve the writing-off of losses.

15.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

15.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16. Information technology

16.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to Data Protection and Computer Mis-use legislation.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

16.2 The Chief Financial Officer shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.3 The Chief of Staff shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.4 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.5 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.6 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

16.7 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy himself/herself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) authorised staff have access to such data; and

d) such computer audit reviews are being carried out as are considered necessary.

16.8 The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17. Patients' property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Nurse is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets, (notices are subject to sensitivity guidance),
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where DHSC instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. Charitable funds

18.1 The Chief Financial Officer and Chief of Staff shall ensure that each charitable fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirement.

18.2 Accountability to Secretary of State for Health and other bodies

1) The trustee responsibilities must be accountable to the Secretary of State for all charitable funds.

2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to funds held on trust

1) In so far as it is possible to do so, most of the sections of the Standing Financial Instructions will apply to the management of charitable funds. (see also SFI paragraph 7.15.6)

2) The over-riding principle is that the integrity of each charitable fund must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19. Acceptance of gifts and hospitality by staff

19.1 The Chief of Staff shall ensure that all staff are made aware of the Trust policy on acceptance of gifts, hospitality and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health and Social Care Standards of Business Conduct for NHS Staff (See Standing Orders 6.2).

20 Retention of records

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DHSC guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with the Health Service Circular (1999) 053 shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of records so destroyed.

21. Risk management and insurance

21.1 The Chief Nurse shall ensure that the Trust has a programme of risk management, in accordance with current DHSC controls assurance requirements, which must be approved and monitored by the Board.

21.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including: internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured;

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current DHSC guidance.

21.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.4 With three exceptions Trusts may not enter into insurance arrangements with commercial insurers. The exceptions are:

i) Trust may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

ii) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

iii) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

21.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complimentary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

21.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

22. ANNEX – Tenders and contracting – Financial limits

22.1 Financial Limits – Competitive Tendering

22.1.1 Competitive Tenders will be invited for:

i) the supply of goods, materials and manufactured articles;
ii) the rendering of services;
iii) building and engineering works (including construction and maintenance of grounds) and;
iv) disposals;

where the estimated income/expenditure is expected to exceed **£70,000 excluding VAT**.

22.2 Invitation to Tender

22.2.1 The number of invitations to tender and tenders required to be received will be as follows:

VALUE	TENDERS
Tenders above **£70,000 excluding VAT** to The Public Procurement Threshold	Minimum of 3 invitations to tender
Tenders above The Public Procurement Threshold	Minimum of 4 invitations to tender

22.2.2 The Audit Committee will be updated on a quarterly basis where three suppliers are invited to tender, but less than three tenders are received.

22.2.3 If the required number of tenders is not received, it will be at the discretion, as to whether to proceed with the contract, of:

- the Chief Executive **or** the Chief Financial Officer above **£70,000 excluding VAT** to The Public Procurement Threshold; and
- the Chief Executive **and** the Chief Financial Officer from The Public Procurement Threshold to £1,000,000.

22.2.3 For the purpose of determining the above limitations of **£70,000 excluding VAT**, **The Public Procurement Threshold** and **£1,000,000 excluding VAT** in circumstances where tenders are invited at any one time for a number of works, which are to be carried out simultaneously or sequentially by one contractor, the total cost may not exceed the appropriate financial limit.

22.3 Financial Limits – Competitive Quotations

22.3.1 The number of quotations required will be as follows:

VALUE	TENDERS
Up to **£25,000 excluding VAT**	Minimum of 1 written quotation (where this may be impractical, 1 verbal quotation may be obtained and the reasons for this documented)
Above £25,000 to **£70,000 excluding VAT**	Minimum of 2 suppliers invited to submit written quotations

22.4 Waivers to Standing Orders

22.4.1 Standing Orders on Competitive Tendering may be waived under certain circumstances and will require the completion and authorisation of a waiver form.

22.4.2 The waiver authorisation limits are:

i) For tenders **£1 - £70,000 excluding VAT**, the Head of Procurement

ii) For tenders above **£70,000 excluding VAT** to **The Public Procurement Threshold**, the Head of Procurement and the Chief Financial Officer or the Chief Executive.

iii) For tenders from **The Public Procurement Threshold up to £500,000 excluding VAT** Head of Procurement and the Chief Financial Officer and the Chief Executive.

iv) For tenders from **£500,000 to £2,5000,000 excluding VAT** the Audit Committee

v) For tenders above **£2,500,000 excluding VAT** the Trust Board

22.4.3 Any waiver request must be submitted on the requisite form and, after authorisation, must accompany the requisition sent to the Head of Procurement.

22.4.4 The Chief Financial Officer will establish and maintain a register of Waivers to Standing Orders.

22.5 Expenditure Authorisation

22.5.1 All requisitions that result in an order for goods and services must be approved in accordance with the scheme of delegation.

22.5.2 In the case of contracts which have a life in excess of one year, the approval value applies to the total value of the contract.

22.6 Capital Expenditure

22.6.1 There are specific requirements for every capital expenditure proposal in excess of £100,000 see section 13.1.2.

22.7 Monetary Values

22.7.1 All values, thresholds and limits contained within this document must refer to VAT exclusive prices except where specifically mentioned.

22.7.2 The Public Procurement Threshold are available from https://www.legislation.gov.uk/uksi/2021/1221/regulation/3/made

CAPITAL AND REVENUE PROCESS

This document sets out the processes for spending:

1. revenue within budget
2. capital within budget, within the Capital Resource Limit (CRL) and included in the annual capital plan

If any procurement with suppliers is required, then it is essential that any contracts are agreed within authorised limits and following appropriate processes.

If spend is not in budget then it shall be escalated to Executive Directors. Any spend must be included within annual plans.

Key contacts if you require further advice

Finance & Business Development:
Matt Backler, Deputy Finance Director

Procurement:
Angela Alletson, Head of Procurement

Capital:
Lydia Crouch, Head of Financial Services

For detailed information on processes, please refer to the following overarching ESHT corporate governance documents:

- Standing Financial Instructions (SFIs)
- Standing Orders
- Schedule of Matters Reserved to the Board and Scheme of Delegation

Process for up to £50k (if within total budget):

1. Division has idea for a business case
2. Log plan with **Capital Team** (capital) **Business Development Team** (revenue) who will assign a reference number, and signpost any additional requirements (CAPEX, liaison with procurement etc.). Cases that are both capital and revenue will need to be logged with both teams.
3. Complete Service Change Proposal
4. Complete Quality / Privacy / Equality Impact Assessment (QIA/PIA/EIA) if required
5. If the plan impacts on a **single division only**, present Service Change Proposal (with reference number) to Integrated Performance Review (IPR) who can approve or reject if funding has been identified
6. If the plan impacts on **more than one division**, present Service Change Proposal (with reference number) to the IPR of the lead division which can approve or reject if funding has been identified then present to Business Development Group (BDG) for logging, noting and socialising with other divisions.

Additional process for between £50k to £500k (please follow steps 1-4 above, then):

5. Business case to be produced with sign off from relevant corporate areas
6. Present Business Case to BDG (revenue) or Capital Resource Group (CRG) (capital) who can recommend a direction of travel. If the business case has both revenue and capital implications it will need to be presented to both groups.
7. Present Business Case to Executive Directors' Meeting for approval

Additional process for between £500k to £15m:

8. Present Business Case to Finance and Productivity Committee for approval if between £500k - £1m
9. Present Business Case to Trust Board for approval if over £2.5m
10. Submit to NHSE/I for approval if over £5m, or over £15m for capital property investments

Waiver of Standing Orders

Reason for Request to Waive Standing Orders:	Please Tick
1 Competitive tenders/quotations were sought insufficient responses returned	
2 Only provider of goods/services	
3 Genuine reason for continuity or compatibility	
4 Risk where timescales/urgency genuinely exceed time required to competitively tender/obtain quotes	
5 Director/Deputy Director of Finance	
6 Retrospective expenditure - goods/services have already been received	
7 Quotes/tenders not obtained due to clinical/technical preference	
8 Market tested and most economical providers not selected	
9 Agency expenditure exceeding the NHSI allowable price caps	

Full written details and justification must be provided in the "Supporting Information" section on the reverse of this form before this waiver request will be considered for approval.

The current limits set by East Sussex Healthcare NHS Trust under which competitive quotations/tenders are required are defined in the Standing Financial Instructions. These are as follows:

Up to £25,000 (ex VAT)	1 Verbal quotation.
£25,001 to £70,000 (ex VAT)	Minimum of 2 invitations to quote.
£70,001 (ex VAT) to The Public Procurement Threshold	Minimum of 3 invitations to tender.
Above the Public Procurement Threshold	Minimum of 4 invitations to tender with at least 2 received.

The waiver authorisation limits are (ex VAT):

For quotations £25,001 to £70,000	Head of Procurement or Chief Financial Officer or Chief Executive.
For tenders £70,001 to Procurement Threshold	Chief Financial Officer or Chief Executive.
For tenders Procurement Threshold to £500,000	Chief Executive **and** Chief Financial Officer.
For tenders £500,001 to £2,500,000	Audit Committee via Chair/Chief Financial Officer.
For tenders over £2,500,000	Trust Board.

In accordance with East Sussex Healthcare NHS Trust's Standing Order number 9.5, I request a waiver of the requirement to obtain competitive quotations/tenders in respect of Requisition Number: _____

Name of Supplier: _____

Description of goods/services: _____

Total value of goods/services: Exc. VAT _____ Inc. VAT _____

Department for which goods are required: _____

Conflicts of interest/subsequent measures taken: _____

CERTIFICATION BY SENIOR BUSINESS MANAGER		HEAD OF PROCUREMENT VERIFICATION **PRIOR** TO APPROVAL BY A DIRECTOR	
Signature:	Date:	Signature:	Date:
Title:	Department:		

APPROVAL OF WAIVER

I/We hereby approve this waiver

Signatures authorising the waiver of Standing Orders.

Signature:	**Signature:**	**Signature:**
Designation:	**Designation:**	**Designation:**
Chief Executive	**Director of Finance**	**Head of Procurement**
Date:	**Date:**	**Date:**

Procurement & Supplies use only Waiver Register Number:	Waiver Register Entry By:	Date:

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DETAILED SUPPORTING INFORMATION This section **must** be completed in all instances. Insufficient information may result in the waiver being returned unauthorised.		
a) Brief description of goods/services: **b) Justification:**		
Has lowest quotation been accepted?	**Yes / No** (Delete as appropriate)	If "No" – reason for accepting higher quotation:
Will this be the subject of a future, formal procurement competition?	**Yes / No** (Delete as appropriate)	If yes, please state when - if "No", please state reason below:
If previously procured, last price paid (if known):	**£**	If previously procured, please state when (if known):
List alternative providers (if any) and reason for not considering:		
Consequences of non-approval of this waiver:		

Please note:

- **All Trust expenditure is subject to Public Sector Procurement Regulations and transparency rules. The information detailed on this form is subject to audit and challenge.**
- **All breaches to Trust Financial policies will be investigated and reported to the Audit Committee.**

ENDS

Appendix C – Scheme of Delegation

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
N/A	The Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 (Emergency Powers). 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6 17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
N/A	The Board	**Appointments/Dismissal** 1. Ratify proposals of the Remuneration Committee regarding the appointment and remuneration of the Chief Executive and with the latter the remuneration of executive directors and very senior managers.
	The Board	**Strategy Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Final Business Cases for Capital Investment over £1,000,000 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3-year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer for losses and special payments. 12. Approve proposals for action on litigation on behalf of the Trust. 13. Review use of NHS risk pooling schemes (CNST/RPST).

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
	The Board	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	The Board	**Audit:** 1. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report of the Audit Committee.
	The Board	**Annual Reports and Accounts:** 1. Receipt and approval the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for charitable funds.
	The Board	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary to the Board. 3. Receive reports from Chief Financial Officer on financial performance against budget and business plan and other Directors on activity, workforce, quality and safety. 4. Receive reports from the Chief Financial Officer on actual and forecast income from SLA's 5. Receive assurance on compliance with the appropriate regulations within the Health and Social Care Act 2008 and the related Care Quality Commission outcomes

DECISIONS/DUTIES DELEGATED BY THE BOARD TO THE CHAIRMAN, CHIEF EXECUTIVE AND COMMITTEES

Section 1

Reference		**Decision/Duties Reserved to the Chairman and Chief Executive**
	Chairman	1. Appoint the Vice Chairman 2. Appoint the Senior Independent Director 3. Appointment and dismiss committees (and individual members) that are directly accountable to the Board. 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
	Chief Executive	1. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2)

Reference	**Committee**	**Decision/Duties Delegated by the Board to Committees**
	Audit Committee	The current terms of reference, including powers delegated by the Board, are available from the Chief of Staff.
	Remuneration and Appointments Committee	The current terms of reference, including powers delegated by the Board, are available from the Chief of Staff.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

Section 1

Reference from Accountable Officer Memorandum	Delegated To	Accountable Officer Memorandum – Duties Delegated
7	Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources.
9	Chief Executive and Chief Financial Officer	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	Chief Executive	Ensure effective management systems that safeguard public funds and the Chairman to implement requirements of corporate governance including ensuring managers: • 'have a clear view of their objectives and the means to assess achievements in relation to those objectives; • be assigned well defined responsibilities for making best use of resources; • have the information, training and access to the expert advice they need to exercise their responsibilities effectively'.
12	Chairman	Implement requirements of corporate governance.
13	Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
15	Chief Financial Officer	Operational responsibility for effective and sound financial management and information.
15	Chief Executive	Primary duty to see that Chief Financial Officer discharges this function.
16	Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

Section 1

Reference	Delegated To	Accountable Officer Memorandum – Duties Delegated
17	Chief Executive	Promote the observance of all staff of the Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by the Secretary of State.
18	Chief Executive and Chief Financial Officer Chief Medical Officer Chief Nurse and Chief of Staff	Chief Executive, supported by Chief Financial Officer, Chief Medical Officer, Chief Nurse and Chief of Staff to ensure appropriate advice is given to the Board and Executive Committee on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.1.7	Audit Committee	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of the Code of Conduct and Accountability, and other ethical concerns.
1.3.1.9 & 1.3.2.2	All Board members	Subscribe to the Code of Conduct and Accountability.
1.3.2.4	Board	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	Chairman and Non-Executive Directors	Chairman and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	Board	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.4	Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the board and draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions to reflect these; 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality targets that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main board.
1.3.2.5	Chairman	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner; 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee and any other sub-Committees of the main Board; and 7. advise the Secretary of State on the performance of Non-Executive Board members.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.5	Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	Non-Executive Directors	Non-Executive Directors are appointed by NHS England to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	Chairman	All members of the Board are required to make annual declarations of conflict of interests and fit and proper persons.
1.3.2.9	Board	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Ref	Delegated To	Standing Orders – Authorities/Duties Delegated
1.1	Chairman	Final authority in interpretation of Standing Orders.
2.4	Chairman	Appointment of Vice Chairman and Senior Independent Director.
3.1	Chairman	Call Board meetings.
3.7	Chairman	Chair all Board meetings and associated responsibilities.
3.9	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings.
3.11	Chairman	Having a second or casting vote.
3.12	Board	Suspension of Standing Orders.
3.12	Audit Committee	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
3.13	Board	Variation or amendment of Standing Orders.
4.1	Board	Formal delegation of powers to sub-committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub-committees may be approved by the Chief Executive).
5.2	Chairman & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chairman and Chief Executive after having consulted at least two Non-Executive Directors.
5.3	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	All	Disclosure of non compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	The Board	Declare relevant and material interests.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Reference	Delegated To	Standing Orders – Authorities/Duties Delegated
7.2	Chief of Staff	Maintain Register(s) of Interests.
7.4	All staff	Comply with national guidance contained in NHS England's 'Standards of Business Conduct Policy' for NHS staff
7.4	All	Disclose relationship between self and candidate for staff appointment.
8.1/8.3	Chief of Staff	Keep seal in safe place and maintain a register of sealing.
8.4	Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
1.1.1	Chief Financial Officer	Training and communication programme for staff on SFIs.
1.1.3	Chief Financial Officer	Approval of all financial procedures.
1.1.4	Chief Financial Officer	Advice on interpretation or application of SFIs.
1.1.6	All Members of the Board and all Staff	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible
1.3.4	Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the system of internal control.

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
1.3.5	Chief Executive & Chief Financial Officer	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.3.6	Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	Chief Financial Officer	Responsible for: a) Implementing the Trust's financial policies and co-ordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and the wider organisation; e) Design, implementation and supervision of systems of internal financial control; and f) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
1.3.8	All members of the Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, SFIs and financial procedures.
1.3.9	Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income is made aware of these instructions and their requirement to comply.
2.1.1	Audit Committee	Provide independent and objective view on internal control and probity.
2.1.2	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3	Chief Financial Officer	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed).
2.2.1 c)	Chief Financial Officer	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
2.3.4	Head of Internal Audit	Provide reports as agreed with the Chief Financial Officer and in accordance with NHS Internal Audit Manual and best practice.
2.4.1	Audit Committee	Ensure cost-effective external audit.
2.5.1 2.5.2	Chief Executive & Chief Financial Officer	Monitor and ensure compliance with Secretary of State's Directions on fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.
2.6.1	Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on HNS security management including appointment of the Local Security Management Specialist.
3.1.1	Chief Executive	Compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain: ▪ a statement of the significant assumptions on which the plan is based; ▪ details of major changes in workload, delivery of services or resources required to achieve the plan. ▪ detailed financial templates, accompanying finance narrative and operational/strategic narrative
3.1.3 & 3.1.4	Chief Financial Officer	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.7	Chief Financial Officer	Ensure adequate financial training is delivered on an on-going basis to budget holders.
3.2.1	Chief Executive	Delegate budgets to budget holders
3.2.2	Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
3.3.1	Chief Financial Officer	Devise and maintain systems of budgetary control.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
3.3.2	Budget Holders	Ensure that: a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.
3.3.3	Chief Executive	Identify and implement cost improvements and income generation activities in line with the Business Plan.
3.6.1	Chief Executive	Submit all statutory and other monitoring returns required of the organisation.
4.1	Chief Financial Officer	Preparation of annual accounts
4.3	Chief of Staff	Preparation of annual report
5.1.1	Chief Financial Officer	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements).
6	Chief Financial Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
6.2.3	All employees	Duty to inform Chief Financial Officer of money due from transactions which they initiate/deal with.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.5.3	Chief Financial Officer	Report waivers of tendering procedures to the Audit Committee.
7.6.2	Chief Financial Officer	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.4	Chief Executive & Chief Financial Officer	Where one tender is received will assess for value for money and fair price.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.6.6	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.
7.7.4	Chief Executive & Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Chief Financial Officer .
7.15	Chief Financial Officer	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
8.1	Chief Financial Officer	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
8.3	Chief Financial Officer	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
9.1.1	Board	Establish a Remuneration Committee.
9.1.2	Remuneration Committee	Take decisions under delegated authority on the remuneration and terms of service of the Chief Executive, other officer members and very senior managers to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements. Monitor and evaluate the performance of individual very senior managers. Oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
9.1.3	Remuneration Committee	Produce an annual report for the Board.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
9.2.2	Chief Executive	Approval of variation to funded establishment of any department.
9.4.1 & 9.4.2	Chief Financial Officer	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 9.4.2).
10.1.1	The Board	Approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer
10.1.2	Chief Financial Officer	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.2.3	Chief Financial Officer	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and regularly reviewed; a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds; b) Be responsible for the prompt payment of all properly authorised accounts and claims; c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; d) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; e) Instructions to employees regarding the handling and payment of accounts within the Finance Department; f) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.2.4	Appropriate Executive Director	Make a written case to support the need for a prepayment.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
10.2.4	Chief Financial Officer	Approve proposed prepayment arrangements.
10.2.4	Budget holder	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Financial Officer if problems are encountered).
10.2.5	Chief Financial Officer	Authorise who may use and be issued with official orders.
10.2.6	Managers and Officers	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer .
10.2.7	Chief Executive Chief Financial Officer	Ensure that Standing Financial Instructions are compatible with Department of Health requirements re building and engineering contracts. Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
11.1	Chief Financial Officer	The Chief Financial Officer will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning any PDC debt and all loans and overdrafts.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
11.2	Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Financial Officer).
11.3	Chief Financial Officer	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	Chief Executive or Chief Financial Officer	Be on an authorising panel comprising one other member for applications for short term borrowing.
11.7.2	Chief Financial Officer	Will advise the Board on investments and report, periodically, on performance of same.
11.7.3	Chief Financial Officer	Prepare detailed procedural instructions on the operation of investments.
12.1	Chief Financial Officer	Ensure that Board members are aware of the Financial Framework and ensure compliance.
13.1.1 & 13.1.2	Chief Financial Officer	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans; b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.1.2	Chief Financial Officer	For every replacement asset capital, as long as the total expenditure falls within the capital allocated to that category (eg Digital or medical equipment) as part of the capital plan approved by the Board, the Chief Executive will ensure: a) that there is a completed Capital Expenditure Approvals Form (CAPEX) approved by the Capital Resource Group (CRG); b) Replacement assets with capital expenditure proposal above £1,000,000 excluding recoverable VAT are approved by Executive Directors and should have a business case; c) Replacement assets with capital expenditure proposal above £2,500,000 excluding recoverable VAT are also approved by Finance and Productivity Committee; and d) Replacement assets with capital expenditure proposal above £5,000,000 excluding recoverable VAT are also approved the Board. For every investment asset capital expenditure proposal over £100,000 a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the Capital Review Group (CRG). b) for every capital expenditure proposal in excess of £250,000 the business case is also required to be submitted to the Executive Directors' Meeting for approval. c) for all projects over £500,000 a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial and TW Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Productivity Committee for approval. d) for all projects over £500,000 the Project Director will be required to co- ordinate and complete a monthly capital monitoring return to CRG showing performance against budget.

		e) for every capital expenditure proposal in excess of £500,000 the business case is also required to be submitted to the Combined Business Development Group (BDG) and Capital Review Group (CRG) for approval before any further expenditure is committed. f) for all projects over £1,000,000 the business case will be submitted to the Trust Board for approval g) where any scheme is forecast to overspend by more than the following amounts the Project Director will be required to report reasons to the CAG for approval before any further expenditure is committed: i. where the scheme value is £250k or less – 10% of the approved scheme value ii. for other schemes up to £1m – the higher of 5% or £25k
13.1.3	Director of Estates and Facilities	Assess the requirement for the operation of the Construction Industry Scheme.
13.1.4	Chief Financial Officer	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.5	Chief Financial Officer	Issue procedures governing financial management, including variation to contracts, of capital investment projects and valuation for accounting purposes.
13.2.1	Chief Financial Officer	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	Board	Proposal to use Private Finance Initiative (PFI) schemes must be specifically agreed by the Board.
13.3.1	Chief Financial Officer	Maintenance of asset registers.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.3.5	Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.7	Chief Financial Officer	Ensure that a review of asset lives is undertaken annually.
13.4.1	Chief Financial Officer	Overall responsibility for fixed assets.
13.4.2	Chief Financial Officer	Approval of fixed asset control procedures.
13.4.4	All senior staff	Responsibility for security of Trust assets including notifying discrepancies to Chief Financial Officer, and reporting losses in accordance with Trust procedure.
14.2	Chief Financial Officer	Delegate overall responsibility for control of stores. Further delegation for day to day responsibility subject to such delegation being recorded.
14.2	Head of Procurement	Responsible for systems of control over stores and receipt of goods.
14.2	Designated Pharmaceutical officer	Responsible for controls of pharmaceutical stocks.
14.2	Designated Estates Officer	Responsible for control of stocks of fuel.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
14.3	Director of Estates and Facilities	Security arrangements and custody of keys
14.4	Chief Financial Officer	Set out procedures and systems to regulate the stores.
14.5	Chief Financial Officer	Agree stocktaking arrangements.
14.6	Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified.
14.7	Head of Procurement/Pharmaceutical Officer	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.7	Head of Procurement/Pharmaceutical Officer	Operate system for slow moving and obsolete stock, and report to Chief Financial Officer evidence of significant overstocking.
14.8	Chief Financial Officer	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	Chief Financial Officer	Prepare procedures for recording and accounting for losses and special payments and informing police in cases of suspected arson or theft.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
15.2.3	Executive Directors	Where a criminal offence is suspected Executive Directors must inform the police if theft or arson is involved. In cases of fraud and corruption Executive Directors must inform the relevant Anti-Crime Service and Counter Fraud Operational Service (CFOS) in line with Secretary of State's directions.
15.2.4	Chief Financial Officer	Notify CFOS and External Audit of all frauds.
15.2.5	Chief Financial Officer	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.6	Audit Committee	Approve write off of losses.
15.2.8	Chief Financial Officer	Consider whether any insurance claim can be made.
15.2.9	Chief Financial Officer	Maintain losses and special payments register.
16.1	Chief Financial Officer	Responsible for accuracy and security of computerised financial data.
16.2	Chief Financial Officer	Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
16.3	Chief of Staff	Shall publish and maintain a Freedom of Information Publication Scheme
16.4	Relevant officers	Send proposals for general computer systems to Chief Financial Officer .

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
16. 5	Chief Financial Officer	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. The contract should also ensure rights of access for audit purposes.
16.7	Chief Financial Officer	Where computer systems have an impact on corporate financial systems satisfy himself/herself that: a) systems acquisition, development and maintenance are in line with corporate policies and IM&T Strategy; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) relevant staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
16.8	Chief Financial Officer	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
17.2	Chief Nurse	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
17.6	Departmental managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1.	Chief Financial Officer and Chief of Staff	Ensure each charitable fund is managed appropriately with regard to its purpose and to its requirement.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
18.3	Trustees and Authorised Signatories	Relevant sections of SFIs are applicable to charitable funds.
18.3	Chief of Staff	The Chief of Staff will arrange for the creation of a new charitable fund where this is required.
19.1	Chief of Staff	Ensure all staff are made aware of Trust policy on the acceptance of gifts and other benefits in kind by staff.
20	Chief Executive	Retention of document procedures in accordance with Department of Health guidance.
21.1	Chief Nurse	Ensure the Trust has a risk management programme.
21.1	Board	Approve and monitor risk management programme.
21.3	Board	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks (where discretion is allowed).
21.5	Chief Financial Officer	Where the Board decides to use risk pooling schemes or commercial insurers the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.
21.6	Chief Financial Officer	Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures to cover these arrangements.
21.7	Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible.

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
1.	To keeping of Declaration of Board Members, Consultants and Senior Staff Interests Register	Chief of Staff	Associate Director of Corporate Governance
2.	Receiving Hospitality, Gifts and Sponsorship other than isolated gifts of a trivial nature or conventional hospitality Applies to both individual and collective hospitality receipt items	Declaration required in Trust's Hospitality Register – all Trust Directors and Employees	N/A
3.	The keeping of the Interests, Hospitality, Gifts and Sponsorship Register	Chief of Staff	Associate Director of Corporate Governance
4.	Quotation, Tendering and Contract Procedures Subject to the requisitioner's responsibility always to obtain best value for money for the Trust, the <u>minimum</u> requirements for goods/services are: **For spend within current budget:**		Authorised Budget Signatory and Purchasing and Supplies Buyer
	a) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	
	b) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
	c) **£70,001** excluding VAT to **te prevailing Public Procurement Threshold**– invite 3 written quotations.	Head of Procurement together with Chief Financial Officer	Authorised Budget Signatory and Head of Procurement
	d) **Above the prevailing Public Procurement Threshold** up to **£500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
	e) **£500,001** to **£2,500,000**	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
	f) **Over £2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer and Chief Executive

For new spend		Authorised Budget Signatory and Purchasing and Supplies Buyer
g) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	
h) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
i) **£70,001** excluding VAT to **the prevailing Public Procurement threshold**– invite 3 written quotations.	Head of Procurement together with Chief Financial Officer	Authorised Budget Signatory and Head of Procurement
j) **Above the prevailing the Public Procurement threshold** up to **£500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
k) **£500,001** to **£2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Finance and Productivity Committee	Finance and Productivity Committee
l) **Over £2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Trust Board	Trust Board and Common Seal of the Trust

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
The waiver authorisation limits are:		
a) For quotations	Chief Executive.	Head of Procurement
b) For tenders **£70,001 excluding VAT** to the **Public Procurement threshold**	Chief Executive or Chief Financial Officer	N/A
c) For tenders from the **Public Procurement threshold** up to **£500,000**	Chief Executive and Chief Financial Officer	N/A
d) For tenders from **£500,001** to **£2,500,000**	Audit Committee	N/A
e) For tenders above **£2,500,000**	Trust Board	N/A
5. Opening electronic Tenders and Quotations	Procurement Department	N/A
6. Attestation of Sealings in accordance with Standing Orders	Chairman/Chief Executive	Executives
7. The keeping of a register of Sealings	Chief of Staff	Board Secretary
8. Implementation of Internal and External Audit Recommendations	Chief Financial Officer	Manager responsible for service.
9. Management of Budgets - Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.	Budget Manager
b) At service level	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
c) For the totality of services covered by a Divisional Triumvirates or Corporate Leaders	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.
10. Capital Schemes		
a) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Director for appropriate budget.	N/A
b) Financial monitoring and reporting on all capital scheme expenditure	Chief Financial Officer	Deputy Chief Financial Officer
c) Granting and termination of leases	Director for appropriate budget.	N/A
11. Authority to open Bank Accounts	Chief Financial Officer	N/A
12. Management of the Investment of Charitable Funds within the approved investment strategy	Chief Financial Officer	Monitored by the Charity Committee
13. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Financial Officer	Manager responsible for the budget together with the Chief Financial Officer
b) Price of NHS Contracts – charges for all NHS Contracts, be they block, cost per case, cost and volume, or spare capacity	Chief Financial Officer	Head of Contract Income
14. Authorisation of Sponsorship deals	Chief of Staff	Director for appropriate budget or Associate Director of Operations
15. Personnel and Pay		
a) Authority to fill funded post on the establishment with permanent staff	Director for appropriate budget or General Manager	Manager responsible for budget

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b)	Authority to appoint staff to post not on the formal establishment	Chief Executive (approval at Executive Directors' meeting)	N/A
c)	The granting of additional increments to staff within budgets	Chief Executive	Manager responsible for budget with the Chief People Officer
d)	All requests for upgrading/re-grading shall be dealt with in accordance with Trust Procedure	Chief Executive	Payroll Manager
e)	Establishments		
	i) Additional staff to the agreed establishment with specifically allocated finance	Director for appropriate budget or General Manager	Manager responsible for budget
	ii) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	N/A
f)	Pay		
	i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Director for appropriate budget or General Manager	Authorised Budget Signatory
	ii) Authority to complete and authorise positive reporting forms	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iii) Authority to authorise overtime	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iv) Authority to authorise travel and subsistence expenses	Director for appropriate budget or General Manager	Authorised Budget Signatory
	v) The approval of merit awards and discretionary points to Consultant and Associate Specialist staff	Remuneration Committee of the Board	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) Leave – all arrangements should be made in accordance with Trust policy		
i) Approval of annual leave	Manager responsible for the budget	N/A
ii) Annual leave – approval of carry forward (up to maximum of 5 days or in the case of Ancillary and Maintenance staff as defined in their initial conditions of service)	Manager responsible for the budget	N/A
iii) Annual leave – approval of carry over in excess of 5 days	Director for appropriate budget or Associate Director of Operations	N/A
iv) Special leave arrangements		
▪ adoption leave ▪ bereavement leave ▪ paternity leave ▪ urgent domestic distress/crisis ▪ carers leave	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget
v) Leave without pay	Director for appropriate budget or Associate Director of Operations Chief Medical Officer or Chief Executive	Manager responsible for the budget
vi) Medical Staff Leave of Absence – paid and unpaid – including study leave		
▪ Consultants and Career Grades	Chief Medical Officer or Clinical Unit Lead	Clinical Unit Lead
▪ Other Medical Staff	Clinical Tutor together with Clinical Unit Lead	Clinical Unit Lead
vii) Time off in lieu	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Director for appropriate budget or General Manager together with Chief People Officer	N/A
ii) Return to work part-time on full pay to assist recovery	Director for appropriate budget or General Manager together with Chief People Officer	Manager responsible for the budget
iii) Extension of sick leave on full pay	Chief People Officer together with Chief Executive	N/A
i) Study Leave (Medical staff included in para 14.g.vi) above		
i) Any Study leave outside the UK	Chief Executive	Chief Medical Officer or Chief Nurse
ii) All other study leave (UK)	Chief People Officer, Director for appropriate budget or General Manager	Training Officer or Manager responsible for the budget
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) within Trust policy limits – currently £10,000.	Chief People Officer or Chief Financial Officer	Payroll Manager or Head of Financial Services
k) Grievance Procedure		
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure	Chief People Officer	Manager responsible for the budget

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
l)	Renewal of Fixed Term Contract	Manager responsible for the budget	N/A
m)	Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief People Officer	N/A
n)	Redundancy	Chief People Officer together with Chief Financial Officer . Approval is required from the Remuneration Committee.	N/A
o)	Ill Health Retirement Decision to pursue retirement on grounds of ill health	Manager responsible for the budget together with Chief People Officer	Manager responsible for the budget together with Personnel Manager
p)	Dismissal	Director for appropriate budget with Chief People Officer	N/A
16.	Engagement of Agency Staff		
a)	Booking of Bank, Agency or Locum Staff – limited to total delegated staffing budgets	Director for appropriate budget or General Manager	Manager responsible for the budget
b)	Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget
c)	Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure)	Chief Executive	Director for appropriate budget
17.	Engagement of Professional Consultancy Services		
a)	Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b) Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure and approval for any consultancy spend must be cleared with region by the Chief Financial Officer)	Chief Executive	Director for appropriate budget
18. Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods and Services		
a) Non-Pay Expenditure for which a specific budget has been set up and which is subject to funding under delegated powers of virement.		
i) Value to the Public Procurement Threshold	Chief Executive	Manager responsible for the budget
ii) From the Public Procurement Threshold to £2,500,000	Chief Executive and Director for appropriate budget	N/A
iii) Value of £2,500,000 or above	Common Seal of the Trust	N/A
In the case of contracts which have a life in excess of one year, the above limits apply to the total value of the contracts.		
b) Non-Pay Expenditure for which specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive and Chief Financial Officer	N/A
c) Commitments/orders exceeding 12 month period	Chief Financial Officer or Chief Executive	Manager responsible for the budget
d) Variations to contract for goods and services	Director for appropriate budget or General Manager.	Manager responsible for the budget together with Purchasing and Supplies Department Senior Buyer

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
e) Approving expenditure > order price up to 10%	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Senior Buyer
f) Approving expenditure > order price by more than 10%		
i) AND the variance is <£1,000	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Category Manager
ii) AND the variance is >£1,000	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Deputy Head of Procurement or Head of Procurement
19. Petty Cash Disbursements		
a) Expenditure up to £50 per item	Director for appropriate budget or General Manager	Authorised Budget Signatory
b) Reimbursement of patients monies held up to £100	Hospital Cashier	N/A
c) Pay advances up to £50	Payroll Manager or Payroll Team Leader	Senior Payroll Clerk
d) Urgent exceptional payments in excess of the above limits	Head of Financial Services	N/A
20. Management and Control of Stocks		
a) Pharmaceutical Stocks	Chief Financial Officer	Designated Pharmaceutical Manager
b) Theatres	Chief Financial Officer	Theatres Manager
c) Estates	Chief Financial Officer	Estates Manager
d) Eastbourne Hospital Services	Chief Financial Officer	Manager responsible for budget
e) General	Chief Financial Officer	Manager responsible for budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
21. Sale and Disposal of Assets (Excluding land and/or buildings)		
Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
a) with current/estimated purchase price < £50,000	Chief Executive	Manager responsible for the budget
b) with current purchase new price > £50,000 (Note: Tender Procedure SFI 7.)	Chief Executive	Manager responsible for the budget together with Head of Procurement
22. Losses, Write-off and Compensation		
a) Losses and cash and cash equivalents due to theft, fraud overpayment and others	Chief Executive and Chief Financial Officer	N/A
b) Fruitless Payments (including abandoned Capital Schemes)		
i) Up to £100,000	Chief Executive and Chief Financial Officer	N/A
ii) Over £100,001	Audit Committee	N/A
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Other	Chief Executive and Chief Financial Officer	N/A
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Chief Executive and Chief Financial Officer	N/A
Special Payments		
e) made under legal obligation	Chief Executive and Chief Financial Officer	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
f) Extra Contractual payments to contractors	Chief Executive and Chief Financial Officer	N/A
g) Ex-Gratia Payments		
i) Patients' dentures repaired or replaced through the Community Dental service	Chief Financial Officer	Trust Solicitor
ii) Dentures and spectacles repaired or replaced < £500	Chief Financial Officer	Trust Solicitor
iii) Dentures and spectacles repaired or replaced > £500	Chief Financial Officer	Trust Solicitor
iv) Other ex gratia claims < £500	Chief Financial Officer	Trust Solicitor
v) Other ex gratia claims > £500	Chief Financial Officer	Director responsible for the budget
h) Payments under the Risk Pooling Scheme for Trusts up to the Policy Excess:		
i) Liabilities to Third Parties Scheme for Public and Employees Liability	Chief Financial Officer	Trust Solicitor
ii) Property Expenses Scheme	Chief Financial Officer	Trust Solicitor
i) Settlements on termination of employment – to a limit of £50,000	Chief Executive and Chief Financial Officer and Chief People Officer. Approval is required from the Remuneration Committee.	N/A
j) Other, except cases of maladministration	Chief Executive and Chief Financial Officer	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
23. Expenditure on Charitable Funds		
a) All expenditure of between £1,000 and £4,999 per request but excluding training and hospitality requests	Director and authorised signatory	Review by Executives, approval from Charity Manager and Authorised Signatory
b) All expenditure over £5,000 per request but excluding training and hospitality requests	Director and authorised signatory	Review by Executives, approval from Charity Committee and Authorised Signatory
c) All other expenditure	Director and authorised signatory	Charity Manager and Authorised Signatory
24. Management and Control of Computer Systems		
a) Financial Data	Chief Financial Officer	Senior Finance Manager Capital Systems Manager
b) Other Data	Chief Medical Officer as Caldicott Guardian	Relevant Service Manager
25. Review of Trust's compliance with Data Protection Act 1998	Chief Medical Officer as Caldicott Guardian	Chief Financial Officer
26. Review the Trust's compliance with the Access to Health Records Act	Chief Medical Officer as Caldicott Guardian	Chief Financial Officer
27. Retention of Records	Chief of Staff	Trust Solicitor
28. Insurance Policies	Chief Executive and Chief Financial Officer	Chief Financial Officer
29. Risk Management	Chief Nurse	Risk & Patient Safety Manager
30. Monitor proposals for contractual arrangements between the Trust and NHS commissioners of healthcare	Chief Financial Officer	Head of Contract Income
31. Maintenance and Update on Trust Financial Procedures	Chief Financial Officer	Technical Accountant

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
32. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Chief Operating Officer	Accommodation Manager
b) Extensions to existing agreements/licences	}	}
c) Letting of premises to outside organisations	} Chief Executive and/or responsible Director	} } N/A }
d) Approval of rent based on professional assessment	}	
33. Reporting of Incidents to the Police or Local Counterfraud service		
a) Where a criminal offence is suspected	Director responsible for the service or department	Each Trust Employee
b) Where a fraud is involved	Chief Financial Officer	Each Trust Employee
34. Patients and Relatives		
a) Overall responsibility for ensuring that all complaints are dealt with Effectively	Chief Nurse	Assistant Director of Nursing
b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	Director for appropriate budget or Associate Director of Nursing	Relevant Service Manager
c) Management of litigation relating to complaints	Chief Financial Officer	Trust Solicitor
35. Relationships with Press		
a) General Enquiries	Chief of Staff	Communications Team
b) Emergency	On-call Director	On-call Manager

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
36.	Facilities for staff not employed by the Trust to gain practical experience		
	Professional Recognition, Honorary Contracts, and Insurance of Medical Staff	Chief People Officer	Clinical Tutor, Post-Graduate Medical Education and HR Manager
	Work experience students	Chief People Officer	Manager responsible for the budget
37.	Review of fire precautions	Director of Estates and Facilities	Nominated Fire Manager
38.	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Chief Nurse	Health and Safety Manager
39.	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Estates and Facilities	Estates Manager and Waste Manager

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Entire document, to ensure that it remains in line with best practice	Richard Milner / Damian Reid	Annual review by finance, procurement and governance teams	Annual	Trust Board	Audit Committee	Audit Committee

In addition to the delegated matters detailed above the executive team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility and in those key functions, supported by consistent evidence.

Collectively, the team is responsible for providing the systems, processes and evidence of governance and ensuring that these are reviewed, maintained and any gaps closed and that this is reflected in their regular updating of the assurance framework, coordinated by the director of corporate services.

The team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the assurance framework.

The team are responsible for monitoring the risk register at corporate level.

The responsibilities of individual posts are set out in the post holders' job descriptions.

Delegated Authority for the Expenditure of Charitable Funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory + Charity Manager
£1,000 to £5,000	One fund signatory + Charity Manager + Review by Executives
Over £5,000	One fund signatory + Charity Committee + Review by Executives

Spending plans for major projects or investment will require the approval of the Corporate Trustee and the Charity Committee.

Appendix D – EHRA Form

East Sussex Healthcare NHS Trust

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	East Sussex Healthcare NHS Trust Governing Documents, incorporating: Standing Orders, Standing Financial Instructions, Scheme of Delegation
Date of completion	8th January 2024
Name of the person(s) completing this form	Peter Palmer
Brief description of the aims of the Strategy/ Policy/ Service	To set out the high level governance processes in the Trust, including how the Trust Board and its Committees operate, finance and procurement procedures and responsibilities of Trust Executives.
Which Department owns the strategy/ policy/ function	Trust Board
Version number	1
Pre Equality analysis considerations	Click here to enter text.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	All Trust Staff
Review date	January 2025
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Positive
Neutral
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table></td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>Choose:
Positive
Neutral
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table></td></tr>
</table>

<table>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose:
Positive
Neutral
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose:
Positive
Neutral
Negative</td><td></td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose:
Positive
Neutral
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
</table>

Access Could the proposal impact positively or negatively on any of the following:		
• Patient Choice	Choose: Positive Neutral Negative	
• Access	Choose: Positive Neutral Negative	
• Integration	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality ***Use the space below to provide more detail where you have identified how your proposal of change will impact.***	Choose: Positive Neutral Negative	
Characteristic	*Rating* ☺ ☹ 😐	*Description*
Race	Choose: Positive Neutral Negative	

Age	Choose: Positive Neutral Negative	
Disability and Carers	Choose: Positive Neutral Negative	
Religion or belief	Choose: Positive Neutral Negative	
Sex	Choose: Positive Neutral Negative	
Sexual orientation	Choose: Positive Neutral Negative	
Gender re-assignment	Choose: Positive Neutral Negative	
Pregnancy and maternity	Choose: Positive Neutral Negative	
Marriage and civil partnership	Choose: Positive Neutral Negative	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		**Y/N**
A2	Right to life	**Y/N**
A3	Prohibition of torture, inhuman or degrading treatment	**Y/N**
A4	Prohibition of slavery and forced labour	**Y/N**
A5	Right to liberty and security	**Y/N**
A6 &7	Rights to a fair trial; and no punishment without law	**Y/N**
A8	Right to respect for private and family life, home and correspondence	**Y/N**
A9	Freedom of thought, conscience and religion	**Y/N**
A10	Freedom of expression	**Y/N**
A11	Freedom of assembly and association	**Y/N**
A12	Right to marry and found a family	**Y/N**
Protocols		
P1.A1	Protection of property	**Y/N**
P1.A2	Right to education	**Y/N**
P1.A3	Right to free elections	**Y/N**

East Sussex Healthcare
NHS Trust

East Sussex Healthcare NHS Charity

East Sussex Healthcare NHS Trust Charitable Fund

Annual Report and Accounts 2022/23
Registered Charity Number 1058599

www.esht.nhs.uk

CONTENTS

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MESSAGE FROM THE CHAIR

Karen Manson Chair of Charitable Funds Committee

2022-2023 was a challenging year for the East Sussex NHS Healthcare Charity. Most charities have reported reduced incomes and a decrease in the vital support provided by volunteers in the wake of the Covid pandemic. These changes are likely to have long term consequences and so, along with many other charities, we are resetting our priorities and refocusing our efforts. This annual report describes some of our achievements and the ways in which we support our patients and staff, together with the financial statements of the Charity for the year ended 31 March 2023.

The annual report and financial statements comply with the Accounting and Reporting by Charities: Statement of Recommended Practice applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015), the Charities Act 2011 and the UK Generally Accepted Accounting Practice.

Our income for 2022/23 was £108,000 pounds, down from £369,000 pre-pandemic (2019/2020). Nonetheless this is still a great achievement, given that a number of fundraising events had to be cancelled or had not been reinstated after the pandemic. This would simply not have been possible without the support of our brilliant donors and creative fundraisers alike.

I would like to take this opportunity to extend a heart-felt thank you to all the fundraisers, donors and volunteers who have supported us this year. The income we have raised has benefited patients across East Sussex and this report demonstrates just how much of a difference the charity has made, and can continue to make, with the invaluable backing of our supporters.

Also, a big thank you to those individuals who have served on our Charity Committee during the year, who have given their energy, time and skills to make a difference.

I hope that, like me, you will be inspired by our plans and want to be part of our story – whether as a fundraiser, donor, volunteer or committee member. Please do email me (karen.manson1@nhs.net) if you would like to get involved.

On behalf of the many patients who have benefitted from your generosity, thank you

Karen Manson
Chair of Charitable Funds Committee

2

ABOUT EAST SUSSEX HEALTHCARE NHS TRUST CHARITABLE FUNDS

East Sussex Healthcare NHS Charity, formerly East Sussex Healthcare NHS Trust Charitable Fund was formed in October 1996 and is registered with the Charity Commission, the Charity Number is 1058599

Our Vision: To provide support to East Sussex NHS Trust to enhance patient care and achieve better health outcomes within our hospitals and community.

Our Core Priorities:

- Supporting patient care will continue to be at the heart of everything that we do, as we want patients to have the best possible experience during their stay in the trust. We will work with our NHS colleagues to support key programmes and services that will enhance the treatment that is offered to patients.

- Creating the right workplace is key to improving patient care. We will support NHS colleagues in transforming the way their services are delivered. We will also support transformative projects aligned with the Trust's strategic priorities.

- The NHS is busier than ever before following the pandemic. Supporting our staff is crucial in ensuring that patients receive the best possible care. We will work with the Trust to build upon existing and new wellbeing activities and to support further improvements to staff spaces and facilities.

Our Hospitals: We are dedicated to raising funds for our four hospitals, as well as to support our services in the community.

- Bexhill Hospital
- Conquest Hospital
- Eastbourne District General Hospital
- Rye And Winchelsea District Memorial Hospital

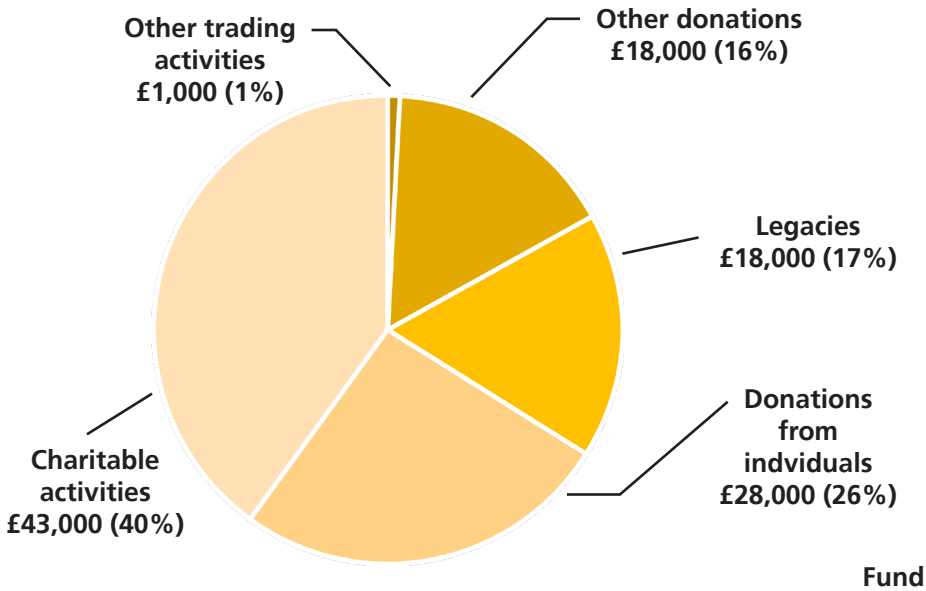
Our Funds: At At 31 March 2023 the Charity had 103 unrestricted funds and five quality funds linked to Bexhill Hospital, Community Services, Conquest Hospital, Eastbourne District General Hospital and an overarching Trust fund. These funds are used to fund Trust wide initiatives as well as bids specific to particular locations.

The Charity has a further 20 restricted funds, which include money received from NHS Charities Together for specific projects, and the Eastbourne District General Hospital Scanning Equipment Fund which is for the benefit of the Intensive Care and Radiology.

3

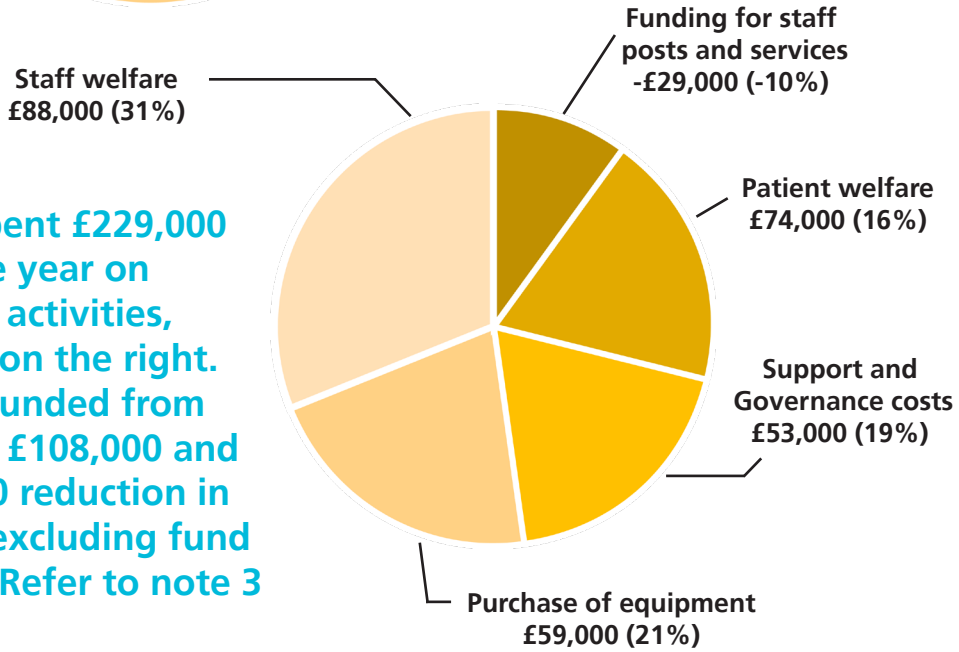
THE YEAR IN NUMBERS

During 2022/23 ESHTCF received income of £108,000 from donations, legacies, investment income and training activities.



From 7 September 2022 it was agreed that the Resuscitation Education Fund held by the Charity would be more appropriately administered by ESHT, resulting in a transfer in year of £37,000 to ESHT.

ESHTCF spent £229,000 during the year on charitable activities, as shown on the right. This was funded from income of £108,000 and a £115,000 reduction in reserves, excluding fund transfers. Refer to note 3 and 4.



4

HOW WE HELPED:

Workscape

We invested £55,000 in Workscape; this was a project at the heart of our Trust's staff welfare initiatives

Jacquie Fuller,Staff Engagement and Wellbeing Manager said.

"We were able to achieve so much in supporting the welfare of our staff, with the incredible support from the local community. Their kind donations enabled us to completely renovate our two Acute Hospital canteens, which really helped to boost the spirits of our front line staff."

Major purchases

7 treatment chairs to improve patient comfort and ease care administration for Pevensey Unit.

£15,763

Hoverjack for community to help safely transport patients with no or limited mobility.

£6,965

Simulation manikin for resuscitation training.

£4,000

2 x Icare Tonometers for Bexhill Ophthalmology to check intra-ocular pressures.

£5,990

Other Highlights

Charitable Funds Requested for:
A hoist for stroke unit.
High Back chairs for patient use.
An Interactive Projector for the Paediatric waiting room at EDGH (using funding kindly provided by the Rockinghorse Children's Charity).
A Electrocardiograph machine.
Continued support for Scalp Coolers for Judy Beard and Pevensey Units (using funding kindly provided by Walk the Walk).
Repairs to a Hydrotilt chair used to treat patients on Sovereign Ward.
RockinR Gaming Cart for use by patients on paediatric wards (funded by Rockinghorse Children's Charity).
Purchase of furniture for a Quiet Room in Conquest Outpatients used to break bad news to patients and their families.
Nebulisers for head and neck cancer patients to use in their own homes.
Cold Caps to be used with the Paxman machine for patients wishing to preserve their hair while having chemotherapy.
Moisturising cream and shower covers for peripherally inserted central catheter (PICC) patients.
Cardiac Rehabilitation exercise equipment.
Portable air conditioner for the Irvine Unit to maintain comfort for patients in high temperatures.
Shower protectors for peripherally inserted central catheter (PICC) patients (single use).
100 x Udderly cream to moisturise skin dehydrated by treatments.
Plants and soil for the Critical Care Sensory Garden.
Comfort Boxes for the relatives and friends of those reaching the end of their lives in hospital.

5

FUNDRAISER AND VOLUNTEER ACHIEVEMENTS

Walk for Wards

We participated in Sussex Community NHS Charity Walk For Wards uniting with other NHS Charities across Sussex for this truly marvellous fundraiser!

Held at the beautiful Glynde Estates, near Lewes, the challenge was to walk, jog or run the 5k or 10k route and it raised over £2,000 for East Sussex Healthcare NHS Charity. The money supported projects that go above and beyond what core NHS funding provides.

We partnered with Heads On (Sussex Partnership NHS Foundation Trust's charity), and SASH Charity (Surrey and Sussex Healthcare NHS Trust's charity) to deliver Walk For Wards, and participants chose to raise funds for the NHS Charity that means the most to them.

It was a fantastic opportunity to raise funds while also having a lovely day out with friends, family and colleagues.

Participants were encouraged to raise a minimum of £50, which could fund additional equipment or diagnostic tools to enhance patient care, contribute to activities that boost staff morale, buy essential items for patient discharge gift baskets or even help to spruce up a waiting area to improve patient experience.

NHS Big Tea

We joined the nation, as thousands of par-teas were held and millions of tea bags squeezed in homes, schools, workplaces, community centres, church halls and hospitals.

On Tuesday 5 July we celebrated the National Health Service's 74th birthday. Led by NHS Charities Together, the NHS Big Tea brought the nation together to celebrate the birthday of our beloved NHS, giving thanks to the workforce, while raising funds to provide the extra support needed.

At East Sussex our charity funded a range of big tea parties across the Trust in our canteens and community sites.

Pictured left to right are:
Staff Nurse Laura Wilkins and Sister Denise Campbell of the EDGH Pevensey Day Unit receiving a cheque from Robert Langford, Dorothy Langford (President, Hailsham Bowling Club) and Bobby Bennett (Chairman, Hailsham Bowling Club)

Local Bowling Club supports local NHS hospital

Members of the Hailsham Bowling Club raised a fantastic £532 for the Pevensey Day Unit at the Eastbourne District General Hospital.

President of the Hailsham Bowling Club Dorothy Langford chose Pevensey Day Unit as her Charity for the annual Presidents Day Fundraiser at the Bowling Club. As well as a competitive bowls tournament, home-made teas and cakes were sold.

Dorothy said she was delighted to be able to raise £532 for the Pevensey Day Unit which had successfully treated husband Robert some years early for facial cancer. Robert is in remission, owing to the care he received, and a keen bowler too.

McDonald Ward Rounders

MacDonald Ward organised a fun rounders tournament on the 10th of July at Claremont School to raise funds for their courtyard. They had 4 teams playing and congratulations to STAR, CGL Hastings who won the tournament.

WI Jubilee Crown walk for MacDonald Ward

THE combined WI's of Fairlight, Ore and Hastings participated in a walk on Hastings and St Leonard's Seafront, Wednesday 1st June to raise more than £500 for MacDonald Ward Sensory Garden.

Reference and Administration Details

Registered Charity Name	East Sussex Healthcare NHS Trust Charitable Funds
Working Name	East Sussex Healthcare NHS Charity
Registered Charity Number	1058599
Registered Address	Email: esht.charity@nhs.net Tel: 0300 131 755255
Contact Details	St Anne's House 729 The Ridge St Leonards-on-Sea East Sussex TN37 7PT
Principle Professional Advisors	Bankers: Lloyds Bank plc 2 City Place Beehive Ring Road Gatwick West Sussex RH6 0PA
	Solicitors: Bevan Britten Kings Orchard 1 Queen Street Bristol BS2 0HQ
	Auditor: Grant Thornton LLP 2nd Floor St John's House Crawley RH10 1HS

6 GOVERNANCE

Trustee Arrangements:

East Sussex Healthcare NHS Trust (ESHT) is the sole Trustee of the Charity. The Trustee confirms that they have referred to the Charity Commission's guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities.]

The Charity Committee Members of ESHTCF during the year, 1 April 2022 to 31 March 2023 were as follows:

Chair:
Karen Manson

Committee Members:
Ama Agbeze
Dr Tom Bate
Angela Colosi
Mike Eastwood
Jaquie Fuller
Richard Milner
Pete Palmer
Paresh Patel
Laura Ransom
Damian Reid

Governing Document

ESHTCF's governing document is the Model Declaration of Trust as registered with the Charity Commission. This provides that the Trustees shall hold the funds on trust to apply the income and, at their discretion so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly, or mainly, for the services provided by ESHT, Sussex Integrated Care Board (ICB).

Structure, Governance and Management

Under the provisions of the Charities Act 2011, the Charity Commission has agreed that ESHTCF should be treated as a single Charity for the purposes of Part 4 of the Act for registration and of Part 8 of the Act for accounts.

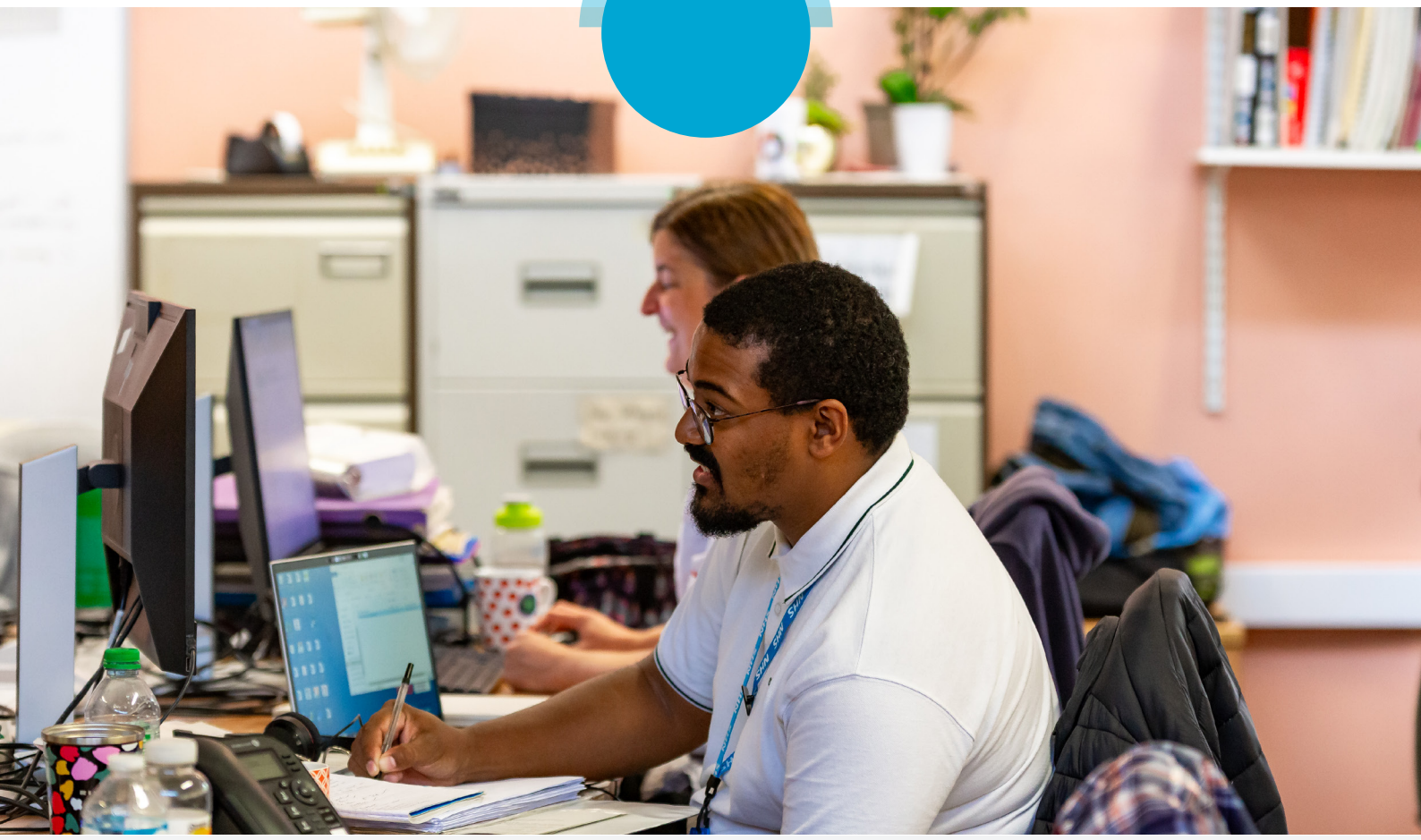
The Charity had four registered non-trading subsidiary charities as at 31 March 2023:

- East Sussex Healthcare NHS Trust Ward Fund;
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund;
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund; and
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund.

The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is the pooling scheme fund for holding all funds.

Charity Committee Meetings

The Committee should meet at least four times a year in order to consider any bids for over £5k and to review the management of the Charity. Reports presented to Trustees include information about income and legacies, expenditure, investment performance, and fund balances.



Governance

The Trustee delegates responsibility for the day-to-day management of the charitable funds to the Director of Corporate Affairs and the Chief Financial Officer. The Director of Corporate Affairs is responsible for:

- the administration and governance of the funds;
- ensuring that spending is in accordance with the objectives and priorities agreed by the Trustees;
- ensuring that the criteria for spending charitable monies are fully met;
- arranging meetings of the Trustees; and
- management of the Fundraising Manager.

The Chief Financial Officer is responsible for:

- ensuring that full accounting records are maintained;
- ensuring the accounts of Charitable Funds show a true and fair view of the year's activity;
- ensuring there is a system of control for all transactions related to expenditure and income;
- ensuring that there is robust oversight of the accounting records; and
- ensuring the accurate reporting of the in-year position to both Trustees and fund holders.

The principal officer overseeing the day-to-day financial management and accounting for the charitable funds for the accounting period 1 April 2022 to 31 March 2023 was the Chief Financial Officer, Damian Reid.

The principal officer overseeing the day-to-day administration and governance for the charitable funds for the accounting period 1 April 2022 to 31 March 2023 was was Board Secretary, Pete Palmer.

7

FINANCE

Financial Management

Expenditure budgets for administration, governance and fundraising costs are approved by the Charity Committee at the start of the financial year and are monitored throughout the year.

The Charity manages its Charitable Activity spending through appointed fundholders for the individual funds. These fundholders manage the funds on a day-to-day basis with agreed authorisation limits, and in accordance with the Trust's Standing Financial Instructions and Orders. Each fund holder receives a quarterly financial statement of their fund which details income, expenditure and fund balances for the period.

The Charity receives expenditure applications from staff throughout the year which are authorised by the fundholder and submitted to the Acting Company Secretary, who reviews all applications to ensure that they meet the objectives of the Charity for quality, value for money and patient benefit. Where an application exceeds £5,000 the fundholder is required to present the application to the Charity Committee for approval. Where any expenditure is considered inappropriate, feedback is given to the fund manager.

The Charity does not directly employ any staff; the Charity enjoys and values the services of volunteers, but is not wholly dependent on them. The Charity is not financially dependent upon the support of any individuals, corporations or specific classes of donors. No funds are held by the Charity on behalf of individuals.

Investments and Investment Policy

The Charity aims to enhance the value of its funds through sound investment.

Money is invested through CCLA Investment Management Limited and M&G Securities Ltd, with the aim of obtaining a return higher than the FTSE All Share Index (dividends reinvested). During the year, investments were held in the following proportions:

The total value of the investment portfolio at 31 March 2022 was £2.35m. The return on investment during the year was an increase of 11% (2020/21 decrease of 2%).

Fund	2022/23	2021/22
Fixed Interest Funds	19%	19%
CCLA Property Fund	28%	31%
M&G Securities Ltd Equities Investment Fund	53%	50%
Total investments	100%	100%

The total value of the investment portfolio at 31 March 2023 was £2.24m. The return on investment during the year was a decrease of 5% (2021/22 increase of 11%).

Risk Management

The major risks to which the Charity is exposed have been identified and reviewed with systems established to mitigate them. The Charity relies on and benefits from the financial controls framework of ESHT.

The most significant risks identified were:

1. possible losses from a fall in the value of the investments; and
2. reputational damage leading to a sudden and dramatic fall in donations.

Both risks have been carefully considered and mitigating procedures put in place. Regular review of the investment policy ensures that both spending income. Both income and expenditure are monitored by the Committee on a quarterly basis in order that any trends can be identified at an early stage in order to avoid unforeseen calls on reserves.

Reserves

ESHTCF hold reserves that are considered to be needed to fund planned expenditure. The Charity acknowledges that charitable donations received need to be spent on patient and staff amenities wherever possible and should not be used to build up reserves.

The reserves of the Charity at 31 March 2023 consisted of £1,888,000 unrestricted funds and £218,000 restricted funds. The Charity regularly reviews all funds held to ensure they remain active and where appropriate, a fund which is inactive for a period greater than 18 months will be closed and the funds transferred to the most relevant quality general fund to ensure that they are spent in a timely manner.

Future plans

In accordance with Charity Commission directives, it is the Charity's continued intention to expend funds for the benefit of both staff and patients.

A strategy has been developed that will lead to increased visibility and awareness for the Chairty. A new website is being developed, along with a new Charity logo, this will formally launch in early 2024. Improved social media presence, and a push to expand the charity's lottery are hoped to drive an increase in donations, and in particular funds for general use rather than those donated to a particular service or ward.

The charity continues to work closely with Friends of Eastbourne Hospital, Friends of Conquest Hospital, The League of Friends of Bexhill Hospital, The Friends of the Rye, Winchelsea and District Memorial Hospital and The League of Friends of Uckfield Community Hospital, using our resources to support the amazing work that they do for the Trust.

Statement of Trustee's Responsibilities

The Trustee is responsible for preparing the Charity's annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Charity law requires the Trustee to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of the resources of the Charity for the year. In preparing those financial statements the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP FRS 102;
- make judgements and accounting estimates that are reasonable and prudent;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business; and
- ensure the financial statements comply with the Trust Deed.

The Trustee is responsible for keeping accounting records that are sufficient to show and explain the Charity's transactions and disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011 and regulations made thereunder. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Approved by the Charity Committee on behalf of the Corporate Trustee on 30 January 2024 and signed on their behalf by:

Signed:

Karen Manson
Chair

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INDEPENDENT EXAMINER'S REPORT TO THE CORPORATE TRUSTEE OF EAST SUSSEX HEALTHCARE NHS TRUST CHARITABLE FUND

Independent examiner's report to the corporate trustee of East Sussex Healthcare NHS Trust Charitable Fund

I report on the accounts of East Sussex Healthcare NHS Trust Charitable Fund (the "charity") for the year ended 31 March 2023, which are set out on pages 32 to 47.

Your attention is drawn to the fact that the charity's trustees have prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019)) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustees have done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

This report is made solely to the charity's trustees, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my work, for this report, or for the opinions I have formed.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011;
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met; or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

John Paul Cuttle

John Paul Cuttle, Director

Grant Thornton UK LLP, Chartered Accountants

London

31 January 2024

Statement of Financial Activities for the year ended 31 March 2023

	Note	2022/23 Unrestricted Funds	2022/23 Restricted Funds	2022/23 Total Funds	2021/22 Total Funds
		£000	£000	£000	£000
Income and endowments from					
Donations	2.1	45	2	**47**	**258**
Legacies	2.2	18	-	**18**	**11**
Charitable activities	2.3	43	-	**43**	**34**
Total income		**106**	**2**	**108**	**303**
Expenditure on Charitable activities					
Patient welfare		(70)	(0)	**(70)**	**(87)**
Funding for staff posts and services		(25)	47	**22**	**(30)**
Staff welfare		(45)	(55)	**(100)**	**(283)**
Purchase of equipment		(79)	(1)	**(80)**	**(74)**
Spend on charitable activities		**(219)**	**(9)**	**(229)**	**(474)**
Fundraising		(1)	-	**(1)**	**-**
Transfer to East Sussex Healthcare NHS Trust		(37)	-	**(37)**	**-**
Total expenditure	**4**	**(258)**	**(9)**	**(267)**	**(474)**
Net gains/(losses) on investments	7.1	(112)	-	**(112)**	**235**
Net income/(expenditure)		**(263)**	**(7)**	**(270)**	**64**
Transfer between funds		(7)	7	**-**	**-**
Net movement in funds	**6**	**(271)**	**0**	**(270)**	**64**
Reconciliations of funds					
Fund balances brought forward at 1 April		2,153	218	**2,371**	**2,307**
Fund balances carried forward at 31 March		**1,882**	**218**	**2,101**	**2,371**

All gains and losses recognised in the year are included in the Statement of Financial Activities.

Balance Sheet as at 31 March 2023

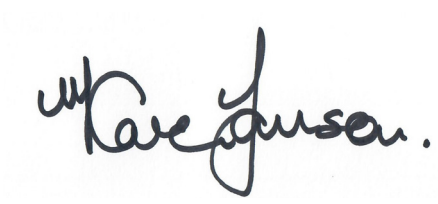
	Note	2022/23 Unrestricted Funds	2022/23 Restricted Funds	2022/23 Total Funds	2021/22 Total Funds
		£000	£000	£000	£000
Fixed assets					
Investments	7	2,072	170	**2,242**	2,354
Total fixed assets		**2,072**	**170**	**2,242**	2,354
Current assets					
Debtors	8	-	-	**-**	-
Cash and cash equivalents		(98)	238	**140**	432
Total current assets		**(98)**	**238**	**140**	432
Liabilities					
Creditors falling due within one year	9	(92)	(190)	**(281)**	(415)
Net current liabilities		(190)	48	**(142)**	17
Total net assets		**1,882**	**218**	**2,100**	**2,371**
Funds of the Charity					
Unrestricted		1,882	-	**1,882**	2,153
Restricted		-	218	**218**	218
Total funds	10	**1,882**	**218**	**2,100**	**2,371**

The notes at pages 35 to 45 form part of these accounts.

Approved and authorised for issue by the Trustees on 30 January 2024 and signed on their behalf.

Karen Manson
Chair
Date: 30-01-2024

Damian Reid
Chief Financial Officer
Date: 30-01-2024



Statement of Cash flows for the year ended 31 March 2023

	Note	2022/23 Total Funds £000	2021/22 Total Funds £000
Cash flows from operating activities:			
Net expenditure for the reporting period		(270)	64
Adjustments for:			
(Gains)/losses on investments	7.1	112	(235)
(Increase)/decrease in debtors		-	1
Increase/(decrease) in creditors		(134)	144
Net cash used in operating activities		**(292)**	**(26)**
Cash flows from investing activities			
Proceeds from sale of investments		-	-
Net cash provided by investing activites		**-**	**-**
Change in cash and cash equivalents in the reporting period		**(292)**	**(26)**
Cash and cash equivalents at 1 April 2022		**432**	**458**
Cash and cash equivalents at 31 March 2023		**140**	**432**

Notes to the Accounts

1. Accounting Policies

1.1. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments at market value. The financial statements have been prepared in accordance with the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011, and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The Trust constitutes a public benefit entity as defined by FRS 102.

The Trustee considers that there are no material uncertainties affecting the accounts or the Charity's ability to continue as a going concern and that no subsequent events have been identified which would be material and would require adjustment in the statements to 31/03/2023. The Trustee confirms that they are satisfied that charity reserves are more than sufficient to cover ongoing liquidity needs and pay creditors as they fall due for a period of at least 12 months from the date of signing the statements.

1.2. Income Recognition

All income is recognised and included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement: control over the rights or other access to the economic benefit has passed to the Charity.
- Probable: it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity.
- Measurement: the monetary value or amount of both the income and the costs to complete the transaction can be measured reliably.

Income from legacies are accounted for as incoming resources once the receipt of the legacy becomes probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled or are within the Charity's control to fulfil.

1.3. Expenditure Recognition

The accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

Support and Governance costs are accounted for on an accruals basis and are recharges of appropriate proportions of the ESHT costs, audit or independent examination fees, fund raising consultancy, support for the accounting software and Trustee Indemnity Insurance.

Support and Governance costs are apportioned between the unrestricted funds based on the average fund balance for the year.

From the 7 September 2022 the Resuscitation Education Funds held within the Charity were transferred to East Sussex Healthcare NHS Trust, this resulted in a transfer in year of £37,000.

During 2022/23 the Charity reversed expenditure that was accrued in 2021/22 as it would no longer be realised, this has resulted in positive expenditure being reported in this financial year. The two accruals reversed were £31,347 for the Youth Volunteers Project and £15,850 for the Appreciative Inquiry Chronicler Project.

All items of expenditure under £5,000 are treated as revenue.

1.4. Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. The major funds held within these categories are disclosed in note 10.

1.5. Investment Fixed Assets

Investment fixed assets are shown at bid price, which is used to measure fair value for accounting purposes of shares that are traded in an active market. The investments are valued at closing unit prices and the net gains and losses on revaluations and disposals are included on the Statement of Financial Activities.

1.6. Gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Gains and losses on investments are calculated as the difference between sales proceeds and opening fair value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between fair value at the year end and opening fair value (or date of purchase if later).

1.7. Pooling scheme

An official pooling scheme, the East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is operated for investments relating to the following funds:

- East Sussex Healthcare NHS Trust Ward Fund
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund
- East Sussex Healthcare NHS Trust Education Fund
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund

The Scheme was registered with the Charity Commission on 17 March 1998.

1.8. Related Party Transactions

The Trustee of the ESHTCF is **East Sussex Healthcare NHS Trust**.

ESHT is the major recipient of funds of the Charity and received grants from the Charity totalling £165,000 during the year (2021/22 £400,000).

ESHT charged a management fee to the Charity of £45,000 (2021/22 £68,000) to recharge administrative costs and services provided.

The Charity owed ESHT £81,000 at 31 March 2023 (£36,000 31 March 2022). Refer to note 9.

None of the members of ESHT Board, senior staff or parties related to them were beneficiaries of the Charity. None of the Trustees or other Members of ESHT Board has received honoraria, emoluments, or expenses in the year.

1.9. Debtors

Debtors are amounts owed to the Charity. They are measured based on their recoverable amount. Refer to note 8.

1.10. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments.

1.11. Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt. There are no amounts which are owed in more than a year.

2. Details of Income

2.1. Donations

	Unrestricted Funds	Restricted Funds	Total 2022/23	Total 2021/22
	£000	£000	£000	£000
Donations from individuals	27	1	**28**	77
Other trading activities	1	-	**1**	6
Other	17	1	**18**	175
Total voluntary income	**45**	**2**	**47**	**258**

2.2. Legacies

M E Harniman	-	-	**-**	5
M G Tookey	-	-	**-**	2
S D Stringer	11	-	**11**	4
S M Lister	7	-	**7**	-
Total legacies	**18**	**-**	**18**	**11**

2.3. Charitable Activities

Training courses	43	-	**43**	34
Total charitable activities	**43**	**-**	**43**	**34**

3. Analysis of charitable expenditure before allocation of Support and Governance Costs

	Unrestricted Funds	Restricted Funds	Total 2022/23	Total 2021/22
	£000	£000	£000	£000
Arts in Healthcare	23	-	**23**	22
Other patients welfare and amenities	29	-	**29**	52
Patient welfare total	**52**	**-**	**52**	**74**
Funded staff posts and services	-	(31)	**(31)**	(5)
Funding for Professional Fees	18	(16)	**2**	24
Funding of staff posts and services total	**18**	**(47)**	**(29)**	**19**
Support to staff training	25	(3)	**22**	75
Other support to staff welfare and amenities	8	58	**66**	187
Staff welfare total	**33**	**55**	**88**	**262**
Purchase of equipment	58	1	**59**	49
Fundraising	1	-	**1**	-
Transfer to East Sussex Healthcare NHS Trust	37	-	**37**	-
Total charitable expenditure	**199**	**9**	**208**	**404**

All critable expenditure is classified as grant funded activities.

4. Analysis and Allocation of Support and Governance Costs

	2022/23 Total Funds £000	2021/22 Total Funds £000
Computer Expenses	5	-
Administration fee	12	27
Total support costs	**17**	**27**
Independent Examiner's fee	8	2
Indemnity insurance	1	-
Governance fee	33	41
Total governance costs	**41**	**43**
Total support and governance costs	**59**	**70**

The support costs and governance costs attributable to charitable activities is apportioned based on the total expenditure for the year for each charitable activity as shown in the table below.

Computer expenses has been segregated from the Administration fee for transparency of management costs for 2022/23.

	2022/23 Grant funding of activities £000	2022/23 Support and Governance Costs £000	2022/23 Total Funds £000	2021/22 Total Funds £000
Allocation of support and governance costs	Note 3			
Patient welfare	52	19	70	87
Funding for staff posts and services	(29)	7	(22)	30
Staff welfare	88	12	100	283
Purchase of equipment	59	21	80	74
Active continuing funds	**170**	**59**	**229**	**474**
Fundraising	1	-	1	-
Transferred funds	37	-	37	-
Total allocated	**208**	**59**	**267**	**474**

Grants paid in year to ESHT £165,000 (2021/22 £400,000), Grants paid to individuals in year £6,500 (2021/22 £4,500).

5. Examiner's remuneration

The Independent Examiner's remuneration of £8,040 including VAT relates solely to the independent examination covering current audit plan of £6,000 and a catch up from previous year of £2,040. There was no other additional work undertaken. Refer to note 4.

6. Changes in Resources Available for Charity Use

	2022/23 Unrestricted Funds	2022/23 Restricted Funds	2022/23 Total Funds	2021/22 Total Funds
	£000	£000	£000	£000
Net movement in funds for the year	(271)	0	**(270)**	64
Net movement in funds available for future activities	**(271)**	**0**	**(270)**	**64**

7. Analysis of Fixed Asset Investments

7.1. Fixed Asset Investments

	2022/23 Total	2021/22 Total
	£000	£000
Market value at start of period	**2,354**	2,119
Net gains/(losses) on revaluation and sales	**(112)**	235
Market value at end of period	**2,242**	**2,354**
Historic cost at end of period	**1,170**	**1,170**

7.2. Market Value

	31 March 2023	31 March 2022
	£000	£000
Investments in a Common Deposit Fund or Common Investment Fund		
CCLA Investment Management Fixed Interest Funds	**388**	403
CCLA Investment Management Property Fund	**634**	721
M&G Securities Fixed Interest Investment Fund	**37**	39
M&G Securities Equities Investment Fund	**1,181**	1,189
Total	**2,240**	**2,352**
Cash held as part of the investment portfolio	**2**	2
Total	**2,242**	**2,354**

All units are held within the UK.

8. Analysis of Debtors

	Balance 31 March 2023	Balance 31 March 2022
	£000	£000
All falling due within one year		
Trade debtors	-	-
Total debtors	**-**	**-**

9. Analysis of Creditors

	Balance 31 March 2023	Balance 31 March 2022
	£000	£000
Falling due within one year		
Accruals and deferred income	200	358
Other creditors	81	57
Total creditors	**281**	**415**

10. Analysis of Funds

10.1.

	Balance 31 March 2023	Income	Expenditure	Transfers	Gains and Losses	Balance 31 March 2022
	£000	£000	£000	£000	£000	£000
Unrestricted funds	**1,882**	**106**	**(258)**	**(7)**	**(112)**	**2,153**
Arts in Healthcare	2	0	(0)		-	**2**
Conquest Courtyards	10				-	**10**
COVID - Deaf App	3				-	**3**
COVID - General Fund	0		19	(23)	-	**4**
COVID - Nursing Fund	2				-	**2**
COVID - Sunflower Scheme	1				-	**1**
COVID - TRiM Training	3				-	**3**
COVID - What Matters to You	(1)		(1)	(25)	-	**25**
Diabetes Inpatient Specialist Nurses	4				-	**4**
EDGH Scanning Equipment for Intensive Care and Radiology	145				-	**145**
Kipling Music	2				-	**2**
Lewes Victoria Hospital	14				-	**14**
Pooja Sharma Memorial	2		(1)			**3**
Workscape Project	0	2	(57)	55	-	**-**
Youth Volunteering Project	31		31		-	**-**
Total Restricted Funds	**219**	**2**	**(9)**	**7**	**-**	**218**
Total Funds	**2,101**	**109**	**(267)**	**-**	**(112)**	**2,371**

10.2. Details of the Restricted Income Funds

Name of fund	Description
Arts in Healthcare	The promotion of the initiative for the provision of Arts in Healthcare
Conquest Courtyards	The fund held for the benefit of the Conquest courtyards
Conquest Equipment	The fund held for the purchase of equipment at Conquest Hospital
COVID - Deaf App	The development of an App for deaf users
COVID - General Fund	To enhance the wellbeing of NHS Staff, volunteers and patients impacted by COVID-19
COVID - Nursing Fund	To enhance the wellbeing of staff nurses
COVID - Sunflower Scheme	The project to promote sunflower lanyards, which demonstrate when someone has a hidden disability
COVID - Trauma Therapist	To support trauma therapy for NHS staff
COVID - TRiM Training	This is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event
COVID - Wellbeing Fund	To enhance NHS staff experience and wellbeing whilst at work
COVID - What Matters to You	To support staff through Covid 19 and beyond – rest areas/staff room
Diabetes Inpatient Specialist Nurses	To support UK Diabetes Inpatient Specialist Nurses Project
EDGH Scanning Equipment for Intensive Care an Radiology	The funds held for the purchase of scanning equipment for Intensive Care and Radiology at Eastbourne District General Hospital
Kipling Music	The fund held to provide interactive music sessions to Kipling Ward
Lewes Victoria Hospital	The fund held for the benefit of Lewes Victoria Hospital
Maternity Bereavement Suite	The fund held for the refurbishment of the Maternity Bereavement Suite
Pooja Sharma Memorial	To commemorate staff member Pooja Sharma
Workscape Project	To enhance staff facilities and workspaces
South East Orthopeadic Training	To provide training for junior doctors in surgical skills
Youth Volunteering Project	The fund held for the development of youth volunteering opportunities in East Sussex

11. Funding Commitments

As at 31 March 2023 the Trustees had not made commitments other than those shown as creditors, note 9.

9

WAYS IN WHICH TO SUPPORT OUR CHARITY

There are many ways you can support our Charity

Donations can be made in the following ways:

Direct into bank account

Bank: Lloyds Bank
Sort code: 30-92-86
Account number: 00460039
Account name: East Sussex Healthcare NHS Trust Charitable Fund
Reference: Please state the General Fund

By post

Cheque to East Sussex Healthcare NHS Trust Charitable Fund

Please write on the back of the cheque which fund you would like to donate to, e.g. General Fund, and send to:

Charitable Funds
St Anne's House
729 The Ridge
St Leonards-On-Sea
East Sussex
TN37 7PT

By a donation on our 'Just Giving' site

www.justgiving.com/esht

As well as making a general donation, you can also open a page in celebration of and in memory of a loved one. If you are a group or an organisation who is interested in raising money on behalf of the Charity, we would love to hear from you too.

For more information and for support if you are holding your own event, please contact our charity team:

esht.charity@nhs.net

Gift Aid

Gift Aid is a simple, government initiative which allows us to increase the value of your donations at no extra cost to you. For every pound you give to us we can get an extra 25 pence from HM Revenue and Customs helping your donation go further to help patients and their families. The only condition is that you are a UK tax payer. When making a donation simply let us know that you wish to Gift Aid your donation, to do this all we need is your name and address.

Contact

Conquest Hospital
The Ridge, St Leonards-on-Sea, East Sussex,
TN37 7RD
0300 131 4500

Eastbourne District General Hospital
Kings Drive, Eastbourne, East Sussex,
BN21 2UD
0300 131 4500

Bexhill Hospital
Holliers Hill, Bexhill-on-Sea, East Sussex,
TN40 2DZ
0300 131 4500

Rye, Winchelsea and District Memorial Hospital
Peasmarsh Road, Rye, East Sussex,
TN31 7UD
(01797) 224499

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East Sussex Healthcare
NHS Trust

Annual Safeguarding Report

2022 – 2023

Contents

Message from the Executive for Lead for Safeguarding Adults and Children Vikki Carruth

As Executive Lead for Safeguarding Children and Adults, it is my responsibility to ensure the board that East Sussex Healthcare NHS Trust (ESHT) meets the statutory requirements required and is assured and updated via this report.

This work includes ensuring robust governance in recruitment, up to date policies, local and Sussex wide procedures, up to date learning and development and multiagency working including representation on both local safeguarding boards. The Chief Nurse also works closely with the Chief Operating Officer and others to ensure systems and processes are in place to safeguard patients presenting with mental ill-health who also need ESHT services or are awaiting transfer or discharge.

This last year, the Safeguarding Team have worked hard to develop robust data collection systems. Staff have continued to have the appropriate access to safeguarding support and advice, this has continued to have been a blended offer of virtual and face to face support and training within the last year.

There has been continued focus to ensure that Safeguarding Policies, Procedures, and practices in place remain up to date, are reviewed regularly and are fit for purpose. All policies and procedures are accessible to staff via the Safeguarding Children and Safeguarding Adults pages on the trust intranet and advice and support is provided by our Safeguarding team.

The last year has once again seen an increase in the numbers and complexity of cases of abuse and neglect across the whole population. Cases referred to respective child or adult social care teams have continued to see a year-on-year increase.

A continued theme has been that of young people experiencing a mental health crisis, with young people requiring mental health support receiving care in acute in-patient beds. This lack of appropriate in-patient mental health beds and of emergency foster placements is both a regional and national issue, exacerbated by the pandemic and the economic situation.

A key area of work for this year has been to review the Deprivation of Liberty (DOLS) process in readiness for forthcoming changes planned for 2022 with the implementation of Liberty Protection Safeguards (LPS). Whilst these legislative changes have now been postponed by the government the preparatory work generated further work in the consideration of the Mental Capacity Act.

The Trust is involved in both local Safeguarding Partnerships; (ESSCP for children and young people and the SAB for adults) and is committed to interagency working and positively supports opportunities to work with other agencies.

I would like to thank all staff for their continued support with this complex agenda and recognise the challenges it presents personally and professionally.

1.0 – Introduction

The 2022/2023 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the safeguarding work undertaken during the year, the work planned to further transform safeguarding practice in 2022/2023 and assurance regarding the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2018)
- The Children's Act (2004) - ESHT must be able to demonstrate that it safeguards children who access our care under section 11 of the act
- Safeguarding Vulnerable Adults in line with the Care Act (2014)
- Department of Health Care & Support Statutory Guidance under the Care Act (2014)
- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (2007), Mental Capacity amendment (2019)
- The Modern Slavery Act (2015)
- Safeguarding Children & Young People: Roles & Competences for Health Care Staff (2019)
- Safeguarding Adults: Roles & Competences for Health Care Staff (2018) The Female Genital Mutilation Act (2003)
- Promoting the Health and well-being of Looked After Children (2015)
- Domestic Abuse Bill (2021)
- Safeguarding accountability and assurance framework (2022)

2.0 - Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the "Safeguarding Vulnerable People in the NHS Accountability Framework" (2022). ESHT must demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including Safeguarding & Safeguarding Supervision
- Effective safeguarding training for all staff commensurate with their role and in accordance with.
    - Safeguarding Children and Young People: roles and competences for healthcare staff. Royal College of Paediatrics and Child Health (2019)

- Looked After Children: Knowledge, skills and competences of healthcare staff. Royal College of Paediatrics and Child Health (2016)
- Safeguarding Adults: Roles and Competences for Health Care Staff (2018)

- Effective safeguarding supervision arrangements for staff working with children/families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Named Safeguarding Professionals covering specific specialist areas: Head of Safeguarding and Mental Capacity Act Lead posts.
- A statutory role in managing safeguarding allegations against staff, alongside Adult Social Care & HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure any poor practice is identified and tackled.
- Policies, arrangements, and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (2004).

The Intercollegiate Document (2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Chief Nurse is the Executive Lead and has responsibility for ensuring effective trust wide safeguarding governance, available advice and expertise, and that robust arrangements and reporting are in place. The Chief Nurse and Deputy Chief Nurse support the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Assistant Directors of Nursing who are responsible for ensuring robust safeguarding arrangements and practice in each of their clinical areas. The Chief Nurse and Deputy Chief Nurse also ensure there is support and development for the Safeguarding team to ensure that knowledge and practice is current with suitable supervision of cases.
The Trust governance and reporting arrangements are based on legislative changes and statutory requirements. Safeguarding Leads are required to provide support, advice, scrutiny, and assurance. ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles, and responsibilities. During 2022/2023.

- Safeguarding governance structures have been strengthened to improve operational understanding of safeguarding responsibilities.
- A new policy pertaining to the processes around patients that substance misuse has been written in consultation with 'Star', the East Sussex Drugs and Alcohol service.
- Compliance with all safeguarding policies is now monitored through a tracker to ensure compliance which is reviewed at the Safeguarding Operational meeting.
- Safeguarding Supervision policy has been refreshed and updated in 2022.
- Progress on actions plans produced following Domestic Homicide Reviews and Serious Case reviews is monitored through a combined spreadsheet, which is reviewed at the Safeguarding Operational meeting.

2.2 System Safeguarding

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate with and support the wider system safeguarding practice and statutory partners including the Local Authority and the Police. The Chief Nurse, Deputy Chief Nurse and Head of Safeguarding are members of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in

East Sussex. The Head of Safeguarding and Named Professionals fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership with others. This ensures active learning from safeguarding reviews; partner agency reports, national safeguarding challenges, and local issues, driving improvements in practice.

- There were staffing challenges within the Safeguarding team due to staff sickness alongside vacancies within both the Named Nurse and Specialist practitioner's cohort of staff. However, posts were successfully recruited to, and essential cover maintained.
- The Safeguarding team are involved in Sussex wide work developing integrated health and social care for the residents of East Sussex. The team provides safeguarding advice and expertise to a range of colleagues and Safeguarding Board members, this moved to a virtual offer during the Pandemic which has continued.
- The Safeguarding team continued to develop and implement the 'Think Family' Safeguarding training, which has been facilitated as a virtual webinar since March 2020.This is continually reviewed and refreshed to reflect feedback from delegates and emerging research.
- Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in clinical areas and highlighted challenges and good practice. This tool allows all Divisions to have oversight of Safeguarding trends and themes, ensuring that 'Safeguarding is everybody's responsibility'. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting.
- The Head of Safeguarding participates in divisional governance meetings and the weekly patient safety summit, ensuring that Safeguarding is a standing agenda item and to enable increased Divisional ownership and engagement.
- The Head of Safeguarding and Named Professionals participate in both Sussex wide Safeguarding forums, led by the ICB and in monthly national forums, to share practice.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in 2019/2020 found outstanding practice in relation to Safeguarding.
There has not been an inspection in the year 2022/2023; however, the Head of safeguarding has met with the CQC Manager.

3.0 - Key Achievements in Safeguarding 2022 - 2023

- The Safeguarding Team have continued to support the Divisions with Safeguarding issues throughout 2022-2023
- Throughout 2022-2023 the Transitional Safeguarding role underwent redevelopment and relaunch in recognition of the increasing complexities and contextual safeguarding issues faced by children and young people presenting to ESHT services. This included a new Specialist Safeguarding Practitioner appointed to lead this portfolio. A vast amount of scoping work has been undertaken and as a result we have strengthened professional networks within ESHT and partner agencies including SPFT, Children's Social Care (CSC) and the Police to support a responsive and child focussed approach for our most vulnerable children who present to ESHT Services. This has been achieved through the introduction

and ongoing development of holistic and trauma informed multi agency care plans that include the child/young person's wishes and feelings. These care plans support with emergency and planned admissions for the Child/Young Person (YP) by helping clinical staff understand their lived experience and promote a trauma informed approach. Whilst this is an emerging area of work for the ESHT safeguarding team, where care plans have been developed, we have seen good outcomes with positive feedback from Emergency Department (ED) staff who have felt more informed and better able to respond to the needs of the young person leading to better engagement in assessment and treatment. The Named Doctor's for Safeguarding have been an integral support to this process further strengthening the professional relationships across Paediatric and Adult disciplines.

In recognition of this emerging area of Safeguarding practice and, following publication and recommendations from Safeguarding Adult Review's, the Safeguarding Adults Board (SAB) and East Sussex Safeguarding Children Partnership (ESSCP) formed a multi-agency task and finish group to develop a strategic approach to Transitional Safeguarding across East Sussex. The ESHT safeguarding team Transitional Safeguarding Lead and Named Nurse are part of this core membership, and this work will continue to be developed throughout 2023-2024. It is of note that within this multi-agency forum, the work so far achieved by the ESHT Transitional Safeguarding practitioner and wider safeguarding team was acknowledged as leading best practice within health.

The Specialist Safeguarding Practitioner who leads this portfolio has begun to deliver bespoke trauma informed training and supervision sessions to paediatric and adult staff across ESHT, this work will continue into 2023-2024.

- In response to the vast numbers of under 18's attending ESHT Emergency Departments, the process of reviewing presentations and identifying risk by the safeguarding team has been further developed within a Pan Sussex working group, led by NHS Sussex. The ESHT Safeguarding team contributed to this significantly and a final Pan Sussex criterion was developed and has now been implemented in ESHT to support robust information sharing, identification of risk and professional development of safeguarding practice for frontline staff.
- ESHT have continued to contribute towards the ESSCP Quality Audit subgroup and participated in 4 multi agency audits focussed on, Invisible Men/hidden partners, Child Sexual Abuse, Electively Home Educated Children and Strategy Discussions.
- Safeguarding Supervision has continued to be embedded across acute and community services within the organisation to support the management of complex cases, promote reflective practice, professional development and provide assurance. Themes that have been highlighted include professional curiosity, responding to neglect, working with highly resistant parents and health reporting to the police. The Safeguarding team have been offering face to face and virtual safeguarding supervision. This offer of Safeguarding supervision was further extended to support the Health Visiting Locality Managers in October 2022. As such the Named Nurse now provides 1-1 Safeguarding supervision to the Locality Manager's to support with leadership in safeguarding and complex case management. Feedback and engagement have been positive.
- Safeguarding training has continued to be a key area of achievement for the team. Alongside the mandatory level 3 This Family training, bespoke sessions focussed on priority safeguarding themes have been delivered throughout the organisation. In response to the

increasing cases of neglect locally and nationally following the covid 19 pandemic, the team have planned and delivered bespoke training to paediatric ED staff. A full Safeguarding development day focussed on recognising and responding to neglect was led by the safeguarding team to the Health Visiting Service. This was a large virtual event delivered to over 150 members of the Health Visiting team and included guest speakers from CSC and NHS Sussex. The feedback was extremely positive, and this will continue as an annual offer to the service.

- Members of the safeguarding team, including the specialist practitioners based within the Duty and Assessment team continue to co facilitate ESSCP training on FII, Domestic Abuse and participating in Child Protection Case Conferences.
- The complexities of responding to neglect in children and young people has been a big focus for ESHT and other agencies in East Sussex over the past year. As such, the safeguarding team have been contributing towards the updating of the East Sussex Neglect Strategy with partner agencies. This has been a key piece of work that has provided the opportunity to advocate for health within the neglect threshold matrix and toolkits to support professionals.
- The weekly risk meeting led by the safeguarding children team has continued to be reviewed to ensure it meets the needs of the service. Throughout 2022-2023 the core professionals have been extended to ensure a more Think Family Approach and to provide further professional scrutiny and support for the 16- and 17-year-olds presenting, and those children under 18 who may be inpatient within ESHT presenting with a safeguarding concern. This has provided a forum for informal peer/multi-disciplinary supervision, reflective practice/learning, and development of robust safeguarding practice.
- ESHT have seen an increasing number of frontline practitioners being requested to participate in Local Authority care proceedings and criminal court proceedings. The Named Nurse has provided a package of support to staff and managers including pre- and post-supervision and de-briefs.
- The Specialist Safeguarding Practitioners based in the Duty and Assessment team continued to contribute towards pre-birth assessments for vulnerable families and supporting SWIFT services with drug testing. Their public health and safeguarding expertise provide an ongoing valuable professional resource to CSC colleagues and families. The team have extended their service offer throughout 2022-2023 to the Wealden area of East Sussex CSC
- A quality improvement plan for Safeguarding Adults was developed and implemented to improve data collection and governance systems and processes.
- A weekly tracker was developed for adult safeguarding to provide real time oversight of themes and trends, with specific reference to any concerns raised about the Trust.
- The Chief Nurse has led safeguarding summits in response to the themes of Safeguarding's raised about the organisation. The forums held with senior staff raised and consolidated awareness to reinforce robust discharge pathways.
- As part of Adult Safeguarding processes, provider reports are sent to staff to complete, which informs the section 42 enquiry. A system to track the progress of these via a database has been established to ensure that they are submitted in a timely manner.
- The Safeguarding Team and Health Independent Domestic Violence Advisor (HIDVA) developed training for Domestic Abuse Champions across the organisation, fourteen members of staff completed the training.
- The Mental capacity lead has worked to raise the profile of Deprivation of Liberty Safeguards as a precursor to the forthcoming changes to Liberty Protection Safeguards.

- Both the Head of Safeguarding and the Named Nurse Adults were part of a Sussex wide Liberty Protection Safeguards steering group.
- The team have continued to provide a modified Safeguarding Supervision offer throughout 2022/2023, in Adult and Children's areas, specifically to teams which have to manage complex caseloads, the mode of delivery continues to be a virtual Micro-Soft teams offer.
- ESHT have contributed to the ESSCP Learning and Development subgroup to consider the multi-agency training programmes going forward that are in line with current themes.
- The Head of Safeguarding participates in Sussex wide Multi-Agency Risk Meetings (MARM) meetings as a forum to discuss complex cases.
- Two Individual Management Reviews (IMR) were completed and submitted as part of Domestic Homicide Review processes. One IMR report was completed as part of a safeguarding child practice review.
- As part of the serious case review processes that encompass adult, child and domestic abuse four rapid reviews have also been completed and submitted.
- The maternity safeguarding team has begun to provide targeted training/updates regarding domestic abuse, trafficking, forced marriage and modern slavery to the maternity day unit and early pregnancy clinic.
- A short video has been produced and uploaded to the intranet to guide staff in how to submit a safeguarding referral.

4.0 - Strategic Context

4.1 Child Safeguarding Arrangements

The East Sussex Safeguarding Children's Partnership board (ESSCP) brings together several key agencies as well as voluntary organisations and lay members, across the county, to ensure a collaborative approach to safeguarding children. Three key agencies, Local Authorities, Health, and Police are integral to the forum and jointly oversee the multi-agency arrangements to safeguard children.

A sub-group of the ESSCP, the Case Review Group holds responsibility for the management of Serious Case Reviews now referred to as a Child Practice Review (CPR). Additionally, there is a national independent body which oversees the learning framework for inquiries into child deaths (CDOP) and to which local boards are now accountable where children have experienced serious harm.

Serious Practice Reviews with East Sussex are managed within these frameworks which highlight the importance of rapid response and transparency in publicising how an area has learned from an incident and what has changed in local practice learning.

4.3 Adult Safeguarding Arrangements

The Chief Nurse, Deputy Chief Nurse and Head of Safeguarding are members of the East Sussex Safeguarding Adults Board (SAB). The Head of Safeguarding also participates in sub-groups of the SAB.

'*The requirement of the SAB is to lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies' www.scie*.org.uk.
The SAB is also instrumental in commissioning safeguarding adults' reviews for any serious cases which meet the threshold criteria. Moreover, locally the SAB has developed resources such as the adult death protocol when abuse could be attributed as a factor in an adult's death.

4.4 Domestic Abuse

The Head of Safeguarding is a member of the East Sussex wide Domestic Homicide Review oversight board.
Change Grow Live who are providers of Domestic Abuse services within East Sussex employ the Health Independent Domestic Violence Advocate (HIDVA) who is commissioned to undertake Specialist work within ESHT.

5.0 - Response to national themes and Trends

5.1 The impact of County Lines

During 2022/2023, the virtual Think Family Safeguarding Training and Supervision has continued to include content on 'County Lines' which is the term used to describe the distribution of drugs from major cities into counties. ESHT continues to support Emergency Department staff, the Police and other agencies to identify children at risk of being drawn into serious crime including drug dealing with pressure to carry weapons. Children in Care have been overly represented in the overall amount of 'County Lines' related cases presenting to our ED department bought in by Police.

5.2 Modern Slavery/Human Trafficking

ESSCP, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked, or going missing from/in East Sussex. Section 54(1) of the Modern Slavery Act (2015) places a legal requirement on ESHT to prepare our staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, ESHT continues to identify suspected cases which have been reported to the police.
Members of the Safeguarding team participate in a monthly meeting chaired by Discovery that reviews local 'hot spots' and multi-agency actions to safeguard victims. The Head of Safeguarding is listed within a local directory as a point of contact**.**

5.3 Multi – Agency Female Genital Mutilation (FGM) Guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure staff can identify females at risk, detect FGM and report it effectively. Information about FGM is included in the 'Think Family' training.

Between April 1st 2022 and 31st March 2023 there were 17 cases of FGM reported by ESHT with data entered onto the NHS Digital National FGM Enhanced Dataset (figure 1). All information was reported by maternity teams. Of these 7 were noted as type 4, one as type 2, two as type1

FGM information sharing, known as FGM-IS, is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of females, under the age of 18, who have a family history of Female Genital Mutilation (FGM). ESHT has implemented the system which is led by the Named and Deputy Named Midwife for Safeguarding.

5.4 The Care Act (2014) - Making Safeguarding Personal

It had been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside the learning from complaints, safeguarding enquiries and case reviews was required. The Care Act (2014) defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions.

- What difference would they want or desire?
- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

Historically Safeguarding Supervision had been the forum within which the ethos of Making Safeguarding personnel had been discussed, however, the Pandemic affected the programme of Supervision facilitated within the organisation. Supervision continued for some groups of staff via video meetings, such as Dieticians and Sexual Health and the safeguarding team are available for 'hot' de-briefs and support for ward staff as required.
In addition, the Think Family training offer, which incorporates all staff at band 5 and above has been vital to deliver the MSP message to staff.

5.5 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015.
Locally the Trust is active on the PREVENT Board and submits numbers of PREVENT (Channel) referrals and training data quarterly to the ICB and NHSE.
Since the Pandemic, PREVENT training is accessed via e-learning format, the training requirement changed from a standalone session to 3 yearly updates.
Compliance is set at 85%, ESHT are close to compliance with both BPAT & WRAP training. The Trust have not made any referrals to Prevent in the last year but engages with Channel when required. (Figure 1)

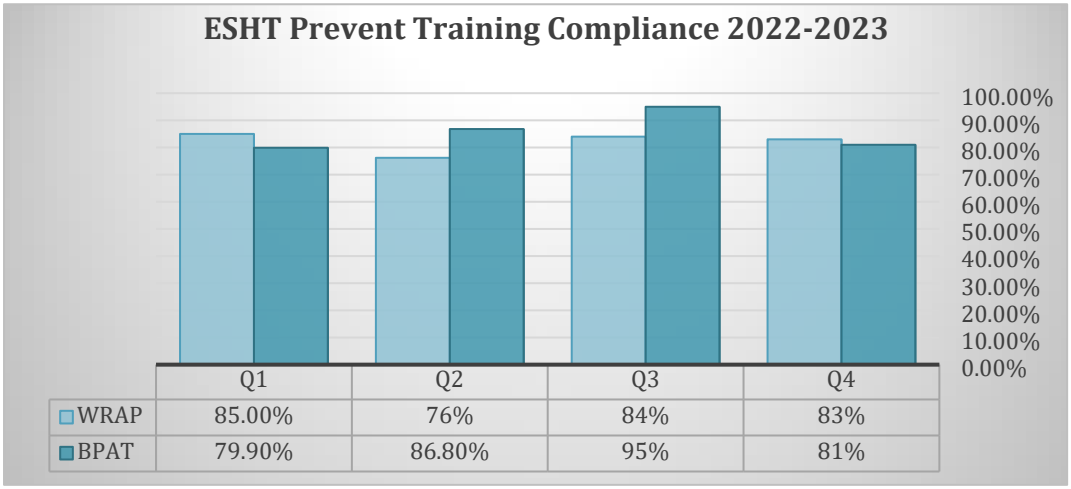


Figure 1

The Prevent lead works closely with the Head of Security to align work between PREVENT and Counter terrorism.

5.6 Domestic Abuse and Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour-based violence. Chaired by Swift, they bring together statutory and voluntary partner organisations to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection. ESHT are members of both MARACs in East Sussex, where Specialist Health Visitors represent the Trust.

Confirmed cases of domestic abuse are flagged on patient administration systems. To strengthen arrangements, the “Care Grow Live” organisation and Sussex ICB resumed the funding for the Health Independent Domestic Violence Advisor (HIDVA) in October 2020 and this is now in place for five years. The role focuses on supporting staff to identify domestic abuse through the process of referral, once made. In addition to supporting staff to manage cases of abuse, the practitioner also works directly with victims and is developing the Domestic Abuse training offer within the organisation. Referrals received by the HIDVA in the last year are documented in figure 2 below.

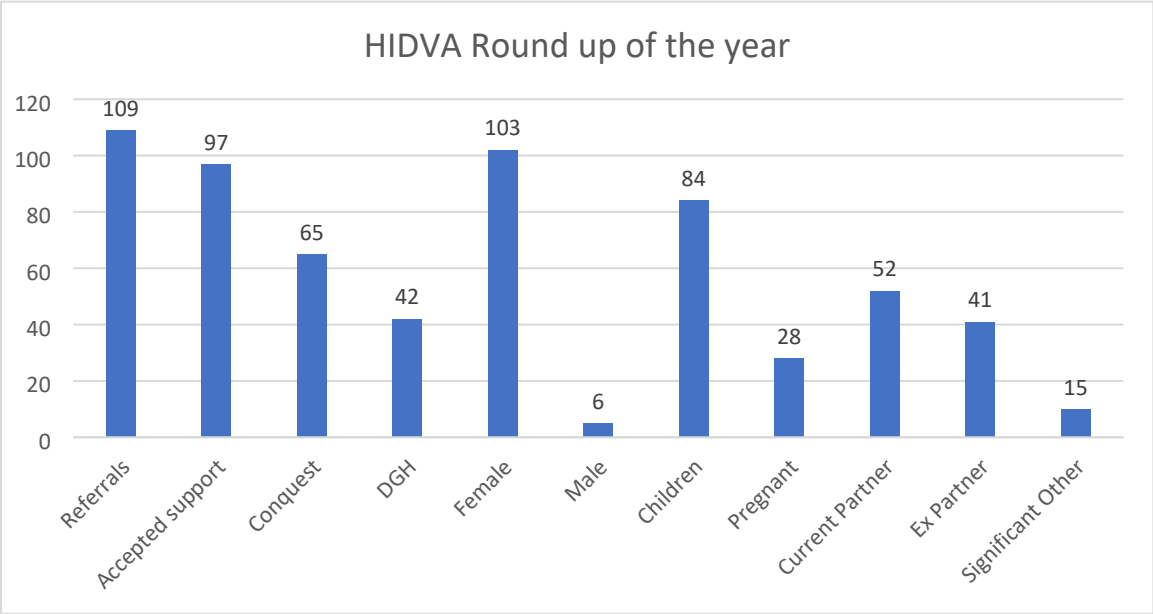


Figure 2

6.0 - Local Serious Case Reviews and referrals

Domestic Homicide Reviews, Safeguarding Practice Review (child) or Serious Adult Review are a multi-agency analysis, undertaken when it is considered that abuse has contributed to the death or serious injury. The purpose of which is to identify whether there is learning. As part of any serious review ESHT alongside other partner agencies submit detailed reports and participate in panel meetings and practitioner learning events. The final reports, identifying lessons to be learned, and recommendations are compiled by an independent reviewer or author and may be published.

6.1 Domestic Homicide reviews.

There continue to be several domestic homicide reviews progressing at differing stages within the East Sussex area, most deaths occurred between 2018-2020, with one historic case from 2016. Of these cases, two will not be published but information is disseminated through learning briefings, and a further four cases are awaiting sign off by the Home Office.
Two cases occurred in 2021 and initial reports have been submitted and further meetings awaited
The victims were predominantly female, 8 of the cases, with two male victims being reviewed.

The predominant theme featured in 7 of the cases was that there was a history of domestic abuse. Substance and alcohol misuse is also a key feature within the cases.
From a health perspective there is a continuing thread of a lack of professional curiosity alongside a lack of routine enquiry.
In two of the cases, the victims had presented with injuries prior to their death which they had reported as being the result of Domestic Violence.

6.2 Children's Activity

In the period April 2022- April 2023, ESHT did not refer any cases to the ESSCP case review panel. ESHT Safeguarding contributed research in the form of three rapid review serious cases, one of the cases is progressing to a child practice review.

Three child cases have been completed within this year Child AA and a Thematic review that considered two cases. Some cases have been published on the East Sussex Safeguarding Children Partnership site and anonymously on the NSPCC national repository, learning briefings and action plans have been shared within the organisation.
There remain three historic cases that occurred between 2018- 2020 where publication has been delayed by judicial proceedings.

6.3 Safeguarding Adult Referrals

Three Safeguarding Adults Reviews taken forward by the Safeguarding Adults Board in 2021- 2022 have now concluded and the reports published on the Safeguarding Adult Board website. The Head of Safeguarding has participated in the panel meetings for two cases this year, a further case did not have Trust involvement.

Key themes emerging from the serious cases includes, Mental Capacity, Making Safeguarding Personal, Application of Safeguarding processes, and multi-agency information sharing and communication.

6.3.1 Actions within the trust

- The Head of Safeguarding was one of the facilitators in two learning events led by the Safeguarding Adult board in response to one of the cases.
- Learning briefings regarding all the cases have been disseminated to Divisions through governance reports, meetings, and a quarterly newsletter.
- Key messages have also been discussed within the Professional Advisory Group forum.

7.0 - Deprivation of Liberty (DOLS)

East Sussex Healthcare applies the Deprivation of Liberty Safeguards (DOLS) to those patients that are deemed to lack mental capacity. The Deprivation of Liberty Safeguards were an amendment to the Mental Capacity Act 2005 and within which the procedure, as prescribed in law, cites when it is necessary to deprive a resident or patient of their liberty, when the person lacks capacity to consent to their care and treatment, in order to keep them safe from harm.
This legislation was further developed following a supreme court judgement in 2014, referred to as the Cheshire West directive, which referred to the 'acid test' to see whether a person is being deprived of their liberty, and which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

Work has continued to embed understanding of the Mental Capacity Act and the ethos of Cheshire West. Furthermore, work was being undertaken to develop readiness for Liberty Protection Safeguards. As part of this process ESHT established a task and finish group to contribute to the draft consultation in 2022, however LPS has now postponed by the government.

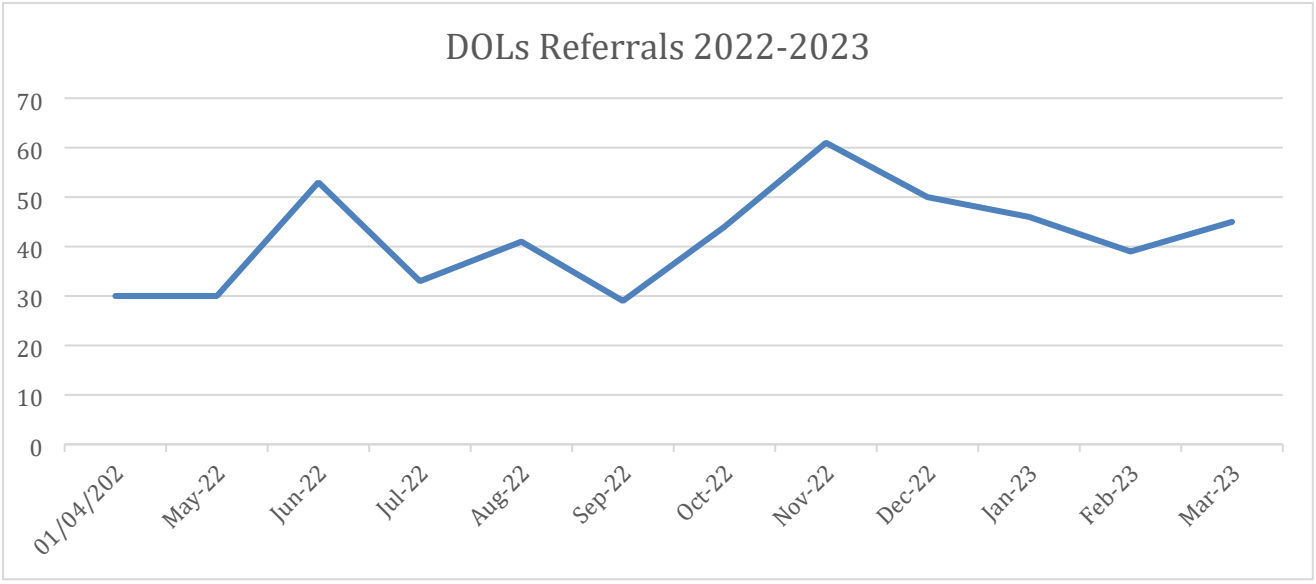


figure 3

7.1 Actions in progress

- A Mental Capacity lead commenced in post February 2022
- Head of Safeguarding and Named Nurse Adults participate in a Sussex LPS steering group and information disseminated via the Professional Advisory group within the trust.
- The Safeguarding team attend Matrons and Divisional meetings to discuss the updates on the forthcoming changes.
- DOLS and LPS was discussed at the patient Safety and Quality Group.

8.0 - Safeguarding Work Plans

Safeguarding have work plans to track all aspects of safeguarding and learning disabilities work. Monthly meetings are held with senior members of the team to review and update progress. This ensures there is a responsive forward strategy with work undertaken by the team, addressing both local and national Safeguarding agendas. The Safeguarding Children and Adults Strategic Group continues to monitor progress, compliance and risk through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting. (Appendix 1)

9.0 Speciality focus

9.1 Maternity Safeguarding

- Maternal safeguarding has seen an increase in complex cases and those presenting with mental ill health who have required additional support and liaison with partner agencies (figure 4, below).

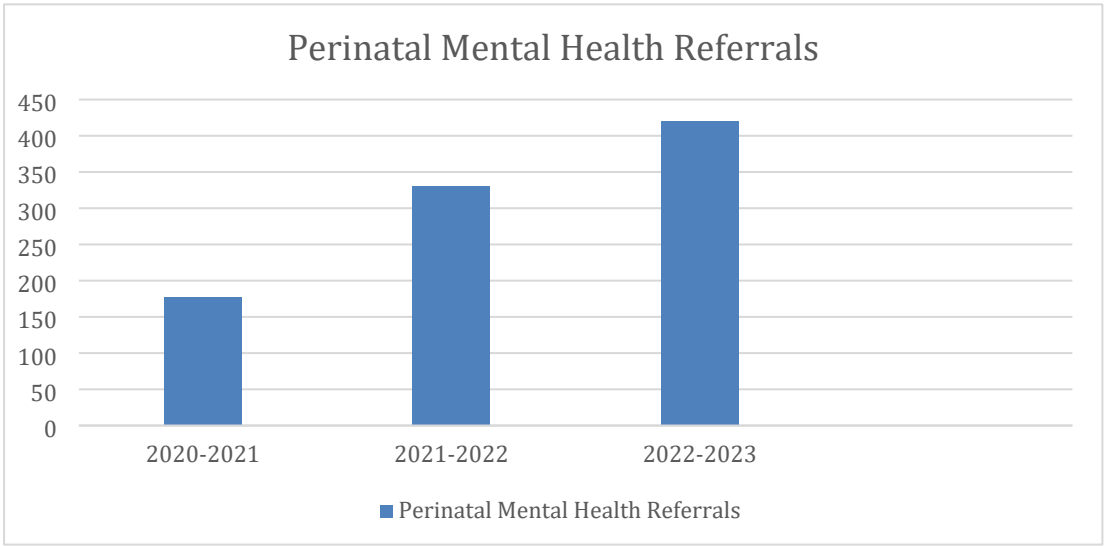


Figure 4

The hospital-based midwives require annual safeguarding supervision which is provided during the Green mandatory annual study day. The community midwives require quarterly safeguarding supervision as they hold a caseload. Quarterly supervision has been challenging due to the workload in the community, midwives being used for escalation within the acute unit and sickness within the maternity safeguarding speciality. The maternity safeguarding team offer single and group supervision to community midwives as well as ad hoc supervision to those wanting to discuss complex cases.

Research led by Lancaster University as part of the Born into Care series "Born into care: newborns in care proceedings in England" - Nuffield Family Justice Observatory (Homepage - Nuffield Family Justice Observatory (nuffieldfjo.org.uk) has demonstrated that there are a growing number of newborn's (less than 7 days old) issued with care proceedings in England.

At ESHT, there were 17 mothers and their babies separated following a court order in 2022. The babies in most cases were placed in a foster placement, some babies were placed within the extended family network. The Maternity Safeguarding Specialists are asked to support the legal process by providing documentation. We sit in on some virtual court cases to support the patient and provide input at discharge as part of the management of these complex cases. All mothers and their babies who are separated by a court order are offered a Baby Hope Box prior to discharge from hospital.

In September 2022, the ESHT maternity safeguarding team attended the Giving Hope event in London, a national event to launch the Baby Hope Box with a vision for every hospital in England to have Hope boxes available as part of broader transformation work across Child Social Care and maternity. ESHT maternity safeguarding was recognised at this event for its innovation as one of the trail blazers for the project. NHS England National Safeguarding Team provided the women with lived experience who led the project with a safeguarding award, and the ESHT Maternity Safeguarding team were also presented with a safeguarding award.

Badgernet, the Maternity record system has enabled data regarding the routine enquiry of domestic abuse by Midwives to be collated, Figure 5. Asking domestic abuse screening questions is embedded in antenatal care.

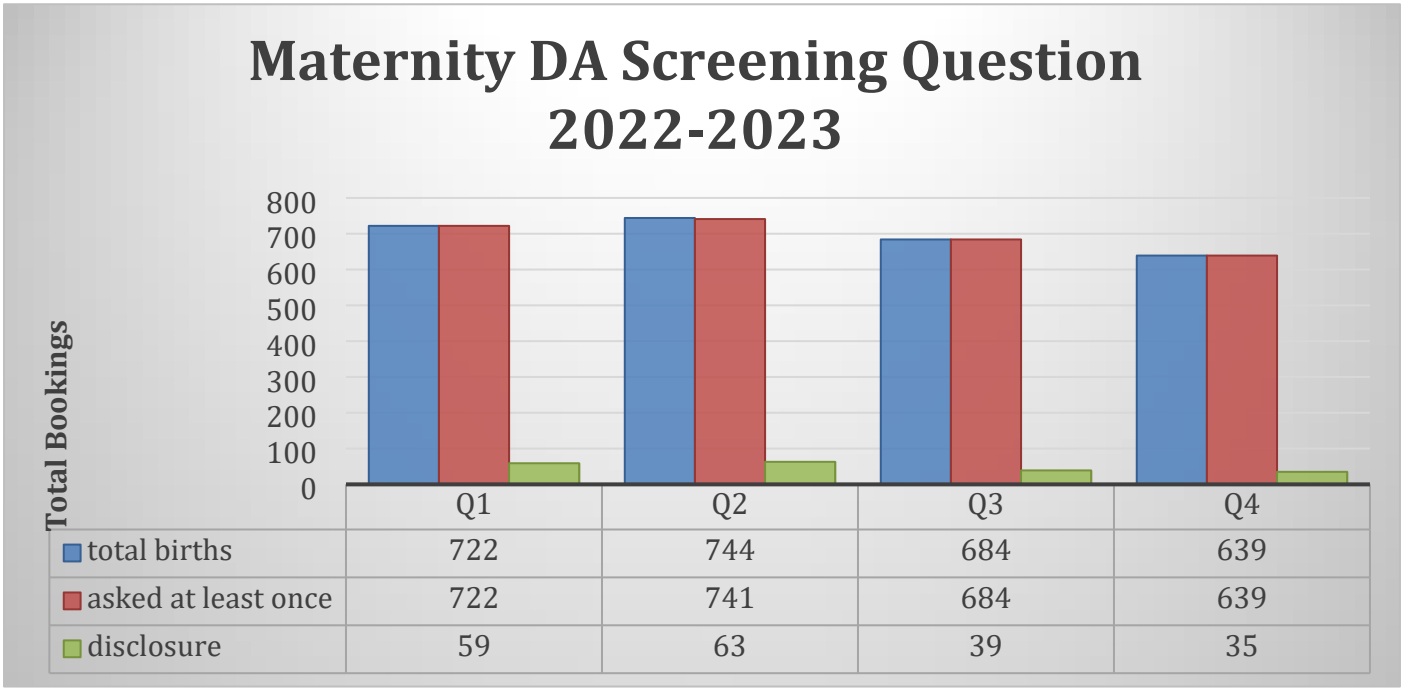


Figure 5

9.2 Safeguarding Children

The Safeguarding Children's Specialist's within the team scrutinise child presentations within ESHT, predominantly the Emergency department and Children's ward, to ensure that safeguarding pathways are recognised and followed. Safeguarding data is collated, such as the numbers of statements of referrals (SOR forms) submitted by the trust to Children's Social Care, furthermore any relevant information shared with colleagues, such as the Health Visiting service. The team participate in strategy meetings and host a weekly multi-agency forum that reviews attendances and admissions where there is a potential safeguarding risk.

During the pandemic, there was an increase in safeguarding children's referrals, the majority of which are submitted by the Emergency Departments and this pattern has been sustained.

The Children's Social Care front door, referred to as the Single Point of Advice (SPOA) has Mental Health Practitioners within the workforce, hence Statement of Referrals forms (SOR) are also submitted for those Children requiring non-urgent mental health support, referred to as Camhs. The proportion of referrals submitted for mental health presentations and safeguarding issues are differentiated.

The charts below figures 6 demonstrate the comparative between current and pre-pandemic referrals (Figure 6).

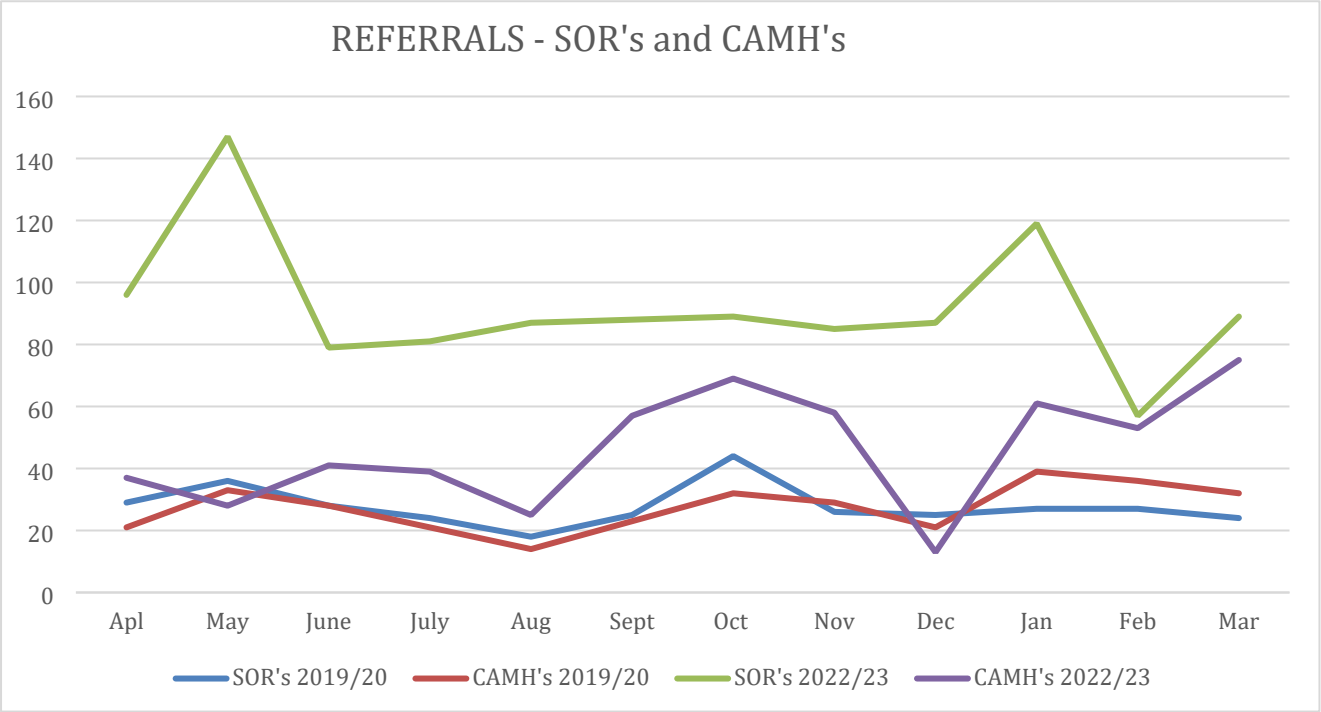


Figure 6

The prevailing theme identified within Children's safeguarding referrals has remained as mental ill health, (figure 7)

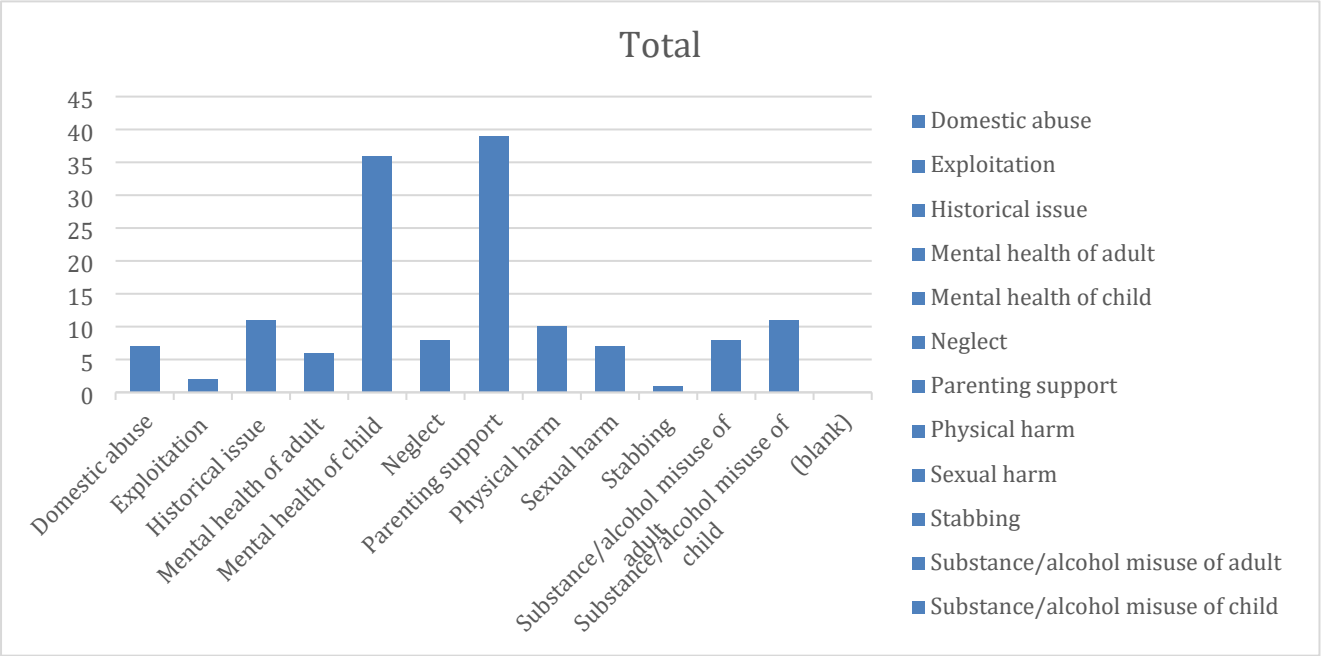


Figure 7

9.2.1 Actions

- The Safeguarding team continue to host a weekly multi-agency risk meeting in which child presentations of concern are scrutinised.
- The ESHT Transitional Safeguarding Lead and Named Nurse are part of the core membership of a multi-agency task and finish group which aims to develop a strategic approach to Transitional Safeguarding across East Sussex.

9.3 Mental Health Presentations under 18

The predominant theme discussed within the weekly children's Safeguarding risk meeting has continued to be mental health issues, demonstrated by presentations following overdose and various forms of self-harm in addition to an increase in referrals to Child and Adolescent Mental Health Services (figure 8).

Furthermore, there were two completed suicides in this year, the Trust and Safeguarding team were then, as a result, involved in wider multi-agency work aimed to reduce risk in the community of additional children.

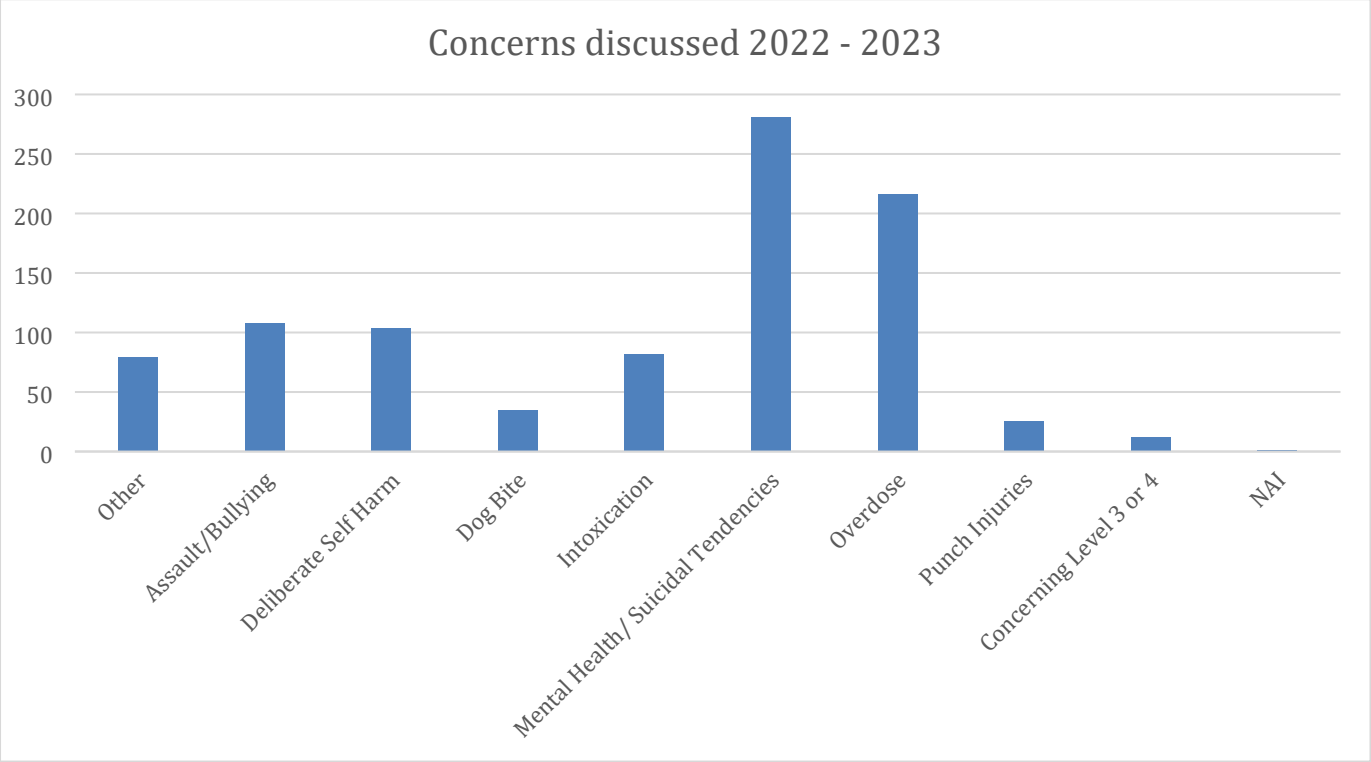


Figure 8

The increasing trend in children seen in the Emergency department or Children's areas with mental health concerns and discussed in the risk meeting can be viewed over five years.
(Figure 9)

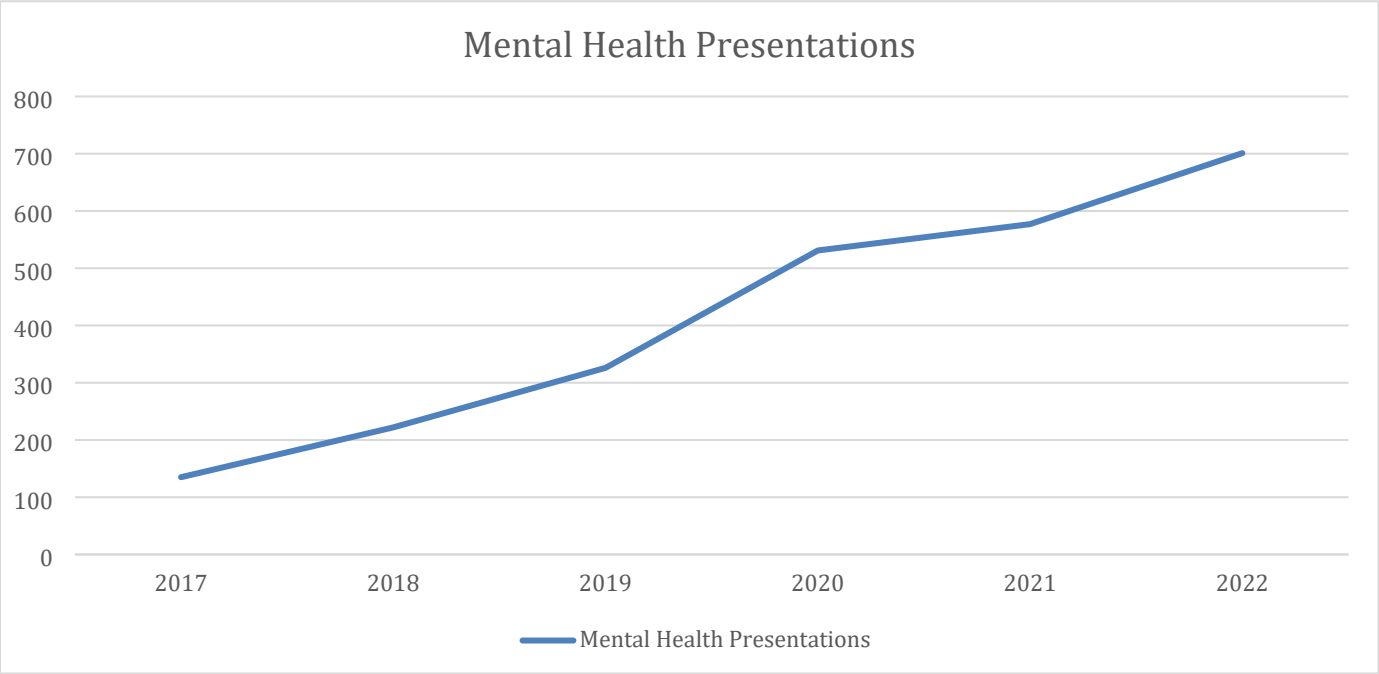


Figure 9

The picture is also with adolescents presenting with complex mental health and psychosocial needs being admitted to the Paediatric ward. There remain challenges regarding the lack of available Specialist Paediatric mental health in-patient beds nationally. However, it is social care issues that have predominantly resulted in children experiencing admissions for sustained periods, whilst the appropriate accommodation is sought.

There continues to be pressures within the organisation where children with Mental Health issues have waited in the Emergency department (figure 10 and 11) for prolonged periods, this is a national issue.

Children detained under the Mental Health Act at ESHT:
Financial Year 2022-23 YOUNG PEOPLE

Conquest Hospital

Ward	Section 2	Section 3	Section 5	**Total Inpatient**
AAU	1	-	2	**3**
Cuckmere	-	-	1	**1**
Kipling	1	1	10	**12**
TOTAL	**2**	**1**	**13**	**16**

Eastbourne DGH

Ward	Section 2	Section 3	Section 5	**Total Inpatient**
AMU	-	-	1	**1**
TOTAL	**-**	**-**	**1**	**1**

Additionally, there are a number of children with a mental ill health presentation recorded as waiting in the Emergency Departments longer than 12 hours. The data is drawn from Nerve Centre at the point a child is documented a Mental Ill Health to leaving the department.

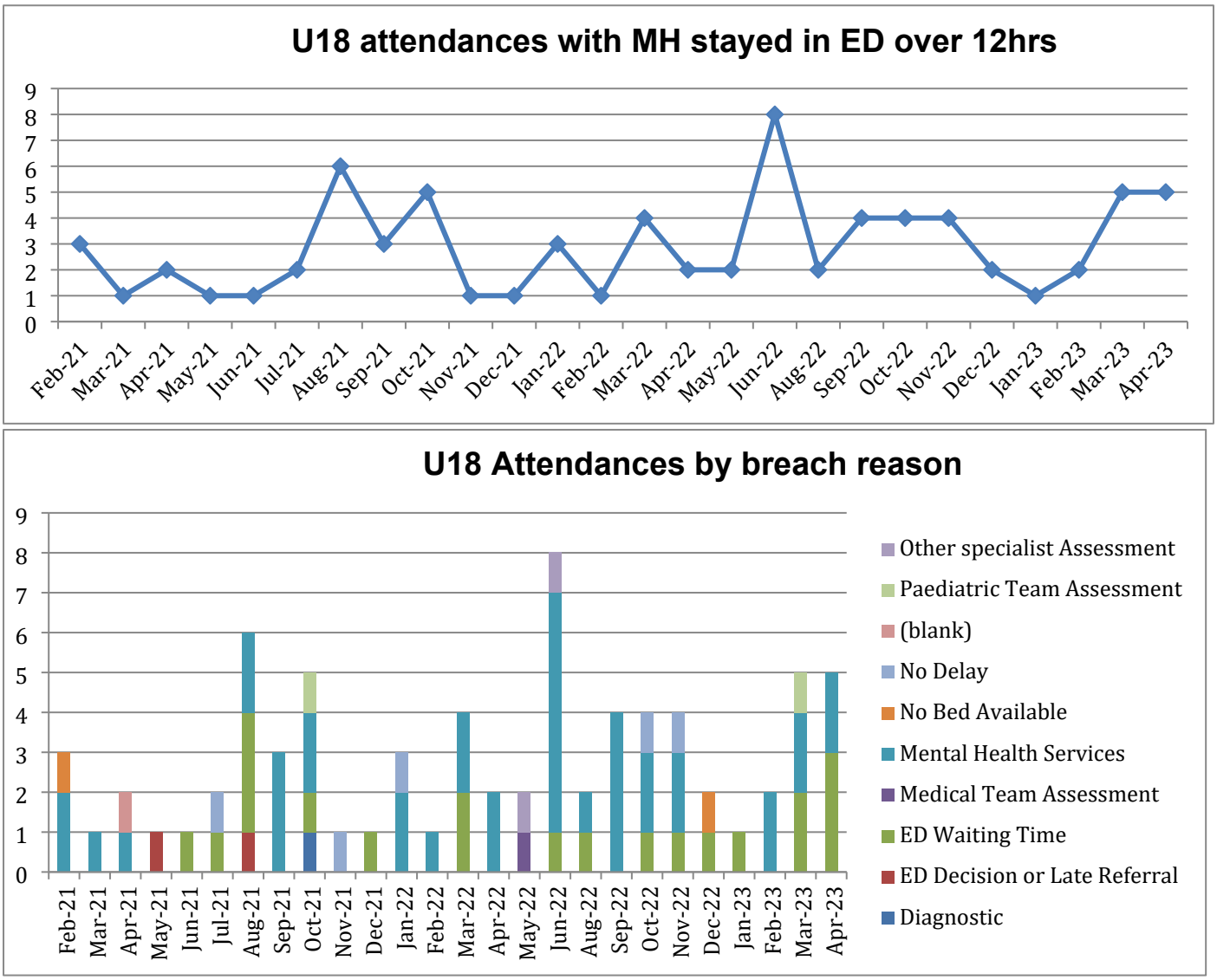


Figure 11

Section 136: Financial Year 2022-23 YOUNG PEOPLE

	Conquest	EDGH
Taken to ED under s136	12	9
Assessed under s136 at ED	8	6

9.3.1 Actions

The Chief Nurse continues to raise this issue at system and regional levels.

- Head of Safeguarding is part of a Sussex Wide multi-agency forums that consider a strategic understanding of mental ill health presentations.
- Regular meetings occur with safeguarding and the Women's and Children's division.
- Joint work has commenced between Sussex partnership and ESHT led by the Chief Nurse and Respective Chief Operative Officers to consider how the organisations can jointly improve systems for adults and children experiencing mental ill health.
- As part of the shared delivery plan there is now a MHLDA board with ESHT attendance.

9.3 Named Doctors for Safeguarding Children

There were three named Doctors in 2022- 2023, two acute based and one community, all three work closely with the Head of Safeguarding and the Specialists Nurses for Safeguarding Children. The three Named Doctors provide clinical advice guidance and support. The Named Doctors have continued to develop safeguarding work within Paediatrics including,

.

- Participation in national network of named professionals to share best practice.
- Regular meetings with CSC locality managers to improve inter-agency communication and working.
- Support for liaison nurses in considering referrals for possible child protection medical examinations.
- Support of colleagues at strategy meetings and case conferences, and in provision of written safeguarding medical reports.
- Leading and facilitating bi-monthly peer support meetings to consider “Children with Perplexing Presentations”.
- Support for medical and nursing colleagues in dealing with the huge increase in patients with mental ill health and complex psycho-social problems admitted to the children’s ward, many of whom have no physical health needs.
- Training for and supporting colleagues in managing young people with eating disorders.
- Consultant peer review of safeguarding cases, provision of safeguarding induction to paediatric and ED physicians, development of regular paediatric and ED safeguarding teaching programme (the last is a work in progress)
- Organising training on the application of the Mental Health Act
- Supported ward stuff with legal issues, including working through the court process last year
- Assisted two colleagues with court appearances.
- Provided input and oversight into a new policy for under 1s in the Emergency Department

As part of a child protection investigation, Paediatricians may be asked to conduct an urgent child protection medical or welfare medical. The process for medical examinations has been more clearly defined and is constantly reviewed and refined as necessary, for example with provision of rapid feedback to social workers of initial opinions, and data is collated as to how many medicals occur during a monthly period. Welfare medicals were adversely impacted due to the Pandemic as it was necessary to repurpose their clinic spaces.

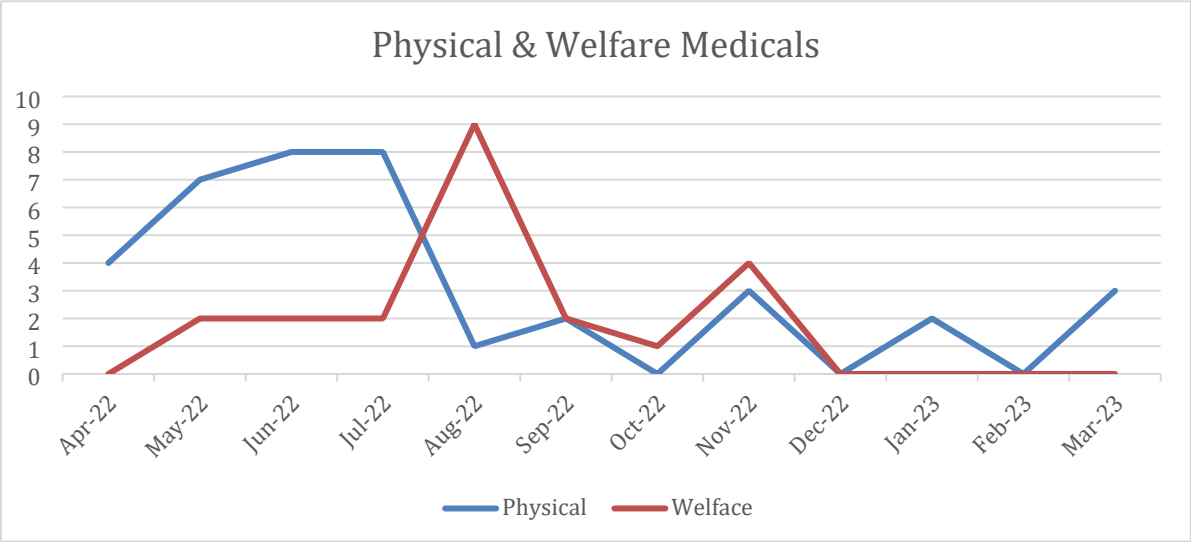


Figure 12

9.4 Safeguarding Adult Referrals

Safeguarding alerts/referrals can be raised by staff, patients, family members or the public and are received by Adult Social Care (ASC), who apply three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern. Of the referrals ASC receive, not all result in a Section 42 Enquiry, and may not progress after information gathering. The work undertaken within the safeguarding team for section 42 enquires and information gathering is however similar and it should be noted that not all enquiries meet the threshold following investigation for section 42.

ESHT, has seen a year-on-year increase in the number of Safeguarding Adults enquiries (figure 13). This covers both acute and community services and includes enquiries raised by ESHT and those about ESHT. The size of the team has not changed in this time.

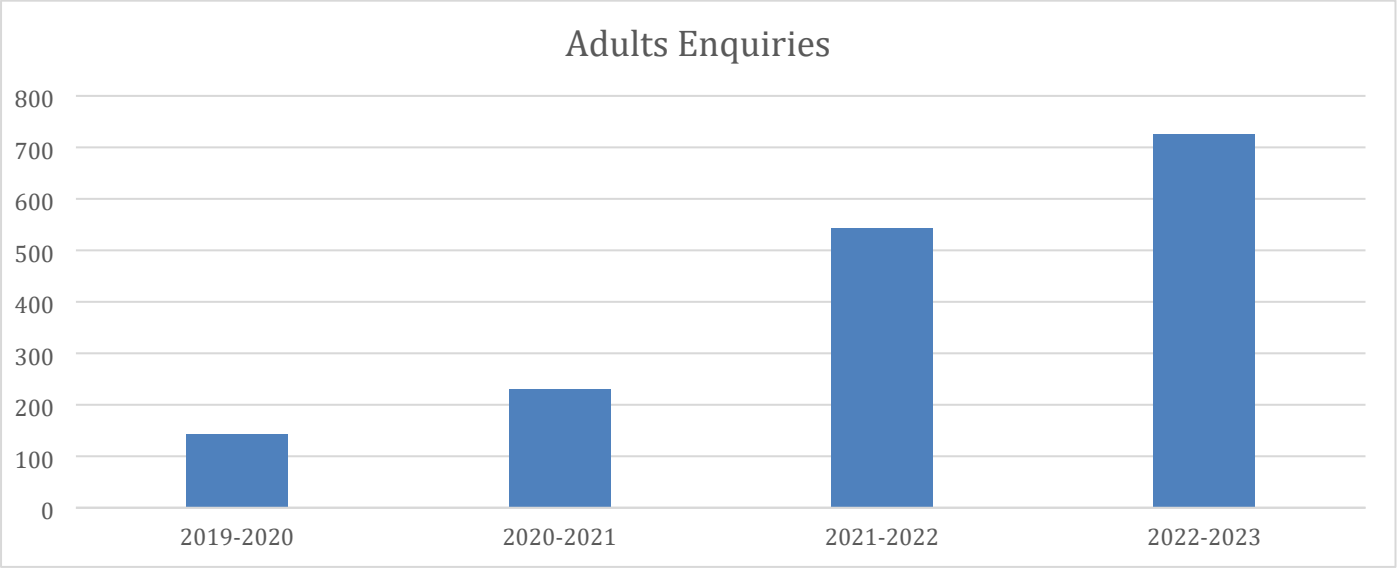


Figure 13

The trust implemented a quality improvement plan in 2022-2023 in response to an increase in the number of enquiries about the organisation that were predominantly attributed to the discharge process and to a lesser extent to skin damage. Improvements in documentation and handover will support the latter. With regard to the former, the concerns regarding discharge frequently included the terms ‘unsafe’ and ‘failed’ discharge. Significant work has been and continues to be undertaken with regard to discharge. This includes safely balancing patient choice whilst also trying to mitigate the risk of harm from deconditioning. In trying to ensure that patients do not rapidly decondition the culture and approach to falls prevention is changing as a result. One element of quality improvement was the development of a weekly tracker (Figure 14) to monitor the themes alongside meetings with the Heads of Divisions and Matrons led by the Chief Nurse, with a Safeguarding Summit during the year to discuss themes and actions.

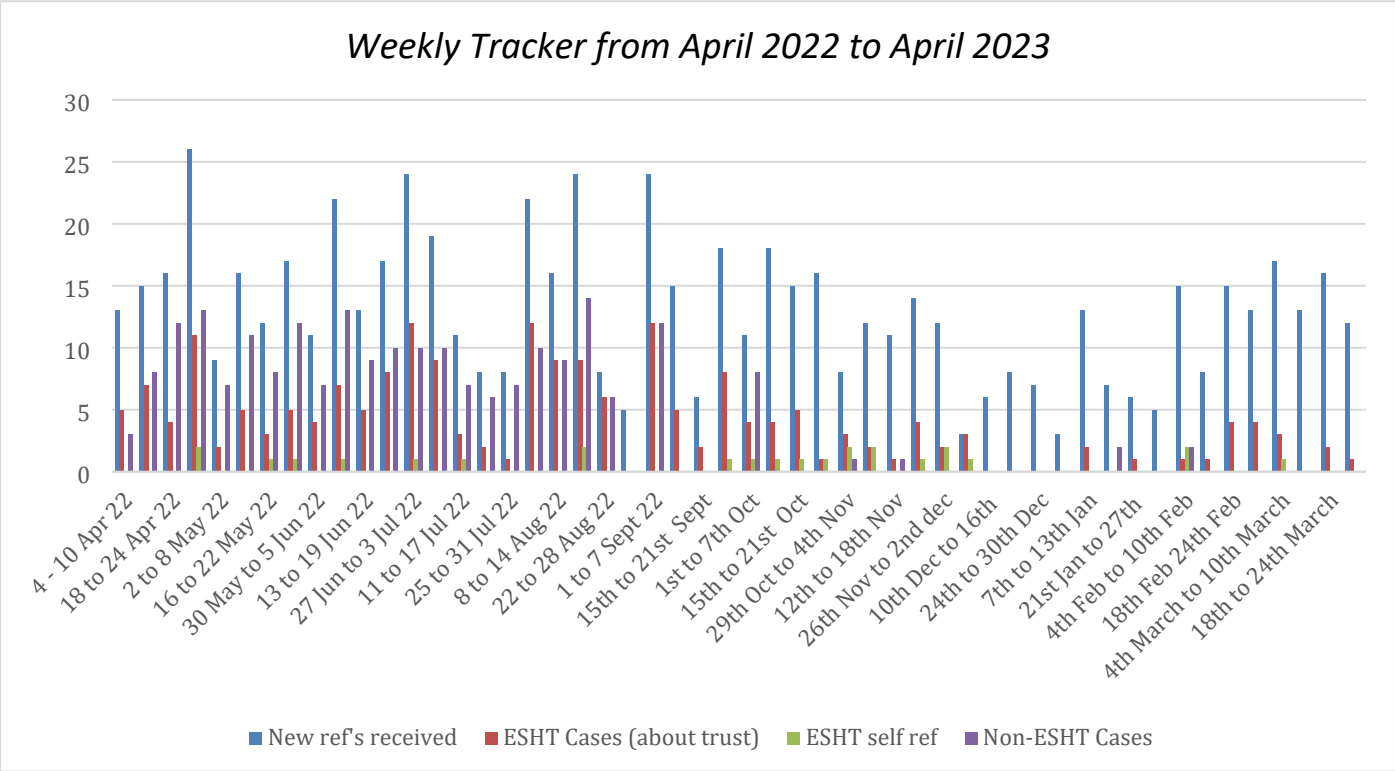


Figure 14

The progress of completion of the provider reports is also monitored through a database and discussion within Divisional governance forums to ensure robust and timely responses. There has been an additional and significant challenge with the very high numbers of patient with a very extended length of stay many of whom are vulnerable, complex and at high risk of harm e.g., falls, pressure damage and psychological distress.

Furthermore, the presentation of some cases is increasingly complex. An area where this also of particular note is within Maternity Safeguarding, for example domestic abuse considerations have also to encompass any risks to new-borns and other families.

Neglect, self-neglect, and domestic abuse are identified as themes raised as safeguarding enquiries (figure 15). The presentation of safeguarding issues has continued to demonstrate complexity of

cases, the Safeguarding team Adults Specialists submitted a referral under the criteria for the Safeguarding Adults Board (SAB) adult death protocol in the last year and a referral to the newly convened Multi-Agency Risk Meeting (MARM).

Safeguarding supervision for some clinical teams was paused in some areas, both during the acute phases of the pandemic and subsequently as a result of staffing challenges within the team. Sessions have been offered virtually via Micro-Soft teams since, for those staff that hold caseloads, such as Dietetics, Health Visiting, Midwifery and Sexual Health. The Safeguarding team are reinstating supervision and have made connections with both the community and acute settings. This has enabled teams to access team support whilst managing complex safeguarding cases and has also enabled the "Think Family" approach to be embedded further.

Safeguarding Adult Enquiry Themes 2022-2023

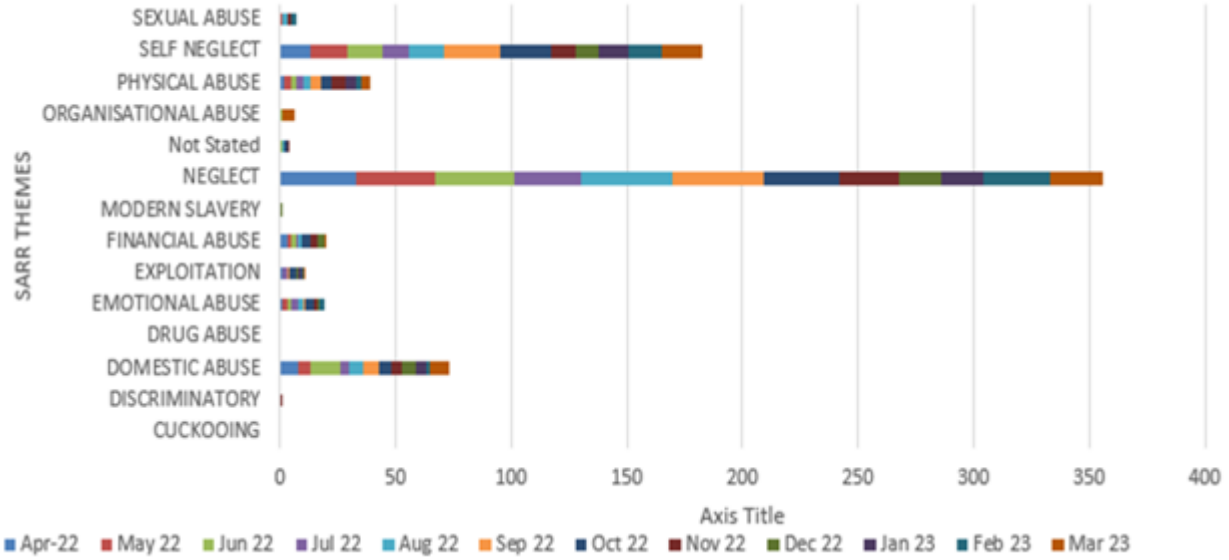


Figure 15

10.0 - The Mental Health Act – ESHT Duties

There continues to be a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements and ensure patients admitted to inpatient beds have their rights protected and their mental health care needs are met by a Responsible mental health clinician. The Head of Safeguarding attends monthly Mental Health Act meetings with colleagues from SPFT and a weekly detention oversight meeting, escalating risk when necessary to the Chief Nurse. The team has strived to improve safeguarding governance in monitoring ESHT compliance and works collaboratively with SPFT teams to address any areas of non-compliance. This work has included the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights.
- Section 135/136 training for ED staff continues to be delivered.
- Revision of the Policy for the Mental Health Act to support staff.
- Ongoing monthly mental Health Act meetings and Liaison meetings
- An area for development is a mental health strategy.

10.1 Mental Health Presentations

Similar to Paediatric Mental Health Presentations, adult detentions under the mental health act have remained high (figure 16), this is predominantly sections 2 and 5 with section 3 remaining stable. Patients have been noted to have increasingly complex presentations and are often awaiting the appropriate in-patient destination.

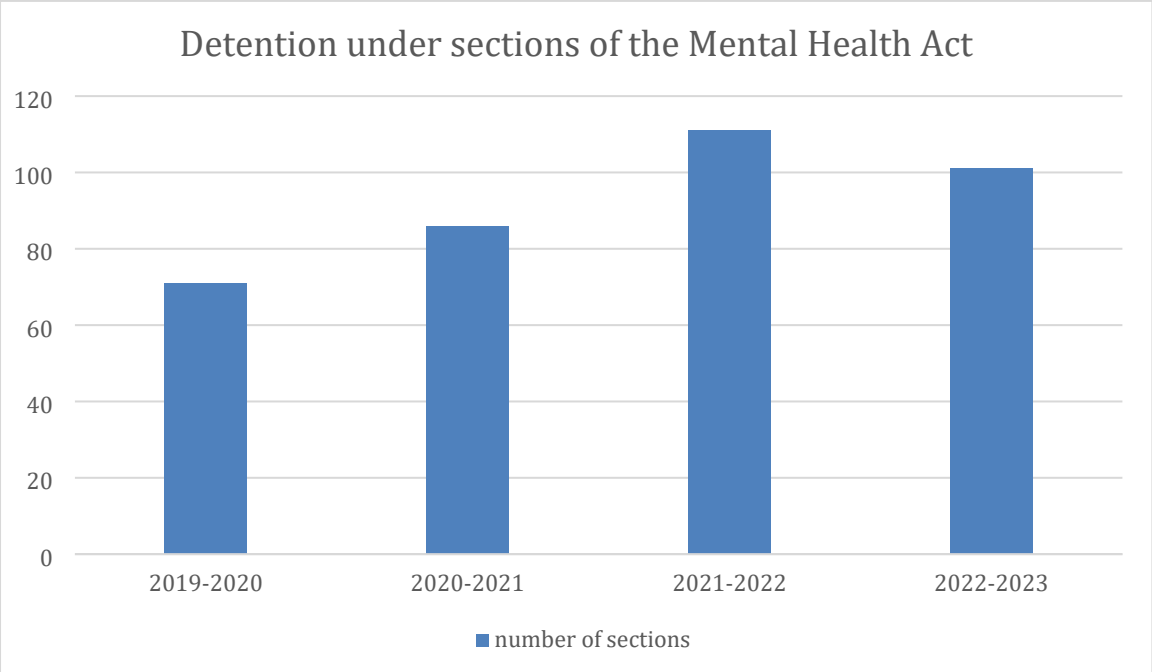


Figure 16

The numbers of section 136 detentions, in which the Police bring people to the Emergency Department when alternatives are unavailable, are similar to the previous year.

Section 136: Financial Year 2022-23 ADULTS

	Conquest	EDGH
Taken to ED under s136	117	148
Assessed under s136 at ED	69	98

11.0 - Safeguarding Training

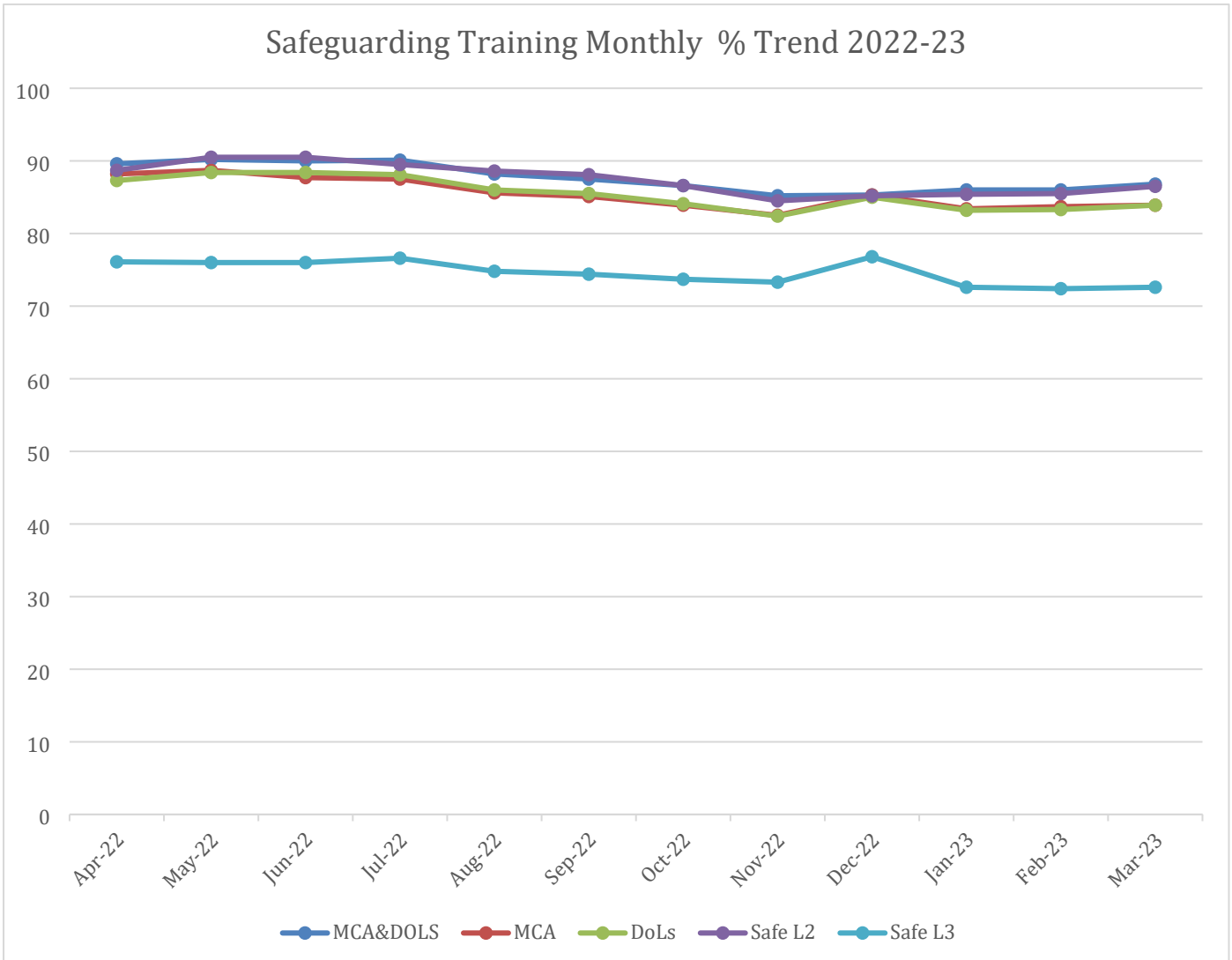
ESHT Safeguarding launched a new model of training in 2020, combining both adults and children's level 3 into a holistic, Think Family offer.
Furthermore, to provide consistency across the organisation and avoid fragmentation all registered staff Band 5 and above have been migrated across to undertake Think Family; this provides assurance in line with the Intercollegiate frameworks (2019) that all registered staff have accessed the required competency. Some of this cohort however previously may have accessed level 2

training for either strand, whilst the migration of staff continues within the next year this will show as a compliance fall, further impacted by the pandemic.
The Think Family project was piloted prior to the Pandemic and launched in February 2020 as a whole day face to face training; at the start of the pandemic this was changed to a virtual offer. Due to Divisional requirements the training was adapted to that of an assessed e-learning module followed by a 4-hour webinar. Each of the training sessions is facilitated by two members of staff from the safeguarding team on a weekly basis. However there was a fall in compliance for level 3 within some clinical groups, which has continued (figure 17). Initially this was identified as in part due to the impact of the pandemic and staff access to the webinar, also the migrating all trained staff Band 5 to Think Family programme and also staffing challenges within the safeguarding team.
The training identifies current safeguarding themes and trends both locally and nationally and has been positively received and well evaluated. However, as a virtual meeting it has been recognised that it does not provide staff with detailed practical elements such as compiling referrals. This has been addressed through flowcharts, a You Tube video developed by the team alongside the team being more visible in clinical areas to support staff.

11.1.1 Actions going forward.

- The Think Family training is being updated in 2023 and will re-commence a face-to-face offer.
- Training will comply with the Intercollegiate guidance and thus will continue as a blended version.
- Other initiatives are being explored such as the recording of virtual sessions.

Safeguarding Training compliance – Figure 17



12.0 - Learning Disabilities Safeguarding

It is known that people with a learning disability can have high levels of health needs that can at times go unrecognised and untreated and it is evidenced that it can be problematic for people with a learning disability to access a hospital setting and support may be required to ensure that individual patient needs are met effectively.
The Trust is in a fortunate position of having an Acute Learning Disability Liaison Nurse in post, which is tri- funded by SPFT, the ICB and ESHT. In recognition of the need to increase resources support for the Learning Disability Liaison Nurse, the ICB released additional resources so that there is additional Acute Learning Disability support is now available, on a part time basis.
The aim of the role of the Acute Learning Disability Liaison Nurse is to support and facilitate equality, access, and treatment for adults with a learning disability who access ESHT services, ensuring compliance with the Mental Capacity Act (2005) and the Equalities Act (2010).
The Trust is fortunate to have Learning Disability MDTs across both sites of Conquest and EDGH, which the Acute Learning Disability Liaison Nurse is actively part of.
Joint working with all agencies including the Community Learning Disability Team, Adult Social Care and Sussex LeDeR (Learning from the Lives and Deaths of People with a Learning Disability and Autism) remains an important aspect of the role in particular with LeDeR highlighting the improvement needs and good practice within the Trust.

13.0 - Children in Care (CIC) / Looked After Children

The Named Nurse attends the Safeguarding weekly risk meeting to contribute to the discussions and action for any Looked After child. The Named nurse takes a lead role for children placed by Other Local Authorities who are discussed at the weekly meeting.
In total 167 Looked After Children were discussed at the weekly meeting over the year
Of those discussed 148 lived in residential homes
Of the 167 attendances 43 were for the same young person

All the specialist nurses and the Named Nurse attend and contribute to specific safeguarding meetings relating to their caseload. These include strategy meetings, multi-disciplinary, transition planning, and other professional multiagency meetings required.

There is a separate Children In Care report that provides oversight and detail on the Children in East Sussex alongside data regarding health assessments.

13.1 Service Development

Work has continued to increase compliance with KPIs in ensuring that statutory initial and review health assessments are a positive and valuable experience, written in child/person centred way using plain English, enabling the child to understand the report, to contribute to building a positive

relationship and improve the experience for the children we care for. There has been investment of 0.6WTE in the nursing workforce to enable caseload working to be embedded. Due to challenges in Health Visiting recruitment and retention the Children in Care nurse team delivered the Healthy Child programme to the under 5s from August 22-March 23

13.2 Quality Assurance by Audit of Health Assessments 'Quality and Dip samples'

The Named Nurse undertakes dip sampling throughout the year of East Sussex review health assessments, RHAs and Other Local Authority (OLAs) RHAs undertaken by the ESHT CIC nurse team. This is usually on a quarterly basis.
Due to long term sickness and vacancies in the nurse team, the Named Nurse has taken on some case loading for children in care and subsequently had not had capacity to complete the Quality assurance process robustly for the year. However, some dip sampling has taken place.

"RHAs continued to be offered in a variety of ways, either telephone, Video calls or face to face. The quality of the RHA's remains high. The RHAs remain detailed and thorough. Strength and Difficulties questionnaires are not always completed by the carer, completion ranging from 52-68%. This is fed back to the SW via the health action plan. The RHAs are person centred and I always hear the voice of the child when I am dip sampling the RHAs."

13.3 Supervision and Training
Supervision

Specialist nurses continue to have access to quarterly supervision with the Named nurse in addition to 6-8 weekly 1:1s with the service manager.
All doctors undertaking CIC assessments have the opportunity for monthly supervision. This is usually group supervision but is occasionally 1 to 1 if felt to be more appropriate.

Named and designated doctors have additional meetings with opportunity for supervision (these are also monthly), there is informal supervision on an ad hoc basis between these also.

To effectively promote the health and well-being of Children in Care, all staff working in healthcare settings must have the knowledge and skills to carry out their roles, as set out in the Looked After Children; Knowledge, skills and competencies of healthcare staff, intercollegiate Framework (RCPCH, RCN, 2020)
ESHT ensures that the staff within the organisation are trained commensurate to their roles and identified through regular performance appraisal. Level 2 and 3 LAC training is now mandatory for all relevant staff. Level 3 training is facilitated via MS teams in 2022, as a webinar monthly by the CIC nurse specialists with support from the Named nurse.

14.0 - Challenges Going Forward

14.1 Whilst the Implementation of Liberty Protection Safeguards has been paused by the government it has not been cancelled and the Trust needs to consider its readiness to apply the changes. These include,

- LPS can be applied to a person aged 16 and above.

- If the LPS is applied for within and NHS setting, the ‘hospital manager’ (the trust), become the responsible body.
- An LPS may move with the person to differing settings i.e., between a care home and hospital
- An LPS can be applied to a patients’ home environment, which will impact community staff requiring additional time to assess a patient’s mental capacity and complete the documentation.

Preparation for LPS has highlighted that further work needs to be undertaken within the trust to embed the ethos of the Mental Capacity Act.

14.2 East Sussex continues to be an area within which there are high numbers of Domestic Homicide Reviews (DHR). Analysis of these has identified missed opportunities to discuss a person’s lived experience within health settings.
Work to embed the routine enquiry of Domestic Abuse within ESHT systems and processes.
Increase in numbers of Safeguarding presentations neglect, self-neglect, and domestic abuse across the population, alongside the complexity of cases.

14.3 2022-2023 saw an increase in safeguarding enquiries about the trust. Work has been undertaken to address this including more responsive data collection systems, weekly tracker, and meetings with staff to discuss discharge and “unsafe/failed” discharge versus the risk deconditioning. This work remains ongoing, and information audited in 2023-2024

14.4 The numbers of patients with mental ill health alongside their complexity and an increase in violence and aggression remains challenging within the organisation. Joint work will continue with Sussex partnership in 2023-2024 to enhance systems and consider pathways going forward.

15.0 Conclusion

Safeguarding continues to be challenging with increased numbers in in terms of complexity and volume. Moreover, there are changes in the demographic with a rise in the complexity of cases, first seen against the backdrop of the pandemic but sustained since. As a trust we have seen rise in both children and adults suffering with mental health issues and with the economic challenges this is likely to continue, with fuel poverty a real issue.

The introduction of the Mental Capacity Lead role has been shown to have a positive impact with clinical areas recognising and submitting Dols applications.

The team have remained passionate and professional continuing to support and advise all clinical areas in addition to driving forward the Think family agenda.

The Q&SC and the board are asked to note the contents of this report and to continue to offer their support for what is an increasingly complex and challenging agenda.

Name: Head of Safeguarding
Date:

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Looked After Children Knowledge, Skill and Competences of Healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

Isolated and struggling social isolation and the risk of child maltreatment, in lockdown and beyond Eleni Romanou and Emma Belton NSPCC Evidence team June 2020

COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association

Safeguarding children, young people and adults at risk in the NHS, Safeguarding accountability and assurance framework

Appendix 1 - Work Plan

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care act 2014	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities training compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	ESSCP Current Child Practice Reviews (CPR)	To undertake the ESSCP Child Practice review	To undertake any action as required by the ESSCP in relation to commissioned child practice reviews	DON	Named Nurse for children	
3	SAB SAAR	To undertake the SAB Safeguarding Adult Case reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
4	SAB DHR	To undertake the Domestic Homicide Reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
5	NHSE / NHS	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any noncompliance's with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legislation	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
7	CQC / Safeguarding Legislation	To ensure there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Director of Nursing	
10	PREVENT Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT awareness and WRAP and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM return is submitted for ESHT	DON	Named Midwife	