EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 4th December 2018, commencing at 09:30 in St. Mary's Boardroom, EDGH

AGENDA			Lead:	Time:
RESPECT presentation				0930
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Monthly award winner(s)		Chair	0945 - 1030
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 2nd October 2018	A		
4.	Matters arising	B		
5	Quality Walks Board Feedback	C	Chair	
6	Board Committee Feedback	D	Comm Chairs	
7	Board Assurance Framework	E	DCA	
8	Chief Executive's Report	F	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
9	Integrated Performance Report Month 7 (October) 1. Quality and Safety 2. Access and Delivery 3. Activity 4. Leadership and Culture 5. Finance 6. Sustainability	Assurance	G	DN/MD COO HRD	1030 - 1130
10	Learning From Deaths (Quarter 1)	Assurance	H	MD	

BREAK

STRATEGY

					Time:
11	Capital Programme – Mid Year Review	Assurance	I	DF	1130 - 1150

GOVERNANCE AND ASSURANCE

					Time:
12	Review of Corporate Governance Documents	Assurance	J	DCA	1150 - 1215
13	Equality Delivery System 2	Assurance	K	DCA	
14	Governance Review	Assurance	L	DCA	
15	Board Sub Committee Minutes	Assurance	M		

ITEMS FOR INFORMATION

				Time:
16	Meeting Dates for 2019	N	Chair	1215 - 1230
17	Questions from members of the public (15 minutes maximum)		Chair	
18	Date of Next Meeting: Tuesday 5th February 2019, Hastings Centre, Hastings		Chair	

David Clayton-Smith

Chairman

8th November 2018

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

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 2nd October 2018 at 09:30 in the Oak Room, Hastings Centre.

Present:
Mr David Clayton-Smith, Chairman
Mr Barry Nealon, Vice Chairman
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mrs Nicki Webber, Non-Executive Director
Dr Adrian Bull, Chief Executive
Ms Catherine Ashton, Director of Strategy
Mrs Vikki Carruth, Director of Nursing
Mrs Joe Chadwick-Bell, Chief Operating Officer
Ms Monica Green, Director of Human Resources
Mr Jonathan Reid, Director of Finance
Dr David Walker, Medical Director
Mrs Lynette Wells, Director of Corporate Affairs

In attendance:
Miss Jan Humber, Joint Staff Committee Chairman
Mr Mark Friedman, Director of Recovery
Mr Christopher Langley, System Improvement Director
Mrs Angela Ambler, NHSI Next NED Programme (observing)
Miss Kelly Porter, Executive Assistant to Chairman & CEO (minutes)

078/2018 **Welcome**

1. Chair's Opening Remarks

Mr Clayton-Smith welcomed everyone to the meeting of the Trust Board held in public.

It was noted Mr Stevens' term of office as a Non-Executive Director had ended since the Board had last met in public and Mr Clayton-Smith thanked him for his significant and valuable contribution to the Board during his time with the Trust.

He reported that two new Non-Executive Directors had joined the Trust, welcoming Mrs Karen Manson and Mrs Nicki Webber to the Board.

2. Apologies for Absence

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

Mrs Jackie Churchward-Cardiff, Non-Executive Director

3. Monthly Award Winners

Mr Clayton-Smith advised that the monthly award winner for July had been Jayne Winter, Nursing Team Leader Supportive & Palliative Care Team.

The winner for August was Liam Currie, an Integrated Support Worker for the

Crisis Response Team in Eastbourne who had organised an NHS 70th Birthday Street Party bringing together local people, practitioners and volunteers.

079/2018 **Declarations of Interest**

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

080/2018 **Minutes**

The minutes of the Trust Board meeting held on 7th August 2018 were considered. Mrs Carruth requested that her title be updated from Ms to Mrs. Subject to this amendment the minutes would be signed by the Chairman and lodged in the Register of Minutes.

081/2018 **Matters Arising**

066/2018 Board Committees' Feedback - Audit Committee

An update on cybersecurity had been added to the agenda of November's Trust Board Seminar.

069/2018 - Integrated Performance Report Month 3 (June) – Activity

Mrs Chadwick-Bell confirmed that she was awaiting confirmation of the definition of MSK and that the matter would be carried forward to the next meeting.

082/2018 **Quality Walks**

Ms Ashton advised the Board that as a non-clinical member of the Trust, visiting the various different wards and departments within the acute and community settings was very valuable and enjoyable. Ms Ashton provided an overview of the Quality Walks she had participated in, commenting that staff were calm and coping with the daily pressures.

The End of Life Care Team were making significant progress with cover across all acute sites; staff on Seaford 1 raised some concerns over staffing following the bed remodelling and the Community Audiology team were very pleased with the recent investment in new equipment.

Ms Ashton also advised the Board that during her recent visit to Pevensey ward (Oncology) she was privileged to spend some time with a patient who expressed their gratitude for the good care they receive and also commented on the good choice of patient food.

Mr Clayton-Smith noted that he had received a question from Mrs Churchward-Cardiff in relation to Quality Walks: "The action plan following the CQC visit gives Quality Walks as a measure for evidence of improvement. I don't think we have particularly targeted walks for this so can this be scheduled for key times in the plan?"

Mrs Wells confirmed that the Trust had a process in place and Quality Walks were linked to the action plan. A number of actions related to the A&E department and the number of visits to a single area had to be appropriate. There were increasing numbers of visits to Community sites to ensure that the Quality Walks covered all areas of the Trust.

Mrs Kavanagh noted that it would be helpful if a brief could be included to confirm why a particular Quality Walk was taking place and if there were any specific areas that need to be addressed. Mrs Wells noted this and advised

that the teams are asked to send a briefing in.

Ms Green advised the Board that the staff appreciate the time taken by the Board when they visit.

083/2018 **Board Committees' Feedback**

1. Audit Committee

Mr Clayton-Smith noted that the Audit Committee meeting scheduled for September had been cancelled as it would not have been quorate. Mr Clayton-Smith also noted that Mrs Webber has been appointed as Audit Committee Chair. The Committee was still meeting its Terms of Reference in respect of the number of meetings required each year.

2. Finance and Investment Committee

Mr Nealon reported that the Finance and Investment (F&I) Committee was working on three work streams; firstly to meet the target deficit of £45m via the CIPs and Grip and Control; secondly the 3+2 strategic plan and thirdly that the Trust is not working in isolation, but working alongside the CCG to reduce the System Deficit.

3. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee met on 5th September 2018 at which recruitment and retention were discussed. Concern was raised over the increasing turnover rate of AHPs within the Trust but confirmed that work was being undertaken to review this.

Ms Green advised the Board that the turnover rate for AHPs was 13.2% against an overall Trust rate of 11%. Where exit interviews have been conducted the main reason for leaving was noted as a lack of career progression.

The Junior Doctors survey results were also discussed noting that whilst there was a significant improvement within the Trust, the results were still showing that ESHT was behind their Peers.

Dr Walker explained that there had been much improvement generally, although there were still areas of concern that needed to be addressed including accommodation and also ARCP forms, although clinical education were now assisting the Junior Doctors with these. He advised that issues were raised and discussed at the Junior Doctor Forums which were hosted by Dr Bull.

Yvonne Coghill, Senior Programme Lead for Inclusion from NHS England attended POD Committee and provided an inspirational talk on Workforce Equality.

Mrs Carruth challenged the statement that there is no BME representative on the Board, as Mrs Carruth comes from a BME background.

4. Quality and Safety Committee

Mrs Wells reported that the Quality and Safety (Q&S) Committee was well attended and the CQC action tracker was discussed in great detail; noting that the report indicated many areas were rated as green and amber; she advised that "mock inspections" and Quality Walks would be undertaken to ensure that standards are maintained.

Mr Clayton-Smith asked the Chairs to make sure that their forward work programmes ensure quality is maintained throughout.

The Board noted the Committee Reports.

084/2018 **Board Assurance Framework**

Mrs Wells reported that within the Board Assurance Framework the only area rated red related to Finance and that this was reviewed at both F&I and Trust Board.

Mrs Chadwick-Bell explained that in relation to the 62 day cancer targets controls were in place but currently the Trust was not delivering the performance expected; a recovery plan had been drafted but at this stage Mrs Chadwick-Bell supported the proposal that the RAG rating should move to red but would expect it to remain red for a short time.

Dr Bull noted that Risk 3.2.1 indicated that an integrated plan was submitted, when in fact two separate plans were submitted. The Trust was working with the CCG in relation to an integrated plan; Dr Bull suggested that the BAF should be updated to reflect that the Trust aspires to have an integrated plan.

Dr Bull reported that in relation to risk 4.2.1, the Trust had two capital bids with NHSI; the ambition was for a loan from the local authority but this was not approved by NHSI, however the Trust had been encouraged to submit an application for an emergency loan from NHSI. Dr Bull advised that the Capital Programme was currently oversubscribed due to the MRI build costs. The Capital Programme budget was being reviewed and the capital spend would be re-profiled.

Mr Clayton-Smith asked when the Trust would hear back as to whether this was successful or not. Mr Reid advised the Board that should the emergency capital loan application be unsuccessful then the Trust would not be able to fulfil the Capital Programme for the remainder of the year; further discussions in relation to this are to be held in the Executive Directors meeting on 3rd October 2018. Mr Clayton-Smith requested that the Trust Board be kept up to date with the process of the emergency loan application.

Mr Nealon questioned whether the Board were comfortable with the assurances in place in relation to risk 2.1.2 which related to young people with mental health issues being admitted to the Trust who may self-harm. Mrs Carruth confirmed that this was discussed at Integrated Assurance Meetings and also at the Clinical Quality Review Group. Mrs Chadwick-Bell noted that this service was not run by the Trust but by Sussex Partnership Foundation Trust. It was noted that this matter was being discussed with commissioners.

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

The Board also agreed that the 62 day cancer target risk should be changed to red.

085/2018 **Chief Executive's Report**

Dr Bull reported that there was continued improvement in the Summary Hospital-level Mortality Indicator which was now 1.01, the lowest score for the Trust since the index began.

The Trust recently had a visit from Tracey Irvine, National Clinical Advisor for Breast Surgery in relation to the Getting it Right First time (GIRFT) programme. The feedback received was excellent and the Trust's quality of care provided to its patients was also complimented. Dr Bull explained that this was a significant programme of work and advised consideration is being given as to how the Trust can support the small team who undertakes the GIRFT programme.

Dr Bull also highlighted a new out-patient follow up database that had been developed to improve the management of the review lists. Currently this was introduced for diabetic retina screening, but will be rolled out to other specialities which deal with chronic conditions. This new system would provide the assurance that patients were being followed up appropriately..

Dr Bull advised that recruitment was a key priority across a number of staff groups and work was being undertaken in areas with a shortage of consultants.

Mr Clayton-Smith asked for further clarification as to the role that MEDACS was taking within the Trust. Ms Green confirmed that MEDACS were working with the Trust to look at the high cost agency spend areas in the first instance, but that this was currently in its infancy.

Mrs Kavanagh questioned what impact Brexit would have on recruitment from EU countries. Ms Green advised that the recruitment programme encompassed a wider range of countries outside of the European union.

Dr Bull advised the Board that the Trust AGM in September 2018 was well attended which indicated the level of support that the Trust has from the public. The Associate Director of Communications, Miss Khalfan had been working hard on rejuvenating the membership programme in relation to this.

Mrs Chadwick-Bell provided the Board with an update on the Bed Remodelling programme explaining that the initial piece of work was carried out eight months ago based on activity levels at the time and length of stay figures. The Trust had delivered its length of stay target at a high level and as a result enabled the Trust to release a number of beds at the Conquest over the summer period and to reconfigure a number of beds at Eastbourne.
This initial piece of work had been reviewed and re-evaluated based on the increased non-elective activity and as a result of this alternative plans were being explored. Whilst some bed numbers had been reduced and staff moved to accommodate this, patient safety remains paramount and Mrs Chadwick-Bell confirmed that the numbers of staff were in line with safer staffing.

Asked whether the Trust can anticipate the remaining bed reconfiguration to be completed before winter; Mrs Chadwick-Bell advised that she did not anticipate that this would occur due to high capacity levels at present.

Action: JCB to present a full update at the Board Seminar linked in with the winter plan.

086/2018 **QUALITY, SAFETY AND PERFORMANCE**

Integrated Performance Report Month 5 (August)

Quality & Safety

Mrs Carruth reported that there had been a reduction in both falls by 5.2% and also Pressure Ulcers. There was however concern over the trajectory regarding the number of *Clostridium difficile* cases, communications had been circulated to staff in relation to antibiotic prescribing and as a result the number of cases has plateaued.

Dr Walker explained that as a result of the improved treatment of Sepsis there had been an increase in the use of broader spectrum antibiotics which had helped to treat Sepsis more effectively, but as a result could be a factor in the increased number of *Clostridium difficile* cases. Dr Sheehan, Consultant Microbiologist attended the Senior Leaders Forum recently where she reminded staff that antibiotics should be reviewed in accordance with policy and where appropriate, de-escalated as soon as practicable. Dr Walker also confirmed that the new E-prescribing system soon to be introduced to the Trust would assist in antibiotic prescribing; confirming that that the ward based pharmacists were on hand to assist with this.

Mrs Carruth confirmed that the Trust had seen one case of MRSA bacteraemia and the post infection review assessed this as unavoidable.

Dr Bull asked whether the query relating to the number of E-coli cases which the Trust reported has been resolved. Mrs Carruth confirmed that the Trust had made significant progress with the reduction in E-coli infections and that the Infection Prevention & Control team were working with colleagues at the CCG looking at the E-coli data previously submitted to the national database, as some cases have been incorrectly attributed to the Trust. Mrs Carruth confirmed that she had no concerns over the number of cases of E-coli as the Trust was below the limited allowed and within the expected range.

Mrs Kavanagh asked whether there were any concerns over the number of re-admissions to the Trust. Mrs Carruth advised that this was being reviewed and believed that this could relate to how re-admissions were coded. A quarterly audit programme reviewed re-admissions and a further report would be presented to the Quality & Safety Board.

Patient Experience has experienced an increase in the number of complaints for the third month in a row, some of which appeared to relate to Accident & Emergency at Eastbourne District General Hospital. Mrs Carruth and Mrs Chadwick-Bell confirmed that they would be meeting to discuss how further support could be provided to the department. It was also noted that the Friends & Family Test response had reduced but that a Volunteer would be situated in Accident & Emergency to help promote the completion of this.

Mr Clayton-Smith questioned whether there were any significant themes within complaints that related to Accident & Emergency at Eastbourne District General Hospital. Mrs Carruth advised it was multi-faceted although the number of complaints had increased overall, there was relatively a small number which were attributed to this department. Mrs Carruth added that there were still challenges within the workforce along with considerable pressures, but assured the Board that this was within safe staffing limits.

Dr Walker presented the Mortality data to the board, noting that the Risk Adjusted Mortality Indicators (RAMI) was below the peer value and that the Summary Hospital-level Mortality Indicator (SHMI) which was now 1.01, the lowest score for the Trust since the index began. The numbers of cases of Septicaemia were within expected levels and there is a commitment to lower these metrics further.

Access and Delivery & Activity

Mrs Chadwick-Bell reported that the 4 hour standard for August was 90.4% and as a system 92.7% which ranked the Trust 35th out of the 138 Trust within the country.

Elective activity had increased by 7.7% year to date and non-elective by 13.4%. A programme of work was being undertaken to assess the causes relating to the continued increase in activity; this was looking at five pathways into urgent care, including frequent attenders and high intensity user group. The aim was to avoid readmissions and provide holistic support rather than clinical support to help reduce demand respectively.

RTT performance for August was 89.4%; the backlog of 18 week referrals had increased from the same time last year, however there were no 52 week waiters within the Trust. There was a plan in place to ensure that the Trust delivered 92% as a minimum and to ensure that the waiting list reached its target by March 2019.

DTOC (Delayed Transfers of Care) increased in August, this was due to the delays in the care package requirements not being finalised, due to the holiday period. An internal review of the counting methodology for the DTOC had taken place and this resulted in improved reporting. The number of stranded patients was reducing due to weekly calls with Adult Social Care to ensure that patients were discharged as soon as practicably possible. An App was being developed to highlight those patients medically fit for discharge as well as detailing what elements of the care package was required place before this happens; this would also help to drive daily conversations with Adult Social Care

Mr Clayton-Smith asked whether there was any evidence that constraints on funding were a factor in the DTOC. Mrs Chadwick-Bell confirmed that this did not appear to be a reason for DTOC.

Diagnostics for August was 1.6%, a new Manager was now in post and Mrs Chadwick-Bell was confident that the target of 1% would be met.

Mrs Chadwick-Bell highlighted the excellent work undertaken by Urology on their 62 day pathway and RTT and proposed this should be presented to the Board at a future meeting.

Mr Clayton-Smith noted the very good performance of the Trust and was assured that Mrs Chadwick-Bell recognised areas which require improvement.

Leadership & Culture

Ms Green confirmed that the workforce figures for August remained static; explaining that whilst the number of staff working for the Trust was below the target figure, the costs associated with this was above budget due to the high cost of locums used to fill positions. However, the use of bank and agency staff had reduced from last month figures. Annual turnover reduced to 11% and

annual sickness remains low and unchanged from last month; long term sickness is monitored and dealt with in accordance to Trust Policy.

Mr Clayton-Smith noted that there was a significant increase in sickness levels from August 2017 to August 2018. Ms Green suggested that probably related to an aging workforce.

The national staff survey had been issued and was open for staff to complete until December 2018 and all staff were being encouraged to complete this. Miss Humber noted that the reduced levels in morale relating to the reconfiguration of bed numbers within the Trust could be reflected in the staff survey results.

Mrs Kavanagh asked whether the percentage appraisal rates in non-clinical staff were measures over a rolling year. Ms Green explained that the figures were looked at over an 18 month period and compliance had increased to over 90%; however work was still ongoing with the divisions.

Mr Nealon noted that the sickness profile reflected that the top reason for sickness absence was Anxiety/stress/depression/other psychiatric illnesses and no longer musculoskeletal problems. Ms Green explained that the Trust had invested in a physiotherapist to work in Occupational Health to assist with musculoskeletal problems and that a new programme was being developed to look at stress related issues but that it was important to note that "stress" could be attributed to stress in the workplace or stress at home.

Finance

Mr Reid reported on month 5 performance, noting that there were positive signs and a continued improvement in the run rate; currently £3.2m, against a target of £2.9m. Mr Reid explained that there were three main areas which have affected the run rate; the Trust is behind on the Cost Improvement Programmes (CIPs); there is a reduced level of elective and planned care activity and also a reduction in the volume of non-elective work.

Work continued to target agency and locum costs and MEDACS were assisting with recruitment to hard to recruit to posts.

Mr Reid confirmed that a clinical audit had been carried out, which sampled non-elective activity, this did not raise any obvious financial issues in relation to the coding of activity carried out by the Trust.

It was noted that £18.8m of CIP had been identified. Mr Friedman provided the Board with an update confirming that a governance had been strengthened; confirm and challenge sessions were now driven centrally with additional internal finance control meetings also taking place. Price Waterhouse Coopers (PwC) had undertaken a Drivers of the Deficit audit which identified a number of opportunities, which could provide in year benefits as well as benefits for 2019/2020. A workforce efficiency steering group had been created to deliver these savings.

Additional work was also being undertaken on expansion of the Cost Improvement Programme (CIPs) pipeline to push the total to £23m in order to gain a minimum of £19m CIPs.

The T3 programme was commencing on 2nd October, it had taken six weeks to implement, a detailed working group had been established and daily panels

would convene to challenge expenditure levels; whilst ensuring that the necessary supplies and services were not obstructed or delayed. Mr Friedman would provide a full update at the next Board meeting.

Mrs Kavanagh noted that the income gap with the CCG was being closed but questioned how this was being balanced with the constitutional standards. Mrs Chadwick-Bell confirmed that it was made very clear at the divisional Integrated Performance Reviews that the Trust must ensure that patient care is paramount and additional waiting lists are instigated where possible but ensuring that income covers the costs of any additional lists; whilst also being aware that waiting list numbers must be reduced.

Mr Reid confirmed that the cash position is strong this is due to a collective grip on payment issues.

Mr Clayton-Smith asked whether there was sufficient management capacity and resource to move the recovery plan forward. Dr Bull confirmed additional resources have been approved to assist with this programme.

The Board noted the IPR for Month 5.

087/2018 **Elective Performance Assurance Submissions to NHSI**

Mrs Chadwick-Bell highlighted the letter received by the Trust from NHSI in August 2018 seeking assurance regarding the delivery of elective care. The NHSI letter and Trust response was included within the Trust Board Papers for information.

088/2018 **Learning from Deaths (Quarter 4)**

Dr Walker advised that the Mortality Reviews had increased to 80% last month; explaining that any cases which are subject to a complaint, Amber investigation or flagged by Bereavement were reviewed by the Mortality Review Group; between 40-50 cases were reviewed every quarter and only a very small number of these cases were considered to be avoidable.

Mr Clayton-Smith questioned whether there should be an aged death review; Dr Walker confirmed that that the majority of these were captured by the Mortality Review Group.

The Board noted the Learning from Deaths Quarter 4 Report.

089/2018 **3+2 and FRP**

Mr Reid confirmed that this was formal noting of the previous discussions held at the recent Board Seminar and that the report detailed the collated issues. The plan was submitted to NHSI and feedback had been received. Mr Clayton-Smith asked whether the report had changed since it's submission to NHSI and Mr Reid confirmed that it had not. Mr Clayton-Smith noted that the Trust Board should approve this but with the caveat that a system plan was required.

Mrs Ashton acknowledged the need to fully engage with regulators, patients, the public and wider in relation to the future plans for the Trust.

Mr Nealon noted that the figures included in the Long Term Financial Model were an indicative target.

090/2018 **Winter Preparedness**

Mrs Chadwick-Bell drew the Trust Boards attention to the full Winter Plan in appendix 1; confirming that Winter Planning occurred year round and that the Trust had developed the Plan in conjunction with the East Sussex Local Health Economy to ensure that the system was able to manage effectively the capacity and demand pressures anticipated during the Winter period.

Mrs Chadwick-Bell confirmed that if activity was at expected levels, then the Trust had enough capacity to meet demand, and that winter funding was in place to open additional beds at Rye Memorial Hospital and Bexhill Hospital; but there were risks and the plan was heavily supported by the system and assurances were sought from external partners in order to deliver this.

Mr Nealon asked whether there were any contractual relationship between the Trust and local care homes. Mrs Chadwick-Bell explained that there were no contracts in place, but there were agreements in place relating to community beds, which are either self-funded or funded by the CCG under continuing healthcare. The Trust could support this but were reliant on external parties.

Mr Reid confirmed that the winter funding money had reduced from £3.1m to £2.1m

The Board noted the Winter Preparedness Report.

091/2018 **Emergency Preparedness, Resilience & Response (EPRR)**

Mrs Chadwick-Bell presented the paper explaining that the Trust had within the last six weeks completed the annual self-assessment; in 2017 the Trust was assessed as partially complaint. Since that time the Trust had recruited a new EPRR Officer and following a substantial work programme it was likely that the Trust will move from “Partially Compliant” to “Substantially Compliant”. A live emergency exercise was being planned for November in conjunction with the Sussex Trauma Network.

The Board agreed that Dr Walker would be the Board Link for EPRR.

092/2018 **Winter Flu-Self Assessment**

Ms Green introduced Mrs Lipsham, Specialist Nurse Manager Occupational Health to the Board who was in attendance to answer any questions from the Board.

Ms Green explained that influenza was a very common, highly infectious illness which could have serious consequences. The Trust was required to offer vaccinations against Influenza to all staff, Ms Green confirmed that last year’s vaccination programme went well. NHSE & NHSI had issued a letter to all Trusts detailing the expectations of the Trust Board to ensure that all front line staff were vaccinated against Influenza, within the letter there was a request that the Trust recorded the reasons if staff choose to decline the vaccination. Ms Green explained that the Trust Board were required to review and agree compliance with the letter.

Mr Clayton-Smith asked Mrs Lipsham what support was required from the Trust Board. Mrs Lipsham explained that support was needed to ensure uptake of the vaccination amongst the Doctors and RGNs, noting that there was greater uptake last year from the AHPs and support workers. Concerns were raised by the Doctors last year regarding the effectiveness of the vaccine and Mrs Carruth confirmed that some RGNs also had very strong views in relation to the

effectiveness of the vaccine.

Mrs Carruth confirmed that both she and Dr Walker would be supporting the campaign, explaining that the vaccine protected not only the person who was vaccinated, but their friends, family and patients that they were in contact with. It was important that staff did not influence other colleagues against receiving the vaccine.

Mrs Lipsham explained that vaccinations would be given to front-line patient facing staff ahead of non-patient facing staff and those who refuse the vaccine will be asked the reason why they have declined.

Mrs Webber asked why the vaccine was not being offered to all staff, Mrs Lipsham explained that the Trust need to ensure that patient facing staff were vaccinated as a priority; but noted that last year's figures showed that non-clinical staff were keen to be vaccinated.

The Board noted the evaluation of the flu programme 2017/18, including data, successes, changes and lessons learnt. The following was supported:

1) Commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and that any healthcare worker who decided on the balance of evidence and personal circumstances against getting the vaccine should anonymously mark their reason for doing so.

2) The Board agreed that Dr Walker would be the Board Champion of the flu campaign.

093/2018 **Infection Prevention and Control and Safeguarding Annual Reports**

Mr Clayton-Smith confirmed that both annual reports had been presented at the Quality & Safety Committee, a sub-committee of Trust Board. Mr Clayton-Smith expressed his thanks to both Miss Redmond, Head of Infection Prevention & Control and Mrs Curties, Head of Nursing (Safeguarding) for their continued hard work and attending the Trust Board.

<u>Infection Prevention & Control</u>

Mrs Kavanagh asked Miss Redmond to explain how communications regarding Infection Prevention & Control and the resulting staff engagement and commitment was monitored. Miss Redmond confirmed that staff engagement to Infection Prevention & Control was measured by regular audits, risk assessments and via the Infection Prevention & Control link programme. Miss Redmond confirmed that ward staff communicate with patients in relation to any Infections and that a number of patient information leaflets were available for patients which provided additional information.

Dr Bull confirmed that he had met with Miss Redmond and Dr Sheehan recently to discuss *Clostridium difficile* and asked whether there were any other measures or actions that the Trust needed to implement to drive appropriate antibiotic prescribing. Miss Redmond confirmed that Communications have issued a "Focus On" document, which was created in conjunction with the Microbiologist to highlight that the duration, review dates and clear documentation of antibiotic prescribing was important. There had also been a Twitter campaign by Medication Education to encourage Doctors to download the Microguide App and the team had received much support following Dr Sheehan attendance at the Senior Leaders Forum.

Miss Redmond also explained that work was ongoing to highlight the importance of hydration in the elderly and those with dementia to help reduce the number of Urinary Tract Infections.

Safeguarding

Mrs Curties was asked to outline the programme that had been developed around self-neglect; Mrs Curties explained that self-neglect could be linked to depression and low self-esteem which could affect younger people and that it did not only affect older people, the Trust was pro-actively engaging with Learning Deprivation in the community to help address this. The Trust were leading the way in rolling out Level 3 Safeguarding training.

Mrs Kavanagh explained that she had recently undertaken a quality walk with the Safeguarding Team and commended the work that they carry out.

Mrs Mason noted the exceptional work carried out by the Trust, asking how these are communicated; both internally and externally to. Dr Walker confirmed that good news stories are highlighted by the communications team who have regular contact with the local press. Mrs Carruth added that the Trust is active on social media and good news stories are also shared within the national collaborative groups. Mrs Carruth also highlighted the good work carried out by the Safeguarding team on human trafficking and modern slavery and that the Trust was constantly pushing the boundaries in moving to "outstanding".

094/2018 **Board Subcommittee Minutes**

The following sub-committee minutes were reviewed and noted:

- POD Committee 11h July 2018

The Minutes were received by the Board

095/2018 **Use of Trust Seal**

Mrs Wells noted that the Trust Seal had been used on three occasions since the last meeting to seal:

- 2nd July 2018 – agreement between Brighton & Sussex University Hospital NHS Trust and East Sussex Healthcare NHS Trust for the lease of ground floor and part of basement at EDGH.

- 2nd July 2018 – agreement between Brighton & Sussex University Hospital NHS Trust and East Sussex Healthcare NHS Trust for lease of land comprising linear accelerator bunkers at EDGH.

- 2nd July 2018 – agreement between Aramark and East Sussex Healthcare NHS Trust for ten year rental of lower ground floor café and ground floor café at EDGH.

096/2018 **Questions from Members of the Public**

Infection Prevention & Control Annual Report
Mr Hardwick asked whether *pseudomonas* was linked to Legionella and Mrs Carruth and Dr Walker explained that *pseudomonas* was a bacteria which led to infection. It commonly occurred in large buildings not just hospitals and that it is found in standing water; as there is less standing water within a family home there is less of a risk to the general public. The Estates & Facilities team undertook regular audits which included the reporting of both *pseudomonas* and legionella levels.

Influenza Vaccination
Mr Hardwick noted that the front line medical staff were prioritised when vaccinating staff at the Trust and asked whether this included housekeepers and volunteers. Ms Green confirmed that it did; any staff who had direct contact with patients would be offered the vaccine as priority.

Health Care Assistants
Mr Hardwick asked the Trust Board if they could explain what the requirements of a HCAs were and whether it was similar to the form State Enrolled Nurse role.. Mrs Carruth confirmed that HCAs are unregistered staff, who support nurses, but made it clear that this was not to say that they are unqualified; HCAs are very capable members of staff who receive a high level of training and are an essential part of the workforce. Mrs Carruth confirmed that there were ongoing discussions as to whether the role of HCA would move to a formal registration in the future.

097/2018 **Date of Next Meeting**
Tuesday 4th December, St Mary's Boardroom, EDGH

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 2nd October 2018 Trust Board Meeting

There are no matters arising from the Trust Board meeting on 2nd October 2018.

Quality Walks September October 2018

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	5
Meeting:	Trust Board	Reporting Officer:	Lynette Wells

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

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

Summary:

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

21 services or departments have received visits as part of the Quality Walk programme by the Executive Team between 1st September and 31st October 2018. In addition to the formal programme the Chief Executive has also visited 18 wards or departments and staff groups. A summary of the observations and findings noted are detailed in the attached report.

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

None

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

The Board are asked to note the report.

QUALITY WALKS REPORT, SEPTEMBER OCTOBER 2018

Introduction

Quality Walks are carried out by Board members and can be either planned or on an ad hoc basis. They are intended to provide an opportunity to observe and review care being delivered, listen to feedback from patients, visitors and staff, observe different roles and functions and afford assurance to the Board of the quality of care across the services and locations throughout the Trust. The process enables areas of excellence to be acknowledged, risks to be identified, allows staff the opportunity to meet and discuss issues with members of the Board and for them to gain a fuller understanding of the services visited.

Analysis of Key Issues and Discussion Points Raised by the Report

The following services or departments were visited as part of the Quality Walk programme by the Executive Team between 1st September and 31st October 2018. In addition the Chief Executive also visited several departments and staff groups.

Date	Service/Ward/Department	Site	Visit by
3.9.18	Health Visiting Team	Peacehaven	Vikki Carruth
4.9.18	Mouth Care Matters Team	Conquest Hospital	Jackie Churchward-Cardiff
11.9.18	Estates Team	Eastbourne DGH	David Clayton-Smith
12.9.18	Egerton Ward	Conquest Hospital	David Walker
19.9.18	Tressell Ward	Conquest	Jackie Churchward-Cardiff
26.9.18	Vascular Access Team	Conquest	Monica Green
4.10.18	Health Visiting Team	Eastbourne	Monica Green
8.10.18	Estates Team	Conquest Hospital	Jonathan Reid
9.10.18	Surgical Admissions Unit	Conquest Hospital	Jackie Churchward-Cardiff
10.10.18	Radiology Department	Eastbourne DGH	Monica Green
11.10.19	Diabetes and Endocrinology Dept.	Conquest Hospital	Lynette Wells
15.10.18	Stroke Unit	Eastbourne DGH	Catherine Ashton
16.10.18	District Nursing Team	Hailsham Health Centre	Miranda Kavanagh
17.10.18	Folkington Ward	Eastbourne DGH	Monica Green
18.10.18	Berwick Ward	Eastbourne DGH	Monica Green
22.10.18	Baird Ward	Conquest Hospital	Monica Green
22.10.18	Electrical Medical Engineering Dept.	EDGH	Jonathan Reid
23.10.18	Decontamination Unit	EDGH	David Clayton-Smith
29.10.18	Mirlees Ward	Conquest	Jonathan Reid
31.10.18	Elective Booked Admissions Team	Conquest	David Clayton-Smith
31.10.18	Endoscopy	Conquest	Lynette Wells

All of these visits were pre-arranged and the Ward or Department Manager notified in advance to expect the visit, other adhoc visits may also have taken place.

Where feedback from the Executive Team has been received this has been passed on to the relevant managers for information.

Key Themes and Observations

Communication and Engagement

- The Eastbourne Health Visiting team are all now based together and reported that this is a really positive initiative as there is integration within the wider team and also with staff that work for social services.
- The Vascular Access Team_reported good communication with other nurses in the Trust and were praised by colleagues within the hospital and community for the training they offer.

- One of the Frailty wards commented that coordination with neighbouring Local Authorities is time consuming and protracted and that there are often patients waiting resettlement or packages of care from Kent and Surrey.

Incidents, Risks and Safety Issues

- The Mouth care Matters service has been funded by KSS and Health promotion but this will end in March 2019. There is a risk that if not funded the substantial improvements for patients that has been achieved will not be sustained.

Environment, Equipment and IT

- Several wards are now recognised as feeling 'dated' and can be cluttered due to lack of storage space.
- Staff also report that PCs are slow and often freeze which makes loading systems such as E-searcher that finds patients past details protracted and inefficient. Staff felt that even when reported there is little remedy or improvement to IT issues.

Staffing

- Most staff spoken to seemed positive about their working environment even though wards and services are very busy. They also cited good support from matrons and managers.
- Staff on one ward that had been through a recent consultation period in relation to the ward transformation programme were still experiencing the changes that this had brought but commented that although the change period had been difficult for them on the whole they felt quite positive about the future. However on another affected ward it was reported that some staff had left as a result.
- Good team working was reported between health visitors, social services staff and nursery staff. They reported some issues relating to different IT systems but felt co-location has helped with this.

Good Practice / Service redesign

- The Implementation of the Mouth care Matters initiative has raised the importance and profile of mouth care with numerous plaudits from patients and their families.
- The role of the ward orderly was cited as a good example of a change in ways of working, and that it has become very important to overall team working and delivery of care.
- In Radiology there has been a redesign of the reception area and the move of the radiology office to a new purpose built area. Excellent feedback was given about this move both in terms of the impact on staff wellbeing and on patient care.

Education and Training

- Staff reported that time for clinical supervision is limited but there is a strong wish to increase time for staff development, mentorship and clinical training.
- The Surgical Admissions Unit reported positive feedback from student nurses about their placements in the department and the degree of support available and in addition nurses from overseas reported a positive experience.

Patient feedback

- Patients spoken to felt there is a commitment to good care with a reassuring environment for patients, and that the food was great. One commented that her mother was receiving great care and that the staff were like a family.

Risks and Implications

Any risks identified are acted upon and escalated to the risk register as appropriate. Any actions identified at a Quality Walk are agreed at the time and noted who will be responsible for taking forward the action.

POD Committee 7th November 2018 Executive Summary

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	
Meeting:	Trust Board	Reporting Officer:	Miranda Kavanagh

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

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

Summary:

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

Executive summary attached for POD Committee meeting held on 5th December 2018.

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

N/A

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

The Board are asked to note the contents of the attached executive summary.

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

1. Introduction

Since the Board last met a POD Committee meeting was held on 7th November 2018. A summary of the items discussed at the meeting is set out below.

2. Review of Action Tracker

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

3. Workforce Resourcing

Workforce Plan linked to Clinical Strategy

The Committee received a presentation of the Workforce Plan from the Deputy Director of HR who commended members of staff for collaborative working, bringing all departments together resulting in a Workforce Resourcing Plan. It was noted that this was the first draft of the plan, which would be submitted in draft format to NHSI on Friday 21st December 2018.

The workforce action plan is a key output of the Workforce Efficiency Group and sub-groups and is a process of continuous improvement to incorporate workforce initiatives over the 5 year period.

Financial Recovery Workforce Efficiency Programme Steering Group

The Committee received a presentation of the Workforce Efficiency Programme Steering Group from the Deputy Director of HR. This report had also been shared at the Financial Improvement & Sustainability Committee (FISC) on 24th October 2018. MT referred to page 2 of the report which provided figures to date and highlighted that there had been an increase in spend on substantive pay, local and agency; spend was over-budget for this month. Key leads had been allocated to each workforce scheme, which linked in to the Workforce Plan.

4. Workforce Development

Leading Excellence / Leading Service evaluation

The Committee received a verbal overview of the Leading Excellence / Leading Service evaluation from the Assistant Director of HR – OD. Once formal evaluation had been received, a formal paper would be written and shared.

The contexts of the programmes were summarised; these had been aimed at band 7 and above, not designed as a remedial piece of work but recognising leadership skills. A training needs analysis had been undertaken; focus groups set up as well as 1:1s looking at what was to be identified as the real focus of these programmes.

Training Needs Analysis

The Committee received a verbal overview of the Training Needs Analysis from the Assistant Director of HR – Education; the report was presented by Nicky McCrudden, McCrudden Training. The training needs analysis was undertaken to support and develop a learning culture that would underpin ESHT being outstanding by 2020.

The methodology of the survey had taken into consideration internal and external policies, communicated with a number of key informants across the Trust, which had informed the development of the survey. The survey had been distributed via the staff newsletter, in person and had been communicated via matron's meetings. Three different ways had been offered to return the survey; on-line, email or hard copy. Over all there was a 60% response rate of questionnaires received.

Health & Wellbeing Plan

The Committee received a presentation of the Health and Wellbeing Plan Strategy from the Assistant Director of HR - OD. The purpose of the strategy is to provide a co-ordinated approach to building on existing work to create a healthy and positive environment for staff and service users. The strategy is based on national strategy and links to mental health and health promoting trusts.

5. Quarterly Report from the Guardian of Safe Working

The Committee received a presentation of the Quarterly Report from the Guardian of Safe Working from the Acting Medical Staffing Manager.

The Trust has peaks in-patient admissions leading to sustained high workload for doctors. Where there is a doctor breaching 48 hours over the rota reference period the GOSWH will issue fines to the divisions for these breaches. The money from the fines is placed in a fund for the support of trainee's education and working environment. These fines to be used for training courses, equipment, and exam fees. It was noted that there was potentially an underreporting of breaches which would warrant exception reporting.

6. POD Annual Report

The Committee received a presentation of the POD Annual Report from the Director of Corporate affairs. Members of the committee had fed back their review of the committee's effectiveness via a set of questions used for Board Committees. The feedback was positive with the areas that people felt could be improved were:

- The structure of the agenda
- Moving the focus on to strategic and organisational development

It was agreed to review the work plan.

7. Feedback from Sub Groups

The Committee received a written update from each of the sub-groups; Engagement & OD Group, Education Steering Group, Workforce Resourcing Group and HR Quality & Standards Group.

Approved minutes of the meeting held on 5th September 2018 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee

7th November 2018

Board Assurance Framework

Meeting information:			
Date of Meeting:	4th Decmber 2018	Agenda Item:	7
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Summary:

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

Attached is the updated Board Assurance Framework (BAF). Revisions to the BAF are shown in red. There are no additions or proposals to remove gaps in control or assurance from the BAF this month. The Board are asked to consider the following revisions to scoring:

2.1.3 Amber to green – this relates to the tracking of patient follow up as an electronic system is now in place.
4.2.1 Amber to red - due to significant pressure on capital

There are two areas rated red – 2.1.1 in respect of delivery of the 62 day cancer metrics and 4.1.1 in relation the to the Trust's financial position.

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

Senior Leaders Forum reviewed all risks in detail – 17th October 2018
Quality and Safety Committee – 14th November 2018
Audit Committee – 28th November 2018

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

The Trust Board is asked to review and note the revised Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks. The Trust Board is asked to consider that 2.1.3 is moved from amber to green due to increased assurance levels and 4.2.1 from amber to red due to reduced assurance levels.

Assurance Framework - Key

RAG RATING:

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

Status:

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

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

C indicated Gap in control
A indicates Gap in assurance

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

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

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

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/milestone**	**RAG**	**Lead**	**Monitoring Group**
1.1.1	A	Quality improvement programme required to ensure trust is compliant with CQC fundamental standards.	Mar-17 CQC Report published end of Jan 17. Trust rating moved to 'Requires Improvement' Good progress evidenced in a number of areas however 2 must do actions and 34 should do actions to address. Programme of improvements in place. May-17 Good progress in implementing CQC actions. Mock inspections planned for May-17 Jul-17 Action tracker in place and monitored with divisions and at Q&S. New CQC regulatory guidance being reviewed and communication plan developed to ensure Trust can evidence compliance. Sep-17 QIP with focus on programmes of work. Continued monitoring of action tracker, internal inspection planned for 21 Sept. CQC progress meeting took place 22 Aug awaiting feedback on scope and timetable for inspection Nov-17 Inspection anticipated early 2018. Tracker being strengthened and prep group meeting. Community mock planned for Nov. Jan-18 Ongoing preparation for inspection. CQC information request completed Dec 2018. CQC first focus groups also taken place. Mar-18 CQC inspection 6/7 March core services and 20/21 Mar Well Led, expect draft reports by end of May May-18 Draft report received and factual accuracy checks taking place Jul-18 CQC inspection report published; significant progress made in all areas inspected. Trust removed from Special Measures for Quality. Action plan developed for Must and Should Do identified by CQC. Ongoing work to continue with quality improvement to achieve "Outstanding" by 2020. Sep-18 Framework being developed in respect of what constitutes "outstanding" - review being undertaken to ensure consistency and strengthen divisional governance structures. Nov-19 Ongoing work to develop framework as outlined above. "HealthAssure" module being piloted across the Trust to support evidencing compliance with CQC core standards. Mock inspections planned for both A&E departments in November/December.	end Dec-18	◄► Jul-19	DN / DCA	Q&S SLF

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.	
Risk 2.1 We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.	
Key controls	Robust monitoring of performance and any necessary contingency plans. Including: Monthly performance meeting with clinical units Clear ownership of individual targets/priorities Daily performance reports Effective communication channels with commissioners and stakeholders Healthcare Associated Infection (HCAI) monitoring and Root Cause Analysis Single Sex Accommodation (SSA) processes and monitoring Regular audit of cleaning standards Business Continuity and Major Incident Plans Reviewing and responding to national reports and guidance Cleaning controls in place and hand hygiene audited. Bare below the elbow policy in place Monthly audit of national cleaning standards Root Cause Analysis undertaken for all IC outbreaks and SIs and shared learning through governance structure Cancer metric monitoring tool developed and trajectories for delivery identified, part of Trust Board performance report. Clinically led Cancer Partnership Board in place
Positive assurances	Integrated performance report that links performance to Board agreed outcomes, aims and objectives. Exception reporting on areas requiring Board/high level review Dr Foster/CHKS HSMR/SHMI/RAMI data Performance delivery plan in place Accreditation and peer review visits Level two of Information Governance Toolkit External/Internal Audit reports and opinion Patient Safety Thermometer Cancer - all tumour groups implementing actions following peer review of IOG compliance. Consistent achievement of 2WW and 31 day cancer metrics

Gaps in Control (C) or Assurance (A):	Actions:	Date/ milestone	RAG	Lead	Monitoring Group

2.1.1	C	Effective controls required to support the delivery of cancer metrics and ability to respond to demand and patient choice.	Mar-18 – 62 day performance remains a challenge, on-going operational improvement work, capacity and demand and pathway analysis and improvement. Operational cancer board established and service managers to be prioritised to focus on cancer, with financial and RTT. Remains amber due to 62 day performance delivery. May-18 – demand for colorectal, breast and urology 2ww has been exceptional and as such is impacting delivery across all cancer standards in these specialties. Governance systems and actions plans are in place, with demand analysis being undertaken by the CCG and Trust. An additional role is being developed to support the DAS services to take swift actions to ensure patients booked and capacity established. A twice weekly meeting is in place with ADOs and CCGs, with the COO. Jul-18 62 day remains challenged particularly for colorectal and urology; additional adhoc activity continuing in both services. New Cancer Matron to be appointed in July to support surgical pathways. Contract Performance notice issued against 62 day performance; additional weekly OPEX call in place to monitor short term action plan. SCR upgrade to enable accurate monitoring of 38 day standard scheduled for deployment week commencing 16th July. Sep-18 NHSI High Impact Actions reviewed and are being incorporated into a revised recovery plan. Urology service has re-designed their pathways and capacity to meet Cancer and RTT targets, full implementation due March 19, but will require completion of the UIS. Colorectal implementing new 'straight' to test' pathway from September. New Cancer tracking Matron in post in DAS. Demand for some tumour sites has remained above plan and hence a review of demand and capacity taking place. Nov-18 A revised recovery plan is being drafted for submission to NHSI and will be sent to Q&S committee for assurance. PTL formats are being revised from Nov and management of the corporate team is moving to the Associate Director of Performance in Dec (interim with the Deputy COO). Capacity and demand analysis being undertaken as well as re-design of patient pathways.	end-Mar 19	Oct-18 ▼	COO	Cancer Operational Board and IPRs

Strategic Objective 2: We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.							
Risk 2.1 Continued - We are unable to demonstrate that the Trust's performance meets expectations against national and local requirements resulting in poor patient experience, adverse reputational impact, loss of market share and financial penalties.							
Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.2	C	Effective controls are required to ensure increasing numbers of young people being admitted to acute medical wards with mental health and deliberate self harm diagnoses are assessed and treated appropriately.	Jul-Nov 17 Ward nurses having mental health training currently as part of away days. Special Observations Policy ratified and specials being requested ad hoc. Paediatric strategic work including mental health in reach plan. Meeting arranged end Sept to review issues. Audit of children admitted to the paediatric ward with mental health diagnosis complete. Jan-18 Audit presented, confirmed children with mental health difficulties primarily present after 4pm and so the majority cannot be assessed until the following day by the mental health nurse. These children require a hospital bed until the assessment is undertaken. Mar-18 Met CAMHS Feb and shared audit results. Acknowledged there is a need for this cover into the evening. Trust to provide numbers of children presenting at ED after 16h00 needing this input to CAMHS who will then put together a business case for extended cover. May/Jul 18 Division are assured adequate Trust controls in place now and are applying for the HEE "we can talk" project to further enhance the skills and competencies of the ward staff. Sep-18 A number of mitigations in place including on site MH (CAHMS) Liaison on both sites Monday – Friday 9am – 5pm which has significantly improved access for MH reviews, Ongoing discussions with SPFT with regards to the provision of on-site support until 22.00hrs. The on call service runs well out of hours, however as it covers the whole of Sussex, there can be a significant wait for review out of hours CAMHS commissioner agreed to write a business case for increased on-site provision from 17.00 – 22.00hrs, ESHT have not had sight of this BC to date. For children admitted there is availability for review on both sites, however if an Eastbourne child is admitted to the Conquest Hospital, this review is by telephone as routine, however Hastings children have a physical review, this does cause disparity for Eastbourne and Conquest children and is an ongoing issue Eating Disorder and in-patient bed availability remains an issue across the country Training continues for staff as indicated Nov-18 Continual monitoring and concerns being flagged with commissioners	end Dec-18	◄►	COO	SLF Q&S
2.1.3	C	Effective controls are required to monitor and formally report on follow up appointments in order to ensure there is no clinical risk to patients suffering a delay.	Mar -Nov 17 Inability to formally extract data from Oasis PAS to report on patients follow up by time period. Local systems in place but require Trust wide system for monitoring and analysis. Liaising with supplier regarding options for reporting Position resolved with community paediatrics due to data transition to Systm One. All doctors validating Follow Up waiting lists and telephone Longest waiter 36 weeks (Aug. 17). IT reviewing to develop a follow up waiting list that can be easily complied from existing systems and monitored at a specialty/consultant level for volumes and timeframe for appointments. E system still under development but as a mitigation data re non appointed follow ups (within clinically defined timeframes) is sent to all service managers weekly for action. Jan-Mar 18 PAS team commenced work on e-follow up database; aim to complete by end May18. Clinical Admin service continues to appoint at requested time and where unable to do so highlights this information to the service managers on a weekly basis. May-/July 18 Development of the database sits within Outpatient Improvement Project and has been delayed due to capacity within the PAS team/overlap with PAS Upgrade project. Scheduled for full go live by end August 18. In the interim above arrangement applies and in addition we are also able to run reports on any follow up appointment cancelled by hospital or patients. On track for end Aug go live as outlined above. Sept-18 Database developed and populated in all areas except Oncology (interim system already in place),T&O, Haematology & cardiology. There will be a transition period to clear backlog in all specialties and link up patient who FU has been booked and then cancelled, expected to be complete by Spring 2019. Nov-19 No longer reliant on paper system - all specialties that should be are on the system and all patients requiring follow up appointment on system. Currently validating and risk stratifying follow up lists. Propose to move to Green	end Mar-19	◄►	COO	SLF Q&S

Risk 2.2 There is a lack of leadership capability and capacity to lead on-going performance improvement and build a high performing organisation.					
Key controls	Clinical Unit Structure and governance process provide ownership and accountability to Clinical Units Clinicians engaged with clinical strategy and lead on implementation Job planning aligned to Trust aims and objectives Membership of SLF involves Clinical Unit leads Appraisal and revalidation process Implementation of Organisational Development Strategy and Workforce Strategy National Leadership and First Line Managers Programmes Staff engagement programme Regular leadership meetings Succession Planning Mandatory training passport and e-assessments to support competency based local training Additional mandatory sessions and bespoke training on request				
Positive assurances	Effective governance structure in place Evidence based assurance process to test cases for change in place and developed in clinical strategy Clinical engagement events taking place Clinical Forum being developed Clinical Units fully involved in developing business plans Training and support for those clinicians taking part in consultation and reconfiguration. Outcome of monitoring of safety and performance of reconfigured services to identify unintended consequences Personal Development Plans in place Significant and sustained improvement in appraisal and mandatory training rates				
Gaps in Control (C) or Assurance (A):	**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
No gaps in control or assurance escalated to BAF					

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	A	Assurance is required that the Trust will be able to develop a five year integrated business plan aligned to the Challenged Health Economy work.	Jul-Dec 17 Our System wide placed based plans (ESBT) are the local delivery plan that aligns commissioners and providers in health and social care. We have undertaken significant work across the system to redesign care pathways and this is linked to our clinical strategy which is currently being consulted on. Work is ongoing with the wider STP work to review pathology provision along with other acute services. Working with commissioners on aligned financial and operational plan to move system to a balanced financial position. Will be agreed by Alliance Exec and progress against plan monitored by this group. Work commencing on Acute strategy with support from the WSHT/BSUH Medical Director and our own Medical Director. Will align with Tertiary currently being developed by BSUH. Work ongoing with commissioners and NHSi to agree and align our long term financial position and operational plan. Planning for 18/19 progressing with divisional teams with regular updates provided to FISC Jan-May 18 Work ongoing to develop long term financial model alongside work to provide assurance on the 18/19 financial and operational plans. The new format of leadership briefing will provide the opportunity for Executive Team to brief the organisation on the progress with our plans. Currently meeting the milestones for 18/19 planning which will feed into the longer term IBP . Jul-18 First phase of the Long term financial plan and associated work on clinical sustainability is now complete and will be discussed at Trust Board seminar in July. This work has been shared with commissioners and NHSI whilst in development. Sep-18 A draft integrated (ESHT and CCGs) sustainability plan was submitted to NHSI and NHSE at the beginning of September 2018. A further more detailed iteration of this is being prepared for submission in November 2018. The request from our regulators to prepare and submit integrated plans is a key mitigation to alignment of Trust and commissioner plans and to developing an integrated plan to achieve system sustainability. Nov-18 Integrated Plan being developed for consideration at Board to Board and final submission to regulators by 20 December timescale	end Dec-18	◄►	DS	F&I SLF

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

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

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

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
3.3.1	C	Effective controls are required to ensure the Trust achieves compliance with the four core 7 day service standards by 2020. There is a risk that the Trust may not achieve compliance with three of the four resulting in loss of reputation due to difficulties in funding, staff recruitment to manage increased rota requirements. Standards 5 (access to diagnostic tests), 6 (access to specialist consultant led interventions) and 8 (Patients with high-dependency care needs receive twice or one daily specialist consultant review depending on condition) are those at risk.	7 Day Service Steering Group established. PMO project support with dedicated project lead assigned. PID agreed by 7DS steering group. Working closely with NHSE/NHSI to gain best practice/lessons learnt from other Trusts also liaising with neighbouring Trusts (MTW, EKH) Baseline template to be reviewed prior to distribution, gap analysis underway. Sep-18 7DS Steering group met in Sept. Participating in regional STC 7DS collaboration event on 25th Sept. • Documentation requirements relevant to 7DS (Esp standards 2, 8) included in induction for new medical staff in August and email communication also sent to existing staff. • Further Grand Round presentations made to medical staff in Aug/Sept on 7DS core standards, the Trust's performance in the national audits and what needs to be done by clinical teams and individuals. • Requirements for 7DS form part of the remit in the financial recovery planning (streams) and clinical strategy at Trust and Divisional level. Standard 2 - Feedback given to Divisional core teams and clinical specialty leads on detail of performance in April audit; particularly where teams are failing to achieve. • AMU consultant presence at weekends strengthened, with regular presence at EDGH and, from next month also at Conquest at both sites Standards 5 / 6 - Changes in medical consultant on call rotas made (from 1st Oct) to support 24/7 endoscopy service diagnostic and therapeutic). Endoscopy nursing support still to be fully upgraded • Radiology working on radiographer work patterns to increase scope of weekend ultrasound service. • Signposting information on how to access specialist services inside and outside the Trust (eg renal, neurology/neurosurgery, radiotherapy) now in induction and in place on all wards and Trust intranet. Standard 8 - Feedback from initial pilot being analysed. Teams continue with acuity assessment and review delegation on ward whiteboards. • The Trust is bidding for funds to enable electronic whiteboards with real time patient tracking. Exploration of whether these can also be used to document acuity and delegation of review. • Procurement process to replace current clinical information systems is proceeding. Clinical engagement being sought for determining functionality requirements. • Roll out of Careflow (part of the VitalPAC software suite) as handover and task management tool. • Audit in Aug of frequency and participants in board/ward rounds for all acute hospital wards. Results currently being analysed. Nov-18 April 18 Audit showed improvement in standards 5,6 and 8 but deterioration in standard 2 (69 to 58%) Raising awareness of documentation requirements and ensuring clinical staff identified in case notes. NHSI/E site visit 31 Oct	end Dec-18	◄► Jul-17	COO	SLF Q&S

Risk 4.1 We are unable to adapt our capacity in response to commissioning intentions, resulting in our services becoming unsustainable.

Key controls	Clinical strategy development informed by commissioning intentions, with involvement of CCGs and stakeholders QIPP delivery managed through Trust governance structures aligned to clinical strategy. Participation in Clinical Networks, Clinical Leaders Group and Sussex Cluster work Modelling of impact of service changes and consequences Monthly monitoring of income and expenditure Accountability reviews in place PBR contract in place Activity and delivery of CIPs regularly managed and monitored.
Positive assurances	Trust participates in Sussex wide networks e.g. stroke, cardio, pathology. Written reports to SLF on progress with QIPP targets to ensure improvements in patient outcomes are planned and co-ordinated. Performance reviewed by senior management and considered at Board level. Evidence that actions agreed and monitored. Decrease in medical admissions at CQ continued and new practice being developed at EDGH (medical input is key)

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.1.1	C	Ongoing requirement for assurance on the controls in place to deliver the financial plan for 2018/19 and achieve efficiency targets leading to a reduction in deficit for the Trust and exit from financial special measures.	May-18 – Trust has submitted an initial financial plan with a deficit of £47.9m for 2018/19. This has a CIP target of £23.5m, but the Trust has identified a minimum ask of £18.2m and no contingency to deliver the plan. The plan has not been accepted by NHSI who are requiring as a minimum a deficit of £40m for 2018/19. The Trust has identified £28m of pipeline CIP schemes, but to date only £13m are 'green,' leaving a £5m challenge. External support from PA Consulting is in place to bring forward the balance of schemes. The Trust is revisiting the financial plan assumptions to establish options for improving the financial plan. The PSO and programme support arrangements have been refreshed for the new financial year, and the Trust is seeking to appoint a Recovery Director to support the delivery of the programme into 2018/19. Jul-18 NHSI have provisionally accepted the refreshed plan for 2018/19, which aims for a deficit of £44.9m and requires a minimum efficiency challenge of £19.2m. The Trust is working closely with PA Consulting and the Clinical Units to secure up to £23m of efficiency savings, and ensure delivery of the minimum requirement of £19.2m. As at M3, the identified pipeline is £29m, but only £15.5m of schemes are identified as green – with a route map in place to secure the balance. The Trust has appointed a Recovery Director, who commences work on 9th July, aimed at supporting delivery of the financial plan. At Month 2, and again at Month 3, the Trust is delivering plan, but with considerable additional activity, and hence income above baseline plan. Sep-18 At Month 5, the Trust has secured a further improvement in run-rate to £3.2m deficit. This is behind plan, but is consistent with delivery of the financial plan with continued focus through the balance of the year. The new Recovery Director is supporting the Trust with intensive work to ensure both an increased pipeline of efficiency schemes, and to move the balance of 'green' CIP from the current £19m to £23.2m. Income for the Trust is considerably above baseline plan, due to significant growth in non-elective activity – and this represents both a challenge to delivery of efficiency schemes and a payment risk. The Trust is working closely with CCGs and NHSI/E to develop an appropriate response to the emergency activity levels, and to understand the financial implications. Confirm & Challenge sessions are in place for all Clinical Units to support delivery of the CIP programme, and the DoF is holding control total review meetings with CUs and specialties to monitor overall financial performance, with issues from both streams escalated to the Executive Team as appropriate. Nov-18 At Month 6 Trust run-rate moved from £3.2m to £4.3m. However, this was a planned reduction, reflecting a shorter working month. Overall, the Trust performance against plan improved in month, with an adverse variance of £699k against plan at Month 6. The Trust is moving towards a formal agreement on income for the year with clinical commissioners and, as a result, is refreshing the full year forecast. The level of financial risk for the year end position has been calculated at £6m, and a full reforecast has been presented to the Finance and Investment Committee, with specific identified mitigations to be updated at Month 7. The Trust is forecasting full delivery of the financial plan, and will continue to review options and mitigations to ensure that this happens.	Commenced and on-going review and monitoring to end Mar-19	◄►	DF	F&I

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

Key controls	Development of Integrated Business Plan and underpinning strategies Six Facet Estate Survey Capital funding programme and development control plan Capital plans operational review on a monthly basis by the Capital Review Group, and detailed review by the Finance and Investment Committee, on behalf of the Board, on a monthly basis. Essential work prioritised within Estates, IT and medical equipment plans
Positive assurances	Draft assessment of current estate alignment to PAPs produced Essential work prioritised with Estates, IT and medical equipment plans. Significant investment in estate infrastructure, IT and medical equipment required over and above that included in the Clinical Strategy FBC. Capital Approvals Group meet monthly to review capital requirements and allocate resource accordingly. Trust achieved its CRL in 2016/17

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.2.1	A	The Trust has a five year plan, which makes a number of assumptions around external as well as internal funding. Assurance is required that the Trust has the necessary investment required for estate infrastructure, IT and medical equipment over and above that included in the Clinical Strategy FBC. Available capital resource is limited to that internally generated through depreciation which is not currently adequate for need. As a result there is a significant overplanning margin over the 5 year planning period and a risk that essential works may not be affordable.	Jan-18 – Month 9 the Trust spent £7.9m of the full capital programme – significantly less than planned at this point in the financial year, reflecting the challenges in delivering capital projects in the context of significant operational pressures. The Capital Review Group undertaking full review of remaining capital expenditure in Q4, to present a refreshed forecast to the Finance and Investment Committee. Detailed work on the long-term capital plan continues, with a five year plan anticipated before end of Q4 for presentation to F&I. Mar-18 – Overall capital plan for year will be on budget; budget has increased from £11m to £15m as a result of successful capital bids by clinical and operational leaders across the Trust. Work commenced on the development of the 2018/19 capital plan with a broadly-based prioritisation process. At the same time, the Trust has to finalise the five year capital plan. Key risks include overall financing for the capital programme, and the early finalisation of the fire strategy business case – both of which will be presented in outline to the Mar F&I May-18 – The Capital Plan for 2018/19 has been refreshed, with a further iteration being considered at May 2018 Finance and Investment Committee – to be followed by a refresh of the five year financial plan in June 2018. Jul-18 – The level of capital spend at Month 1-3 is below plan, reflecting the strategy of carefully managing capital approvals until the financial arrangements for each component of the plan are secured. The Trust is making good progress with a number of key stakeholders to secure the additional capital investment for the MRI and estates works, and it is anticipated that NHSI approval for the capital loan agreements will be sought in August with the aim of reaching agreement in September. Sep-18 Trust has two capital bids with NHSI (for MRI approvals, and medical equipment), a bid with the STP for fire remediation work, and a bid to NHS Digital for EPMA investment. Capital programme remains oversubscribed, but receipt of loan funding would support delivery of the key infrastructure improvements required across the organisation. A 'plan B' is in development to ensure that, in the case of non-receipt of the various loans, the Trust can deliver the capital budget within national target levels, and that any clinical or operational impact is mitigated. This will be provided to the Sept Finance and Investment Committee for review, following executive review and agreement. Nov-18 The Trust is holding all capital programmes, other than those with immediate clinical impact, without further investment until the outcome of the capital review process is completed. The Trust has made a number of iterations of the business cases with NHS Improvement and continues to work closely with regulatory colleagues All capital budget-holders are reviewing their full year forecasts in detail and are seeking to minimise future capital spend over the remaining months of the financial year. The Trust remains committed to delivering the capital plan, but there are significant risks to the overall budget being carefully managed within the Capital Review Group. On-going review and monitoring to end Mar-19. Proposal to move gap in assurance to red.	On-going review and monitoring to end Mar-19	◄►	DF	F&I

Gaps in Control (C) or Assurance (A):			Actions:	Date/ milestone	RAG	Lead	Monitoring Group
4.3.1	C	Adequate controls are required to ensure that the Trust is compliant with Fire Safety Legislation. There are a number of defective buildings across the estate and systems which may lead to failure of statutory duty inspections. This includes inadequate Fire Compartmentation at EDGH	Sept - Dec 17 Programme behind schedule as unable to decant wards and asbestos issues. Fire doors replaced and stairwells upgraded. Meeting with ESFRS 6 Nov. Jan-Mar18 Full survey and supporting information provided to ESFRS. Business case presented at the board seminar in Dec, resulting amendments to be incorporated. Seaford and Hailsham areas surveyed and reports and plans produced. Survey identified fire walls in areas previously thought to be deficient of them. The walls roughly reflect Ward areas. Surveys commissioned to identify the breaches and pictorial evidence sourced. ESFRS visited Feb-18 to check on progress. advised that breaches in both areas will be rectified by the end of May 2018. As there has been a reduction in risk the opportunity for an enforcement notice has decreased but is still being considered. Business case for investment to introduce new smaller fire compartments at EDGH will be presented to the F&I committee in Mar-18. May-18 Fire compartmentation business case developed, Board review Jun-18 before submission to NHSi. Fire stopping works being carried out to reduce the size of the Seaford and Hailsham fire compartments in line with the recommendations by ESFRS. ESFRS visited 10th May and were impressed by standard of work now being completed by third party certified contractors.They will be seeking Trust permission to use ESHT as a best practice model in this subject. Seaford and Hailsham areas are due to be completed by the end of June18. Jul-18 ESFRS visited 28th of June and noted Trust efforts to achieve targets; impressed by the standard of fire stopping work noting the high standard of remedial works. Seaford and Hailsham on track for completion by the end of June18 when the risk of fire spread will be considerably lower. Business case drafted, approved by F&I and submitted in the STP wave 4 bids @ £11.16m. Sep-18 Works were substantially completed by Mid July and ESFRS have been updated with regular meetings and have noted progress made within a letter to the Trust. One final piece of work needs to be completed and is proving difficult due to access issues, once complete ESFRS "project closure" meeting will be held. Nov-18 Initial works completed as planned and meeting to update ESFRS on progress to date is due early Nov 18. Business case to NHSI for funding being submitted.	end Dec-18	Sep 17 ◄►	CEO	Audit Committee

Risk 4.4 We are unable to respond to external factors and influences and still meet our organisational goals and deliver sustainability.	
Key controls	Horizon scanning by Executive team, Board and Business Planning team. Board seminars and development programme Robust governance arrangements to support Board assurance and decision making. Trust is member of FTN network Review of national reports Clear process for handling tenders/gathering business intelligence and mobilisation or demobilisation of resources Participating in system wide development through STP and ESBT Alliance Strategy team monitoring and responding to relevant tender exercises Anti-virus and Anti-malware software Client and server patching NHS Digital CareCert notifications Data Security and Protection Toolkit (DSPT)
Positive assurances	Policy documents and Board reporting reflect external policy Strategic development plans reflect external policy. Board seminar programme in place Business planning team established SESCSG Sussex and East Surrey Cyber Security Group

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
4.4.1	C	Adequate controls are required to minimise the risks of a cyberattack to the Trust's IT systems. Global malware attacks can infect computers and server operating systems and if successful impact on the provision of services and business continuity.	Jan-Mar 18 Action plan published Jan-18. Reviewing IT Security Systems. Phishing email simulation software in place and simulation being undertaken. Funding approved by Sussex COIN board to implement DNS security across Sussex COIN. Will require a long term sustained programme of work to deliver assurance that threats from cyber-attacks are adequately controlled. Ongoing development and implementation of action plan, progress presented to IG Steering Group. May-Jul 18 Workstreams to ensure adequate controls in place. STP wide Cyber security framework being proposed; aim to adequately address security concerns. Patching policy developed and approved. More aggressive patching regime for PCs and laptops in place, aim to be no further than 1 month behind Windows operating system patch release dates. Process introduced to manage Carecert security alerts to improve response and action. Signed up to National Windows 10 licencing agreement, requires implementation of Microsoft advanced threat protection (ATP) to monitor for threats on PCs and Laptops. Threats reported locally and nationally to NHS digital. Letter from Will Smart to CIO's stated all Trust should ensure every board has executive director as data security lead. Sep-18 Information Security Paper presented to Audit committee/Execs. Funding approved to initiate structured approach to addressing the Information Security Agenda; to be known as the ESHT Information Security Maturity Programme and implemented as part of the Trusts Digital Strategy which is due at Nov Trust Board. Third party engaged to carry-out an initial assessment with the aim to plan a 18-24 month programme of work. Same approach is being presented to STP Digital Steering group to create STP wide approach. ATP is deployed to 10% of Trust devices in-line with NHS planning, aiming for 100% deployment by Jan 2019. DNS security being implemented 13.9.18 Nov-18 Information Security table top exercise run by the Serious Organise Crime Quad being organised for 2019 board seminar. TIAA audit commissioned to include assessment of - Information Risk Management Regime; Home/Mobile Working & Removable Media Controls, in particular the Mobile Device Management controls; User education and awareness; Incident Management & Managing User Privileges; Security Monitoring & Configuration; Malware Protection & Network Security. Advanced Threat Protection (ATP) deployment 100% complete STP wide joined up approach to assess Information security maturity not agreed by all members. ESHT facilitated successful workshop for the CCG Alliance to develop Cyber Incident Response plan; will be repeated at ESHT to improve local Cyber Incident planning processes.	end Mar-19	◄►	DF	Audit Committee

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.1 We are unable to effectively recruit our workforce and to positively engage with staff at all levels.

Key controls	Workforce strategy aligned with workforce plans, strategic direction and other delivery plans On going monitoring of Recruitment and Retention Strategy Workforce metrics reviewed regularly by Senior Leadership Team Quarterly CU Reviews to determine workforce planning requirements Monthly IPR meetings to review vacancies. Review of nursing establishment quarterly KPIs to be introduced and monitored using TRAC recruitment tool Training and resources for staff development In house Temporary Workforce Service
Positive assurances	Workforce assurance quarterly meetings with CCGs Success with some hard to recruit areas e.g. Paeds and A&E Full participation in HEKSS Education commissioning process Positive links with University of Brighton to assist recruitment of nursing workforce. Reduction in time to hire Reduction in labour turnover.

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.1.1	C	Assurance required that the Trust is able to appoint to "hard to recruit specialties" and effectively manage vacancies. There are future staff shortages in some areas due to an ageing workforce and changes in education provision and national shortages in some specialties	Mar-18 Since Apr-17 vacancies reduced in all staff groups excluding nursing. % of nursing vacancies relatively constant at 10%. Recruitment strategy for nurses widened to include return to practice; offering OSCE assistant to overseas nurses already in UK. Launching return to Trust project for nursing leavers. Monthly Divisional meetings to review vacancies versus establishment. New starters offered the opportunity to auto-enrol on the bank. Workforce Resourcing Group established, will develop a longer term strategy to meet workforce requirements, taking into account the age profile of the population and will look at new roles and skill mix to meet patient demand. Work continues on driving roster efficiency and job planning. May-18 Medical workforce vacancy rate 4.1% - decreased by 10% over the last twelve months. .All areas % vacancy showing declining run rates. April 2017-March 2018 . UK Nurse Attraction campaign targeting return to practice and OSCE candidates continues with a number of new nurses joining the Trust. International recruitment continuing for Medical and AHP staff groups-27 International Nurses to join by Aug-18. Jul-18 Continued Headhunter activity to address Hard to Recruit posts, emphasis on ED and Consultants. Ongoing International Nurse recruitment with 35 Nurses due to join the Trust between July-January 2019. All areas except Medical workforce showing declining vacancy percentage run rate May 2018 vs May 2017. Targeted social media activity for specific areas e.g. Endoscopy. Sep-18 International recruitment continuing in Philippines and Indian sub-continent for Medical and AHP staff groups. European recruitment will be reviewed post Brexit. 32 International Nurses joining by July 2019. 54 International Nurses in recruitment pipeline.Targeted Recruitment campaigns commenced to support Radiology Department, Histopathology and Haematology (Consultant posts) Social media activity supported by Headhunters. Medacs (RPO- Recruitment Practice Optimisation)Medacs are on site 13th Sept to start the Discovery process to understand our existing end to end recruitment process. Medacs will be targeted to recruit 50 'hard to recruit' medical posts over the next two years. Successful recruitment and on boarding of July intake of Junior Doctors. October Intake - 61 posts 9 vacancies. 3xCardiology/1xDiabetes/2xGeneral Surgery/2x Geriatrics/1xObs and Gynae. Recruitment activity underway to fill these vacancies. Nov-18 International recruitment continuing for Band 5 Nurses and Radiographers. Social media activity undertaken to support targeted recruitment campaigns for A and E, Radiology and Endo and Diabetes. Medacs (RPO- Recruitment Practice Optimisation) now on site and assisting to recruit against 50 Hard to Fill vacancies. To date 7 offers have been made including 3 at Locum Consultant and Consultant for Stroke, Orthodontics and Rheumatology. Successful recruitment and on boarding of October intake of Junior Doctors. Recruitment activity underway to fill remaining vacancies.	end Apr-19	◄►	HRD	SLF

Strategic Objective 5: All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfil their roles.

Risk 5.2 If we fail to effect cultural change we will be unable to lead improvements in organisational capability and staff morale.

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

Gaps in Control (C) or Assurance (A):			**Actions:**	**Date/ milestone**	**RAG**	**Lead**	**Monitoring Group**
5.2.1	A	The CQC staff surveys provide insufficient assurance in some areas that staff are satisfied, engaged and would recommend the organisation to others.	Jan-18 Continued work on ensuring staff feel valued and wellbeing is key priority. National staff survey response rate 49% - 3% above national average and 4% improvement on last year. Survey results will be published in early Mar18. Medical engagement score results published and shared with a great improvement in all areas. Mar-May 18 National Staff survey results published: • 11 key findings significantly better than average • 6 key findings significantly worse than average • 5 key findings shown significant improvement since 2016 • O key findings shown significant decline since 2016 Staff survey one of the few Trusts nationally to show sustained improvements. Drill down identifies some areas that require further review and this will be locally reviewed and actions developed. Awaiting results of GMC survey. Jul-18 June CQC report highlighted positive engagement work that the trust was doing internally and externally had supported cultural change. We continue to increase our response rate to Staff FFT currently 27%. 80% of respondents would recommend the trust to a friend or family as a place to work. All divisions have action plans in place to respond to any issues raised and progress updated regularly. Organisation was one of three trusts out of 235 trusts to meet the CQUIN for Staff Health and Wellbeing. Sep-18 Refreshed plans and approach to Staff retention. Each division has received workforce information about why staff are leaving /dissatisfied and information used to conduct deep dives with staff groups/specific work areas to identify how we can improve retention/improve their response to recommending ESHT as a place to work. Launching Staff Health and Well Being plan that sets out 7 priorities; focusing on proactively supporting physical and emotional wellbeing. Nov-18 Continuing to seek feedback through staff FFT and the National Staff survey. Q2 Staff FFT response rate 22%. – a 1% Increase on previous quarter. National average response rate 13%. 79% of respondents would recommend the Trust for care and treatment to a friend/ family member which is consistent with the previous response. 56% of respondents would recommend the trust as a good place to work to friends and family which is a decrease of 3% compared to Q1.It was agreed that this information will be included in the retention plans for each division. The current response rate for the National staff survey is 36%with staff being actively encouraged to complete the survey by the closing date of 28/11/18 Approach to medical engagement is being further developed and there is ongoing work linked to GMC survey results. A range of activities linked to Health and Wellbeing continue to be rolled out across the trust – this includes managing stress , healthy weights, menopause clubs	end Apr-19	◄►	HRD	POD SLF

Chief Executive Report

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Dr Adrian Bull, Chief Executive

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

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

1. Quality and Safety

Our work on falls prevention continues with significant reductions in the Trust's falls rate & continued hard work by our clinical teams. Similarly our incidence of pressure damage remains steady and is falling in certain areas with some teams declaring no harm for some time now. There are no concerns to note regarding Infection Control with teams working hard preparing for the Winter challenges that are likely.

Patient Experience Feedback is largely positive overall with significant improvements in the Eastbourne ED regarding the number of FFT surveys collected.

The complete redesign of the Trust's Excellence in Care tool is well underway with a recent demonstration by Matrons, Service Improvement and Business Intelligence colleagues to the Quality & Safety Committee. Regular reporting using this framework has now commenced.

7 Day Service Update

- The trust has made good progress on standards 5 and 6 (investigations and interventions) and is compliant in nearly all parameters.
- Performance on standard 2 (consultant review within 14 hours) and standard 8 (ongoing review) remains a challenge. We are working with NHSE on improving these across all specialties
- We will be tracking standard 2 performance on a monthly basis and the new electronic patient management system will support further improvement against these standards.

Workforce remains one of our biggest challenges with many colleagues working hard on a daily basis to ensure safe staffing especially in our most challenged areas. The bed remodelling work has now completed – 42 beds have been closed from an original target of 75. Members of staff have been redeployed. We will re-open beds as required to provide resilience against winter pressures. This

will mean more staff movement to ensure safety and will be monitored closely and supported by divisional and corporate nursing/operational colleagues

Mortality

The latest Standardised Hospital Mortality Index for the Trust has been reduced to 100, which is the best the Trust has achieved since this measure began. Risk Adjusted Mortality Index (Aug 17 - July 18) is 78.1 compared with national level of 87.9, and our previous year's level of 84.3.

2. People, Leadership and Culture

Recruitment

The substantive staff fill rate is 90.5 % for August; key actions being undertaken include:-

- International recruitment is continuing in the Philippines and Indian sub-continent for Medical, Nursing and AHP staff groups.
- Targeted Recruitment campaigns commenced to support Radiology Department and Urgent Care Nurses.
- Social media activity to promote Trust Brand.
- 28 additional International Nurses will join the Trust by July 2019.
- 32 UK Nurses due to join the Trust between November and February.

Medical Recruitment

- Medacs have been on site since 1st October. Six posts, (Consultant Orthodontics, 2 Speciality Doctor Paediatrics, Locum Consultant Rheumatologist, 2 ST3 Obstetrics and Gynaecology) recruited to date against a list of 30 "difficult to recruit" posts. Candidates due to start Jan 2019. Weekly review meetings in place with Medacs on site Recruitment Partner.
- Successful on boarding of October intake of Junior Doctors, recruitment activity is underway to address any vacancies.

Workforce Planning, Efficiency and Change

Workforce Planning

- ESHT Strategic Workforce Plan (3 + 2) delivered by Staff Group at Trust level detailing optimise and transformation best practice with associated workforce action plan.
- Specialty Workforce Plans are currently in progress as part of the Business Planning process and will dovetail with the Strategic Workforce Plan to outline tactical approach for 19/20.

Workforce Efficiency

- Workforce Efficiency Programme underway with 4 key Task & Finish Staff groups targeting CIP opportunities to support Financial Recovery.
- Consultant Job Planning in progress with gap analysis reporting by Division to support successful delivery.

Staff Engagement

Staff Survey

Staff survey response rate is currently 49%. The closing date for surveys is 30th November 2018. There will be a continued focus on those areas whose response rates are relatively low particularly the Medicine and DAS divisions. The target response rate is 52% with a stretch target of 56%.

Talent Management Conversations
Developing a High Potential Programme; 3 pilots have been undertaken to test out how talent management conversations will work in practice. A model is being developed to be rolled out across the Trust.

Retention
A small task and finish group are reviewing the implementation of the Exit Procedure and how the information gathered at the exit interview stage is used. There is also a focus on stay interviews. Work is ongoing in identifying specific actions re divisions and retention linked to the workforce plan. Each division has been sent a detailed pack on turnover for their areas and have been asked to have a divisional action plan in place

Leadership
The Leading the Community programme aimed at community team Leaders is due to commence in December. Work is stating on the development of management competences so that all leaders are clear of our expectations this work will commence with matrons.

Education

- A Trust-wide Training Needs Analysis is now complete; an associated action plan will now be developed
- Consultation regarding the restructuring of multi professional education has commenced.
- Work on going to review mandatory training requirements and content along with compliance

3. Access and Delivery

The Trust continues to perform at system level within the national upper quartile range, improving on the same period last year. Following significant engagement across the Trust and social care, patients are increasingly being discharge in a timely way. Length of stay and the number of bed days has reduced, despite an increase in demand.

The Trust is working with system partners to reduce demand, focusing on supporting patients in their own homes, and where a hospital visit is required avoid overnight stays unless this is clinically required. We have also been working through the summer to ensure we have robust winter plans in place in recognition that this is a challenging time of year. We will be opening additional capacity after Christmas in the community and seeking to provide additional medical support in our A&E departments.

The number of patients on our elective waiting list continues to decrease, although we recognise that in some areas the waiting time is longer than we would wish and are working to resolve this. We are also developing a programme of work to transform how we offer out- patients services over the next few years, seeking more innovative and digital options, reducing the need for patients to attend the hospital sites.

We continue to focus on our cancer standards, we have continued to see high numbers of referrals, upto 40% higher than the previous year and have working to deliver a recovery plan, which improves our response times and ensures patients have a diagnosis within 28 days. This is a new standard coming in from next year. There is a detailed review of all 62 day cancer pathways underway to bring our performance back up to the national standard.

The community teams continue to support patients in their own homes and are looking to combine individual services to offer a better skill mix and additional capacity.

4. Communication and engagement

During this period, the Trust received positive media coverage that highlighted the number of external organisations recognising our excellent services. This included the Pathology Department receiving ISO accreditation, winning the prestigious Royal College of Speech and Language Therapists Sternberg Award for Clinical Innovation, our success in the Trauma Audit and Research Network (TARN) report and our participation in a research collaborative that aims to improve outcomes after total hip and total knee replacements. We also received positive coverage for welcoming 29 newly qualified nurses. In August, September and October 2018 the Trust received 82 pieces of coverage in print and broadcast media, in both local and national news – the vast majority of the stories were generated from Trust press releases. We record the 'tone' of each piece of news. Over this period, 81% of the coverage was positive, 9% was neutral, 10% was negative.

The autumn/winter edition of ESHTNews, our free patient newspaper, was published mid-November. Five thousand copies are being distributed around our acute and community sites, with an electronic version emailed to our 2000 Trust 'members' and made available on the Trust website. Included in the autumn/winter edition is advice and guidance about how to stay well this winter.

The Trust's digital presence continues to improve. ESHT's new website that was launched a year ago has received over 2,150,000 page views year to date, making it one of the most important ways of communicating with members of the public and external audiences. Our social media reach is also impressive with the Trust's Twitter and Facebook pages receiving nearly 440,000 and 385,000 impressions (number of times our posts are seen) respectively year to date. During this period, stories that saw the highest number of impressions were Nursing Team Leader, Jayne Winter, winning the Trust's employee of the month award for her help in transforming the palliative care service, the results of our most recent cancer care survey, Trust nurses raising money for victims of Kerala floods and the Trust welcoming newly qualified nurses.

Finally, our public engagement work continues with representatives from the trust speaking to 80 local people about the quality improvements that we have made over the last year at the East Sussex Better Together Shaping Health and Social Care event in November, and at the East Sussex Senior forum and Healthwatch AGM in October

5. Finance

Activity and Contracts

Activity levels continue to be significant across the services provided by the Trust, both in hospital and in the community. This is particularly evident in urgent care, and the services providing a rapid response to patients, where levels have risen in line with, and sometimes ahead of, national trends. The Trust and local commissioners have reached agreement on a financial settlement for the year, which enables the Trust and the CCG to focus on managing activity levels and reducing costs as appropriate over the remaining months of the financial year. The level of 'system financial risk' has therefore reduced, but remains significant, and is continues to be managed through the System Financial Recovery Board. For the Trusta key priority is now to understand and implement the activity requirements to maintain our access standards. Detailed work is in train across the organisation to establish, agree and cost, the trajectories for planned care to meet access standards within the available financial envelope.

Delivery of the Trust's 2018/19 Financial Plan

At Month 7, the Trust's monthly run-rate has improved £3.2m. This is a significant achievement in challenging circumstances, and reflects a continued focus on the delivery of income and activity

levels, as well as management of temporary resourcing. If the Trust can maintain a monthly deficit of £3.4m for the rest of the financial year, then the financial plan will be delivered.

The T3 process is settling in, and colleagues across the organisation have been both patient and supportive in the implementation period for this process. T3 is now being extended beyond non-pay to pay in order to provide additional scrutiny and review in respect of requests for additional resources – but arrangements are in place to ensure that urgent requests for medical or nursing staff can be effected without delay and retrospectively reviewed.

6. Strategic Development and Sustainability

Working Together as a System

Work continues as planned on the development of a sustainable financial plan for the East Sussex system. The Trust and the local CCGs (now working under the leadership of Adam Doyle, and aligned with the wider Sussex and East Surrey CCG Alliance) submitted a refreshed '3+2' medium term financial plan to regulators for review. The plan delivers a balanced financial position for the system in 5 years and further work is being undertaken to understand how we can safely deliver this in a shorter timescale The plan was reviewed before submission in a joint Board session across the Trust and the local CCGs. Finance and planning teams, alongside clinical and operational leaders, are working to develop the plans further for the next submission to the regulators on 20th December.

The Trust's 19/20 business planning process is now well underway with the first cut of financial and demand information being shared with divisional and corporate teams. These will be refreshed as we are able to include revised national and local planning assumptions. Service level plans will be aligned with the strategic programmes for ESHT as outlined in the 3+2 plan. Plans will reflect the limited opportunity to generate new income and the limited access to capital funding in 19/20.

East Sussex Healthcare NHS
NHS Trust

Month 7 – October 2018

TRUST INTEGRATED PERFORMANCE REPORT

East Sussex Healthcare NHS Trust

Contents

East Sussex Healthcare NHS Trust

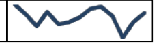
Action: The board are asked to note and accept this report.

QUALITY AND SAFETY

DIRECTOR OF NURSING & MEDICAL DIRECTOR

Indicators

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Total falls	M	135	93	-31.1%	938	865	-7.8%	128	
Number of no-harm falls	M	98	68	-30.6%	682	625	-8.4%	95	
Number of minor/moderate falls	M	36	23	-36.1%	253	233	-7.9%	32	
Number of major/catastrophic falls	0	1	2	1	3	7	4	1	
All patient falls per 1000 Beddays	5.5	5.8	4.4	-1.4	5.8	5.6	-0.12	5.4	
All patient falls with harm per 1000 Beddays		1.6	1.2	-0.4	1.6	1.6	-0.01	1.4	
Falls assessment compliance	M	92.9%	94.0%	1.2%	90.5%	92.3%	1.8%	84.6%	
Total grade 2 to 4 pressure ulcers per 1000 Beddays	M	1.4	2.2	55.7%	2.0	1.8	-6.7%	1.9	
Number of grade 2 pressure ulcers	M	30	46	53.3%	299	274	-8.4%	43	
Number of grade 3 to 4 pressure ulcers	M	3	1	-2	20	6	-14	2	
Pressure ulcer assessment compliance	M	93.6%	85.0%	-8.6%	90.4%	83.8%	-6.6%	70.7%	
VTE Assessment compliance	95.0%	96.5%	96.0%	-0.5%	95.9%	95.7%	-0.2%	95.6%	

Please note: The falls and pressure ulcers by bed days are still subject to change as the bed day figures change for at least 4 months after the initial report.

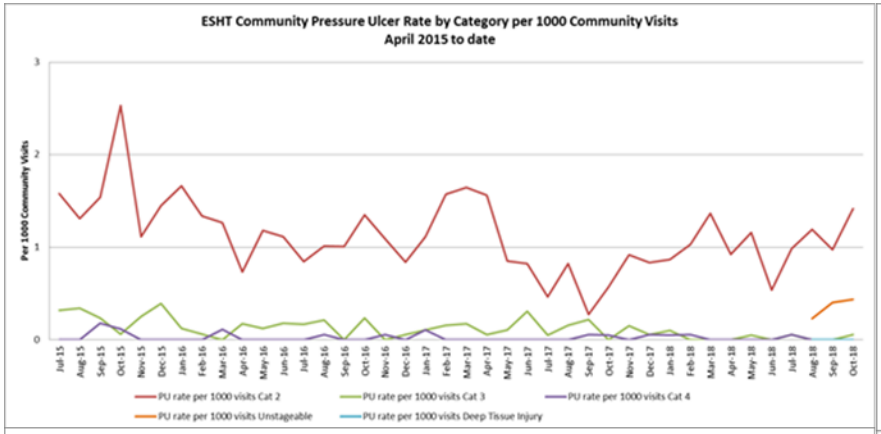
- The percentage of no harm/near miss patient safety incidents for October is 81% (national figure 73%).

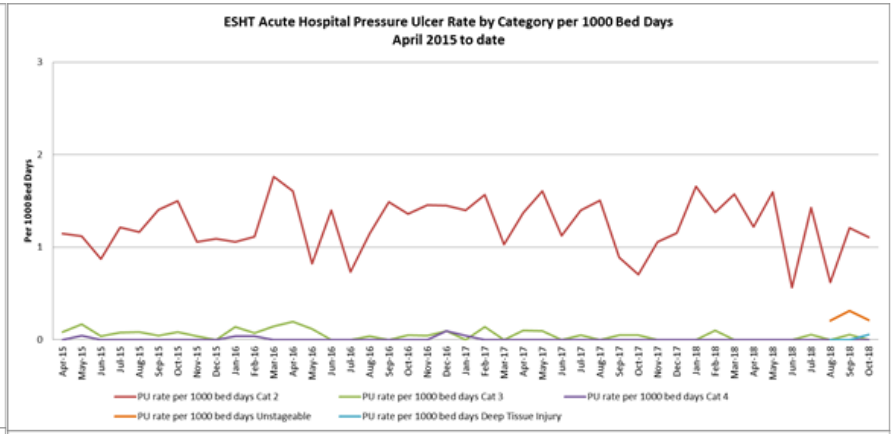
- Falls have decreased for the third month running and the rate per 1,000 bed days is the lowest its ever been.
- This is currently well below our ambition to reduce the rate to 5.0
- There is now a clear system in place to ensure staff complete a robust assessment and ensure actions are in place to reduce the likelihood of falls.

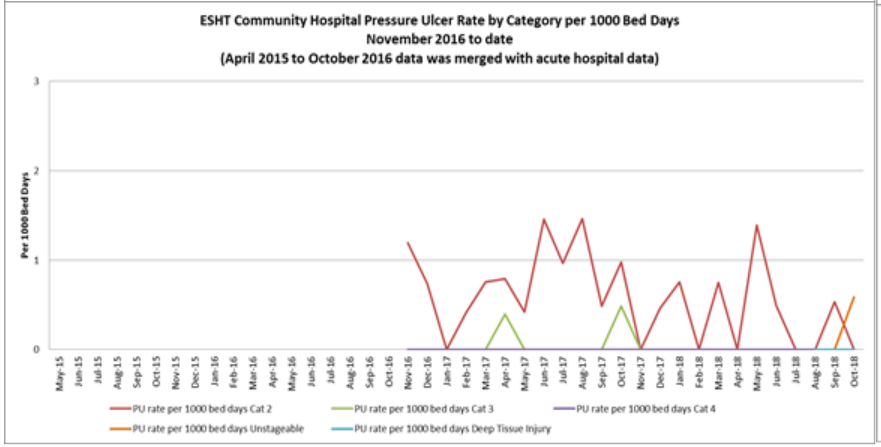
- There is still some variability across clinical teams in terms of well embedded this is yet with more focus required in some areas.

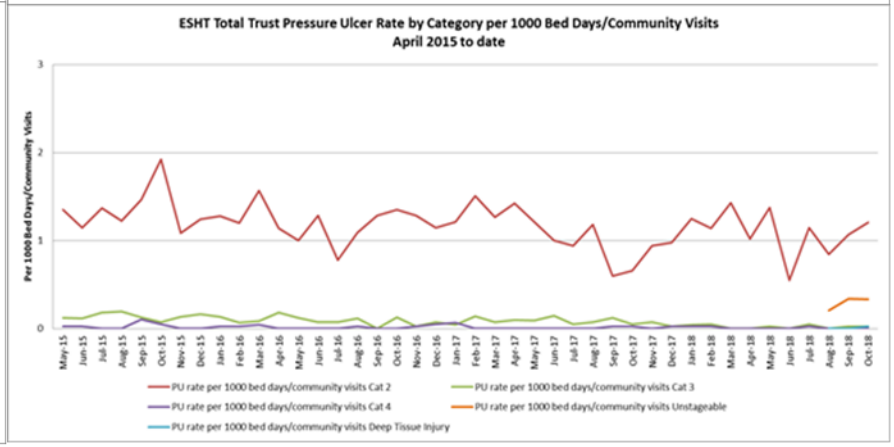
Pressure Ulcer Incidents - Oct 2018

East Sussex Healthcare NHS
NHS Trust





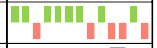




Category 2 damage has remained relatively static with 47 ulcers in Oct. There are quarterly deep dive reports for category 2 pressure ulcers with a recent report to PS&Q. There were 13 unstageable pressure ulcers which now have a root cause analysis (RCA) investigation completed and submitted to the Pressure Ulcer Review Group (PURG). The trust has had no category 4 ulcers and 1 category 3 pressure ulcer in October which was in the Community setting with the RCA underway. Community Hospitals have reported no category 3/4 pressure ulcers since April 2018.

East Sussex Healthcare NHS Trust

Infection Control

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Number of MRSA Cases	0	0	0	0	1	1	0	0	
Number of Cdiff cases	4	4	5	1	21	30	9	4	
Number of MSSA cases	M	1	1	0	5	10	5	1	

MRSA bacteraemias

- Zero in October

C. Difficile –

threshold for 2018/19 is 40 cases.

- There were 5 validated cases in October with PIRs in progress. This means year to date cases are at 30 which is 7 above trajectory for the time of year.
- The increase in cases does not appear to be related to cross infection. All positive samples are sent for ribotyping to help exclude this.
- There were no lapses in care contributing to cases in October. Ten cases year to date confirmed as green (no lapses).

MSSA bacteraemias

- 1 case associated with Hosp Acq Pneumonia in patient investigated for falls. Also 1 case diagnosed on 01/11 from specimen taken on 31/10 in Critical Care, likely Pneumonia.

Gram negative bacteraemias

- 5 E.coli = 2 urinary tract infection,1 hepatobilary case, 1 respiratory case and 1 gastrointestinal case.
- 3 Klebsiella = 1 unknown cause, 1 skin/soft tissue infection and 1 hepatobilary case.
- No cases of hospital onset Pseudomonas in October.

There were no serious incidents or outbreaks of infection to report with minimal incidence of Noro virus.

East Sussex Healthcare NHS
NHS Trust

Serious Incidents (SI) reported in October

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Number of Serious Incidents	M	2	9	7	30	27	-3	4	
Number of Never Events	0	1	0	-1	4	0	-4	0	

There were 8 **serious incidents** reported during October 2018:

- 2 x delay in diagnosis of cancer in AAU and Gastroenterology Outpatients
- 2 x falls to fracture on Newington and Berwick wards
- 1 x Information governance breach regarding letter sent by email to Endoscopy patients
- 1 x delay in diagnosis of a cystic lesion for MRI Scanning
- 1 x prolonged treatment of steroid eye drops resulting in Glaucoma for Ophthalmology Outpatients
- 1 x patient underwent Endoscopy procedure in error (incorrect identification)

There was 1 **Never Event** during October 2018 relating to a retained suture needle following an Outpatients procedure

All details are scrutinised at the Weekly Patient Safety Summit and the Patient Safety & Quality Group.

Serious and Amber (Moderate) Incident Management and Duty of Candour
There are currently 25 Serious Incidents open in the system all within the correct timescales (8 of which are with the CCG for review). The Amber incident backlog is at 44 with still more work to do in the divisions to reduce this. A full breakdown of those overdue by number of days is presented to the Patient Safety and Quality Group on a monthly basis with updates from AND colleagues for any/all over 200 days.
Duty of Candour compliance for all moderate and above harm incidents is at 98% informed verbally, 97% followed up in writing and 95% findings shared with patient or family upon completed investigation.

Patient Experience

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Inpatient FFT response rate	45.0%	41.8%	46.5%	4.7%	39.6%	43.4%	3.8%	42.5%	
Inpatient FFT score	96.0%	97.6%	97.5%	-0.1%	97.0%	97.8%	0.8%	97.6%	
A&E FFT response rate	22.0%	7.0%	7.5%	0.5%	9.4%	4.5%	-4.9%	5.3%	
A&E FFT score	88.0%	88.1%	93.7%	5.6%	88.5%	93.3%	4.8%	92.5%	
Outpatient FFT Score	M	97.7%	96.8%	-0.8%	95.8%	97.1%	1.4%	97.1%	
Maternity FFT response rate	45.0%	17.6%	8.0%	-9.5%	33.3%	13.0%	-20.2%	19.4%	
Maternity FFT score	96.0%	98.0%	95.7%	-2.4%	97.8%	96.4%	-1.4%	98.0%	

NHS Choices

- Overall rating at EDGH = 4 Stars Overall rating at Conquest = 4.5 Stars
- FFT increase for Eastbourne ED markedly improved to 12% so increased ED score overall as Conquest remained low.

Examples of FFT/ questionnaire comments in October:

Positive comments

- I consider that all things that needed doing were carried out A1 under sometimes very difficult conditions
- All things were done well, staff are professional & friendly at all times even though really busy.
- All nursing staff on Mirlees are excellent

Negative comments

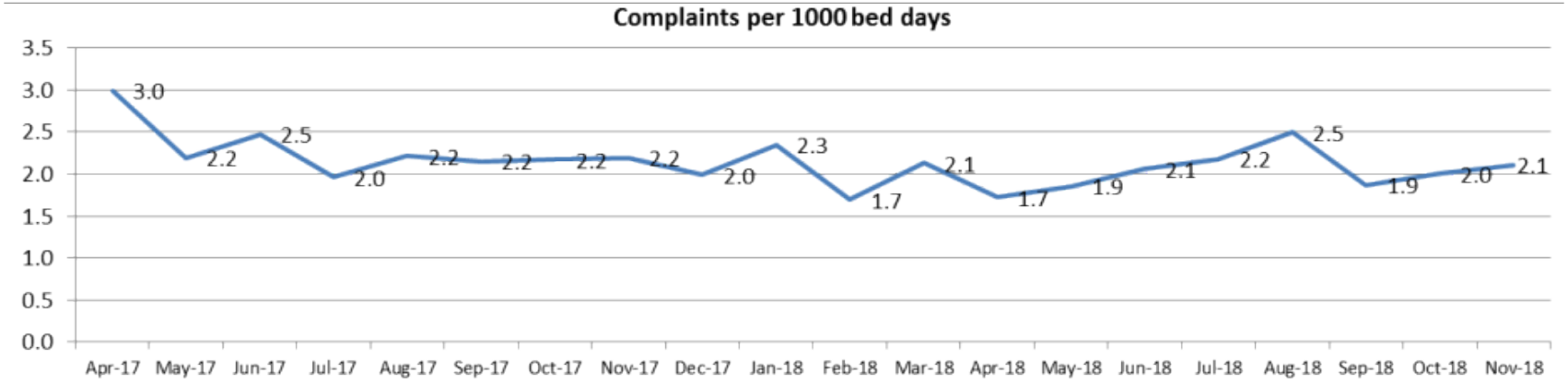
- Pain relief in Baird ward over a weekend was poor and unnecessary.
- One nurse answered personal calls whilst helping me onto a commode on Cookson Devas ward. Reading notes - a few weren't aware of pain from cancer on top of operation.
- No personal things but would have helped if Zimmer frame fitted in bathroom
- Make WiFi a known thing

The lowest scoring questions from the inpatient experience questionnaire (part of FFT data) are as follows:

- Were you ever bothered by noise at night?
- Were you informed as to why you had to repeat clinical information when asked by a doctor or nurse?
- Overall how would you rate the care you received from a therapist?

Complaints

East Sussex Healthcare NHS
NHS Trust



56 new complaints were received in October and no overdue complaint responses. The complaints rate per 1,000 bed days for the Divisions are as follows:

- Medicine – 1 per 1000 bed days (13 complaints)
- DAS – 4.1 per 1000 bed days (21 complaints)
- Out of Hospital – 3.1 per 1000 bed days (4 complaints)
- Women, Children and Sexual Health – 2.6 per 1000 bed days (4 complaints)
- Urgent Care - 13 complaints.

“Unable to contact department” remains the highest PALS activity.

The Parliamentary and Health Service Ombudsman (PHSO) had 4 contacts in October and shared one investigation outcome. The PHSO have decided to investigate two cases following their initial enquiries, one further case would automatically be investigated, and there was one new enquiry regarding a case. The outcome received was that the PHSO had decided not to uphold a case they had been investigating.

Mixed Sex Accommodation

East Sussex Healthcare NHS
NHS Trust

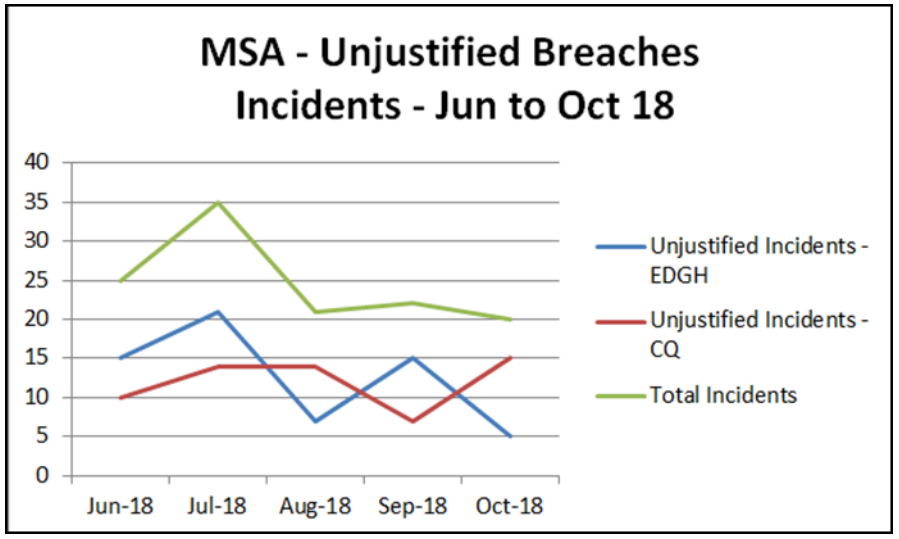
In October the total number of validated and reportable unjustified incidents for the Trust was 20, affecting 58 patients.

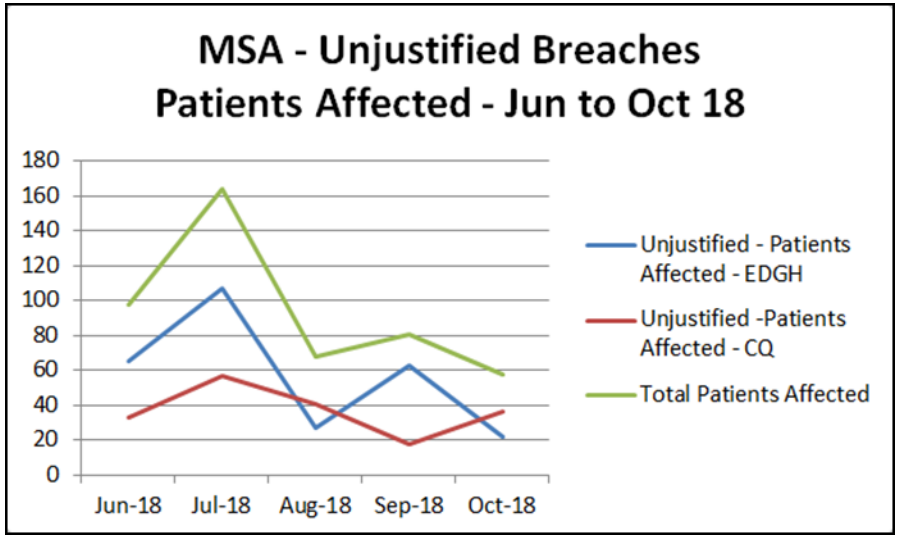
Breaches at the Conquest in October were associated with ITU patients. This was due to lack of immediate speciality beds to transfer patients to.

At Eastbourne the breaches were associated with CCU/ITU/Coronary Step Down Unit. This was due to the same reasons as above.

In addition, the trust has remained very busy operationally with pressure on capacity and occupancy.

There were no complaints or concerns regarding MSA raised in October. Staff move patients to the “right” bed as soon as possible and the board are reminded that same sex sleeping accommodation is very important but only one part of the Privacy & Dignity agenda.





Safer Staffing

Fill rate and CHPPD by Division	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	CHPPD
Medicine	92.1%	107.6%	89.6%	115.0%	8.79
Out-of-Hospital	84.5%	103.1%	93.9%	100.5%	6.31
Surgery Anaesthetics & Diagnostics	86.6%	93.3%	83.5%	95.9%	9.08
Women Children & Sexual Health	85.4%	82.7%	76.8%	85.4%	15.51
Totals	89.0%	102.1%	85.9%	107.2%	9.00

Fill Rate and CHPPD by Site	Day		Night		
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	CHPPD
BEXHILL HOSPITAL - RXC03	82.6%	102.1%	96.4%	97.3%	9.74
CONQUEST HOSPITAL - RXC01	92.0%	100.7%	88.6%	105.2%	8.84
EASTBOURNE - RXC02	86.8%	103.4%	83.0%	110.7%	9.66
Totals	89.0%	102.1%	85.9%	107.2%	9.00

•Trust CHPPD has increased from 8.75 last month to 9 this month. Whilst each of the wards affected by the remodelling had their establishments set using evidence based best practice, the actual usage and acuity is different to that expected as additional beds are being used above funding and acuity changes have been reported.
•Overall, registered nurse shifts remain more difficult to fill using TWS and the skill mix can be changed on shift when HCA staff are used to backfill RN shifts.
•WSCH division contains a number of specialties which require specified staffing levels which are different to general wards.

**CHPPD = day + night shift hours for registered and unregistered nurses/midwives divided by daily count of patients in beds at 23.59 hrs.*

Safer Staffing

East Sussex Healthcare NHS
NHS Trust

- The 18/19 nursing establishment review to review safety of staffing and provide the annual assurance to the Board, is currently being planned with the Director of Nursing. Going forward ADN colleagues will actively drive the process with support and oversight from the DoN/corporate nursing team. This is key to ensure ownership and engagement going forward. It will also be more closely aligned with business planning/budget setting.

- The Maternity staffing establishment review will be presented to the Finance and Investment Committee ensuring it is also aligned with Business Planning and Budget setting as for all divisions.

- The staffing plan for all surge (bedded) capacity over winter has been finalised and is being implemented in the divisions with input from TWS colleagues. Some staff have been deployed to the 'winter wards' over this coming period to ensure robust substantive skill mix in all areas.

- Trust RN vacancy rate is approximately 10% with a range from 7.8% to 25.3% in the Emergency Departments. Recruitment is expected to ensure a further 99.5 WTE RN/RMs are joining the Trust with 18.2 HCA WTE joining.

- Turnover has increased slightly to 9.9% but remains in the lowest quartile when benchmarked nationally.

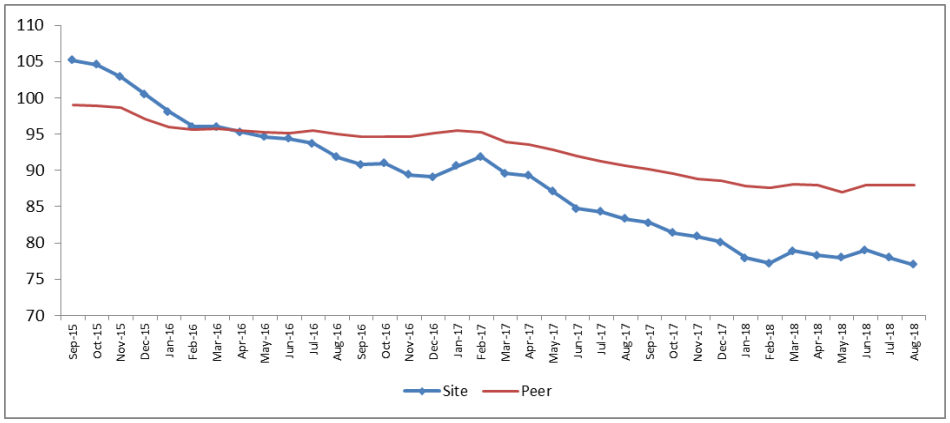
- The audit of additional duties process is complete and evidences senior clinical divisional sign off for all shifts, which exceed the planned staffing template, prior to booking of additional staff. The use of additional staff (specials) is now considerably lower than last year and has remained so with robust controls. Use of additional staff otherwise is for vacancies and sickness.

**CHPPD = day + night shift hours for registered and unregistered nurses/midwives divided by daily count of patients in beds at 23.59 hrs.*

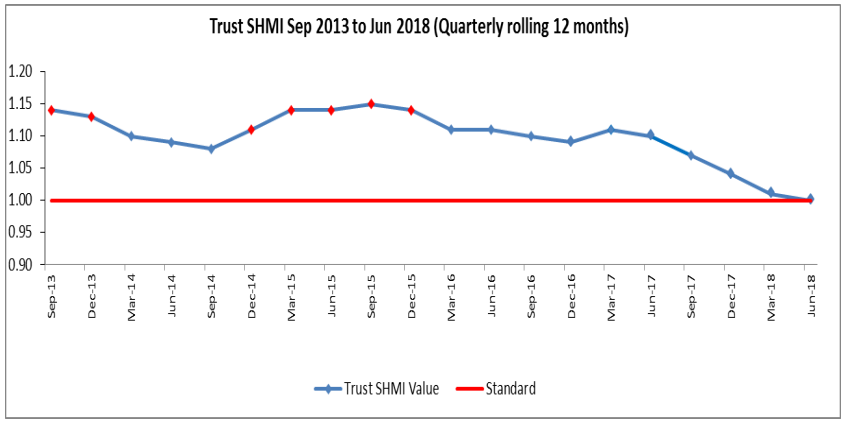
Mortality Metrics

East Sussex Healthcare NHS Trust

RAMI 17 (Rolling 12 months)



SHMI (Rolling 12 months)



SHMI for the period July 2017 to June 2018 is **1.00**. The Trust remains within the EXPECTED range.

RAMI 17 - September 2017 to August 2018 (rolling 12 months) is **77** compared to 83 for the same period last year (September 2016 to August 2017). August 2017 to July 2018 was 78.

RAMI 17 shows an August position of 57. The peer value for August is 83. The July position was 62 against a peer value of 81.

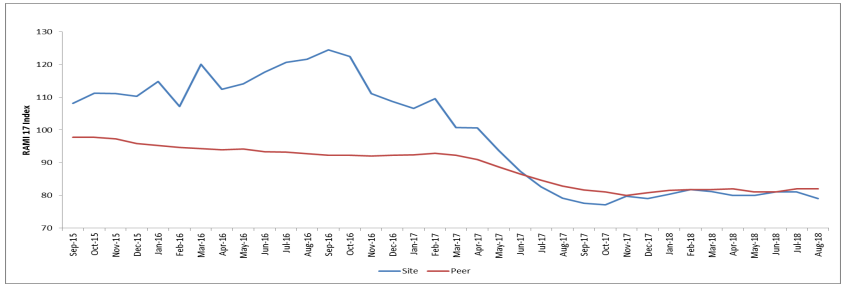
Crude mortality shows September 2017 to August 2018 at 1.72% compared to 1.81% for the same period last year.

The percentage of deaths reviewed within 3 months was 84% in July 2018, which is the same as in June 2018.

SHMI (NHS Digital) Top 5 diagnostic groups by Volume Jul 17 to Jun 18	Observed deaths	Expected deaths	SHMI
Septicaemia (except in labour), Shock.	514	517	0.99
Pneumonia (except that caused by tuberculosis or sexua	392	407	0.96
Acute cerebrovascular disease.	139	133	1.05
Congestive heart failure; nonhypertensive.	100	89	1.12
Fracture of neck of femur (hip).	79	63	1.25

Main causes of death during October 2018 (Mortality Database)	
Pneumonia	34
Sepsis/Septicaemia	22
Cancer	15
Chronic Obstructive Pulmonary Disease (COPD)	3
Community-acquired Pneumonia	3
Myocardial Infarction	3

RAMI 17 Septicaemia CCS Group (Rolling 12 months)



Access & Delivery

ACCESS AND DELIVERY

East Sussex Healthcare NHS Trust

URGENT CARE

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Four hour standard	95.0%	92.1%	93.7%	1.6%	87.1%	92.3%	5.1%	90.6%	
A&E Minor Performance	98.0%	99.7%	99.4%	-0.3%	97.1%	98.8%	1.7%	98.7%	
Four hour standard (Local System)	95.0%		94.8%			94.0%			
12 Hour DTAs	0	0	0	0	0	0	0	0	
Unplanned re-attendance to Emergency Department	5.0%	2.7%	3.6%	1.0%	2.8%	3.5%	0.7%	3.2%	
% Patients waiting less than 15 minutes for assessment in ED	M	84.0%	90.6%	6.6%	82.9%	86.5%	3.5%	84.7%	
% Patients waiting less than 60 minutes for treatment in ED	M	52.2%	52.4%	0.2%	43.5%	49.8%	6.4%	49.9%	
% Patients waiting less than 120 minutes for treatment in ED	M	82.1%	85.4%	3.2%	72.7%	81.4%	8.6%	80.9%	
% Patients that left without being seen in ED	M	1.7%	2.2%	0.5%	1.7%	2.2%	0.6%	2.1%	
% Patients admitted from ED (Conversion rate)	M	28.4%	29.3%	0.9%	27.4%	28.8%	1.4%	29.9%	
Number of ambulatory care admissions with zero length of stay	M	543	810	267	3725	5633	1908	768	
% of ambulatory care admissions with zero length of stay	M	57.6%	64.4%	6.9%	57.9%	65.3%	7.3%	64.3%	
Emergency Department attendances	M	9911	10814	9.1%	70526	76216	8.1%	10378	
Ambulance conveyances	M	3183	3144	-1.2%	22308	21762	-2.4%	3182	
Admissions via A&E	M	28.4%	29.3%	0.9%	27.4%	28.8%	1.4%	29.9%	

The Trusts' 4 hour performance was 93.7% for October 2018.

The system, walk in centres and the acute trusts combined performance was 94.8%.

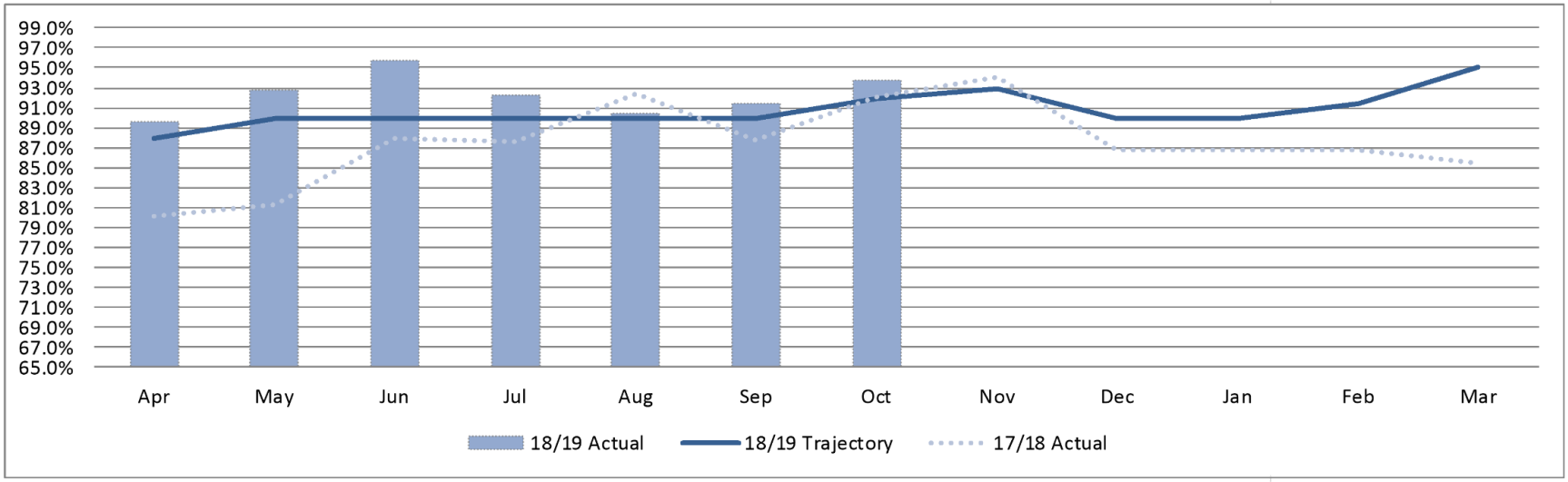
Activity continues to be higher than previous years, A&E attendances are up 8.1% year to date and non-elective spells are up 12.0% year to date.

The system has some key schemes in place focusing on reducing non-elective demand, with a particular focus on reducing frequent attenders and supporting frail elderly patients in an out of hospital setting.

A&E Trajectory

East Sussex Healthcare NHS
NHS Trust

A&E Monthly Performance (4Hr Wait)-Type 1 Only



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	92.0%	93.0%	90.0%	90.0%	91.5%	95.0%
18/19 Actual	89.5%	92.8%	95.7%	92.2%	90.4%	91.4%	93.7%					
17/18 Actual	80.1%	81.4%	88.0%	87.7%	92.5%	87.8%	92.1%	94.1%	86.7%	86.7%	86.8%	85.5%

The Trusts' 4 hour performance for October was 93.7% and above the planned trajectory:

EDGH 92.4%
Conquest 95.1%

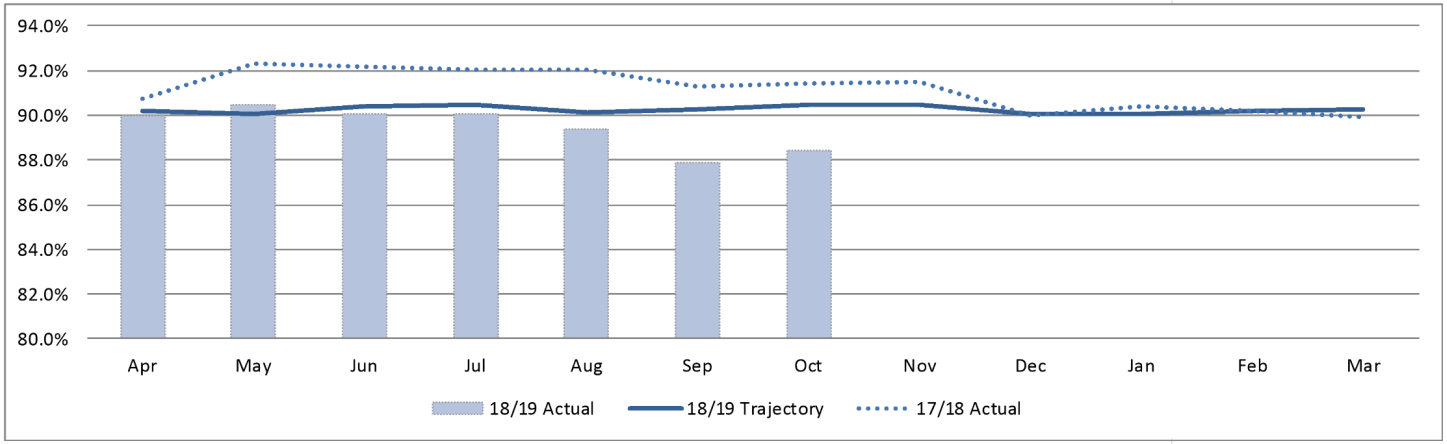
- Minors performance for October was 99.4%.
- Attendances in October were up 9.1% against the corresponding month last year.
- Ambulance conveyances have decreased by 2.4% year to date.

East Sussex Healthcare NHS
NHS Trust

RTT

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
RTT Incomplete standard	92.0%	91.4%	88.4%	-3.0%	91.7%	89.5%	-2.2%	89.9%	
RTT Backlog (Number of patients waiting over 18 weeks)	M	2623	3242	619	2623	3242	619	2902	
RTT Total Waiting List Size	28221	30655	27983	-2672	30655	27983	-2672	29034	
RTT 52 week waiters	0	0	0	0	0	0	0	0	
RTT 35 week waiters	M	164	174	6.1%	164	174	6.1%	186	

RTT (Referral to Treatment 18 Weeks)

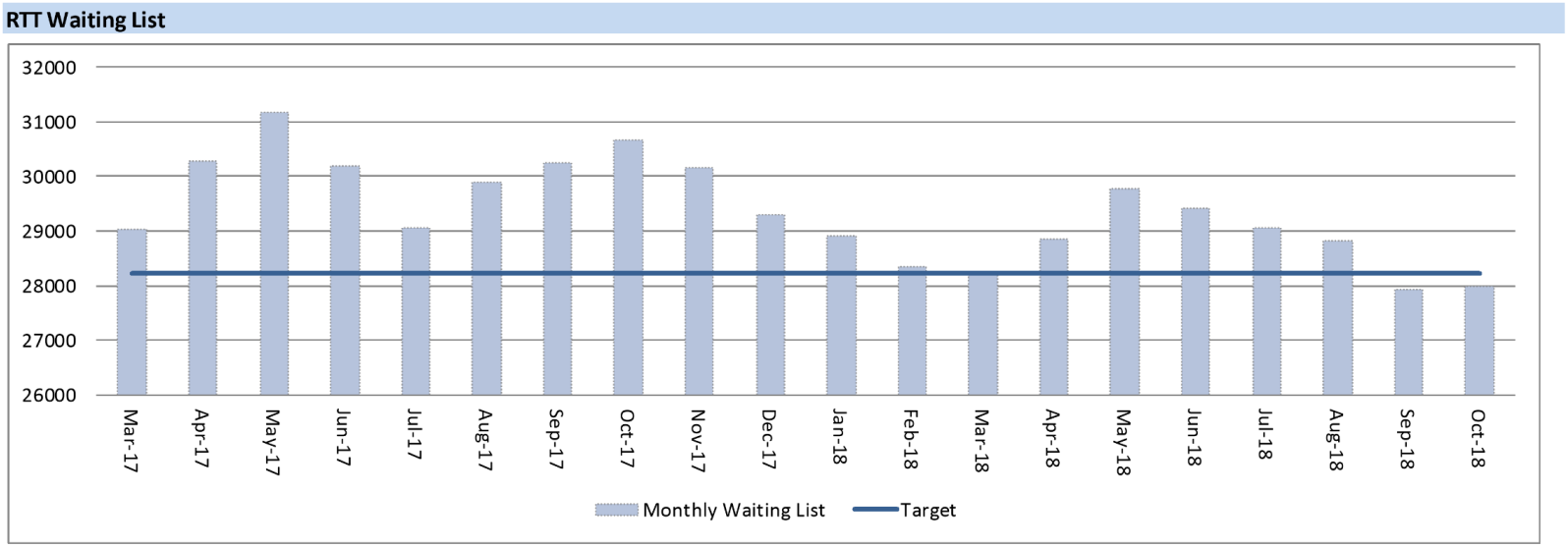


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	90.2%	90.0%	90.4%	90.5%	90.1%	90.3%	90.5%	90.5%	90.0%	90.0%	90.2%	90.3%
18/19 Actual	90.0%	90.5%	90.1%	90.1%	89.4%	87.9%	88.4%					
17/18 Actual	90.8%	92.3%	92.2%	92.0%	92.0%	91.3%	91.4%	91.5%	90.0%	90.4%	90.2%	89.9%

- The Trust performance for October was 88.4%, with performance 2.1% below trajectory.
- Daycase and elective activity increased against September. Primary care referrals remain down against last year (-6.2%), however 2 week wait referrals have increased year to date.
- Focus is on out-patient and theatre efficiency in order to manage demand and capacity without additional costs.

RTT Waiting list

East Sussex Healthcare NHS
NHS Trust

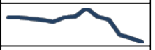


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Actual	28853	29767	29426	29066	28818	27942	27983					
17/18 Actual	30284	31188	30179	29053	29886	30260	30655	30149	29302	28909	28348	28221

- October saw a marginal increase in the waiting list against September, however the waiting list remains below target. The October waiting list was 27,983 and marginally below the end of March 2018 figure of 28,221 - the target for year end.
- Performance at Trust level is impacted by the following key specialties; Trauma and Orthopaedics, Ophthalmology, Gynaecology and Neurology, where performance is below plan due to limited capacity and if these specialties met 92% the Trust performance would be 91.95%.
- Trauma and Orthopaedics is impacted by the extended pathway through the MSK service.

East Sussex Healthcare NHS Trust

CANCELLATIONS AND DTC

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Super Stranded (Census on last day of month)	M	131	96	-35					
Avg Daily Super Stranded Beddays (single month metric)	142	179	139	-40	207	161	-46	169	
Avg Daily Super Stranded Beddays (rolling 3 month avg NHSI metric)	142	182	139	-43					
Delayed transfer of care national standard	3.5%	2.8%	2.9%	0.2%	5.1%	2.5%	-2.6%	2.1%	
Cancellations									
Urgent operations cancelled for a second time	0	0	0	0	1	4	3	0	
Proportion of last minute cancellations not rebooked within 28 days	0.0%	0.0%			0.0%	0.5%	0.5%	1.5%	
Outpatient appointment cancellations <6 weeks	M	50	20	-60.0%	313	238	-24.0%	38	
Outpatient appointment cancellations >6 weeks	M	1299	1399	7.7%	9585	9856	2.8%	1386	

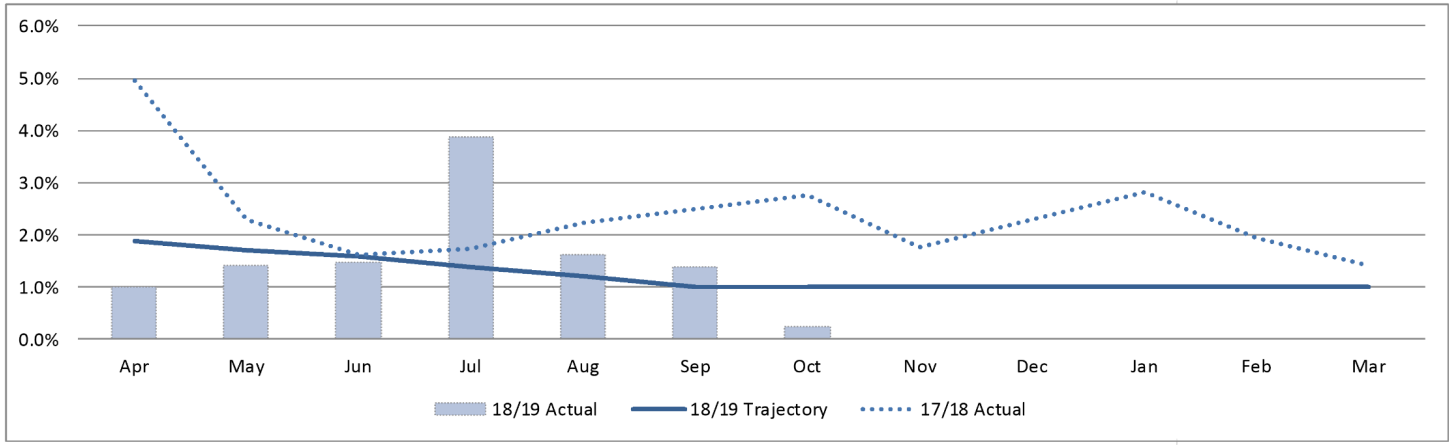
- DTC performance for October was 2.9%, an improvement against September and below the 3.5% target, however performance continues to be higher than trajectory (2.0%).
- Despite the increases in non-elective activity, non-elective bed days have reduced by 6.4% year to date.
- Stranded patient numbers have declined and we are achieving the national mandated target ahead of winter delivery.
- The Trust is establishing an outpatients transformation service and this will impart focus on the outpatient booking process and the high Trustwide cancellation rate.

Diagnostics

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Diagnostic standard (% patients waiting more than 6 weeks)	1.0%	2.8%	0.3%	-2.5%	2.6%	1.6%	-1.0%	1.8%	

Diagnostic waiting times (over 6 weeks)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	1.9%	1.7%	1.6%	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
18/19 Actual	1.0%	1.4%	1.5%	3.9%	1.6%	1.4%	0.3%					
17/18 Actual	5.0%	2.3%	1.6%	1.7%	2.3%	2.5%	2.8%	1.8%	2.3%	2.8%	1.9%	1.4%

Diagnostics performance improved significantly in October and surpassed the national target of 1%. This national target was last achieved by the Trust in January 2017. 13 breaches did however occur in October and these were shared amongst CT (1), Non-obstetric US (4), Colonoscopy (3), Gastroscopy (2) and Cystoscopy (3).

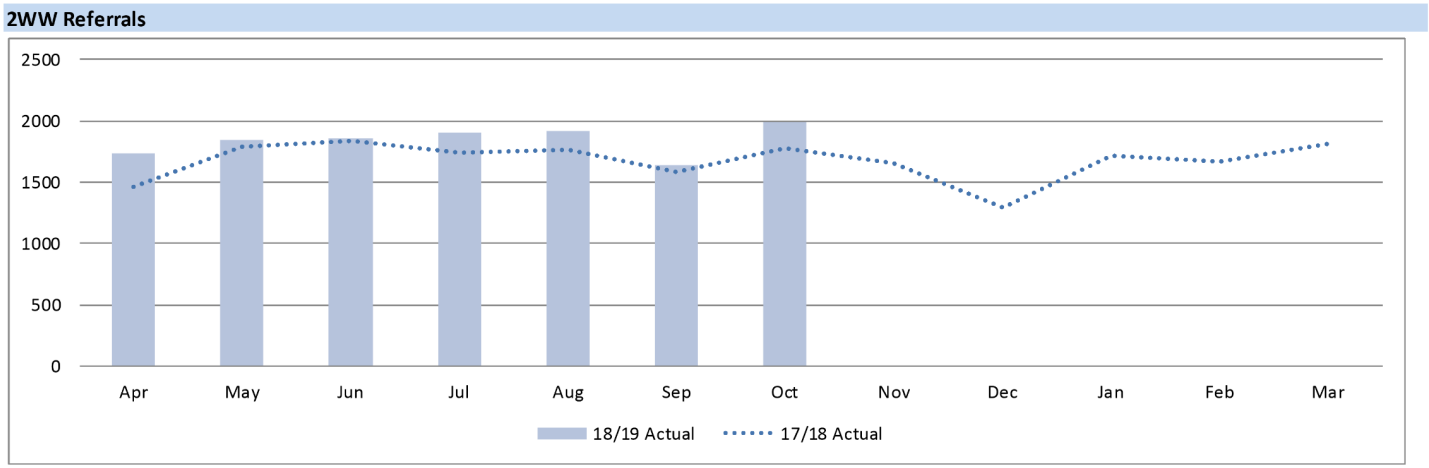
East Sussex Healthcare NHS Trust

CANCER STANDARDS

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Sep-17	Sep-18	Var	2017/18	2018/19	Var		
Cancer 2WW Standard	93.0%	96.4%	83.7%	-12.7%	95.7%	94.6%	-1.1%	95.8%	
Cancer 62 day urgent referral standard	85.0%	80.8%	59.7%	-21.1%	76.7%	74.8%	-1.9%	74.8%	
Cancer 2WW Standard (breast symptoms)	93.0%	96.7%	99.2%	2.5%	96.0%	94.9%	-1.1%	95.3%	
Cancer 31 day standard	96.0%	96.8%	90.4%	-6.3%	97.3%	95.8%	-1.6%	96.5%	
Cancer 31 day subsequent drug treatment	98.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Cancer 31 day subsequent surgery	94.0%	100.0%	75.0%	-25.0%	97.9%	95.3%	-2.6%	97.8%	
Cancer 62 day screening standard	90.0%	66.7%	61.9%	-4.8%	77.2%	46.2%	-31.1%	52.2%	

- Performance against the Cancer standards was challenged again this month. 2WW performance for September decreased to 83.7% from 91.1% in August. 62 Day performance for September decreased to 59.7% from 68.0% in August.
- The Trust reported 258 2WW breaches for September compared to 141 in August, 68 in July and 55 in June.
- The Trust reported 48 62 Day breaches for September against 40 in August, 35.5 in July and 53 in June.

Cancer 2 Week Wait Referrals



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Actual	1735	1844	1854	1901	1911	1638	1991					
17/18 Actual	1460	1784	1833	1736	1771	1579	1777	1656	1300	1717	1671	1809

Suspected Cancer Site by Date of Decision to Refer

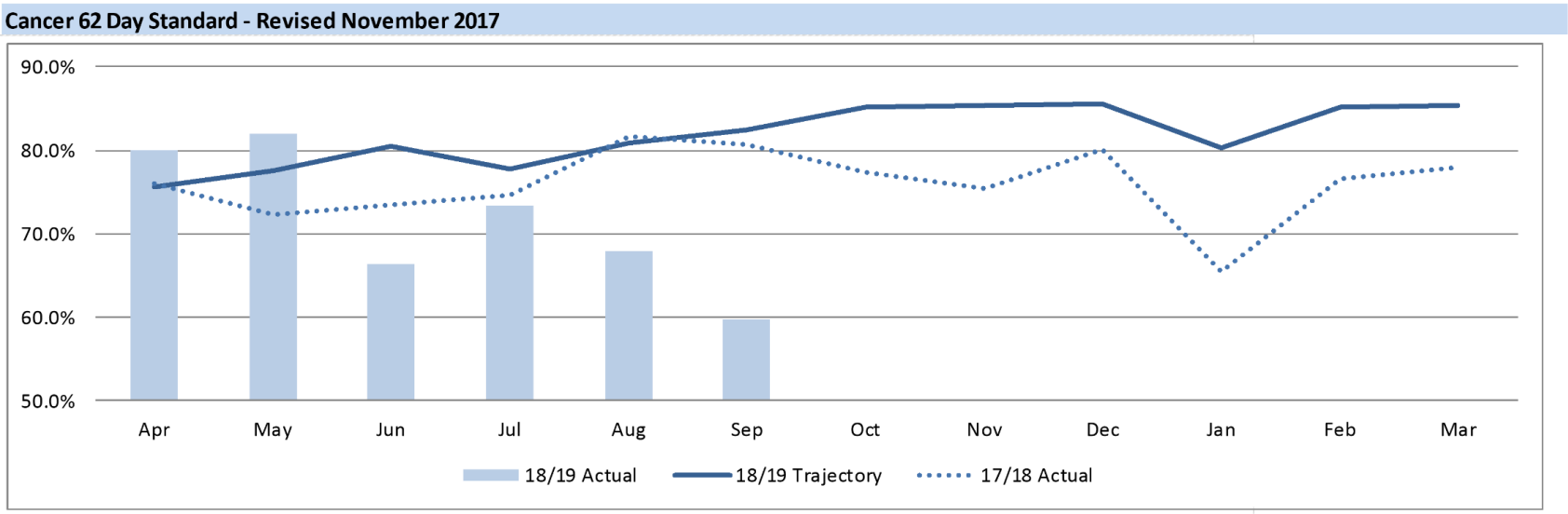
Suspected Cancer Site	Apr 17 to Sep 17	Apr 18 to Sep 18	% Variance
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1094	999	-8.7%
Other suspected cancers	30	21	-30.0%
Suspected brain/central nervous system tumours	49	35	-28.6%
Suspected breast cancer	1285	1713	33.3%
Suspected childrens cancer	10	13	30.0%
Suspected gynaecological cancers	910	998	9.7%
Suspected haematological malignancies (excluding acute leukaemia)	96	117	21.9%
Suspected head & neck cancers	1331	1258	-5.5%
Suspected lower gastrointestinal cancers	1862	2356	26.5%
Suspected lung cancer	444	402	-9.5%
Suspected sarcomas	1	0	-100.0%
Suspected skin cancers	2441	2502	2.5%
Suspected testicular cancers	94	136	44.7%
Suspected upper gastrointestinal cancers	1191	961	-19.3%
Suspected urological cancers (excluding testicular)	1102	1363	23.7%
Grand Total	**11,940**	**12,874**	**7.8%**

2 week wait referrals increased in October to the highest number year date. This increase has added further pressure into the system.

A detailed tumour site action plan has been developed and an assurance meeting held with NHSI.

Cancer 62 Days

East Sussex Healthcare NHS Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	75.7%	77.5%	80.6%	77.8%	80.8%	82.4%	85.1%	85.4%	85.6%	80.3%	85.2%	85.4%
18/19 Actual	80.1%	81.9%	66.3%	73.4%	68.0%	59.7%						
17/18 Actual	76.0%	72.4%	73.4%	74.7%	81.6%	80.8%	77.4%	75.4%	80.2%	65.5%	76.6%	78.0%

Colorectal, Lung and Breast are the highest breaching specialities this month (September).

Whilst capacity struggles to meet an up to 44% increase in demand in some tumour sites, the Trust is focusing on actions within its immediate control while services are redesigned to meet new demand levels:

- Improved booking for outpatient follow-ups.
- On day booking for Radiology appointments.
- Implementation of straight to test for the Colorectal pathway is now in place, however we are expecting to implement the FIT pathway from January 2019 (this will reduce patient pathways by two weeks at a minimum).
- 7 day booking implementation plan for Radiology and 24 hour reporting for cancer pathways.

Cancer Standards – 62 days (target 85%)

September 2018 Summary					
Standard	Total Seen /Treated	On Target	Breaches	Compliance	Target
Cancer Two Week Wait	1,583.0	1,325.0	258.0	83.7%	93%
Breast Symptom Two Week Wait	125.0	124.0	1.0	99.2%	93%
31 Day First Treatment (Tumour)	167.0	151.0	16.0	90.4%	96%
31 Day Subsequent Surgery	8.0	6.0	2.0	75.0%	94%
31 Day Subsequent Drug Treatments	19.0	19.0	0.0	100.0%	98%
31 Day Subsequent Palliative Treatments	3.0	3.0	0.0	100.0%	N/A
Cancer 62 Day Standard (Tumour)	119.0	71.0	48.0	59.7%	85%
62 Day Screening Standard (Tumour)	10.5	6.5	4.0	61.9%	90%
62 Day Upgrade Standard (Tumour)	20.0	15.5	4.5	77.5%	N/A

Community

East Sussex Healthcare NHS
NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
InPatients Total									
Number of Admissions	N/A	75	71	-4.0	1041	1129	88.0	82	
Number of Discharges	25	75	74	-1.0	1055	1020	-35.0	77	
Average Length of Stay	25	26.1	23.8	-2.4	27.2	31.6	4.4	26.8	
Occupancy rate	85%	84.1%	70.0%	-15.0%					
InPatients Irvine Unit									
Number of Admissions	N/A	24	30	6.0	385	366	-19.0	27	
Number of Discharges	25	23	26	3.0	378	367	-11.0	25	
Average Length of Stay	25	34.3	26.3	-8.0	24.7	33.3	8.6	26.8	
Occupancy rate	85%	87.9%	94.0%	6.0%					
InPatients Irvine Stroke Unit									
Number of Admissions	N/A	13	16	3.0	175	262	87.0	13	
Number of Discharges	25	9	15	6.0	200	155	-45.0	12	
Average Length of Stay	25	43.6	36.4	-7.2	37.1	43.7	6.5	26.8	
Occupancy rate	85%	96.6%	96.6%	0.0%					
InPatients Rye Memorial									
Number of Admissions	N/A	16	25	9.0	225	291	66.0	25	
Number of Discharges	25	23	24	1.0	216	292	76.0	22	
Average Length of Stay	25	18.7	16.6	-2.0	22.3	19.4	-2.9	26.8	
Occupancy rate	85%	80.4%	78.5%	-1.9%					
InPatients Firwood House									
Number of Admissions	N/A	22	0	-22.0	256	210	-46.0	18	
Number of Discharges	25	20	9	-11.0	261	206	-55.0	18	
Average Length of Stay	25	22.4	14.8	-7.6	24.7	30.0	5.4	26.8	
Occupancy rate	85%	71.0%	11.0%	-60.0%					

The inclusion of Firwood House will impact on the inpatient performance figures for October 2018 as the last patient discharge from Firwood House took place on the 14th October 2018. Activity figures for Firwood House will be removed moving forward.

Community figures require final validation and sign off by Division following completion of the new reporting layout.

Community

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Community Nursing									
Number of Referrals	1900	4186	3908	-6.6%	28675	27581	-3.8%	4041	
Number of Contacts	M	36140	35215	-2.6%	246995	246308	-0.3%	35365	
Overall response rate	100%	80.8%	86.3%	5.4%	86.1%	85.6%	-0.5%	82.6%	
Average Waiting Times (days)	M	6.08	5.01	-17.6%	44.65	6.19571	-86.1%	6.3	
JCR									
Number of Referrals	M	930	992	6.7%	6090	6756	10.9%	926	
Number of interventions started	M	632	653	3.3%	4109	3928	-4.4%	572	
Average Waiting Times (days)	M	21	20	-4.8%	129	20.2857	-84.3%	19	
Podiatry									
Number of Referrals	M	629	721	14.6%	4136	4883	18.1%	653	
Number of Contacts	M	9384	10418	11.0%	65600	68969	5.1%	9654	
Overall response rate	100%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	
Average Waiting Times (weeks)	13	1.94	1.47	-24.2%	13.45	1.94	-85.6%	2.0	
SALT									
Number of Referrals	M	140	384	174.3%	967	2478	156.3%	266	
Number of Contacts	M	1098	2830	157.7%	7063	15634	121.4%	1647	
Overall response rate	100%	100.0%	81.4%	-18.6%	100.0%	85.5%	-14.5%	90.9%	
Average Waiting Times (weeks)	13	31.74	10.59	-66.6%	144.24	17.3	-88.0%	15.2	
Average Waiting Times (days)	2	0	2.28	n/a	0	4.1	n/a	2.4	
Dietetics									
Number of Referrals	M	709	659	-7.1%	5349	4807	-10.1%	689	
Number of Contacts	M	6536	6310	-3.5%	43848	46881	6.9%	6576	
Overall response rate	100%	97.6%	100.0%	2.4%	97.6%	100.0%	2.4%	100.0%	
Average Waiting Times (weeks)	13	3.79	3.59	-5.3%	28.82	3.1	-89.3%	3.3	
Bladder and Bowel Service									
Number of Referrals	M	353	330	-6.5%	1981	2116	6.8%	309	
Number of Contacts	M	3039	3074	1.2%	18691	20612	10.3%	2927	
Overall response rate	100%	61.7%	100.0%	38.3%	72.4%	95.9%	23.4%	83.1%	
Average Waiting Times (weeks)	13	7.27	1	-80.6%	58.73	4.4	-92.6%	5	

Community

East Sussex Healthcare NHS
NHS Trust

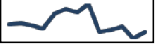
Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Hastings and Rother MSK Physio									
Number of Referrals	M	1688	999	-40.8%	5988	5814	-2.9%	794	
Overall response rate (% under 13 weeks)	100%	99.0%	49.8%	-49.2%	94.5%	50.1%	-44.4%	52.7%	
Women and Mens Health									
Number of Referrals	M	113	117	3.5%	870	722	-17.0%	122	
Overall response rate	100%	100.0%	100.0%	0.0%	89.8%	100.0%	10.2%	99.3%	
Neuro Physio									
Number of Referrals	M	43	46	7.0%	476	366	-23.1%	75	
Overall response rate	100%	81.3%	53.5%	-27.7%	82.8%	69.1%	-13.8%	66.2%	
HIT									
Number of Referrals	M	558	372	-33.3%	3889	2934	-24.6%	491	
Number of Contacts	M	933	582	-37.6%	5039	4790	-4.9%	803	
Frailty									
Number of Referrals	70	73	341	367.1%	598	864	44.5%	107	
Number of Contacts	M	473	1153	143.8%	4020	4235	5.3%	524	
Overall response rate	100%	71.7%	45.5%	-26.3%	60.6%	18.6%	-42.0%	32.7%	
Average Waiting Times (days)	5	68.68	4	-94.3%	35.118571	46.8	33.1%	56.7	
ProActive Care									
Number of Referrals	M	98	83	-15.3%	359	640	78.3%	120	
Number of Contacts	M	203	1153	468.0%	942	7308	675.8%	986	
Overall response rate	100%	59.6%	57.1%	-2.5%	32.7%	55.6%	22.9%	61.4%	
Average Waiting Times (days)	5	27.7	11.79	-57.4%	908.65	14.8	-98.4%	19	
Crisis Response									
Number of Referrals	M	165	596	261.2%	963	3609	274.8%	437	
Admissions Avoidance Referrals	M	114	167	46.5%	637	1706	167.8%	247	
Number of Contacts	M	1516	2633	73.7%	9386	16493	75.7%	2068	
Overall response rate	100%	57.6%	53.7%	-4.0%	53.5%	57.0%	3.5%	59.5%	
Average Waiting Times (hours)	M	9.11	7.24	-20.5%	51.87	49.7	-4.1%	7.1	

Activity

ACTIVITY

Acute Activity

East Sussex Healthcare NHS Trust

Indicator Description	Target	Month Comparison			YTD Comparison			Rolling 12 month Avg	Trend
		Oct-17	Oct-18	Var	2017/18	2018/19	Var		
Emergency Department attendances	M	9911	10814	9.1%	70526	76217	8.1%	10378	
Ambulance conveyances	M	3183	3144	-1.2%	22308	21763	-2.4%	3182	
Admissions via A&E	M	28.4%	29.4%	0.9%	27.4%	28.8%	1.4%	29.9%	
Elective spells	M	618	594	-3.9%	4314	3815	-11.6%	562	
Day Cases	M	4044	4219	4.3%	27564	27430	-0.5%	3899	
Elective Beddays	M	1581	1649	4.3%	11561	11346	-1.9%	1614	
Total Non-Elective Spells	M	4242	4682	10.4%	28535	31972	12.0%	4543	
Number of Emergency spells	M	3553	4056	14.2%	24178	27879	15.3%	3951	
Number of Maternity spells (ante and post partem)	M	381	336	-11.8%	2343	2184	-6.8%	318	
Number of other non-elective spells (Births/Transfers from other hospitals)	M	308	290	-5.8%	2014	1909	-5.2%	274	
Non-Elective beddays	M	21781	19581	-10.1%	151460	141712	-6.4%	21128	
LOS									
Elective Average Length of Stay	M	2.6	2.8	0.2	2.7	3.0	0.3	2.9	
Non-Elective Average Length of Stay	M	5.2	4.4	-0.8	5.4	4.5	-0.9	4.7	
Inpatient Average Length of Stay at intermediate care units	M	26.1	23.8	-2.4	28.9	26.1	-2.8	26.8	

Leadership & Culture

LEADERSHIP & CULTURE

East Sussex Healthcare NHS
NHS Trust

TRUST OVERVIEW

TRUST														
WORKFORCE CAPACITY	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend line
Budgeted fte	6,852.0	6,879.3	6,873.2	6,859.5	6,859.8	6,859.1	7,060.0	6,981.2	6,993.4	7,031.1	6,941.3	6,914.1	6,915.7	
Total fte usage	6,756.7	6,813.8	6,846.7	6,888.7	6,716.4	6,875.5	6,910.5	6,681.7	6,707.4	6,755.4	6,667.0	6,679.1	6,622.4	
Variance	-95.3	-65.5	-26.5	29.2	-143.4	16.4	-149.5	-299.5	-286.0	-275.7	-274.3	-235.0	-293.3	
Permanent vacancies	647.0	622.0	609.9	577.7	537.1	527.6	644.6	605.2	651.3	663.5	641.2	611.9	576.4	
Fill rate	90.4%	90.8%	91.0%	91.4%	92.0%	92.2%	90.5%	91.0%	90.4%	90.3%	90.5%	90.9%	91.4%	
Bank fte usage (as % total fte usage)	9.3%	9.3%	9.7%	9.7%	6.7%	9.1%	10.1%	7.3%	8.1%	8.3%	7.8%	8.1%	6.8%	
Agency fte usage (as % total fte usage)	1.8%	2.1%	1.8%	2.0%	1.9%	1.9%	1.6%	1.9%	1.8%	1.7%	1.6%	1.4%	1.2%	
Turnover rate	11.3%	11.3%	11.3%	11.2%	11.1%	11.0%	10.9%	11.0%	10.9%	11.1%	11.0%	10.8%	10.7%	
Stability rate	91.6%	91.5%	92.1%	92.2%	91.9%	92.7%	92.1%	91.9%	89.5%	92.0%	92.0%	91.8%	91.4%	
SICKNESS ABSENCE	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend line
Annual sickness rate	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	
Monthly sickness rate (%)	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%	3.6%	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%	
Short term sickness (<28 days)	58.6%	61.6%	59.0%	65.4%	48.4%	57.5%	45.9%	44.3%	46.0%	41.2%	45.0%	42.6%	46.5%	
Monthly long term sickness (28 days+)	41.4%	38.4%	41.0%	34.6%	51.6%	42.5%	54.1%	55.7%	54.0%	58.8%	55.0%	57.4%	53.5%	
MANDATORY TRAINING & APPRAISALS	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend line
Appraisal rate	82.3%	81.4%	81.3%	81.8%	81.3%	79.6%	79.5%	79.2%	78.1%	78.2%	79.7%	80.1%	79.5%	
Fire	85.8%	86.0%	85.8%	86.4%	86.5%	86.6%	86.2%	87.4%	87.1%	86.6%	87.6%	87.2%	88.2%	
Moving & Handling	89.1%	89.3%	89.4%	90.4%	90.3%	90.1%	89.4%	89.9%	89.8%	88.7%	89.2%	89.2%	90.2%	
Induction	91.9%	93.5%	92.5%	95.1%	95.1%	94.8%	94.4%	95.0%	94.3%	94.8%	96.2%	95.5%	91.3%	
Infec Control	88.8%	88.8%	88.7%	89.8%	89.9%	90.2%	89.9%	90.5%	90.1%	89.6%	90.0%	89.7%	90.9%	
Info Gov	85.0%	85.8%	84.6%	86.8%	86.5%	86.3%	85.8%	85.1%	83.8%	84.7%	84.0%	82.5%	82.0%	
Health & Safety	87.9%	88.8%	87.9%	88.0%	87.4%	88.0%	88.8%	89.1%	88.6%	89.4%	88.7%	88.2%	88.3%	
MCA	94.8%	94.8%	95.1%	95.0%	95.3%	95.8%	95.8%	96.1%	96.1%	96.5%	96.5%	95.7%	95.7%	
DoLs	95.5%	95.5%	95.8%	95.1%	96.3%	96.4%	96.4%	96.8%	96.9%	97.2%	96.7%	94.9%	94.9%	
Safeguarding Vulnerable Adults	88.0%	87.8%	87.4%	86.2%	85.2%	84.7%	84.2%	85.8%	86.0%	86.7%	86.6%	86.3%	87.2%	
Safeguarding Children Level 2	85.9%	86.0%	85.7%	85.0%	85.4%	85.3%	84.7%	86.4%	87.4%	87.6%	87.8%	87.5%	88.2%	

***Source data**: ESR & Finance Ledger*

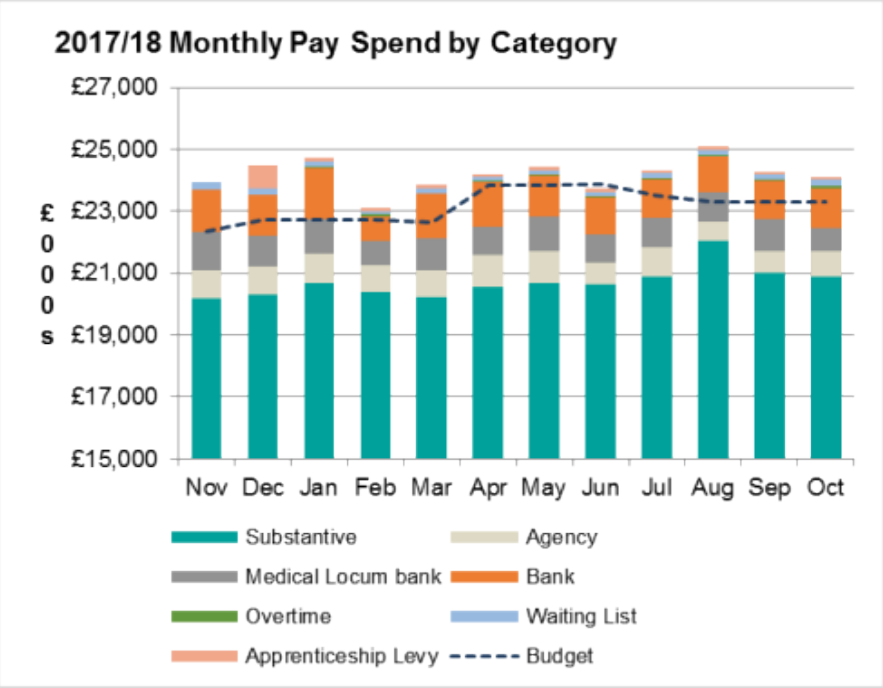
MONTHLY HEADLINES

HEADLINES – SEPTEMBER 2018

- Actual workforce utilisation 6,622.4 fte, -293.3 fte below the budgeted establishment
- October '18 monthly budget £23,228k against monthly actual expenditure £24,122 (-£894k)
- Substantive expenditure £20,868k
  - Temporary staff expenditure £3,156k (15.1% of total pay expenditure) as follows:
    - Bank expenditure £2,047k
    - Agency expenditure £833k
    - Overtime £51k
    - Waiting List payments £225K
- Vacancies in September have reduced to 576.4 fte (8.6%), this is a decrease of 35.5 ftes
- Annual turnover reduced by -0.1% to 10.7%, which represents 627.4 fte leavers in the last year
- Annual sickness rate unchanged at 4.4%
- Monthly sickness increased by +0.2% against September to 4.4%.
- Mandatory Training rate and Appraisal rates:
  - Mandatory Training rate increased by +0.5% to 88.8%. Compliance has increased, or stayed unchanged, for all courses except for Trust Induction and Information Governance which have decreased.
  - Appraisal compliance reduced by -0.6% to 79.5%

WORKFORCE EXPENDITURE

Actuals in Month (£000s)													
Category	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Budget	£22,366	£22,726	£22,733	£22,733	£22,657	£23,830	£23,824	£23,875	£23,490	£23,321	£23,282	£23,282	
Substantive	**£20,189**	**£20,306**	**£20,679**	**£20,401**	**£20,228**	**£20,540**	**£20,683**	**£20,635**	**£20,873**	**£22,044**	**£21,024**	**£20,868**	
Apprenticeship Levy		£744	£123	£128	£126	£94	£100	£92	£99	£108	£93	£98	
Agency	£889	£907	£929	£848	£863	£1,053	£1,037	£697	£954	£604	£667	£833	
Medical Locum bank	£1,249	£976	£1,145	£796	£1,014	£911	£1,086	£923	£977	£960	£1,037	£738	
Bank	£1,347	£1,329	£1,663	£801	£1,448	£1,451	£1,343	£1,210	£1,229	£1,172	£1,244	£1,309	
Overtime	£32	£31	£31	£45	£34	£46	£28	£30	£43	£41	£42	£51	
Waiting List	£238	£195	£153	£108	£135	£110	£151	£128	£136	£156	£183	£225	
Total Temp Expenditure	**£3,755**	**£3,438**	**£3,921**	**£2,598**	**£3,494**	**£3,571**	**£3,645**	**£2,988**	**£3,339**	**£2,933**	**£3,173**	**£3,156**	
Total Spend	**£23,944**	**£24,488**	**£24,723**	**£23,127**	**£23,848**	**£24,205**	**£24,428**	**£23,715**	**£24,311**	**£25,085**	**£24,290**	**£24,122**	



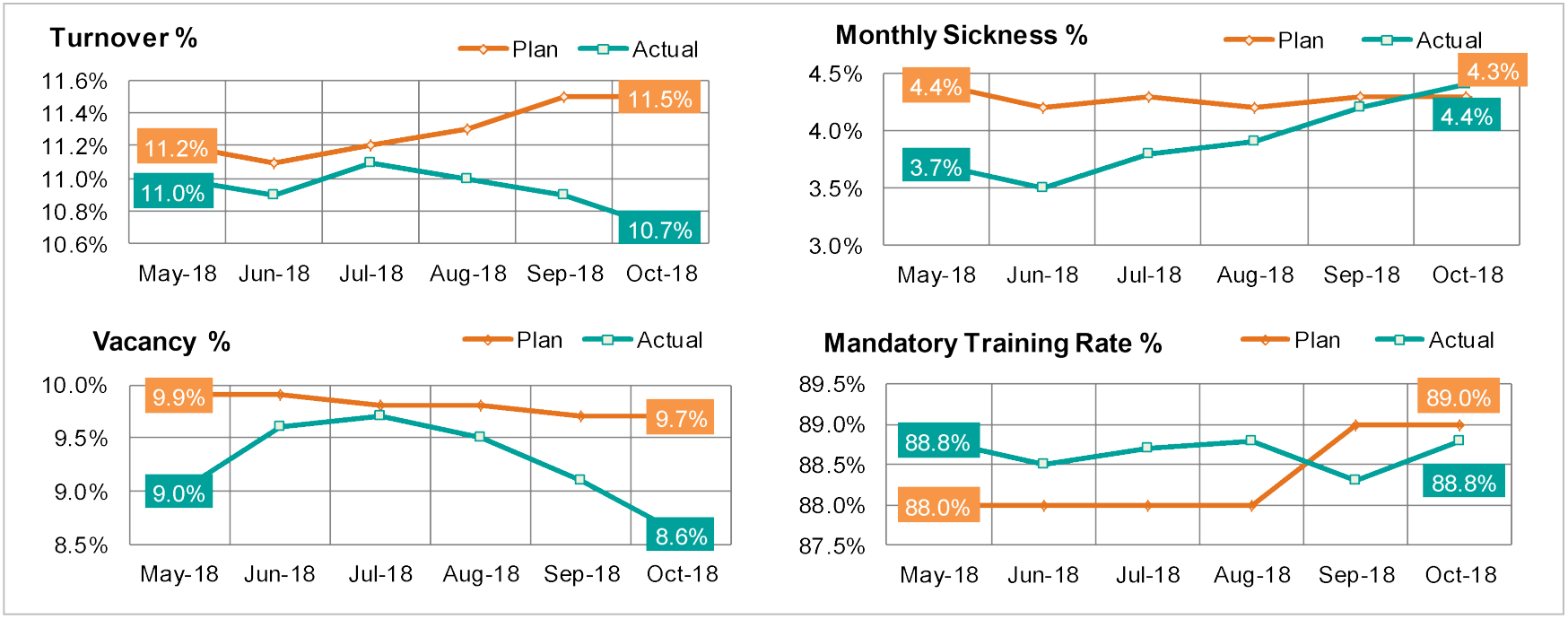
- **BANK** - Expenditure reduced by -£234K this month due to locum consultants leaving in Rheumatology, Gastroenterology/Endoscopy and Respiratory Medicine. Spend was also higher last month in Urgent Care for locums covering additional shifts and has returned to more normal levels this month.
- **AGENCY** - Expenditure increased by +£166K overall this month. This includes temporary medical agency cover in Respiratory Medicine and for Gynaecology consultants, increased Theatres activity this month and backdated costs for agency cover for the Radiology General Manager.
- **OVERTIME** – Expenditure increased by £9K. This was, in part due to the increased Theatres activity, cover for nursing vacancies in A&E, on both sites, and in Endoscopy to cover lists.

***Source data**: Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL

- The Trust is performing better than forecast on turnover and vacancy rate (compared to the KPIs from the Workforce Submission to NHSI refresh as of 20th June '18)
- KPIs)

Category	Plan/Actual	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Annual Turnover %	Plan	11.2%	11.1%	11.2%	11.3%	11.5%	11.5%
	Actual	11.0%	10.9%	11.1%	11.0%	10.9%	10.7%
Monthly Sickness %	Plan	4.4%	4.2%	4.3%	4.2%	4.3%	4.3%
	Actual	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%
Vacancy Rate %	Plan	9.9%	9.9%	9.8%	9.8%	9.7%	9.7%
	Actual	9.0%	9.6%	9.7%	9.5%	9.1%	8.6%
Mandatory Training rate	Plan	88.0%	88.0%	88.0%	88.0%	89.0%	89.0%
	Actual	88.8%	88.5%	88.7%	88.8%	88.3%	88.8%

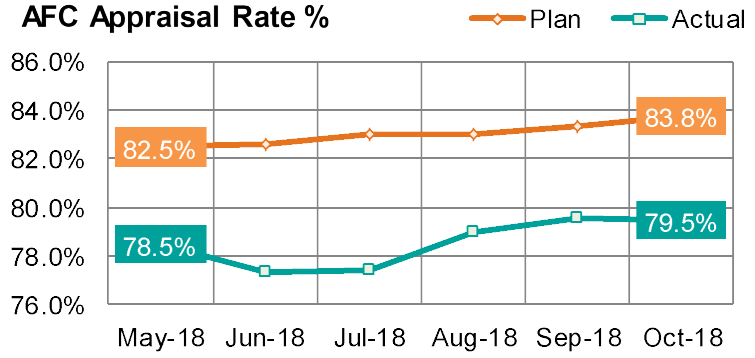


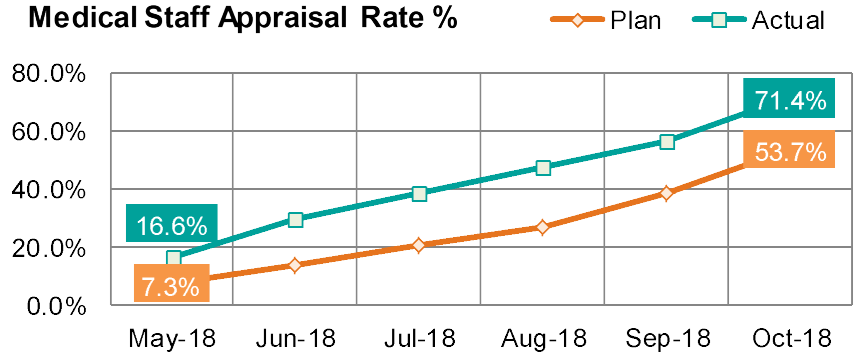
***Source data**: ESR & Finance Ledger*

NHSI KPI'S - PLANNED v ACTUAL (continued)

- Agenda for Change appraisal rate % based on a rolling year whilst the Medical Staff Appraisal rate represents year to date (as per Revalidation reports)
- Agenda for Change appraisal rate below forecast and has reduced slightly this month

Category	Plan/Actual	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
AfC Appraisal Rate (rolling year)	Plan	82.5%	82.6%	83.0%	83.0%	83.4%	83.8%
	Actual	78.5%	77.3%	77.4%	79.0%	79.6%	79.5%
Medical Staff Appraisal Rate (Yr to date)	Plan	7.3%	13.5%	20.5%	26.8%	38.6%	53.7%
	Actual	16.6%	29.9%	38.8%	47.6%	56.2%	71.4%





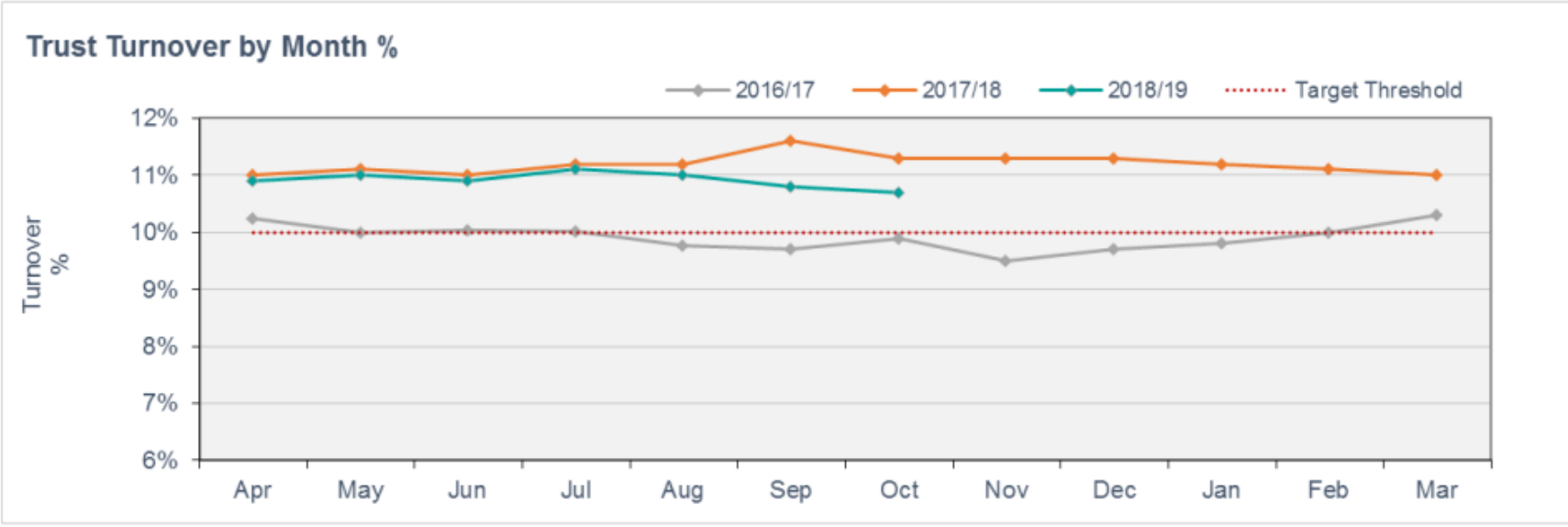
***Source data**: ESR & Finance Ledger*

TURNOVER TREND – STAFF GROUP

- Turnover rate of 10.7% in October equates to 627.4 fte leavers.
- Comparative figures for Surrey & East Sussex (SES) STP Trusts show that in June 18 this Trust had the third lowest turnover rate, whilst four Trusts had rates of over 14%.

TRUST TURNOVER BY STAFF GROUP (%)

Year on Year	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Additional Clinical Services	14.5%	13.8%	13.5%	13.5%	13.5%	13.4%	13.5%	13.4%	14.0%	13.5%	12.9%	12.3%	
Administrative and Clerical	10.8%	11.1%	11.4%	11.1%	11.3%	11.7%	12.5%	11.7%	11.8%	11.6%	11.6%	12.0%	
Allied Health Professionals	11.6%	12.7%	12.7%	12.9%	13.2%	12.1%	10.6%	10.0%	9.6%	9.6%	9.7%	10.5%	
Estates and Ancillary	11.4%	10.4%	10.7%	10.3%	9.9%	8.9%	8.6%	9.1%	9.9%	9.1%	8.8%	8.2%	
Healthcare Scientists	12.4%	11.0%	9.7%	10.9%	12.1%	11.8%	10.8%	12.3%	12.5%	12.1%	10.2%	10.1%	
Medical & Dental	9.4%	10.0%	9.1%	9.7%	10.8%	10.4%	11.1%	11.7%	11.8%	11.5%	10.7%	10.4%	
Nursing & Midwifery Registered	10.2%	10.4%	10.2%	10.0%	9.4%	9.2%	9.4%	9.3%	9.5%	9.9%	10.2%	10.1%	
Prof Scientific and Tech	8.8%	8.8%	8.3%	9.7%	8.8%	8.7%	8.6%	8.7%	9.3%	9.1%	8.9%	8.2%	
TOTAL TRUST TURNOVER	**11.3%**	**11.3%**	**11.2%**	**11.1%**	**11.0%**	**10.9%**	**11.0%**	**10.9%**	**11.1%**	**11.0%**	**10.8%**	**10.7%**	



***Source data**: ESR*

LEAVERS & STABILITY – STAFF GROUP

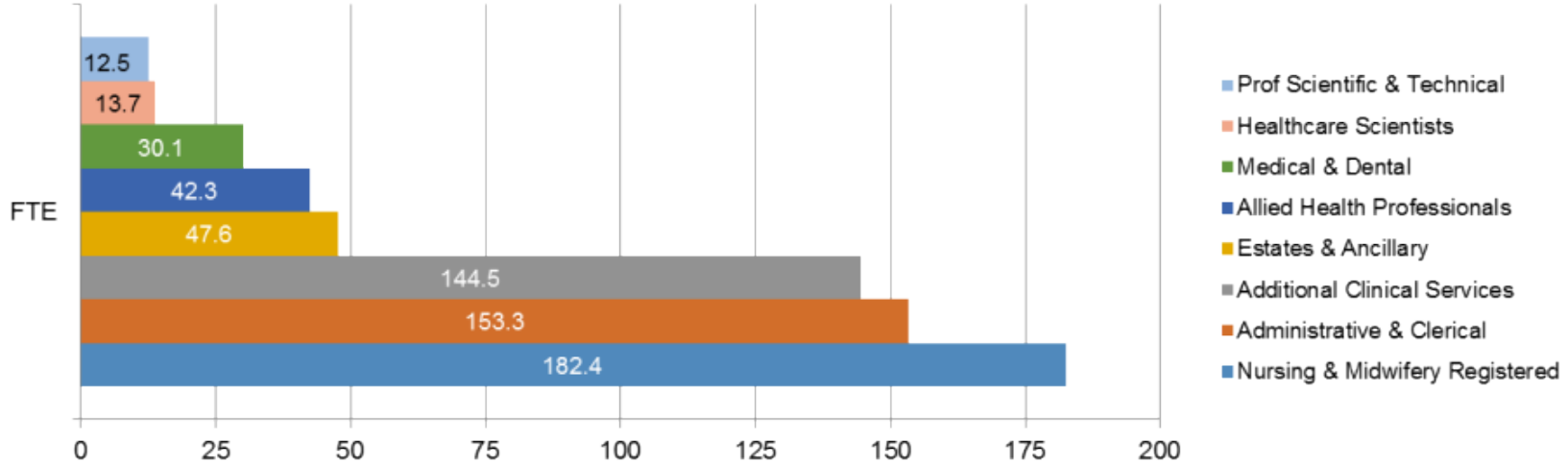
STAFF GROUPS	STABILITY > 1YR
Medical & Dental	92.5%
Prof Scientific & Technical	86.1%
Administrative & Clerical	92.3%
Nursing & Midwifery Registered	91.7%
Estates & Ancillary	96.2%
Additional Clinical Services	89.1%
Healthcare Scientists	92.6%
Allied Health Professionals	89.2%
TRUST	**91.4%**

Overview

- The Stability Rate measures the number of current staff who have more than 1 year's service with ESHT
- Nursing & Midwifery Registered staff remain the largest cohort of leavers with 182.4 ftes leaving in the last year. The next largest group, this month, is now Administrative & Clerical staff
- Medical & Dental leavers does not include junior doctor rotation, in line with common NHS practice.

Source: ESR October 2018

ANNUAL LEAVERS BY STAFF GROUP (fte)

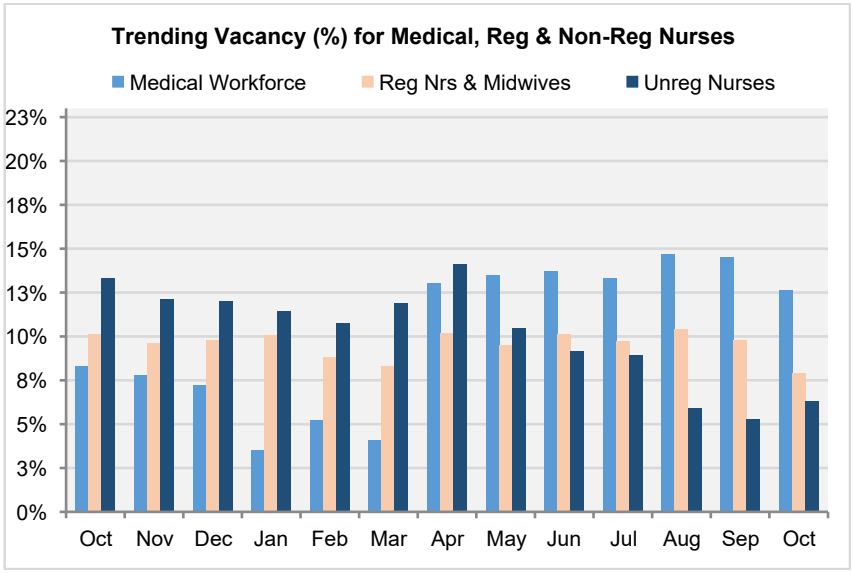


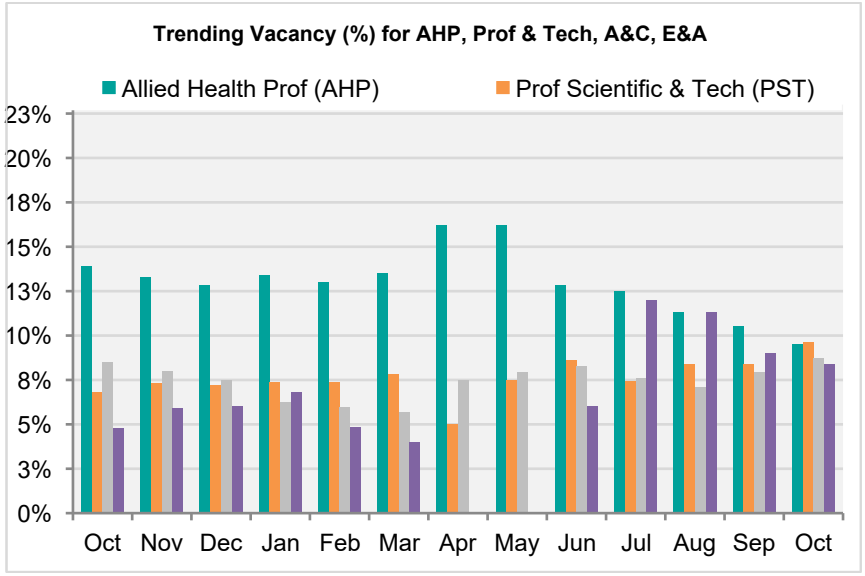
***Source data**: ESR*

RECRUITMENT – TRENDING NET VACANCIES BY STAFF GROUP (%)

- Vacancy rate has reduced by 0.6%. Total vacancies for the Trust is 576.4 fte. Reductions in medical and qualified nursing vacancies.
- 6 offers made on "hard to recruit" medical posts through Medacs agency. Another 23 posts identified for action.
- In June, the Trust had the lowest vacancy rate amongst SES STP Trusts. The range was 9.6% - 11.3%.

OCT 2017 TO OCT 2018	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Trend line
Medical Workforce	8.3%	7.8%	7.2%	3.5%	5.2%	4.1%	13.0%	13.5%	13.7%	13.3%	14.7%	14.5%	12.6%	
Reg Nrs & Midwives	10.1%	9.6%	9.8%	10.1%	8.8%	8.3%	10.2%	9.5%	10.1%	9.7%	10.4%	9.8%	7.9%	
Unreg Nurses	13.3%	12.1%	12.0%	11.4%	10.7%	11.9%	14.1%	10.5%	9.2%	8.9%	5.9%	5.3%	6.3%	
Allied Health Prof (AHP)	13.9%	13.3%	12.8%	13.4%	13.0%	13.5%	16.2%	16.2%	12.8%	12.5%	11.3%	10.5%	9.5%	
Prof Scientific & Tech (PST)	6.8%	7.3%	7.2%	7.4%	7.4%	7.8%	5.0%	7.5%	8.6%	7.4%	8.4%	8.4%	9.6%	
Admin & Clerical	8.5%	8.0%	7.5%	6.2%	6.0%	5.7%	7.5%	8.0%	8.2%	7.6%	7.1%	7.9%	8.7%	
Estates & Ancillary (E&A)	4.8%	5.9%	6.0%	6.8%	4.8%	4.0%	-1.5%	-2.7%	6.0%	12.0%	11.3%	9.0%	8.4%	
TRUST	**9.6%**	**9.2%**	**9.0%**	**8.6%**	**8.0%**	**7.8%**	**9.5%**	**9.0%**	**9.6%**	**9.7%**	**9.5%**	**9.1%**	**8.6%**	





***Source data**: ESR & Finance Ledger*

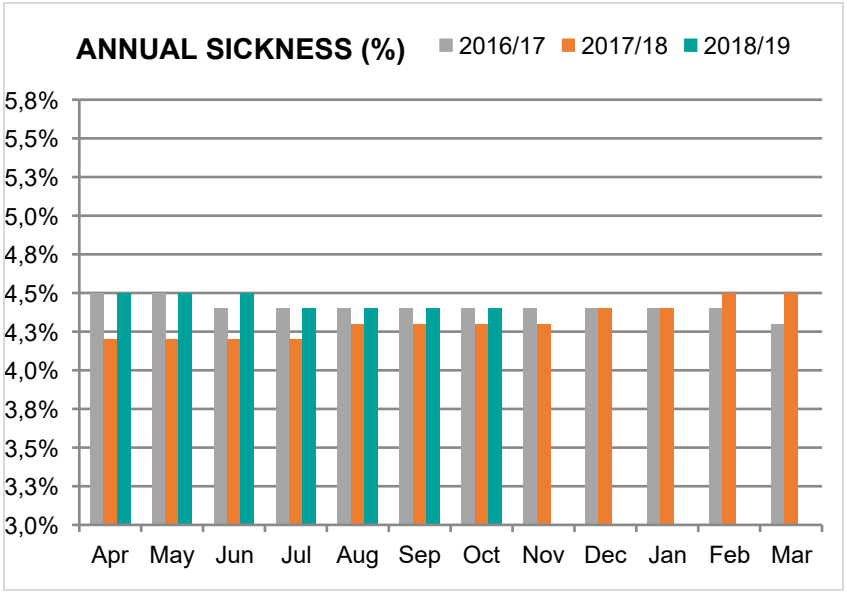
East Sussex Healthcare NHS
NHS Trust

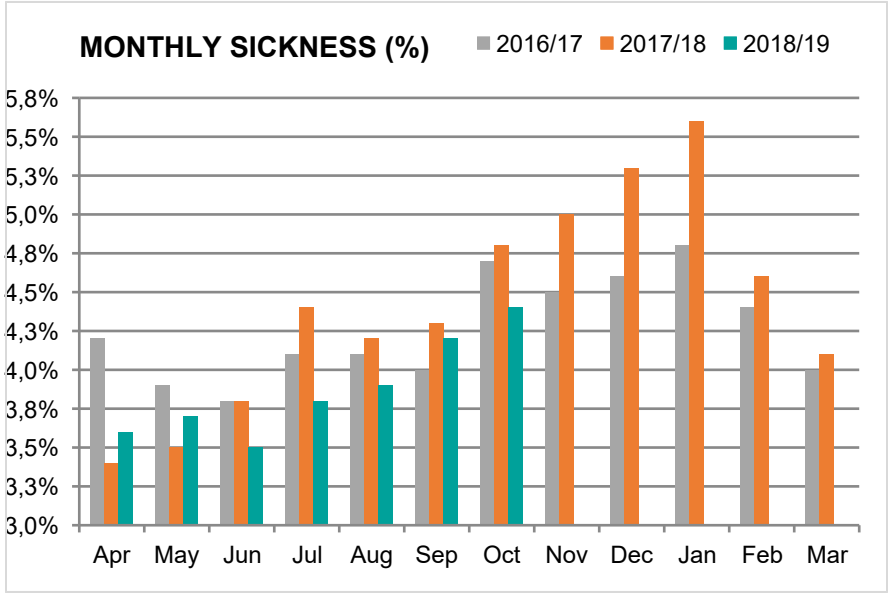
ABSENCE MANAGEMENT – SICKNESS RATES

- The monthly sickness rate has increased by +0.2% to 4.4%, following the seasonal pattern, but is lower than for October '16 or '17.
- The latest national comparison rates relate to 2017/18. The national NHS rate was 4.2%. The Trust's rate, at that time, of 4.5% sits between the national rate for Acute Trusts at 4.0% and for Community Trusts at 4.8%.
- Amongst SES STP Trusts we had the fourth highest monthly rate in May (out of 9 Trusts) The range was 3.0% - 4.8%.

ANNUAL (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.3%
2017/18	4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.4%	4.5%	4.5%
2018/19	4.5%	4.5%	4.5%	4.4%	4.4%	4.4%	4.4%					

MONTHLY (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	4.2%	3.9%	3.8%	4.1%	4.1%	4.0%	4.7%	4.5%	4.6%	4.8%	4.4%	4.0%
2017/18	3.4%	3.5%	3.8%	4.4%	4.2%	4.3%	4.8%	5.0%	5.3%	5.6%	4.6%	4.1%
2018/19	3.6%	3.7%	3.5%	3.8%	3.9%	4.2%	4.4%					





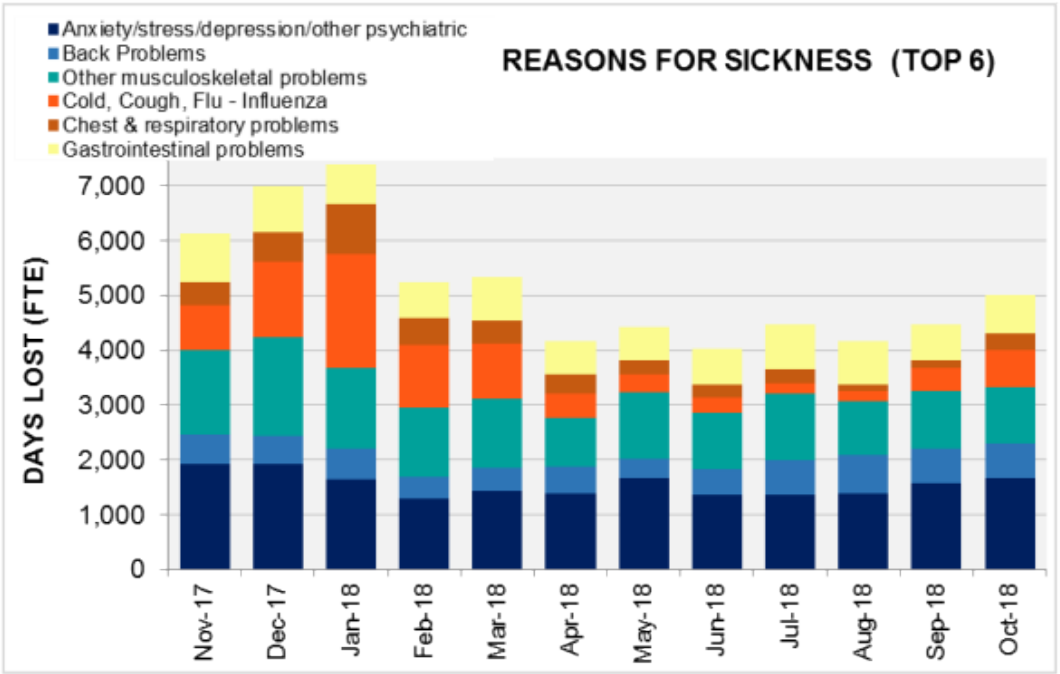
***Source data**: ESR*

East Sussex Healthcare NHS
NHS Trust

ABSENCE MANAGEMENT – SICKNESS REASONS

- Anxiety/stress/depression remains the highest reason for sickness and has increased by +72 ftes days lost this month.
- Other seasonal illnesses such as Cold, Cough, Flu (+272 days) and Chest & Respiratory (+150) problems are increasing
- Fte days lost to sickness in October were 8,491 (+787 days) which equates, in total, to 274 fte staff off sick.

TOP 6	Fte Days Lost by Month												
Reason for sickness	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend line
Anxiety/stress/depression/other psychiatric	1,912.3	1,912.1	1,641.5	1,299.1	1,433.3	1,376.5	1,660.3	1,363.5	1,369.6	1,391.9	1,583.4	1,655.6	
Back Problems	548.2	532.2	553.9	396.6	415.1	490.1	346.1	462.9	629.8	691.8	617.0	641.4	
Other musculoskeletal problems	1,532.5	1,803.4	1,490.5	1,259.0	1,270.8	905.9	1,231.1	1,032.2	1,212.7	977.0	1,058.3	1,031.5	
Cold, Cough, Flu - Influenza	829.0	1,360.5	2,070.4	1,139.0	990.8	442.9	313.0	275.3	189.2	185.8	410.6	682.5	
Chest & respiratory problems	409.5	555.1	920.1	499.6	438.6	353.0	264.0	235.8	244.2	132.8	142.1	291.9	
Gastrointestinal problems	895.1	831.8	723.1	647.3	777.1	587.5	604.9	657.3	825.8	782.7	657.3	698.0	

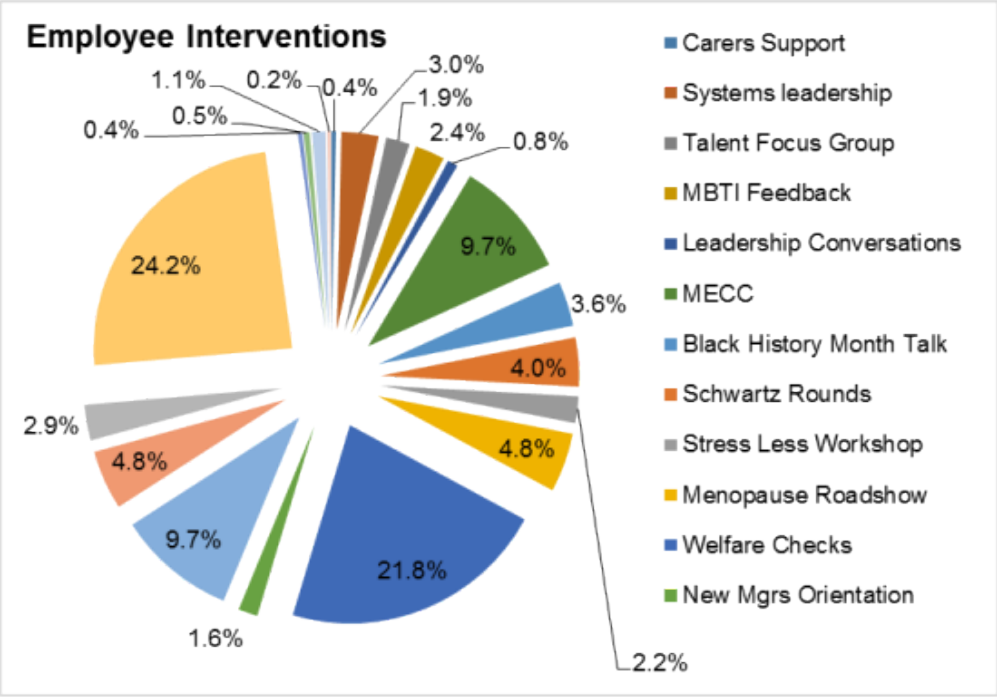


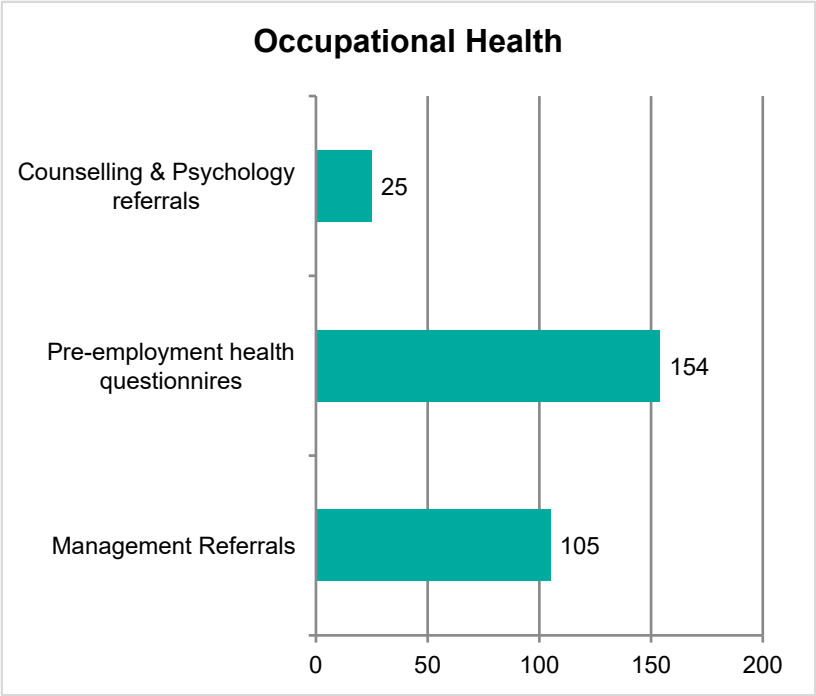
Oct 2018 - Top 10 in descending order (%)		%
1	Anxiety/stress/depression/other psychiatric illnesses	19.5%
2	Other musculoskeletal problems	12.1%
3	Other known causes - not elsewhere classified	8.8%
4	Gastrointestinal problems	8.2%
5	Cold,Cough,Flu - Influenza	8.0%
6	Back Problems	7.6%
7	Unknown causes / Not specified	6.2%
8	Injury, fracture	4.9%
9	Genitourinary & gynaecological disorders	3.5%
10	Chest & respiratory problems	2.8%
	TOP 10 REASONS	**81.6%**

***Source data**: ESR*

WELLBEING & ENGAGEMENT

- Flu uptake is at 63%
- Health and wellbeing strategy launching over next few weeks
- Task and finish group underway for exit interview process
- Stay interviews pilot underway





East Sussex Healthcare NHS
NHS Trust

TRAINING & APPRAISAL COMPLIANCE BY DIVISION

MANDATORY TRAINING

- Overall mandatory training compliance increased by +0.5%
- Comparative information for SES STP Trusts shows the Trust as ranking 4th out of the 7 Trusts who reported on compliance in June, at 88.5%. The range was 77.3% to 93.0%.
- Learning & Development have been working to identify new starters who have not been booked onto Trust Induction and are following this up with staff and managers.
- Divisions are being reminded that it is a priority for staff to complete their Information Governance training through e-learning in line with the GDPR toolkit.

APPRAISAL OVERVIEW

- The overall appraisal rate for the Trust has reduced by 0.6% to 79.5%.
- Of the 4 SES STP Trusts reporting 12 month appraisal rates, the Trust was the lowest at 78.1%, in June. The range was 78.1% - 87.5%.

DIVISION	APPRAISAL COMPLIANCE	
	12 mth	16 mth
Urgent Care	71.6%	80.4%
Medicine	79.9%	88.9%
Out of Hospital	76.1%	86.0%
Diag/Anaes/Surg	82.0%	90.1%
Womens, Child, S/Health	72.0%	83.1%
Estates & Facilities	88.9%	92.5%
Corporate	79.8%	87.3%
TRUST	**79.5%**	**87.9%**

										SAFEGUARDING		
DIVISION	FIRE SAFETY	MANUAL HANDLING	INDUCTION	INFECTION CONTROL	INFO GOV	HEALTH & SAFETY	MENTAL CAPACITY ACT	DEPRIV OF LIBERTIES	END OF LIFE CARE	VULNERABLE ADULTS	CHILDREN (LEVEL 2)	CHILDREN (LEVEL 3)
Urgent Care	76.5%	79.1%	71.4%	78.4%	74.6%	87.7%	90.8%	83.1%	16.6%	83.8%	87.8%	88.7%
Medicine	86.3%	87.9%	89.0%	88.3%	78.3%	87.3%	94.4%	89.9%	39.3%	86.7%	86.6%	n/a
Out of Hospital	87.7%	92.0%	99.4%	94.2%	77.9%	86.8%	98.1%	99.3%	31.0%	87.1%	86.3%	62.0%
Diag/Anaes/Surg	86.3%	88.8%	84.6%	88.3%	80.6%	83.5%	96.1%	94.2%	32.8%	87.9%	88.6%	n/a
Womens, Child, S/Health	89.3%	88.9%	93.3%	92.2%	81.8%	90.7%	95.2%	94.7%	1.4%	89.0%	93.8%	94.4%
Estates & Facilities	91.7%	92.4%	94.3%	92.7%	87.8%	92.7%	n/a	n/a	n/a	n/a	n/a	n/a
Corporate	94.3%	96.0%	97.6%	95.8%	92.2%	94.6%	99.0%	98.8%	4.3%	82.3%	83.6%	100.0%
TRUST	**88.2%**	**90.2%**	**91.3%**	**90.9%**	**82.0%**	**88.3%**	**95.7%**	**94.9%**	**29.1%**	**87.2%**	**88.2%**	**85.1%**

Training & Appraisal Parameters: +85% **Green**, 75% to 85% **Amber**, < 75% **Red**

***Source data**: ESR*

APPENDIX

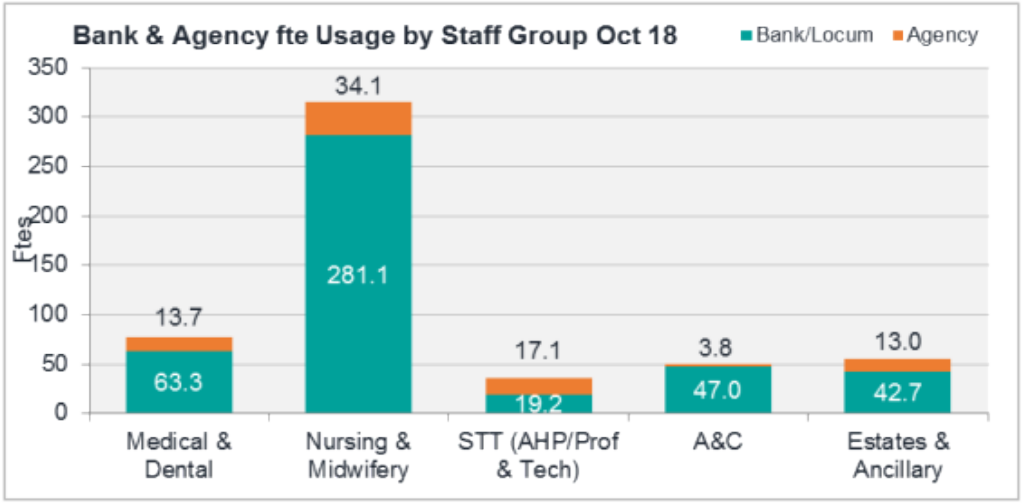
- Supporting documents

WORKFORCE UTILISATION BY DIVISION – OCTOBER '18

RESOURCE RATIO - MONTHLY					
DIVISION	**BUDGET FTE**	**SUBSTANTIVE**	**BANK**	**AGENCY**	**TOTAL**
Diagnostics Anaesthetics & Surgery	1,758.5	1,539.8	92.8	22.5	1,655.1
Medicine	1,413.2	1,196.8	191.2	14.8	1,402.8
Out of Hospital Care	1,073.9	976.5	28.3	7.1	1,011.9
Womens Childrens & Sexual Health	700.0	623.1	24.6	8.0	655.7
Estates & Facilities	635.1	554.4	42.4	13.0	609.8
Urgent Care	323.7	248.0	44.4	12.4	304.8
Corporate	1,011.3	949.0	29.6	3.8	982.3
TRUST	**6,915.7**	**6,087.5**	**453.3**	**81.6**	**6,622.4**

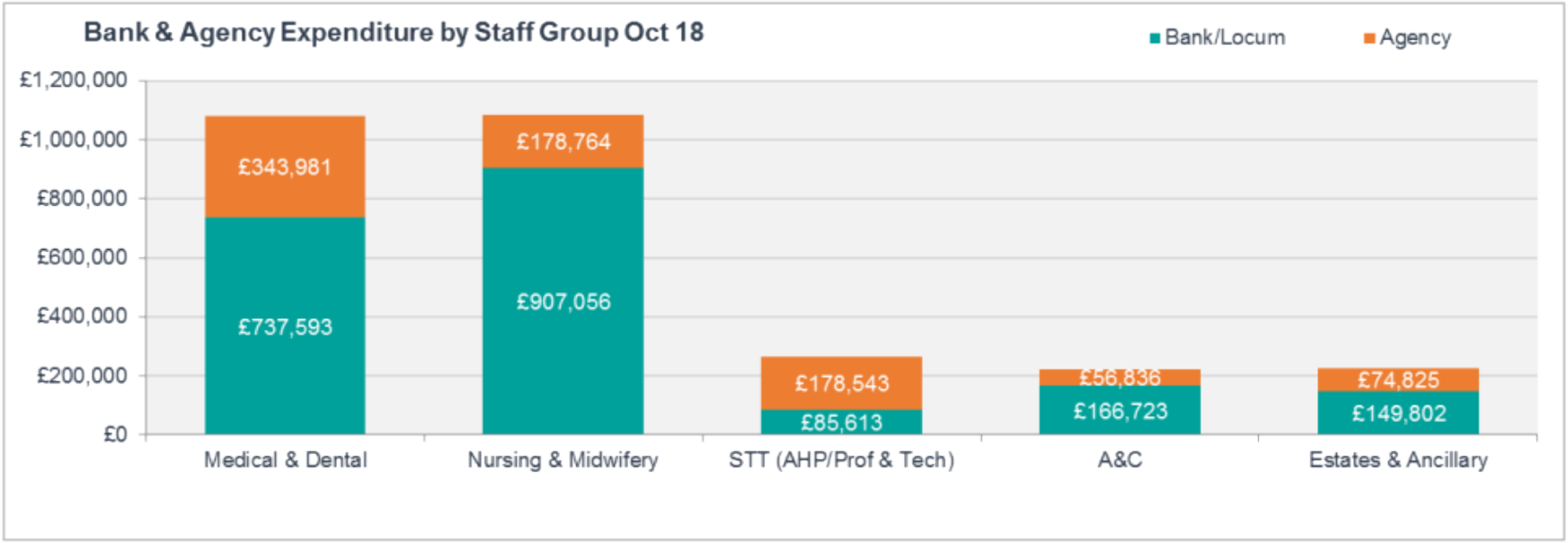
***Source data**: Finance Ledger*

FLEXIBLE LABOUR – FTE & EXPENDITURE FOR OCTOBER '18



- Total temporary workforce expenditure decreased in Oct '18 against Sep '18 by -£17K:
  - Bank costs reduced by -£234K
  - Agency costs increased by +£166K
  - Overtime costs increased by +£9K
  - Waiting list costs increased by +£42K

(Source data: Finance Ledger M7)



***Source data**: Finance Ledger*

GLOSSARY

No.	TERM	DEFINITION
1	Prof Scientific and Tech	Professional Technical staff including Pharmacists & Pharmacy Technicians, Chaplaincy staff, Theatre Operating Dept Practitioners (this latter is in accordance with current NHS Occupational Code guidelines)
2	Additional Clinical Services	Unregistered staff including unregistered nurses & therapy helpers
3	Administrative and Clerical	All administrative & clerical staff including senior managers
4	Allied Health Professionals	Registered Chiropodists, Dietitians, Occupational Therapists, Orthoptists, Physiotherapists, Radiographers, Speech & Language Therapists
5	Estates and Ancillary	Estates, Facilities, Housekeeping, Catering, Portering, Laundry staff
6	Healthcare Scientists	Biomedical Scientists, Audiologists, Cardiographers, EME Technicians, Medical Photographers
7	Medical & Dental	All medical & dental staff; consultants, career grades & junior doctors
8	Nursing & Midwifery Registered	Registered nurses, midwives and health visitors
9	Students	Students are included within their relevant professions
10	Urgent Care	Also known as Emergency Department
11	Annual Sickness Calculation	Fte days lost to sickness over rolling 12 months divided by fte days available over same period

September 2018

FINANCE

Jonathan Reid, Director of Finance

Finance Report Summary - Month 7

Single Oversight Framework

	Plan YTD	Actual YTD	Plan FOT	Forecast FOT
Capital Service Capacity	4	4	4	4
Liquidity	2	2	2	2
I&E Margin	4	4	4	4
Distance from Financial Plan	4	4	4	4
Agency Spend	1	1	1	1
Finance Rating	**3**	**3**	**3**	**3**
Rating With Overrides	**4**	**4**	**4**	**4**

Operational Deficit

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(27,580)	(25,986)	(27,667)	(1,681)
Year End Forecast	(68,422)	(45,000)	(45,000)	0

At M7 the run rate has improved by £1.3m. The Trust is £1.7m behind plan YTD due to profiling. The YTD value of the fixed income deal brokered with ESBT CCGS is included in the financial position. Overspends are primarily in medical pay, WLIs, premium payments and nursing special observations £0.6m. CIP is £0.8m behind plan YTD. Non pay underspends include non recurrent benefits from VAT and stock adjustmentsYTD non-pay overspends include NHS Property Services void costs and drugs offset by non-recurrent benefits from VAT and stock adjustments.

Agency Usage

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(9,362)	(5,860)	(5,845)	15
Year End Forecast	(13,799)	(9,305)	(9,305)	0

Agency spend has reduced by £3.5m (38%) compared to the same period 2017/18. However, there is continued requirement for agency in difficult to recruit medical and AHP posts. Overall agency costs are within the NHSI ceiling for 2018/19 and £15k below plan YTD. Internal bank and locum spend is overspent against plan.

Income

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	229,442	232,577	237,291	4,714
Year End Forecast	387,935	397,467	397,467	0

YTD under performance on elective and day case activity £1.6m is fully offset by increased non-elective activity above planned values. A&E activity is significantly above plan in month which is in line with national trends. £2.9m national funding for the 18/19 pay award is showing above plan on income, and offsetting increased pay costs. The YTD value of the fixed income deal is included in the financial position.

Operating Costs

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Year to Date	(252,549)	(254,039)	(260,475)	(6,436)
Year End Forecast	(448,948)	(434,713)	(434,713)	0

Overall costs are reporting £6.5m overspent against plan YTD. 18/19 AfC wage award national deal (£2.9m offset by additional funding in income), medical pay costs including agency (£2.3m) drugs overspend (£0.6m) and CIP under delivery are offset by non-recurrent benefits from stock adjustments and VAT.

Cost Improvement Programme

	Plan £k	Actual £k	Variance £k
Year to Date	10,287	9,516	(771)
Year End Forecast	23,516	23,516	0

YTD the Trust is behind the plan for M7 by £0.8m. The main adverse variances are bed modelling (£1,028k), slippage in month 1 and 2 on endoscopy scopes (£102k) and WLI reduction in DAS (£198k); this underperformance is partially offset with over delivery on pharmacy drugs (£400k), vacancies in Emergency Care (137k) as well as the Maternity CNST being received early.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	2,512	412
Year End Forecast	2,100	2,100	2,100	0

Cash balance above minimum balance at month end.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	11,928	7,336	4,592
Year End Forecast	23,856	23,856	0

Current CRL is £14m (which includes £0.8m of winter funding). To enable the Trust to deliver the planned spend significant external funding will need to be applied for, approved and delivered in year. Two submissions for emergency capital funding have been developed and submitted to NHSI.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	68.09%	63.46%	62.93%	71.08%
NHS Invoices	93.06%	93.51%	85.05%	96.82%

68% of trade invoices were paid within 28 days which equates to 63% of the total value paid in month.

93% of NHS invoices were paid within contract or within 28 days of receipt which was 94% of the total NHS invoices paid.

Divisional Performance

Division	In the Month			Year to Date			Forecast Outturn		
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,758.49	1,655.09	103.40	386	(220)	(607)	(2,420)	(5,693)	(3,273)	(3,924)	(3,924)	0
Medicine	1,413.19	1,402.78	10.41	3,049	3,182	133	19,627	17,861	(1,766)	32,610	32,610	0
Urgent Care	323.73	304.80	18.93	721	777	56	5,159	5,888	730	8,454	8,454	0
Out of Hospital Care	1,073.90	1,011.87	62.03	(497)	(838)	(341)	(4,082)	(4,821)	(760)	(6,973)	(6,973)	0
Women's, Children's & Sexual Health	699.96	655.70	44.26	1,270	1,067	(203)	7,773	6,936	(837)	13,166	13,166	0
Estates & Facilities	635.07	609.82	25.25	(1,906)	(2,245)	(340)	(13,900)	(14,952)	(1,052)	(23,765)	(23,765)	0
Corporate	1,011.33	982.34	28.99	(3,857)	(3,982)	(125)	(29,194)	(28,939)	255	(49,887)	(49,887)	0
Central	0.00	0.00	0.00	(1,289)	(844)	444	(8,969)	(3,948)	5,021	(14,681)	(14,681)	0
Total	**6,915.67**	**6,622.40**	**293.27**	**(2,122)**	**(3,104)**	**(982)**	**(25,986)**	**(27,667)**	**(1,681)**	**(45,000)**	**(45,000)**	**0**

Key Risks

Key Risk 1	Medical pay costs increased by 3% compared to M1-7 2017/18 (£2.3m overspend YTD)
Key Risk 2	Day case and Elective activity £1.6m below plan YTD (gynae, orthopaedics, ophthalmology and dermatology).
Key Risk 3	Unidentified CIP and delivery of CIP YTD £0.8m behind plan
Key Risk 4	Special observations £0.6m cost YTD on wards against annual budget of £0.5m
Key Risk 5	Contract challenges (counting and coding, MRET, fines and penalties, CQUIN, HWLH NHSPS)

Mitigations

Mitigation 1	Recruitment to substantive medical posts including working with Medacs to fill to hard to recruit roles. Additional controls implemented on agency and locum spend including review of highest overspends in medical pay costs in ophthalmology, gastroenterology, radiology and respiratory. T3 pay costs controls will be rolled out shortly and will include premium pay and WLIs.
Mitigation 2	Ongoing review of elective and day case activity during specialty reviews to understand correlation with costs, waiting list and referral trends. Divisions to increase activity to get back on planned trajectory.
Mitigation 3	Divisions being held to account via Confirm & Challenge sessions and IPRs. Grip and control to be tightened across Trust. Capacity identified as bed modelling CIP remains open in M7 due to an increase in NEL activity.
Mitigation 4	Additional controls in place and number of shifts booked to cover special observations has reduced in month.
Mitigation 5	Annual 18/19 income from ESBT CCGs (including contract challenges) has been agreed at a fixed value income deal (£279m). Discussions with other commissioners are ongoing.

Income & Expenditure Summary - Month 7

	In Month				Year to Date				Forecast Outturn		
	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	17/18 Actual (£m)	18/19 Plan (£m)	18/19 Actual (£m)	Variance (£m)	18/19 Plan (£m)	18/19 FOT (£m)	Variance (£m)
NHS Patient Income	27.8	28.7	30.3	1.6	184.6	192.3	191.5	(0.8)	329.1	329.1	0.0
Tariff-Excluded Drugs & Devices	3.0	3.1	3.5	0.4	20.1	21.4	21.4	0.1	36.4	36.4	0.0
Private Patient / ICR	0.1	0.4	0.2	(0.1)	1.4	1.9	1.4	(0.5)	3.7	3.7	0.0
Other Non-Clinical Income	2.7	2.3	3.3	1.1	22.1	17.0	22.9	5.9	28.3	28.3	0.0
Total Income	**33.6**	**34.4**	**37.3**	**2.9**	**228.2**	**232.6**	**237.3**	**4.7**	**397.5**	**397.5**	**0.0**
Pay - Substantive	(20.4)	(20.9)	(21.2)	(0.4)	(140.8)	(145.4)	(148.7)	(3.3)	(250.2)	(250.2)	0.0
Pay - Bank	(2.3)	(1.6)	(2.0)	(0.4)	(13.9)	(13.6)	(15.6)	(2.0)	(22.8)	(22.8)	0.0
Pay - Agency	(1.3)	(0.7)	(0.8)	(0.1)	(9.4)	(5.9)	(5.8)	0.0	(9.3)	(9.3)	0.0
Total Pay	**(23.9)**	**(23.2)**	**(24.1)**	**(0.9)**	**(164.1)**	**(164.9)**	**(170.2)**	**(5.3)**	**(282.2)**	**(282.2)**	**0.0**
Drugs	(3.5)	(3.5)	(4.6)	(1.0)	(24.9)	(24.8)	(26.4)	(1.6)	(42.2)	(42.2)	0.0
Supplies & Services - Clinical	(3.2)	(2.9)	(3.2)	(0.2)	(20.3)	(20.6)	(20.6)	(0.0)	(35.3)	(35.3)	0.0
Supplies & Services - General	(0.4)	(0.4)	(0.3)	0.1	(2.5)	(2.8)	(2.6)	0.2	(4.8)	(4.8)	0.0
Purchase of Healthcare (non-NHS)	(0.5)	(0.5)	(0.5)	(0.0)	(2.9)	(3.3)	(3.4)	(0.1)	(5.8)	(5.8)	0.0
Services from Other NHS Bodies	(0.5)	(0.6)	(1.0)	(0.4)	(4.3)	(4.4)	(4.7)	(0.3)	(7.5)	(7.5)	0.0
Consultancy	(0.0)	(0.1)	(0.1)	(0.0)	(0.3)	(0.7)	(0.7)	0.0	(1.0)	(1.0)	0.0
Clinical Negligence	(1.2)	(0.9)	(0.9)	0.0	(8.5)	(6.1)	(5.9)	0.3	(10.3)	(10.3)	0.0
Premises	(1.2)	(1.2)	(1.6)	(0.4)	(7.8)	(8.0)	(8.4)	(0.4)	(14.6)	(14.6)	0.0
Depreciation	(1.0)	(1.0)	(1.0)	(0.1)	(7.4)	(8.0)	(7.3)	0.7	(12.9)	(12.9)	0.0
Other	(1.4)	(1.5)	(2.5)	(0.9)	(9.4)	(10.6)	(10.4)	0.2	(18.3)	(18.3)	0.0
Total Non-Pay	**(13.0)**	**(12.7)**	**(15.7)**	**(3.0)**	**(88.4)**	**(89.2)**	**(90.3)**	**(1.1)**	**(152.6)**	**(152.6)**	**0.0**
Total Operating Costs	**(36.9)**	**(35.9)**	**(39.8)**	**(3.9)**	**(252.5)**	**(254.1)**	**(260.5)**	**(6.4)**	**(434.8)**	**(434.8)**	**0.0**
Net Surplus/(Deficit) from Operations	**(3.3)**	**(1.5)**	**(2.5)**	**(1.0)**	**(24.4)**	**(21.5)**	**(23.2)**	**(1.7)**	**(37.4)**	**(37.4)**	**0.0**
Financing Costs	(0.7)	(0.6)	(0.6)	(0.0)	(4.5)	(4.5)	(4.5)	(0.0)	(7.6)	(7.6)	0.0
Total Non-Operating Costs	**(0.7)**	**(0.6)**	**(0.6)**	**(0.0)**	**(4.5)**	**(4.5)**	**(4.5)**	**(0.0)**	**(7.6)**	**(7.6)**	**0.0**
Total Costs	**(37.6)**	**(36.5)**	**(40.4)**	**(3.9)**	**(257.0)**	**(258.6)**	**(265.0)**	**(6.4)**	**(442.5)**	**(442.5)**	**0.0**
Net Surplus/(Deficit)	**(4.0)**	**(2.1)**	**(3.1)**	**(1.0)**	**(28.8)**	**(26.0)**	**(27.7)**	**(1.7)**	**(45.0)**	**(45.0)**	**0.0**
Donated Asset/Impairment Adjustment	0.0	0.0	(0.0)	(0.0)	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Operational Surplus/(Deficit)	**(4.0)**	**(2.1)**	**(3.1)**	**(1.0)**	**(28.8)**	**(26.0)**	**(27.7)**	**(1.7)**	**(45.0)**	**(45.0)**	**0.0**
Sustainability & Transformation Fund	(0.0)	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus/(Deficit)	**(4.0)**	**(2.1)**	**(3.1)**	**(1.0)**	**(27.5)**	**(26.0)**	**(27.7)**	**(1.7)**	**(45.0)**	**(45.0)**	**0.0**

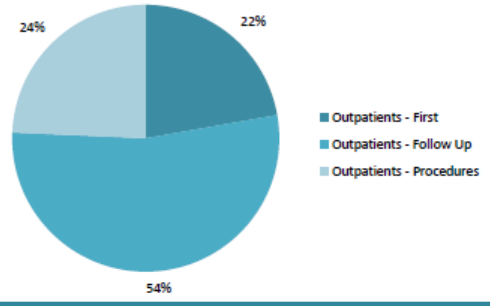
Summary & Next Steps

The Trust's YTD performance at M7 is £1.7m behind plan with a CIP underperformance of £0.8m. Income overperformed in month by £2.9m in month, £1.6m of this is due to overperformance in PBR income. Elective activity is above plan in month (£116k) which is a partial recovery of YTD underperformance, YTD effect of 18/19 final income outturn figure for ESBT CCGs has been recognised in month. Other non clinical income includes over performance on Pharmacy Manufacturing Unit (£0.2m), central funding for the AfC wage award (£2.9m) and Education & Training income above plan. Drugs continued to overspend in M7, £0.5m of this overspend relates to high cost drugs which are offset within income; old year premises costs were received in month relating to NHS Property Services costs for prior years (£0.3m) as well as 18/19 YTD costs (£0.1m).

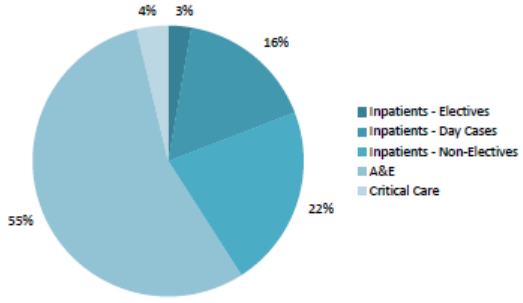
Income & Activity Summary - Month 7

	In Month								Year to Date								Forecast Outturn		
	17/18 Activity Actual	18/19 Activity Plan	18/19 Activity Actual	18/19 Activity Variance	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)	Variance (£k)	17/18 Activity Actual	18/19 Activity Plan	18/19 Activity Actual	18/19 Activity Variance	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)	Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)
Contract Income																			
Inpatients - Electives	615	662	581	(81)	1,890	1,968	2,050	82	4,295	4,287	3,793	(494)	12,449	12,746	11,927	(819)	21,643	21,643	0
Inpatients - Day Cases	3,400	3,634	3,361	(273)	2,630	2,731	2,623	(108)	23,060	23,545	22,758	(787)	17,229	17,692	16,892	(800)	30,041	30,041	0
Inpatients - Non-Electives	3,844	4,173	4,345	172	8,439	8,786	9,052	266	26,040	28,806	30,140	1,334	54,895	60,655	62,343	1,688	103,454	103,454	0
Outpatients	35,333	37,044	36,688	1,644	3,735	4,156	3,922	(234)	230,532	239,930	242,869	2,939	24,284	25,843	25,611	(232)	44,731	44,731	0
A&E	9,979	10,381	10,886	505	1,353	1,395	1,489	94	70,915	71,660	76,639	4,979	9,469	9,629	10,474	844	16,424	16,424	0
CQUIN	0	0	0	0	681	617	590	(27)	0	0	0	0	3,824	4,160	4,238	78	7,100	7,100	0
Critical Care	667	750	705	(45)	693	823	700	(123)	5,084	5,176	5,209	33	5,517	5,680	5,594	(85)	9,687	9,687	0
Direct Access	9,120	9,441	8,769	(672)	374	380	323	(57)	61,427	61,163	58,443	(2,720)	2,442	2,462	2,176	(286)	4,180	4,180	0
ESBT	0	0	0	0	455	588	588	(0)	0	0	0	0	2,832	4,115	4,115	(0)	7,055	7,055	0
Excess Bed Days	1,134	1,508	1,201	(307)	280	367	148	(219)	11,114	10,365	5,873	(4,492)	2,668	2,522	1,428	(1,094)	4,301	4,301	0
Exclusions	0	0	0	0	2,962	3,095	3,470	375	0	0	0	0	20,098	21,358	21,450	92	36,434	36,434	0
iMSK	0	0	0	0	431	118	118	(0)	0	0	0	0	2,653	829	829	(0)	1,421	1,421	0
Maternity Pathway	622	609	564	(45)	632	620	578	(42)	3,968	3,943	3,915	(28)	4,048	4,017	4,068	50	6,822	6,822	0
Other	320,212	312,036	334,709	22,674	6,770	5,759	8,115	2,356	2,107,910	2,152,181	2,147,021	(5,160)	43,557	39,946	41,824	1,878	68,424	68,424	0
Contract Income Total	384,926	380,237	403,809	23,572	31,323	31,404	33,766	2,363	2,544,345	2,601,056	2,596,660	(4,396)	205,964	211,655	212,969	1,314	361,717	361,717	0
Divisional Income					2,800	3,001	3,562	561					23,484	20,922	24,322	3,400	35,750	35,750	0
Total Income	**384,926**	**380,237**	**403,809**	**23,572**	**34,123**	**34,405**	**37,328**	**2,923**	**2,544,345**	**2,601,056**	**2,596,660**	**(4,396)**	**229,448**	**232,577**	**237,291**	**4,714**	**397,467**	**397,467**	**0**

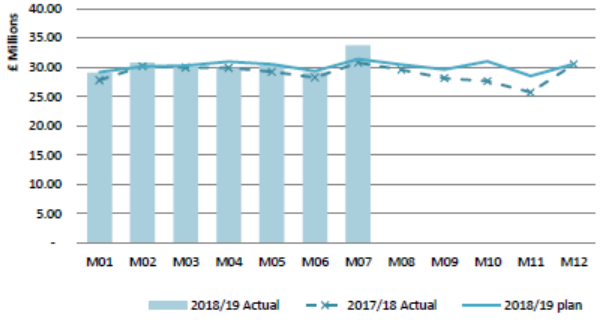
YTD Outpatients Activity by POD



YTD Inpatient & A&E Activity



Contract Income Run Rate



Summary & Next steps

Inpatients - Electives & Day Cases (YTD) **£1,619k below plan** **-5.3%**
Trauma and Orthopaedics have under performed by £767k YTD against plan.
Ophthalmology (£537k) and Gynaecology (£415k) have under performed YTD against plan.

Inpatients - Non-Electives (YTD) **£1,688k above plan** **2.8%**
Over performance YTD in General Medicine (£1,659k) and Stroke Medicine (£1,425k), offset by under performance in Geriatric Medicine (£1,161k).

Outpatients (YTD) **£232k below plan** **-0.9%**
Trauma and Orthopaedics (£341k) and Respiratory Medicine (£267k) have over performed YTD against plan, offset by under performance in Ophthalmology (£230k) and Paediatrics (£233k).

A&E (YTD) **£844k above plan** **8.8%**
Financial over-performance of £844k YTD. October 2018 activity is comparable to September 2018, however, in-month activity is 9% higher than October 2017.

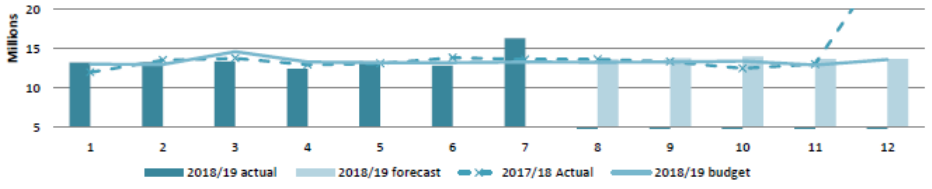
Other (YTD) **£1,878k above plan** **4.7%**
The Trust and ESBT CCGs have agreed a fixed income deal for 2018/19 (£2,688k), offset by prior year dispute resolution with High Weald Lewes Havens CCG resulting in a credit note YTD (£435k).
Under performance YTD in Health Visiting (£308k). Ward Attenders has under performed YTD (£469k) due to positive coding changes.
Activity under performance in Pathology (8,971) and Ward Attenders (3,236), offset by over performance in Diagnostic Imaging (3,032) and Telephone Appointments (1,706).

Financial Risks (YTD)
Previously reported financial risks have been mitigated by the 2018/19 income agreement discussions with the Trust's local CCGs.

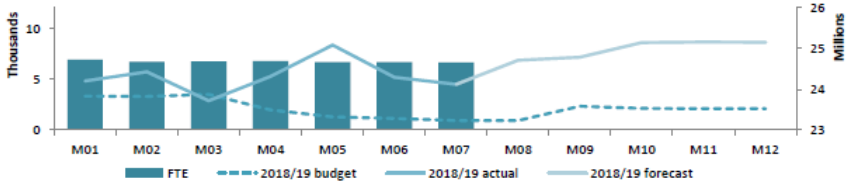
Operating Expenditure & Workforce Summary - Month 7

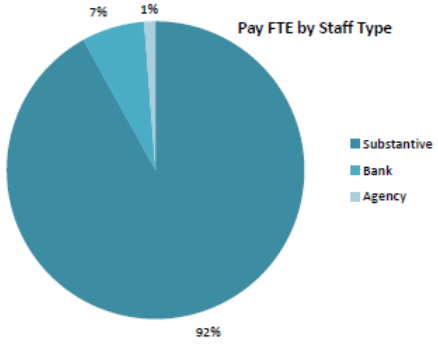
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	18/19 Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Administrative & Management	1354	1393	1309	85	3,707	3,817	3,557	260	25,391	26,678	25,826	852	45,763	45,763	0	
Ancillary	689	702	669	34	1,435	1,505	1,569	(64)	9,876	10,758	10,667	91	18,495	18,495	0	
Medical	677	708	662	46	6,019	5,616	6,013	(397)	39,993	39,096	41,361	(2,265)	67,136	67,136	0	
Nursing & Midwifery	3091	3068	3019	49	9,491	9,489	9,678	(189)	66,142	66,981	68,071	(1,090)	115,422	115,422	0	
Prof, Scientific & Tech	524	529	497	32	1,783	1,686	1,788	(101)	12,485	11,904	12,398	(494)	20,338	20,338	0	
Professions Allied to Medicine	436	522	467	55	1,486	1,754	1,607	147	10,150	12,371	10,963	1,408	21,136	21,136	0	
Other	0	-8	0	-7	13	(640)	(90)	(551)	87	(2,938)	869	(3,806)	(6,063)	(6,063)	0	
Total Pay	**6772**	**6916**	**6622**	**294**	**23,933**	**23,228**	**24,122**	**(894)**	**164,125**	**164,850**	**170,155**	**(5,305)**	**282,227**	**282,227**	**0**	
Services from Other NHS Bodies					496	630	1,000	(370)	4,264	4,397	4,694	(297)	7,480	7,480	0	
Clinical Negligence Premium					1,218	619	876	(256)	8,525	5,884	5,872	12	10,270	10,270	0	
Consultancy					44	62	103	(41)	316	680	664	16	1,036	1,036	0	
Drugs					909	742	1,276	(533)	6,774	5,468	6,465	(997)	9,105	9,105	0	
Drugs - Tariff Excluded					2,621	2,795	3,284	(489)	18,150	19,291	19,906	(615)	32,902	32,902	0	
Education and Training					88	132	97	35	648	911	559	352	1,572	1,572	0	
Establishment Expenses					635	623	839	(216)	4,231	4,451	5,071	(620)	7,624	7,624	0	
Premises					1,248	1,195	1,588	(393)	7,828	7,864	8,446	(582)	14,310	14,310	0	
Purchase of Healthcare from Non NHS Bodies					450	327	537	(209)	2,902	3,156	3,402	(246)	5,608	5,608	0	
Supplies and Services - Clinical					3,214	2,591	3,185	(594)	20,348	19,983	20,598	(615)	33,869	33,869	0	
Supplies and Services - General					377	331	295	36	2,516	2,351	2,578	(227)	4,052	4,052	0	
Other Non-Pay					11,965	2,618	2,587	32	11,920	14,813	12,066	2,747	24,786	24,786	0	
Total Non-Pay					**23,265**	**12,667**	**15,666**	**(2,999)**	**88,424**	**89,249**	**90,320**	**(1,071)**	**152,614**	**152,614**	**0**	
Total Expenditure	**6772**	**6916**	**6622**	**294**	**47,198**	**35,895**	**39,787**	**(3,893)**	**252,549**	**254,099**	**260,475**	**(6,377)**	**434,841**	**434,841**	**0**	

Non-Pay Monthly Run rate



Pay Monthly Run Rate vs FTE





Summary & Next Steps

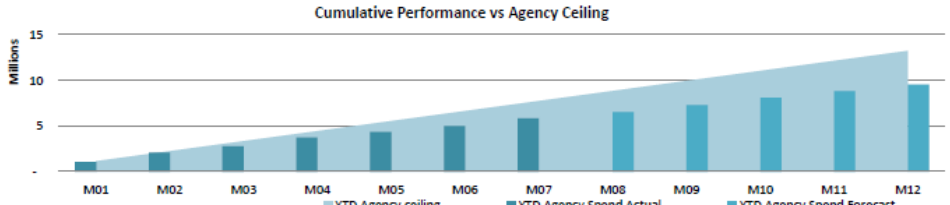
The arrears for AfC national pay award was paid to eligible staff in M5. £2,870k income has been received YTD to offset the additional pay increase. Variances in Other Pay is attributable to unidentified CIP and has increased as a result of the new deal AfC pay award in each staff group. Medical pay is £2,265k overspent YTD (which includes waiting list premium payments, agency covering vacancies and Emergency Care Twilight shifts).

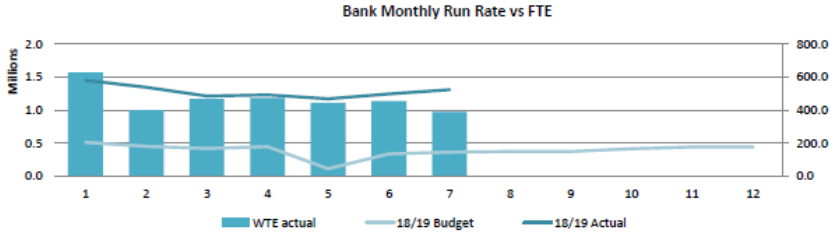
Drugs spend is showing £997k overspend due to inflationary pressures and increase in non-elective activity. Tariff excluded drugs are overspent by £615k YTD, which is offset by income. A number of non-recurrent stock adjustments and capitalisation of grouped assets have improved in YTD performance in clinical supplies, establishment expenses and premises costs. Due to an external review of VAT treatment in July, the Trust has been recovered £547k of VAT relating to the 2017/18 financial year which was reflected in position in M4. £258k Maternity CNST benefit was been reported in M6, linked to Womens and Childrens CIP.

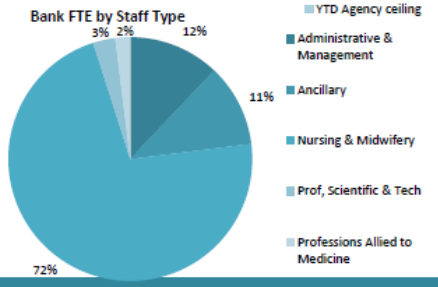
In M7 old year premises costs were received in month relating to NHS Property Services costs for prior years (£0.3m) as well as 18/19 YTD costs (£0.1m).

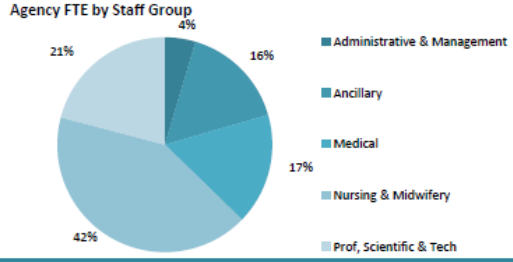
Temporary Workforce Summary - Month 7

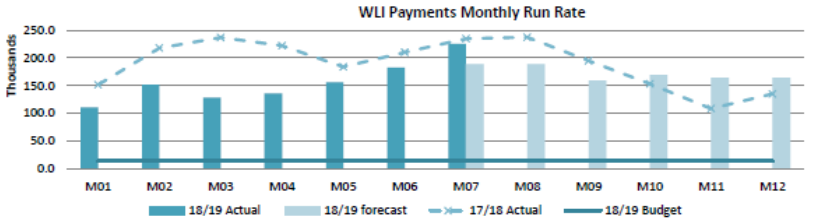
Cost Element	In Month								Year to Date				Forecast Outturn			
	17/18 WTE Actual	18/19 WTE Plan	18/19 WTE Actual	WTE Variance	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	17/18 Expenditure Actual (£k)	18/19 Expenditure Plan (£k)	18/19 Expenditure Actual (£k)	Expenditure Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)	Variance (£k)	
Agency																
Administrative & Management	7	1	4	-3	141	69	57	12	748	530	408	122	872	872	0	
Ancillary	26	0	13	-13	89	69	75	(6)	408	530	471	59	872	872	0	
Medical	24	9	14	-5	490	274	344	(70)	4,453	2,210	2,120	90	3,580	3,580	0	
Nursing & Midwifery	44	0	34	-34	257	101	179	(78)	1,809	1,077	1,376	(299)	1,582	1,582	0	
Prof, Scientific & Tech	40	0	17	-17	293	177	179	(2)	1,944	1,514	1,470	44	2,399	2,399	0	
Total Agency	**141**	**10**	**82**	**-71**	**1,269**	**689**	**833**	**(144)**	**9,362**	**5,860**	**5,845**	**15**	**9,305**	**9,305**	**0**	
Bank																
Administrative & Management	94	4	47	-43	180	305	167	138	1,219	2,135	980	1,155	3,510	3,510	0	
Ancillary	83	22	43	-21	162	0	150	(150)	1,129	0	951	(951)	0	0	0	
Nursing & Midwifery	345	106	281	-175	936	789	907	(118)	6,472	6,494	6,498	(4)	11,763	11,763	0	
Prof, Scientific & Tech	11	0	11	-11	33	58	47	11	218	406	306	100	696	696	0	
Professions Allied to Medicine	3	0	8	-7	10	33	38	(5)	83	231	222	9	436	436	0	
Total Bank	**535**	**133**	**390**	**-257**	**1,321**	**1,185**	**1,309**	**(124)**	**9,120**	**9,266**	**8,958**	**308**	**16,405**	**16,405**	**0**	
Total Locum	**90**	**19**	**63**	**-45**	**968**	**464**	**738**	**(274)**	**4,820**	**4,299**	**6,630**	**(2,331)**	**6,361**	**6,361**	**0**	
Total Waiting List Initiative	**15**	**0**	**13**	**-13**	**235**	**14**	**225**	**(212)**	**1,457**	**95**	**1,089**	**(994)**	**164**	**164**	**0**	
Total Temporary Workforce	**781**	**161**	**547**	**-386**	**3,793**	**2,352**	**3,105**	**(753)**	**24,759**	**19,520**	**22,522**	**(3,001)**	**32,235**	**32,235**	**0**	









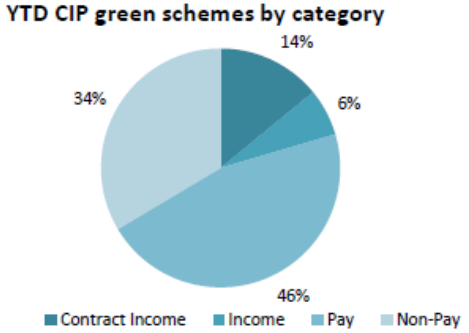


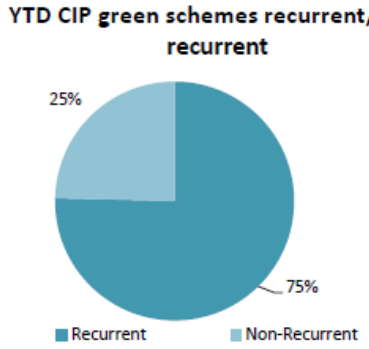
Summary & Next steps

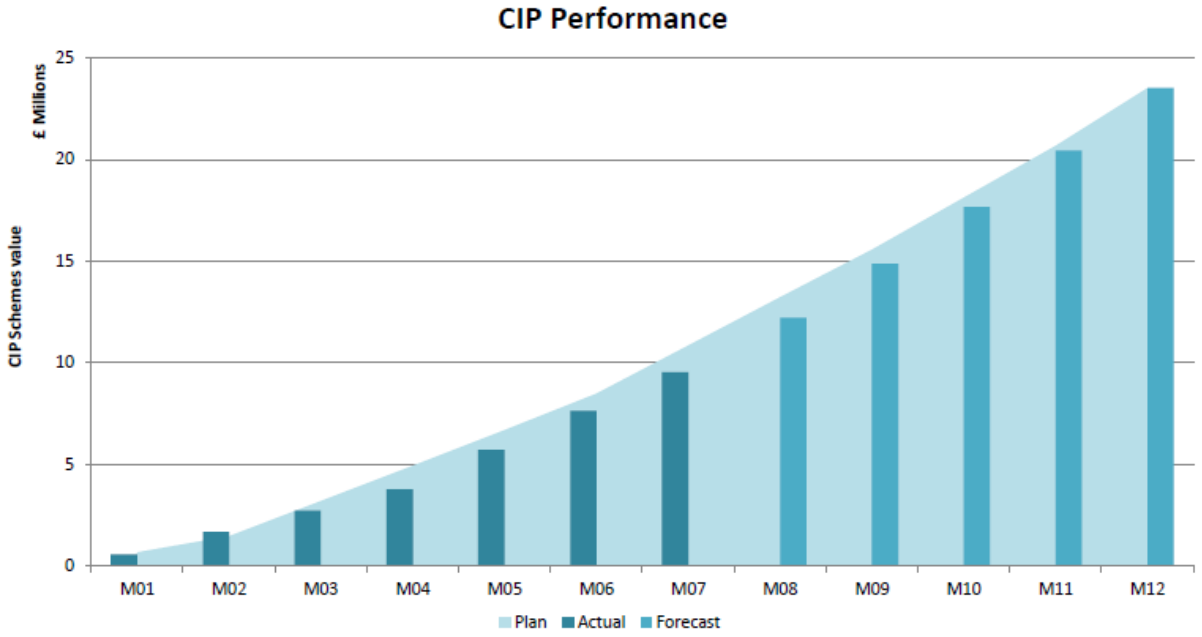
Medical specialties which are heavily reliant on agency are neurology, rheumatology, pathology, general surgery, radiology and A&E. There is a shift from prior year towards utilisation of bank and locum resource opposed to agency and some progress is being made with recruitment to locum or substantive posts through Medacs recruitment and the Temporary Workforce team. Continued focus needed on hard to fill vacancies to look at alternative staffing models. Non clinical agency has reduced and plans are in place to further reduce clinical coding agency further. Overall agency is £15k below plan YTD and has seen a significant reduction compared to the previous financial year. Total temporary staffing costs have fallen by 9% compared to the previous year (£2,237k lower). An internal audit of WLI payments is being performed to understand links with under performance on elective and day case activity and ensure robust approvals process in place as spend is 25% higher than last year.

Cost Improvement Programme Summary - Month 7

Category	In Month			Year to Date			Forecast Outturn			YTD Rec (£k)	YTD Non-Rec (£k)
	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)	Plan (£k)	Actual (£k)	Variance (£k)		
Contract Income	207	405	198	1,002	1,338	336	2,234	2,711	477	925	413
Income	132	140	8	521	481	-40	1,236	1,068	-168	393	214
Pay	860	674	-186	5,684	4,421	-1,264	9,978	8,130	-1,848	2,777	1,601
Non-Pay	769	672	-98	3,079	3,276	197	6,187	5,188	-999	3,079	114
Total 'Green' schemes	**1,969**	**1,891**	**-78**	**10,287**	**9,516**	**-771**	**19,636**	**17,097**	**-2,539**	**7,174**	**2,342**
Pipeline/Unidentified	0	0	0	0	0	0	3,880	6,419	2,539	75%	25%
Total	**1,969**	**1,891**	**-78**	**10,287**	**9,516**	**-771**	**23,516**	**23,516**	**0**		







Summary & Next Steps

YTD: The Trust is behind the plan for Month 7 by £0.8m. The main adverse variances are bed modelling (£1,028k), slippage in month 1 and 2 on endoscopy scopes (£102k) and WLI reduction in DAS (£198k); this underperformance is partially offset with over delivery on pharmacy drugs (£400k), vacancies in Emergency Care (137k) as well as the Maternity CNST being received in September (£258k) previously planned for March.

Forecast: Against 'process green plan' the Trust is forecasting an adverse outturn variance of £2.5m, patient flow makes up over half of this. The Emergency Department is the only division forecasting to deliver in full against its plans.

In Month: The variance on contract income is associated with over performance on adult audiology activity as well as some of the bed savings being realised through additional non-elective activity income, this is reduced by cardiology echo and COPD activity shortfall which continues as a result of unsuccessful recruitment.

By category: There is an increasing reliance on income schemes (20% in total, up from 16% last month) and a corresponding reduction in workforce schemes (down to 47% from 50% in month 6).

Finance Report Divisional Summaries - Month 7

Divisional Performance

Division	In the Month						Year to Date			Forecast Outturn			Summary
	Plan FTE	Actual FTE	Variance FTE	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	
Diagnostics, Anaesthetics & Surgery													
Contract Income				9,381	9,355	(26)	62,302	60,436	(1,865)	106,181	106,181	0	Contract income under performance and unidentified CIP are key drivers of underperformance. Medical agency expenditure and continued waiting list payments. Theatres non pay costs reported an overspend in M7 and ongoing overspends in pathology send away testing.
Divisional Income				406	452	46	2,714	2,638	(76)	4,747	4,747	0	
Pay	1,758.49	1,655.09	103.40	(6,868)	(7,083)	(215)	(49,440)	(50,368)	(929)	(84,281)	(84,281)	0	
Non-Pay				(2,532)	(2,943)	(411)	(17,996)	(18,399)	(403)	(30,571)	(30,571)	0	
Overall	**1,758.49**	**1,655.09**	**103.40**	**386**	**(220)**	**(607)**	**(2,420)**	**(5,693)**	**(3,273)**	**(3,924)**	**(3,924)**	**0**	
Medicine													
Contract Income				8,564	9,051	487	57,736	58,620	884	98,428	98,428	0	Key drivers of divisional underperformance are special observations £0.6m overspend YTD, £0.8m medical pay and CIP under delivery, partly offset by NEL activity above income plan.
Divisional Income				(12)	104	116	1,000	785	(215)	1,731	1,731	0	
Pay	1,413.19	1,402.78	10.41	(4,915)	(5,248)	(333)	(34,335)	(36,574)	(2,238)	(59,166)	(59,166)	0	
Non-Pay				(588)	(726)	(138)	(4,772)	(4,970)	(197)	(8,384)	(8,384)	0	
Overall	**1,413.19**	**1,402.78**	**10.41**	**3,049**	**3,182**	**133**	**19,627**	**17,861**	**(1,766)**	**32,610**	**32,610**	**0**	
Urgent Care													
Contract Income				2,163	2,226	63	14,944	15,929	984	25,497	25,497	0	A&E activity continues to be above planned levels. Continued medical agency and R&R payments to medical staff have deteriorated the pay position by £792k YTD. Overspends on discharge and site team offset by underspend on GP streaming £384k and A&E nursing vacancies £342k underspend.
Divisional Income				31	32	1	196	221	25	364	364	0	
Pay	323.73	304.80	18.93	(1,411)	(1,390)	21	(9,583)	(9,737)	(154)	(16,697)	(16,697)	0	
Non-Pay				(62)	(91)	(28)	(399)	(524)	(126)	(711)	(711)	0	
Overall	**323.73**	**304.80**	**18.93**	**721**	**777**	**56**	**5,159**	**5,888**	**730**	**8,454**	**8,454**	**0**	
Out of Hospital Care													
Contract Income				3,285	3,293	7	22,941	22,987	46	39,316	39,316	0	Drugs overspend £566k YTD. £258k Pharmacy Manufacturing Unit overspend, due to staff awaiting redeployment and therefore this continues to be a stranded cost. Offset by vacancies across Therapies and District Nursing.
Divisional Income				338	319	(19)	2,262	2,195	(66)	3,953	3,953	0	
Pay	1,073.90	1,011.87	62.03	(3,096)	(3,074)	21	(22,180)	(22,023)	158	(37,985)	(37,985)	0	
Non-Pay				(1,025)	(1,375)	(350)	(7,084)	(7,981)	(897)	(12,257)	(12,257)	0	
Overall	**1,073.90**	**1,011.87**	**62.03**	**(497)**	**(838)**	**(341)**	**(4,062)**	**(4,821)**	**(760)**	**(6,973)**	**(6,973)**	**0**	
Women's, Children's & Sexual Health													
Contract Income				4,096	3,995	(102)	27,746	26,883	(863)	47,409	47,409	0	Contract income under delivery of Health visiting contract, lower activity in Paediatrics (non-elective) and Gynaecology (day case/elective). Continued vacancies in Health Visiting agency usage in midwifery unit and agency medical in month.
Divisional Income				48	65	16	400	548	148	641	641	0	
Pay	699.96	655.70	44.26	(2,599)	(2,625)	(26)	(18,447)	(18,299)	148	(31,585)	(31,585)	0	
Non-Pay				(275)	(367)	(93)	(1,926)	(2,196)	(271)	(3,299)	(3,299)	0	
Overall	**699.96**	**655.70**	**44.26**	**1,270**	**1,067**	**(203)**	**7,773**	**6,936**	**(837)**	**13,166**	**13,166**	**0**	
Estates & Facilities													
Divisional Income				668	765	97	4,874	5,036	162	8,409	8,409	0	£638k CIP under delivery against target YTD, £78k Laundry overspend linked to Salisbury and stock adj, increased utilities costs £184k overspend and £58k catering provisions overspend YTD are the key drivers of overspends.
Pay	635.07	609.82	25.25	(1,331)	(1,499)	(168)	(9,981)	(10,305)	(324)	(16,916)	(16,916)	0	
Non-Pay				(1,243)	(1,512)	(269)	(8,793)	(9,684)	(890)	(15,258)	(15,258)	0	
Overall	**635.07**	**609.82**	**25.25**	**(1,906)**	**(2,245)**	**(340)**	**(13,900)**	**(14,952)**	**(1,052)**	**(23,765)**	**(23,765)**	**0**	
Corporate													
Divisional Income				1,176	1,314	138	7,952	8,738	786	13,538	13,538	0	Training and education income is above plan. Unidentified CIP in pay and non pay. Non pay overspend of £0.6m YTD includes EDM cost pressure of £0.7m, offset by CNST maternity benefit of £258k.
Pay	1,011.33	982.34	28.99	(3,159)	(3,039)	120	(22,510)	(22,474)	36	(38,201)	(38,201)	0	
Non-Pay				(1,874)	(2,256)	(383)	(14,636)	(15,203)	(567)	(25,224)	(25,224)	0	
Overall	**1,011.33**	**982.34**	**28.99**	**(3,857)**	**(3,982)**	**(125)**	**(29,194)**	**(28,939)**	**255**	**(49,887)**	**(49,887)**	**0**	
Central													
Contract Income				3,914	5,847	1,933	25,987	28,114	2,127	44,885	44,885	0	YTD Divisional income includes national pay deal £2.9m, which offsets increased pay costs in divisions. Tariff Exclusions income is above plan YTD to contra £0.7m overspend on non-pay costs. Central CIP risk adjustment (division target £23.5m allocated vs NHSI plan £19.2m). Identification of CIP in operational divisions has led to central phasing adjustments between Income, Pay and Non Pay in order to ensure alignment to NHSI plan.
Divisional Income				347	512	165	1,524	4,160	2,635	2,366	2,366	0	
Pay	0.00	0.00	0.00	151	(164)	(314)	1,627	(376)	(2,003)	2,603	2,603	0	
Non-Pay				(5,700)	(7,034)	(1,334)	(38,107)	(35,860)	2,247	(64,535)	(64,535)	0	
Overall	**0.00**	**0.00**	**0.00**	**(1,289)**	**(839)**	**449**	**(8,969)**	**(3,962)**	**5,006**	**(14,681)**	**(14,681)**	**0**	
Donated assets adjustment				**0**	**(5)**	**(5)**	**0**	**14**	**14**				
Total	**6,915.67**	**6,622.40**	**293.27**	**(2,122)**	**(3,104)**	**(982)**	**(25,986)**	**(27,667)**	**(1,681)**	**(45,000)**	**(45,000)**	**0**	

Statement of Financial Position - Month 7

	Year to date				Forecast Outturn			
	17/18 Actual (£k)	18/19 Plan (£k)	18/19 Actual (£k)		Variance (£k)	18/19 Plan (£k)	18/19 FOT (£k)		Variance (£k)
Property, Plant and Equipment	215.7	215.7	216.2		0.5	215.7	215.7		0.0
Intangible Assets	1.9	1.9	1.9		(0.1)	1.9	1.9		0.0
Other Assets	1.3	1.3	1.7		0.3	1.3	1.3		0.0
Non Current Assets	**219.0**	**219.0**	**219.8**		**0.8**	**219.0**	**219.0**		**0.0**
Inventories	7.3	7.3	6.6		(0.7)	7.3	7.3		0.0
Trade and Other Receivables	35.3	26.0	32.0		5.9	26.0	26.0		0.0
Cash and Cash Equivalents	2.1	2.1	2.5		0.4	2.1	2.1		0.0
Non Current Assets Held for Sale	0.0	0.0	0.0		0.0	0.0	0.0		0.0
Current Assets	**44.7**	**35.4**	**41.0**		**5.6**	**35.4**	**35.4**		**0.0**
Trade and Other Payables	(37.7)	(28.6)	(35.9)		(7.2)	(28.6)	(28.6)		0.0
Borrowings	(35.7)	(0.4)	(35.6)		(35.2)	(0.4)	(0.4)		0.0
Other Financial Liabilities	0.0	0.0	0.0		0.0	0.0	0.0		0.0
Provisions	(0.6)	(0.6)	(0.5)		0.0	(0.6)	(0.6)		0.0
Other Liabilities	(1.7)	(1.7)	(2.8)		(1.1)	(1.7)	(1.7)		0.0
Current Liabilities	**(75.7)**	**(31.3)**	**(74.8)**		**(43.5)**	**(31.3)**	**(31.3)**		**0.0**
Borrowings	(121.5)	(201.6)	(147.3)		54.2	(201.6)	(201.6)		0.0
Trade and Other Payables	0.0	0.0	0.0		0.0	0.0	0.0		0.0
Provisions	(2.3)	(2.3)	(2.2)		0.1	(2.3)	(2.3)		0.0
Total Assets Employed	**64.2**	**19.2**	**36.5**		**(32.6)**	**19.2**	**19.2**		**0.0**
Public Dividend Capital	156	156	156		0	156	156		0
Income & Expenditure Reserve	(187)	(232)	(214)		17	(232)	(232)		0
Revaluation Reserve	94	94	94		(0)	94	94		0
Total Tax Payers Equity	**64.2**	**19.2**	**36.5**		**17.3**	**19.2**	**19.2**		**0.0**

Summary & Next Steps

Cash above £2.1m minimum cash balance at month end and borrowing in line with planned deficit.

Cashflow & Borrowing Summary - Month 7

Short Term (13 week) Cashflow Forecast

	Actual (£k)				Forecast (£k)								
Week Ending (Friday)	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov	16-Nov	23-Nov	30-Nov	07-Dec	14-Dec	21-Dec	28-Dec
Balance Brought Forward	4,425	4,335	2,867	18,567	4,698	5,741	4,601	31,512	5,684	3,975	2,102	29,276	7,660
Receipts													
WGA Income	282	745	27,509	330	3,101	5	27,758	0	480	0	28,183	410	0
Other Income	288	1,317	275	832	630	2,540	1,535	438	740	719	1,473	624	822
External Financing	0	0	2,122	0	0	0	3,061	0	431	0	0	4,322	0
Total Receipts	570	2,062	29,906	1,162	3,730	2,545	32,354	438	1,651	719	29,655	5,356	822
Payments													
Pay	(260)	(250)	(10,026)	(12,961)	(301)	(277)	(270)	(23,003)	(270)	(270)	(270)	(23,552)	(270)
Non-Pay	(397)	(2,921)	(4,179)	(1,902)	(2,385)	(3,404)	(5,174)	(3,090)	(3,090)	(2,322)	(2,210)	(3,090)	(3,090)
Capital Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0
Other payments	(3)	(359)	(1)	(169)	(2)	(3)	0	(173)	0	0	0	(330)	0
Total Payments	(660)	(3,530)	(14,206)	(15,031)	(2,688)	(3,684)	(5,444)	(26,266)	(3,360)	(2,592)	(2,480)	(26,972)	(3,360)
Net Cash Movement	(90)	(1,467)	15,700	(13,869)	1,043	(1,139)	26,910	(25,828)	(1,709)	(1,873)	27,175	(21,617)	(2,539)
Balance Carried Forward	4,335	2,867	18,567	4,698	5,741	4,601	31,512	5,684	3,975	2,102	29,276	7,660	5,121

NB: The above classification do not directly match the I&E subjective classifications, for example Non-pay above includes agency staff expenditure and VAT thereon

Loans

Description	Draw Value £k	Date Drawn	Term	Interest Rate	Value £k	Annual Interest £k
Prior Years						
Capital Loan 1 -Decontamination Cer	1,500	Dec 08	10	3.50%	151	4
Capital Loan 2 - Endoscopy Develop	2,000	Dec 09	20	4.00%	1,167	45
Capital Loan 3 - Endoscopy Develop	2,000	Jun 10	20	3.90%	1,200	46
Capital Loan 4 - Health Records	428	Mar 15	10	1.40%	300	4
Capital Loan 5 - Health Records	441	Mar 15	10	1.40%	309	4
Capital Loan 6 - Ambulatory Care	800	Feb 18	20	1.60%	800	13
Revolving Working Capital	31,300		5	3.50%	31,300	1,096
Interim Loan Agreement	35,218		3	1.50%	35,218	527
2016/17 Loans	23,144	Dec 16 - Mar 17	3	6.00%	22,619	1,356
2017/18 Loans	13,755	Apr 17 - Jul 17	3	6.00%	13,785	827
2017/18 Loans	50,393	Aug 17 - Mar 18	3	3.50%	50,363	1,781
Prior Years Total	160,979				157,212	5,703
Current Year						
Loan Apr 2018	3,916	Apr 18	3	3.50%	3,916	69
Loan May 2018	3,917	May 18	3	3.50%	3,917	71
Loan June 2018	3,771	Jun 18	3	3.50%	3,771	69
Loan July 2018	3,080	Jul 18	3	3.50%	3,080	55
Loan August 2018	4,835	Aug 18	3	3.50%	4,835	88
Loan September 2018	4,346	Sep 18	3	3.50%	4,346	76
Loan October 2018	2,122	Oct 18	3	3.50%	2,122	0
Current Year Total	25,987				25,987	428
Total Loans	186,966				183,199	6,131

Summary & Next steps

1. Opening balance was £2.1m - planned closing balance (March 2019) is £2.1m.

2. Maintaining minimum cash balance of £2.1m at month-end.

3. Planning assumption is to draw cash equivalent to deficit during 2018/19.

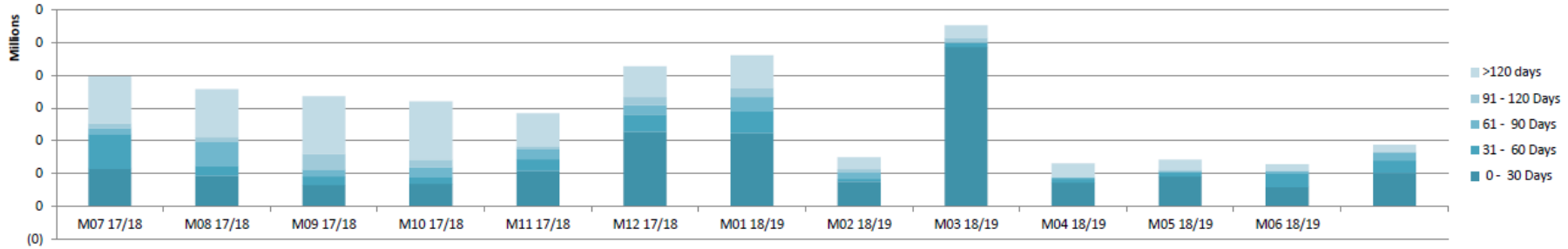
4. All existing loans listed in the table on the left.

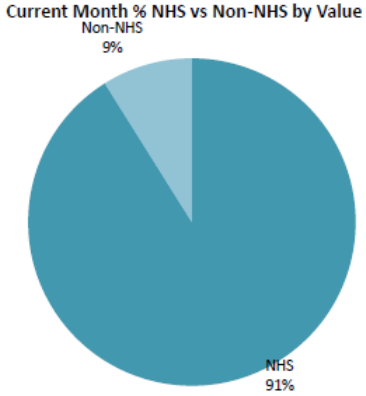
5. The "Interim Loan Agreement" for £35.2m is due to be repaid in February 2019 - discussions will be had with NHSI about this being extended as it is unlikely that the Trust will have generated sufficient cash for this to be repaid.

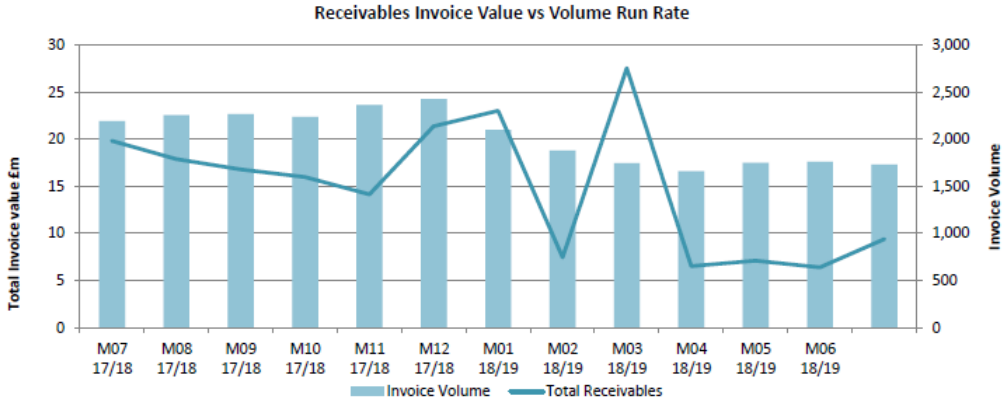
Receivables Summary - Month 7

Receivables Aging Run rate (£k)

Aging Profile	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19
0 - 30 Days	5,737	4,648	3,269	3,418	5,379	11,332	11,164	3,753	24,337	3,630	4,559	2,924	5,070
31 - 60 Days	5,217	1,450	1,286	960	1,745	2,686	3,335	448	696	566	685	2,033	1,918
61 - 90 Days	941	3,850	1,099	1,588	1,573	1,467	2,189	968	(44)	273	161	369	1,248
91 - 120 Days	782	583	2,331	1,133	470	1,214	1,316	518	618	(71)	100	95	131
>120 days	7,179	7,372	8,809	8,897	4,997	4,685	5,048	1,775	1,963	2,111	1,586	988	1,021
Total Receivables	**19,856**	**17,903**	**16,794**	**15,996**	**14,164**	**21,384**	**23,053**	**7,461**	**27,572**	**6,508**	**7,091**	**6,408**	**9,389**
Invoice Volume	**2,193**	**2,260**	**2,269**	**2,241**	**2,366**	**2,426**	**2,100**	**1,880**	**1,749**	**1,660**	**1,752**	**1,761**	**1,732**







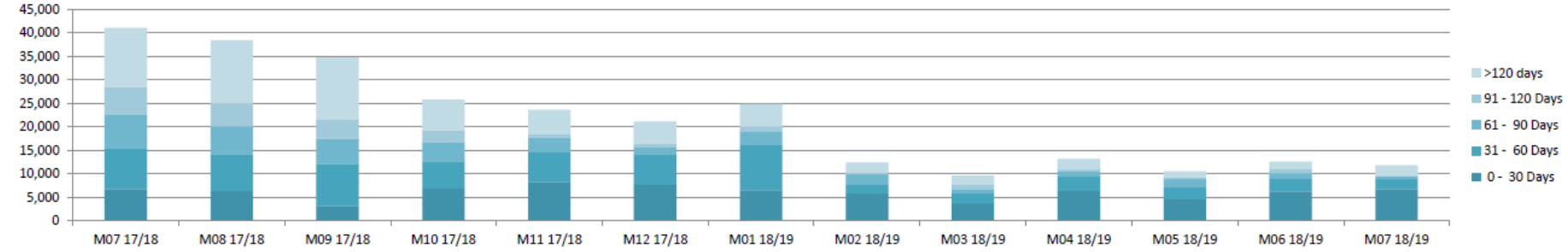
Summary & Next Steps

1. Internal plan for September was to reduce aged receivables to £2.0m. However aged receivables in month increased to £4.3m. Steps are in hand to reduce the receivables value.
2. Reduction in over 90 day debt of £70k in month.
3. Debtor days 29 days (23 days in September).

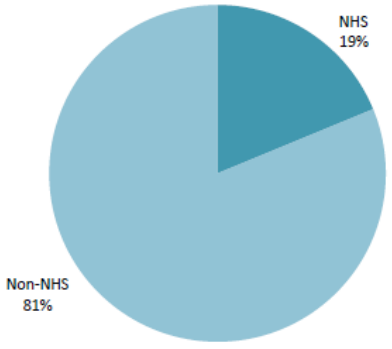
Payables Summary - Month 7

Payables Aging Run rate (£k)

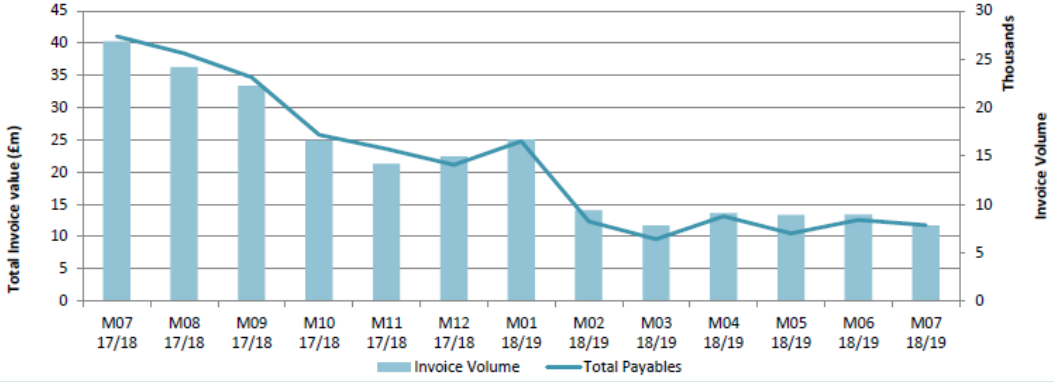
Aging Profile	M07 17/18	M08 17/18	M09 17/18	M10 17/18	M11 17/18	M12 17/18	M01 18/19	M02 18/19	M03 18/19	M04 18/19	M05 18/19	M06 18/19	M07 18/19
0 - 30 Days	6,726	6,227	3,130	6,872	8,184	7,668	6,423	5,752	3,711	6,387	4,552	6,153	6,708
31 - 60 Days	8,620	7,924	8,902	5,760	6,341	6,360	9,679	1,843	2,117	3,002	2,547	2,774	2,102
61 - 90 Days	7,267	5,929	5,430	4,064	3,128	1,681	2,969	2,267	766	1,039	1,703	1,099	599
91 - 120 Days	5,851	4,875	4,025	2,521	729	655	932	367	1,148	452	366	1,078	124
>120 days	12,599	13,449	13,202	6,556	5,220	4,753	4,762	2,135	1,854	2,249	1,315	1,464	2,233
Total Payables	**41,063**	**38,405**	**34,688**	**25,773**	**23,602**	**21,118**	**24,765**	**12,363**	**9,596**	**13,129**	**10,484**	**12,568**	**11,765**
Invoice Volume	**26,840**	**24,162**	**22,223**	**16,609**	**14,182**	**14,954**	**16,715**	**9,382**	**7,829**	**9,092**	**8,889**	**8,947**	**7,830**



Current Month % NHS vs Non-NHS by Value



Payables Invoice Value vs Volume Run Rate



Summary & Next Steps

1. Significant reduction in age and value of payables since the highpoint of last year (September 2017).
2. Creditor days at 100 days in month (90 in September)
3. Internal KPI's to target elimination of registered > 120 days and creditor days < 60.
4. Cash availability short term means we can let the system generate the payment run (more efficient).

Capital Programme Summary - Month 7

YTD Capital Programme Performance	TOTAL PLAN ADJUSTED £000	CRG COMMITTED £000	ACTUAL EXPENDITURE £000	FORECAST EXPENDITURE £000	SYSTEM COMMITTED £000
Brought Forward	500	992	1,002	1,002	612
External Funding	3,709	250	85	250	18
2018/19 Business Cases	2,370	100	85	1,800	43
Medical Equipment	2,200	362	253	2,200	0
Digital	2,072	2,505	864	2,911	189
Estates	11,005	10,306	3,842	12,805	3,354
Finance	2,000	1,657	1,102	1,500	0
Total Owned	23,856	16,172	7,233	22,468	4,216
Donated	0	0	510	0	0
Less donated Income	0	0	(510)	0	0
Total	23,856	16,172	7,233	22,468	4,216

Capital Resource Limit	Source	£k
Opening Capital Resource Limit		13,911
Closing Capital Resource Limit		13,911

Summary & Next steps

1. The Capital Resource Group has committed £16m of this year's Capital Resource Limit (CRL) of £13.9m.
2. External funding and bids to increase CRL are being processed for fire, UIS and medical devices.
3. A MRI finance sub group meets on a weekly basis to review and challenge costs and assumptions.
4. The Capital Programme will deliver the CRL target at year end.
5. The Trust has submitted two applications for emergency capital funding to NHS Improvement.


WHAT
MATTERS
TO YOU
MATTERS
TO US
ALL

Mortality Report – Learning from Deaths 1st April 2017 to June 30th 2018

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Dr David Walker

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

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

Summary:

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

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. The mortality database reflects the new review process and all plaudits and care concerns raised by family or carers of the deceased are recorded.
This report details the April 2017 – June 2018 deaths recorded and reviewed on the mortality database.

The importance of reviewing deaths within the 3 month timescale is critical to ensure reporting is accurate and provides a useful overview of the number of deaths that were actually or potentially avoidable. A higher percentage of deaths are now being reviewed within the 3 month timescale and the backlog of deaths outstanding for review has decreased. The Mortality Review Audit Group review the deaths with a much higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

As of April 2019, national changes for the reviewing of deaths are to be put in place in England and Wales and preliminary discussions have taken place regarding the introduction of medical examiners, who will be completing the mortality reviews.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme however, feedback to individual Trusts from these external reviews is slow. Internal reviews are therefore being continued in order to mitigate against any risk.

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

N/A

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

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

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard to June 2018-19

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

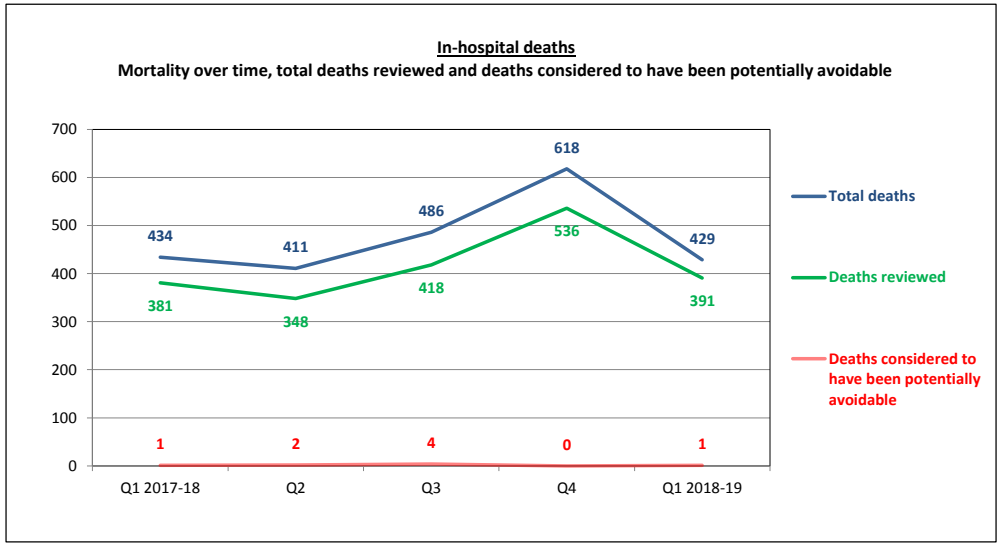
Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 22/11/2018)

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	2018-19	Q1

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
127	143	118	133	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
429	618	391	536	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
429	1949	391	1683	1	7



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	66.7%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	33.3%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	66.7%	This Year (YTD)	0	0.0%

Data above is as at 22/11/2018 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 4 care concerns expressed to the Trust Bereavement team relating to Q1 deaths, none of which were subsequently raised as a complaint.
Complaints - Of the complaints relating to 'bereavement' which were partially or fully upheld during Q1 2018/19, two had been given overall care ratings of 'poor care' when reviewed on the mortality database. 1 - 'Possibly avoidable but not very likely' which related to a Q4 2017/18 death, and 1 - 'Slight evidence of avoidability' which related to a Q2 2017/18 death. Both were investigated as Amber incidents and also reviewed at the quarterly Mortality Review Audit Group.
Serious incidents - There were no severity 5 incidents reported in Q1 2018/19.
As at 22/11/2018 there were 304 April 2017 - June 2018 deaths still outstanding for review on the Mortality database.

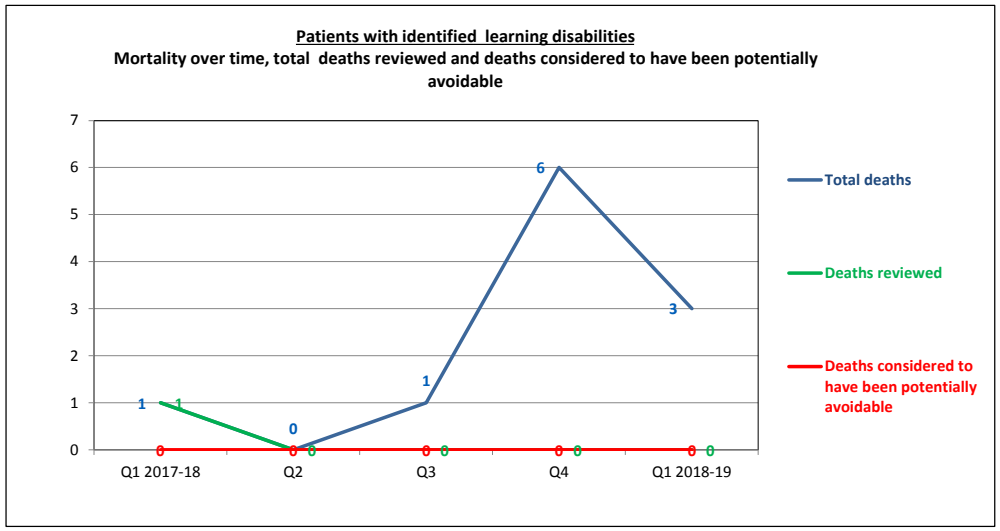
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 22/11/2018)

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	2018-19	Q1

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	6	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	8	0	1	0	0



The LeDeR (learning disability mortality review) programme is now in place and the learning disability deaths are being reviewed against the new criteria externally. Feedback from these external reviews will be received by the Trust in due course. Prior to the national requirement to review learning disability deaths using the national LeDeR methodology, the deaths were reviewed by the learning disability nurse and Head of nursing for safeguarding who entered their review findings on the mortality database.
As the feedback from the wider external LeDeR has been slow to come back, the internal reviews are being continued in order to mitigate against any risk.

Capital Programme – 2018/19 Month 7 Update

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	11
Meeting:	Trust Board Seminar	Reporting Officer:	Jonathan Reid

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

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

Summary:

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

This report presents an update on the capital programme for 2018/19 as at Month 7.

The programme was set at the start of this financial year based on funding through depreciation and a planning assumption that external funding would be received to fund the MRI Project. The capital programme at Month 7 is oversubscribed as the Trust was unable to accept an external loan to fund the MRI project in line with advice obtained from NHS Improvement (NHSI).

The Capital Review Group (CRG) is working to mitigate the risk of overspending against the Trust Capital Resource Limit (CRL). This includes capital expenditure being personally approved by the Director of Finance.

The Trust has submitted two emergency capital funding applications to NHSI for additional Public Dividend Capital (PDC) which are:

- £3.95m for essential medical devices and backlog maintenance.
- £13.86m to address the fire risks noted by East Sussex Fire and Rescue Services at Eastbourne District General Hospital.

We are currently awaiting the outcome of these submissions but are not expecting to hear back until sometime in Quarter 4 of 2018/19.

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

Finance and Investment Committee receive a monthly update on the capital plan.

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

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

Introduction

1. The Trust has a limited capital programme, the value of which was determined by the depreciation charge plus capital donations. The Capital Resource Limit (CRL) for the Trust is £13.911m. This has the potential to increase should the Trust's two submissions for emergency capital funding be approved for additional Public Dividend Capital (PDC). The two submissions made to NHSI are:

    - £3.95m for essential medical equipment and backlog maintenance.
    - £13.86m to address the fire risks noted by East Sussex Fire and Rescue Services at Eastbourne District General Hospital

    The Trust has also been successful in a bid for winter funding of £862k which we will receive in two tranches in November and December (the CRL has been raised to include this funding). These funds will be used to provide a Live Bed State to help patient flow as we enter the winter months.

2. The capital plan was developed by the Capital Review Group (CRG) during January to March 2018 with this Committee approving the plan in May 2018. The 2018/19 capital plan included a significant over planning margin as the MRI project was anticipated to be funded externally. It was agreed that the MRI project would proceed in advance of that funding being received with the fall-back position being that other schemes would be delayed or put on hold if the Trust failed to generate the external funding. The Trust was unable to accept the offer of external funding which has created significant pressure on the capital plan. The capital plan is monitored by CRG which meets monthly and reports to the Finance & Investment Committee.

3. At Month 7 the Trust has forecast significant pressure on the capital plan. The CRG has agreed that all capital schemes other than the MRI, Urology Investigation Suite, minor capital projects (transfer of revenue to capital) and the Front of House scheme at Conquest are on hold. A fortnightly review of forecast spend is in place to ensure the year-end position falls within the CRL limit.

4. The pressures on the capital plan are moving across in to revenue cost pressures as the capital constraints increase. The two main areas where there is a cost pressure are endoscopy scopes (£900k) and EDM (£1m). Mitigation strategies have been developed and are being discussed with the relevant divisions.

Month 7 Expenditure

5. The table below shows the £7.3m spend to date at month 7, with spend in Estates (£3.8m), Digital (£0.9m) and Medical Equipment (£0.3m).

YTD Capital Programme Performance	TOTAL PLAN ADJUSTED £000	ACTUAL EXPENDITURE £000	SYSTEM COMMITTED £000
Brought Forward	**500**	**1,105**	**594**
External Funding	3,709	85	12
2018/19 Business Cases	2,370	85	42
Medical Equipment	2,200	253	0
Digital	2,072	864	178
Estates	11,005	3,842	3,066
Finance	2,000	1,102	0
Total Owned	**23,856**	**7,336**	**3,892**

Full Year Forecast for Capital Expenditure

6. The Table below shows the forecast as at month 7 against a CRL that has been updated for the approved Winter Funding bid. The forecasts, including spend and potential deferral of costs in to 2019/20 all contain a level of volatility and risk which will require continued careful management and oversight. The continuing work and mitigations in place will enable the Trust to deliver a capital plan at year-end within the final CRL position.

7. We await the outcome of our two NHSI applications for emergency funding. Should these be approved this will ease some of the pressure on the capital plan.

	MRI	Minor Capital	Winter Funding	Other Schemes	TOTAL EXPENDITURE	FORECAST CRL	FORECAST VARIANCE
Actual Expenditure	1,191	946	-	5,199	7,336		
System Commitments	952	-	-	2,940	3,892		
Manual Adjustments	-	-	-	(1,053)	(1,053)		
Forecast	2,657	554	862	-	4,073		
TOTAL EXPENDITURE	**4,800**	**1,500**	**862**	**7,086**	**14,248**	**13,911**	**337**
2019/2020	500						
TOTAL BUDGET	**5,300**						

Next Steps

8. The Trust is tightly managing a constrained capital budget and is working closely with colleagues across the organisation to ensure delivery of key infrastructure developments within the available capital resource.

9. The CRG will continue to monitor and work closely with the budget-holders to support delivery within the budget with the support of the Director of Finance.

10. Capital Planning forms part of the Trust business planning process so a refresh of the 5 year capital plan and a detailed plan for 2019/20 is now underway.

Jonathan Reid
Director of Finance
East Sussex Healthcare NHS Trust

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

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	12
Meeting:	Trust Board	Reporting Officer: Jonathan Reid/Lynette Wells	

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

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

Summary:

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

An annual review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation has been performed.

This paper sets out the changes that are being proposed to be made which are:

- Standing Orders: remains extant with no proposed changes;
- Standing Financial Instructions: the proposed changes are detailed below; and
- Scheme of Delegation: the proposed changes to the SFIs have been carried across in to the Scheme of Delegation and are detailed below.

Full versions of the updated Standing Financial Instructions and Scheme of Delegation can be found in the Appendices to the Board paper, if required.

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

Audit Committee 28th November 2018

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

The Board is asked to approve the proposed changes to the SFIs and Scheme of Delegation.

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

Introduction

The Trust Board is required to review the Standing Orders, Standing Financial Instructions and the Scheme of Delegation on an annual basis. The Audit Committee reviews and makes recommendation to the Board. 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 review is carried out jointly by the Director of Finance and Director of Corporate Affairs.

The changes proposed are to the Standing Financial Instructions and the Scheme of Delegation are detailed below.

Standing Financial Instructions

Page Number and Reference	From	Replaced with..
P6 - 1.1.1	Director of Finance and Performance	Director of Finance
P17 – 4.3	Department of Health's Manual for Accounts	Department of Health and Social Care Group Accounting Manual
P22 – 7.4	Capital Investment Manual	Capital Regime, Investment & Property Business Case Approval Guidance
P22-34		Content updated by Head of Procurement to remove "Approved Contractors" to drive increased instances of competitive tendering, reflecting current guidance and best practice.
P25 – 7.6.1 iv)	The standard documents shall be modified to accord with Concode and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.	The standard documents shall be modified to accord with any relevant guidance and, in minor respects, to cover special features of individual projects.
P42 – 10.2.7	CONCODE	Removed
P45 – 13.1.2	CAPITAL SECTION	Capital section to be reviewed depending on outcome of Capital Investment Programme – Procedure review
P48 – 13.3.2	Capital Accounting Manual	Capital Regime, Investment & Property Business Case Approval Guidance
P48 – 13.3.7	The Trust will use commonly available and appropriate indices for the revaluation of assets.	The Trust will use commonly available and appropriate indices for the revaluation of assets or take advice from independent experts
P52 – 16.3	The Director of Strategic Development & Assurance	The Director of Corporate Affairs

Scheme of Delegation

Page Number and Reference	From	Replaced with
Page 14 – 1.3.7	(new entry)	e) Design, implementation and supervision of systems of internal financial control; and
Page 15	2.5.1	2.5
Page 15	2.6.1	2.6
Page 16	3.5.1	3.5
Page 16	5.1.1	5.1
Page 17	Where a supplier is chosen that is not on approved list the reason shall be recorded in writing to the Chief Executive.	(deleted)
Page 17	7.6.3	7.6.4
Page 18	7.6.5	4.6.6
Page 18	Will appoint a manager to maintain a list of approved firms.	(deleted)
Page 18	7.6.9	7.6.7
Page 18	7.15	7.14
Page 18 - 8	(new entry)	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
Page 18 – 8.4	(new entry)	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
Page 19 -10.1.1	(new entry)	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 Director of Finance
Page 19 – 10.1.2	(new entry)	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.
Page 22 – 13.1.2	For every capital expenditure proposal over £100,000 a) ensure the project director produces a business case and submits to the Capital Advisory Group b) ensure for every business case over £250,000 that it is submitted to the Finance Committee and for every business case over £500,000	For every capital expenditure proposal over £100,000 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 Review Group (CRG).

	that it is submitted to the Trust Board c) for all business cases over £500,000 a risk assessment is completed d) for all projects of £500,000 the project director is required to complete a capital monitoring return e) where schemes are forecast to overspend the project director will report reasons and corrective action to CAG f) ensure that capital expenditure over £1000k whole life cost) is approved by the Regulator	for every capital expenditure proposal in excess of £250,000 the business case is also required to be submitted to the Finance & Investment Committee for approval. or 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 Services (or Deputy Head of Financial Services) in conjunction with the Project Director. for all projects over £500,000 the Project Director will be required to co- ordinate and complete a monthly capital monitoring return to the Business Development Group (BDG) and Capital Review Group (CRG) showing performance against budget. 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. 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: where the scheme value is £250k or less – 10% of the approved scheme value for other schemes up to £1m – the higher of 5% or £25k
Page 26 – 16.3	Company Secretary	Director of Corporate Affairs
Page 27 – 16.5	Seek periodic assurances from the provider that adequate controls are in operation	The contract should also ensure rights of access for audit purposes

The Committee should also note that the Capital Review Group (CRG) will be receiving an updated Capital Investment Programme Procedure in December. If the CRG approves the new procedure then additional changes will be put to the Audit Committee for approval at a later meeting.

Equality Delivery System (EDS2) 2017/18

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Kim Novis

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

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

Summary:

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

The Equality Delivery System (EDS2) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a toolkit that assists NHS organisations in improving their services, both as service providers to their local communities, and also as employers. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Based on this evaluation and subsequent engagement with the NHS and key stakeholders, a refreshed EDS – known as EDS2 – was made available in November 201 and 2017/18's EDS2 report is attached.

EDS2 comprises four goals that lead to 18 outcomes, supporting the Trust in meeting its statutory obligations. The four goals are:

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

A report on the Trust Equality objectives including progress to date is provided at the end of the report.

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

Quality & Safety Committee
Organisational Development Group
People & Organisational Development

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

The Board is asked to receive assurance that the Trust is meeting its obligations under the Public Sector Equality Duty.

East Sussex Healthcare NHS Trust

The Equality Delivery System (EDS2)

Equalities Analysis Report 2017/18

Contents

Summary

Introduction
East Sussex Healthcare NHS Trust continues to work towards the requirements set out under the Public Sector Equality Duty. This Annual Equality Report is compiled annually from information provided by different departments on the work they have undertaken during year and highlights some of the innovative work that is carried out to support meeting legal obligations to eliminate discrimination, promote equality and build positive relationships.

The Report seeks to provide assurance for patients, carers, the public and staff that we continually aspire to be inclusive of the needs of all people. Whether people are accessing services, visiting or working for the Trust, no matter where they live within the organisation's geographical reach, they can be confident that we are continually seeking to improve the services offered as a healthcare provider and employer.

Achievements
There have been a number of achievements throughout 2017/18:

- The Equality assistant received the Skills for Life regional award for 'Operational Services Support Worker of the Year' along with Workforce Planning receiving 'Team of the Year'.
- Sexual Health teams continue to build relationships with LGBT patient groups and local communities and developing new methods to target hard to reach groups.
- There has been a focus on identifying innovative ways to meet the communication needs of all service users with Learning Disabilities, sensory and cognitive impairments and other disabilities
- Training has been delivered to 87% of staff on the implementation of the Accessible Information Standard.
- A dedicated email for patients unable to use traditional methods of contacting the Trust was established. This enabled deaf patients to contact the Trust regarding a range of queries including checking the status of a booked interpreter, cancelling or amending appointments.
- Project Search, a collaborative approach to a supported internship programme for young people with learning difficulties/ disabilities, has continued to grow and received excellent feedback and recognition.
- The Health and Well Being team have undertaken range of initiatives in place to support staff including Schwartz Rounds, "Take a Break" campaign and various health and campaigns.
- LGBT, BME and Disability staff networks are in place and undertaking a wide range of activities.

Areas of focus from 2016/17 report:
Implementing the new Accessible Information Standard across the Trust continued through 2017/18 to ensure patients, service users and carers have access to healthcare information in a format that is suitable to them. The Standard aims to identify, record, highlight, share information and support the communication needs of all those that require communication support due to a disability, sensory or cognitive impairment. This work will continue through 2018/19 to ensure electronic systems are equipped to meet the standard requirements.

It was agreed to further review the disability access audit and identify areas requiring improvements. The actions are being managed through the disability staff network and the Estates department. Local audits will be completed annually.

A scoping exercise commenced during 2017/18 to identify training opportunities to develop the communication skills of bilingual staff to become qualified interpreters to support translation during medical appointments to patients who do not use spoken English as their primary method of communication. This is an ongoing exercise that will continue through 2018/19.

Further innovative ways to communicate with patients are planned for 2018/19 including the use of video interpreting to support patients using British Sign Language BSL.

EDS2 Outcomes and Grading 2017/18 (Grading is reviewed bi-annually)

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

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

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

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

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

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

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

Equality sits with the highest level of leadership at ESHT with a robust governance framework to support monitoring and delivery. Patient groups, staff groups and networks will discuss and address concerns and capture innovative ideas that will assist the Trust in being the Healthcare provider of choice for local people and an employer where staff feel valued and respected.

1.1 The four Goals that lead to the 18 outcomes

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

1.2 EDS2 Grading

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

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

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

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

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

2. Trust Performance

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

Summary of Activity:

ESHT 2020 continues to be a major programme of work consisting of 5 key strategic priorities that support the organisation in achieving its vision of being 'Outstanding' by 2020.

Integrated Musculoskeletal Care

Following being awarded the successful contract to provide Hastings and Rother Integrated Musculoskeletal (iMSK) care, the team began improving the MSK health of people in the Hastings and Rother localities through an integrated community based service. People aged 16 or over with a registered GP in Hastings and Rother are eligible to self-refer to the iMSK Physiotherapy Service for a range of muscle and joint problems that may include back/neck pain, joint pains, strains and sprains. The service commenced in July 2017 and 13,132 referrals had been received to 31st March 2018.

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
3072	1274	1426	1359	1331	950	1225	1201	1294	13132

Language and communication

Meeting the needs of people with foreign spoken community languages, through telephone, face to face and written translation has always proved challenging due to the Trust's semi-rural geographical location and the high demand for interpretation services. Many interpreters who provided communication support were not local, which often caused delays to patient care and increased the financial impact. In October 2017 the SLA with a single supplier to provide all methods of interpreting and translation ended, enabling the Trust to bring the booking process back in-house and reassess the service. The use of local companies providing local interpreters has successfully mitigated risks whilst a new supplier was sourced.

Grade:	ACHIEVING

Evidence for grading:

- Effective rocurement processes
- iMSK data
- Interpreting data

Areas of focus from 2016/17 Report for 2017/18

An action plan to successfully implement the Accessible Information Standard across the Trust was developed and included utilising resources supplied by the current Service Level Agreement. A dedicated team to support both staff and patients to

communicate effectively was formed to identify innovative ways to meet the communication needs of all service users with Learning Disabilities, sensory and cognitive impairments and other disabilities. Initiatives include on demand video sign for British Sign Language, a dedicated email for patients with sensory losses to communicate with the Trust.

Further robust Service Level Agreements for Interpreting Services that can truly meet the needs of all service users who do not communicate using spoken English will be awarded using tender processes during 2018/19.

Areas of focus for 2018/19

- Award Service level agreements to individual companies that can provide local interpreters
- Identify further resources, such as translated patient leaflets, to support patients with foreign spoken languages

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

Summary of Activity:

Learning Disabilities (LD)
Patients continue to be supported in a variety of ways which are unique to the individual. Resources regularly used to support patients include the use of 'this is me - my care passport' and 'DisDAT' to assist staff in understanding communication including atypical presentations. Hospital communication books, easy read materials on procedures and individual care plans.

Equality & Human Rights Analysis (EHRA)
The Trust EHRA was successfully embedded into relevant documents ensuring inequalities are identified and removed wherever possible. The group continues to ensure 100% of all relevant Trust policies are appropriately assessed by 2019. Currently the EHRA looks at all protected characteristics but does not specifically differentiate between patients and staff. Separating these groups in the EHRA process is planned for 2018/19.

Language and communication
Staff responsible for providing patients with communication support did not always feel there was adequate resources or support to enable them to meet their patients' needs. Following the end of the Service Level Agreement (SLA) to supply face to face interpreters, telephone interpreters, and bilingual advocates, the Trust developed a new internal process to provide greater support to staff and patients. Language and communication needs continue to be assessed and met in a variety of ways using a simplified system that is now supported by a dedicated 'Accessible Information Team'.

Patients who rely on British Sign Language (BSL), presenting in Emergency Departments have not had access to BSL interpreters in a timely manner due to interpreters geographical location, plans to pilot video sign interpreting is planned for 2018/19.

Grade:	DEVELOPING

Evidence for grading:

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

Areas of focus from 2016/17 Report for 2017/18
During 2017/18 the newly formed Staff Disability Network was established and undertook the task to review the 'Disability Access Audit Toolkit' to identify barriers and share their experiences and provide guidance on further developing an access

audit toolkit. The toolkit continues to be developed with the view to engaging with patients, service users, carers and parents through a patient engagement group

Areas of focus for 2018/19

- Review the current EHRA to separate patients and staff during the process.
- Pilot Video BSL Sign language, obtaining patient feedback.
- Develop an engagement group to identify and remove barriers for patients with sensory loss.

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

Summary of Activity:

Care pathways for patients with communication needs
Training was delivered to 87% of staff on the implementation of the Accessible Information Standard. This has greatly improved the use of the alert system on the Patient Administration System (PAS). The alert system highlights communication needs to all clinicians providing care on the patient's care pathway. This enables support to be implemented for smooth transitions ensuring carers are well-informed.

Waiting Times
Trends in A&E waiting times followed those from 2016/17. The older the patient, the longer the time that was spent waiting. White British/white other and unknown groups had the longest waiting times compared with those identifying as any other ethnic group. Females again waited slightly longer on average compared to males.

Grade:	DEVELOPING

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

Areas of focus from 2016/17 Report for 2017/18
Staff continue to be reminded about the importance of collecting additional equalities data such as ethnicity, disability and support needs, to ensure access to care pathways is accessible.

Areas of focus for 2018/19
- Continue to raise the profile of using the PAS alert system to ensure communication and other access needs are captured and shared with clinicians providing care
- Continue to promote the importance of recording ethnicity and other equality data at the point of access

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

Summary of Activity:

Patient safety remains the highest priority with an extensive system for reviewing and reporting on patient experience, clinical effectiveness and patient safety providing detailed information enabling the organisation to identify mistakes, mistreatment and abuse. Regular clinical quality review meetings continued to review actions and learning outcomes to ensure that they were implemented.

Serious Incidents
Any incidents regarding equality are highlighted during Serious Incident meetings. There have been no SI reports in relation to equalities issues for the past 3 reporting periods. A large number of serious incidents continue to relate to falls and pressure ulcers which are prevalent in older people. There were 5.7 falls per 1000 bed days in 2017/18 which is a reduction from 6.2 in 2016/17. Work is planned for 2018/19 to reduce Category 2 Pressure ulcers by 10%. The Serious Incident Review Group (SIRG) investigates incidents thoroughly to identify what went wrong and why, so that improvements can be made to services and, most importantly, prevent it from happening again. A root cause analysis is completed for every incident and is discussed and reviewed by the SIRG.

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

Grade Change – This grade has been downgraded from Developed (green) to 'developing'.

Grade:	DEVELOPING

Evidence for grading:

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

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

Areas of focus for 2017/18

- Reduce the number of falls and pressure ulcers using new toolkits.

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

Summary of Activity:

Health Promotion

'Making Every Contact Count' (MECC) is an ongoing project that provides training for staff to identify, when in contact with patients, opportunities to talk about their patients' wellbeing and to empower those individuals to make healthier lifestyle choices. The emphasis is on prevention of problems and early intervention by providing information and signposting to other services. Over 1000 staff had received training and the project now runs in Eastbourne.

Sexual Health

The Sexual Health teams continue to build relationships with LGBT patient groups and the local communities. Sexual Health continue to offer new ways to target hard to reach groups. Plans to introduce Video Sign Language to enable access to planned and drop-in services for deaf people are expected in 2018/19

Testing was offered taking a less clinical approach in a more relaxed atmosphere at both Hastings and Eastbourne Gay Pride events along with resources, information, advice and support. The stand at the events were well attended.

Grade:	ACHIEVING

Evidence for grading:

- Sexual health data
- Service accessibility reviews
- MECC Newsletter
- Promotional events

Areas of focus from 2016/17 Report for 2017/18

Key projects aimed to attract a 10% increase in male attendances within the sexual health service. During 2016/17 the clinics saw an increase of over 22%.

Areas of focus for 2018/19

- MECC will continue to develop across Eastbourne.
- Continue to improve access to ESHT Sexual Health Services including through the use of video sign language for drop-in clinics

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

Summary of Activity:

Engagement
The Trust is committed to ensuring all of its sites are accessible to all who may use them. Many provisions already exist including lifts, ramps, induction loops, disabled toilets and free of charge disabled parking. Engaging with disabled patients to further improve access is planned for 2018/19.

Accessibility
Reasonable adjustments to improve accessibility are continually sought throughout the Trust. A dedicated email for patients unable to use traditional methods of contacting the Trust was established. This enabled deaf patients to contact the Trust regarding a range of queries including checking the status of a booked interpreter, cancelling or amending appointments.

A review of the disability access audit by the staff disability network is ongoing. The audit and outcomes are being used by the group to inform the Trust on where improvements and changes are needed. The Trust has a 'changing places' initiative which forms part of the organisation's five year 2016-2021 estates strategy. As part of this strategy an area for disabled changing/public disabled toilets with hoist has been identified for Eastbourne and a similar facility in Hastings is currently being identified.

To improve navigating around the hospital sites and to enhance the environment for patients with a disability and dementia, a 'Wayfinding Steering Group' is currently managing upgrading signage and colour schemes across Eastbourne Hospital. A Hastings upgrade will commence upon completion of Eastbourne Hospital. To ensure the steering group is considering accessibility, the group includes patients with disabilities (including visual impairments), community organisations and a representative from the Staff Disability Network.

Language and communication
The Trust provides a wide range of interpretation services for patients, carers and service users.

- Face to face interpreters (including BSL, Lip Speakers, Deaf-blind manual)
- Advocacy & Bilingual Advocacy
- On demand telephone interpreters
- Written & Audio Translation (including Braille)
- BSL on video

The Equality & Human Rights department continue to deliver training to staff to advise on best methods when communicating with patients, service users and their carers to ensure healthcare and information about it, is accessible without delay.

Over 42% of all interpreting was carried out by telephone during 2017/18. Further details of the languages requested are found in 2017/18 Equalities Analysis.

Accident and Emergency Waiting times

The national target for A&E waiting times in acute hospitals remains at 4 hours. Data suggests that waiting times in A&E are longer for those aged over 65 years. Analysis of A&E data by age, ethnicity and gender can be found in the Equalities Analysis.

Grade:	**DEVELOPING**

Evidence for grading:

- Interpreting data
- Wayfinding Steering Group minutes
- Estates strategy 2016-2021

Areas of focus from 2016/17 Report for 2017/18

Annual departmental Access Audits include Accessible Information as part of the audit process.

Areas of focus for 2018/19

- Planned improvements to access and navigation around Eastbourne hospital to include provisions for people with disabilities including visual impairments.

ESD2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.2
Outcome: People are informed and supported to be as involved as they wish to be in decisions about their care	

Summary of Activity:

The Trust is committed to ensuring patients, as well as their families and carers, are as involved as they wish to be in decisions about their care and treatment. All patients continue to have a personalised care plan which is developed with them.

The results of the National Inpatient Survey 2016 were published in 2017. Question 35 asked 'Were you involved as much as you wanted to be in decisions about your care and treatment?

Score for ESHT	Lowest Trust Score	Highest Trust Score	2015 Score for ESHT
7.2	6.3	8.8	7.6

This score has dropped from 2015 and therefore will be monitored locally by the Friends and Family Test.

The Trust has recently reviewed the following policies to ensure they continue to meet the needs of patients, public and members of staff:

- Inpatient Survey
- Consent Policy
- Privacy & Dignity Policy
- Equality & Human Rights Policy
- Delivering Accessible Information Policy
- Guidance for Staff on the Implementation of the Mental Capacity Act (MCA)
- Policy for the use of the Mental Health Act 1983

As part of the policy review, EHRA's are also reviewed and updated accordingly.

Patients, service users and their carers identified as not speaking English are provided with interpreters or bilingual advocacy to support decision making. All patient leaflets are made available, upon request, in alternative formats and languages. Documents that are translated into alternative formats are kept and uploaded onto the Trust website for further future use.

The Trust Patient Advice and Liaison Service (PALS) continues to support patients in accessing support and signposting should they require help. If people report that they do not feel informed after speaking to PALS then this is investigated as a concern and/or are advised about the formal complaint procedure.

A new policy 'Delivering Accessible Information' was developed to reflect the implementation of the Accessible Information Service which guides staff in how to obtain resources and support as well as tips for good communication.

Grade:	DEVELOPING

Evidence for grading:

- Delivering Accessible Information Policy
- Consent Policy and Process
- Individualised care plans
- Patient Administration Systems
- Communication & Engagement Strategy

Areas of focus from 2016/17 Report for 2017/18

A review was undertaken of the new system for interpretation services to ensure that it was meeting demands and providing value for the Trust. Following this, it was decided that the contract would not continue and that the Trust would bring the process in-house to provide greater, direct support to patients and staff.

Areas of focus for 2018/19

- Pilot video interpreting at the Trust to gain insight and feedback into how patients may benefit from this service
- Implement individual interpreting lots to multiple companies, retaining the booking process in-house.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.3
Outcome: People report positive experience of the NHS	

Summary of Activity:

The CQC survey is a snap shot of adult inpatients' experience of the Trust. Response rate for ESHT was 49%, which is higher than the national response rate, and compares ESHTs' performance to other trusts.

Section scores	ESHT Score	Lowest Trust Score (nationally)	Highest Trust Score (nationally)
1. The Emergency/A&E Department (answered by emergency patients only)	8.2	7.7	9.0
2. Waiting list and planned admissions (answered by those referred to hospital)	8.8	8.2	9.6
3. Waiting to get to a bed on a ward	7.5	5.8	9.6
4. The hospital and ward	8.0	7.3	9.0
5. Doctors	8.4	8.0	9.5
6. Nurses	8.1	7.3	9.1
7. Care and treatment	7.7	7.1	8.9
8. Operations and procedures (answered by patients who had an operation or procedure)	8.5	7.9	9.1
9. Leaving hospital	7.1	6.3	8.5
10. Overall views of care and services	5.6	4.8	6.9
11. Overall experience	8.0	7.4	9.2

The NHS Choices website continues to allow patients and service users to leave their feedback. All feedback is responded to by the Patient Experience Manager. Overall feedback was positive including comments on how friendly and helpful staff were, great communication and attentive doctors (including time taken with teenagers). There was a few lower scores which highlighted time spent on waiting lists.

Grade:	DEVELOPING

Evidence for grading:

- NHS Choices
- Patient Experience Steering Group minutes

Areas of focus from 2016/17 Report for 2017/18
Bilingual FFT were explored as part of the Interpreter services contract. Due to the contract ending these were not fully explored. As part of the plans for 2018/19 the Trust will explore pictorial FFT's as well as bilingual phrases. The Patient Experience and Engagement teams developed a strategy for patient and public engagement.

Areas of focus for 2018/19

- Ensure people accessing Trust services, and who do not use spoken English as their first language, are included in the FFT.
- Equality team to work more closely with patient and public engagement on initiatives.

EDS2 Goal 2: Improved patient access and experience	EDS2 Reference Number: 2.4
Outcome: People's complaints about services are handled respectfully and efficiently	

Summary of Activity:

The Trust welcomes complaints from patients, their relatives and general members of the public. Approximately a third of all new complaints received in 2017/18 came from the relatives of patients and in many of these cases, personal data about the complainant was not included within the body of the complaint. However, elements of data about patients that help to identify and understand their protected characteristics can be sought from their electronic patient records when this has been recorded by clinical services.

Of the 567 new complaints received in 2017/18, 543 were related to patient care. Although not all complainants are patients of the Trust, the patient demographics (based on the information held on electronic patient records) for complaints are set out in the patient analysis at the end of this report.

Grade Change – This grade has been uplifted from Undeveloped (Red) to 'developing' (Amber).

Grade:	DEVELOPING

Evidence for grading:

- Annual Complaints Report 2017/18
- Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)
- Complaints Process
- Post Complaint Survey

Areas of focus from 2015/16 Report for 2016/17
The "Deep Dive" review into Divisional complaints did not highlight complainants with protected characteristics being disadvantaged by the complaints procedure.

Complaint handling was delivered at the Nursing Preceptorship course in February 2018 with a further slots planned in 2018/19. A complaints factsheet is to be delivered at the Junior Doctors Induction Programme in July and August 2018.

The Complaints Module within the Trust's Risk Management Software (Datix) was reviewed and updated to improve reporting on trends and themes, providing detailed data on complaints.

Areas of focus for 2018/19

- To continue to intelligently register and utilise data on complaints.
- To progress work on the recording and implementation of actions/learning arising from complaints to the benefit of all patients, regardless of protected characteristics.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.1
Outcome: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	

Summary of Activity:

The Director of Human Resources continues to oversee the operational delivery of recruitment and selection to support the Trust's strategic aims.

Recruitment
The Trust has a robust Recruitment and Selection Policy which adheres to the mandate for employment checks in the NHS (in England). The policy is regularly reviewed and updated following consultation with various stakeholder groups such as the Trust Staff BME and Disability Networks.

The relative likelihood of white staff being appointed from shortlisting compared to BME staff was 0.91 times greater. This is an decrease from last year where the relative likelihood was 1.02.

To further enhance of the Recruitment and Selection Process for higher band positions (band 8a and above) the Trust aims to have a representative recruitment panel to ensure that no unconscious bias or unlawful discrimination occurs during the recruitment and selection process and that equality of opportunity is an integral part of the procedure.

Grade:	ACHIEVING

Evidence for grading:

- Trust policies and training on recruitment & selection
- Policy review by relevant staff networks (Disability, BME, LGBT)
- Retention of Disability Positive Scheme
- Recruitment processes
- The Workforce Race Equality Standard (WRES)

Areas of focus from 2016/17 Report for 2017/18
An action plan was developed to increase BME representation of underrepresented groups at all levels. Details of the action plan are contained in the WRES Report 2016/17.

Areas of focus for 2018/19

- Implement the WRES action plan through the BME Staff Network
- Disability Staff Network to support implementation of the Workforce Disability Standard (WDES)

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.2
Outcome: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil legal obligations	

Summary of Activity:

The Trust follows national established pay scales for all staff:
Agenda for Change – All non-medical staff
Medical & Dental Pay Scales
VSM Pay Scales – For very senior staff where AfC is not applicable.

Equal Pay Audit
The 2017 Trust Gender Pay Gap report identifies that there is a gap between the genders of 22.6% in relation to the mean hourly rate within the Trust. When this is broken down, it identifies that the largest difference exists within the medical workforce. This is similar to other Trusts and it is subject of further review to identify the underlying reasons for this difference.

A working group is currently reviewing the data to identify key areas for targeted improvement and a detailed action plan will be developed.

The full audit can be viewed at
http://nww.esht.nhs.uk/wp-content/uploads/2018/03/Gender-pay-gap-report-31-March-2017-snapshot.pdf

Grade:	UNDEVELOPED

Evidence for grading:

- Established national guidance and local policies
- ESHT Equal Pay Audit 2016
- ESHT Equal Pay Audit 2017

Areas of focus from 2015/16 Report for 2016/17
The Equal Pay Audit is a national requirement of all employers with over 250 employees. A full equal pay audit commenced in 2017 achieving 2018 national reporting targets.

Areas of focus for 2018/19

- Working group to identify areas to close the gender pay gap.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.3
Outcome: Training and development opportunities are taken up and positively evaluated by all staff	

Summary of Activity:

Non-mandatory training (NMT) including CPD are recorded and reported below. Records suggest that around 10% of all staff have under taken some form of non-mandatory training. 13.68% of all disabled staff have accessed NMT which is higher than those not having a disability (11.45%) or not declaring a disability (8.19%). The proportion of staff accessing NMT is proportionate.

	Access to Non-Mandatory Training (NMT) inc CPD						
		Ethnicity				Disability	
	All Staff	White	BME	UN	No	Yes	UN
All staff	7131	5490	912	729	3571	190	3370
Access to NMT	711	579	87	45	409	26	276
Accessing NMT (%)	9.97%	10.55%	9.54%	6.17%	11.45%	13.68%	8.19%
Total distribution of all accessing NMT		81.43%	12.24%	6.33%	57.52%	3.66%	38.82%

Staff Survey

The staff survey suggests that staff identifying as having a disability felt they do not have equal access to opportunities for career progression. This will be evaluated through the staff disability network.

Staff Survey Question	Gender		Disability		Ethnic Background		Age			
	Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
KF15. % satisfied with the opportunities for career progression	85	89	80	90	89	80	49	59	57	48

Commissioned and funded training courses continued to be evaluated through Higher Education Institutes which is then fed back to the organisation. Internal Trust courses are evaluated by participants at the end of each course. Poor evaluations are fed back to the lead trainers for action.

Project SEARCH

Project SEARCH is a collaborative approach to a supported internship programme for young people with learning difficulties/ disabilities, run from the Eastbourne DGH site. With many departments participating, this is a rewarding programme for the interns and the departments involved. The programme has continued to grow and attract positive media attention and recognition. The benefits to the interns include increased confidence, self-esteem and aspirations, giving them an opportunity to acquire new skills, receive tailored support, gain interview skills and apply for

employment. In addition, their internship continues to create a wider social network with work colleagues.

Grade:	DEVELOPING

Evidence for grading:

- Established policies and processes.
- Staff training records
- Staff Survey
- Project SEARCH

Areas of focus from 2016/17 Report for 2017/18

Career progression has continued to be a key agenda item at the BME Staff Network meetings.

Career development workshops were rolled out in 2017/18 with further sessions planned for 2018/19

Areas of focus for 2018/19

- Career development sessions to include interview skills and CV writing to offered to all staff with priority given to BME and staff with disabilities.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.4
Outcome: When at work, staff are free from abuse, harassment, bullying and violence from any source	

Summary of Activity:

Engagement

The Trust has issues a large amount of communications and undertaken engagement to promote a zero tolerance to bullying and harassment. If staff do experience unwelcome behaviour from any source, they are supported to speak up and use the Trust's reporting processes. The 'Speak Up Guardian' supports staff in ensuring issues that have been raised are addressed. Every month the Speak Up Guardian, Chief Executive and the Director of Human Resources meet to review all incidents of bullying, harassment and discrimination. Senior managers are committed to ensuring that the culture of the organisation empowers staff to speak up and work in an environment which is free from harassment, bullying, and victimisation or violence.

NHS Staff Survey Feedback

The survey results suggest that females experience higher levels of physical violence, harassment, bullying or abuse from patients, relatives or the public as well from staff than males. Females were less likely to report physical violence than males but more likely to report harassment, bullying or abuse. Staff identifying as having a disability were more likely to experience physical violence; harassment, bullying or abuse but less likely to report on either form of abuse.

Staff Survey Question	Gender		Disability		Ethnic Background		Age			
	Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths	14	16	17	15	14	21	25	20	15	10
KF23. % experiencing physical violence from staff in last 12 mths	2	2	2	2	2	3	2	3	2	2
KF24. % reporting most recent experience of violence	76	70	69	72	68	84	66	71	72	74
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	22	30	34	27	28	31	30	29	29	26
KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths	25	27	39	24	27	29	24	28	28	27
KF27. % reporting most recent experience of harassment, bullying or abuse	44	53	50	52	51	53	51	57	52	48

Grade:	DEVELOPING

Evidence for grading:

- Dignity at work policy. Raising Concerns policy, Independent Board member
- Staff survey Results 2017

Areas of focus from 2016/17 Report for 2017/18

The Trust continues to implement Harassment and Bullying (H&B) initiatives and empowers staff to speak out. EDHR training continues providing channels for reporting H&B.

Areas of focus for 2018/19

Develop robust actions in response to staff feedback including from the national survey.

Continue to monitor and address and concerns raised.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.5
Outcome: Flexible working options are available to all staff consistent with the needs of the service and the way that people lead their lives	

Summary of Activity:

Flexible working is encouraged wherever possible and the Trust recognises flexible working as an attraction to potential employees that may otherwise struggle to seek employment. There is a work life balance policy that supports staff to remain in their roles and also guides managers in how to apply flexible working. This approach also supports the Health and Well-Being of staff in reducing stress and is discussed in the staff appraisal process.

The Trust Child and Family Care Manager offers drop-in sessions for all staff whilst on maternity or adoption leave to offer advice and support on a range of topics that will help support returning to work.

- On-site childcare facilities,
- Childcare salary sacrifice schemes from ESHT
- Trust policies to support returning to work
- The Government's new childcare tax free scheme
- Benefit information
- Private providers who offer discounts
- NHS discounts to help save money

The staff survey suggests that staff from BME backgrounds are more satisfied with flexible working opportunities when compared to staff who are white British/Irish. Staff identifying as having a disability report being less satisfied with flexible working opportunities than staff who report not having a disability. A deep dive into sickness absence and flexible working for staff with a disability is planned for 2018/19.

Staff Survey Question	Gender		Disability		Ethnic Background		Age			
	Male	Female	Yes	No	White	BME	16-30	31-40	41-50	51+
% satisfied with the opportunities for flexible working patterns	46	54	46	54	52	59	49	59	57	48

Grade:	DEVELOPING

Evidence for grading:

- Flexible Working Policy
- Recruitment and Retention Strategy
- Organisational Change Policy
- Special Leave Policy
- Attendance Management Policy

- Work-Life Balance Policy

Areas of focus from 2016/17 Report for 2017/18
Increasing flexible working monitoring arrangements remains a challenge. Many staff regularly receive informal and temporary flexible working arrangements without going through a formal process. Implementing or attempting to enforce all requests to comply with a robust process for monitoring, poses a risk of losing the flexibility to accommodate temporary flexible working and potentially delaying many requests especially where these request are required to be implemented quickly or where flexible working occurs regularly in large teams. Carrying out retrospective reporting on short term requests could become very resource intensive.

Areas of focus for 2018/19
- Conduct a deep dive into sickness absence and flexible working for staff with a disability.

EDS2 Goal 3: A representative and supported workforce	EDS2 Reference Number: 3.6
Outcome: Staff report positive experiences of their membership of the workforce	

Summary of Activity:

The Health and Well Being team have many initiatives to support staff in feeling motivated and engaged. In the NHS Staff Survey staff have reported improvements to all 6 questions relating to job satisfaction. A score of 3.64 (max is 5, combined acute and community score is 3.71) for staff recommendation of the organisation as a place to work or receive treatment. BME staff reported increased job satisfaction in all questions relating to job satisfaction compared to White staff.

There is more work to do however this feedback is a demonstration of the Trust's and individual commitment to improving equality, staff experience and wellbeing.

Staff survey questions on job satisfaction (the higher the score the better)										
Staff Survey Question	Gender		Disability		Ethnic background		Age (years)			
	Male	*Female*	*Yes*	*No*	*White*	*BME*	*16-30*	*31-40*	*41-50*	*50+*
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.64	3.64	3.45	3.67	3.6	3.9	3.8	3.66	3.61	3.6
KF4. Staff motivation at work	3.8	3.92	3.76	3.92	3.86	4.19	3.9	3.83	3.93	3.9
KF7. % able to contribute towards improvements at work	65	70	61	71	68	73	76	71	70	65
KF8. Staff satisfaction with level of responsibility and involvement	3.84	3.89	3.73	3.91	3.86	4.03	3.91	3.9	3.87	3.86
KF9. Effective team working	3.7	3.81	3.68	3.81	3.78	3.89	3.89	3.8	3.81	3.74
KF14. Staff satisfaction with resourcing and support	3.22	3.26	3.1	3.28	3.22	3.51	3.44	3.2	3.25	3.23

Grade:	DEVELOPING

Evidence for grading:

- Staff Health & Well-Being Policy
- Staff feedback
- Operational Development and Staff Engagement Group Action Plan
- Staff Conversations
- NHS Staff Survey 2016

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

Identify further opportunities to engage with seldom heard staff groups on their experiences of the Trust.

The LGBT Staff Network and BME Staff Network commenced at the end of summer 2016, these groups are chaired by the Trust Chairman (LGBT) and Chief Executive (BME). Both Networks are managed by the Equality & Human Rights Lead.

Areas of focus for 2017/18

- Deliver training to provide staff with the knowledge and understanding of trans and gender non-conforming individuals,
- Identify further training opportunities to support BME Staff through the BME Staff Network
- Following a review of access audit of the Trust sites, commence an engagement and disability access improvements for staff through a Disability Staff Network.

EDS2 Goal 4: Inclusive leadership	**EDS2 Reference Number: 4.1**
Outcome: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	

Summary of Activity:

Leadership

Chief Executive – Dr Adrian Bull continued to chair the well-attended BME Network with passion and determination to improving equality and the working lives of BME staff in all areas of the Trust. Informal feedback revealed how the members welcomed Dr Bull's excellent leadership and inspiration.

Associate Director of Estates & Facilities – Chris Hodgson Chairs the Disability Staff Network jointly with the Equality & Human Rights Lead Kim Novis. The first meeting took place and reviewed the disability access audit of the Trust's main sites. Plans for 2018/19 include improving access to developmental opportunities for staff with a disability.

The Equality & Human Rights Team – Equality Lead - Kim Novis continued to support the good work that staff do in their roles to promote equality both as colleagues and healthcare providers.

The Trust Board supported and participated in Equality week in May 2017 promoting various aspects of equality. From celebrating different cultures by delivering food from around the world in the restaurants to promoting sensory loss awareness, through to enjoying cream teas with patients visitors and staff wearing simulation goggles and ear plugs to simulate various sensory losses.

In November 2017 the Trust's Equality Assistant - Danii Clark was successfully awarded 'Our Health Hero's' Regional award for 'Operational Support worker of the year 2017'. This was awarded for the development and promotion of the Trust's Equality staff lapel badges.

The Trust Board received the organisation's leadership strategy and updated Organisation Development Strategy and work programme during the year.

The Trust Board remains underrepresented for ethnicity as all members identify as White British. The Board is representative of other protected characteristics; including LGBT+, having beliefs other than Christianity (including no belief) and having a disability as defined by The Equality Act 2010.

Grade:	**DEVELOPING**

Evidence for grading:

- Equality Action plans
- Staff Network meetings
- Award recognition

Areas of focus from 2016/17 Report for 2017/18

Following the announcement of the Chairman stepping down a new Board level lead will be recruited to support the LGBT+ staff network and continue to provide leadership to the LGBT Staff Network

Areas of focus for 2018/19

- The Chief Executive will continue to provide leadership to the BME Staff Network
- The Trust Board will continue to engage regularly with the EDHR Lead to ensure equality remains at the most senior level within, and beyond the organisation forming relationships with wider stakeholders.

EDS2 Goal 4: Inclusive leadership	**Reference Number: 4.2**
Outcome: Papers that come before the Board and other major committees identify equality related impacts including risks, and say how these risks are to be managed	

Summary of Activity:

The Trust Equality Objectives 2015 – 2019 have been regularly reviewed to monitor progress. One objective includes "all strategies, business plans and annual reports that come before the Board or other major committees will include the Trust's standard Due Regard, Equality & Human Rights Analysis (EHRA), highlighting how inequalities will be managed". This form is an integral part of the policy writing template and therefore no strategy, business plan or procedural document has been considered by the Board or other major committee without this information being completed. A full report on the Trust Equality Objectives will be published in March 2019 where new objectives will be identified and an action plan on how these objectives will be met.

The Trust's dedicated Equality, Diversity and Human Rights (EDHR) Lead is line managed by the Director of Corporate Affairs. The EDHR Lead meets regularly with the Chairman, Chief Executive, Director of Nursing and other Medical and Non-Medical Executives.

The Trust Policy group manages and ratifies policies that are to be used with the Trust. Since the implementation of the Trust Equality Objectives there have been no policies ratified without a completed EHRA. All Trust policies should have an updated EHRA by 2019.

Grade:	**ACHIEVING**

Evidence for grading:

- Trust Quality Objectives 2015- 2019
- EHRA Database
- EHRA training sessions
- Equality, Diversity & Human Rights Policy
- Policy & Procedure for the Development and Management of Procedural Documents

Areas of focus from 2016/17 Report for 2017/18

Areas of focus for 2018/19

- Review current EHRA's to ensure robust measures are in place to manage equality related risks.
- Separating staff and patients in the EHRA process is planned for 2018/19.

EDS2 Goal 4: Inclusive leadership	EDS2 Reference Number: 4.3
Outcome: Middle managers and other line mangers support their staff to work in culturally competent ways within a work environment free from discrimination	

Summary of Activity:

Mentoring
Mentoring opportunities are available to staff who wish to gain skills and knowledge from other managers. Shadowing opportunities are open to all staff wishing to gain an insight into other roles within the Trust. BME and staff with a disability are encouraged to seek mentoring opportunities.

Staff with English as a second Language
Functional skills sessions over 6 months were provided to staff of all ages to develop their skills, knowledge. Learning & Development in conjunction with Greater Brighton Metropolitan College hosted Functional Skills information sessions to help staff who wanted to improve in areas such as English and/or Maths or needed additional support.

Regular support sessions were also provided for Speakers of Other Languages (ESOL).

Training
The Trust has introduced new and further supported various leadership and development training opportunities including the Leading Excellence Programme.

Equality and Diversity (E&D) training continues to be mandatory every 3 years, either face to face or via E-learning. E&D training forms part of the Trust induction programme and First Line managers are offered additional training for cultural awareness and also training for completing Equality & Human Rights analysis when developing policies, procedural documents, guidance, strategies etc. These are offered on a one to one basis and group sessions including telephone support.

Bespoke training packages were delivered to managers to equip them with the skills to identify, prevent and tackle prejudice arising from language and communication.

Transgender awareness training was delivered to first line staff as well as managers and Human Resources. These sessions provided managers with the knowledge to meet transgender patient needs, support initiatives, best practice and support colleagues transitioning at work. The sessions and further support from the course facilitators will support the development of a staff and a patient focused policy.

Grade:	DEVELOPING

Evidence for grading:

- Trust commitment to leadership and development activities
- Bespoke training sessions for Transgender awareness

- Equality and diversity training evaluations
- NHS Staff Survey results

Areas of focus from 2016/17 Report for 2017/18
Data on uptake of mentoring opportunities was not available due to many staff reporting they had received informal mentoring which was not recorded.

Funding was obtained from Eastbourne charitable funds for EDGH staff to undergo basic British Sign Language lessons. Further funding is being explored to ensure staff on both the acute and community sites have equal access to this training

Areas of focus for 2018/19
- Identify further sources of funding to support basic BSL lessons for staff.
- Explore options to promote and monitor mentoring

Governance Review

Meeting information:			
Date of Meeting:	4th December 2018	Agenda Item:	
Meeting:	Trust Board	Reporting Officer:	David Clayton-Smith, Trust Chairman

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

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

Summary:

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

We engaged Deloitte in May 2018 to undertake a review of Board leadership, governance and culture across at the Trust and the final report is attached.

The report commends the "impressive progress" to improve quality, culture and performance under a well-respected leadership team. It notes the comprehensive financial governance structure and progress made in respect of the financial agenda.

The report outlines the need for a greater focus on strategy; the "3+2" modelling was being developed at the time of the review but had not been finalised. It also recommends improvements to financial scrutiny, management information and strengthening the accountability framework throughout the organisation. The report contains 17 recommendations, 4 of which are rated high. All recommendations are achievable and an outline action plan was considered at the November Board Seminar.

Overall the report is positive and implementation of the recommendations will build on existing progress to strengthen governance and accountability across the organisation.

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

Board Seminar 6th November 2018

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

The Trust Board is asked to formally note the Governance Review Report and the recommendations contained therein.

Deloitte.

NHS
East Sussex Healthcare
NHS Trust

East Sussex Healthcare NHS Trust

Independent review of Board leadership, governance and culture

Final Report for publication | 22 November 2018

Contents

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22 November 2018

Independent review of Board leadership, governance and culture at ESHT

In accordance with our Engagement Letter dated 20 May 2018 (the 'Contract'), for the review of Board leadership, governance and culture arrangements at East Sussex Healthcare NHS Trust (the 'Trust'), we enclose our final report for publication dated 22 November 2018 (the 'Final Report').

The Final Report has been prepared for your sole use and shall be subject to the restrictions on use and other terms specified in the Contract. Whilst we have agreed that the Final Report may be published on the Trust website, such publication may only be made on a non-reliance basis since no person except the addresses, or NHS Improvement (NHSI), is entitled to rely on the Final Report for any purpose whatsoever and to the extent permitted by law we accept no responsibility or liability to any other person in respect of the contents of this Final Report. Should any person other than the Trust choose to rely on this Final Report, they will do so at their own risk.

The Final Report must not, save as expressly provided for in the Contract be recited or referred to in any document, or copied or made available (in whole or in part) to any other person. The Board is responsible for determining whether the scope of our work is sufficient for its purposes and we make no representation regarding the sufficiency of these procedures for the Trust's purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the Trust.

We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of the financial information has been performed.

The matters raised in this Final Report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by the Trust for their full impact before they are implemented.

Yours faithfully

Deloitte LLP

Executive Summary

Executive summary - overview

We have conducted a review of Board leadership, governance and culture at East Sussex Healthcare NHS Trust ('the Trust') as per the Services outlined in our Engagement Letter dated 20 May 2018. We outline a summary of our key conclusions below.

The Trust provides a range of acute and community services across its two main district general hospitals based in Hastings and Eastbourne. It has tackled a number of challenges in recent years, under the leadership of a transitioning Board, having been in both quality and financial special measures. It was removed from special measures for quality in June 2018, following a CQC inspection, but remains in special measures for finance. This review considers leadership, governance and culture at the Trust, with a particular emphasis on financial governance, where relevant.

Our overall view is that the Trust has made impressive progress in relation to improving quality, organisational culture, and operational performance in recent years under the leadership of a well-respected Chair and Chief Executive. Furthermore, the Trust is currently making positive progress in relation to the financial agenda with good in-year performance, a comprehensive financial governance structure, some excellent financial reporting and the recent development of a longer-term financial strategy.

The Trust has a number of Executive Directors (EDs) who have high levels of functional capability as well as experienced Non-Executive Directors (NEDs) who have demonstrated good levels of insight. However, in our view, delivery of financial sustainability alongside current quality, cultural and performance improvements, will require a comprehensive focus on strategy, as well as improvements to the effectiveness of financial scrutiny. The Board would benefit from ongoing support to specifically promote greater integrated working across corporate areas, improve long-term strategic thinking, and ensure the adequate scrutiny of financial plans and activities. Furthermore, consideration should be given to developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future.

In addition, there is a fundamental priority to provide greater support and development to operational leadership teams, including a clear accountability framework, consistency in governance arrangements, improved management information and ongoing leadership development training in relation to functional skills.

Our review findings set out within this report are grouped into the following themes:

A. Board leadership

B. Board governance

C. Divisional leadership and governance

We outline below a summary of our key conclusions in relation to these areas, as well as our corresponding recommendations.

A. Board leadership

A.1 Executive Director leadership

- The Trust Chief Executive Officer (CEO), who enjoys high visibility and credibility across the organisation, has built an executive team with a range of experience and skills in their functional areas. The team is credited with delivering strong improvements in quality and operational performance in recent years although the finance agenda remains a significant challenge for the team and the Trust.
- The team has demonstrated a strong commitment towards delivering financial improvement but this process is evolving and there is a need to address a number of development areas within the executive team to help facilitate this process. This includes the need for an ongoing executive team development programme aimed at promoting a more proactive and integrated executive team approach to tackling financial and strategic challenges facing the Trust. The team would also benefit from greater clarity in relation to responsibility for service transformation as there is currently a level of overlap across executive portfolios.

Executive summary - overview

A. Board leadership (continued)

A.1 Executive Director leadership (continued)

- There is also a need for the CEO to further reinforce the internal messaging regarding the criticality of addressing the current financial position. He may also benefit from taking a more 'helicopter' view at times, to allow other EDs to assume greater ownership and authority over the financial agenda.

A.2 Non-Executive leadership and the Board

- The Board is led by a Chair who is credible, valued, and well-liked. There is a range of depth and breadth within the NED cohort, with a particular strength in the quality domain. The Board, as a whole, has led the Trust through a period of significant and positive cultural change, leading to greater levels of staff engagement across the organisation.
- However, given the experience and strength of the NED group, we would have expected to see greater pace and influence in setting the strategic direction of the Trust as it attempts to address a long-standing structural issue which will require a strategic solution. Early stage plans are gaining momentum as the Trust develops its '3+2' plan, but this is essentially a financial strategy, and numerous steps are required to develop and deliver a comprehensive corporate strategy, underpinned by a refreshed clinical strategy, which is owned by senior clinicians and supported externally. We have concerns over the current depth of strategic skills amongst the NED group to lead the delivery of this significant piece of strategic work. We therefore believe that the Board would benefit from developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future.
- We also observed relatively low levels of scrutiny and challenge, particularly in relation to the finance agenda, and believe that improvements are required to enhance the quality of debate in Board and committees, with a view to stimulating more insightful and challenging debate whilst generally raising levels of accountability amongst the executive team. The process will require a focused Board development activity but will also benefit from new NED perspectives at the F&IC.

B. Board governance

B.1 Board and committee governance

- We have observed some areas of good practice in relation to the structure and operation of the Board and committees and the Trust is largely in line with good practice when benchmarked against other similar organisations. We note multiple layers of financial scrutiny at the sub-committee level but understand this given the Trust's financial situation. However, we would concur with the Trust's decision to disband the Financial Improvement and Oversight Group (FIOG) as its role relative to the Financial Improvement and Sustainability Committee (FISC) is unclear and there is significant duplication in our view.
- There is also scope for improving divisional representation and participation in the Finance & Investment Committee (F&IC) and FISC with a view to enhance the levels of ownership and accountability operational leadership teams have in relation to the financial agenda. We also note potential for improving the Trust approach to performance review to help in this respect. In addition, we have some concerns regarding the effectiveness of scrutiny in the F&IC.

B.2 Board reporting

- The general quality of financial reporting to the Board, F&IC and FISC is of a high standard and is an area of strength for the Trust. We understand that the quality of financial reporting has evolved over recent times but in our view reporting in other domains has failed to evolve at the same pace. There is therefore an imperative to ensure that all domains of the Integrated Performance Report (IPR) are progressed to ensure a consistent standard. We also note a lack of alignment between the information presented to the Board as part of the IPR, and that covered as part of the Quality and Safety Committee (Q&SC) and the People and Organisational Development Committee (PODC) and therefore believe there is a need to consolidate and improve reporting in these domains.

Executive summary – detailed findings

B. Board governance (continued)

B.3 Risk management

- The Trust has a positive risk management culture which is highlighted by an integrated approach to quality and risk, as well as good awareness of the process for raising concerns. Additionally, the BAF is used well at the Board level although there is a need for greater alignment between BAF risks and the relevant Board committee. Learning and improvement represent a core function of the Trust's risk and quality management strategy and we believe the Trust follows good practice overall in this area.

C. Divisional governance

- The Trust follows a number of areas of good practice in relation to its divisional operating model in terms of structure, leadership arrangements and approach to performance review. However, the divisional arrangements remain relatively immature having been in place for less than two years. Further work is required to ensure there is consistency and clarity of roles, responsibilities and accountabilities in leadership groups at divisional and speciality level, as well as standardisation of governance arrangements. These arrangements should be formally captured in job descriptions and an accountability framework.
- The standard of informatics and data analytics at the Trust does not compare well with other NHS organisations and this places practical restrictions on the ability of operational leaders to do their jobs on a day-to-day basis. The Trust would benefit from a central informatics function with the capability, capacity and operational knowledge to produce customised and insightful information to support various aspects of operational activities such as facilitating the management of performance, forward business planning and service transformation.
- We also note a significant investment in leadership development which senior leaders have appreciated. There is a need though for a continuing programme of targeted leadership development to provide senior leaders with the tools required to successfully deliver a challenging agenda. Specifically, further leadership development training should include a focus on functional aspects for respective leadership roles and should be used to help convert the improved levels of medical engagement experienced at the Trust with improved levels of medical involvement, where medics make a more practical contribution to all aspects of Trust business.

Key Recommendations

A summary of our recommendations can be found on page 41-42. The priority recommendations are outlined below:

- The CEO should consider the need for additional actions to reinforce the message across the organisation that the financial situation is critical, and that all staff need to own the issue and tackle it collectively. This could involve greater clarity in internal communications in addition to introducing an extended senior leadership forum to include all EDs and the Chiefs of Service;
- There is an imperative for the Trust to enter an extensive period of internal and external consultation with a view to developing the '3+2' financial strategy into a comprehensive corporate strategy, owned by senior clinicians within the organisation and supported by a range of external stakeholders;
- Consideration should be given to developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future; and
- The Trust should introduce a more explicit accountability framework which clearly sets-out expectations regarding roles, responsibilities and accountabilities; the leadership model at all levels; and the Trust operating structure down to the ward level.

Review Scope

Introduction

Review Scope

Our approach

This review sets out the findings of our independent review of leadership, governance and culture at the Trust against the project scope in our Contract dated 20 May 2018.

Our approach to delivering the project scope has consisted of the following key activities:

1. Conducting a **desktop review of key supporting information**. This has included a review of: Board and relevant Committee papers; divisional performance information; and relevant strategy documents;
2. Conducting 1-1.5 hour non-attributable **interviews with each member of the Board**;
3. Conducting 1 hour non-attributable **interviews with members of staff** across a range of clinical and operational roles;
4. **Observation** of a **private and public Board meeting** on 5 June 2018;
5. **Observing a range of financial forums** including the 30 May 2018 and 27 June 2018 Finance and Investment Committees; the Financial Improvement and Sustainability Committee on 26 June 2018; and a confirm and challenge meeting on 11 July 2018;
6. **Observing an Integrated Performance Review** meeting on 12 June 2018;
7. Conducting a **series of service visits into clinical and non-clinical areas** across the Trusts sites;
8. Undertaking a **Board survey**, to which all 14 Board members responded
9. Undertaking a **senior leaders survey** to which we received 16 responses;
10. Undertaking a **staff survey** to which we received 698 responses;
11. Conducting **two focus groups** with clinical and non-clinical staff; and
12. Conducting telephone **interviews with ten external stakeholders**.

Surveys

Throughout the body of this report we have presented the findings from our Board, senior leaders and staff surveys. The key for these graphs is as follows:

SA	Strongly agree
A	Agree
Sl A	Slightly agree
Sl D	Slightly disagree
D	Disagree
SD	Strongly disagree
CS	Cannot say

Glossary

Throughout the body of this report, we include reference to a number of terms and abbreviations. A full glossary of terms can be found at on page 11.

Glossary

Glossary

Glossary of terms used throughout this report

A&E	=	Accident and Emergency
AC	=	Audit Committee
ADO	=	Associate Director of Operations
ADN	=	Associate Director of Nursing
BAF	=	Board Assurance Framework
Board	=	The Board of East Sussex Healthcare NHS Trust
BPPC	=	Better Payment Practice Code
CEO	=	Chief Executive Officer
CIP	=	Cost Improvement Programme
COO	=	Chief Operating Officer
CRR	=	Corporate Risk Register
CQC	=	Care Quality Commission
DD	=	Divisional Director
DoCA	=	Director of Corporate Affairs
DoHR	=	Director of Human Resources
DoN	=	Director of Nursing
DoF	=	Director of Finance
DoS	=	Director of Strategy
ED	=	Executive Director
ESBT	=	East Sussex Better Together
ESHT	=	East Sussex Healthcare NHS Trust
F&IC	=	Finance and Investment Committee
FIOG	=	Financial Improvement and Oversight Group
FISC	=	Financial Improvement and Sustainability Committee
FY	=	Financial year
IPR	=	Integrated Performance Review
IT	=	Information Technology
HR	=	Human Resources
MD	=	Medical Director
MRI	=	Magnetic Resonance Imaging
NED	=	Non-Executive Director
NHS	=	National Health Service
NHSI	=	NHS Improvement
NSS	=	National Staff Survey
PMO	=	Project Management Office
PODC	=	People and Organisational Development Committee
PSO	=	Project Support Office
RAC	=	Remuneration and Appointments Committee
RAG	=	Red, amber, green (rating)
RTT	=	Referral to treatment
Q&SC	=	Quality and Safety Committee
Trust	=	East Sussex Healthcare NHS Trust

Observations and commentary

Section A – Board leadership

A. Board leadership

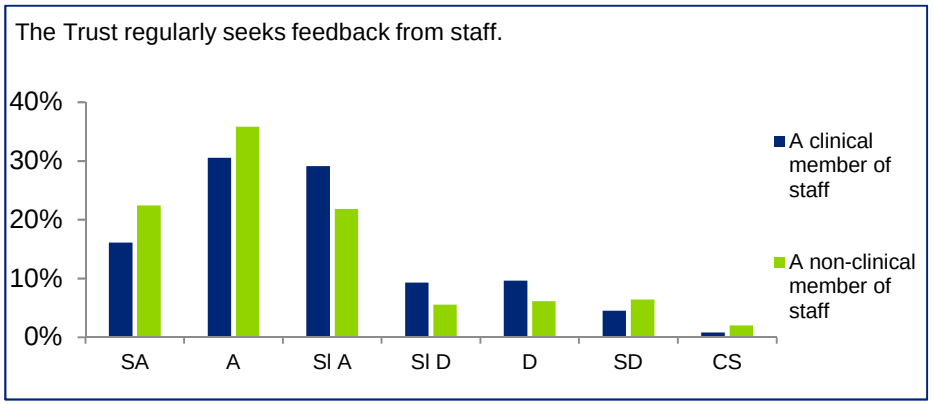
A.1 Executive leadership

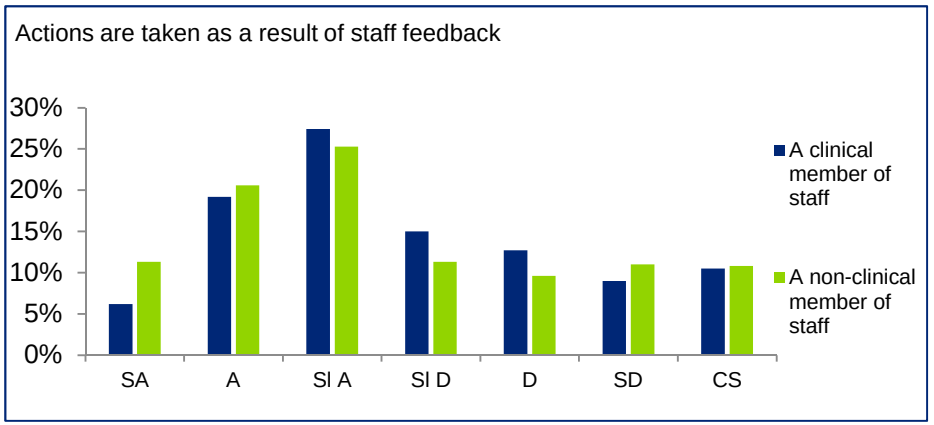
- **The Trust Chief Executive Officer (CEO), who enjoys high visibility and credibility across the organisation, has built an executive team with a range of experience and skills in their functional areas. The team is credited with delivering strong improvements in quality and operational performance in recent years although the finance agenda remains a significant challenge for the team and the Trust.**
- **The team has demonstrated a strong commitment towards delivering financial improvement but this process is evolving and there is a need to address a number of development areas within the executive team to help facilitate this process. This includes the need for an ongoing executive team development programme aimed at promoting a more proactive and integrated executive team approach to tackling financial and strategic challenges facing the Trust. The team would also benefit from greater clarity in relation to responsibility for service transformation as there is currently a level of overlap across executive portfolios.**
- **There is also a need for the CEO to further reinforce the internal messaging regarding the criticality of addressing the current financial position. He may also benefit from taking a more 'helicopter' view at times, to allow other EDs to assume greater ownership and authority over the financial agenda.**

A.1.1 Chief Executive leadership

The CEO joined the Trust in April 2016 and has since established a good reputation throughout the organisation, with a range of stakeholders commenting positively on his contribution. He has built a stable executive team around him with substantive appointments made to a number of key positions since joining, including appointments to the Director of Nursing (DoN) (October 2017), Chief Operating Officer (COO) (November 2016), Medical Director (MD) (September 2016), Director of Strategy (DoS) (August 2017) and Director of Finance (DoF) (June, 2016) roles. He is well regarded at all levels, with strong support voiced by staff and Board members interviewed as part of this review. He is described as being a value driven, caring and supportive leader with a significant focus on staff engagement, empowerment and clinical quality.

At the Board level, interviewees felt that the CEO strikes a good balance between support and accountability. Throughout the Trust he is described as highly visible, with detailed knowledge of the organisation. Some interviewees commented that he takes time to know staff at all levels of the Trust, personally. Staff also report that he takes time to listen to their concerns and comments and follows up to check actions have been taken where necessary. He models a principle of open and honest dialogue, and provides strong support to facilitate employee empowerment which helps to foster a culture of organisational learning. One interviewee commented that *'we learn better with this CEO than we ever have before'.* This emphasis on learning is evident in the staff survey results shown below.





A. Board leadership

A.1.1 Chief Executive leadership (continued)

The leadership style the CEO displays has resulted in a fundamental change to the Trust's organisational culture. When the CEO joined the Trust in April 2016, it had recently received a poor CQC inspection rating and was suffering from low staff engagement, with concerns of bullying and harassment. The CEO has been instrumental in changing that culture by recognising the need for compassionate, supportive leadership and ensuring that he built an executive team who also follow this leadership style. A frequent comment during our interviews was that the current culture at the Trust is completely different to that of the culture two years previous, and that this positive change is primarily down to the CEO's recognition of the leadership that was needed (see section A.2.3 for further commentary on culture).

Our observations and interviews highlighted that the CEO is well engaged with the financial agenda, attending or chairing a number of relevant committees and meetings. Furthermore, despite the need to focus heavily on quality and safety over the last two years, our interviews with the CEO indicate an acute awareness regarding the need to place equal emphasis on the quality and financial agendas. However, the Trust remains in financial special measures, and a number of comments made by interviewees at both Board and divisional level did suggest that not all senior leaders, particularly senior medical leaders, fully grasp the imperative to place equal emphasis on both areas. We believe that the CEO could take additional steps to set the organisational tone by more clearly communicating the extent of the financial challenges facing the organisation, as well as the importance of all staff jointly owning and proactively tackling the financial problems facing the Trust. This could be achieved by improved messaging in internal communications to ensure that there is no ambiguity over the fact that the Trust is in financial turnaround. In addition, there may be other areas where actions could be modified to ensure the tone is appropriately set. For example, the absence of several EDs in the weekly meeting the CEO and Medical Director (MD) have with the Chiefs of Service may be unconsciously sending the wrong message to the wider organisation regarding the priorities for the Trust, and the criticality of tackling the financial problems, in parallel to quality and safety issues.

Whilst this meeting is technically a MDs meeting with the senior medical leaders, it has evolved into a wider meeting with the COO regularly in attendance. Notably this meeting does not have any ED representation from a strategy and financial perspective, two of the most critical areas of focus for the Trust, as discussed below. We fully understand the need for a senior medical leaders meeting to take place but believe that this should be separate from an extended senior leadership meeting, including EDs and Chiefs of Service to discuss the wider Trust agenda. One model we have seen for example in other NHS organisations is where alternate ED meetings are used for the EDs to meet with the Chief of Service equivalent to consider a range of business. It is not uncommon for the Associate Director of Operations (ADO) or Associate Director of Nursing equivalent to occasionally deputise for the Chiefs of Service equivalent in these meetings.

R1: The CEO should consider the need for additional actions to reinforce the message across the organisation that the financial situation is critical, and that all staff need to own the issue and tackle it collectively. This could involve greater clarity in internal communications in addition to introducing an extended senior leadership forum to include all EDs and the Chiefs of Service.

As noted above, we also observed a high level of activity undertaken by the CEO who actively participates in many committee meetings, engages with a significant number of staff and generally has a high level of understanding of issues across the organisation. Whilst these are all positive qualities, we also believe that it is important that the CEO encourages his EDs to take a more prominent leadership role in the forums when he is in attendance. For example, we observed that at times, the CEO's profile had the effect of diluting the way ED experience and accountability were perceived. We believe that at times, there is scope for the CEO to step back from the operational detail, allowing his executive team to take greater ownership in order to collectively address these problems. This point is particularly noticeable in relation to the financial agenda.

R2: The CEO should actively consider opportunities to step back from operational detail in certain forums with a view to allowing other EDs to assume greater ownership and authority.

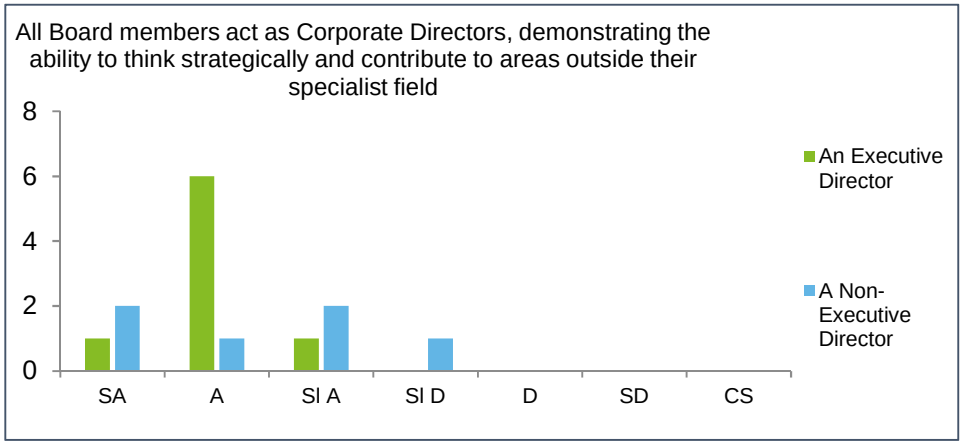
A. Board leadership

A.1.2 Executive team leadership

The executive team comprises a number of highly experienced individuals who have demonstrated a sound grasp of their respective portfolios as observed through our meetings and interviews. Additionally, the executive team are visible throughout the Trust and are described as approachable and open by staff. We found evidence of a cohesive, supportive team, with no obvious factions during meetings or interviews. The team meets regularly and we are aware that the CEO has helped to facilitate development with a number of individuals.

We recognise that the executive team is still relatively new, with the majority of members joining over the last two years and as such, the team continues to form as a unit. We believe that the executive team has the potential to become highly effective but there are a number of areas that will require focused development as the team continues to evolve. Initially, we note potential for improved levels of integrated working across executive portfolios. Specifically, EDs are largely focused on their respective portfolios, with low levels of contribution to adjacent portfolios. This was apparent in a number of areas; for example, the corporate oversight of the Trust strategy and Trust finances where we note potential for a more integrated approach and collective ownership. This pattern of silo working creates a situation in which the capability and experience of the EDs are not utilised fully in tackling the significant financial challenges facing the organisation. During our observations and interviews, examples of this pattern of working practice was highlighted, with comments being that *'finances are left to the DoF and CEO',* or that *'there is not a collective approach to strategy development amongst the executive team'.* Our interviews also highlighted that many executives are aware of this pattern, as well as a clear recognition of the long-term challenges, which is encouraging. However, given the Trust's current financial situation, the pace of transformation is likely to need increasing if the Trust is to operate in a sustainable, long-term way, and this must be driven by the executive team. In addition, our observation of Board and Committee meetings indicated limited contributions by EDs outside of their immediate portfolio areas.

This silo working amongst the executive team is partly reflected in our Board survey, as shown below, where a small number of NEDs were unable to agree that all Board members acted as Corporate Directors. However, a number of EDs agreed with this point, potentially indicating low levels of awareness amongst the executive team regarding team dynamics, and a need for some facilitated executive development activities.



We also observed a focus on short-term performance and delivery issues, with a consistent emphasis on the in-year plan, although recognise that the external requirements associated with special measures can result in a focus on short-term objectives. Whilst this is important, and has led to some efficiency savings, in our view there is a need for clearer long-term objectives in order to address the long-term challenges in a transformational way, and the current balance of short term objectives over longer term plans is having a negative impact on the ability of the executive team to drive the strategic agenda appropriately. We discuss this point in more detail in section A.2.4 on strategy.

We acknowledge that the tendency towards silo working as well as the operational, short-term focus is being positively addressed by the fact that the '3+2' strategy is being progressed at pace, and involves a more integrated approach with strategy and finance directorates working together, as well as wider executive team engagement.

A. Board leadership

A.1.2 Executive team leadership (continued)

Whilst this is a positive step, it is primarily a financially driven strategy that will need to subsequently incorporate other dimensions, aided by more proactive, integrated and coherent consultation process, such as a clearer clinical strategy and workforce dimension, for example.

Another symptom of executive team silo working is apparent through a disconnect between the Programme Management Office (PMO), Project Support Office (PSO), business intelligence and the work performed by the Head of Planning and Performance. Specifically these functions sit within different executive portfolios and there is a significant element of fragmentation. We note that the individuals involved appear to work collaboratively to overcome some of the structural challenges, and that a sustainable services group has been formed to bring together the various strands, but we believe that the organisation would benefit from a more structured approach.

An additional point noted during observations and interviews was that there was a tendency for the executive team to externalise a number of issues, for example around the cause of the financial deficit or external pressures, preventing a long-term strategy being developed. A number of comments from some internal and external stakeholders described a culture of 'learned helplessness' and a need to take a more proactive approach in setting and driving the agenda. Whilst we recognise that there are historical and external factors which invariably have an influence on the Trust's sustainability, there is also a need for the Trust's leadership to model behaviours which address challenges in a pro-active way, including how external pressures are managed.

R3: The CEO should introduce a structured executive team development programme aimed at supporting the ongoing evolution of team behaviours with a particular emphasis on developing longer-term objectives. This should include a focus on promoting a more proactive and integrated approach to tackling financial and strategic challenges facing the Trust.

R4: The CEO should consider consolidating executive portfolio responsibilities to ensure more formal alignment between key transformational responsibilities including the PMO, PSO, business intelligence and strategic planning.

A.1.3 Financial leadership

The DoF is in his second finance director level role having spent four years in a similar role at a local community trust. This is his first acute trust DoF level role but he has worked in other acute trusts at deputy DoF level. We observed the DoF operating in a number of forums and gathered a range of comments from interviews. We observed good levels of technical competency, a comprehensive understanding of the detail and a clear commitment to the organisation and to delivering financial performance. This was coupled with a friendly and generally engaging approach to the observed meetings. These factors have resulted in the Trust building some momentum around the finances with progress against plan in FY19, a positive trajectory for the year, and early progress in developing a longer term financial strategy.

It is widely recognised by a range of internal and external stakeholders that the DoFs leadership style is evolving and in order to drive the challenging finance agenda, further development will be required.

Our observation is that the DoF assumes a significant level of personal responsibility for the financial position and there is a need for that responsibility to be spread across all EDs. We also note that the ability of the DoF to drive a more strategic financial plan is dependent on other ED portfolios working together and that it is not all within his gift. This has led to a situation where the DoF has been stretched beyond an appropriate capacity, requiring an excessive amount of his time and effort, with many interviews citing his '*phenomenal work rate'.* To compound this, until recently the DoF has not had the appropriate deputy support to enable him to step back from the detail in order to concentrate on a more transformational, strategic approach to leadership. However, we were impressed by the new Deputy Director of Finance during interview and believe the post holder will provide the DoF with the appropriate support, in conjunction with a very experienced finance team, to begin to deliver the financial agenda in a more strategic way.

A. Board leadership

A.2 Non-Executive Directors

- **The Board is led by a Chair who is credible, valued, and well-liked. There is a range of depth and breadth within the NED cohort, with a particular strength in the quality domain. The Board, as a whole, has led the Trust through a period of significant and positive cultural change, leading to greater levels of staff engagement across the organisation.**

- **However, given the experience and strength of the NED group, we would have expected to see greater pace and influence in setting the strategic direction of the Trust as it attempts to address a long-standing structural issue which will require a strategic solution. Early stage plans are gaining momentum as the Trust develops its '3+2' plan, but this is essentially a financial strategy, and numerous steps are required to develop and deliver a comprehensive corporate strategy, underpinned by a refreshed clinical strategy, which is owned by senior clinicians and supported externally. We have concerns over the current depth of strategic skills amongst the NED group to lead the delivery of this significant piece of strategic work. We therefore believe that the Board would benefit from developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future.**

- **We also observed relatively low levels of scrutiny and challenge, particularly in relation to the finance agenda, and believe that improvements are required to enhance the quality of debate in Board and committees, with a view to stimulating more insightful and challenging debate whilst generally raising levels of accountability amongst the executive team. The process will require a focused Board development activity but will also benefit from new NED perspectives at the F&IC.**

A.2.1 Chair leadership

The Chair is described by colleagues as being a supportive, credible and open person who enjoys a level of support from Board members and the majority of comments offered during our interviews were favourable towards the Chair. He has breadth and depth in his experience with high level NHS non-executive roles, as well as operating at senior Board level in the private sector. He appointed the current CEO and has helped re-build the executive team since his appointment in January 2016.

His colleagues describe him as supportive and we note that there is a positive and cohesive working relationship between the Chair and the CEO. Comments from staff interviews described him as being particularly supportive of business plans within the Trust. We also note that the Chair is described as a systems leader and has spent time focusing on system collaborations including chairing the East Sussex Better Together (ESBT) Alliance Governing Board, as well the Kent, Surrey and Sussex Academic Health Science Network.

Additionally, the Chair meets with the NED cohort as a group, occasionally, and while he does not have regular one-on-one meetings with all NEDs, he is described as operating an open-door policy, where people describe him as approachable.

A.2.2 Non-Executive Director leadership

In contrast to the executive team, the NED cohort has experienced limited turnover in recent years with four of the NEDs being in place prior to the Chair joining in January 2016, and one joining a few months after the Chair joined. The NEDs have a variety of backgrounds and have all operated at senior levels across a number of significant private and public sector organisations. They bring experience in healthcare, corporate governance, communications, law, finance, strategy, HR and business. One of the NEDs stood-down in August 2018 and the Trust is currently in the process of appointing a new NED and an Associate NED. We understand that these two positions will be used to strengthen the Board skill set in financial management and in partnerships, which would be a sensible solution given the financial and strategic agenda at the Trust.

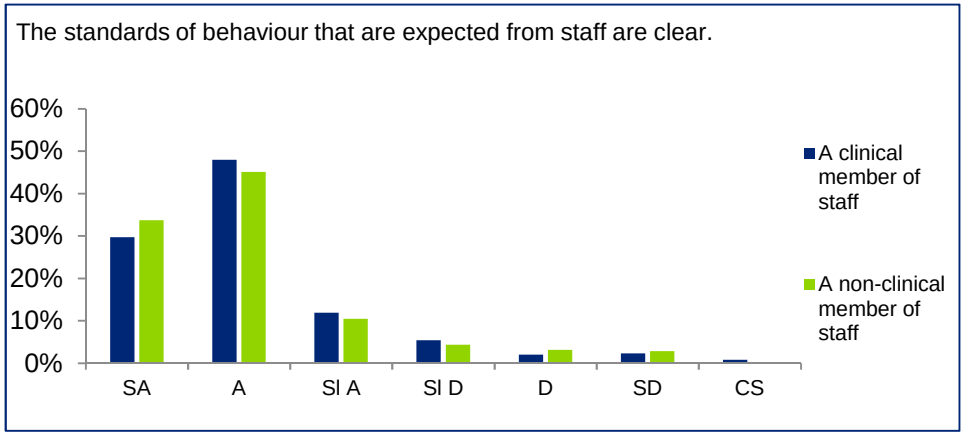
Individually the NEDs came across well in interview, each being able to offer insight into the Trust challenges, with particular strengths noted in relation to the quality agenda. However, similar to our point in relation to the Chair, we note that there are some areas for development in relation to strategy development, and the level of scrutiny and challenge, as set out below.

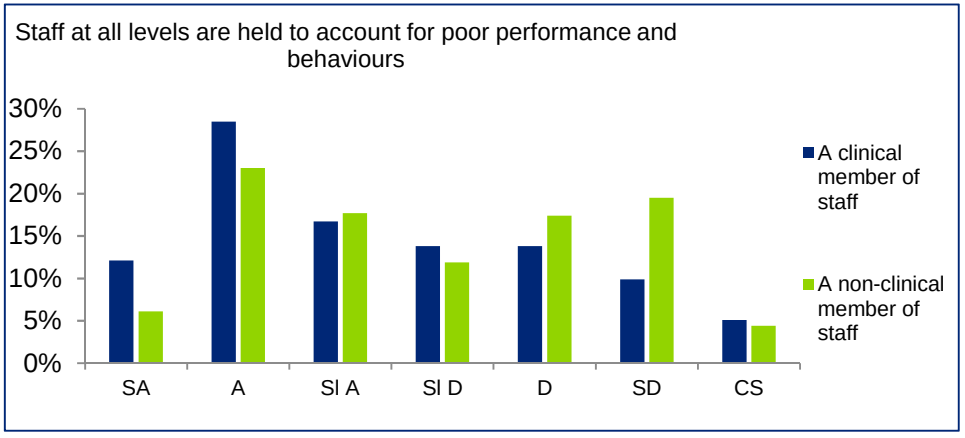
A. Board leadership

A.2.3 Organisational Culture

The Board has presided over a period where the Trust's culture has greatly improved. As described in section A.1.1, when the CEO was appointed in 2016 the culture of the Trust was characterised by low staff engagement and a number of accusations regarding bullying and harassment. The Trust has established a number of avenues through which the Board has led positive cultural change. Interviews also highlighted that this change in culture has been combined with a clear and consistent focus on quality and safety, which has directly led to CQC's recommendation that the Trust exits quality special measures.

The focus on quality and safety has also facilitated improved Trust relations with its medical staff. Improvements have been made to the way the Trust communicates with its clinicians, which has led to an increase in medical engagement, and clinicians beginning to take a more active role in the Trust's operations. Additionally, the Trust has taken steps to tackle poor behaviour from some clinicians, in order to clearly communicate expected standards of behaviour. These actions have helped to take the Trust's medical engagement score from the bottom 10%, to within the top 10%, as well as facilitating quality improvements. In addition, staff report that the standards of behaviour that are expected are clear, as illustrated by the staff survey results below. However, the staff survey below indicates, particularly amongst non-clinical staff respondents, that there may still be some work to ensure poor behaviours at all levels is addressed.



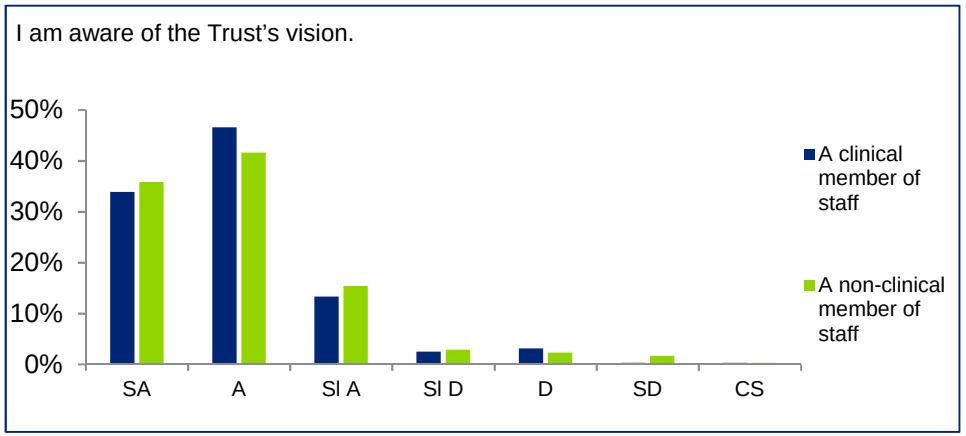


The shift in culture has also been facilitated by a detailed and thorough staff engagement programme, which has included introducing clear expectations from leaders, alongside some leadership development training (but note our commentary in section C.4). There has also been an explicit focus on demonstrating that staff are valued, and a number of awards, unsung heroes, mentorship programmes and campaigns to showcase excellent and caring teams have been widely communicated. This had a clear aim of introducing a positive mind set amongst staff, and staff engagement scores in the National Staff Survey (NSS) have increased, likely as a direct result. Furthermore, the Trust has been identified as being the most improved across England on staff reports of bullying and harassment since 2016, as indicated by the NSS.

A. Board leadership

A.2.4 Strategy

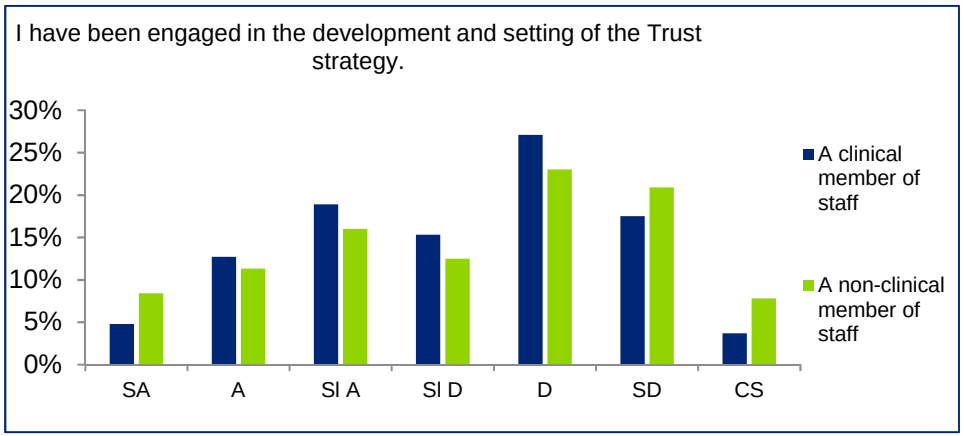
The Trust has a clear vision of improving services to be outstanding by 2020 entitled 'ESHT 2020'. We also found this vision to have been well communicated and understood throughout the organisation, as illustrated in the results of our staff survey below.



However, we found less clarity regarding the detailed corporate strategy to enable delivery of the 2020 Vision, with Board members unable to clearly articulate the specifics of the strategic direction. Moreover, Board members recognised that the focus on the development of a detailed corporate strategy aimed at delivering sustainability has been hindered due to a variety of factors including: embedding the new executive team; moving the Trust out of quality special measures; health economy financial challenges; and tackling in-year financial issues.

We do note however that a level of momentum has grown in this area over recent months with a '3+2' financial strategy presented to the Board in July 2018. The current focus of this financial strategy is to present a break-even financial plan to NHSI by September 2018. Although the plan has a financial focus, it has been developed in close collaboration between the DoF, the Director of Strategy and COO and there are a number of assumptions in the plan which are driven by service transformation and productivity improvements. The plan aims to break-even by FY21, with a large portion of the savings being realised in years two and three of the plan.

Although we believe the current '3+2' strategy is a step in the right direction, it has been developed at pace and without the Trust having a fully refreshed clinical strategy that has undergone a clear internal or external consultation process. This point was reflected in our interviews and through our staff survey which is set-out below. We do note that some internal consultation has gone into its development, as previous work done with the divisions produced each division's 'plan on a page' which fed into a clinical strategy which went to the Board during 2017. However, this work was performed in the previous year and there has been no on-going consultation.



Additionally, external stakeholders suggested that their involvement with the Trust did not adequately address the system-wide strategic solutions that are necessary to address the challenges faced by the wider local health economy. Mutually agreed objectives and evidence of long-term commitment is required to bring together a number of organisations across the system, and concerns were raised about the long-term commitment displayed by the Trust: for example, that appropriate time and resources are not allocated to this agenda.

A. Board leadership

A.2.4 Strategy (continued)

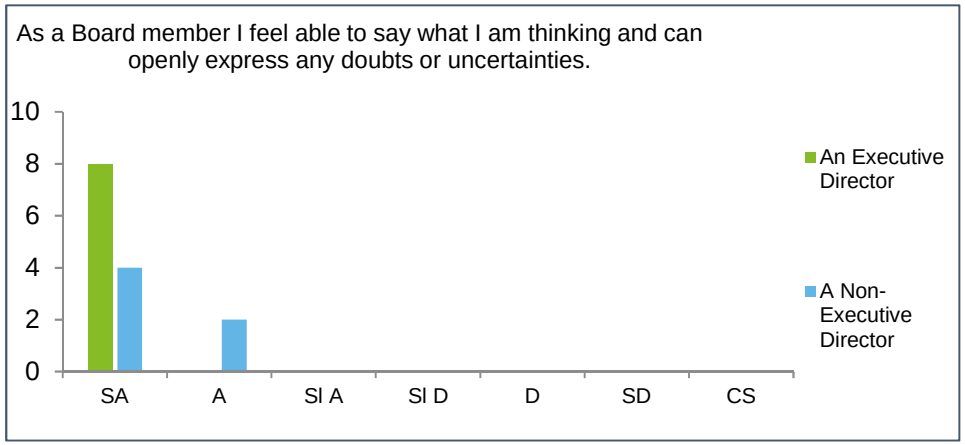
Overall, we are concerned that there has been a significant structural financial challenge at the Trust for a number of years with a circa £50m deficit reported at least as far back as 2014/15, which has not been proactively and strategically tackled by the Board. Whilst we are positive regarding the development of the '3+2' strategy, there are a number of material steps required to develop this document into a comprehensive corporate strategy, underpinned by a coherent and refreshed clinical strategy which is supported by senior clinicians and external stakeholders. Based on this lack of strategic focus in previous years and the limited insight offered by Board members during interview regarding the Trust strategic direction, we have fundamental concerns over whether Board leadership has sufficient depth to provide drive and direction in relation to the strategic agenda. As such we believe that now is an appropriate time for consideration to be given to planning for a refresh in NED membership to ensure appropriate levels of strategic and financial capability to address the future challenges facing the Trust.

R5: There is an imperative for the Trust to enter an extensive period of internal and external consultation with a view to developing the '3+2' financial strategy into a comprehensive corporate strategy, owned by senior clinicians within the organisation and supported by a range of external stakeholders.

R6: Consideration should be given to developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future.

A.2.5 Scrutiny and Challenge

As part of our review, we observed the 5 June 2018 public and private Board meetings and the F&IC meeting on both 30 May 2018 and 27 June 2018. We discuss these observations in more detail in section B.1.2. In relation to NED scrutiny specifically, we noted that there were elements of insightful, challenging questioning, in particular relating to the quality agenda. We also received positive feedback from Board members regarding the transparency of discussion and the ability of Board members to raise any uncertainty or concerns, particularly in relation to financial performance. This is also reflected in our Board survey illustrated below, where there were high levels of agreement in relation to openness.



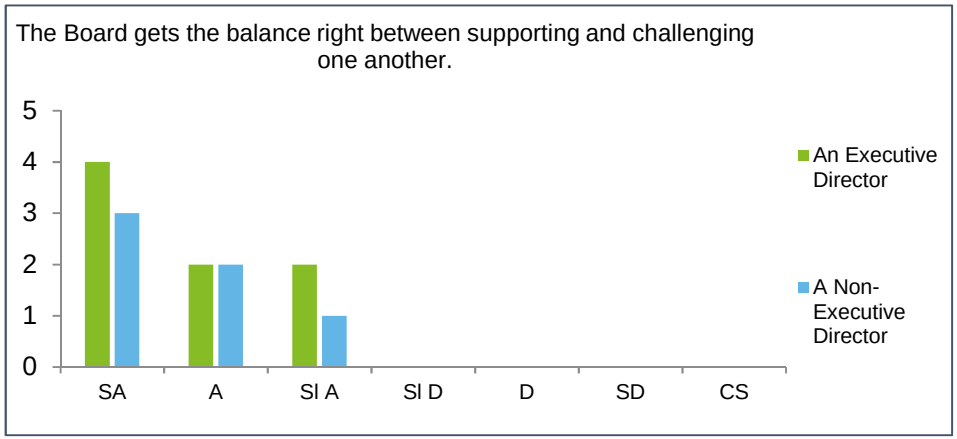
However, we also observed a number of instances where we felt the level of insight and the quality of contributions could have been stronger. This was apparent with a number of NEDs appearing to be passive during conversations and a range of questions, particularly at the F&IC observations, being at a basic level and not necessarily providing a layer of scrutiny to proceedings. Furthermore, there was a tendency to probe into detailed areas which were more for the benefit of NED knowledge, as opposed to furthering Board understanding or decision making. We also observed a lack of consistent follow-up questioning from Board members, with formal question-answer style between individuals in some forums, rather than free flowing, effective discussion.

A. Board leadership

A.2.5 Scrutiny and Challenge (continued)

The results of our Board survey did not match with our observations and Board members reported that the level of support between scrutiny and challenge is appropriate (see below). We note comments that the NEDs may be keen to show support rather than challenge, based on the pressure the EDs are under. However, we believe that there is still scope to effectively challenge without being confrontational. We also note a number of comments from external stakeholders who perceive that advice, scrutiny and challenge is not encouraged in a constructive way, and that more effective, integrated working across the system could be achieved if this were to happen. The disconnect between the results of the Board survey, our observations and comments from external stakeholders suggests that there is work to be done in this area.

In our view, the Chair has a role to play in setting the tone of the Board, and for the NED cohort in particular, in relation to the acceptable boundaries for constructive challenge and scrutiny. In addition, the Chair also has a role to play in ensuring discussion remains at an appropriately strategic level, and that debate does not diverge into operational detail for information purposes.



Furthermore, we are not aware of the Board undertaking any development activities aimed at improving the effectiveness of debate and challenge, or members visiting other high performing NHS trusts to observe best practices.

It is possible that there is a level of uncertainty amongst the leadership team with regards to the way in which a highly functioning, long-term strategic Board should operate within a wider challenged health system. We therefore believe that the NED cohort and the Board more generally is in need of focused development aimed at enhancing the style and effectiveness of Board scrutiny, and that a fresh perspective in NED membership would also help in this respect.

R7: Consideration should be given to implementing a focused Board development module aimed at enhancing the style and effectiveness of Board scrutiny and challenge, particularly in relation to the strategic and financial agenda.

See R6.

See R8.

Section B – Board governance

B. Board governance

B.1 Board and Committee governance

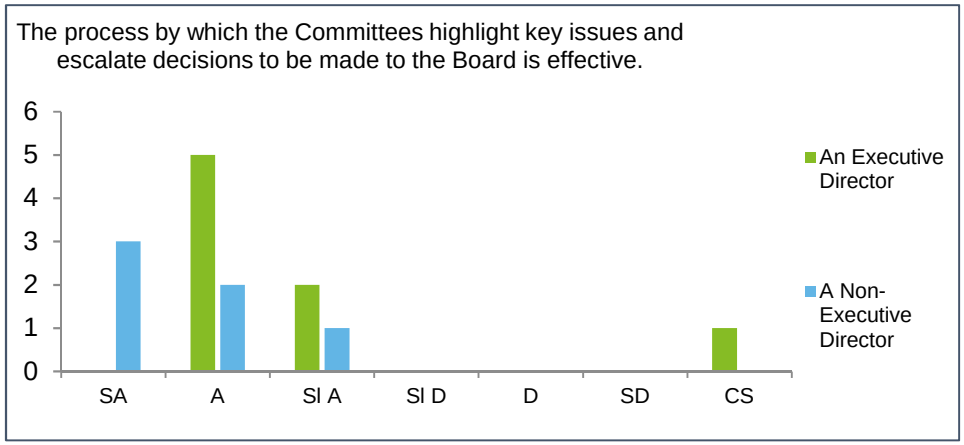
- **We have observed some areas of good practice in relation to the structure and operation of the Board and committees and the Trust is largely in line with good practice when benchmarked against other similar organisations. We note multiple layers of financial scrutiny at the sub-committee level but understand this given the Trust's financial situation. However, we would concur with the Trust's decision to disband the Financial Improvement and Oversight Group (FIOG) as its role relative to the Financial Improvement and Sustainability Committee (FISC) is unclear and there is significant duplication in our view.**

- **There is also scope for improving divisional representation and participation in F&IC and FISC with a view to enhance the levels of ownership and accountability operational leadership teams have in relation to the financial agenda. We also note potential for improving the Trust approach to performance review to help in this respect. In addition, we have some concerns regarding the effectiveness of scrutiny in the F&IC.**

B.1.1 The Board

The Board meet every two months, with both a public and private session generally taking place on the same day, although there have been exceptional occasions such as May 2018 where the private session was held a week ahead of the public Board. The Board holds Board seminars during alternative months, although these only occasionally incorporate facilitated Board development sessions. Some NEDs also mentioned that the NED group previously met more regularly with the Chair, but that had become less frequent.

There is an appropriate balance of business which is conducted in the meetings held in public and private, with the private agenda operating on an exceptions basis and generally running for one hour compared to three hours for the public session. The structure of the public Board is consistent with good practice, with coverage of quality, safety and performance; strategy; governance and assurance; and items for information. It also includes feedback from quality walks and written and verbal escalation updates from key Board committees. Feedback via the Board survey was generally positive regarding escalation from committees as shown below. In addition the public Board meeting provides good coverage of the Board Assurance Framework as discussed in section B.3.2.



We also noted good levels of transparency with committee reports, business case approvals (for example the MRI business case which went to the June 2018 Board) and financial improvement plans all being discussed openly in the public session of the Board.

We observed the public and private Board meetings on 5 June 2018 and found a number of areas of strength:

- There were a number of positive comments from individuals around the table which included a good level of scrutiny and challenge from some NEDs. This included highlighting the risk of slipping into a short term perspective, and highlighting the need for greater ambition for quality priorities;
- EDs generally demonstrated a good command of their respective portfolio areas and came across as experienced and capable;
- The atmosphere in Board meetings was professional and there were no obvious tensions or factions, and members behaved in an appropriate manner;

B. Board governance

B.1.1 The Board (continued)

- We also found the quality of reports presented to the board to be of a high standard, with a full professional suite being presented. We discuss this further in section B.2 below.

However, we also found a number of areas for development, the most notable of which are:

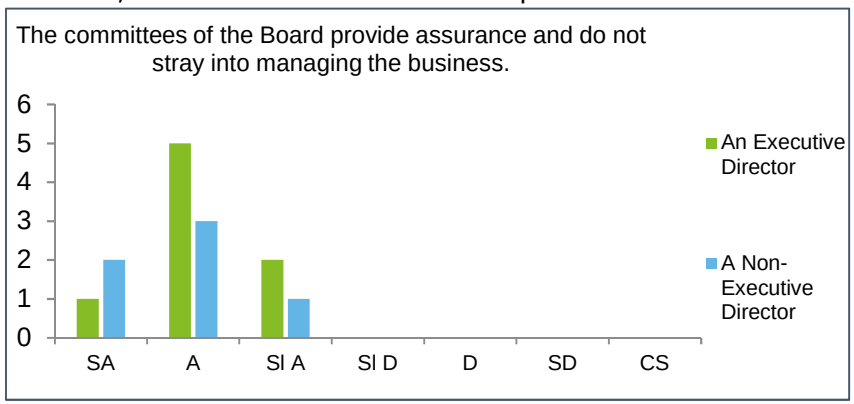
- ED contribution to the meeting was often limited to their own portfolios. Our observation was that the ED team does not work as a cohesive group, in an integrated way. For example, financial issues are left to the DoF and CEO with little or no input from other EDs. See Section A.1.2 for further detail on ED leadership and A.1.3 for financial leadership;
- Although we acknowledge that NEDs made a range of contributions across the public and private sessions, we observed that scrutiny could have been more focused and probing at times. See section A.2 for further consideration of NED scrutiny and Board culture;
- We felt that at times, the Chair did not hold the room effectively, and that there is room for development in terms of summarising key points, ensuring all are contributing, maintaining the appropriate perspective and direction for the Trust, ensuring that details are only used to highlight wider, strategic issues, moving discussions on when necessary, and contributing insightful and effective comments; and
- We also found that the overall perspective of the Board was predominantly short term, with a lack of coherent, thorough long term planning being displayed. See section A.2.4 for comments regarding strategy.

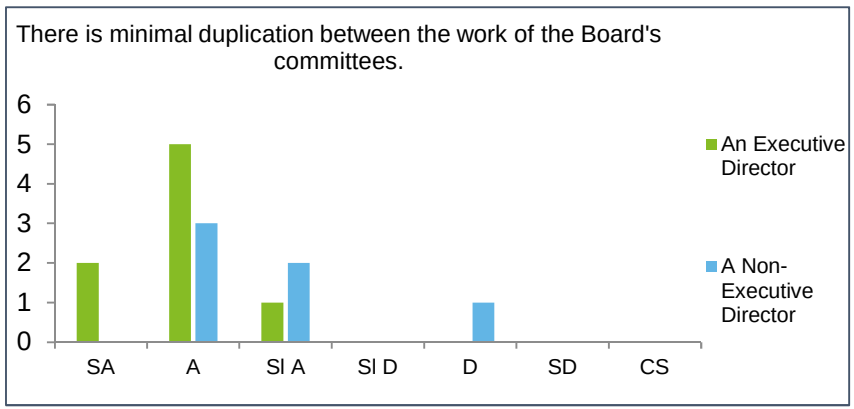
B.1.2 Board committees and other financial forums

The Board delegates duties to five core sub-committees which comprise the Remuneration and Appointments Committee (RAC), the Audit Committee (AC), the People and Organisational Development Committee (PODC), the Quality and Safety Committee (Q&SC), and the Finance and Investment Committee (F&IC).

The Trust's overall committee structure and Terms of Reference are generally in line with good practice and we note no material gaps with key areas covered. Specifically, the frequency of meetings, membership, NED chairmanship, common membership across committees, meeting agendas and number of committees are all in line with good practice. We also note regular annual effectiveness reviews for committees, including a review of the F&IC which went to the 27 June 2018 meeting. The DoCA is highly experienced and has demonstrated good levels of awareness regarding Board governance and as such provides a level of assurance and confidence over the robustness of Board and committee governance arrangements.

Our Board survey, set out below, also reflects positively on the functioning of Board committees, with the majority of Board members agreeing that committees provide assurance without straying into managing the business, and that there is minimal duplication across committees.





B. Board governance

B.1.2 Board committees and other financial forums (continued)

Given the financial focus of this review, we only observed the F&IC as part of this review, although this involved observations of both the May and June 2018 F&ICs. In addition, we observed other financially focused sub-committees to examiner the layers of financial scrutiny between the Board committee level and the divisional level. This included an observation of the 26 June 2018 Financial Improvement and Sustainability Committee (FISC) and a confirm and challenge meeting on 11 July 2018. In addition, we observed an Integrated Performance Review (IPR) meeting on 12 June 2018. We outline our views from these observations below.

Finance and Investment Committee

The F&IC is the main Board Committee with responsibility for detailed coverage of the Trust's financial agenda including financial risks, financial planning, capital investment and overseeing financial strategy. It is NED Chaired, with two other NED members and a range of EDs, including the CEO and COO. It is scheduled to meet four times per annum but regularly meets on a monthly basis. The format and focus of the committee is broadly in line with good practice. Our observations of the 30 May 2018 and 27 June 2018 F&IC meetings highlighted a number of positive aspects as outlined below:

- A number of papers presented were clear and underpinned with good analysis. The reports were preceded by an executive summary detailing the contents of the paper and providing a good balance of narrative and data. In addition, the use of dashboards and visualisation tools was effective and there were some clear indicators to flag issues. Similarly the level of reporting regarding risk was high;
- The Chair provided summaries at the end of discussions, extracting key actions and areas which were highlighted as needing more focus; similarly, providing the same level of summary at the end of the meeting; and
- The CEO and DoF demonstrated a comprehensive grasp of the detail, giving the overall impression that the organisation is dealing with immediate issues, as well as starting to take a longer term perspective over the coming years in line with the financial strategy.

However, we also noted certain areas for development, including:

- Divisional representation was low during the meetings we observed, with only two ADOs present. We note that discussions referenced that divisional representation would happen as the year progressed however. Additionally, we noted no executive clinical representation at the meetings;
- We also note that the level of insight and scrutiny from a number of attendees was not at the level we would expect. For example, while the Chair and other NEDs provided good information summaries, the questioning at times was generic in nature and did not address the underlying issues in full. Where questions were raised, we felt that there was a tendency to focus on the detail without stepping back to consider the wider perspective. Scrutiny of the financial strategy at the June 2018 F&IC did not adequately explore some of the key risks associated with a number of high level assumptions for example; and
- The balance of contribution also has room for improvement. For example, we observed scope for the CEO to step back as there were times we felt his character dominated the meeting, making it difficult for others to contribute effectively. Similarly, we noted that key papers were presented by the DoF when they may have been better presented by the DoS or COO. Also, during a number of discussions, the key contributors were the Chair and the DoF without input from other EDs, NEDs, or other participants. These discussions and meetings would be much richer and more effective if there was greater engagement from a wider range of members.

Financial Improvement and Sustainability Committee

The FISC is the senior executive forum for overseeing delivery of the Trust recovery plan and meets on a monthly basis. It is chaired by the CEO with membership including EDs, DDs, ADOs and other corporate leads. The structure is consistent with similar recovery board arrangements in place across many NHS organisations. We observed this committee on 26 June 2018 and found the following areas of good practice:

- The meeting was chaired by the CEO in a professional manner, which facilitated action and ensured the committee is fully supported from the Trust's leadership. In addition the meeting was well attended by other EDs including the DoF, COO, DoN and the Deputy Director of HR;

B. Board governance

B.1.2 Board committees and other financial forums (continued)

- There was a professional suite of papers presented, which made good use of dashboards, visualisation tools and the information was clear and accessible; and
- The meeting covered a comprehensive range of topics, with a strong emphasis on CIPs, and was sufficiently detailed in its approach. The CEO, DoF, and Head of PMO came across particularly well, with a good grasp of detail.

However, we note the following areas for development:

- The balance between finance and non-finance attendees was weighted heavily in favour of finance staff. There were 6 finance staff out of 13 attendees, and the meeting was influenced by this as a consequence;
- Additionally, the level of divisional attendance and contribution was lower than we would typically expect. We observed that none of the DDs were present and some divisions were not represented, and those that did attend did not contribute in any meaningful way to the debate;
- There was a natural tendency for the CEO to be an active lead-member. This combined with the low levels of contribution from the divisions resulted in the meeting not facilitating integrated, well-rounded debate and action;
- The general outlook of the meeting we observed was focused on the short term and we noted a lack of a long term, strategic perspective in the discussions; and
- We note that while there was comprehensive coverage of a number of topics, the level of scrutiny and challenge did not contribute to improving the debate and questions were largely limited to information sharing, rather than providing meaningful, insightful commentary or stimulating innovation or improvements.

R8: The Trust should actively promote improved divisional participation in F&IC and FISC with a view to enhancing accountability and enriching debate.

Confirm and Challenge

The Trust holds fortnightly confirm and challenge meetings with each division which are chaired by the DoF and are aimed at providing detailed scrutiny of CIPs. These meetings are typically attended by the DoF and COO and the divisional ADO and ADN. We observed a confirm and challenge meeting, but our observation coincided with the first meeting which included the new Improvement Director and as such, was focused on sharing information with him. Consequently, we are unable to critique the meeting itself, but note the introduction of an Improvement Director to the meeting is an encouraging development in itself. However, we have received reports that these meetings, which are relatively new, continue to evolve and that they were not always focused on progressing actions in a robust way. We also understand that there were inconsistencies in the chairing of these meetings which has led to unnecessary repetition. We note that the DoF is now chairing these meetings.

Financial Improvement and Oversight Group

The Financial Improvement and Oversight Group (FIOG) is a weekly meeting which oversees the overall financial position at the Trust. This includes receiving feedback from the Confirm & Challenge meetings and agreeing the agenda for FISC. Its membership includes the DoF, Deputy DoF and a number of other corporate heads but no divisional leads. We did not observe FIOG as part of this review but it is unclear to us how FIOG complements the activities of FISC and Confirm and Challenge meetings. A number of interviewees have referenced a level of overlap across FISC, FIOG and the Confirm and Challenge meetings. The meeting confuses accountabilities in our view and is an unnecessary layer of governance which duplicates elements of FISC and executive team meetings. We understand that the Trust is in the process of disbanding this forum post our field work and we would concur with this decision.

B.1.3 Performance Review

The Trust holds monthly Integrated Performance Reviews (IPRs) with each of the clinical divisions. The meeting covers the full range of quality, finance, workforce and operational metrics and are attended by the divisional leadership teams, including the finance and HR partners, and all EDs are invited. The CEO chairs the majority of IPR meetings although the meeting observed by us on 12 June 2018 was chaired by the COO. We noted some high quality papers produced for the IPR and felt that the finance papers in particular were very clear and well presented. We also noted good levels of participation from a range of EDs and divisional leaders and comprehensive coverage across a range of topics.

B. Board governance

B.1.2 Board committees and other financial forums (continued)

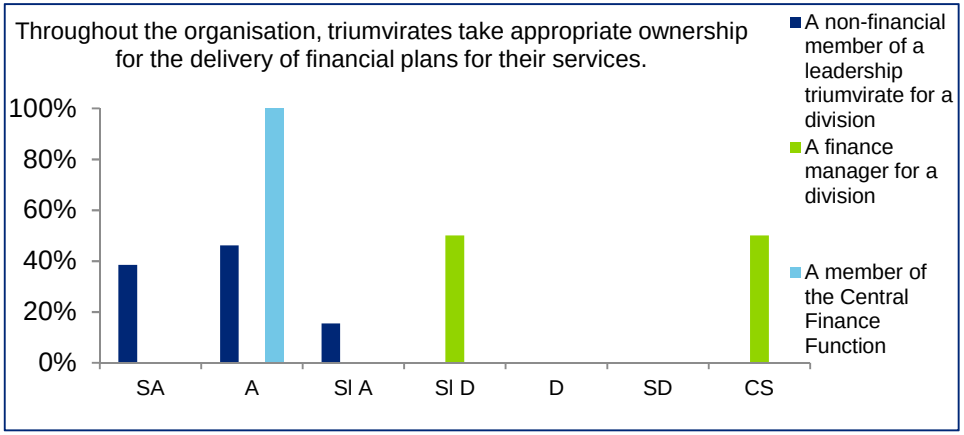
Divisional leaders have commented positively on the IPR meetings and describe them as a helpful and constructive meeting where there is a good balance between holding to account and supporting divisional leaders. Whilst recognising some positive aspects of the meeting, we would also make the following observations in relation to potential development areas:

- The level of discussion in the meeting had a tendency to delve into a significant degree of detail to the extent that it felt like the meeting was trying to manage a solution to the issue rather than perform an assurance function. This is a dynamic that executive participants should look to actively manage;
- The length of the meeting was excessive at three hours and is longer than most IPR meetings we observe which tend to be in the 1-2 hour region. There could have been a more focused, strategic and insightful discussion within a shorter agenda;
- There was a timing issue with papers where the meeting was discussing month one finance numbers on the 12 June, despite the month two numbers being available to some participants around the table. This rendered parts of the conversation out-of-date;
- There was low levels of ED participation at the observed meeting with only the DoF and the COO present and the DoN dialling in. We would have anticipated workforce, medical and strategic representation, even if at a deputy level. This is linked to our point in section A regarding silo working amongst EDs; and
- The EDs present generally avoided conflict and whilst we are proponents of a non-confrontational approach to performance review, we are of the opinion that there was a need to convey a greater sense of urgency and imperative over the financial situation at the Trust.

Following on from our point above regarding the level of challenge and accountability for delivery in observed meetings, there are a number of other indications that there may be a need to modify the style of performance review to improve accountability for financial delivery. One such indicator is that finance business partners appear to be taking a prominent role in answering questions in relation to financial delivery and we would expect to see more central ownership from the core triumvirate.

Another indicator is that divisional representation at key forums is not consistent, for example with one division having no representation in the observed FISC. Furthermore, it was not immediately clear how this lack of representation or engagement was being addressed as a consequence, in order to meet the requirements for effective operational performance. The results of our staff survey also highlight that some non-clinical staff feel there is a culture which does not effectively manage poor performance and behaviours (as shown in section A.2.3, page 20).

Our Senior Leaders' Survey also showed that some divisional finance leaders believe that there is room for improvement regarding triumvirate ownership for financial plans, while others were unable to answer the question.



Overall, whilst we do not believe that the Trust should take an overly challenging approach to performance review, there is scope for refinements to the approach take to performance review with a view to clarifying and enhancing the levels of accountability for financial delivery expected from operational leaders.

R9: The Trust should consider the need to modify the approach to performance review with a view to raising the levels of accountability currently demonstrated by operational leadership teams.

B. Board governance

B.2 Board Reporting

- **The general quality of financial reporting to the Board, F&IC and FISC is of a high standard and is an area of strength for the Trust. We understand that the quality of financial reporting has evolved over recent times but in our view reporting in other domains has failed to evolve at the same pace. There is therefore an imperative to ensure that all domains of the Integrated Performance Report (IPR) are progressed to ensure a consistent standard. We also note a lack of alignment between the information presented to the Board as part of the IPR, and that covered as part of the Quality and Safety Committee (Q&SC) and the People and Organisational Development Committee (PODC) and therefore believe there is a need to consolidate and improve reporting in these domains.**

As part of our work, we have conducted a review of key documentation used by the Trust to aid discussion, scrutiny and decision making in Board and Committee meetings. This includes a review of the IPR which is presented at each public Board meeting and a specific look at finance reporting given the financial focus of this review. We also provide additional commentary in relation to quality and workforce reporting, with a particular emphasis on the relationship between Board and Committee reporting. We discuss our review of these areas of reporting in further detail below.

B.2.1 Integrated Performance Report

In line with good practice, the Board receives an IPR on a monthly basis. We have reviewed recent IPRs presented to the Board and identified a number of strengths, including:

- Structure of the IPR provides coverage across quality, access, finance, workforce and sustainability areas with an overall executive summary that describes positive outcomes, key issues and key risks. There are then further key headlines for most sub-sections of the report and a good use of graphics throughout;
- Service level reporting, in some areas such as: A&E, RTT, staffing levels including absenteeism and agency staff, and activity headlines for directorates;
- Particular strength in the quality of the finance report which we discuss in further detail below;
- In line with good practice, the quality reporting includes a range of national, local and contractual metrics. The report includes a number of other elements of good practice, such as clinical effectiveness, clinical audit, safeguarding, complaints, serious incidents, and patient experience reports; and
- In line with good practice, a range of workforce indicators are included within the Performance Report under the 'Leadership and Culture' theme heading. Graphical and narrative information is used, for example absenteeism rates and associated reasons for sickness.

There are also areas where further improvements could be made, such as:

- The executive summary is very basic and does not signpost the key risks facing the organisation. Furthermore it does not include commentary triangulating across the different domains. The report would benefit from a top level dashboard which draws overall headlines, risks and mitigations. Similarly, more concise and clearer summaries at the beginning of each sub-section would be helpful;
- There is a significant level of overlap with the CEO Report and there may be merit in reducing the focus of the CEO report on operational performance to allow coverage of this area within the individual sections of the IPR;
- The format of the individual sections vary considerably with differences in use of graphics, style of commentary and focus on risk and mitigations, and would benefit from greater levels of consistency to aid the reader. We also note material variations in individual sections of each domain, for example from serious incidents, to pressure ulcers, to patient experience;
- The commentary is generally of a backward looking nature and largely states the facts that can be drawn from reading the charts or graphs. It would provide greater insight if commentary was used to interpret the problem and highlight the actions being taken to address the problem. This could include the use of 'softer' intelligence, which would enable the cause and impact of underperformance to be more fully understood;
- There is not a consistent focus on risk and mitigations throughout the reports;
- The section on sustainability follows a different style to the rest of the report and the purpose of the analysis is unclear and challenging for the reader to interpret; and

B. Board governance

B.2.1 Integrated Performance Report (continued)

- Though positive regarding the report, some interviewees commented that the length of the reports received meant that it was difficult to extract key information from the amount of information presented. We are aware that the length of the report has reduced recently but also believe it could be more succinct, insight driven and aided by greater use of summaries and signposting.

Overall, the finance element of the IPR has received significant attention in recent times and stands out as the highest quality section of the report. The workforce report also includes some areas of strength. There is considerable work to be completed in our view to bring all sections of the report to a consistent standard and to ensure that the overall conclusions are appropriately summarised and triangulated.

R10: The Trust should continue to evolve the IPR to ensure consistency in standard of reporting across the various domains to ensure that reporting is of a similar standard to the current quality of financial reporting.

B.2.2 Financial Reporting

The financial report incorporated in the IPR is a summary of more detailed papers presented to the F&IC; it is relatively straightforward to map the information between the two committees as it is essentially extracts which are drawn from F&IC for the IPR. We are also aware that there has been a recent refresh of the financial reporting, and that this format will also be used consistently by the divisions. We have considered financial reporting to the Board and to the F&IC and set out our views below, with a number of good practice elements including:

- The overall summary of the financial position is clear, concise, insightful and covers a range of areas of good practice such as variance analysis, forward looking element, BPPC analysis, divisional analysis and consideration of risk and mitigations;
- The structure of the presentation is intuitive and generally follows the structure of the executive summary with separate sections analysing income, activity, costs, capital, cash and CIPs;
- Sub-sections that are appropriately split between graphical analysis and financial data, with good levels of data down to the divisional and service level in relation to a range of areas. There is a good use of dashboards with easy to follow visualisation tools throughout;
- Appropriately detailed reporting throughout, with a good level of narrative which provides a level of insight which complements the graphics and tables; and
- Links made with activity and operational performance, with in-month plan and actual –performance compared, and associated commentary included to clarify notable movements or variance.

There are also a number of areas where the report could be improved, including:

- There could be a greater illustration of risks and mitigation in the report presented to the Board in order to further highlight longer term planning, as well as presenting a detailed analysis of the data rather than a more information based report. However, the report which is seen at F&IC is more comprehensive regarding risk and mitigation although at times the mitigation presented is a little vague;
- Both the Board and the F&IC report lack clear analysis of the Trust's cash position. Though narrative information is included, the historic and forecast cash position could be made clearer through the inclusion of rolling cash-flow charts; and
- Whilst the commentary is of a good standard, it does occasionally drift into an accounting analysis where it interprets the tables and charts rather than draws the 'So what' factor as well as key actions to address.

Moreover, we note that the finance report presented to the F&IC is complemented with a number of other key papers which provide more detailed analysis in relation to areas such CIPs ,capital planning and Service Level Reporting for example. The CIP paper in particular provides a high level of granularity which enables the reader to drill-down into divisional and individual scheme performance, including analysis in relation to the top ten underperforming schemes. We also acknowledge the financial strategy which went to the June 2018 F&IC which includes high quality analysis, clear presentation, good use of bridge analysis and a generally intuitive and easy to understand commentary. Whilst we have some concerns over the robustness of the underlying assumptions, the quality of the report was of a high standard.

B. Board governance

B.2.2 Financial Reporting (continued)

Overall, the quality of financial reporting at the corporate level is of a high quality, is comprehensive and compares well with many other Trusts we work with. Financial reporting at the corporate level is an area of strength, in our view, and it is a natural step for the Trust to continue with its evolution so that a similar standard of financial reporting is achieved at the divisional level and that areas of good practice can be shared across other domains.

B.2.3 Board versus Committee level reporting – Quality and Workforce

A critical component of an effective governance structure is the ability to track information and risks as they make their way through the organisational governance structure. As noted above, it is relatively straightforward to map coverage of the finance agenda at Board with that at the F&IC as there is consistency in reporting, and the IPR essentially draws extracts from the F&IC to produce a more succinct version for the Board.

Making this connection with other domains is more challenging as there is not a direct mapping between the reports going to the Q&SC and the PODC and the quality and workforce metrics included in the IPR. Whilst the same metrics are considered in Board committees, they are covered across a range of different papers and there is a level of fragmentation in relation to the presentation. Furthermore, some of the reporting at the Q&SC and PODC is of a relatively low quality with duplication, heavy use of narrative, lack of sign posting, poor use of dashboard and material variations in presentation style. In our view, the update of the IPR should be associated with a greater alignment with committee reporting so that the IPR is essentially a summary extract from the Committee meetings. This would improve the quality and consistency of reporting at Board and Committee level and also provide enhanced assurance to the Board that key risks and actions are being covered appropriately across the committee structure prior to being considered at Board level.

R11: The Board should ensure that committee reporting at the Q&SC and PODC in particular is less fragmented and fully aligned with the IPR presented to the Board.

B.3 Risk management

- **The Trust has a positive risk management culture which is highlighted by an integrated approach to quality and risk, as well as good awareness of the process for raising concerns. Additionally, the BAF is used well at the Board level although there is a need for greater alignment between BAF risks and the relevant Board committee. Learning and improvement represent a core function of the Trust's risk and quality management strategy and we believe the Trust follows good practice overall in this area.**

B.3.1 Risk Strategy

The Trust has developed a Risk and Quality Delivery Strategy, which was most recently reviewed and revised in March 2018, with a formal review taking place on an annual basis. At a high level, the policy is clear that the Board recognises the importance of risk management within the governance structure, and seeks to ensure the Risk and Quality Delivery Strategy is implemented throughout all levels of the organisation. We note that the Trust's ESHT 2020 strategy is explicitly referenced in the document and key objectives in relation to the Trust's strategy are set out. Additionally, the integration of quality within the risk strategy explicitly ensures that risk is aligned to quality improvements.

Within the policy, there is clear reference to the risk responsibilities throughout the governance structure of the organisation, which explicitly outlines responsibilities of individuals, wards, divisions, Board Committees, and the Trust Board. Risk management is clearly defined as part of the document, as is a definition of risk as well as types of risk. This is accompanied by a clearly laid out risk assessment process which establishes the steps required to take to complete a risk assessment. Additionally, recruitment, training and development needs are highlighted, IT systems to support risk are described, and reference to national guidance and standards is made.

The strategy makes explicit and detailed reference to improvements through learning from experience and this is broken down into a number of areas including serious incidents, patient feedback, staff engagement, inquests, and mortality. Furthermore, the activities designed to ensure ongoing monitoring of risk are described, for example through clinical audit.

B. Board governance

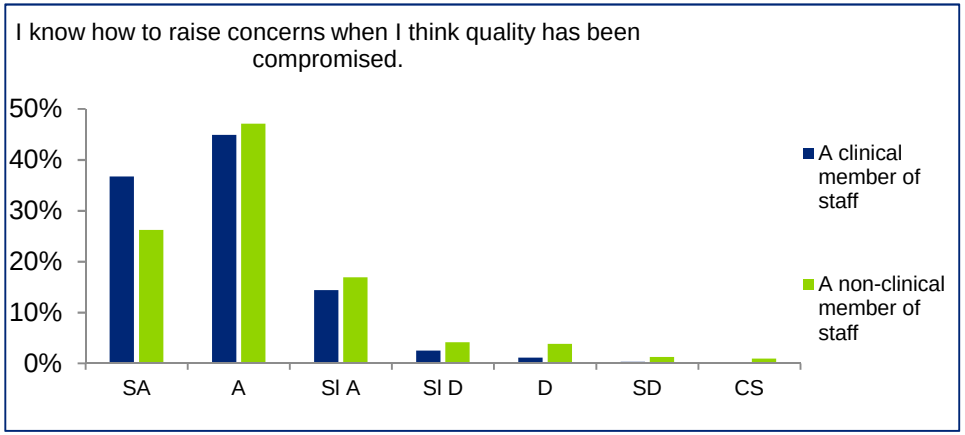
B.3.1 Risk Strategy (continued)

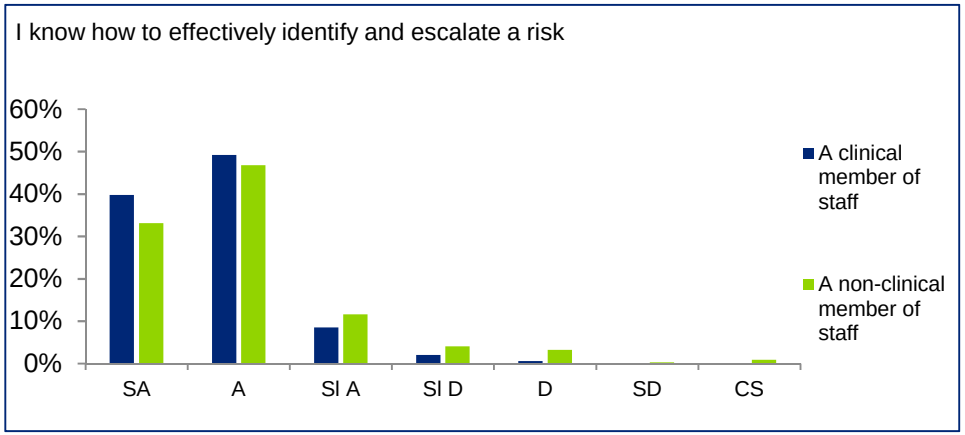
The document then makes explicit note of information sharing strategies and the Trust's policy and documents through which learning will be disseminated throughout the organisation. The policy regarding learning is complemented by our previous commentary regarding a culture of learning and continuous improvement, which is driven by the CEO.

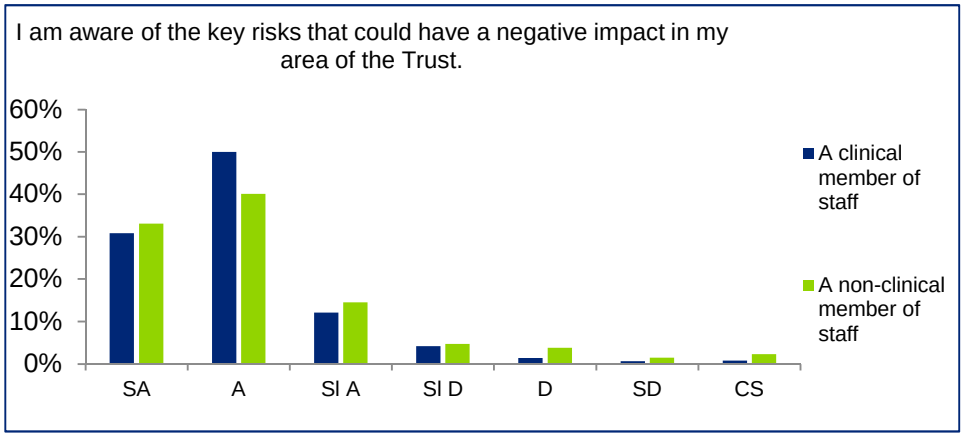
During our review, interviewees reflected positively on the way risk is managed and this is reflected in the staff survey results which highlight strong risk management awareness where staff are confident in reporting risks, as well as good understanding of the specific risks relevant to their area of the Trust. The benefits of integrating quality and risk is also shown where staff report high levels of awareness about how to raise concerns if they feel quality has been compromised. Overall, this highlights a general trend of a mature approach to risk management and good ownership being taken for service-level risks.

To aid this, the Trust's Integrated Governance function has put in place a range of risk management support for the divisions, with monthly meetings between corporate governance and divisional governance teams to follow a consistent risk approach. Furthermore, the corporate team has developed a series of standardised documents, such as the ESHT Risk Assessment (General Policy), ESHT Health and Safety Policy and ESHT Incident Reporting and Management Policy (amongst a number of other documents) to aid the functioning of risk management throughout the organisation. Whilst improvements should always be pursued, overall, we believe that the current approach is largely in line with good practice.

One observation of the Risk and Quality Strategy is that it is principally drafted in the context of integrating clinical governance and risk management. Whilst we recognise the benefits of this approach, and also note the document also assigns responsibility for financial risk management to the DoF, much of the document, particularly at the divisional/clinical unit level, does not explicitly consider management of financial risk more generally. In the absence of a stand-alone risk management strategy covering all risks, updating the Risk and Quality Strategy with a wider risk management perspective would be a natural evolution.







B. Board governance

B.3.1 Risk Strategy (continued)

R12: The Board should ensure that the Risk and Quality Strategy explicitly covers the wider risk management agenda as it is currently focused on quality governance.

B.3.2 Board Assurance Framework (BAF)

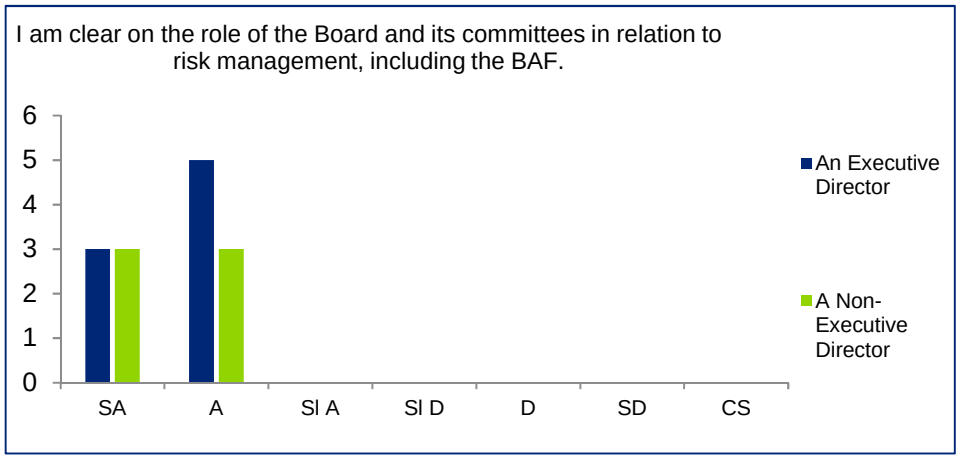
The BAF details the principal risks impacting on the Trust's strategic objectives, sets out controls to mitigate these risks and details assurances, or a lack of, in relation to the effectiveness of these controls. The BAF provides a starting point for the Trust Board to record risks affecting strategic objectives.

We have reviewed a recent version of the BAF, comparing it against other Trusts with which we have worked, and highlight the following areas of good practice:

- In general, the BAF content is in line with good practice, with appropriate detail included in relation to controls and, where gaps in assurance have been identified, the document consistently outlines the required actions;
- Each risk is clearly aligned underneath the over-arching Strategic Aims and supporting Strategic Objectives;
- Within the BAF, specific risks are assigned to Board Committees. This is an area of good practice and allows for a more refined and regular focus on these risks and the related action plans. In addition, key individuals are assigned to lead on items within the BAF;
- There is a clear introduction to the BAF which outlines strategic objectives and an overview of all key risks;
- After strategic objectives are introduced in each section, clear key controls and positive assurances are highlighted and listed which represents good practice allowing for ongoing monitoring of actions taken to mitigate risks.
- The BAF clearly includes previous actions so it is easy to track developments regarding specific issues.

We have also identified potential areas for improvement, including:

- There is a lack of unmitigated and mitigated risk scoring information included in the BAF. Furthermore, BAF risks are not RAG rated at either unmitigated or mitigated stage. As a result, the severity or impact of identified risks is not clear from this document and the Board's focus could be better directed onto residual, high risk areas;
- Whilst the BAF is aligned to corporate objectives, the links between the Corporate Risk Register (CRR) and BAF are less clear. The CRR information could more clearly highlight the corresponding strategic risk and objective for each operational risk, in order to ensure there is the appropriate 'golden thread' through the Trust's risk management structure; and
- The response to our Board Survey indicated high levels of agreement in relation to risk management at the Board and committee level, including use of the BAF. However, in our view the Trust's performance reporting could also be more-clearly aligned to corresponding BAF risks as the majority of BAF coverage occurs within the Q&SC with limited coverage in F&IC and PODC.



R13: The Board should ensure that there is appropriate coverage of the BAF across the relevant Board committees.

B. Board governance

B.3.3 Corporate Risk Register

The Trust makes use of Datix, using this system as the driver for a single, Trust-wide Risk Register. Within this, individual risks are allocated to their respective service or department for more regular monitoring and action. For local risks that score 15 and above, these are entered onto the CRR. Much like the BAF, each of these high-scoring risks is clearly linked to one of the Trust's strategic objectives. However, there is no explicit link to the respective BAF risk. The CRR is reported at the Board level, Q&SC, as well as at a range of further specific groups and committees.

A review of recent Board minutes suggests that while the BAF is a standing item for Board meetings, CRR is not routinely discussed although it is highlighted through assurances provided by the AC and Q&SC. This does not represent poor practice however. Indeed, providing assurance from sub-Board committees is likely to increase accountability within divisions and for the risks raised within their areas. Subsequently, risks are reviewed and monitored through Divisional Quality Committees, Divisional Performance Reviews and Divisional Boards.

A review of a range of divisional minutes and documentation found varying levels of discussion around risk, although all divisions focused on risks, to varying degrees, as part of their IPR meetings.

Finally, a review of the CRR also highlights a number of aged risks on the register. For example, the CRR include a number of red RAG rated risks from 2012 (for example on Neuraxial Safety), a number from 2014 and 2015. The Trust should constantly review its CRR to ensure that it remains a dynamic document.

Section C – Divisional governance

C. Divisional governance

- **The Trust follows a number of areas of good practice in relation to its divisional operating model in terms of structure, leadership arrangements and approach to performance review. However, the divisional arrangements remain relatively immature having been in place for less than two years. Further work is required to ensure there is consistency and clarity of roles, responsibilities and accountabilities in leadership groups at divisional and speciality level, as well as standardisation of governance arrangements. These arrangements should be formally captured in job descriptions and an accountability framework.**

- **The standard of informatics and data analytics at the Trust does not compare well with other NHS organisations and this places practical restrictions on the ability of operational leaders to do their jobs on a day-to-day basis. The Trust would benefit from a central informatics function with the capability, capacity and operational knowledge to produce customised and insightful information to support various aspects of operational activities such as facilitating the management of performance, forward business planning and service transformation.**

- **We also note a significant investment in leadership development which senior leaders have appreciated. There is a need though for a continuing programme of targeted leadership development to provide senior leaders with the tools required to successfully deliver a challenging agenda. Specifically, further leadership development training should include a focus on functional aspects for respective leadership roles and should be used to help convert the improved levels of medical engagement experienced at the Trust with improved levels of medical involvement, where medics make a more practical contribution to all aspects of Trust business.**

C.1 Divisional structure and leadership model

The Trust has five clinical divisions: Urgent Care; Medicine; Diagnostics, Anaesthetics and Surgery; Women, Children's and Sexual Health; and Out of Hospital. The current structure is a result of a divisional restructure undertaken in 2016, which consolidated a previous structure incorporating multiple clinical units. Each Division is led by a leadership triumvirate comprising the medical Chief of Service, Associate Director of Operations, and Assistant Director of Nursing. The operational management of each hospital site includes a Hospital Director and an Associate Medical Director and Deputy Director of Nursing.

Each division has a number of specialties reporting into it, and the leadership structure of each speciality is largely similar to the divisions with a Clinical Director, Service Manager and Matron triumvirate model. The senior leadership teams from the divisions also attend the Trust's senior leaders' forum.

The Trust operates a medically led model where the Chief of Service has ultimate accountability for divisional delivery and the Clinical Directors have accountability for delivery at the speciality level. Roles, responsibilities and accountabilities are set-out in respective job descriptions for divisional and speciality level leaders. However, we found from interviews and focus groups that this accountability arrangement is not consistently understood by staff and senior leaders, where a number of interviewees were unable to articulate the accountability model as a triumvirate-led division or speciality with the Chiefs of Service or Clinical Leads being the accountable officer. Furthermore, Chiefs of Service appear to be operating in different ways across the divisions to reflect the different understanding of roles. Additionally, we found variation in the levels of senior medical engagement and ownership of divisional leadership with some being highly engaged in terms of attending meetings and taking responsibility, while others were less visible or present in meetings. For example, we noted low levels of medical involvement in the observed IPR meeting and no clinical representation at the observed FISC meeting.

More generally, it was brought to our attention that senior leaders regularly escalated issues which could potentially have been resolved locally. We also note low levels of proactivity at the divisional level in relation to driving delivery of the current and future CIP/service transformation agenda, with a reliance on direction from the corporate level.

C. Divisional governance

C.1 Divisional structure and leadership model (continued)

In addition to the points above, there are currently variations in the way the leadership model is applied across the divisions. Specifically, while the clinically led, triumvirate model is largely replicated throughout the divisional specialties, we encountered reports that some divisions operate in different ways. For example, triumvirates can be aligned to multiple specialties in some divisions while others have a core team for each specialty. Furthermore, divisions do not all have the same number of leadership layers at the speciality and team level.

We recognise the need to provide a level of flexibility for divisions to organise themselves in a way which best suits their specific needs, but it is good practice to have a coherent model consistently applied throughout the divisional structure.

The above factors are indicative of a relatively low level of maturity in divisional and specialty leadership in our view and will need to be addressed as a priority. This will require a period of time to increase experience amongst senior leaders but would also benefit from a clearly articulated accountability framework which sets out expectations at both the divisional and speciality level. This should cover various areas of the operating model such as respective roles and responsibilities, performance review and earned autonomy, engagement with clinical and corporate support service and delegation of authority and escalation. This is in addition to ongoing improvements in relation to the provision of management information and a continuing programme of targeted leadership development as discussed further below.

R14: The Trust should introduce a more explicit accountability framework which clearly sets-out expectations regarding roles, responsibilities and accountabilities; the leadership model at all levels; and the Trust operating structure down to the ward level.

C.2 Divisional governance arrangements

Whilst we have not conducted a detailed review of divisional governance arrangements as part of this review, we have been made aware of attempts to standardise agendas and reporting for divisional management boards. Our conversations with divisional leadership teams suggest that whilst there is some consistency across divisional governance arrangements, there is also some material variances in practices. For example, we note that one division has a monthly divisional governance board meeting while others have smaller, weekly management board meetings. We also note that there appears to be a significant level of discretion and variability in governance arrangements at the speciality level. Specifically, there is inconsistency in the format of team meetings, agendas, reporting templates, meeting frequency/attendee requirements and approach to performance management. Similar to the point above relating to clarifying expectations regarding leadership roles and responsibilities, the Trust would also benefit from improved guidance and standardisation in relation to governance arrangements down to the speciality level.

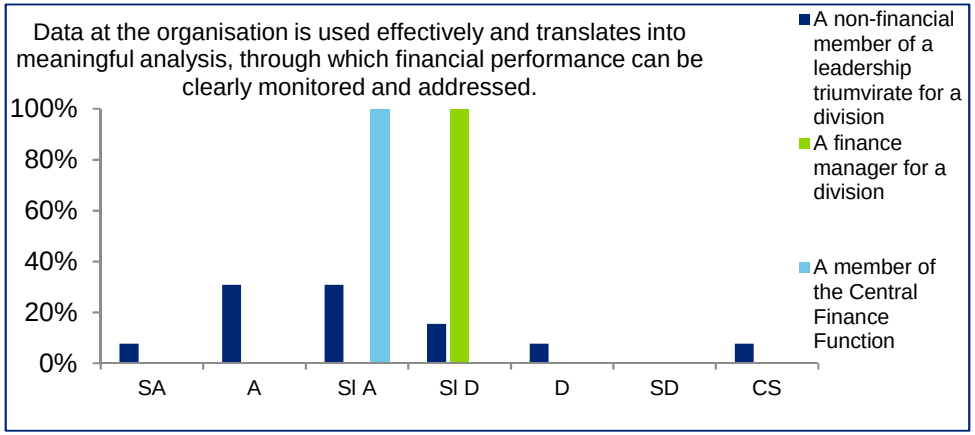
R15: The Trust should consider introducing consistency in management meetings at the divisional and speciality levels through standard reporting templates, agendas and minutes to promote consistency in standards.

C.3 Business intelligence

We note some good examples of performance reporting at the Board and Committee level but the quality of management information/business intelligence at the operational level has been repeatedly described by staff and operational leaders as not being of a sufficiently high quality to support management and decision making. Specifically, staff point towards not having access to a centrally coordinated information management function with the capability of producing customised and insightful business intelligence. Furthermore, some operational leads stated that they approach certain individuals outside of the informatics department to get usable intelligence, rather than the informatics department itself, due to a lack of confidence in the informatics department's ability to deliver the required analysis. This point is captured in our senior leaders' survey regarding financial reporting specifically.

C. Divisional governance

C.3 Business intelligence (continued)

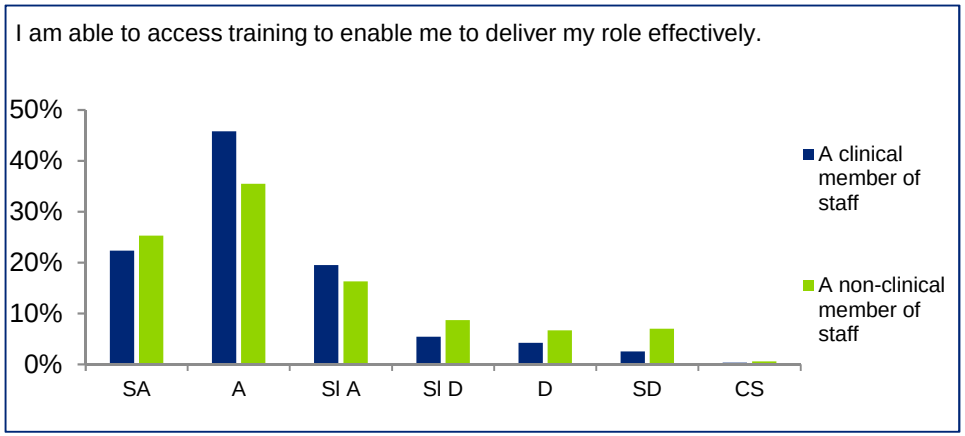


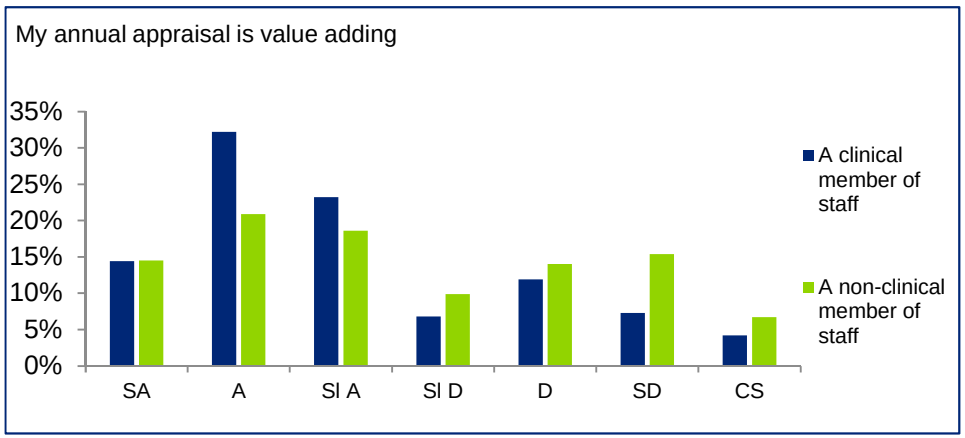
Our observation of the Trust informatics function and the available information to service divisional and speciality level management forums indicates that the Trust is some way behind other organisations with its business intelligence agenda and that there is scope for this area gaining greater prominence at the Trust. Specifically, the current focus is on low level analysis with a skill set in processing data rather than high quality business analytics. The Trust would therefore benefit from a central function with the capability, capacity and operational knowledge to produce customised and insightful information to support various aspects of operational activities. This should include provision for supporting the management of performance, forward business planning and service transformation.

R16: The Trust should consider the development of a centrally coordinated business intelligence capability with the skill set and business knowledge to support corporate, divisional and speciality level departments with the production of high quality and insightful business intelligence.

C.4 Leadership development and medical engagement

Throughout our review, interviewees have commented on a number of examples of leadership development in place at the Trust. We are aware of a 'leading excellence' programme which is aimed at developing clinical leaders as well as work done to clarify leadership pathways including leadership expectations such as performing 1 to 1 meetings, appraisals and running team meetings. We have also noted a coaching and mentoring initiative which is highly regarded by those who have taken part. The staff survey also reflects that there is a range of training options available to staff. However, whilst leadership training may be available, there are some reports that there is not universal support from line managers to undertake training, although we note that staff report generally positive experiences of their annual appraisal, as reflected in the staff survey.





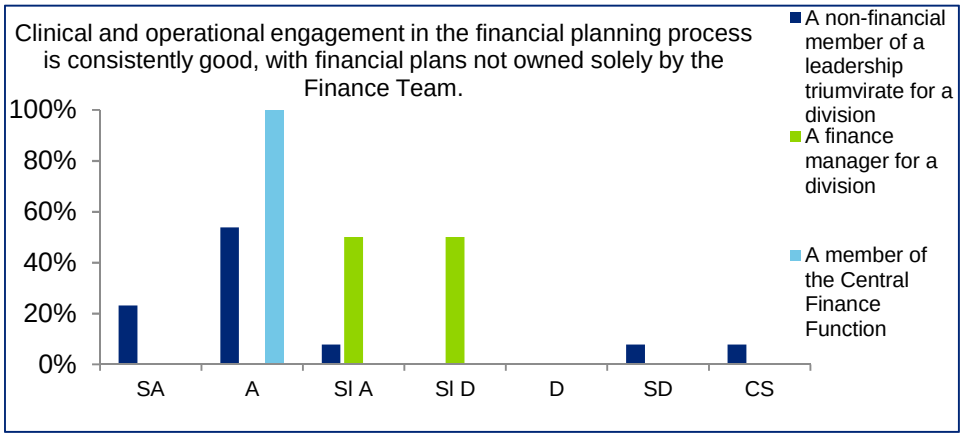
C. Divisional governance

C.4 Leadership development and medical engagement (continued)

In addition, we note that many comments describe the leadership development that staff have received has focused largely on the softer skills, without giving clear functional training. For example, how to read and develop a budget, how to manage conflict within teams, or how to manage individual performance in order to provide the support people need when they are unable to meet performance expectations. We also encountered a smaller number of comments which suggested that some of the activities targeting softer skills on the leadership development courses were not as rigorous or helpful as they could be.

Given the still maturing nature of the divisions and their leadership teams, it is important to provide continuous support and development. This is particularly relevant in the case of clinical leadership, where a number of senior clinicians reported needing further leadership training to perform their leadership and management role effectively. For example, during our interviews it was raised that clinical leadership development was required at lower leadership levels in order to promote medical leadership and development further down the organisation, as well as to actively support succession planning.

A number of interviewees have also made the distinction between medical 'engagement' and medical 'involvement' and indicated that whilst medical engagement scores have improved, there is still some way to go to promote a culture where medical staff throughout the organisation practically contribute to the wider operationally agenda, as opposed to solely medical aspects. This point was also highlighted by a number of external stakeholders who suggested that practical clinical engagement from the Trust's medics was poor, and this impacted the wider system strategy to deliver care. Our Senior Leaders' Survey also highlights that perceptions of clinical and operational engagement with financial planning could be improved.



In addition, we also noted a number of times when medical representation was not present in key meetings, and a culture of 'clinicians performing clinical tasks, and managers performing managerial tasks', rather than a collective triumvirate leadership approach. Appropriately enhanced leadership development is likely to increase buy-in from clinicians further down the organisation, which should lead to greater accountability and ownership throughout the organisation.

R17: The Trust should consider the need to expand the leadership development programme to make provision for development activities aimed at enhancing functional skills relating to operational leadership. This should incorporate a work stream which focuses on modern medical leadership and practically contributes to the wider operational agenda.

Appendix 1:
Summary of recommendations

Appendix 1: Summary of recommendations

Ref.	Section	Recommendation	Priority
R1	A.1.1	The CEO should consider the need for additional actions to reinforce the message across the organisation that the financial situation is critical, and that all staff need to own the issue and tackle it collectively. This could involve greater clarity in internal communications in addition to introducing an extended senior leadership forum to include all EDs and the Chiefs of Service.	HIGH
R2	A.1.1	The CEO should actively consider opportunities to step back from operational detail in certain forums with a view to allowing other EDs to assume greater ownership and authority.	MEDIUM
R3	A.1.2	The CEO should introduce a structured executive team development programme aimed at supporting the ongoing evolution of team behaviours with a particular emphasis on developing longer-term objectives. This should include a focus on promoting a more proactive and integrated approach to tackling financial and strategic challenges facing the Trust.	MEDIUM
R4	A.1.2	The CEO should consider consolidating executive portfolio responsibilities to ensure more formal alignment between key transformational responsibilities including the PMO, PSO, business intelligence and strategic planning.	MEDIUM
R5	A.2.4	There is an imperative for the Trust to enter an extensive period of internal and external consultation with a view to developing the '3+2' financial strategy into a comprehensive corporate strategy, owned by senior clinicians within the organisation and supported by a range of external stakeholders.	HIGH
R6	A.2.4	Consideration should be given to developing a plan for a refresh in NED membership to ensure there is sufficient strategic and financial capability for the future.	HIGH
R7	A.2.5	Consideration should be given to implementing a focused Board development module aimed at enhancing the style and effectiveness of Board scrutiny and challenge, particularly in relation to the strategic and financial agenda.	MEDIUM
R8	B.1.2	The Trust should actively promote improved divisional participation in F&IC and FISC with a view to enhancing accountability and enriching debate.	MEDIUM

Appendix 1: Summary of recommendations

Ref.	Section	Recommendation	Priority
R9	B.1.3	The Trust should consider the need to modify the approach to performance review with a view to raising the levels of accountability currently demonstrated by operational leadership teams.	MEDIUM
R10	B.2.2	The Trust should continue to evolve the IPR to ensure consistency in standard of reporting across the various domains to ensure that reporting is of a similar standard to the current quality of financial reporting.	MEDIUM
R11	B.2.3	The Board should ensure that committee reporting at the Q&SC and PODC in particular is less fragmented and fully aligned with the IPR presented to the Board.	MEDIUM
R12	B.3.1	The Board should ensure that the Risk and Quality Strategy explicitly covers the wider risk management agenda as it is currently focused on quality governance.	MEDIUM
R13	B.3.2	The Board should ensure that there is appropriate coverage of the BAF across the relevant Board committees.	MEDIUM
R14	C.1	The Trust should introduce a more explicit accountability framework which clearly sets-out expectations regarding roles, responsibilities and accountabilities; the leadership model at all levels; and the Trust operating structure down to the ward level.	HIGH
R15	C.2	The Trust should consider introducing consistency in management meetings at the divisional and speciality levels through standard reporting templates, agendas and minutes to promote consistency in standards.	MEDIUM
R16	C.3	The Trust should consider the development of a centrally coordinated business intelligence capability with the skill set and business knowledge to support corporate, divisional and speciality level departments with the production of high quality and insightful business intelligence.	MEDIUM
R17	C.4	The Trust should consider the need to expand the leadership development programme to make provision for development activities aimed at enhancing functional skills relating to operational leadership. This should incorporate a work stream which focuses on modern medical leadership and practically contributing across the wider operational agenda.	MEDIUM

Deloitte.

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee meeting held on Wednesday 5th September 2018 09:00 – 11:00 Bob Webster Room, EDGH with vc to Room 1, Education Centre, Conquest

Present:

Mrs Miranda Kavanagh, Non-Executive Director (MK) – Chair
Dr Adrian Bull, Chief Executive (AB)
Mrs Dawn Urquhart, Assistant Director HR, Education (DU)
Dr David Walker, Medical Director (DW)
Mrs Joe Chadwick-Bell Chief Operating Officer (JCB)
Mrs Lynette Wells, Director of Corporate Affairs (LW)
Mr Salim Shubber, Director of Medical Education (SS)
Mrs Vikki Carruth, Director of Nursing (VC)
Mrs Lesley Houston, Deputy GM – Medicine (LH)
Mrs Brenda Lynes O'Meara – Associate Director of Operations (BLO)
Mrs Kim Novis, Equality & Human Rights Lead (KN)
Mrs Lorraine Mason, Assistant Director of HR - OD (LM)
Mrs Moira Tenney, Deputy Director of HR (MT)
Ms Leigh Holloway, Staff Side Representative (LH)
Ms Monica Green, Director of HR (MG)

In Attendance:

Ms Anne Canby, Associate Director of AHPs (AC)
Ms Penny Wright, Head of Workforce Planning (PW)
Ms Yvonne Coghill, Senior Programme Lead for Inclusion – NHS England (YC)
Mr Owen Chinembiri, Senior Health Informatics Manager – NHS England (OC)
Mrs Jeanette Williams, Staff Engagement & Wellbeing Manager
Mrs Nicky Hughes, EA to Director of HR (NH) (minutes)

No	Item	Action
1	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Mr Jamal Zaidi, Associate Medical Director – Workforce Mrs Jackie Churchward-Cardiff, Non-Executive Director Ms Fran Edmunds, Head of Nursing, Women & Children Mrs Sharon Gardner-Blatch, Deputy Director of Nursing Mrs Jan Humber, Staff Side Chair Mrs Michelle Elphick, Associate Director of Operations Mr Jonathan Reid, Finance Director Ms Emma Chambers, Interim Assistant Director of Nursing	
2	**Minutes and Matters Arising** **2.1 Minutes of the last meeting held on 11th July 2018** The minutes were reviewed and agreed as an accurate reflection of the meeting.	

	2.2 Review of Action Tracker: The outstanding items on the Action Tracker were reviewed: <u>Training Needs Analysis</u> A full written response and formal report would be provided at the November meeting. <u>Physician Assistant Roles</u> The Executive Team had made the decision that the fund for physician assistant roles would sit within the divisions. **Action: Closed** <u>Terms of Reference</u> No further update, although it was noted that there were two representatives for AHP present at the meeting. **Action: DW to secure representation of SAS Doctor.** <u>CQC Well Led</u> MK queried whether CQC updates should be discussed more frequently than 6 monthly. AB referred to the Deloitte review and stated that any ESHT actions in response to this review and CQC well led should be brought to the November 2018 meeting. Further decisions on the frequency also to be discussed. **Action: LW to share actions from Deloitte Review and CQC Well Led at the November 2018 meeting.** <u>Junior Doctors Survey Results</u> Survey Results to be presented under Agenda Item 4.3. <u>Retention of AHPs</u> Retention of AHPs to be presented under Agenda Item 4.2. <u>Apprenticeships Awareness</u> DU reported that an HR whole systems review of tools that could be used was underway. Also looking at Twitter account for apprenticeship. **Action: Further update at November 2018 meeting.** <u>Workforce / Business Planning</u> Workforce to be presented under Agenda Item 3.1.	**DU** **DW** **LW** **DU**
3	**Workforce Costs** <u>3.1 Workforce Costs: Trend Analysis Substantive and Temporary Staff</u> PW provided a verbal overview of the submitted report and stated that the department were working with finance to develop more succinct reporting. Key points were highlighted: *Month 4 (in month)* • Total annual budget for "special observations" in medicine was £0.5m • New rostering compliance process initiated seeing a decrease of £40k and 352 shifts • Medical agency in month £443k • £0.4m increase to pay costs in M4 across nursing/A&C/AHPs due to Agenda for Change pay award; to be offset with funding from DHSC.	

YTD

- YTD overspend of £1.6m largely due to Medical Staff Group (£1.25m), Nursing (£0.5m) and Prof & Tech (£0.3m)
- Whilst medical pay costs increased by 4% (£895k) against last year causing £1.3m overspend, agency costs were below agency ceiling YTD and forecast to continue this trend
- Increase in non-elective activity higher than planned with an increase in acuity due to adverse weather conditions.

VC referred to the "special observations" and reported that a number of discussions had taken place at board level and it had been agreed that the target on reducing spend was ambitious. The data was not as accurate as it could have been and a percentage had been incorrectly coded. MK queried the percentage that was miscoded. VC replied that currently it was 15% for all requests for extras (vast majority being vacancies or sickness) but the percentage had been much higher.

AB referred to medical agency and asked for the reasons for the increase that had originally been included in the budgets and plans. PW stated that there were a number of key areas where there was a requirement for adjustments to be made; overspend on locums and temporary workforce had been paying premium for some time and looking at the hard to fill posts.

AB referred to the Workforce Efficiency Groups and stated that the areas of focus should be reported back to these groups. PW stated that the department were looking at priorities and actions to be put in place, linking in with finance and planning for external benchmarking.

MK thanked PW for the comprehensive report and asked how the Trust would find £1.6m+ of reductions in non-pay costs. AB replied that this was part of the discussion going forward and stated that the Trust came off plan by £350k in month 4; awaiting figure for month 5.

MG asked PW to give a brief update on moving forward on the Workforce Plan and the workforce response to the Clinical Strategy. PW stated that the Workforce Plan would be submitted with workforce numbers and costs into the financial plan for the next 3 years. The workforce response was in the early stages and work was being undertaken with the planning department.
Action: PW to provide further update at the November 2018 meeting. **PW**

AB referred to the Strategic Plan that had been discussed at the Board Seminar, from a system point of view, the demand trends would continue but there would need to be some interventions in the change to the trajectory of demand. The framework was in place but there would be a need to pull together workforce productivity.

MT stated that spend would be monitored each month, additional workforce spend/hours look at in a balanced way, coded and reported correctly

A discussion took place regarding non-elective and elective medical spend within budget and additional capacity required. MK highlighted the importance on having correct reporting in place and that other senior managers were trained in managing the activity. PW stated that she had been working with finance to articulate the reporting and were in the early stages of training.

4	**Recruitment and Retention** 4.1 Trust Retention Plan LM provided a verbal overview of the submitted report and highlighted that the target was to reduce retention to 11.3 as outlined in ESHT 2020 strategy but based on current performance this would have to be reviewed. LM highlighted key points: • Commence work with each division for retention in terms of setting individual targets on areas highlighted • Exit Interviews - challenge where they sit within the learning process as an organisation and how we utilise them • Challenges around age groups • To encourage staff to attend listening conversations; target areas • Admin & Clerical highest number of leavers in March LM confirmed that a comprehensive plan was in place, although a living document, where priorities would be highlighted and the data used to focus on challenging areas. AB stated that this was a very helpful and important area for ESHT and referred to "stay" interviews asking if these would be incorporated into a 6 month review or appraisal and how to make them more specific. LM stated that a pilot of "stay" interviews was being carried out in three areas; Out of Hospitals, Estates and Facilities and Urgent Care, which would be evaluated to understand if they do add value. **Action: LM to provide update in January 2019.** A discussion took place regarding reasons for leaving and LH highlighted some themes that had arisen from AHPs leaving the Trust: bullying, lack of configuration, lack of training, lack of support and no incentives. MK reported that it was important for LH to share this information and suggested a conversation with AC outside of this meeting. JCB stated that data was important but there is also a need to listen to staff. 4.2 Retention of Allied Health Professionals (AHPs) AC provided a verbal overview of the submitted report. AC highlighted key points: • The recruitment report in May showed a turnover rate of 13.2% for AHPs in March 2018 against an overall Trust rate of 11%. This was following a rising trend throughout the year • In June 2018 the turnover rate was 10% and stability had improved over the previous 8 months to 91%; turnover rate reduced and vacancy rate had improved • Work underway with the workforce team to ensure that the correct data had been captured for the number of leavers • A report had been developed for themes and trends for AHP sickness across the groups, which had been shared with professional managers and service leads • Talent Management and role development tool kit had been launched across Out of Hospitals to support "in house" development opportunities • Actively working together with the Strategic Workforce Resourcing Group to develop the AHP workforce intelligence.	**LM**

DU reported that she had met with AC and they had found a few problems around training for AHPs; apprenticeship qualifications were still in development and a lot of access was predominantly via conferences where funding had been an issue.

AB asked if the Trust had data across the board in terms of training access i.e. were staff receiving supervision, training opportunities and professional training requirements. AC stated that previously training support and supervision structure had not been collated under a single professional leadership. It was agreed to have further discussions at the next IPR meeting.

4.3 Junior Doctors Survey

SS provided a verbal overview of the comprehensive submitted report; an annual survey hosted by the GMC sent out to all doctors within the UK. Key highlights:

- 99.1% within ESHT compliance
- 4th best region for training according to GMC survey
- 33 red flags in 2017 to 25 in 2018
- 2016 – 49 areas with red flags, ESHT in bottom quartile. Currently 25, a significant improvement
- Speciality areas that did particularly well were Core surgical, Emergency Medicine, GP Programme (Paediatrics and Child Health), GP (F2) and Trauma & Orthopaedics
- Speciality areas that had shown the most improvement were Gastroenterology, Geriatric Medicine, Respiratory Medicine and Stroke Medicine
- An improvement across most specialities in the feedback on Trust reporting
- Areas of concern to be focussed on were Clinical Supervision, Educational Supervision and Teamwork
- Interventions to be focussed within areas under pressure for support and improvement
- Concerns of higher speciality training within Obstetrics & Gynaecology
- Over all a good improvement for the Trust.

JCB queried how this information was shared with all consultants. SS reported that the Medical Education Department had commenced working with Managers within the speciality areas where training had been identified. The Department continued to work with college tutors and speciality/divisional leads identifying issues and sharing at focus groups. AB requested that DW present a summary of the Junior Doctors Survey to the consultants meeting in October.

Action: DW to present a summary of the Junior Doctors Survey at the October Consultant meeting. **DW**

An action plan had been put in place, discussed with speciality leads and response and reports would be submitted to HEE by the end of the month.

The PowerPoint presentation of the Junior Doctors Survey would be shared with the minutes of this meeting.

5	**Workforce Equality**
	
	5.1 Workforce Race Equality
	YC and OC provided a verbal overview of the comprehensive submitted report.
	
	Key findings for ESHT:
	• 12.3% of ESHT Trust were from a BME background
	• BME staff under-represented in Senior AfC pay bands
	• BME staff are
	  ○ More likely to enter the formal disciplinary process
	  ○ Less likely to access non-mandatory training
	• For all four WRES NHS staff survey questions, BME staff reported a worse experience than white staff
	• For five out of the seven indicators benchmarked, ESHT is worse that the peer Trusts median
	• In 2017 four indicators improved and three deteriorated
	• There is no BME representation on the board.
	
	KN asked how many BME members were on the NELFT board; OC replied four.
	
	AB highlighted that he was currently chair of the BME network for ESHT. OC commented that it was positive for the CEO to be involved as leadership was key. AB also stated that the Trust were encouraging BME representation on interview panels.
	
	JCB referred to micro-stresses and stated that there were various networks in place but questioned whether these were fed back to the Service/General Manager population; this would need to be managed appropriately.
	
	KN commented that the data reported from NELFT was re-assuring for ESHT.
	
	MK thanked YC and OC for sharing their informative presentation.	

6	**Finance** 6.1 Financial Recovery Workforce Efficiency Programme Steering Group MG reported that a lot of good work had been undertaken in terms of some of the enablers across the organisation i.e. Health Roster, Job Planning, Time to Recruit and work around agency and bank spend. The next step would be to review the governance and commence looking at areas that were driving the continued overspend in terms of workforce. The proposal adopted by FISC was to set up a Workforce Efficiency Programme Steering Group to be chaired by MG. This group would have 4 workstreams: • Medical Workforce • Nurse & Midwifery • AHP & Technical Services • Corporate Services and Enabling Tactical Schemes Feedback from this meeting to become a standing item on the agenda.	

7	**POD Annual Report** LW confirmed that the annual report consisted of core questions and would be circulated to relevant staff for a response, collated and discussed at the November meeting. **Action: LW to circulate template of questions for discussion at the November 2018 meeting.**	**LW**
8 **8.1** **8.2** **8.3**	**Items for information:** Nursing Report Item noted. Workforce Report Item noted. Feedback from sub-groups: <u>Engagement & OD Group</u> Item noted. <u>Education Steering Group</u> Item noted. <u>Workforce Resourcing Group</u> The Group had not met since the previous POD Committee meeting. <u>HR Quality & Standards Group</u> Item noted.	
9	**Any other business** No other business.	
10	**The next meeting of the Committee will take place on:** **Wednesday 7th November 2018** **15:00 – 17:00** **John Cook Room, Post Grad Centre, EDGH**	

Trust Board Meetings in Public 2019

5th February	0930 - 1230	Hastings
2nd April	0930 - 1230	Bexhill
4th June	0930 - 1230	Eastbourne
6th August	0930 - 1230	Hastings

To be followed by the AGM

1st October	0930 - 1230	To be confirmed
3rd December	0930 - 1230	Eastbourne

East Sussex Healthcare NHS
NHS Trust

ADMINISTRATIVE GUIDANCE NOTES

SCHEDULE OF MATTERS RESERVED TO THE BOARD AND SCHEME OF DELEGATION

Written/Produced By:	Title/Directorate	Date:
Stephen Hoaen	Head of Financial Services	November 2018

Person Responsible for Monitoring Compliance & Review	Director of Finance
Signature & Date	November 2018

Multi-disciplinary Evaluation/Approval

Name	Title/Speciality	Date
Audit Committee		November 2011
Audit Committee	Annual Review	November 2012
Audit Committee	Annual Review	November 2013
Audit Committee	Annual Review	November 2014
Audit Committee	Annual Review	November 2015
Audit Committee	Annual Review	November 2016
Audit Committee	Annual Review	November 2017
Audit Committee	Annual Review	November 2018

Ratification Committee

Version	Date of Issue	Next Review Date	Date Ratified	Name of Committee/Board/Group
v 1.2	Oct-11	Oct 2012	Dec-11	ESHT Trust Board
v 1.3	Nov -12	Nov 2012	Dec-12	ESHT Trust Board
v 1.4	Nov -13	Nov 2013	30 Nov 13	ESHT Trust Board
v 1.5	Nov-14	Nov 2015	26 Nov14	ESHT Trust Board
v 1.6	Nov-15	Nov 2016	3 Dec 15	ESHT Trust Board
v 1.7	Dec-16	Nov 2017	14 Dec 16	ESHT Trust Board
v 1.8	Dec-17	Nov 2018	28.11.17	ESHT Trust Board
v 1.9	Dec-18	Nov 2019		ESHT Trust Board

CONTENTS

SCHEME OF DECISIONS RESERVED TO THE BOARD

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 – Nov 2018 v 1.9

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 senior employees.
	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 £500,000 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 Director of Finance 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. Policies so adopted shall be listed and appended to this document by the Director of Corporate Affairs.
	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 Director of Finance on financial performance against budget and business plan and other Directors on activity, workforce, quality and safety. 4. Receive reports from the Director of Finance 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 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 Director of Corporate Affairs.
	Remuneration and Appointments Committee	The current terms of reference, including powers delegated by the Board, are available from the Director of Corporate Affairs.

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 Director of Finance	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 Trust 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	Director of Finance	Operational responsibility for effective and sound financial management and information.
15	Chief Executive	Primary duty to see that Director of Finance 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 Director of Finance Medical Director Director of Nursing and Director of Corporate Affairs	Chief Executive, supported by Director of Finance, Medical Director, Director of Nursing and Director of Corporate Affairs 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	Board	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 Code of Conduct, and other ethical concerns.
1.3.1.9 & 1.3.2.2	All Board members	Subscribe to Code of Conduct.
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	Chair 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 and Appointments 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 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 the Trust Development Authority 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 and Directors	Declaration of conflict of interests.
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 meetings.
3.9	Chairman	Chair all Board meetings and associated responsibilities.
3.10	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 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 5.2	Board Chairman & Chief Executive	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). 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 Executive	Maintain Register(s) of Interests.
7.4	All staff	Comply with national guidance contained in HSG 1993/5 'Standards of Business Conduct for NHS Staff'
7.4	All	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board).
8.1/8.3	Chief Executive	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	Director of Finance	Training and communication programme for staff on SFIs.
1.1.3	Director of Finance	Approval of all financial procedures.
1.1.4	Director of Finance	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 Director of Finance 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.

SCHEME OF DELEGATION FROM STANDING FINACIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
1.3.5	Chief Executive & Director of Finance	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	Director of Finance	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	Chairman	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3	Director of Finance	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)	Director of Finance	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.

SCHEME OF DELEGATION FROM STANDING FINACIAL INSTRUCTIONS

Section 1

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 Director of Finance and in accordance with NHS Internal Audit Manual and best practice.
2.4.1 2.4.2	Chief Executive Director of Finance	Monitor and ensure compliance with Secretary of State's Directions on fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.
2.5.1	Audit Committee	Ensure cost-effective external audit.
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.
3.1.2 & 3.1.3	Director of Finance	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.6	Director of Finance	Ensure adequate 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	Director of Finance	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 CE 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.
3.5.1	Chief Executive	Submit all statutory and other monitoring returns required of the organisation.
4.1	Director of Finance	Preparation of annual accounts and reports.
5.1.1	Director of Finance	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements).
6	Director of Finance	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 Director of Finance 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	Director of Finance	Report waivers of tendering procedures to the Audit Committee.
7.6.2	Director of Finance	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.4	Chief Executive & Director of Finance	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.
7.6.7	Chief Executive	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
7.7.4	Chief Executive & Director of Finance	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 Director of Finance.
7.14	Chief Executive	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	Chief Executive	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
8.4	Chief Executive	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
9.1.1	Board	Establish a Remuneration and Appointments Committee.
9.1.2	Remuneration and Appointments Committee	Take decisions under delegated authority on the remuneration and terms of service of the Chief Executive, other officer members and senior employees 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 senior employees. Oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
9.1.3	Remuneration and Appointments Committee	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.

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	Director of Finance	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 Director of Finance
10.1.2	Chief Executive	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	Director of Finance	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 Director of Finance 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	Director of Finance	Approve proposed prepayment arrangements.
10.2.4	Budget holder	Ensure that all items due under a prepayment contract are received (and immediately inform Director of Finance if problems are encountered).
10.2.5	Chief Executive	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 Director of Finance.
10.2.7	Chief Executive Director of Finance	Ensure that Standing Orders 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	Director of Finance	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the 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 Director of Finance).
11.3	Director of Finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	Chief Executive or Director of Finance	Be on an authorising panel comprising one other member for applications for short term borrowing.
11.7.2	Director of Finance	Will advise the Board on investments and report, periodically, on performance of same.
11.7.3	Director of Finance	Prepare detailed procedural instructions on the operation of investments.
12.1	Director of Finance	Ensure that Board members are aware of the Financial Framework and ensure compliance.
13.1.1 & 13.1.2	Chief Executive	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	Director of Finance	For every 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 Finance & Investment Committee 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 Board 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) 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 Finance	Assess the requirement for the operation of the Construction Industry Scheme.
13.1.4	Chief Executive	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	Director of Finance	Issue procedures governing financial management, including variation to contracts, of capital investment projects and valuation for accounting purposes.

13.2.1	Director of Finance	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 PFI must be specifically agreed by the Board.
13.3.1	Chief Executive	Maintenance of asset registers (on advice from Director of Finance).

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.3.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.7	Director of Finance	Ensure that a review of asset lives is undertaken annually.
13.4.1	Chief Executive	Overall responsibility for fixed assets.
13.4.2	Director of Finance	Approval of fixed asset control procedures.
13.4.4	All senior staff	Responsibility for security of Trust assets including notifying discrepancies to Director of Finance, and reporting losses in accordance with Trust procedure.
14.2	Chief Executive	Delegate overall responsibility for control of stores (subject to the Director of Finance responsibility for systems of control). 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	Nominated Officers	Security arrangements and custody of keys
14.4	Director of Finance	Set out procedures and systems to regulate the stores.
14.5	Director of Finance	Agree stocktaking arrangements.
14.6	Director of Finance	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 Director of Finance evidence of significant overstocking.
14.8	Chief Executive	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	Director of Finance	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	Director of Finance	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	Director of Finance	Where a criminal offence is suspected Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption Director of Finance must inform the relevant LCFS and CFOS in line with Secretary of State's directions.
15.2.4	Director of Finance	Notify CFOS and External Audit of all frauds.
15.2.5	Director of Finance	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.6	Board	Approve write off of losses.
15.2.8	Director of Finance	Consider whether any insurance claim can be made.
15.2.9	Director of Finance	Maintain losses and special payments register.
16.1	Director of Finance	Responsible for accuracy and security of computerised financial data.
16.2	Director of Finance	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	Director of Corporate Affairs	Shall publish and maintain a Freedom of Information Publication Scheme
16.4	Relevant officers	Send proposals for general computer systems to Director of Finance.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
16. 5	Director of Finance	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	Director of Finance	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	Director of Finance	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 Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	Director of Finance	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.	Director of Finance	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	Director of Finance	The Director of Finance will arrange for the creation of a new charitable fund where this is required.
19.1	Director of Finance	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 Executive	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 the NHS Litigation Authority or self insure for some or all of the risks (where discretion is allowed). Decisions to self insure should be reviewed annually.
21.5	Director of Finance	Where the Board decides to use risk pooling schemes or commercial insurers the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.
21.6	Director of Finance	Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance 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 Director of Finance will draw up formal documented procedures to cover these arrangements.
21.7	Director of Finance	Ensure documented procedures cover management of claims and payments below the deductible.

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

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 Executive	Director of Corporate Affairs
2.	Receiving Hospitality 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 Executive	Director of Corporate Affairs
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:		
	a) Up to **£7,500** – 2 written quotations (where this may be impractical, 2 verbal quotations may be obtained and the reasons for this documented)	Director for appropriate budget or General Manager	Authorised Budget Signatory and Purchasing and Supplies Buyer
	b) **£7,501** to **£35,000** excluding VAT– obtain 3 written quotations	Head of Procurement	Head of Procurement
	c) **£35,000** excluding VAT to the prevailing European Union Threshold – a minimum of 4 Invitations to Tender with at least 3 received.	Head of Procurement together with Director of Finance	Head of Procurement together with Director of Finance
d)	Above the European Union Threshold – a minimum of 6 Invitations to Tender with at least 4 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Board	Chief Executive or Director of Finance

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
The waiver authorisation limits are:		
e) For quotations	Chief Executive, or Director of Finance or Head of Procurement.	N/A
f) For tenders **£35,000 excluding VAT** to the EU threshold	Director of Finance	N/A
g) For tenders from the EU threshold up to £1,000,000	Chief Executive and the Director of Finance	N/A
h) For tenders above £1,000,000	Board – prior to the initiation of the tender process	N/A
i) Opening electronic Tenders and Quotations	Procurement Department	N/A
5. Attestation of sealings in accordance with Standing Orders	Chairman/Chief Executive	N/A
6. The keeping of a register of Sealings	Chief Executive	Director of Corporate Affairs
7. Implementation of Internal and External Audit Recommendations	Manager responsible for budget.	N/A
8. Management of Budgets Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Director for appropriate budget or General Manager.	Budget Manager
b) At service level	Chief Executive	Director for appropriate budget or General Manager
c) For the totality of services covered by a General Manager or Executive Director	Chief Executive	Director for appropriate budget or General Manager.

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
9.	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	Director of Finance	Deputy Director of Finance
	c) Granting and termination of leases	Director for appropriate budget.	N/A
10.	Authority to open Bank Accounts	Director of Finance	N/A
11.	Management of the Investment of Charitable Funds within the approved investment strategy	Trustees of the Charitable Funds.	N/A
12.	Setting of Fees and Charges		
	a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Manager responsible for the budget together with the Director of Finance	N/A
	b) Price of NHS Contracts – charges for all NHS Contracts, be they block, cost per case, cost and volume, or spare capacity	Director of Finance	Deputy Director of Finance
13.	Authorisation of Sponsorship deals	Director for appropriate budget or General Manager	N/A
14.	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
	b) Authority to appoint staff to post not on the formal establishment	Chief Executive	n/a

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
c) The granting of additional increments to staff within budgets	Chief Executive	Manager responsible for budget with the Director of Human Resources
d) All requests for upgrading/re-grading shall be dealt with in accordance with Trust Procedure	Chief Executive	Payroll Manager
e) <u>Establishments</u>		
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) <u>Pay</u>		
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 and Appointments Committee of the Board	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) Leave		
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 General Manager	N/A
iv) Special leave arrangements		
▪ adoption leave ▪ bereavement leave ▪ paternity leave ▪ urgent domestic distress/crisis ▪ carers leave	Director for appropriate budget or General Manager	Manager responsible for the budget – in accordance with Trust Special Leave Policy
v) Leave without pay	Director for appropriate budget or General Manager Medical Director or Chief Executive	Manager responsible for the budget
vi) Medical Staff Leave of Absence – paid and unpaid – including study leave		
▪ Consultants and Career Grades	Medical Director 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 General Manager	Manager responsible for the budget

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

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 Director of Human Resources	N/A
ii) Return to work part-time on full pay to assist recovery	Director for appropriate budget or General Manager together with Director of Human Resources	Manager responsible for the budget
iii) Extension of sick leave on full pay	Director of Human Resources 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	N/A
ii) All other study leave (UK)	Director of Human Resources, 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.	Director of Human Resources or Director of Finance	Payroll Manager or Head of Financial Services
k) Grievance Procedure		
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure	Manager responsible for the budget	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

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	Director of Human Resources	N/A
n)	Redundancy	Director of Human Resources together with Director of Finance	N/A
o)	Ill Health Retirement		
	Decision to pursue retirement on grounds of ill health	Manager responsible for the budget together with Director of Human Resources	Manager responsible for the budget together with Personnel Manager
p)	Dismissal	Director for appropriate budget	N/A
15.	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
16.	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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

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)	Chief Executive	Director for appropriate budget
17. 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 EU threshold	Chief Executive	Manager responsible for the budget
ii) From the EU threshold to £1,000,000	Chief Executive and Director for appropriate budget	N/A
iii) Value of £1,000,000 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 Director of Finance	N/A
c) Commitments/orders exceeding 12 month period	Director of Finance 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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

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 Senior Buyer
ii) AND the variance is >£1,000 }		
18. 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
19. Management and Control of Stocks		
a) Pharmaceutical Stocks	Director of Finance	Designated Pharmaceutical Manager
b) Theatres	Director of Finance	Theatres Manager
c) Estates	Director of Finance	Estates Manager
d) Eastbourne Hospital Services	Director of Finance	Manager responsible for budget
e) General	Director of Finance	Manager responsible for budget

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
20. 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
21. Losses, Write-off and Compensation		
a) Losses and cash and cash equivalents due to theft, fraud overpayment and others	Chief Executive and Director of Finance	N/A
b) Fruitless Payments (including abandoned Capital Schemes)		
i) Up to £100,000	Chief Executive and Director of Finance	N/A
ii) Over £100,001	Board	N/A
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Other	Chief Executive and Director of Finance	N/A
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Chief Executive and Director of Finance	N/A
Special Payments		
e) made under legal obligation	Chief Executive and Director of Finance	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
f) Extra Contractual payments to contractors	Chief Executive and Director of Finance	N/A
g) Ex-Gratia Payments		
i) Patients' dentures repaired or replaced through the Community Dental service	Director of Corporate Affairs	Trust Solicitor
ii) Dentures and spectacles repaired or replaced < £500	Director of Corporate Affairs	Trust Solicitor
iii) Dentures and spectacles repaired or replaced > £500	Director of Finance	Trust Solicitor
iv) Other ex gratia claims < £500	Director of Finance	Trust Solicitor
v) Other ex gratia claims > £500	Director of Finance	Deputy Director of Finance
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	Trust Solicitor	N/A
ii) Property Expenses Scheme	Trust Solicitor	N/A
i) Settlements on termination of employment – to a limit of £50,000	Chief Executive and Director of Finance and Director of Human Resources	N/A
j) Other, except cases of maladministration	Chief Executive and Director of Finance	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
22. Expenditure on Charitable Funds		
a) All expenditure up to £5,000 per request but excluding training and hospitality requests	Director for appropriate budget or General Manager	Authorised Signatory
b) All other expenditure	Trustee to authorise	N/A
23. Management and Control of Computer Systems		
a) Financial Data	Director of Finance	Senior Finance Manager Capital Systems Manager
b) Other Data	Medical Director	Relevant Service Manager
24. Review of Trust's compliance with Data Protection Act 1998	Medical Director	Director of Corporate Affairs
25. Review the Trust's compliance with the Access to Health Records Act	Medical Director	Director of Corporate Affairs
26. Retention of Records	Director of Corporate Affairs	Trust Solicitor
27. Insurance Policies	Chief Executive and Director of Finance	Director of Corporate Affairs
28. Risk Management	Director of Nursing	Risk & Patient Safety Manager
29. Monitor proposals for contractual arrangements between the Trust and NHS commissioners of healthcare	Director of Finance	Deputy Director of Finance
30. Maintenance and Update on Trust Financial Procedures	Director of Finance	Technical Accountant

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
31. 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 d) Approval of rent based on professional assessment	} Chairman/Chief Executive under } Seal }	} Commercial Director and } Director of Finance }
32. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected	On-call Manager or Manager responsible for the budget	Each Trust Employee
b) Where a fraud is involved	Director of Finance	Deputy Director of Finance
33. Patients and Relatives		
a) Overall responsibility for ensuring that all complaints are dealt with Effectively	Director of Nursing	Assistant Director of Nursing
b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	Director for appropriate budget or General Manager	Relevant Service Manager
c) Management of litigation relating to complaints	Director of Corporate Affairs	Trust Solicitor
34. Relationships with Press a) General Enquiries	Director of Corporate Affairs	Head of Communications
b) Emergency	On-call Manager	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
35.	Patient Services Manage the provision of clinical services to accepted professional standards	Chief Executive	Medical Director and Director of Nursing
36.	Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, and Insurance of Medical Staff	Clinical Tutor	Post-Graduate Medical Education and Personnel Manager
	Work experience students	Manager responsible for the budget	N/A
37.	Review of fire precautions	Associate 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	Director of Nursing	Health and Safety Manager
39.	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Operating Officer	Estates Manager and Waste Manager

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.

East Sussex Healthcare NHS
NHS Trust

ADMINISTRATIVE GUIDANCE NOTES

STANDING FINANCIAL INSTRUCTIONS

Written/Produced By:	Title/Directorate	Date:
Lydia Crouch	Deputy Head of Financial Services	November 2018

Person Responsible for Monitoring Compliance & Review	Director of Finance
Signature & Date	November 2018

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Audit Committee	Annual Review	November 2013
Audit Committee	Annual Review	November 2014
Audit Committee	Annual Review	November 2015
Audit Committee	Annual Review	November 2016
Audit Committee	Annual Review	November 2017
Audit Committee	Annual Review	November 2018

Ratification Committee

Issue Number (Administrative e use only)	Date of Issue & Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
	Nov 2012 v1.1	Oct 2013		ESHT Trust Board
	Nov 2013 v1.2	Nov 2014		ESHT Trust Board
	Nov 2014 V 1.3	Nov 2015	26.11.14	ESHT Trust Board
	Nov 2015 v1.4	Nov 16	3.12.15	ESHT Trust Board
	Nov 2016 v1.5	Nov 17	14.12.16	ESHT Trust Board
	Nov 2017 v1.6	Nov 18	28.11.17	ESHT Trust Board
	Nov 2018 v1.7	Nov 19		ESHT Trust Board

FOREWORD

1. The Code of Accountability requires the Boards of NHS Trusts to 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. These SFIs have been adopted by the Board and are therefore mandatory for all directors and employees of the organisation.

4. Where reference is made to other documents, these are available from the Company Secretary.

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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 Director of Finance 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 Reservation of Powers to the Board and the Delegation of Powers 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 Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance **MUST BE SOUGHT BEFORE ACTING**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders.

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 Standing Financial Instructions 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 Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance 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) 'Director of Finance' 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 S.90 of the NHS Act 1977, as amended. 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, Director of Finance, 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.

1.3 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 Delegation of Powers 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 'Reservation of Powers to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Delegation of Powers 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 Chairman and 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 Director of Finance 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 Director of Finance 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 Director of Finance 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 loss;

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 Delegation of Powers.

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 Director of Finance.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by providing assurance to the Board on:

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

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

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

d) compliance by the Trust with legal and regulatory requirements.

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. (To the Director of Finance in the first instance.)

2.1.3 It is the responsibility of the Director of Finance 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 Director of Finance

2.2.1 The Director of Finance 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 15.2.3.1):

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 in accordance with current Assurance Framework issued by the Department of Health including for example compliance with control criteria and standards;
ii) major internal (financial) control weaknesses discovered,
iii) progress on the implementation of internal audit recommendations,
iv) progress against plan over the previous year,
v) strategic audit plan covering the coming three years,
vi) a detailed plan for the coming year.

2.2.2 The Director of Finance 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;

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 that involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Head of Internal 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 Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.4 Fraud and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with the Secretary of State's Directions on fraud and bribery.

2.4.2 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.

2.4.3 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.

2.4.4 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.

2.4.5 The Local Counter Fraud Specialist shall report to the Director of Finance 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.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.5 External Audit

2.5.1 The External Auditor is appointed and paid for by the Trust. The Audit Committee must ensure a cost-efficient service.

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. The annual business plan will 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.

3.1.2 Prior to the start of the financial year, the Director of Finance 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.

3.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the

commencement of each financial year.

3.1.6 The Director of Finance 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, including pooled budget arrangements under Section 31 of the Health Act 1999 and subsequent legislation. This delegation must be in writing and be accompanied by a clear definition of:

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.

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 Director of Finance 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;
   ii) movements in cash and capital;
   iii) capital project spend and projected outturn against plan;
   iv) explanations of any material variances from plan;
   v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's and Performance view of whether such actions are sufficient to correct the situation;
   vi) identification and evaluation of financial risks to the achievement of plan and their potential mitigation

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 Director of Finance;

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 Capital Expenditure

3.4.1 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)

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Regulator.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, 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.

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 Department of Health's Group Accounting Manual.

5. BANK AND OFFICE OF PAYMASTER GENERAL ACCOUNTS

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account Department of Health 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 Director of Finance 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; and

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 DoH guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Director of Finance 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 Director of Finance 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 Director of Finance.

5.4 Tendering and Review

5.4.1 The Director of Finance 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 Director of Finance 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 Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow Department of Health guidance in setting prices for NHS service agreements.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health 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 Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Director of Finance 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 Director of Finance 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 Director of Finance 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 Director of Finance.

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 3.30 Suspension of Standing Orders is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DoH) 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 Reverse eAuctions. For further

guidance on Reverse eAuctions refer to www.gov.uk/guidance/eauctions.

7.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health 'Capital Regime, Investment and Property Business Case Approval 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

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials, services and manufactured articles;
- the rendering of goods, materials, services and manufactured articles including all forms of management consultancy services (other than specialised services sought from or provided by the DoH);
- 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 does not, or is not reasonably expected to, exceed **£35,000** excluding VAT.
b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;
c) regarding disposals as set out in Standing Financial Instruction No 15

Formal tendering procedures may be waived in the following circumstances:

d) 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;
e) where the requirement is covered by an existing contract;
f) where NHS Supply Chain agreements are in place and have been

approved by the Board;

g) for construction works under the provision of the DoH ProCure21 + framework;

h) where the timescale genuinely precludes competitive tendering. Please note - failure to plan the work properly would not be regarded as a justification for a single tender;

i) where specialist expertise is required and is available from only one source;

j) 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;

k) 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;

l) 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 or 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 Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

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 (k) 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.

7.5.4 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 7.1 and 7.5.3 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 that two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.5 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 Departmental of Health approval.

7.5.6 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 Estate Code 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 relevant 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 Institute of Civil Engineers, The standard documents shall be modified to accord with relevant guidance and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DH.

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

Formal competitive tenders shall be returned: - electronically via the Trust's nominated provider, BIP Delta exchange;

(iii) When tenders are received in electronic format a BIP Delta Vault Box will be set up which automatically records the date and time of receipt of each tender.

7.6.3 Opening Formal tenders (Electronic Format)

i) An audit report detailing the names and details of all documents received in the Vault shall be printed, signed and dated stamped by the Procurement & Supplies representative.

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 Director of Finance 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 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 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.

c) 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.

i) Tender documentation will require confirmation that 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..

ii) 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.

b) Financial Standing and Technical Competence of Contractors

The Director of Finance 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 Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced, any staff member involved in the original process should not have 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 not to exceed **£35,000** excluding VAT**.**

7.7.2 Competitive Quotes

i) As a minimum, 2 written quotations should be obtained from firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust, where the expected cost or income is up to **£7,500,** though if this is not practical 2 verbal quotes may be obtained and reasons documented. A minimum of 3 written quotations should be obtained where the expected cost or income is expected to be between **£7,501** and **£35,000.**

ii) 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.

iii) All quotations should be treated as confidential and should be retained for inspection.

iv) 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) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotation;

ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

iii) miscellaneous services, supplies and disposals;

iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: i) and ii) of this SFI) apply.

v) Where the goods or services are purchased through charitable funds /donations from Leagues of Friends, provided that 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 Director of Finance.

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:

Value of EU Threshold	Manager responsible for the Budget
from EU Threshold to £1,000,000	Chief executive and Director for the Budget
Value of £1,000,000 or above	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.

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 Director of Finance.

7.10 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) EU Directives 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.

7.11 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.

7.12 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 1990 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.

7.13 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.

7.14 In-house Services

7.14.1 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.

7.14.2 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 supplies officer and a Director of Finance representative.

7.14.3 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.

7.14.4 The evaluation team shall make recommendations to the Board.

7.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.14.6 Applicability of SFIs on Tendering and Contracting to Charitable Funds (See also SFI section 18)

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 (is 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.
- 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.

8.4 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 and Appointments 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 senior employees

d) review and agree the grading and remuneration package of any Director post that falls vacant, prior to the vacancy being advertised

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 the basis for its decisions. Minutes of the Board's meetings should record such decisions.

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.

9.3 Staff Appointments

9.3.1 Employees may only be engaged, re-engage, or regrade employees, 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 Director of Finance 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 Director of Finance 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 Director of Finance's instructions and in the form prescribed by the Director of Finance; 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 Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance 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 Director of Finance.

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 Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.2 The Director of Finance 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 Director of Finance 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 Delegation of Powers 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 Director of Finance 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 Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement 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 Director of Finance;

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 Executive.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Delegation of Powers or delegated budget), leases, tenancy agreements

and other commitments which may result in a liability are notified to the Director of Finance 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 Director of Finance.

b) contracts above specified thresholds are advertised and awarded in accordance with EU on public procurement;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

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 Director of Finance 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 Director of Finance 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 Director of Finance and;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

l) petty cash records are maintained in a form as determined by the Director of Finance.

10.2.7 The Chief Executive and Director of Finance shall 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.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11. EXTERNAL BORROWING

11.1 The Director of Finance 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 Department of Health. The Director of Finance 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 Director of Finance.

11.3 The Director of Finance 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 Department of Health.

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 Director of Finance. 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 Director of Finance 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 Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12 PLANNING FRAMEWORK

12.1 The Director of Finance shall ensure that members of the Board are aware of the operational planning and contracting guidance issued by the regulator. The Director of Finance 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 For every capital expenditure proposal in excess of £100,000 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 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 Finance & Investment Committee 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 Board 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) 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 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 Finance 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 Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.4 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 Delegation of Powers for capital investment management in accordance with 'Estatecode' guidance and the Trust Standing Orders.

13.1.5 The Director of Finance 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.

13.2 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 Director of Finance 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 DoH 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 Director of Finance 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 DoH.

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 Director of Finance 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 Director of Finance 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 Director of Finance. 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 Director of Finance.

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;

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the Director of Finance 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 to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of 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 Head of Procurement/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

14.4 The Director of Finance 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 Director of Finance 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 Director of Finance.

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance 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 Director of Finance 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 Director of Finance 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 Director of Finance 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 Director of Finance;

b) recorded by the Condemning Officer in a form approved by the Director of Finance 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 Director of Finance.

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

Director of Finance 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 Director of Finance prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The Director of Finance 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

15.2.3.1 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 Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance and/or Chief Executive.

Where a criminal offence is suspected, the Director of Finance 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 Director of Finance must inform the Department of Health Directorate Counter Fraud Services in accordance with the Secretary of State's directions and the Local Counter Fraud Service.

15.2.4 The Director of Finance 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 Director of Finance must immediately notify:

a) the Board, and

b) the External Auditor.

15.2.6 The Board shall approve the writing-off of losses.

15.2.7 The Director of Finance 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 Director of Finance should consider whether any insurance claim can be made.

15.2.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16. INFORMATION TECHNOLOGY

16.1 The Director of Finance, 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 Director of Finance 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 Director of Corporate Affairs 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 Director of Finance:

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 Director of Finance 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 Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.7 Where computer systems have an impact on corporate financial systems the Director of Finance 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 Director of Finance 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 Executive 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 Director of Finance 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 Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

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 Director of Finance 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 & HOSPITALITY BY STAFF

19.1 The Director of Finance 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 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 DoH guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with HSC (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 Executive shall ensure that the Trust has a programme of risk management, in accordance with current DoH 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 DoH 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 Director of Finance shall ensure that the arrangements entered into are appropriate and complimentary to the risk management programme. The Director of Finance 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 Director of Finance 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 Director of Finance 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 Director of Finance 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 **£35,000 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 from **£35,001 excluding VAT** to the European Union Threshold	Minimum of 4 invitations to tender with at least 3 received
Tenders above the European Union Threshold	Minimum of 6 invitations to tender with at least 4 received (Where such number of suppliers exist)

22.2.2 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 Director of Finance from **£35,001** excluding VAT to the EU threshold; and
- the Chief Executive **and** the Director of Finance from the EU threshold to £1,000,000.

22.2.3 For the purpose of determining the above limitations of **£35,001** excluding VAT, the European Union Threshold and £1,000,000 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 **£7,500**	2 written quotations (where this may be impractical, 2 verbal quotations may be obtained and the reasons for this documented)
£7,501 to **£35,000** excluding VAT	3 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 - £35,000** excluding VAT, the Head of Procurement

ii) For tenders **£35,001** excluding VAT to the **EU Threshold**, the Head of Procurement and the Director of Finance or the Chief Executive.

iii) For tenders from the **EU Threshold up to £1,000,000** the Head of Procurement, the Director of Finance and the Chief Executive.

iv) For tenders above £1,000,000 the Trust Board must give approval prior to initiation of the tender process.

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 Director of Finance 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 following financial limits:

VALUE	RESPONSIBILITY
Value to the European Union Threshold	Budget Holder/Budget Manager
From the European Union Threshold to £1,000,000	Chief Executive and Director for appropriate budget.
Value of £1million or above	Common Seal of the Trust

22.5.2 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.

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.

22.7.2 The European Union Tendering Thresholds are expressed exclusive of VAT and are available from **www.ojec.com/thresholds.aspx**

Reason for Request to Waive Standing Orders:	Please Tick
1 Compatible with existing equipment and therefore not available from more than one supplier	
2 No other equipment meets specification requirement	
3 Sole supplier/manufacturer	
4 Other	
5 "Technical" - not subject to competition, unable to find sufficient suppliers after OJEU advert, etc.	

Full written details and reasons must be detailed as Supporting Information on the reverse of this form before the waiver can be accepted.

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 and exclude VAT:

Up to £7,500	-	2 Written quotations. (Where this may be impractical, 2 verbal quotations may be obtained and the reasons for this documented.)
£7,501 to £35,000	-	3 Written quotations
£35,001 to European Union Threshold	-	Minimum of 4 invitations to tender with at least 3 received.
Above the EU Threshold (OJEU advert)	-	Minimum of 6 invitations to tender with at least 4 received.

The waiver authorisation limits are:

- For quotations below £35,000, the Head of Procurement.
- For tenders £35,001 to EU Threshold, the Head of Procurement and Director of Finance or Chief Executive.
- For tenders from the EU Threshold to £1,000,000 the Head of Procurement, the Director of Finance and the Chief Executive.

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:

Total cost of goods (inc VAT):

Department for which goods are required:

CERTIFICATION BY SENIOR BUSINESS MANAGER		**PRIOR TO FURTHER APPROVAL, HEAD OF PROCUREMENT APPROVAL MUST BE OBTAINED IN "APPROVAL OF WAIVER" BOX BELOW**	
		AUTHORISATION THRESHOLDS:	
Signature	Date	HEAD OF PROCUREMENT	£1 - £35,000
		DIRECTOR OF FINANCE	£35,001 – EU THRESHOLD
Title	Department	CHIEF EXECUTIVE	£ EU THRESHOLD - £1m

APPROVAL OF WAIVER

I/We hereby approve this waiver

Signatures authorising the waiver of Standing Orders.

Signature	**Signature**	**Signature**
Designation **Head of Procurement**	**Designation** **Director of Finance**	**Designation** **Chief Executive**
Date	**Date**	**Date**

Purchasing & Supplies use only		
Waiver Register Number:	Waiver Register Entry By:	Date:

THIS WAIVER REQUEST MUST ACCOMPANY THE REQUISITION SENT BY THE ORIGINATING OFFICER TO THE PROCUREMENT DEPARTMENT

DETAILED SUPPORTING INFORMATION
(This section must be completed in all instances, insufficient information may result in the waiver being returned)

a) Brief description of goods/services:

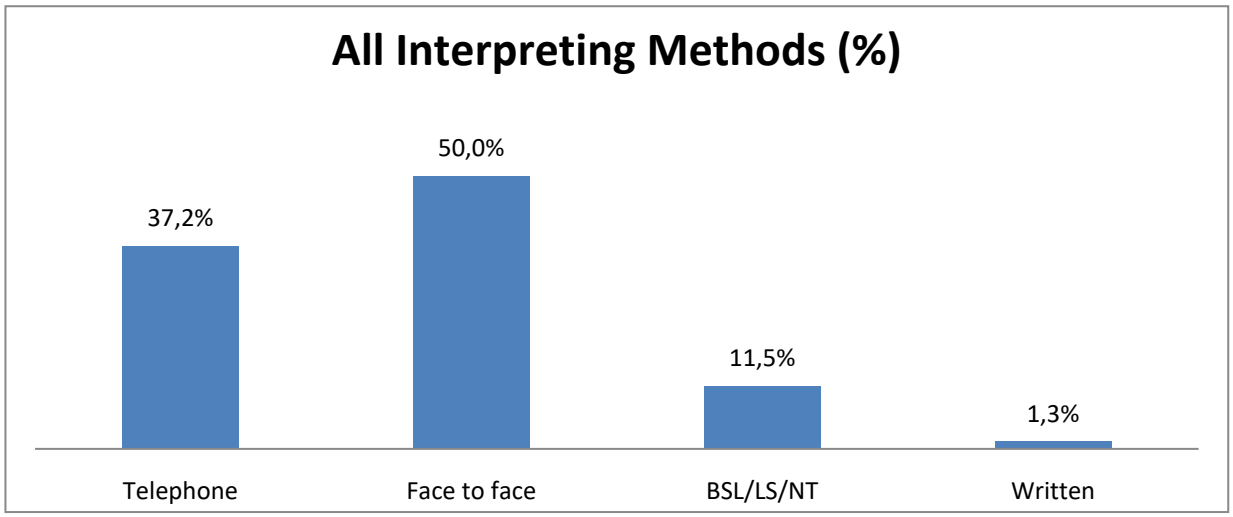
b) Justification:

Patient Equalities Analysis to Support EDS2 Report 2017/18

All interpreters supplied to patients, service users or carers during 2017/18 in order of most requested

Language Requested	Total	St Leonards	Eastbourne	Surrounding
Polish	140	50	86	4
BSL	131	53	70	8
Mandarin	114	63	42	9
Arabic	106	33	68	5
Turkish	86	40	44	2
Portuguese	64	11	49	4
Albanian	58	33	25	0
Spanish	56	8	47	1
Bengali	54	21	30	3
Farsi	44	9	35	0
Russian	36	15	21	0
Bulgarian	29	8	21	0
Cantonese	27	10	14	3
Lithuanian	25	4	21	0
Romanian	25	12	10	3
Kurdish (Sorani)	24	17	6	1
French	21	7	12	2
Czech	19	15	2	2
Vietnamese	14	9	5	0
Hungarian	11	9	2	0
Italian	8	2	6	0
Tamil	8	7	0	1
Pashto	7	3	4	0
Slovak	6	6	0	0
Dari	3	3	0	0
Greek	3	1	2	0
Urdu	3	1	1	1
German	2	2	0	0
Persian	2	0	2	0
Somali	2	1	1	0
Behdini	1	1	0	0
Gujarati	1	0	0	1
Hindi	1	0	1	0
Japanese	1	0	1	0
Korean	1	1	0	0
Sylhetti	1	1	0	0
Zaghawa	1	0	1	0
TOTAL	**1135**	**456**	**629**	**50**

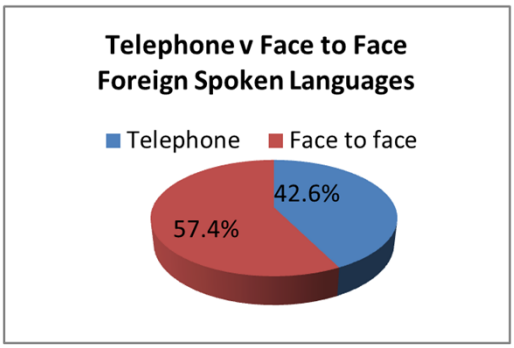
ESHT Interpreting Methods (%) 2017/18

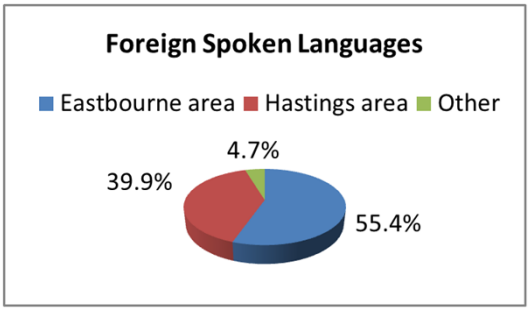


Breakdown by Speciality (Top 15)

Department	Interpreters (Total)	Interpreters (Telephone)	Interpreters (Face to face)
Maternity CQ	112	60	52
Outpatients EDGH	84	6	78
Health Visiting EDGH	73	28	45
Endoscopy EDGH	73	69	4
Health Visiting CQ	65	24	41
Outpatients CQ	52	20	32
Maternity EDGH	49	31	18
Paediatrics EDGH	38	4	34
Urology EDGH	37	7	30
Gynaecology EDGH	30	19	11
Endoscopy CQ	30	4	26
Paediatrics CQ	24	6	18
Oncology EDGH	23	1	22
Gynaecology CQ	22	15	7
Ophthalmology EDGH	21	7	14

Method used

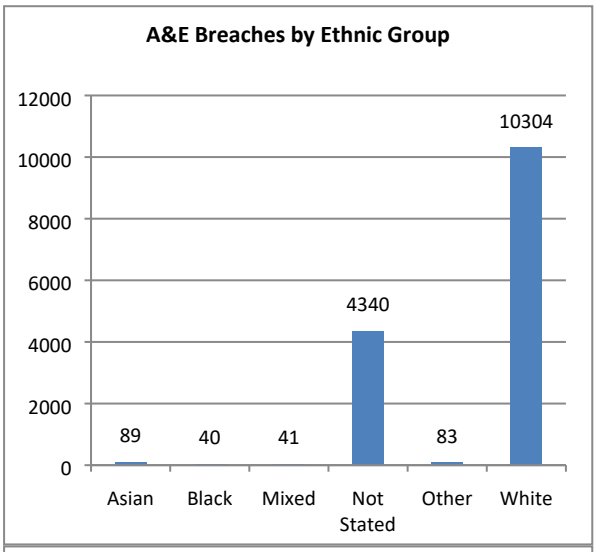


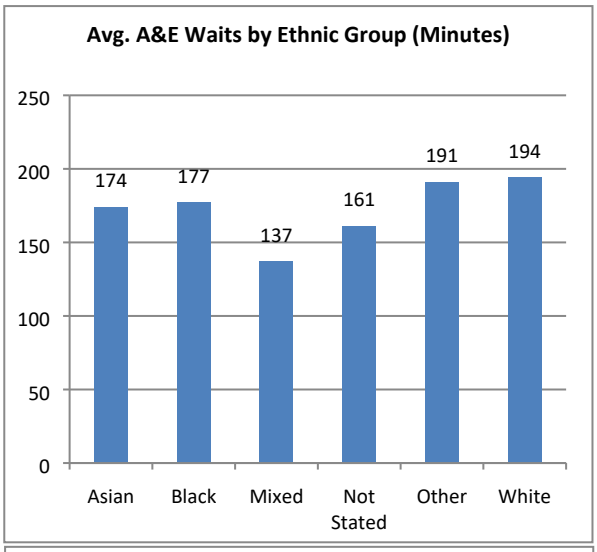


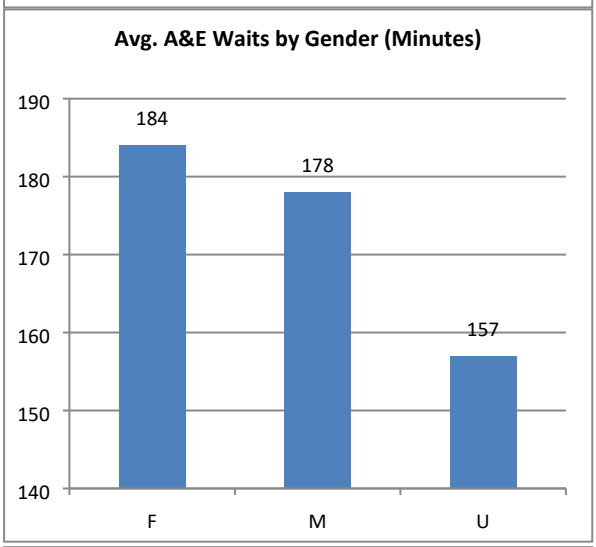
Accident & Emergency waiting times 2017/18

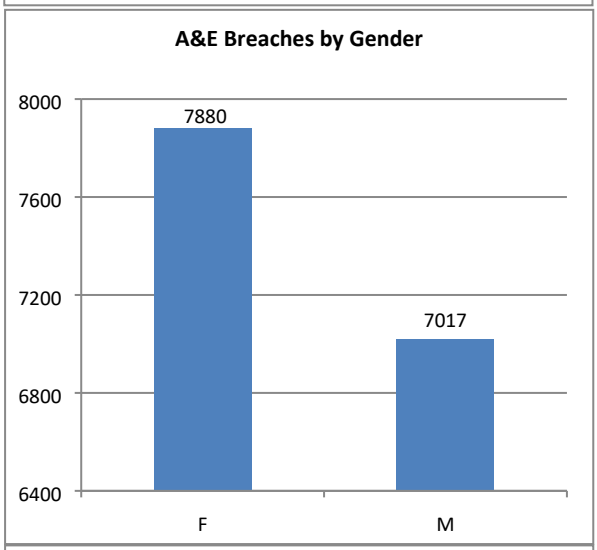
Interpreters provided for Sensory Support

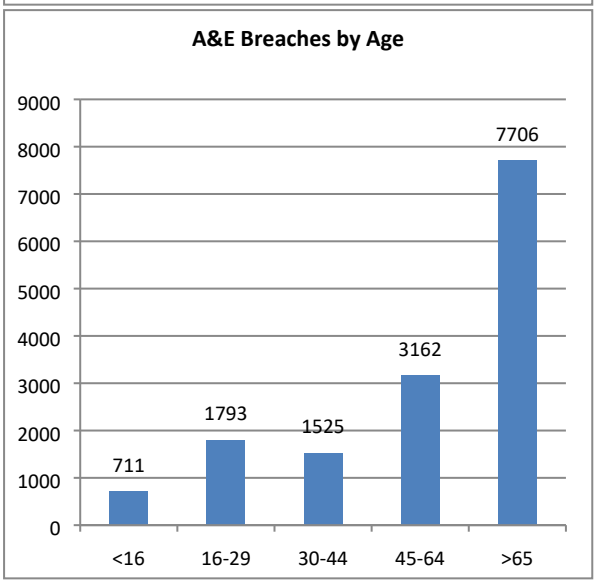
Language Requested	Total	St Leonards	Eastbourne	Surrounding
BSL	131	53	70	8
Lipspeaker	0	0	0	0
Note Taker	0	0	0	0
Total	131	53	70	8

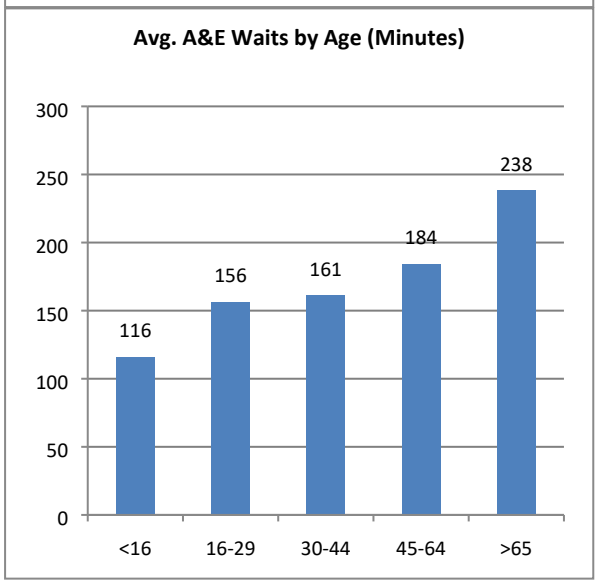

A&E Breaches by Ethnic Group
12000
10000
8000
6000
4000
2000
0
89
40
41
4340
83
10304
Asian
Black
Mixed
Not Stated
Other
White


Avg. A&E Waits by Ethnic Group (Minutes)
250
200
150
100
50
0
174
177
137
161
191
194
Asian
Black
Mixed
Not Stated
Other
White


Avg. A&E Waits by Gender (Minutes)
190
180
170
160
150
140
184
178
157
F
M
U


A&E Breaches by Gender
8000
7600
7200
6800
6400
7880
7017
F
M


A&E Breaches by Age
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
711
1793
1525
3162
7706
<16
16-29
30-44
45-64
>65


Avg. A&E Waits by Age (Minutes)
300
250
200
150
100
50
0
116
156
161
184
238
<16
16-29
30-44
45-64
>65

ESHT Risk Adjusted Mortality (RAMI) 2017 - April 2017 to March 2018 35 Years and Over by Age Band

	Male		Female		Total	
Age band	Observed deaths	RAMI Index	Observed deaths	RAMI Index	Observed deaths	RAMI Index
35-39	4	117	6	189	10	152
40-44	5	126	5	206	10	157
45-49	11	84	9	81	20	83
50-54	19	89	24	123	43	105
55-59	19	70	13	71	32	71
60-64	37	92	39	149	76	115
65-69	68	78	41	64	109	72
70-74	105	93	68	84	173	89
75-79	133	75	104	75	237	75
80-84	157	81	139	79	296	80
85-89	163	59	198	64	361	62
90+	191	98	262	88	453	92

Access to Sexual Health by Area, Ethnicity, Sexual Orientation and Age Group 2017/18

Area	Female	Male	Total
Eastbourne	17903	5901	23804
Hastings	18138	5254	23392
Total	36041	11155	47196

Ethnicity	female	Male	Total
British	85.09%	84.28%	84.90%
Any other White background	6.96%	6.02%	6.74%
Any other mixed background	2.06%	2.54%	2.17%
Any other Asian background	1.03%	1.21%	1.08%
Any other Black background	0.81%	1.06%	0.87%
African	0.86%	0.87%	0.86%
White and Black Caribbean	0.67%	1.13%	0.78%
White and Asian	0.50%	0.48%	0.50%
White and Black African	0.50%	0.44%	0.49%
Any other ethnic group	0.41%	0.49%	0.43%
Irish	0.27%	0.35%	0.29%
Not stated	0.23%	0.33%	0.25%
Indian	0.18%	0.13%	0.17%
Caribbean	0.10%	0.25%	0.14%
Bangladeshi	0.14%	0.09%	0.13%
Chinese	0.13%	0.04%	0.11%
Pakistani	0.02%	0.28%	0.08%
Unknown	0.00%	0.01%	0.00%
Total	100%	100%	100%

Sexual Orientation	Female	Male	Total	Total %
Heterosexual	34744	7655	42399	89.84%
Gay/Lesbian	112	2791	2903	6.15%
Bi-sexual	1059	649	1708	3.62%
Not Known	126	60	186	0.39%
Total contacts	36041	11155	47196	100.00%
Total (percent)	76.36%	23.64%	100%	

Age Group	Female	Male	Total	Total %
Under 16	1258	99	1357	2.88%
16 to 19	7554	1150	8704	18.44%
20 to 29	15799	4493	20292	43.00%
30 to 39	6691	2202	8893	18.84%
40 to 49	3476	1335	4811	10.19%
50 to 59	1002	1135	2137	4.53%
60 to 69	203	466	669	1.42%
70 Plus	51	273	324	0.69%
Unknown	7	2	9	0.02%
Total	36041	11155	47196	100%

Summary of Complaints Activity 2017/18:

Complaints Report for Equality 2017/18

In 2017/18, the Trust received 567 new complaints across all sites; this represents a reduction in complaints received of 15.4% compared to the number of complaints received in 2016/17 (667). All complaints are acknowledged within three working days, and are accompanied by a fact sheet which explains the complaints process, and what to do next if the complainant is unhappy with the response provided. Furthermore, a leaflet is also provided with all acknowledgement letters to advise complainants about our local Advocacy Service, in case they would find it helpful to have some independent advice or support in making their complaint.

In terms of complaint themes for the Trust in 2017/18, the top three themes reflect that reported for 2016/17 as follows:

	2016/17		2017/18	
	Theme	No. Received	Theme	No. Received
1	Standard of Care	221	Standard of Care	194
2	Communication	143	Communication	137
3	Patient Pathway	127	Patient Pathway	94

The Trust has two timescales for responding to complaints; non-complex complaints are assigned a 30 working day timeframe, whilst complex complaints are assigned 45 working days. At the end of 2017/18, the Trust had responded to 83% of non-complex complaints in time, with 71% of complex complaints being responded to in time. These are significant improvements compare to 2016/17, where the response rates were 54% and 53% respectively. This further underpins the Trust's commitment to treating complaints seriously by improving and respecting the importance of handling complaints efficiently and effectively.

In addition to these achievements, the Trust had no complaints that were overdue at the end of 2017/18, compared to 14 complaints overdue at the end of 2016/17, and the Trust facilitated 69 Local Resolution Meetings (LRM) which provided complainants and their relatives with an opportunity to discuss their complaint face to face with key and senior staff.

The Trust welcomes complaints from patients, their relatives and general members of the public, and approximately a third of all new complaints received in 2017/18 came from the relatives of patients. In many cases, personal data about the complainant is not available within the body of the complaint however, elements of data about patients that help to identify and understand their protected characteristics can be sought from their electronic patient records wherever it is has been recorded by clinical services.

Of the 567 new complaints received in 2017/18, 543 were related to patient care. Although not all complainants are patients of the Trust, the patient demographics (based on the information held on electronic patient records) for complaints are set out below.

Gender

Female	331
Male	212

Marital Status

Divorced/Civil Partnership Dissolved	23
Married/Civil Partnership	167
Separated	3

Single	108
Widowed/Surviving Civil Partner	15
Unknown/Not Recorded	227

Religion

Atheist/No Religion	17
Christian	166
None/Null	281
Other	79

Ethnicity

Not Stated/Null	159
White British and Any Other White Background	378
Any other ethnic background	6

Some of the protected characteristics data about patients such as sexuality and disability are not readily available from electronic patient records, the above tables demonstrate patients who have complained, or who were the subject of a complaint.

In September 2016, the Trust launched a strategy to assess the effectiveness of its complaint handling procedure. This involved the development of a twelve question complaint satisfaction survey that would be sent to all complainants (with the exception of bereavement cases), approximately one month after the complaint response had been sent. The survey included an Equalities Monitoring Form, which invited complainants to respond to questions on the following protected characteristics fields; age, gender, ethnicity, sexuality, religion and whether they considered themselves to be a disabled person as defined by the Equality Act 2010.

In 2017/18, the Trust sent out 299 surveys, with 96 (32%) being returned or completed online; the following tables summarise the protected characteristics data for all respondents.

Age

Under 39	13
40 – 59	19
60 – 69	19
70+	27
No Answer Given	18

Gender

Female	44
Male	28
No Answer Given/declined	24

Ethnicity

No Answer Given/declined	17
White – British and Any Other White Background	84

Sexuality

Lesbian/Gay/Bisexual or other	(figure to small to declare)
Heterosexual	59
I Do Not Wish To Disclose This	14
No Answer Given/declined	35

Religion

Christian – All Denominations	41
No Religion	24
Other or declined	11
No Answer Given	20

Disability

No	53
No Answer Given/Declined	20
Yes	23

In terms of the three survey questions scoring the highest positive feedback (by combining all responses scoring questions with Strongly Agree or Agree), these were:

I was able to communicate my concerns in the way I wanted	74%
It was easy to find out how to make a complaint	64%
I was able to understand the response as everything was clearly explained, including names and terminology	60%

Conversely, the three questions scoring the highest negative feedback (by combining all responses scoring questions with Disagree or Strongly Disagree) were:

I felt the response answered all of the concerns I had raised	58%
I felt assured that the Trust would learn from my experience	52%
I felt the Trust understood my concerns and what I wanted from raising a complaint	46%

The Complaints Team have already undertaken a piece of work to improve key negative feedback areas, and will continue to do so during 2018/19. In more specific terms, there are potentially five survey questions which address the desired outcome of this EDS2 Goal. The survey question most closely related to the outcome is:

"I felt the Trust had listened to my concerns and took into account my feelings and the responses were personal to me."

The following tables map out the protected characteristics for respondents providing positive and negative feedback, based on the criteria above, against this question.

Age	Strongly Agree/Agree	Disagree/Strongly Disagree
Under 39	3	9
40 – 59	6	12
60 – 69	8	7
70+	14	8
No Answer Given	6	10

Gender	Strongly Agree/Agree	Disagree/Strongly Disagree
Female	20	18
Male	8	15
No Answer Given/Declined	9	13

Ethnicity	Strongly Agree/Agree	Disagree/Strongly Disagree
No Answer Given/Declined	6	9
White – British and Any Other White Background	31	37
Sexuality	Strongly Agree/Agree	Disagree/Strongly Disagree
Heterosexual	24	27
I Do Not Wish To Disclose This/Declined	11	19
Lesbian/Gay/Bisexual or Other	2	0

Religion	Strongly Agree/Agree	Disagree/Strongly Disagree
Christian All Denominations	16	18
Other	3	0
No Religion	10	12
No Answer Given/Declined	8	16

Disability	Strongly Agree/Agree	Disagree/Strongly Disagree
No	19	25
No Answer Given/Declined	10	14
Yes	8	7

These tables reflect the subjective views of complainants, but reflect the fact that complainants across a range of protected characteristics have been encouraged to and provided feedback on the process for making a complaint, and further work will be undertaken during 2018/19 to improve the positive feedback.

Workforce Profile broken down by protected characteristics

East Sussex Healthcare NHS Trust employed 7131 people as of 31st March 2018

Workforce breakdown by protected characteristics.

Gender	Number of Employees	Percentage of Employees (%)
Female	5523	77.5%
Male	1608	22.5%
TOTAL	7131	100.0%

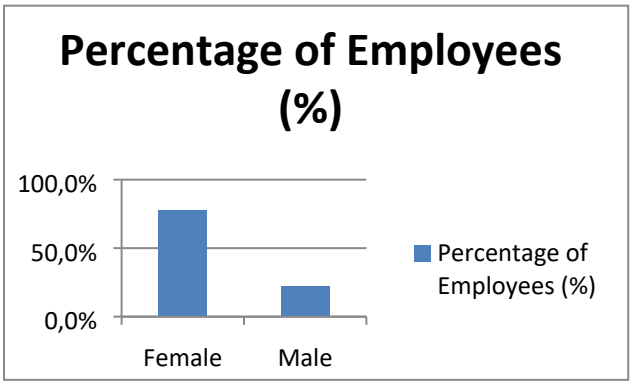
Ethnic Origin	Number of Employees	Percentage of Employees (%)
White British/White Irish/White Other	5490	77.0%
BME	912	12.8%
Undefined/Not Stated	729	10.2%
TOTAL	7131	100.0%

Age Group	Number of Employees	Percentage of Employees (%)
<29 yrs	1003	14.1%
30-44	2407	33.8%
45-59	2998	42.0%
60-79	723	10.1%
TOTAL	7131	100.0%

Religion	Number of Employees	Percentage of Employees (%)
Atheism	772	10.8%
Buddhism	41	0.6%
Christianity	2697	37.8%
Hinduism	100	1.4%
Islam	106	1.5%
Other	475	6.7%
Undisclosed/not stated	2940	41.2%
TOTAL	7131	100.0%

Sexual Orientation	Number of Employees	Percentage of Employees (%)
Bisexual	31	0.4%
Gay	35	0.5%
Heterosexual	4348	61.0%
Lesbian	31	0.4%
Undisclosed/ not stated	2686	37.7%
TOTAL	7131	100.0%

Disability	Number of Employees	Percentage of Employees (%)
Yes	190	2.7%
No	3571	50.1%
Not Declared/Undefined	3370	47.3%
TOTAL	7131	100.0%



Further breakdowns of data contained in this report are available upon request by contacting the Equality & Human Rights department.

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Appendix 3

ESHT 2015 – 2019 Equality Objectives

EDS2 Goal	EDS2 Goal	Method	Actions	EDS2 Outcome	EDS2 Outcome	Lead	Monitored / Reviewed
1	Better Health Outcomes	Review SI action points	Review learning from incidents to ensure we are not treating anyone less favourably and implement actions appropriately	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	1.4	Director of Nursing/ Patient Safety Lead	TNMAG EDS2/WRES SG
2	Improved Patient Access and Experience	Evaluate arrangements and awareness of existing interpreting and translation services	Enter a Service Level Agreement to implement a robust streamlined system providing easy access to interpreters. A post interpretation survey will be conducted by the interpreter. Raise staff awareness of access to interpreting service	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds People are informed and supported to be involved as they wish to be in decisions about their care People report positive experiences of the NHS	2.1 2.2 2.3	Company Secretary / EDHR Lead	EDS2/WRES SG
3	A Representative and Supported Workforce	Analyse percentage of BME staff at all levels of the organisation and ensure that the recruitment process is reflective of best practice.	Conduct analysis of BME staff at all levels and develop actions such as encouraging BME staff to participate in training and development opportunities Band 8+ recruitment panel will consist of a BME member or the EDHR Lead.	Fair NHS recruitment and selection process lead to a more representative workforce at all levels	3.1 WRES metric 1 & 2	Director of HR / Assistant Director Workforce Development	EDS2/WRES SG
4	Inclusive Leadership	Strategies, business plans and annual reports will require EHRA.	Approval of all strategies, business plans and annual reports that come before the Board, will be subject to completion of Due Regard, Equality & Human Rights Analysis, which includes how inequalities will be managed.	Papers that come before the board and other major committees identify equality –related impacts including risks, and say how these risks will be managed.	4.2	EDHR Lead / Assistant Director of Nursing (Safeguarding)	EDS2/WRES SG

ESHT 2015 – 2019 Equality Objectives Progress 2016-18

EDS2 Goal	Method	Actions	Completion/target date	Risk	Lead
1	Review SI action points	Review how learning outcomes link to incidents	May 15	Complete	DATIX Team SI Lead
		Triangulate SI, Learning outcomes	Dec 16	Complete	
		Review outcomes	Dec 17	On target	EDHR Lead
		Audit 2018 SI's	Mar 19	On target	EDHR Lead
2	Evaluate arrangements and awareness of existing interpreting and translation services	Service Level Agreement implemented with robust streamlined system providing easy access to interpreters.	Jun 16	Complete	Procurement Director, Corp Affairs EDHR Lead
		KPI's agreed	Jul 16	Complete	Capita EDHR Lead
		Training to raise awareness of access to interpreting service	Jul 16	Ongoing	EDHR Ass Capita
		A post interpretation survey will be conducted by the interpreter.	Jan 18	On target. Financial impact may be risk	Capita Service users
		Review post interpretation survey feedback	Jan 19		EDHR Lead Patient Experience team
		Review led to termination of contract – reprocurment required	Dec 18	Low numbers of Local interpreters	EDHR Lead/Procurement
3	Analyse percentage of BME staff at all levels of the organisation and ensure that the recruitment process is reflective of best practice.	Band 8+ recruitment panel will consist of a BME member or the EDHR Lead.	May 15	Ongoing. Risk of no BME staff at interview	Director of HR / Assistant Director Workforce Development
		Conduct analysis of BME staff at all levels and develop actions	May 16	Complete	
		Deep dive into BME recruitment (application – offer stage	May 17	Complete	
		Develop action plan to support BME recruitment embed into WRES	July 17	Complete	
			Mar 18	Complete	Recruitment Lead

		Likelihood - BME recruitment greater than White applicants. Recruiting panel to be established	Jan 19	Training staff availability/backfil	Recruitment Lead
4	Strategies, business plans and annual reports will require EHRA.	Policy Group to embed new EHRA into Policy for Policies New EHRA mandatory Audit Policies for EHRA uptake Audit Policies for EHRA uptake Audit EHRA quality Separate staff & Patient protected characteristic impact assessment	May 15 Jun15 Jun 16 Jun 16 March 18 Jan 19	Complete Complete 100% uptake 100% uptake Increased staff training	EDHR Lead / Assistant Director of Nursing (Safeguarding) Complete EDHR Lead

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