EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 9th February 2021 commencing at 09:30 via MS Teams

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 1st December 2020	A		
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback (including written reports from each Committee)	C	Committee Chairs	
6.	Board Assurance Framework	D	DCA	
7.	Chief Executive's Report, including Covid update		CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
8.	The Ockenden Review – ESHT response		E	Emma Chambers / Dexter Pascall	1015 - 1120
9.	Integrated Performance Report Month 9 (December) 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	F	CND MD COO CPO CFO	

BREAK

STRATEGY

					Time:
10.	NHSI Integrating Care Paper	Information	G	DS	1145 - 1155

GOVERNANCE AND ASSURANCE

					Time:
11.	Review of Corporate Documents	Approval	H	DCA/ CFO	1155 - 1215
12.	Paper for review and noting: • Charity Annual Report	Approval	I	DCA	

ITEMS FOR INFORMATION

				Time:
13.	Use of Trust Seal	J	Chair	1215 - 1230
14.	Questions from members of the public (15 minutes maximum)		Chair	
15.	Date of Next Meeting: Tuesday 9th March 2021		Chair	

Chairman

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

Steve Phoenix

17th December 2020

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 1st December 2020 at 10:30 video conference via Microsoft Teams

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

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

In attendance:
Mr Chris Hodgson, Director of Estates and Facilities (from item 077/2020 onward)
Mrs Tracey Rose, BFF Programme Director (for item 077/2020 only)
Mr Peter Palmer, Deputy Company Secretary (minutes)

070/2020 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting, and in particular Mr Aumayer and Mrs Argent to their first meetings of the Board.

2. Apologies for Absence
Mr Phoenix advised that no apologies for absence had been received.

071/2020 **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.

072/2020 **Minutes**
The minutes of the Trust Board meeting held on 6th October 2020 were considered and were agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

073/2020 **Matters Arising**

Recovery and Restoration – Relocation of Services
This was discussed under item 076/2020.

074/2020 **Board Committee Chair's Feedback**

i. Audit Committee

Mrs Webber reported that the Audit Committee had met on 26th November. The Committee had received a cybersecurity report; this acknowledged the risk that the aging IT infrastructure posed to the organisation, providing assurance about mitigations in place for addressing the issues. The Committee received a positive security annual report, despite increasing local levels of crime and violence. The Trust's tenders and waivers position continued to improve, a testament to the work of the team.

A report had been received from the Emergency Preparedness, Resilience and Response (EPRR) team who had reported that limited training had restarted in the Trust. Business continuity plans were being updated across the organisation, with good progress being made. The Committee received an update on the process for managing and updating policies within the organisation. Seven internal audits had been completed since the previous meeting. One was advisory, one had given substantial assurance and five gave reasonable assurance. There were no outstanding internal audit actions, which was a commendable position for the Trust.

ii. Finance and Investment Committee

Mr Phoenix reported that the Finance and Investment (F&I) Committee had met on 29th October. The Committee had discussed the in-year financial position which remained on target; a number of risks and challenges to the position were noted. Discussions had taken place about revised financial requirements for the second half of the financial year, and about the changes that might be seen in 2021/22. The Trust's capital plans were reviewed by the Committee.

iii. Finance and Investment (Strategy) Committee

Mr Phoenix reported that the Finance and Investment (Strategy) Committee had met on 26th November. The framework for refreshing the Trust's five year plan had been discussed, along with Building for our Future (BFF), and integrated care system collaborations.

iv. People and Organisational Development Committee

Mrs Kavanagh reported that the People and Organisational Development (POD) Committee had met on 19th November. The Committee had received the Integrated Care System's (ICS) people plan, which aligned with many aspects of work already underway at ESHT. The Committee had viewed the report positively, noting the increased collaboration being seen with the ICS and the good suggestions included within the plan.

The Committee had a received the workforce report. Appraisal rates had reduced in the Trust, partly due to an appraisal holiday for doctors' during the pandemic. Appraisals would be reviewed in greater detail by the Committee in the future. An analysis of exit interviews was being undertaken to see if any themes emerged, although Mrs Kavanagh noted that the Trust's turnover rate was not of particular concern. Vacancy figures had recently been rebased following the identification of a data error.

A report on psychological anxiety and stress had been received, highlighting initiatives available for staff and managers. The Committee had asked for hotspots for stress and anxiety to be identified to ensure that interventions were being made in the most needed areas.

v. Quality and Safety Committee

Mrs Churchward-Cardiff reported that the Quality and Safety (Q&S) Committee had met on 19th November. The Committee had received three annual reports:

1. Safeguarding, which had given high level assurance about processes; the main issue raised by the report concerned access to Child and Adolescent Mental Health Services, which was a long standing issue and outside of the Trust's control.

2. Infection Control, which had given significant assurance about processes and actions in place in the Trust. The report was for 2019/20, so had been written just before the first wave of Covid.

3. Maternity services, whose report had been very positive. The maternity environment was noted as a key risk for the maternity team.

The Committee had received an update on restoration and recovery to pre-pandemic performance levels and was pleased that progress was ahead of trajectory in a number of services. However, staff were under significant pressure in managing the restoration of services while continuing to manage covid patients and winter pressures. A new risk management policy had been approved.

075/2020 **Chief Executive's Report**

Mrs Chadwick-Bell presented a verbal update, noting that Monica Green had now retired from the Trust. She would be greatly missed, and she wished her well in her retirement. She welcomed Mrs Argent and Mr Aumayer to the organisation.

She reported that both elective and non-elective activity was slightly below the levels seen in 2019/20. The Trust was working with the ICS to ensure equity of access to services.

Covid continued to be managed within the Trust, with ring-fenced green and red elective capacity. She praised staff for their hard work, explaining that their dedication, hard work and commitment enabled the Trust to continue to offer patients excellent care. She noted that winter pressures would add to the workload of staff, and explained that staff wellbeing and recruitment were key priorities for the organisation. Other priorities included the management of covid, winter planning and key transformation programmes, including frailty, front door and discharge programmes, outpatient transformation and the delivery of financial sustainability.

An interim operational strategy had been introduced for winter, with enhanced management of site teams overseeing the flow of patients on a day-to-day basis. Cancer and outpatient services had been combined into a clinical support division, with a plan to add diagnostics to this following formal consultation. An Incident Control Centre had been re-established which would also help manage the pandemic and winter pressures.

The Board noted the Chief Executive's Report.

076/2020 **Integrated Performance Report Month 7 (October)**

i. Quality & Safety

Mrs Carruth reported that there had been an increase in falls during October, which was of concern. The number of falls resulting in harm had also increased. A cluster review was being undertaken by the medical division. The enhanced infection control demands of covid presented additional challenges in reducing falls; some areas had needed to keep curtains pulled between patients, reducing visibility of patients, and the need to don PPE had led to slower response times. Trials of screens to physically separate patients had been successful, and these would shortly be installed in key clinical areas. Patients were being supplied with fluid resistant surgical masks and asked to wear these for as long as they could tolerate. It was hoped that these measures would help reduce falls.

Mrs Carruth reported that the hospital continued to remain safe, providing high quality care for patients. Staff were busy, but managing well, although were concerned about the challenge of managing a second wave of covid and winter pressures.

Dr Walker reported that covid rates in East Sussex had risen during November, and had peaked on 24th November; they remained significantly below the national average, but were higher than in some surrounding areas. There had been a reduction in cases in the community in the previous few days, but otherwise the effects of the second lockdown were yet to be seen. Covid mortality rates during the second wave had been about a tenth of those seen during the first wave.

The Trust's Summary Hospital Level Mortality Indicator (SHMI) had stabilised in October at 96; the Risk-Adjusted Mortality Index (RAMI) was higher than at the same time in 2019/20, but remained ahead of peer organisations. Dr Walker explained that patients who had not presented at hospital due to the first wave of the pandemic were now attending and anticipated that their worsening health would likely lead to an increase in crude mortality. Some patients remained concerned about coming into hospital.

Mrs Manson asked about the increase in clostridium difficile (c.diff) cases seen in September. Mrs Carruth explained that the Trust remained within the threshold for cases. Each of the cases was subject to post-infection review, with antimicrobial ward rounds increased in some areas. She explained that she had no particular concerns about the increase.

Mrs Fadero thanked teams for the excellent work they were doing under difficult circumstances. She asked whether the Trust was an outlier for falls in comparison to other Trusts. Mrs Carruth explained that chief nurses from across the system continued to meet on a weekly basis to discuss shared issues. Other Trusts were reporting similar numbers of falls and learning was shared across the system. The increase in falls were due to a combination of challenges including visibility of patients due to Covid, enhanced PPE and a stretched workforce. No particular trends or themes had been identified, but a cluster review would be undertaken to identify learning.

Mrs Churchward-Cardiff explained that discussions had taken place at Q&S about how the perspective on patient falls could be altered within the organisation to one where it was assumed that patients would fall. This was being considered within design work for Building for our Future (BFF). She

asked for further information about c.diff infections reported in October, noting that three of the four were marked as Hospital Onset Healthcare Associated. Mrs Carruth explained that all infections were subject to a post infection review, led by Infection Control team. A report would be presented to Q&S once the reviews had been completed.

Mr Phoenix asked whether the measures to reduce falls being introduced were effective and Mrs Carruth explained that the Trust was not a significant outlier in the rate of falls being reported, compared to other organisations. The Trust had joined a national collaborative with NHSI/E to reduce falls.

Mrs Fadero asked that a report including benchmarking data for falls and best practice examples be presented to Q&S in the future.

ii. Access and Delivery

Mrs Argent explained thanked staff for their hard work during a recent period of operational pressure. She explained that the Trust was performing well against its recovery trajectory and contributing to the achievement of system-wide phase three recovery targets. During October, the Trust's performance for day cases had been 84% of its previous year's activity, elective inpatient performance had been 88%, new outpatient performance at 89%, and follow up outpatient performance had been 87%. These Trust's diagnostic performance continued to improve.

Almost all services that had been stopped during the first wave of the pandemic had been restored. Directly bookable appointments had not restarted and would resume when it was safe to do so. Repatriation of gynaecology services from the independent sector back to the Trust's main sites was ongoing, and the private patient service at EDGH had been restored on an ad hoc basis. Community paediatric services had been restored, but were not operating at pre-covid levels.

A&E performance during October had been 90.1%. 111 First had launched nationally, with directly bookable appointments available with GPs, Pharmacy, the Urgent Treatment Centre, A&E or for self-care. The Trust had provide support to Brighton and Worthing with their roll outs of 111 First. The Trust had been fourth in the country for Referral To Treatment (RTT) performance in October, at 83.65%.

The Trust was focussed on continuing to improve diagnostic performance. A mobile CT scanner was being used to increase capacity once a week, and diagnostic capacity would remain a priority for the Trust if there was a second wave of the pandemic. 101 patients had been waiting for more than 52 weeks for treatment, and 83 of these now had plans in place. The Trust's performance against the 62 day cancer target had been 75.69% in October. 34 patients had waited for more than 104 days for cancer treatment, and 136 patients had waited for more than 62 days; the Trust was working hard to address this backlog and deliver the best possible care for patients.

Mrs Churchward-Cardiff acknowledged how hard staff were working to recover the Trust's performance but noted concern about the Trust's diagnostic backlog, and performance in discharging patients by midday. She asked about the key risks and areas of focus for the next couple of months. Mrs Argent explained that the Trust's diagnostic backlog was comparable to other Trusts in the country and would be an area of focus over the coming months. The backlog in endoscopy was being addressed using a system-wide approach.

She explained that discharges remained a key area of focus for the Trust, and a hospital director had joined the organisation with a primary focus on early discharge of patients. Improving early discharge would be a very visible target for the organisation moving forward. A system where patients were issued a 'ticket home' with an anticipated discharge date when they came into hospital was being considered.

Mrs Chadwick-Bell explained that a system approach to discharge was being taken with a senior member of staff leading on end-to-end discharge of patients across CCGs and social care. An accountable officer conversation at system level took place every week, and discharge remained a key focus for both the organisation and system.

Mrs Manson praised the progress being seen and noted a fluctuating pattern of upper gastrointestinal two week referrals being seen; she asked if this was a concern. Mrs Argent explained that the numbers of referrals were small; weekly cancer access meetings took place, prospectively looking at next couple of weeks, and was being managed as part of the diagnostic backlog.

Mrs Fadero commended the brilliant performance of the organisation and the well-presented IPR report. She asked about the anticipated outputs from the introduction of 111 First, asking whether the previous work undertaken by PA Consulting would help improve diagnostic capacity. Mrs Argent explained that the work undertaken by PA Consulting had focussed on outpatients, so had not focussed on diagnostic capacity. She agreed to feedback on potential outputs from 111 First outside of the meeting.

Mrs Fadero asked about any mental health elements linked to 111 First and Mrs Chadwick-Bell agree to feed back about this outside the meeting, noting that patients with mental health issues should continue to attend A&E.

Mrs Chadwick-Bell praised the work of community teams who had been supporting discharge in an integrated way by running discharge hubs. She explained that community teams, including district nursing and crisis response, had restored their services, while also being extremely flexible in supporting patients to get out of hospital quickly.

iii. <u>Leadership and Culture</u>

Mr Aumayer explained that a review of the Trust's establishment would be undertaken over the next couple of weeks; he expected this to result in vacancy rates returning to expected levels. Sickness rates in the Trust had reduced from those seen between November and June, but levels of anxiety and stress amongst staff were higher than the previous year and staff were being supported in a number of different ways.

Appraisals rates had slightly reduced, partly due to the suspension of doctors' appraisals, and divisions were working hard to increase these in a supportive manner. The annual Staff survey had closed, and had seen a response rate of 51%, against 50% the previous year. The results of the survey were anticipated in early 2021.

Lateral flow tests had been given to staff to allow them to self-test for covid. The Trust had received 3,500 testing kits, each containing 25 tests and these were being distributed. A task and finish group was meeting on a daily basis to ensure that the organisation was ready to commence staff vaccinations for covid as soon as they were available.

Mrs Churchward-Cardiff asked whether the number of staff working from home and unable to work was increasing. Mr Aumayer explained that the occupational health team were doing a fantastic job in supporting staff, identifying those who should work from home or shield. Activities had been identified that staff who were required to shield could undertake, with some working as interviewers for mass vaccinations across the system. It was important to balance keeping staff safe and continuing to run the Trust and this was being closely monitored.

Mrs Churchward-Cardiff asked what action was being taken to address late notifications of leavers. Mr Aumayer explained that he had noticed this issue soon after joining the Trust and would be prioritising this moving forward. Mr Reid noted that this was an indication of in-month control, and not a sign of failure to pay by any individuals. Staff who were overpaid on leaving the Trust were asked to repay any outstanding monies.

Mrs Kavanagh asked why it was difficult to roster six weeks in advance. Mrs Carruth explained the process for approving rosters, noting that any gaps in rotas were submitted to Temporary Workforce Services so that they could be filled. Any issues was discussed in detail at divisional performance reviews. There were challenges in some areas due to the different timescales for nursing and consultant rotas and work was being undertaken with workforce teams to ensure reporting to divisions was as helpful as possible. A report on rostering would be submitted to POD in the future.

iv. <u>Finance</u>

Mr Reid explained that during the first six months of the year the financial regime for the Trust had been established using a base-line from months 8-10 of 2019/20, with additional top-ups offered to ensure that Trusts reached a breakeven position. The regime for months 7-12 of 2020/21 was based on similar assumptions but with additional checks by the centre, leading to a revised financial position for the year. A revised budget for the year had been agreed, with additional spending required to meet recovery and restoration targets.

The Trust had seen a significant underspend against divisional income due to the focus on core treatments, and an increase in additional spending related to Covid. The Trust had recruited more staff through temporary and permanent staffing than the previous year, and had also seen increase in agency staffing. The Trust had received money in advance to ensure that there was no pressure to collect payments, and to ensure that staff were paid on time during the pandemic.

Mr Reid explained that the Trust was £2k ahead of its financial plan for the year at month seven. The financial challenges would increase during the rest of the year, with increasing restore and recover targets, winter pressures and the second wave of Covid all likely to have an impact.

Capital spending was slightly below the annual plan, but a number of schemes had recently been approved. Mr Reid anticipated that significant expenditure would be undertaken during the final six months of year. £45m of plans against the total capital of £56m were in place, and he anticipated that the Trust would come very close to spending all of capital budget.

Mrs Kavanagh asked whether divisional pay overspend on staff was due to

Covid. Mr Reid explained that most of the overspend had been due to bank and agency staff as a result of the pandemic, which could be reclaimed.

Mr Patel asked whether the residual risk previously reported to the Board about the Trust's claim for Covid costs in Quarter One had been resolved. Mr Reid explained that this was still outstanding, but anticipated that this no longer constituted a risk to financial performance.

Mrs Churchward-Cardiff asked whether the Trust would be subject to financial penalties if restore and recover trajectories were not met. Mr Reid reported that no penalties had been applied by the ICS, but noted that it was possible that financial incentives might be applied during the next five months.

Mrs Churchward-Cardiff asked how business planning for 2021/22 was progressing and Mr Reid confirmed that planning had started. Draft baselines were being prioritised, with a pragmatic approach being taken. Initial plans would be presented to the F&I Committee in January.

Mrs Fadero noted the importance of working in partnership in East Sussex at place level and asked whether there were any financial and operational risks at Integrated Care Partnership level with partners in local authorities. Mr Milner explained that regular conversations took place across the system about plans for integrating health and social care, but that he was unsure of any specific risks. Mrs Chadwick-Bell noted that the ICS were working to fully understand what a place based budget would look like for East Sussex.

The Board noted the IPR Report for Month 7 and actions in place

077/2020 **Building for our Future**

A video explaining the Building For our Future project was shown to the Board. In response to a query from Mr Phoenix, Mrs Chadwick-Bell explained that it wasn't anticipated that any major reconfiguration of services would be undertaken under BFF. Consultation for potential changes to cardiology and ophthalmology had already begun and would be subject to public consultation.

She noted that maternity services were of particular interest to the Save the DGH campaign, who would like to see obstetric services return to Eastbourne. A review of the original maternity case for change would be undertaken to see if the rationale for change remained the same. This would be shared with the Board when completed. She noted that this did not mean that the model for the delivery of maternity services would change, as this had been looked at on a continual basis over last few years.

The Board noted the Building for our Future Update.

078/2020 **Quality Account 2019/20**

Mrs Carruth explained that the annual Quality Account would normally be received by the Board at the AGM; however, reporting had been delayed nationally due to the pandemic. The priorities identified for 2019/20 had been achieved and the new priorities for 2020/21 were:

- Embedding patient safety
- Infection Control excellence
- Perfecting discharge

She thanked staff for their hard work in making progress with the 2019/20

priorities and explained that a continued focus on a range of quality improvements and initiatives continued within the organisation, not all of which were included within the Quality Account.

Mrs Churchward-Cardiff confirmed that the Q&S Committee had approved the Quality Account, explaining that it provided a good overview of the work that had been undertaken within the Trust during the year.

Mrs Kavanagh asked about feedback from Healthwatch about the accessibility of the report. Mrs Carruth explained that the format of the report was nationally mandated, so the Trust had very little control over how it looked. Colleagues worked hard to try ensure that the document was as accessible as possible, and it was made available in differing formats and languages on the Trust's website. She thanked Healthwatch for their continued support for the Trust. Mrs Wells noted that a shorter, more accessible version of the Annual Report and Quality Account were normally written for the AGM.

079/2020 **Winter Flu Plan**

Mr Aumayer presented the report, noting that winter flu vaccinations had recently been stopped in line with national guidance, in order to prepare for the Covid vaccination. 82% of staff had received the flu vaccination, compared to 52% in 2019/20 and he thanked the vaccination team for their hard work.

He explained that iPads had been used to allow staff to self-report their staff groups, due to covid, which had resulted in some staff groups reporting more than 100% vaccination rates. This would be reviewed for the following year to ensure that data was accurate.

Mrs Churchward-Cardiff asked how absences due to flu were managed for staff who were not vaccinated. Mr Aumayer explained that the Trust did not make any staff have the vaccination, and therefore sickness would be managed in the same manner as for any other member of staff.

Papers for Review and Noting

080/2020 Learning from Deaths, Quarter One

Dr Walker presented the report, explaining that it showed two deaths as a result of nosocomial Covid infections. Both had been classified as potentially avoidable. He explained that in both cases, patients were elderly and very frail, and that the nosocomial infection were unlikely to have affected the patients' outcomes.

The Board noted the Learning from Deaths report.

081/2020 Infection Control Annual Report

Mrs Carruth presented the annual report. She explained that she would be meeting with the head of Infection Control and the governance team to identify if additional data could be taken from the Assure system around hand hygiene, as this had been the subject of detailed discussion at Q&S. She explained that the following year's report would have a large focus on Covid.

The Board noted the Infection Control Annual Report.

082/2020 Complaints Annual Report

Mrs Carruth presented the annual report, noting that it had been approved by the Q&S Committee.

The Board noted the Complaints Annual Report.

083/2020 Safeguarding Annual Report

Mrs Carruth presented the report, explaining that the service had had a challenging year due to vacancies and sickness.

The Board noted the Safeguarding Annual Report.

084/2020 **Trust Board Meeting Dates 2021**

Mr Phoenix noted that the Board dates had been moved back by a week in 2021 to allow more time for papers to come from Committees.

The Board noted the meeting dates for 2021.

085/2020 **Use of Trust Seal**

There was one use of the Trust Seal reported:

Sealing 58 – Salisbury Trading Ltd, 1st October 2020
Laundry Lease at EDGH for a 3 year term.

086/2020 **Questions from Members of the Public**

Mr Phoenix noted that a number of questions had been received from Mr Colin Campbell in advance of the meeting. Mrs Wells explained that she would reply to him directly, but asked a couple of questions on his behalf:

BFF
Have we looked at recent other hospital builds in the UK and elsewhere to identify best practice? Mrs Chadwick-Bell explained that the Trust was working closely with NHSE, health planners and other Trusts to take advice on best practice. Mr Hodgson explained that the Trust had formal links with NHSE/I as well as informal links through a network. Specialist advisors would be used to ensure that the latest advice and thinking was included in planning.

Patient Discharge
Does the Trust follow up on discharged patients to ensure that actions in discharge plans had taken place? Mrs Chadwick-Bell explained that not all patients were followed up post-discharge. Patients discharged to home could be followed up by crisis response if required, or by placing them on the Home First pathway introduced due to Covid. Healthwatch had been commissioned by the CCG to do long-term piece of work looking at the potential to follow up of patients on day 14 or day 28. She explained that it would be very challenging to follow up every patient who was discharged.

BFF and Maternity
Mrs Walke explained that she had been very pleased to have recently met with Mrs Chadwick-Bell, and that the original case for change for maternity would be subject to review. She explained that the necessity for 2,000 births included in the original case may no longer be essential. She hoped that relations between Mrs Chadwick-Bell and Save the DGH would be very positive, and hoped that BFF and the reviews might lead to consultant led obstetric services returning to Eastbourne. She also hoped that independent reviews of the service could be included within the process.

Mr Phoenix noted that the expectation was that any review would not lead to a change. Mrs Walke explained that she understood this, but felt that the expectation of people in Eastbourne is that maternity services would return. She appreciated that Board's current position, but expressed hope that this

might change in the future.

Mrs Chadwick-Bell recognised that the views of the Trust, Save the DGH and the public might not align and explained that the review would help in restating the position on maternity. Mrs Walke explained that she was pleased with the approach being taken.

087/2020 **Date of Next Meeting**
Tuesday 9th February 2021

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Meeting of the Board on 1st December 2020.

Questions from the public.

1. Re the contract with 111 First, how will this contract be monitored and managed to ensure that performance is of an acceptable standard, offering value for money and improving the process? Also what reporting requirements have been included in the contract?

   This is a question for local commissioners as they hold this contract. However, we will monitor agreed quality metrics and discuss these with the provider/commissioners.

2. Re the Building for Our Future consultation has a permanent internal staff cross-discipline board been created to empower staff a voice in this programme?
   Yes a programme Board and governance framework has been established

3. Can the Trust please advise where the details of the Integrated Care Programme and Integrated Care System have been published so that the impact of those projects on the Building for Our Future programme can be cross checked?

   We do not administer these meetings but website is https://www.sussexhealthandcare.uk/ and you can post an enquiry here

4. Can the details of the Building for Our Future partners and the minutes of the programme board be published with the same level of detail as that which was published for the East Sussex Better Together project?

   BFoF is our capital development programme and although we have no plans to publish the minutes it will be a regular item on the Board agenda.

5. Why was it necessary for PA Consulting to be employed in re-designing the care pathways? Surely this type of project is better undertaken using internal staff resources like the Improvement Hub and Programme Board bearing in mind the extensive exercises undertaken within the East Sussex Better Together project?
   It is a capacity issue and the need to have specialist skills but our staff are very much involved and work alongside PA Consulting

6. Will the Patient Flow programme be checked for performance and quality using feedback surveys?

7. Within the Integrated and Quality Performance Report can labels be appended to lines appearing on graphs or at least keys be given where they currently are missing e.g. Safe Care- Incidents?
   Will feed this back to the team that present this

8. Where Control Limits are referenced are these realistic in their values for reporting purposes or should the target for each be set at zero?
   They are realistic and are reviewed and readjusted regularly.

9. Are the data for falls, pressure sores and complaints analysed by originating source to establish if there is any commonality of occurrence?

   Yes they are and each ward/department and division review those related to their area and at Q&S themes and trends are considered.

10. Where the list of causes of deaths for October was published it would have been useful to have that data shown for a 12 month period. Is this possible?
    The Medical Director advises that there would be limited benefit to doing this as the causes of death are generally consistent, with of course the exception for Covid.

11. Also are all deaths attributed to Sepsis/septicaemia reviewed for the possibility of prevention?

    Yes all deaths are reviewed for learning.

12. Within the Personnel reporting can a definition of FTE be provided?
    Full Time Equivalent

13. If one third of the salary overpayment is due to late notification of leaving, what causes the other two thirds and are they being removed?
    See finance response

14. Within Access and Responsiveness is it possible to measure the impact of Covid-19?

    Not specifically as it has had a wide impact eg elective surgery was cancelled, wards have been reconfigured to red and green pathways.

15. What is an Intermediate Care Unit and how does the Nerve Centre operate?

    An intermediate care unit is a step down facility for those who don't need acute care eg Bexhill Irvine unit. Nerve Centre helps us with patient

safety and flow by tracking a patient's journey from for example ED to ward. It also assists in identifying where we have spare bed capacity.

16. Could the Trust publish data for Emergency Re-Admissions within 15, 30 and 45 days of discharge?
We only report 30 days as this is the national standard

17. Does every patient leave with a Discharge Plan and is a copy of the Discharge Plan given to their next of kin?

Yes every patient receives a discharge letter – this is also sent to their GP. It is not automatically shared with NoK unless the individual does not have capacity.

18. Does the Trust currently follow up on discharged patients to ensure that the expectations of action by other care providers identified in Discharge Plans has taken place?

Not routinely but dependent on condition some patients discharged home do get a follow up call and they are given a contact number. Some patients are also supported by Crisis Response and Home First.

19. Within the Financial Reporting what is the value in using planning average data to compare against actual when there is presumably a set of budget figures available?
See Finance Response

20. Why is the phrase Operational Deficit used in the Operational Deficit year to Date tile? Surely this is an over expenditure and not an operational deficit as no income is shown in the tile?
See Finance Response

21. Within the Divisional Performance tile what is the explanation for a value for Actual FTE's but no Plan FTE's?
See Finance Response

22. What are the constituent elements of the Financials shown against Divisional Expenditure?
See Finance Response

23. With the Divisional Expenditure where there are losses shown for the Year to Date what action will be required to recover those losses by the end of the financial year?
See Finance Response

24. What are the values of the Block contract and where can they be found in the IPR?
See Finance Response

25. What exactly are the Block Contract issues notified to NHSE/I?
See Finance Response

26. Will the Block Income gap continue and if so what will be the magnitude of the gap at the financial year end?
See Finance Response

27. What does the M7-M12 Run Rate actually describe in terms of the Financial Year Outturn Forecast?
See Finance Response

28. Could we rename the Statement of Financial Position as either the Balance Sheet or a Statement of Assets and Liabilities? The use of the phrase "Financial Position" is misleading.
See Finance Response

29. Can the purchase ledger and other payment runs made by the Trust be adjusted to absorb the high levels of cash that appear on the balance sheet at the month end?
See Finance Response

30. Will the Building for Our Future look at recent new hospital builds in the UK to measure or identify best practice or at least to try and avoid the issues that have arisen with some e.g. Liverpool and Glasgow?

Yes we are reviewing other new builds with specialist advisers and have had conservations with many other Trusts and there is a formal structure in place through NHSI/E..

31. Will the Building for Our Future programme revisit the issues around the provision of transport between sites?

This is not part of the programme.

32. Within the papers prepared for the combined Sussex Primary Care Commissioning Committees in common there was a paper entitled Public Involvement in Governance which contained a proposal on the providing greater access for the public to discuss agenda matters with the representatives from the CCG. Given that there is much that is likely to change within the NHS over the next few years would the Trust agree to

review the contents of this CCG paper and consider offering the same level of access to members of the public attending ESHT Board meetings?

Will review it but it may be that we do other engagement events as there is limited time at the Board already.

33. Can the Trust please explain why it was felt necessary to amend the financial reporting and remove the Income and Expenditure statement and the 12 month Cash Flow Forecast from the Board pack? The current quality of the financial reporting is not as clear as it used to be and could even be described as obfuscatory. Given the Trust's financial history, a clear and easily understood statement of the Trust's financial performance should be provided to give confidence to the taxpaying public that limitations in service provision through adverse financial outcomes will not happen.

See Finance Response

34. Will the Trust undertake to publish on its website the minutes of all committees and programme boards on which members/employees of the Trust sit or participate? Minutes of the Trust's committees used to be included in Board packs but this is another area of information that has disappeared.

We do not have plans to do this – some of the minutes include confidential discussions and therefore it would not be appropriate. Our papers are scrutinised by the media and it also has the impact of inhibiting discussions or the quality of the minutes if some matters are then in the press and the full picture is not reported.

Colin Campbell, 27/11/20.

East Sussex Healthcare NHS Trust

#	Question	ESHT Response
1.	If one third of the salary overpayment is due to late notification of leaving, what causes the other two thirds and are they being removed?	The key other reasons for overpayments include incorrect sick pay, incorrect hours and salary sacrifice. In addition, there are also other minor reasons.
2.	Within the Financial Reporting what is the value in using planning average data to compare against actual when there is presumably a set of budget figures available?	The NHS implemented a financial regime for the first 6 months of the 2020/21 financial year which included block payments and a top up income mechanism which was based on M8-M10 2019/20 level. Therefore this was the 'benchmark' that performance needed to be monitored against. Guidance has recently been issued by NHSE/I and budgets have been issued. Consequently, going forward the Trust will be monitoring performance against budgets.
3.	Why is the phrase Operational Deficit used in the Operational Deficit year to Date tile? Surely this is an over expenditure and not an operational deficit as no income is shown in the tile?	The Trust is on a block income contract therefore it is correct to use operational deficit.
4.	Within the Divisional Performance tile what is the explanation for a value for Actual FTE's but no Plan FTE's?	The Plan FTE is shown in the divisional performance tile (please see first column after divisional name column).
5.	What are the constituent elements of the Financials shown against Divisional Expenditure?	All of the constituent expenditure elements that are reported at Board level are also reflected in Divisional expenditure reporting (they are not included in the Trustwide IPR due to space constraints but divisions do receive this information).
6.	With the Divisional Expenditure where there are losses shown for the Year to Date what action will be required to recover those losses by the end of the financial year?	Each division has a financial action plan which identifies financial risks and mitigations to address overspends.
7.	What are the values of the Block contract and where can they be found in the IPR?	The income block value is stated in the income YTD tile (top row, left hand corner).
8.	What exactly are the Block Contract issues notified to NHSE/I?	The income block contract issues relate to lost non-NHS income e.g. non-staff car parking, private patient, catering, overseas patients etc that we may not be able to recover.
9.	Will the Block Income gap continue and if so what will be the magnitude of the gap at the financial year end?	All NHS organisations have been asked by NHSE/I to recover income to 19/20 levels. ESHT is focusing on achieving this. The forecast level of lost non-NHS income is £4.4m.
10.	What does the M7-M12 Run Rate actually describe in terms of the Financial Year Outturn Forecast?	The key elements are that it shows the planned operational deficit and what the actual deficit is (please look at the first three rows as this will give you the Trust overall performance).
11.	Could we rename the Statement of Financial Position as either the Balance Sheet or a Statement of Assets and Liabilities? The use of the phrase "Financial Position" is misleading.	International Accounting Standards mandate what the primary financial statements labelling. Consequently, the Trust uses the terminology set out in these standards.
12.	Can the purchase ledger and other payment runs made by the Trust be adjusted to absorb the high levels of cash that appear on the balance sheet at the month end?	Yes, this is what the Trust is doing to reduce the cash balance.

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 1st December 2020 Trust Board Meeting

There were no matters arising from the Board meeting on 1st December 2020.

Item 5Ci - 28th January 2021 Audit Committee Summary

1. Introduction
An Audit Committee was held on 28th January 2021. A summary of the meeting is set out below.

2. Impact of EU Exit
A paper setting out the impact of the EU Exit on the Trust was received. It was noted that the process was being well managed, with any issues discussed on a daily basis at IMT meetings, and with the trade deal concluded materially mitigating key risks previously identified.

3. Tenders and Waivers
Good progress in reducing the number of waivers issued was noted. Processes for estates contracting had been strengthened in the update of Trust governance documents, which should help to realise a further reduction in the future. Reporting to be aligned with governance processes.

4. Review of Corporate Governance Documents
A full review of the Standing Financial Instructions, Standing Orders and Scheme of Delegation had been undertaken and was presented to the Committee. Thresholds for the approval of business cases, contracts etc. had been standardised in order to simplify the process for staff. The Committee approved the changes for presentation to the Board.

5. Board Assurance Framework and Risk Register
Increasing risk ratings in some areas of the BAF due to the pandemic were noted. New risks from the Trust Covid risk register had been included. The Committee agreed to recommend to the Board that the BAF5, protecting staff, should be updated to include risks associated with Covid, having previously focused on violence and aggression for staff. This could lead to a change to the risk rating.

6. Information Governance Update
It was reported that one data breach had been recently been reported to the ICO, which had been due to human error. The ICO had confirmed that no further action would be taken and had closed the matter. It was noted that the annual DSPT toolkit submission might be delayed due to the pandemic.

7. DPST Toolkit Report
32 Information Governance breaches had been reported to date in 2018/19, an increase on the previous year. All of the breaches were low level, with none having to be reported, and it was felt that the increase was a result of improved awareness of Information Governance within the organisation.

8. Losses and Special Payments
Pharmacy write offs, due to reduced activity because of covid, and the process for recovering outstanding debts for the treatment of overseas patients were discussed. Confirmation that no material dated or otherwise unrecoverable balances remained within the balance sheet was requested.

9. Internal Audit
One final report had been issued since the last meeting, concerning workforce pre-employment checks; this had received reasonable assurance. Four draft audit results had been issued. Issues with the completion of the 2020/21 workplan due to the pandemic were discussed, and the draft audit plan for 2021/22 was agreed.

10. External Audit
The extended external audit timetable for the annual report and accounts for 2020/21 were discussed, along with the potential difficulties of undertaking stock audits remotely and in light of social distancing.

11. Local Counterfraud Service
An update was received from LCFS, who were commended by the Committee for their proactive approach to staff training during the pandemic.

Nicki Webber
Chair of Audit Committee
01.02.21

East Sussex Healthcare NHS Trust

Finance & Investment Committee

1. Introduction
A Finance & Investment Committee was held on 17 December 2020. A summary of the items discussed is set out below.

2. Month 8 Financial Performance
An update on Month 8 Financial Performance was given and the potential risk with regard to historic invoices and NHS Property Services was noted. The ICS were keen to escalate this for both ESHT and also for SCFT

3. Month 8 Capital Programme
The 2020/21 capital plan was noted, including the financial performance to the end of November, the financial risks pertaining to the delivery of the capital programme and the revised Capital Resource Limit.

4. Building for the Future (BFF) Draft Strategic Outline Case (SOC) (financial chapters)
The Financial Case and Economic Case that formed part of the Strategic Outline Case (SOC) for the Building For Our Future (BFF) project, and a slide deck that detailed key elements of work performed to date, and the associated issues were presented. The work will continue to be progressed on development of these chapters and this will be brought back to a future F&I Committee for feedback and formal approval before formal submission.

5. Productivity & Efficiency Update
The progress against the Trust 20/21 efficiency plan and the developing plan for the "£28m" Programme and noted. Planning for 21/22 is underway and would be year 1 of the "£28m" Programme.

6. 2021/22 Financial Planning
NHSE/I have yet to issue planning guidance so the assumptions might need to be revisited in light of this guidance. Further information would be provided in January once the guidance was available.

7. ICS Update
Modelling was continuing and the target for next year would include an ICS wide target as well as a Trust target.

8. Commercial Update
The Committee received an update on Commercial Projects.

9. Digital Pathology Business Case for Sussex Trusts
The Digital Pathology Business Case for Sussex Trusts was presented to the Committee. This was considered and approved in principal subject to receiving further clarity on the points provided

10. Annual Work Plan
Members reviewed the Annual Work Plan for the Committee.

Steve Phoenix
Chair of Finance & Investment Committee

21 January 2021

POD Committee Executive Summary 21 January 2021

Meeting information:	
Date of Meeting:	Agenda Item:
Meeting: Trust Board	Reporting Officer:

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 that was held on 21 January 2021. The meeting scheduled for the 10 December 2020 was cancelled.

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 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 21 January 2021. A summary of the items discussed at the meeting is set out below.

2. Review of Action Tracker

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

3. Workforce Status

The Head of Workforce provided an overview of the workforce status.

Staffing profile and context

Wave 2 of the pandemic has significantly impacted on the workforce resulting in staffing gaps; there is a lower supply of staff due to absence with an increase in demand and activities.

Workforce sickness

ESHT currently has 531 total staff sickness with 235 Covid related. Staff isolating had reduced slightly although 80% of these staff are unable to work from home.

Current workforce

Redeployment has been challenging due to activities and services not being suspended as per Wave 1 of the pandemic. 250 staff have been redeployed supporting clinical and non-clinical areas, students have commenced early and surgeons have been supporting ICU. Support has also been provided by Kent Community and the military.

Retention & Turnover

Retention remains stable and turnover continues to be consistently under 10%.

Recruitment

Recruitment continues to be a key focus. The Trust has seen a 30% increase in applications from the UK which equates to 20,000 applicants year to date. There have been challenges regarding travel corridors but pleased to report that 20 overseas nurses are due to commence shortly. Temporary workforce costs have increased due to Covid and operational pressures.

4. Workforce Welfare

The Assistant Director of HR, OD, provided an update on the work being undertaken for the health and wellbeing of staff during Covid and referred to the Health and Wellbeing Strategy: "We want our colleagues to know we care and that we are in this together as well as feeling safe". Key highlights:

- Accelerated recruitment process, redeployment and working with other health care providers and agencies to seek additional support.
- All wards receiving lunch and supper every day for the whole ward – highly commend the catering team for their support.
- Introduction of "wobble rooms" for staff to go to during shifts.
- Introduce memory trees/boxes for both patients and staff.
- Working group in place focussing on supporting staff who are absent from work due to stress/anxiety and depression.
- Psychological support for teams.
- Trauma therapy for individual staff members suffering PTSD.

- Financial wellbeing advice.
- Time to Talk Service available for any member of staff who needs to talk.
- Care First – free counselling 24 hours a day, 365 days a year.

5. Guardian of Safe Working Hours Report

The Guardian of Safe Working Hours provided a verbal overview of the Guardian of Safe Working Report which covered the 3 induction months for the DiT (Doctors in training) joining the Trust or starting new posts. The Report covers approximately 240 trainees. Key Issues:

- GOSWH fines – balance stands at £14,245.64 after penalty fines paid.
- 21 work pattern/work schedules have been implemented to reflect the revised rules on safety and rest limits.
- A work pattern review is required to resolve the difficulties to take annual leave.
- Important that all trainees have been risk assessed during this second wave of the pandemic and take into consideration for rota gaps and redeployment.
- Additional funding of £60,000 was made available to the Trust in 2019 negotiated under the BMA Fatigues and Facilities Charter.
- Junior Doctor Forums meet quarterly.
- Exception reports have decreased.

6. Supplementing the Workforce

The Chief People Office provided an overview of the Supplementing the Workforce paper and highlighted the importance of accelerated recruitment and onboarding; employing people into the organisation quickly and as safely as possible through the relevant risk assessments:

- Onboarding risk assessment
- Equalities risk assessment
- Divisional risk assessment

The Chief People Officer asked the POD Committee to support accelerated recruitment; all POD Committee members present agreed to support this process.

7. Vaccinations

The Chief People Officer provided an update on Covid Vaccinations:

- Over 10,000 delivered to date within the Trust
- Patient facing staff vaccinations complete; now open to all staff across the Trust.
- Delivering vaccines to other health and social care organisations and working with the local authority.
- All appropriate staff within health and social care captured including contractors and security guards.
- Over 70 care homes have been approached.
- 108,000 require vaccinations throughout the community.
- Following the national instruction to deliver 2nd doses at 12 weeks.
- Current data issues on the National Immunisations and Vaccination System (NIVS) which should be closed today.

Approved minutes of the meeting held on 19 November 2020 are attached for the Board's information.

Miranda Kavanagh
Chair of POD Committee
January 2021

Quality and Safety Committee Report 21st January 2021

- The Quality and Safety (Q&S) Committee last met on the 21st January with reduced attendance required given the operational pressures related to COVID 19.

- The Committee received assurance on a number of actions on the action log which demonstrated continued effort to close out issues.

- In regard to the Board Assurance Framework (BAF) and High Level Risk Register, some updating is required and it was suggested that controls could now relate to Covid as much as the original risk. For instance, capacity is not just about beds or appointments but equally concern staffing.

- There was a concern as to whether COVID is all consuming for our staff and as such there may be limited ability to report or review risks and how the risk may be being affected by COVID.

- Under quality governance the Committee remain concerned over the fall rate (6.9). There has been a fall in incident reporting but the rate of no harm remains stable. There were two Never Events reported, both related to not following procedure and human error. A review of Amber and SIs was conducted given the number but no common themes were addressed using current criteria. In future reviews will also consider context and operational risks.

- The Committee felt that, given the pandemic, we are delivering care in changing parameters where the potential for an increase in risk is possible. The current operating climate is very different and difficult for staff to deliver care to the high standards achieved pre COVID. That said the Committee expressed their pride in the lengths staff have gone to to maintain standards and provide compassionate care. It is felt that an acknowledgement of staff effort should be made in some tangible way once we come through the current surge.

- The Committee received a progress report on the 62-day cancer metric and noted that for the 3rd month the Trust received over 2000 referrals. The Trust made progress during the first wave and demonstrated improvement prior to the second wave but this is now limited.

- In regard to performance the Trust is reporting increases to some waiting lists given limited capacity across the Integrated Care System (ICS). There are measures to prioritise clinical need and utilise the ICS to mitigate some delays.

- The Infection Prevention and Control BAF was received and the two red reported actions after discussion should be amber given the measures taken with ventilation and monitoring of PPE compliance. All mitigations are in place but it is not possible to entirely remove infection risk.

- The Equailty Delivery System (EDS2) report was received giving assurance on the proposed actions. Further assurance is sort on the flagging of patients with access needs.

- The RIDDOR report gave assurance the Trust is correctly reporting incidents.

- The Committee received verbal assurance that the response to the Ockendon report is in hand and with no significant issues that we cannot address within the deadline for submission.

Jackie Churchward-Cardiff
Quality and Safety Committee Chair
21st January 2021

East Sussex Healthcare NHS Trust

Finance & Investment Strategy Committee

1. Introduction
The Finance & Investment Strategy Committee was held on 28th January 2021. A summary of the meeting is set out below.

2. Five-Year Strategy Development: Draft plan for review
An update on the development was presented, providing a brief description of initiatives, programmes and actions that would drive the delivery of the priorities. The programme remained a work in progress and would be informed by the Divisional business plan conversations. The strategy is due to be shared with ICS and CCG/Council colleagues for comment during February/March and the final draft version would come for sign-off to the March F&I Strategy Committee.

3. Building for the Future: (SOC) assurance update
A paper was presented providing assurance to the committee of the action taken following feedback received about the draft Strategic Outline Case (SOC) for BFF from Executive Directors, Finance and Investment Committee members and the Trust Board. The Digital Strategy development piece of work was progressing with AECOM, additional workshops and round table sessions had been arranged to include full engagement processes and was progressing well.

4. Frailty Paper – update from September position
It was noted that staff who would normally be helping to develop the frailty programme had been redeployed as a result of the pandemic. However, a frailty consultant had been appointed and hot frailty clinics were being established to support a programme of work between the acute frailty team and the Peri-operative service. A Frailty Steering Group had been held in November, followed by a Community Steering Group, which had looked frailty in relation to community pathways.

5. Business Planning: Process & Progress Update
The Trust usually held a business planning away day in February; this had been postponed due to the pandemic. It was anticipated that business plans would be completed in April/May 2021; work was being undertaken to update business plans with divisional leads and ADO's, and business planning priorities for the year were being finalised.

6. ICS response to NHSEI integrating Care Consultation paper
The paper noted the Trust and ICS' formal response to the NHSE/I consultation paper on integrated care, published in late November 2020. It considers the response provided from East Sussex County Council to the NHSEI paper.

7. Radiology Imaging System (RIS) Business case
The Committee approved a multi-Trust business case for the procurement of a Surrey and Sussex wide Radiology Information System (RIS).

Steve Phoenix
Chair of Finance & Investment Committee

January 2021

Board Assurance Framework

Meeting information:			
Date of Meeting:	9th February 2021	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

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

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

Summary:

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

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

Due to the significant impact of the second wave of Covid-19:

- BAF 2 - Restoration and Recovery - ongoing impact of Covid19; and
- BAF 3 - Trust's performance against access standards;

have increased from a risk rating of 16 to 20. Target ratings for reducing the risk have also moved from Mar-21 to Sep-21 to provide sufficient time for recovery.

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

- Quality and Safety Committee, 21st January 2021
- Audit Committee, 28th January 2021

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

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

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF)

Quarter 3 2020/21

Overview

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

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

There are no new risks added to the BAF this quarter and all existing risks have been reviewed and progress updated. Due to the significant impact of the second wave of Covid-19 – BAF 2 Restoration and Recovery - ongoing impact of Covid19 and BAF 3 Trust's performance against access standards have increased from a risk rating of 16 to 20, target ratings for reducing the risk have also moved from Mar-21 to Sep-21 to provide sufficient time for recovery.

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS East Sussex Healthcare NHS Trust

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

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

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

RESIDUAL RISK MATRIX

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

Risk Summary						
BAF Reference and Summary Title:	**BAF 1: Safe care – sustained and continuous improvement**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk that we will not provide sustained and continuous improvement in patient safety and quality of care**					
Lead Director:	Director of Nursing/ Medical Director	**Lead Committee:**	Quality and Safety Committee	**Date of last Committee review:**	Jan-21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	25/09/15	1360	Cardiology catheter labs breakdowns	16	16	◄►
	19/02/16	1458	Non-Compliance with NICE guidance NG19 (Diabetic Foot)	20	16	◄►
	03/12/20	1942	Risk of insufficient acute beds during winter	20	16	**New**
	03/12/20	1941	Risk to the delivery of planned/elective activity against Phase 3 recovery	20	16	**New**
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	13/08/20	1907	Insufficient isolation areas and testing kits for Covid-19	16	16	◄►
	24/09/20	1913	Increased waiting times due to cancellations as a result of Covid-19	16	16	**New**

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**4**		Despite some individual risks, the Trust has a robust quality and governance framework in place to manage and monitor quality and safety metrics. The second wave of the Covid 19 pandemic has resulted in some services being suspended/additional pressures and therefore, likelihood has increased to 'probable' Consequence scored as 'moderate' due to the potential implications on patient safety and experience if controls are not fully implemented.	**Likelihood:**	**2**	Sep-21
Consequence:	**3**	**3**	**3**			**Consequence:**	**3**	
Risk Level:	**9**	**9**	**12**			**Risk Level:**	**6**	

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

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

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Oversight of excellence in care at ward and service level (F) • Health Assure being utilised by wards and services as depository for CQC evidence (A) • Divisional management of risk and control framework (A) • Quality improvement champions in place and projects in train (E) • Daily clinical review of patients on waiting list (G)	• Divisional IPR meetings cover quality and safety (A) • Weekly patient safety summit (A) • Clinical Outcomes and effectiveness group (B) • Integrated Performance Report and incident reporting to Quality and Safety Committee and Trust Board (A) (B) • Improved quality in a number of areas for example sepsis, falls resulting in harm and reduced mortality (A) (C) (D) • Getting it Right First Time (GIRFT) in place has improved learning and actions to improve quality of care (A) (B) • Mortality review group meeting (C) (D) • MDT meetings to manage patient pathways (G)	• CQC inspection regime – Trust rated Good overall and Outstanding at Conquest and Community Services (A) • CCG review of incidents prior to closure (A) • Internal audit conduct annual audit of quality account indictors (A) (B) • External accreditation and quality surveillance such as JAG, audiology (B) • Nationally mandated audits and benchmarking (B)
Gaps in control/assurance:			
• CQC identified some "should do" requirements • Improvements required in discharge particularly around information and communication to care homes • Refer to BAF 2 for other gaps related to Covid-19 pandemic			

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

Risk Summary						
BAF Reference and Summary Title:	**BAF 2: Restoration and Recovery**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk that the historical and ongoing impact of Covid 19 will be detrimental to the trust's ability to operate effectively, which could impact service delivery, clinical outcomes and patient experience.**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee Finance and Strategy Committee	**Date of last review by Committee:**	January-21	

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	03/12/20	1941	Risk to the delivery of planned/elective activity against Phase 3 recovery	20	16	**New**
	03/12/20	1942	Insufficient acute beds during winter	20	16	**New**
	24/09/20	1915	Outpatient backlog causing delays	16	16	**New**
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	12/06/20	1888	Staff shortages due to Covid-19	20	16	◄►
	11/06/20	1887	Use of Anaesthetic machines off-label during COVID-19	20	15	▼
	11/06/20	1885	Insufficient oxygen supplies	20	16	◄►
	01/07/20	1894	COVID-19: Diabetic Eye Screening Restoration	20	20	◄►
	12/06/20	1883	Insufficient critical care trained staff to manage additional capacity	16	16	▲

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

Cause of risk:	Due to a significant and sharp increase of Covid-19 admissions, a number of actions have been implemented to support the Trust in being able to effectively respond whilst maintaining patient safety.	**Impact:**	Failure to effectively manage the pandemic and establish a robust restoration and recovery programme gives rise to risk of • patient harm • impaired patient and staff experience

	Measures include cancelling all non-urgent surgery and services, a move to virtual outpatients, relocating services, redeployment of staff and managing reduction in staffing due to self-isolation. Recovery and restoration will be required when admissions reduce.		• failure to meet constitutional and contractual standards • damage to Trust's stakeholder relationships and reputation
Current methods of management (controls)	A. Workstreams in place aligned to patient, people, process, finance, digital and estates B. NHSEI Guidance on priorities for Restoration and Recovery – 'Trilogy' of correspondence issued C. Activity Tracker being developed – focussing on restoration and to track actual pts vs expected capacity D. Estates space utilisation being reviewed taking account of requirements for recovery of safe services whilst maintaining social distancing E. Identifying areas where improvements have been made eg such as virtual out-patient appointments and maximising these opportunities F. Staff track and trace in place G. Utilisation of capacity in private providers H. Development of harm review process I. Incident declared and controls and actions agreed through daily Incident Management meeting chaired by CEO J. Vaccine being rolled out across the Trust		

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

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

Risk Summary						
BAF Reference and Summary Title:	**BAF 3: Inconsistent performance against key access standards**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk that we will not fully and consistently meet mandated access standards**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee	**Date of last review by Committee:**	Jan-21	
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	15/04/13	999	Cancer 62 day compliance	16	12	◄►
	24/09/20	1915	Outpatient follow up backlog – particularly ENT, Ophthalmology and Urology.	20	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	5		Risk level has increased due to the certainty that the second wave of Covid-19 will impact delivery, restoration and recovery of services. The impact has moved to "certain" and the consequence "major"	**Likelihood:**	2	Sep-21
Consequence:	3	4	4			**Consequence:**	3	
Risk Level:	12	16	20			**Risk Level:**	6	
Cause of risk:	Increased demand for services and diagnostics year on year and a reduction and cancellations due to the ongoing Covid-19 pandemic. This has been further impacted in patient presentations to GPs during the pandemic, leading to a growing backlog of currently unidentified need, and to reluctance on the part of some patients to engage with treatment plans during the pandemic period.				**Impact:**	Failure to meet access standards consistently gives rise to risk of • patient harm • impaired patient experience • failure to meet constitutional and contractual standards • damage to Trust's regulatory and contractual relationships and public reputation		
Current methods of management (controls)	A. Urgent care programme of work in place B. ESHT has been allocated a Cancer Alliance Relationship manager who is working in partnership with the Trust. This work focuses on best practice timed pathways along with partnership working with other providers to learn and share best practice. C. Pathway improvements and monitoring for A&E, Cancer and Diagnostics - pathway review in line with 28/62 days - identifying digital opportunities to proactively manage cancer - Alliance decision to be confirmed re AI digital tracking - Contact with individual patient and agreeing individual approaches to mitigating concerns							

	- Contact with GPs / CCGs / Primary Care Networks etc D. Working closely with the Cancer Alliance on improvement actions such as: - Recruitment of sonographers - Addressing inconsistent reporting times in Radiology - Implementation of Breast Triple Assessment clinics - Campaign to support seeing all referred patients by day 7 E. Addressing Histology turnaround times and implementation of the Faster Diagnostic Standard

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

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

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

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

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

Cause of risk:	**Impact:**
• Recognised national shortages in some staff groups • Geographical location • Continued pressure in a number of clinical areas • Uncertainty about the effect of exit from the EU impacting recruitment and retention • Lack of opportunity for career development	Failure to maintain workforce stability gives rise to risk of: • Increased workforce expenditure due to agency requirements • Detrimental impact on patient care and experience • Failure to comply with regulatory requirements and constitutional standards • Detriment to staff health and well-being

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

Assurance Framework – 3 Lines of Defence – mapped to controls A-I			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H) (D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas eg consultants in Histopathology, Radiology, Neurology and Acute medicine.(A) (C) • Introduction of Certificate of Eligibility of Specialist Registration (CESR) programme in A&E Sept 2020.Proposed roll out across other areas early 2021. (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Direct communication to all EU staff re settled status. Task and finish group to be established in Jan 2021 (J)	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • 3 year Recruitment Strategy refreshed (A) • Overall Time to hire 80.1 days Nov 2020. (inc advertising/notice period). A slight reduction since last update. Medical and Nurse TTH however remain high due to Covid 19 travel restrictions (D) • Trust net vacancy trending at 1.9% in Nov 2020 due to budget re alignment. Predicted year end finish 9.5% (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E)
Gaps in control/assurance:			
• Covid travel restrictions have continued to impact on some overseas recruitment/new starters			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers and Sonographers	DHR	March 2021	82 international nurses and 5 radiographers recruited to date (Nov 2020). Planned monthly interviews for 2020/2021 targeting specialist roles. Target of 100 nurse candidates and 10 radiographers by end of financial year 2020/2021.	
2.	Establishment of local networks with BAME groups and organisations to increase diversity and talent.	DHR	March 2021	Planned communication in January 2021, linked with WRES activities.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 5: Protecting our Staff**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk to staff welfare and morale if we do not undertake and act upon risk assessments to ensure a safe working environment**					
Lead Director:	Director of Human Resources	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	Jan-21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	16/08/20	1908	Protecting our Staff	16	12	◄►
	07/07/20	1900	Availability and use of Personal Protective Equipment	16	12	▼
	18/11/19	1849	Impact of Violence and Aggression on staff wellbeing	16	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	3	3		Significant work has been undertaken in conducting and acting upon risk assessments for Covid-19. There is also a robust programme of work in place to support wellbeing of staff and manage violence and aggression and the rating will reduce when the revised policy has been rolled out.	**Likelihood:**	1	end Sep-21
Consequence:	4	4	4			**Consequence:**	4	
Risk Level:	12	12	12			**Risk Level:**	4	

Cause of risk:	Failure to ensure that we provide a safe working environment for staff where they is adequate protection and support from a number of risks eg Covid-19 and violence and aggression	**Impact:**	Adverse impact on staff health and wellbeing. Risk of increased absences and therefore inability to deliver on services; possible closure of services and adverse impact on patient experience and reputational risks.

Current methods of management (controls)

A. Systems and processes in place to risk assess staff to reduce the risk from infection of COVID 19. Managers are required to complete a risk assessment to identify measures that need to be put in place to enable a member of staff to remain safe at work. If this cannot be achieved managers need to consider deploying their staff member to a different area or working from home if need be.
B. Training for managers to have compassionate conversations about risk assessments with vulnerable staff
C. Daily compliance reviews take place at the Risk Assessment Task and Finish Group to identify targeted actions
D. Systems and processes in place both reactive and proactive to manage violence and aggression – including conflict resolution training, OH support, risk assessments and security support. Trialling revised policy and red and yellow letters.

	E. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. F. Reviewing and implementing best practice from other areas

Assurance Framework – 3 Lines of Defence			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Covid risk assessment process implemented to be undertaken by line manager and retained on personnel file. Risk assessment compliance now 98.4% for all staff and 96.9% for BAME staff. (A) (C) • Completion of risk assessments to be recorded on ESR. (A) • Appropriate PPE provided (A)	• Occupational Health and Health and Safety Team support and audit of risk assessments and datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Weekly COVID19 Workforce Group (A) (C) • Local Security Management Specialist advice and support (D) • Oversight by Violence and Aggression Task Group and monitoring by Health and Safety Steering Group (D)	• CCG undertaking assurance reviews (A) • Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management (F) • Health and Safety Executive review of violence and aggression (D) • Collaboration with ESCC on lone working (F)

Gaps in control/assurance:

- Although a process is in place, there needs to be greater pace in completing and acting upon Covid risk assessments and ensuring that these are recorded on ESR
- The Covid-19 pandemic has impacted some of the progress in supporting staff with incidence of violence and aggression
- Need to develop a single software solution to support staff who are lone/community working

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Focus on ensuring that Covid risk assessment outcomes are implemented with ongoing assurance provided to staff about their safety at work	DHR	End Dec 2020	Compliance improved ongoing focus to manage safety at work	
2.	Progressing introduction of Critical Incident Stress Management (CISM) or Trauma Risk Management (TRiM) within the Trust	DHR	End Jan 2021	Bid submitted for Charitable Funds to support TRiM	
3.	Agreed business case for lone worker alert software and this is to be procured and rolled out	DHR	End Jan 2021	Business case approved and exploring options for joint working with ESCC	
4.	Revised V&A policy to be published and communicated to staff	DN	End Sept 2020	Revised Violence and Aggression Policy including Red and Yellow sanctions published and communicated	**Complete**

Risk Summary						
BAF Reference and Summary Title:	**BAF 6: Financial Sustainability**				**Strategic Objectives Impacted**	
					SO1	SO2	SO3	SO4 ✓	SO5 ✓
Risk Description:	**There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run-rate at the end of 20/21 or not complying with Covid financial guidance and audit breaches**					
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	August 2020	
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	20/05/20	1878	Delivery of 20/21 Financial Plan	**20**	12	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**3**		NHSE/I have agreed M7-12 funding that should deliver breakeven, with risk against the financial incentive scheme depending on activity levels. Funded on the basis of last year actuals plus Covid costs (no allowance for business cases). The Trust has had 6 months with a focus on responding to Covid but will need to deliver recovery of activity within a financial envelope and with a refreshed efficiency plan.	**Likelihood:**	**2**	Mar-21
Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
Risk Level:	**12**	**12**	**12**			**Risk Level:**	**8**	
Cause of risk:	Controls for financial delivery are established and robust, but the CIP challenge and financial plan for 2020/21 need continual monitoring and support. It will be harder to maintain efficiency as service delivery transforms and PbR is harder to track during the block contract period. From December, Covid levels have increased and the elective plan is not currently being delivered.				**Impact:**	Failure to maintain financial sustainability gives rise to risk of • Unviable services and increased cost improvement programme • failure to meet contractual standards and possible regulatory action • damage to Trust's stakeholder relationships and reputation		
Current methods of management (controls)	A. Risk adjusted CIP programme in place and PID produced for each scheme. B. Transformation programmes in place to realise benefits of cost effectiveness C. Reviewing approved business cases for realisations of benefits and un D. Restatement of budgets in 2021 issued in September E. Process in place for setting and managing budgets "grip and control" F. Developed financial 'solution' for non-recurrent component of CIP delivery driven by delayed investment							

	G. The finance team have combined a forecast update on the budget with the planners producing a revised activity plan as part of recovery. Key areas of focus include: - A refresh of the efficiency plans working with divisions; - Cost pressures arising from service developments/ recruitment; - How to strengthen the controls and accountability frameworks

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

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

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

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	27/05/20	1879	Capital sustainability	20	12	◄►
	12/02/14	1152	Obsolete medical devices	20	15	◄►
	25/09/15	1360	Cardiac catheter lab breakdowns	16	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	3	3		Capital plan was delivered in 19/20, with elements continuing in the 20/21 capital plan. Most of the requests for capital funding in 20/21 have been agreed, with some risk against an element of Emergency Capital and concern over capital in future years	**Likelihood:**	1	Sep-21
Consequence:	4	4	4			**Consequence:**	4	
Risk Level:	16	12	12			**Risk Level:**	4	

Cause of risk:	The historic financial performance of the Trust has led to a restricted internally generated capital budget for many years. Although the Trust has successfully bid for emergency capital funding from NHSE/I the demand for capital outstrips the supply.	**Impact:**	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.
Current methods of management (controls)	A. 2020/21 capital plan is being reprioritised to ensure that it is fit for purpose post COVID-19. B. Continuous prioritisation of spending and active management of capital resource limit through capital programme work-streams Capital bids being prioritised and prepared for submission to ICS. C. Essential work prioritised with estates, IT and medical equipment D. Lease/Managed Equipment Service options will be considered during 2021/22		

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

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

Risk Summary						
BAF Reference and Summary Title:	**BAF 8: Infrastructure**				**Strategic Objectives Impacted**	✓
Risk Description:	**There is a risk that the Trust estates infrastructure, buildings and environment, will not be fit for purpose**					
Lead Director:	Director of Estates	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	January 2021	

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

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

Cause of risk:	The Trust's historic financial performance has led to a restricted internally generated capital budget for many years. Despite a successful bid for HIP2 seed funding to develop the Strategic Outline Case there is an immediate need for capital which outstrips availability	**Impact:**	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.
Current methods of management (controls)	A. 2020/21 capital plan is being reprioritised to ensure that it is fit for purpose post COVID-19. B. Continuous prioritisation of spending and active management of capital resource limit through capital programme work-streams Capital bids being prioritised and prepared for submission to ICS. C. Essential work prioritised with estates, IT and medical equipment D. Maintenance of active fire precautions eg automatic fire detection. emergency lighting and firefighting equipment		

Assurance Framework – 3 Lines of Defence- linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (B) (C) (D)	• Oversight by Finance and Strategy Committee (A) (B) • Simulated patient safety exercise undertaken on Seaford ward in June 2019 - will support refinement of evacuation plans (D) • Estates and Facilities IPR (A) (B) (C)	• Capital business cases reviewed by ICS (A) (C) • The Trust has been named as part of the HIP Programme (Phase 2) and has commenced dialogue with NHSI/E colleagues on next steps to secure significant funding over the next 3-5 years. £5m seed funding to develop the SOC has been approved by DHSC (A) • NHSI funding confirmed Sept-19 in order to facilitate additional fire compartmentation works (D). • Oversight of Fire requirements by East Sussex Fire and Rescue Service (D). • Six Facet Survey (A)

Gaps in control/assurance:

- Longer term capital programme required to identify pressures and requirements
- Need to recommence fire infrastructure work impacted by Covid-19
- Building works delayed to impact of Covid-19
- Challenges with oxygen insufficient supply and capability of system
- Some areas inadequately ventilated

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Developing "Building for Our Future" full business case and project board being established – first phase develop Strategic Outline Case	Chief Executive	End Mar 2021	Programme Director recruited and progressing developing Strategic Outline Case	
2.	Aiming to resume fire compartmentation works at DGH in Autumn 2020	Director of Estates	End Mar-2021	Now that the Maternity Day Unit has become available the 1st phase of the refurbishment plan has commenced	
3.	Oxygen – Vacuum Insulated Evaporator (VIE) plant on both sites to be further upgraded	DE	28 February 2021	Some upgrades taken place and EDGH upgrade is due to complete mid-January and Conquest at the end of February.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Infrastructure**				**Strategic Objectives Impacted**	
					✓	✓ ✓ ✓
Risk Description:	A large-scale cyber-attack could shut down the IT network and severely limits the availability of essential information and access to systems for a prolonged period which would impact the Trust's ability to deliver its strategic objectives					
Lead Director:	Director of Finance	**Lead Committee:**	Audit Committee		**Date of last review by Committee**	January-2021
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	23/08/17	1660	Cyber Security	20	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4		There are a number of robust controls in place but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda.	**Likelihood:**	4	Mar-21
Consequence:	4	4	4			**Consequence:**	2	
Risk Level:	16	16	16			**Risk Level:**	8	
Cause of risk:	Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website,				**Impact:**	A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.		
Current methods of management (controls)	A. Advanced Threat Protection (ATP) solution implemented to defend against hacking /malware. Regular scanning for vulnerability. B. Anti-virus and Anti-malware software in place with programme of ongoing monitoring. Client and server patching programme in place and monitored C. Process in place to review and respond to national NHS Digital CareCert notifications D. Self-assessment against Cyber Essential Plus Framework to support development of actions for protection against threats E. Education campaign to raise staff awareness - training ongoing with cyber security awareness campaign commenced October 2019 F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary and signed up to implementing it at ESHT							

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Pursuing ISO27001 certification and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework.	Director of Finance	End March 2021	Ongoing - cyber position greatly improved and aiming to achieve Cyber Essentials Plus early in 2021	
2.	Further investment in monitoring solutions and to increase compliance with server patching will be addressed as part of digital programme.	Director of Finance	End March 2021	Tool being introduced	
3.	SOP for the network security administration will be created to ensure a standard approach	Director of Finance	End March 2021	SOP being developed	

Appendix One: Risk Matrix

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

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

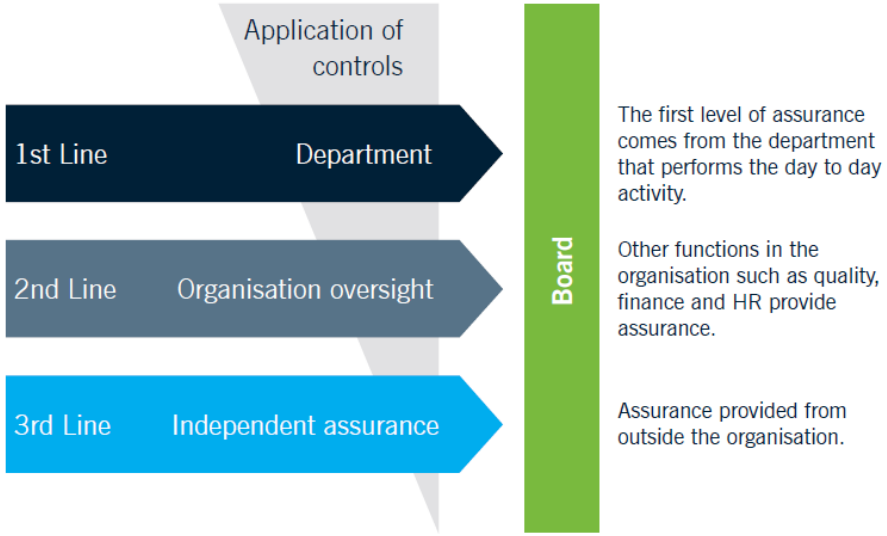
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

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

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

Appendix Two – Three Lines of Defence Assurance Model

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



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

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

Ockenden Maternity Report

Meeting information:			
Date of Meeting:	9th February 2021	Agenda Item:	8
Meeting:	Trust Board	Reporting Officer:	Emma Chambers, Head of Midwifery

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

In 2017 the former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The review involved a multidisciplinary team of experienced maternity clinicians and other specialists as required. The review also involved in depth discussion with families affected by poor outcomes.

Initially the review included 23 families however, following publicity this expanded to include analysis of 1862 cases which resulted in poor outcomes during births from 2000 - 2019; the interim report includes findings from 250 cases resulting in 7 Immediate and Essential Actions (IEAs) with 12 urgent clinical priorities.

Timeline:

- The report was published on 10th December – an urgent multidisciplinary benchmarking meeting was arranged
- 15th December 2020 a letter was received from Amanda Prichard, Chief Executive of NHS Improvement requesting that 12 urgent clinical priorities were implemented by 21st December 2020 (4 working days)
- Urgent review of priorities took place, a response was prepared and submitted following sign off by Joe Chadwick-Bell ESHT Chief Executive and the Local Maternity System (LMS) Senior Responsible Officer (SRO)
- Further full Gap Analysis of all recommendations signed off by the Board and the LMS SRO was requested to be completed and submitted by 15th January 2021
- Submission date delayed to 15th February following escalation of concerns about extremely tight timeframe in current business continuity and regional major incident status.

The Immediate and Essential Actions and clinical priorities are detailed in the paper, they encompassed the following themes:

- Enhanced safety
- Listening to women and their families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring fetal wellbeing
- Informed consent
- Trusts were also asked to conduct a workforce benchmarking exercise.

Of the 12 clinical priorities, our position is:

- Compliance with five.
- Partially meeting six – requiring assurance audits, the appointment of a Non-Executive Director Safety Champion, Establishment review to incorporate recommendations from the Ockenden Report and Executive agreement regarding funding streams for training.
- One is not met – requiring consultant discussion, job planning and funding agreement.
- The workforce benchmarking exercise is complete.

This compliance is in line with other maternity services in the region. The ask from NHSE/I to implement the actions within 4 working days was unrealistic and unachievable. The maternity service team are committed to implementing all recommendations in a managed and sustainable way.

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

Quality and Safety Committee 18th February 2021

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

1. **Perinatal Clinical Quality Surveillance Model agreement for implementation and process for review – suggested to review as part of the Quality and Safety Committee agenda.**

2. **Confirm that the Ockenden report has been reviewed at Public Board.**

3. **Confirm that the Board is confident that the assurance mechanisms within ESHT are effective and that the Board is assured that poor care and avoidable deaths with no visibility or learning cannot happen our organisation.**

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

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

East Sussex Healthcare
NHS Trust

East Sussex Healthcare NHS Trust (ESHT) Maternity Service and Executive Board requirements from the Ockenden Report into maternity services at Shrewsbury and Telford NHS Trust published on 10th December 2020.

9th February 2021

The report can be accessed here: OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (publishing.service.gov.uk)

In the summer of 2017, following a letter from bereaved families raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The review team comprised obstetricians, midwives and neonatologists working collaboratively. Where specialist advice was required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians were available in the review team. Families were interviewed by the review team providing the opportunity for them to tell their stories.

The first terms of reference in 2017 were written for a review to include 23 families. They were amended in November 2019 to encompass a much larger number of families, the team are now in the process of analysing 1862 cases which resulted in poor outcomes during births from 2000 - 2019; this interim report includes findings from 250 cases resulting in 7 Immediate and Essential Actions (IEAs) with 12 urgent clinical priorities detailed later in this report.

On the day of publication of the Ockenden Report ESHT Head of Midwifery requested that a multidisciplinary meeting was organised to analyse the report recommendations and perform a Gap Analysis. On 15th December 2020 a letter (appendix 1) was received from Amanda Prichard, Chief Executive of NHS Improvement, requesting that 12 urgent clinical priorities were **implemented** by 21st December 2020 (4 working days). An urgent review of these priorities took place and a response was prepared and submitted following sign off by Joe Chadwick-Bell, ESHT Chief Executive and the Local Maternity System (LMS) Senior Responsible Officer (SRO) (appendix 2). A further full Gap Analysis of all recommendations signed off by the Board and the LMS SRO was requested to be completed and submitted by 15th January 2021. This submission date was extended to 15th February 2021 following escalation of concerns regarding this very tight timeframe by the South East Heads of

Midwifery group, due to Covid-19 Trust business continuity status and South East major incident status.

The report outlines the expectation that Trust Boards should review the report and Trust response at the next public board. The Board is asked consider whether the assurance mechanisms within our Trust are effective and that poor care and avoidable deaths with no visibility or learning would not occur within our organisation. To support these discussions, the maternity team have completed the **Assurance Assessment Tool** (attached) which includes:

a) All 7 Immediate and Essential Actions (IEAs) of the Ockenden report,
b) NICE guidance relating to maternity,
c) Compliance against the CNST safety actions, and
d) A current workforce gap analysis

The Trust Board is also asked to review the **Perinatal Clinical Quality Surveillance Model** (appendix 3) and confirm agreement for the model to be reviewed as part of the Quality and Safety Committee agenda.

A summary of the Immediate and Essential Actions (IEAs) and the current ESHT position

IEA 1) Enhanced safety

a) A plan to implement the Perinatal Clinical Quality Surveillance Model (PCQSM)
The PCQSM was published in December 2020. This has not yet been implemented pending agreement from the Board regarding the preferred version. (Detail later in this paper)

b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

ESHT position - We hold daily risk meetings where any new Datix submissions are discussed by the multidisciplinary team. A multidisciplinary professional review takes place for any case with a poor outcome or unexpected outcome. Triggers for a professional review are:

The submission of a severity 3 Datix report where harm has been caused to the patient whether it is:

- Physical/organ damage
- psychological trauma as a result of sub-optimal care
- increased length in hospital stay
- need for further treatment investigations and procedures owing to sub-optimal care
- potential that the patient may experience complications in the long term as a result of sub-optimal care
- delay in diagnosis or owing to a failure of a pathway to offer the correct screening at the correct time
- expected/unexpected child death

The case is discussed in depth with healthy debate and challenge. The patient safety team are invited to these reviews for scrutiny external to the Division. The anaesthetic team are invited when appropriate. The findings from the review are then discussed at the Weekly Patient Safety Summit where a decision is made regarding the severity of incident and investigation required. Immediate actions from professional reviews are completed while awaiting the outcome and any resultant actions from the formal investigation.. Parents will be involved in the investigation process when a serious incident investigation is required or if the case is referred to the Healthcare Safety Investigation Branch (HSIB). Details of any maternity SIs are shared at the Divisional Integrated Performance Review Meeting monthly chaired by the Chief Executive. Maternity SIs are not reported separately to the Board monthly currently but form part of a report on SIs. SIs and learning from these cases are shared internally and at the bi-monthly LMS Quality and Safety Forum on an ad-hoc basis, this is not mandated.

In a recent peer review of maternity governance processes by a Head of Midwifery within our LMS region, we were commended for our "methodical, respectful and robust" processes which provide "real rigour and ensure that issues are dealt with quickly". We perform a benchmarking exercise against all national maternity reports (for example HSIB themed reviews, MBRRACE reports, CQC reports regarding services in difficulty) and action plan to meet recommendations.

We have identified opportunities to strengthen assurance that actions and improvements are embedded and this is a work in progress requiring additional resource. We have also developed a Maternity Improvement Hub to develop sustained and successful improvement within our service.

IEA 2) Listening to women and their families

a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

ESHT position - Feedback on our services is overwhelmingly positive. We recognise however, that we don't get it right every time but we are committed to learning from feedback to continually improve. We offer debriefing services to women/people who have had a difficult experience in our care – we have recently employed a full time debriefing specialist midwife. Themes from complaints or debriefs are discussed and addressed in our monthly senior midwives meeting, for example, a theme of women/people not feeling listened to while in early labour has been deeply explored by the midwifery senior team during a dedicated workshop, resulting in the development of an action plan, these actions are progressed and reviewed during our monthly senior midwives meeting. Issues with individual behaviour are addressed through the line management process. We provide women/people with a maternity specific Friends and Family Test (FFT) – receiving sustained recommendation rates of > 97%.

We are about to complete a new bereavement suite for families to recover following the loss of their baby. This project was completed in collaboration with service users. We have a full time Bereavement Specialist midwife and support worker.

We have several social media sites linked to our service and managed by our midwifery team, we reach more than 4000 women/people with these sites, allowing us to share information quickly and to receive feedback from families. We work with our Maternity Voices Partnership group to co-design improvements and hear service user feedback. There have been some governance issues and relationship issues with this group in the recent past but work is ongoing to improve working relationships and ensure the group is more effective.

b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

ESHT position – We have an Executive Director Maternity Safety Champion (Chief Nurse) and a Non-Executive Director has been identified for this role and this will be formally noted at the next Board meeting.

IEA 3) Staff training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

ESHT position - Our consultants support 72 hours of presence on labour ward, this is in excess of the expected 60 hours. A consultant is on call and contactable outside of these hours however, we are not currently complaint with the new recommendation from this report that a consultant present ward round must take place during the day and night shifts 7 days a week. Job planning, investment and recruitment are required to facilitate this.

We have a supernumerary midwifery matron on every shift that is available to support clinicians and assist with escalation. We have a senior midwife on call 24/7 to provide support with advice or escalation.

b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.

ESHT position – we have been providing Practical Obstetric Multi-Professional Training (PROMPT) for several years. This training is attended by the midwifery, obstetric, anaesthetic and support teams. Compliance with this standard was evidenced in the 2019 CNST Incentive Scheme success. Attendance in 2020 has been impacted by Covid-19 however, the training is now provided virtually and we are on trajectory to meet the requirements set by the CNST Incentive Scheme standards for 2021 submission.

c) Confirmation that funding allocated for maternity staff training is ring fenced and any CNST Maternity Incentive Scheme (MIS)

ESHT position - The Women and Children's division receive the maternity incentive scheme refund and some of this is allocated to staff training and improving safety. A review will be undertaken to ensure the totality of the refund is ring-fenced to improve maternity safety.

IEA 4) Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place

ESHT position – we have clear guidelines in place regarding referral pathways in complex pregnancy. We currently do not have a process of audit in place, this is being developed but is challenging as records are hand held not electronic. We have invested in a new maternity IT system due to launch in the summer (delayed due to Covid-19) which will mean the maternity service is paper free. This system will automatically trigger referrals and assist with audit of compliance. If cases of inappropriate or lack of referral are identified during case review this is raised with the clinician by their line manager.

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

ESHT position - This work is being led by NHSE/I Regional Maternity Team. Scoping submitted and activity work underway. Full compliance is dependent on NHSE/I processes.

IEA 5) Risk assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

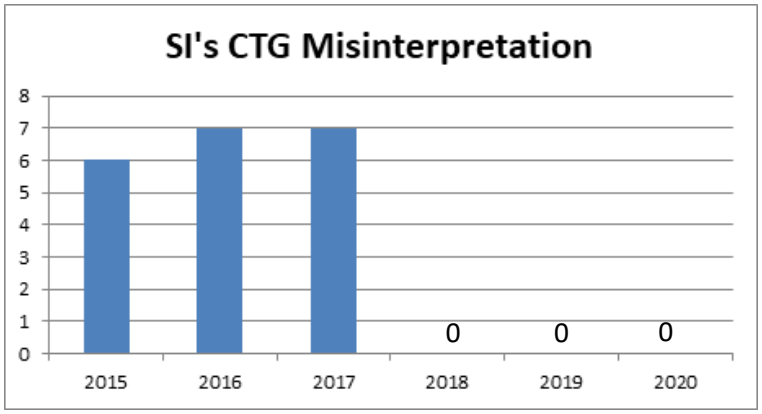
All woman/people have a full booking assessment at the beginning of their pregnancy. We follow NICE guidance (goal specific in antenatal contacts) with regards to routine pregnancy care and antenatal assessments throughout pregnancy and have guidelines in place to support this. All women/people have 36 week birth place risk assessment. If the clinical picture changes prior to or during labour, the intended place of birth will be revisited with an evidence based discussion. The PSCP was launched in March 2020. Audit processes are being designed but are challenging due to paper based notes. There will be auditable entries on the new IT system.

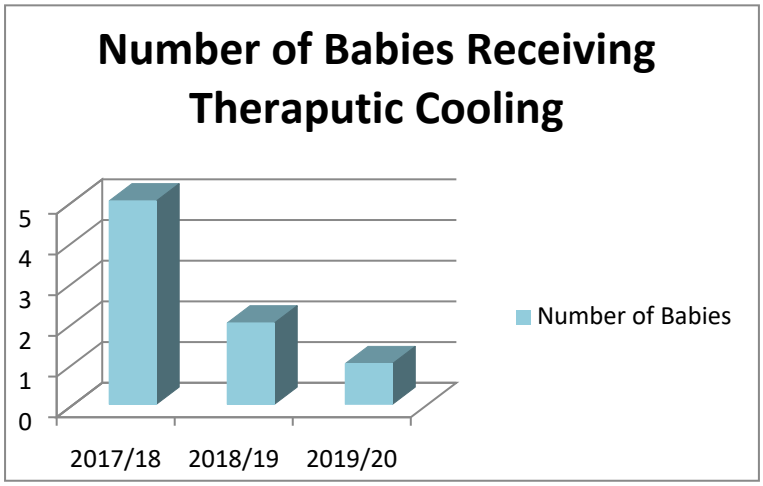
IEA 6) Monitoring fetal wellbeing

a) Implement the Saving Babies Lives Care Bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

ESHT position - We have implemented the Saving Babies Lives care bundle. We have a dedicated midwife in post to lead this work. We also have had a named consultant assigned to the project.

We have invested a great deal of time and funding into improving our fetal monitoring training. This investment has resulted in a significant reduction in incidents and suboptimal outcomes. The Cardiotocograph (CTG) is a recording of the fetal heart rate during labour and is used to monitor the condition of the fetus, sometimes indicating that early delivery is required to prevent brain injury. Therapeutic Cooling is required if there is a suspicion of brain injury due to a shortage of oxygen during birth. The number of SIs related to CTG misinterpretation and babies requiring cooling have significantly reduced.





IEA 7) Informed consent

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

ESHT position - We have a multitude of information leaflets and signposting available online for women/people. This information is provided to assist with gaining informed consent. One of the most important aspects of Continuity of Carer teams is so that women/people and midwives build a trusting relationships to support open conversations about risk and consent – 25% of women/people are currently cared for within these teams. We are launching 2 further teams in the spring meaning

that 45% of women/people will be cared for within teams. Our ambition is for as many women/people to be cared for within a team as possible by March 2022.

Work is needed to improve our ESHT maternity website by refreshing and modernising the site, we will perform a gap analysis against the website recommended above.

Workforce requirements

a) The report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.
b) Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2021 confirming timescales for implementation.

ESHT position

Midwifery – we completed a BirthRate + assessment in 2019 – we were awarded an establishment uplift to meet the clinical staffing requirements of this assessment and have recruited into these posts. We complete an annual staffing establishment review and provide quarterly staffing/ acuity reports to the Integrated Performance Review Meeting. There are increased requirements for specialist midwives and staff training within the Ockenden report recommendations which will require funding.

Obstetrics – Obstetrics and Gynaecology leads are guided by the RCOG recommendations for planning the workforce at all levels (Royal College of Obstetricians and Gynaecologists (RCOG) Workforce Status Report 2018). We contribute to the Yearly RCOG workforce census. The Kent Sussex and Surrey (KSS) Deanery work closely with us at a local level to ensure matching of trainees to the number of deliveries in the unit and we plan our rota with SAS/Specialty Doctors. In 90% of units in the UK there are gaps in the middle grade rota and we have a rolling recruitment advert to try and fill these vacancies as well as recruiting from international schemes such as the Medical Training Initiative scheme arranged through the RCOG. Consultant expansion is happening in line with Obstetric presence on the delivery suite.

Anaesthetics – Our workforce planning is guided mostly by recommendations from the Obstetric Association and Association of Anaesthetists. We are compliant with all recommendations.

Paediatrics – The service follows RCPCH guidance on workforce. We work with KSS to anticipate any gaps on the rota. Our registrar and consultant rota are fully staffed. We have introduced Advanced Nurse Practitioners into general paediatrics so that our trainees can spend more time with neonates.

Benchmarking

Below is an overview of the position of Trusts in our LMS (ESHT, Western Sussex and Brighton). It is clear to see that all three Trusts are in a similar position with the IEA requirements. The request to implement all of these requirements within 4 working days was unrealistic and unachievable. Significant investment and logistical changes are required for some of the requirements. (Permission was gained to share this information from other Trust leads).

IMMEDIATE AND ESSENTIAL ACTIONS (IEA) - 12 URGENT CLINICAL PRIORITIES (21/12/2020)

Requirements		Trust Compliance			Notes / Actions	ESHT progress on actions since 21st December 2020
IEA	Clinical Priority	BSUH	ESHT	WSHFT		
Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	MET	MET	MET	**Note** - The new Perinatal Clinical Quality Model was published December 2020 and is a whole system model. Sussex is not compliant with the model, compliance is limited to a plan to implement the model.	**Model on agenda for discussion and decision at Maternity Board meeting 22nd January 2021**
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	MET	MET	MET	**Note** - There is variation in how, when the LMS is involved in SI's / receives reports, which will be standardised to meet the Perinatal Clinical Quality Surveillance Model and requirements. .	
Listening to Women and their Families	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	MET	MET	MET	**Note** - MVP per Trust in place funded until April 2021. **Actions** - Local agreement to fund each MVP required. **Risk** - Failure to have MVPs will lead to reduced compliance with CNST, Ockenden and CQC inspections.	
	Confirmation of a named nonexecutive director who will support the Board maternity safety champion bringing a degree of independent challenge and ensuring that the voices of service users and staff are heard	PARTIALLY MET	PARTIALLY MET	PARTIALLY MET	**Note -** NED JD for this role has now been published. **Action** - Formally appoint identified NED to the role as defined in the National JD (BSUH, WSHFT, ESHT)	**NED identified. To be appointed formally at next Board meeting**

Staff training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	**NOT MET**	**NOT MET**	**NOT MET**	**Note - requires job planning to meet this new requirement.** **Action** - New requirement and planning underway. Current Consultant cover meets pre-Ockenden requirements in all 3 Trusts.	**For discussion at consultant meeting 29th January 2021 – will require funding and recruitment**
	Assurance that a MDT training schedule is in place	**PARTIALLY MET**	**PARTIALLY MET**	**PARTIALLY MET**	**Note** - MDT training model published in Dec 2020 being reviewed to inform schedule. **Action** - New requirements. Planning underway to meet new MDT requirements (BSU, ESHT, WSHFT)	**Increased training requirement. Previous requirements met as evidenced by CNST Incentive scheme compliance in 2019. Funding for staffing backfill/ reassessment of staffing levels required**
	Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	**NOT MET**	**PARTIALLY MET**	**NOT MET**	**Action** - ESHT process being revised to use total CNST refund for maternity, rather than partial. Business case being submitted to cover the increased costs (BSUH/WSHFT)	**Several external funding streams have been provided and used for training however, this is not a formal arrangement – to be agreed by Exec team**
Managing Complex Pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	**PARTIALLY MET**	**PARTIALLY MET**	**PARTIALLY MET**	**Note** - Named Consultant in place, not urgently audited. Plan to audit (BSUH/WSHFT) and urgent audit underway (ESHT).	**Urgent audit in progress**
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	**MET**	**MET**	**MET**	**Note** - This work is being led by NHSE/I Regional Maternity Team. Scoping submitted and activity work underway. Full compliance is dependent on NHSE/I processes.	
Risk assessment throughout pregnancy	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	**PARTIALLY MET**	**PARTIALLY MET**	**PARTIALLY MET**	**Note** - Audit approach varies and notes are currently handheld. PCSP is being implemented across all 3 Trust to achieve 100% of service users having access to PCSP by March 2021. NHSE/I audit approach for PCSP set out. Local work needed to capture this via MSDS2, is underway with data analysts. **Action** - Badger net implementation (BSUH/ ESHT) and data analysts working to capture MSDS2 data (BSUH	**Audit process being developed**

Monitoring Fetal Wellbeing	Every unit to have a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training and review of cases and ensuring compliance with the Saving Babies' Lives Care Bundle (SBLCB)	**PARTIALLY MET**	**MET**	**PARTIALLY MET**	**Note** - Interim Leads nominated by BSUH and WSHFT. Job planning to make a substantive role. ESHT has Consultant and Midwife leads in place. **Note** - SBLCB2 Training compliance not yet 100% BSUH and WSHFT. ESHT 100% compliant.	
Informed Consent	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website	**MET**	**PARTIALLY MET**	**MET**	Note - Urgent review of information for the pathways of care is underway with website updates following (ESHT).	**Website update required but all pathways of care available in guideline form**
Workforce	Workforce - confirm a plan in place to the Birth-rate Plus (BR+) standard by 31 January 2021 confirming timescales for implementation	**PARTIALLY MET**	**MET**	**MET**	**Note** - workforce currently partially funded to birth-rate Plus (BSUH).Birth-rate Plus compliant workforce (WSHFT, ESHT) New training requirements will impact Birthrate Plus staffing requirements. Working to submit plan by 31st January 2021 (BSUH, ESHT and WSHFT).	

On 8th January 2021 a multidisciplinary Gap Analysis meeting was held, attended by consultant obstetricians, anaesthetist, neonatologist, senior midwives, midwifery managers and maternity safety champions (Chief Nurse and Non-Executive Director).

The Gap Analysis document accompanies this paper.

For ease, those recommendations rated as Red or Amber are presented here (more detail regarding responsibility from actions and timeframes can be found within the Gap Analysis document.

New recommendations not mandated prior to the publication of the Ockenden report are shaded purple:

RED – Action to be commenced

	Recommendation	Current Position	Actions Required
1	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	* Healthcare Safety Investigation Branch (HSIB) and Perinatal Mortality Review Tool (PMRT) process in place * Ad hoc process for external review which is case dependent reliant on professional courtesy but no formal process in place * Royal College of Obstetricians and Gynaecologists (RCOG) process for external clinical specialist opinion outside of Trust is available but not formally utilised	* If parents decline a HSIB investigation a process needs to be established for external specialist review * Establish relationships with neighbouring trusts, particularly with regional centres, all staff groups especially at consultant level for peer support. * Peer review outside region suggested. * Adopt RCOG process for external clinical specialist opinion outside of Trust * Finalise and enact assurance programme for embedded actions/ changes
2	All maternity Serious Incident (SI) reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	* Maternity SIs are immediately escalated to the Chief Nurse by the HOM. * Any maternity SIs are discussed at the Weekly Patient Safety Summit chaired by the Medical Director and Chief Nurse. * SIs are discussed at the Integrated Performance Review Meeting monthly * Maternity SIs are not formally and separately reported to Trust Board * There is no requirement currently to share with the LMS but SIs are often shared at the Quality and Safety Forum	* Review terms of reference (TOR) for LMS Quality and Safety Meeting and ensure a robust reporting requirement is incorporated * Finalise and enact assurance programme for embedded actions/ changes * Decision regarding formal and separate reporting process of SIs to Trust Board
3	a) A plan to implement the Perinatal Clinical Quality Surveillance Model (PCQSM) b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB. * Note that there is discrepancy between this recommendation and recommendation 2	a) Model now available - implementation to be discussed at Maternity Board on 22.1.2021. Challenging template which mixes narrative and numerical data, may need to be reviewed once trialed. b) See recommendation 2	a) Confirmation of use of PCQSM (appendix 3) from Board and process of review b) Decision regarding formal and separate reporting process of SIs to Trust Board
4	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Trust committed to implementing the Advocate role once role descriptor available from NHSE and funding identified.	Await guidance from National team re Advocate role – there is now discussion that this may be a regional position not a Trust position.

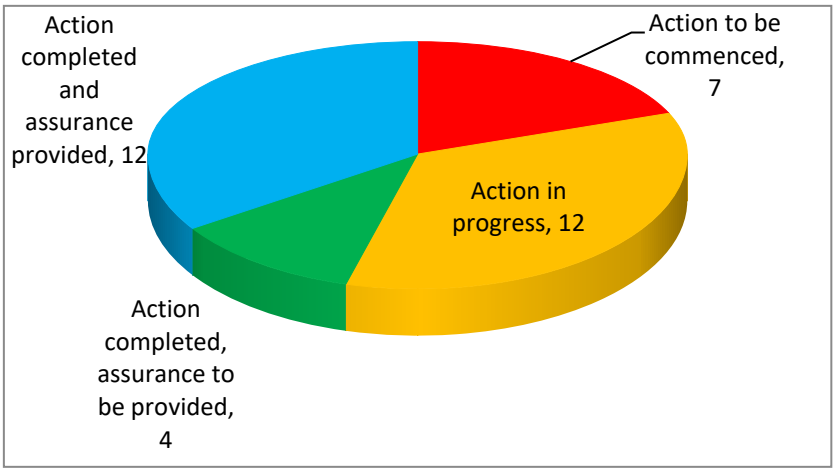
5	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. * Note this recommendation was repeated later in the spread sheet so appears as 2 separate recommendations	* Labour ward rounds twice daily although no written record of attendance kept * Not compliant with 7 days a week - consultant joins weekend evening round by phone * Consultant present on unit until 13:00 at weekends. * 72 hours of consultant presence established in ESHT. Standard: 60 hours.	* Develop a way of recording ward rounds to evidence compliance. * Discuss attendance at evening ward round - job planning and funding required * New IT system (launching July 2021) will provide a record of consultant ward rounds
6	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Several externally funded training courses have been provided e.g. * Documentation * Human Factors * Development of PMAs, * Return to practice midwives * Midwifery apprenticeships * Midwife sonographers	Board assurance that all funding is ring-fenced e.g. CNST Incentive Scheme funds – previously partly used as CIP.
7	Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	No Director of Midwifery Currently. Head of Midwifery in post	Associate Director of Midwifery in post

AMBER – Action in progress

	Recommendation	Current Position	Actions Required
1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Definition of Clinical change agreed by MDT as not defined in report = **Where there are changes within a pathway of clinical care to: approach, treatment, lead clinician, or timescale.** * Robust internal process in place for assessing and implementing clinical change within the Trust e.g. Guideline and Implementation Group, Labour Ward Forum, Daily and Monthly Risk meetings, Morbidity & Mortality meetings, Professional Reviews, PMRT, Local Steering Group Meetings. All have MDT in-put. * Structured reporting mechanisms within Trust e.g. Incident Reporting Guideline and Maternity Risk Management Strategy. * Structured reporting mechanism to LMS via Quality and Safety Meeting held bi-monthly - SIs can be shared but currently not mandated * Maternity dashboard shared with Board, CCG and with LMS - themed reviews take place if indicated -e.g. third and fourth degree tear rates triggered an improvement project * Monthly reporting to Board members via Integrated Performance Review Meetings. * Bi-monthly Maternity Board Meetings allow direct review of maternity services and escalation of issues to Board members	* Review TOR for LMS Quality and Safety Meeting * Finalise and enact assurance programme for embedded actions/ changes
2	Are you submitting data to the Maternity Services Dataset to the required standard?	* Awaiting E3 (maternity IT system) maternity services dataset update to submit continuity of carer data - by end January 2021. Compliant with all other data sets to achieve CNST standard * Robust CNST action plan led by IT in place.	* E3 update
3	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	PRactical Obstetric Multi-professional Training (PROMPT) is and held on a monthly basis for staff to attend yearly. * Compliance data submitted to CNST on a yearly basis. *QI lead keeps evidence of attendance via signed sheets and database. * Not currently validated through LMS. * Training was suspended for 6 months owing to pandemic. recommenced in Oct. Suspended again in Jan 2021. Training now virtual.	New requirement - * Establish a mechanism to validate data through LMS

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	* Medical staffing workforce planning as RCOG O&G Workforce Status Report 2018, recruitment challenges persists. All RCOG recruitment initiatives have been attempted. * Midwifery staffing - Birthrate+ assessment completed in 2019 with re-assessment in 2020 to allow for Continuity of Carer teams. Funding uplift awarded to recruit staff up to BR+ recommendations - recruited to establishment.	* Medical staffing recruitment improvements * Board discussion re BR+ frequency
5	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	NHSE/I leading planning to establish a maternal medicine network underway.	Development of pathways by NHSE?I and processes to enable the network
6	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on various areas detailed in the Gap Analysis tool.	* Fetal Wellbeing Midwife leads on Fetal Monitoring. * Senior Consultant lead have been in post for a number of years. * Second consultant lead also in place. * Significant investment of time and training re fetal monitoring has resulted in a very significant decrease in incidents related to misinterpretation. * MDT day being implemented. * Central monitoring system launch in the summer * Full compliance with K2 CTG training	* Time and personnel to be invested to increase team capacity. Meeting planned to discuss increased capacity for Fetal monitoring team. Additional support: from Labour ward matrons to be CTG champions - No current formal process.
7	* All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care * Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care * Women's choices following a shared and informed decision-making process must be respected	* All guidelines are evidence based and have multidisciplinary involvement in the ratification process. * Complex care planning appointments available * Second opinions available * Record keeping training by Bond Solon offered to staff. Frequent reminders about full and contemporaneous documentation * Omissions in documentation detected through case reviews discussed with individuals	* Undertake gap analysis with Chelsea and Westminster website.
8	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	* All guidelines and patient information leaflets are evidence based and reflect national guidance. *ESHT has a Consent and Health Records Group	* Undertake gap analysis with Chelsea and Westminster website.
9	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	* Guideline explaining the process for approval of all guidelines, policies and SOPs - * NICE Guidance changes or new guidance are alerted to the Division by the Trust Clinical Effectiveness team - compliance is then assured by the Quality Assurance Lead and Guideline lead consultant. * Guideline Implementation Group is well established with a SOP TOR. * QI lead provides an exception report monthly to the Governance and Accountability Meeting of all Women's and Children's guidelines. * QI lead has a database where all guidelines are monitored and updated as required. There is a robust Trust process to review and provide assurance that we are compliant with current NICE guidance. All steps involved provide assurance. * It is rare that our guidelines don't follow NICE guidance, one example if the meconium stained liquor guideline - we have been more cautious with our guideline because we have a freestanding MLU. This was agreed at GIGs but has not been agreed outside of the Division.	* Agree process to alert Board to guidelines that do not comply with NICE - Divisional Governance and Quality and Safety Committee discussion
10	We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	Compliant with BirthRate + (BR+) recommendations and midwifery uplift supported by board. Recruited to establishment.	Consider further staffing requirements of Ockenden report - training and specialist midwife recommendations - further BR+ assessment needed to encompass increase training uplift

11	A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specialist substance misuse mental health specialist	Good investment in Specialist Midwife team - * Safeguarding lead midwife, Safeguarding deputy midwife (includes FGM specialist) * Quality Improvement and Assurance nurse/midwife * Governance Lead, deputy governance midwife * Perinatal mental health midwife * Screening lead midwife, deputy screening midwife * Project lead midwife (IT) * Fetal wellbeing midwife * Preceptorship facilitator * Professional midwifery partner * De-brief specialist midwife * Diabetes specialist midwife * Clinical education midwife * Infant feeding lead * Young people specialist midwife * Bereavement specialist midwives * Better Births Lead (LMS funded) * Public Health Midwife (LMS Funded) (includes smoking cessation)	Ongoing funding required for Better Births Lead and Public Health Midwife to address local inequalities and progress national recommendations
12	Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into the right jobs.	Fit and proper persons test' from Board level. General service requirements are key rather than being individual specific.	Strategic role - essential to incorporate time for strategic planning. Include importance of need to mentor HOM. Discussion re Director of Midwifery Decision re JD re-evaluation and Director status



Summary

As a maternity team we are proud to provide safe, kind and high quality care and a supportive and fulfilling working environment for our staff. We have robust and transparent governance processes in place, have identified areas for improvement are and have plans in place to progress these improvements. We have progressed significant service transformation with the support of the Trust Board and continue to implement changes which will contribute to enhanced safety outcomes and experience for families. The majority of our multidisciplinary team report that they feel valued and involved in service changes and are encouraged to progress in their chosen career direction. Our extremely positive recruitment and retention success within midwifery is an indicator of staff wellbeing.

The Trust Board is requested to note that 63% of the recommendations rated red or amber are new and only released with the publication of the report in December 2020. The majority of the remaining red or amber recommendations require investment and/or Board or system level agreement. The maternity service is committed to implementing all of the recommendations with the relevant support. 45% of the total recommendations are either met with assurance available or met but require assurance data.

Priority actions requiring Board decision:

1) **Perinatal Clinical Quality Surveillance Model agreement for implementation and process for review – suggested to review as part of the Quality and Safety Committee agenda**
2) **Confirm that the Ockenden report has been reviewed at Public Board**
3) **Confirm that the Board is confident that the assurance mechanisms within ESHT are effective and that the Board is assured that poor care and avoidable deaths with no visibility or learning cannot happen our organisation**
4) **Confirm that the maternity service have completed the assurance and assessment tool**
5) **Formalise the appointment of the Non-Executive Director Maternity Safety Champion.**

Appendix 1 – Letter from NHS Improvement – Amanda Pritchard

NHS

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21 December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) **Monitoring Fetal Wellbeing**
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) **Informed Consent**
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15 January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely

A. Pritchard

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May

Ruth May
Chief Nursing Officer, England

Professor Steve Powis
National Medical Director
NHS England and NHS Improvement

Appendix 2 – ESHT response to Amanda Prichard letter dated 21st December 2021

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

21st December 2020

Dear Amanda,

We write in reference to your letter dated 14th December 2020 in relation to the Ockenden Review of Maternity Services and outline below our response to the seven immediate actions.

1) Enhanced Safety
a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly.

The guidance was published on Friday 18th December at 5pm and the Trust will undertake a rapid review and plan accordingly.

b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

The Trust Board receives a formal report every two months on all SIs. The maternity service also reports on maternity SIs via the Integrated Performance Review Meeting monthly which is chaired by the Trust Chief Executive. Outside of the formal reporting process if there are any serious safety concerns, such as never events, then the Board is notified of these at the earliest opportunity. CCGs hold a Sussex wide panel to close all SI's. The LMS Safety lead is notified of SIs and is part of the CCG closure process. Sharing of learning is through the LMS Quality and Safety Forum.

We will however amend our process and ensure Trust Board members have sight of a monthly report and it will also be added to the LMS agenda.

2) Listening to Women and their Families
a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

This is in place with very active social media feedback as well. This is being supported by the SRO for the LMS and the CCG.

b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety

champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.
This is underway and the NED Champion will be offered membership of the ESHT Maternity Board and MVP meetings. Guidance has just been published and this will be reviewed and actioned accordingly.

3) Staff Training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

We can confirm that this is in place at ESHT. This was evidenced by compliance with this CNST Incentive Scheme standard in 2019.
* This response was updated on 10th January 2021 as this action had been misinterpreted due to missing detail in Amanda Prichard's letter. We are not complaint with this action. Evening consultant present ward rounds do not take place at the weekend.

b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.

An MDT training schedule is in place and the recently published guidance will be reviewed and actioned accordingly.

c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

The Women and Children's division receive the maternity incentive scheme refund and some of this is allocated to staff training and improving safety. A review will be undertaken to ensure the totality of the refund is ring-fenced to improve maternity safety.

4) Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place

This is in place with urgent work required to audit compliance and ensure robust reporting and monitoring via divisional performance review.

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

Sussex LMS has scoped the current arrangements and is liaising with NHSE/I about future Maternal Medicine Network arrangements. This is being led by the NHSE/I Regional Team. The Trust will link in with all developments.

5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

Clinical risk assessment is in place and there is a focussed programme of work to strengthen audit compliance and ensure robust reporting and monitoring via divisional performance review.

PCSP is being implemented with a target date for 100% of service users by March. Implementation in Sussex is a year-long quality improvement project and the Trust is currently off plan as IT systems present a challenge to achieving this.

6) Monitoring Fetal Wellbeing

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

This is in place with two named Consultant leads and a midwife lead leading SBLCB2; the midwife lead had presented internationally about our work.

7) Informed Consent

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

An urgent review is underway of information available for pathways of care with plans to update the Trust's website accordingly.

A systematic calculation of midwifery staffing was completed by BirthRate+ in February 2020, commissioned by the Local Maternity System. The findings were that ESHT Maternity services are budgeted for sufficient midwifery and support staffing to provide high quality care and safely implement continuity of care.

We can confirm that the Ockenden Report will be shared at ESHT's next public Trust Board meeting, which is being held on 9th February 2021 and that the assurance assessment tool will be shared through our LMS and regional teams by 15th January 2021.

Yours sincerely

Joe Chadwick-Bell Peter Kottlar
Chief Executive Sussex LMS

Appendix 3

Perinatal Clinical Quality Surveillance Model

Implementation of the use of this tool is a recommendation from the Ockenden report. The intention would be for the tool to be reviewed as part of the Quality and Safety Committee agenda if the Board is in agreement.

The intention of this tool is to provide:

- Trust board oversight, helping to ensure that issues are addressed in a timely fashion without the need for external intervention.
- Local oversight, by enhancing the role of the LMS through the ICS level local quality group, enabling a system-wide view of quality.
- Aligned national oversight, if interventions do not resolve the quality issue or if they are so serious as to warrant immediate escalation.
- At all levels of the model, the constituent parts have a clear sense of their role, remit and interventions at their disposal and of when to escalate issues.

Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021						
	Jan	Feb	Mar	Apr	May	Jun	Jul
Findings of review of all perinatal deaths using the real time data monitoring tool							
Findings of review all cases eligible for referral to HSIB.							
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.							
Service User Voice feedback							
Staff feedback from frontline champions and walk-							
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust							
Coroner Reg 28 made directly to Trust							
Progress in achievement of CNST 10							

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period December 2020 (Month 9)

Content

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

About our IPR

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

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

East Sussex Healthcare NHS Trust

Performance Summary

Safe	Target	Nov-20	Dec-20	Variation	Assurance
Serious Incidents	<>	10	2	Common Cause	No Target
Never Events	0	2	0	Common Cause	Inconsistent
Falls, per 1000 Beddays	< 5.5	5.5	6.7	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	4	1	Common Cause	Inconsistent

Infection Control	Target	Nov-20	Dec-20	Variation	Assurance
MRSA Cases	0	0	0	Common Cause	Inconsistent
Cdiff cases	< 5	3	2	Common Cause	Inconsistent
MSSA cases	<>	2	3	Common Cause	No Target

Mortality	Target	Prev	Latest	Variation	Assurance
RAMI	<>	87.5	87.5	Concern	No Target
SHMI (NHS Digital monthly)	<>	0.97	0.98	Common Cause	No Target

Caring	Target	Nov-20	Dec-20	Variation	Assurance
Complaints received	<>	30	31	Common Cause	No Target
A&E FFT Score	> 96%				
Inpatient FFT Score	> 96%				
Out of Hospital FFT Score	> 96%	FFT suspended mid March 2020			
Maternity FFT Score	> 96%				
Out of Hospital FFT Score	> 96%				
Outpatient FFT Score	> 96%				

Operational Performance (Responsive)	Target	Nov-20	Dec-20	Variation	Assurance
A&E 4 hour target	> 95%	87.5%	72.6%	Concern	Inconsistent
12 Hour DTAs	0	0	0	Common Cause	Consistently Hit
Acute Non Elective LoS	3.6	3.9	4.7	Concern	Inconsistent
Community LoS	25	21.8	20.6	Common Cause	Inconsistent
RTT under 18 weeks	> 92%	88.6%	86.5%	Common Cause	Consistently Missed
RTT 52 week wait	0	73	73	Concern	Consistently Missed
Out of Hospital within target wait time	<>	80.0%	89.0%	Common Cause	No Target
Diagnosic under 6 week	< 1%	23.7%	25.7%	Concern	Consistently Missed
Cancer 2 week wait	> 93%	97.3%		Common Cause	Consistently Hit
Cancer 62 day	> 85%	87.5%		Common Cause	Inconsistent

Organisational Health	Target	Nov-20	Dec-20	Variation	Assurance
Trust Level Sickness Rate	<>	4.5%	4.6%	Concern	No Target
Trust Turnover Rate	10.4%	9.9%	9.9%	Improvement	Consistently Hit
Vacancy Rate	9.3%	1.9%	2.1%	Improvement	Inconsistent
Mandatory Training	90%	88.2%	87.9%	Common Cause	Consistently Missed
Appraisal Rate (%) 12 months	85%	76.6%	75.1%	Concern	Consistently Missed

Exceptions in month	Target	Nov-20	Dec-20	Variation	Assurance
VTE Assessment compliance	95%	94.4%	91.1%	Concern	Consistently Missed

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

Phase 3 Recovery	Nat. Target	ESHT Target	ESHT Actual
First Outpatient Attendances	100%	93%	86%
FollowUp Outpatient Attendances	100%	100%	87%
Elective DayCase Spells	90%	90%	83%
Elective Ordinary Spells	90%	80%	78%
Diagnostic Tests	100%	99%	98%

Quality and Safety

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

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

December 2020 Data

Complaints received
Rate of complaints was highest in WC&SH and this was reviewed and discussed at their Div IPRM. No specific themes or trends. Divisions tried hard to maintain responses but this became more difficult as the month progressed.

Falls
The rate of falls for Dec was 6.8 per 1000 bed days (within control limits) and there were two falls to fracture in month. Staffing was significantly adversely affected in Dec (and still is at time of writing in Jan) with considerable operational pressures.

Infection Control
The trust continues to meet all mandatory HCAI reporting requirements. The number of Clostridium difficile infections was within the monthly limit in December and the trust remains within the annual limit (based on previous year still due to Covid). Post infection reviews underway (may be delayed) and anti-microbial ward rounds are taking place on wards of high incidence.

COVID-19
The trust has seen an eightfold increase in in-patients with COVID. A rapid and significant increase in admissions to Conquest hospital in early December was followed by a similar increase in incidence at EDGH late in the month and into January reflecting the escalating prevalence in the local population. The new variant of concern (VOC) also caused much greater transmission within the hospital and is reported nationally to be 70% more infectious. HCAI rate due to COVID was at approximately 25% but now improving. Outbreaks have been managed as per trust policy and national guidance with DIPC oversight. The new IPC BAF continues to be reviewed at the Q&SC with good progress and assurance to date.

Serious incidents
There were 2 serious incidents reported in December. This is a reduction from November and there may be some under reporting due to the significant impact on staffing coupled with the enormous operational pressures. The Governance team are supporting as much as possible.

Pressure Ulcers
Rates remained within control limits with common cause variation. There may be some under reporting and all but one of the Tissue Viability Team have now been redeployed to clinical areas so validation may be delayed. One Category 3 PU was reported in December, the RCA will be reviewed by a specialist Tissue Viability Nurse as the PURG has not able to take place.

Workforce
Staff absence continued to rise through December and is higher at time of writing. There was and still is unprecedented additional capacity open increasing the demand with ratios and skill mix significantly adversely affected. All efforts have been made to maintain urgent elective services as well as the launch of the Covid Vaccination programme. Health and well-being support for staff continued including the provision of lateral-flow tests.

Mortality
Our current SHMI is 96. RAMI results suggest there had been an increase in mortality, over and above any coding issues, however we remain better than average.

Author(s)

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

David Walker
Medical Director

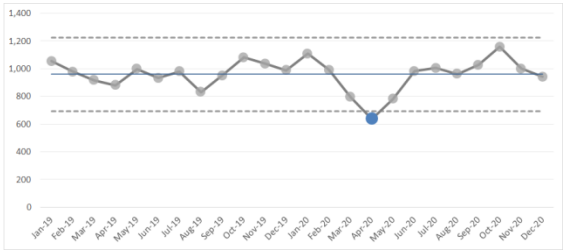
Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

Patient Safety Incidents
(Total Incidents ESHT and Non ESHT)

Target: monitor
Variation normal
Current Month: 941



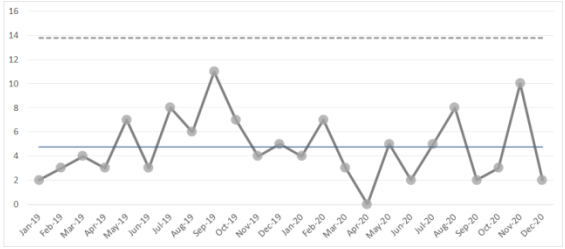
The number of patient safety incidents reported decreased slightly over November and December. This is likely due to the significant pressures, increased Covid activity and impact on staffing causing a reduction in reporting. This is being monitored with extra support being provided to clinical teams from the central governance teams.

Top 3 categories for **ESHT safety incidents**:

- Slips, Trips and Falls (146)
- Medication-related incidents (75) – a reduction, no specific concerns and monitored via Patient Safety & Quality Group
- Diagnosis and Diagnostics (60) – no specific concerns and no particular themes or trends.

Serious Incidents
(Incidents recorded on Datix)

Target: monitor
Variation: normal
Current Month: 2



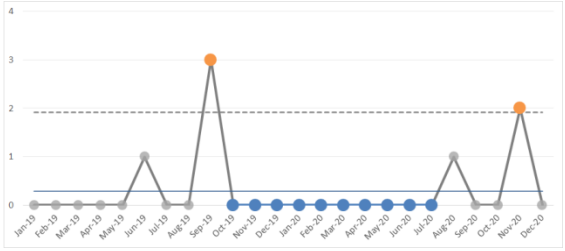
Serious Incident Management
There were 2 **serious incidents** reported during December:

- 2 x falls to fracture both subject to RCA

At the end of December there were 31 Serious Incidents open in the system; 23 under investigation and within timescales, 1 kept open by the Clinical Commissioning Groups (CCG), 5 with CCG for closure and 2 incidents are with the Healthcare Safety Investigation Branch. (Process now suspended again at time of writing)

Never Events
(Incidents recorded on Datix)

Target: 0
Variation: normal
Current Month: 0



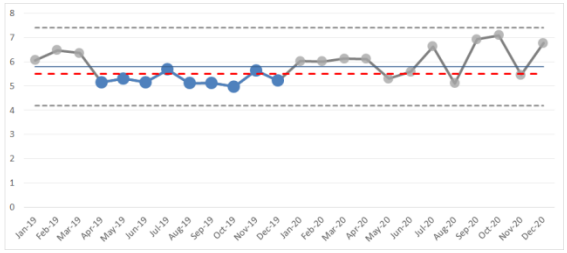
Duty of Candour (DoC):
For December verbal DoC was 77% and written was 76% which were both an improvement compared to November. This is is a rolling 12 month figure and is discussed at the Weekly Patient Safety Summit, Senior Leaders Forum and the Quality & Safety Committee.

Safe Care - Falls

East Sussex Healthcare NHS Trust

Total Falls Per 1000 bed days

Target: 5.5
Variation: Normal
Current Month: 6.8

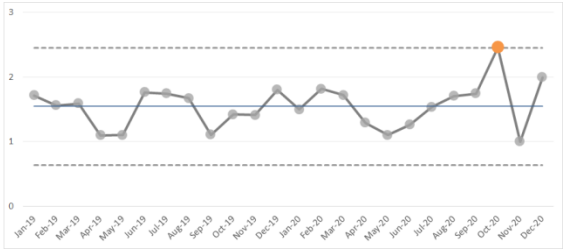


Falls in December reported at 6.8 per 1000 bed days, with the rate near the trust's determined Upper Control Limit just within normal variation. There may be some underreporting due to challenges and workforce issues.

Work is ongoing with discussion at the Q&SC. Clinical areas were extremely busy with significant amounts of additional areas open and increasing workforce challenges. The IPC requirements for Covid continued to present significant workforce and operational challenges in some areas. Donning (applying) additional PPE may mean slightly longer response times in certain clinical situations including falls.

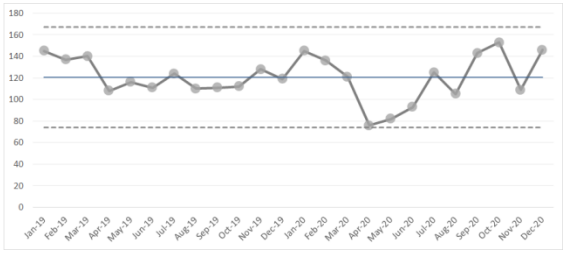
Falls with Harm Per 1000 beddays

Target: monitor
Variation: Normal
Current Month: 1.99



Total Falls

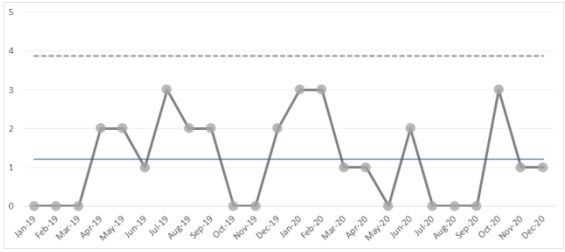
Target: monitor
Variation: normal
Current Month: 146



A cluster review for falls resulting in severe harm is being undertaken by the Medicine Division but is delayed due to the significant pressures. It will report back to the Falls Group, Patient Safety & Quality Group and the Quality & Safety Committee.

Major or Catastrophic Falls

Target: monitor
Variation: normal
Current Month: 1



There were two falls with harm in December now being investigated as SI's. One occurred in November but was reported as an SI in December.

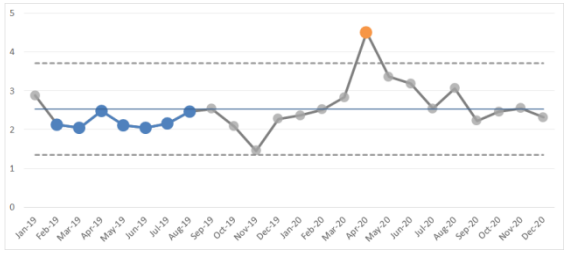
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

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

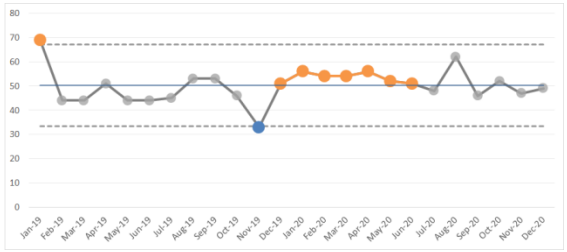
Target: monitor
Variation: normal
Current Month: 2.3



Pressure Ulcer (PU) Incidence was returning to pre Covid levels. Rates remained within control limits with common cause variation. As with other harms and incidents there may be under reporting of PU incidents with support from the central governance team. At time of writing all but one of the Tissue Viability Team have been redeployed to clinical areas.

Pressure Ulcers Category 2 (inpatient and community)

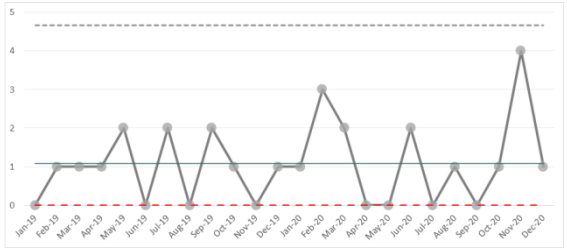
Target: monitor
Variation: normal
Current Month: 49



Of the 49 category 2 pressure ulcers reported in December ; 29 occurred in the acute hospitals, and 20 amongst patients in the community. No specific themes or trends to report.

Pressure Ulcers Category 3&4

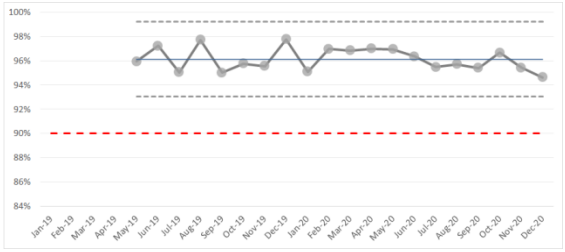
Target: zero
Variation: normal
Current Month: 1



One category 3 pressure ulcer was reported in December within the District Nursing Team case load with full RCA underway.

Pressure Ulcers Assessment Compliance

Target: 90%
Variation: normal
Current Month: 94.6%



Consistently achieved since May 2019.

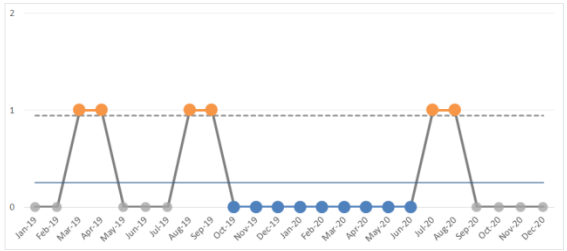
Safe Care - Infection Control (non COVID)

East Sussex Healthcare NHS Trust

Quality and Safety

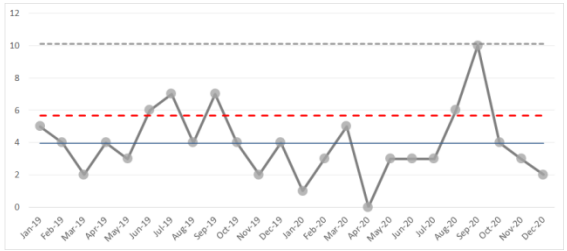
MRSA cases

Target: zero
Variation: normal
Current Month: 0



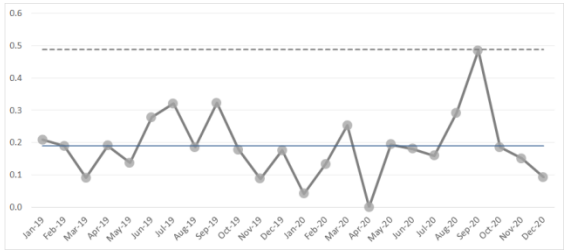
CDIFF cases

Target: 5.66
Variation: normal
Current Month: 2



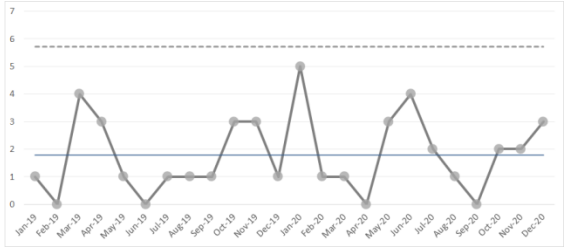
CDIFF per 1000 bed days

Target: monitor
Variation: normal
Current Month: 0.09



MSSA

Target: monitor
Variation: normal
Current Month: 3



MRSA bacteraemia –
There were no attributable MRSA bacteraemias reported for the month of December.

Clostridium Difficile –
For the month of December, the trust reported 2 hospital attributable cases against a limit of 6. Of those 2 cases, 1 were HOHA (Hospital Onset Healthcare Associated) and 1 was a COHA (Community Onset Healthcare Associated). Post infection reviews will be undertaken.

MSSA bacteraemia -
For the month of December, there were 3 reported hospital attributable cases. Two of the 3 cases were assessed as possibly avoidable infections. One infection related to joint replacement surgery and a second avoidable infection in a neutropenic patient related to a PICC line.

Safe Care - Infection Control - COVID

Cases

Since November, COVID cases have continued to rise in East Sussex. At time of writing in January 20201 the trust currently has 428 positive inpatients and is experiencing significant operational challenges including severe staffing shortages across almost all areas. A significant increase began in early Dec and speed of spread at the Conquest was rapid with Eastbourne following some weeks later. This was likely to be the new variant of concern (VOC).

Total positive cases to date is 1,585 with daily reporting now regarding likely onset. The four categories are community onset, indeterminate, probable and definite healthcare acquired based on the national definitions as agreed in May 2020 based on timescales for positive results. There was an increase in likely acquisitions which is thought to be linked to the new VOC. This has reduced and is now an improving picture. Many patients (and staff) are well and asymptomatic which can also make it difficult in terms of outbreak management and investigation. Mitigations include pts wearing masks, enhanced cleaning, HEPA filtered air purifiers, screens between beds and ongoing close working with Public Health colleagues and regional and national IPC teams.

Testing

In-house testing has increased considerably now with additional rapid testing on line. Twice weekly staff testing is well established now with robust reporting, support and management in place.

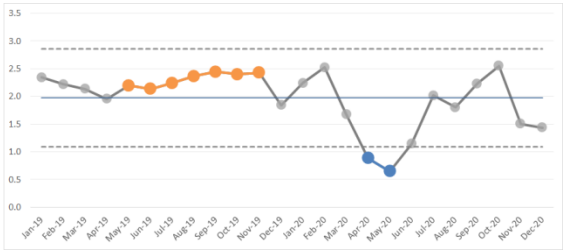
Covid Vaccination

The Trust is a hospital Hub and the vaccination programme is now established which is focusing on all health and care staff across Sussex as well as ESHT staff.

What patients are telling us?

East Sussex Healthcare NHS Trust

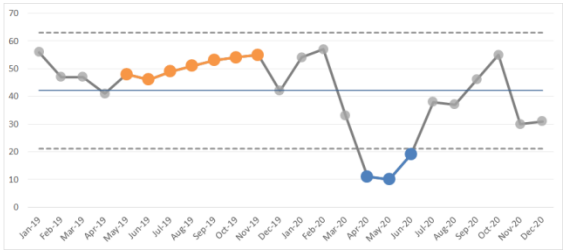
Complaints Received per 1000 bed days



Target: Monitor
Variation: normal
Current Month: 1.44

Themes continued to be about standard of care, patient pathway and communication with issues relating to lack of confidence in delivery of care and missed diagnosis.

Complaints Received

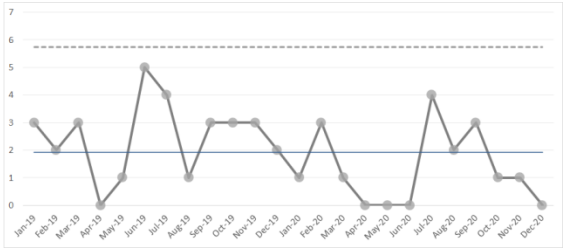


Target: Monitor
Variation: normal
Current Month: 31

- Medicine - 11 complaints – 0.8 per 1000 bed days*
- Urgent Care - 6 complaints
- DAS - 9 complaints – 1.8 per 1000 bed days*
- Out of Hospital - 1 complaint
- WC&SH – 2 complaints – 1.9 per 1000 bed days*
- Other depts - 2 complaints

* This includes all complaints not just inpatient stays

PHSO contacts



Target: Monitor
Variation: normal
Current Month: 0

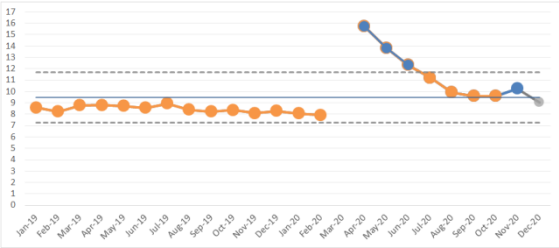
There were no contacts from the PHSO in December.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

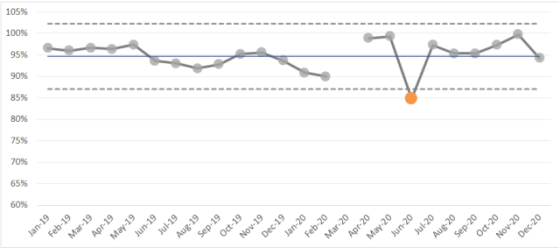
CHPPD
(Trust)



Target: monitor
Variation: normal
Current Month: 9.0

Care Hours Per Patient Day (CHPPD):
Care Hours Per Patient Day remained within accepted levels. The Model Hospital data has now been updated for *October 2020* and ESHT CHPPD at that time was 9.6 in line with the national acute and integrated peer medians which were at 9.1 and 9.3 respectively. CHPPD is calculated by the total number of hours worked by Registered and Unregistered Nursing Staff divided by the total number patients in beds at midnight.

Staff Fill Rate
(total)



Target: 100%
Variation: normal
Current Month: 94.2%

Staff fill rate – planned vs actual:
The fill rate for nursing across the Trust decreased overall. Additional escalation areas were opened and the rate of staff absence increased. Whilst there are some areas such as Critical Care where a large number of staff over the planned establishment has been required, the majority of in -patient areas have not reached the planned establishment due to high numbers of staff absences overall and significant additional capacity being required and opened. The fill rate is a percentage of actual staff on duty compared to the budgeted or planned establishment

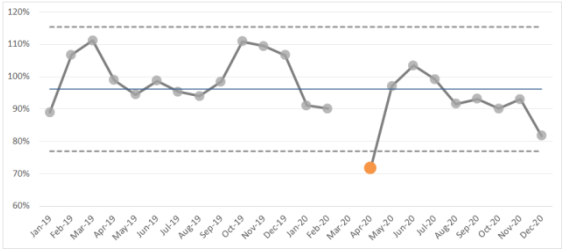
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

Staff Fill Rate (Bexhill)

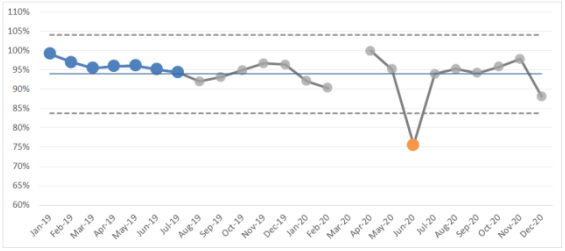
Target: 100%
Variation: normal
Current Month: 81.7%



Bexhill Irvine Unit saw a decrease in fill rate which mirrors that of the Conquest Hospital. It has remained a challenge to fill shifts due to an increase in staff absences and Covid related sickness.

Staff Fill Rate (Conquest)

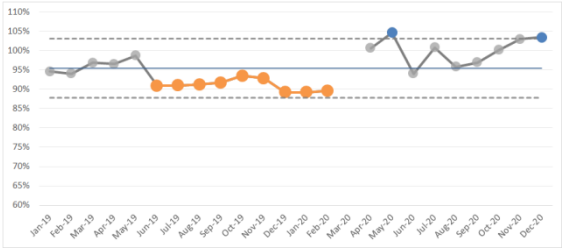
Target: 100%
Variation: normal
Current Month: 88.2%



There has been a decrease in the fill rate for Conquest against the planned nursing establishment due to the high numbers of staff absences.

Staff Fill Rate (Eastbourne DGH)

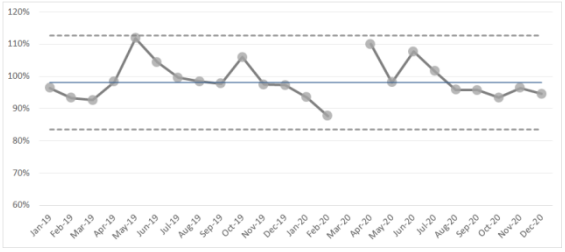
Target: 100%
Variation: normal
Current Month: 103.4%



The fill rate for Eastbourne Hospital reflected the increased number of escalation areas open to accommodate the high number of admissions in December but not all gaps were able to be filled and skill mix and ratios were/are affected.

Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: normal
Current Month: 94.5%



Rye Memorial remained at an acceptable level of filled shifts in Dec.

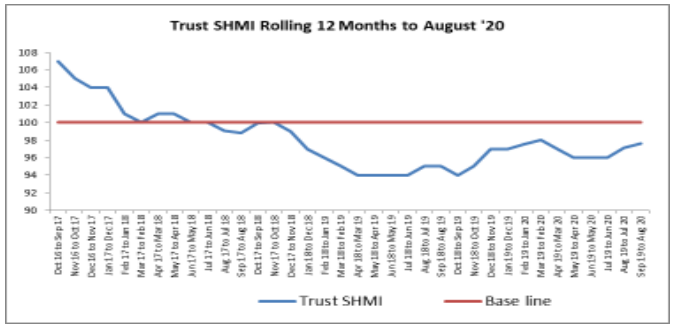
Effective Care - Mortality

East Sussex Healthcare NHS Trust

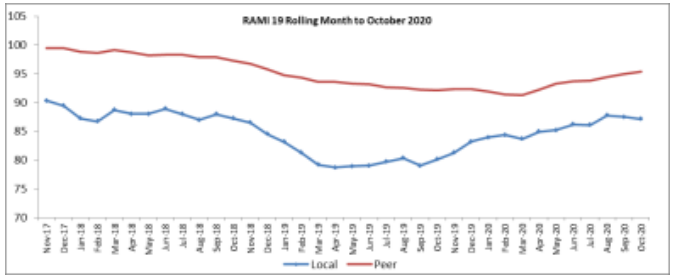
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

Summary Hospital Mortality Indicator (SHMI)

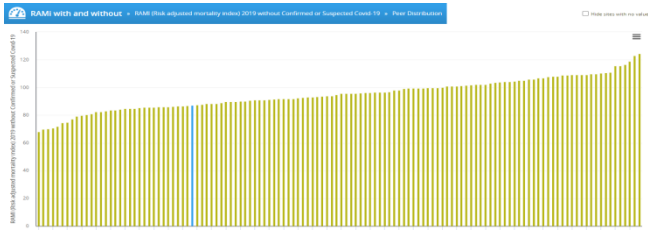
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



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



- SHMI – September 2019 to August 2020 is showing an index of 0.98
- RAMI has been rebased and has been updated to RAMI 19
- RAMI 19 without confirmed or suspected Covid-19 – November 2019 to October 2020 (rolling 12 months) is 87 compared to 80 for the same period last year. October 2019 to September 2020 was also 87.
- RAMI 19 was 84 for the month of October and 77 for September with a peer position of 94 and 89 respectively. As with SHMI, RAMI is not designed for this type of pandemic activity, so RAMI without Covid-19 has been provided for consistency.
- Crude mortality without confirmed or suspected covid-19 shows November 2019 to October 2020 at 1.61% compared to 1.45% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 82% in October 2020 compared to.73% in September 2020.



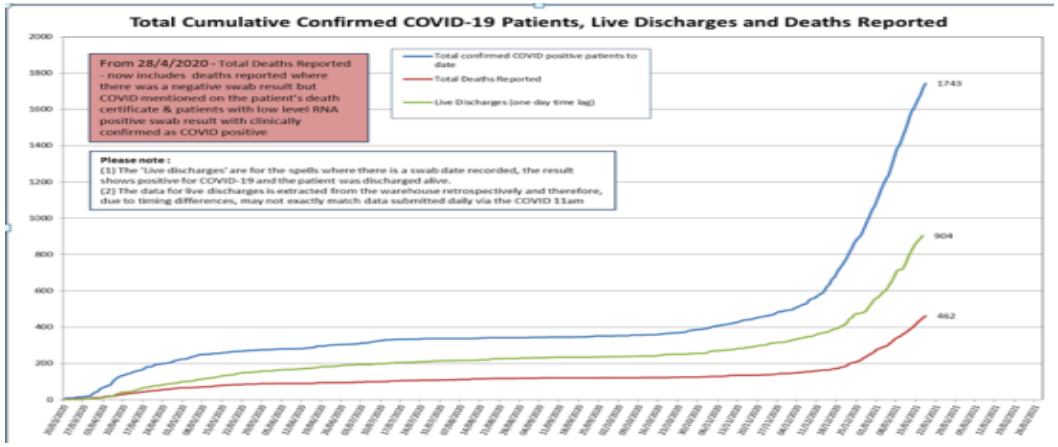
RAMI v Peer

This shows our position nationally against other acute trusts - currently 33/126

December 2020 Main Cause of In-Hospital Death Groups (ESHT)

COVID-19	120
Sepsis/Septicaemia	26
Pneumonia	19
Cancer	14
Heart Failure	11
Cerebro-vascular Incident	8
Chronic Obstructive Pulmonary Disease (COPD)	3
Urinary Tract Infection (UTI)	3
Acute Kidney Injury (AKI)	2
Community-acquired Pneumonia	2
Dementia	2
Myocardial Infarction (MI)	2
Atrial Fibrillation (AF)	1
Liver Disease	1

There were 120 COVID-19 related deaths in December compared to 11 in November.



02/02/2021

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

Workforce

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

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Annual turnover** is unchanged at 9.9% has reduced by 0.1% to 9.8% reflecting 601.5 FTE leavers in the rolling 12 months	**Monthly sickness** has increased 1.5% to 5.9%. **Annual sickness** rate has increased by 0.1% to 4.6% The **Trust vacancy rate** has increased by 0.2% to 2.1% . **Current vacancies** are showing as 142.8 ftes **Mandatory Training** compliance rate has reduced by 0.3% to 87.9% **Appraisal** compliance has reduced by 1.5% to 75.1%	 **Steve Aumayer** Chief People Officer

Actions:

- The next cohort of 17 Nurses and 8 Radiographers are due to arrive at the Trust by early February, bringing the total of international nurses arriving at the Trust since Dec 2017 to 225. A further 40 candidates are in the pipeline for arrival by the end of March. Campaign planned for 2021/22 to deliver a further c150 Nurses. Retention rates remain high at over 95%. Continued support given with accommodation, visas and wellbeing both during quarantine and as part of their on boarding programme at the Trust.
- All overseas nurses who had their OSCE suspended have now successfully passed and gained their NMC registration
- Occupational Health (OHD) providing 7 day access for staff COVID enquiries and to support management of staff contacts with positive COVID cases.
- OHD continue with contacting staff members who are away from work linked to reasons of stress and anxiety. Operational HR are contacting staff who are recorded as COVID sick, self-isolating or under quarantine 48 hours before due return date, to offer wellbeing support and confirmation of a return to work date. The OHD COVID hub supports staff and managers with contact tracing of those who test COVID positive, welfare checks during absence, access to PCR testing via the national route currently.
- OHD are providing continued psychological intervention for teams to reduce the likelihood of PTSD and burnout and have established a direct referral for staff requiring individual trauma therapy to deal with work based trauma and PTSD. They are also progressing commencement of Trauma Risk Management training to key staff in front line areas in order to better support colleagues experiencing trauma as part of a debrief intervention.
- Mass Vaccination Training Programme is underway for COVID vaccinators. The programme continues to expand and support provided to ensure Covid Vaccinators are developed as quickly as possible. Currently there are 93 trained Covid Vaccinators; with a further 140 undertaking the HEE/PHE COVID modules in accordance with HEE/PHE requirements.
- Mass Vaccination dynamic forecasting tool designed and built to manage vaccine usage, booking slots and workforce to support the acceleration of administering immunisation.
- Workforce Situation Reports continue supported by daily analysis to track staffing gaps and hotspots so operational reassignment can take place
- Redeployment Office has reassigned over 200 staff despite services not being postponed to release staff in the same way as wave1. Co-ordination of workforce pipelines include substantive, bank, Voluntary Services, healthcare partners.
- Lateral Flow testing distribution planning underway for 2nd tranche of test kits to all staff as well as supporting patient flow through ED
- Business Planning and workforce planning has been provided centrally for 21/22 due to operational pressures. The expectation is that business cases, CIP's and cost pressures will be added to adjust the position later in the year

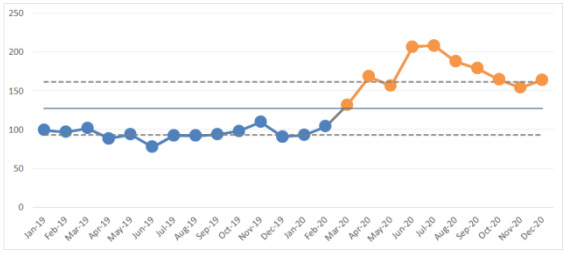
Workforce – Contract type

East Sussex Healthcare NHS Trust

Quality and Safety

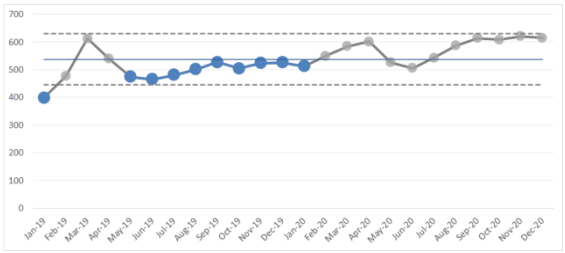
Agency FTE Usage

Current Month: 164.0



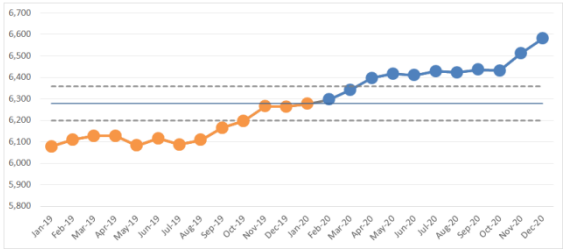
Bank FTE Usage

Current Month: 614.5



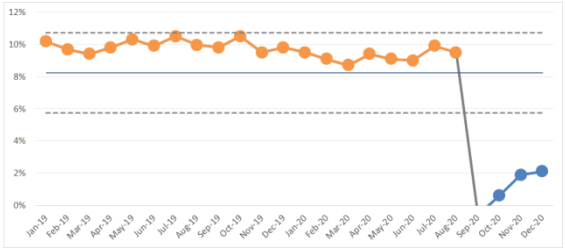
Substantive FTE Usage

Current Month: 6,580.6



Vacancy Rate

Current Month: 2.0%



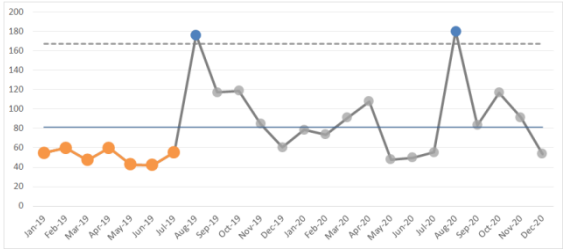
- Agency fte usage has increased by 9.9 fte overall.
- Agency supply has decreased by 38%, however. Approximately 5% has converted from agency to bank (mainly within Estates) but the significant driver for decrease in supply is due to agency staff declining to work within Red areas.
- Bank fte usage has decreased by -6.5 ftes. Bank reporting is in done in arrears, however, reflecting November timesheets.
- Trust Bank resourcing has increased by 28% compared to April.
- The demand for temporary staffing has increased by 39% compared to Nov 20 (total shift request 26,600) . December requests have exceeded the Trust's previous highest month, which was Apr 20 during the 1st wave (24,029 requests).
- Substantive fte usage increased by 68.0 ftes this month, including a decrease in Medical usage (-11.4 ftes) and an increase in Nursing usage (+46.0 ftes; comprising +1.2 fte registered and +44.8 unregistered).
- The Trust vacancy rate has increased by 0.2% to 2.1%, partly due to further adjustments to the budgeted fte establishment that have taken place this month. The vacancy rate is still historically low, due to the changes in the budgeted establishment in September. Total vacancies this month are 142.8 ftes.

Workforce - Churn

East Sussex Healthcare NHS Trust

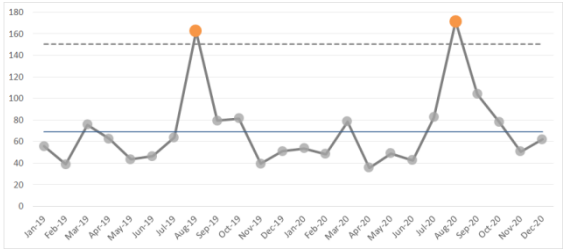
Starters FTE

Current Month: 53.8



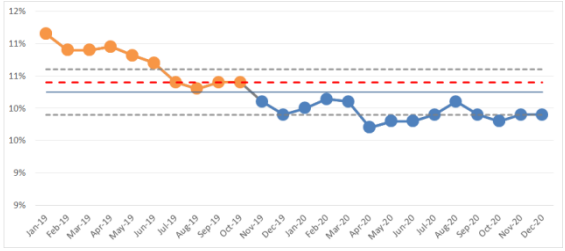
Leavers FTE

Current Month: 62.0



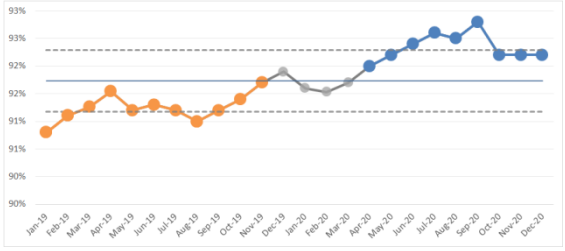
Annual Turnover Rate

Current Month: 9.9%



Retention Rate

Current Month: 92.2%

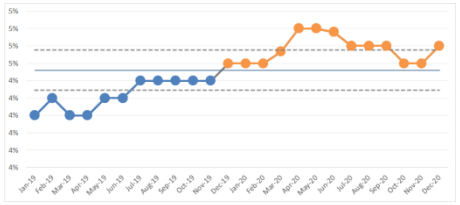


- 53.8 ftes joined ESHT with 62.0 ftes leaving the Trust. We have seen an improvement in the net gain for all staff groups over the last 12 months by +174 ftes in total
- The majority of the Recruitment activity has focused on supporting TWS and ensuring that candidates start as soon as possible by increasing the number of spaces on Induction spaces and reducing the overall Time To Hire, where possible. Month on month (Jan 2020 –Jan 2021) there has been a 12% increase in Medical applicants, with other staff overall showing a 30% increase in the same time period. This has resulted in filling some of the hard to recruit posts such as Consultants in Anaesthetics, Neurology, Rheumatology, Community Paeds as well as Middle Grade Doctors in A&E. Medacs, our Recruitment Practice Outsourcing partner is still continuing to source candidates for these difficult to recruit posts.
- Since Sept, and the opening of the borders, 53 International nurses have joined the Trust with a further 17 joining in January. We are on target to achieve 100 by March 2021. Planning is underway to deliver c185 International Nurses to the Trust during 2020/2021.8 Radiographers are due to be with the Trust by the second week of February with a correlated forecasted reduction in costly temporary workforce for these roles
- The retention rate (i.e. % of staff with more than 1 year's service with ESHT) has remained unchanged, for the third month in a row, at 92.2%.

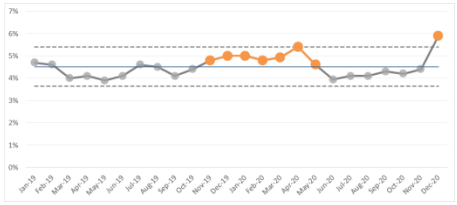
Workforce - Sickness

East Sussex Healthcare NHS Trust

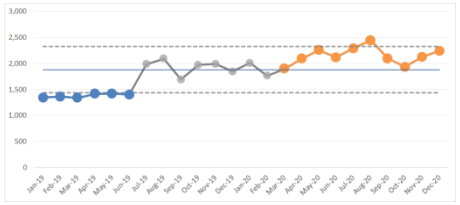
Annual Sickness Current Month:4.6%



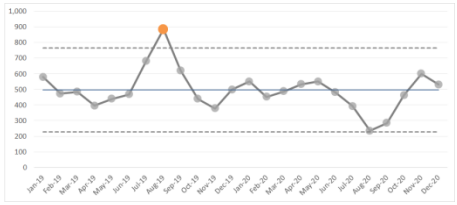
Monthly Sickness Current Month: 5.9%



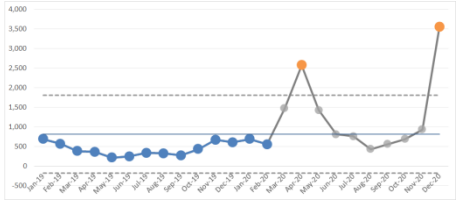
Anxiety/Stress/Depression



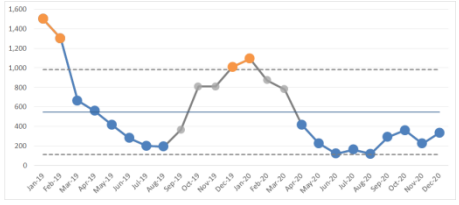
Back Problems



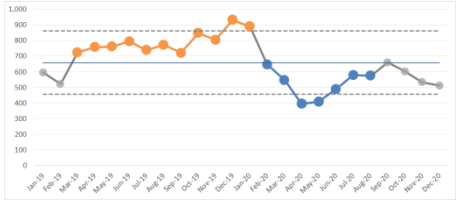
Chest & Respiratory Problems



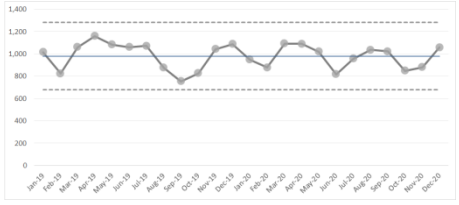
Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



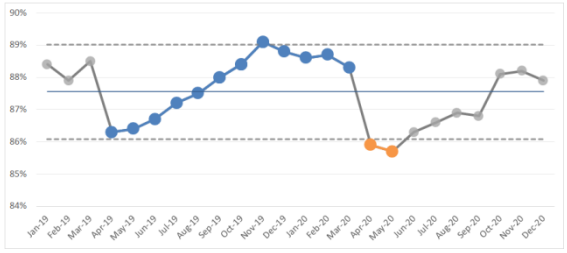
- Monthly sickness has increased sharply by 1.5% to 5.9%, reflecting the impact of the second Covid wave. Chest & Respiratory illnesses are up by 2,619 fte days lost this month to a new high of 3,552 fte days lost (a 74% increase). Annual sickness has risen slightly by 0.1% to 4.6%..
- Total staff reported as absent due to Covid sickness reached 228 for the first time on 14th January (compared to a peak of 128 at the wave #1 peak in early April). Overall 522 staff were off on that date due to all types of sickness, compared to a peak of 478 staff in early April during COVID 19 wave #1.
- Operational HR are in contact with all staff who are sick for reasons of COVID, 48 hours prior to planned return to work date to ensure employee is fit to return to work; confirming date of return and identifying whether additional intervention is required to facilitate their return to role. Ensuring Healthroster is updated with up to date information on the absence to enable up effective roster management.
- Staff absent with stress and anxiety continue to be contacted and supported by Occupational Health on 3rd day of absence; with staff from the HWLB team being aligned to Divisions with a view to contact them on a weekly basis to provide appropriate advice and guidance.

Workforce - Compliance

East Sussex Healthcare NHS Trust

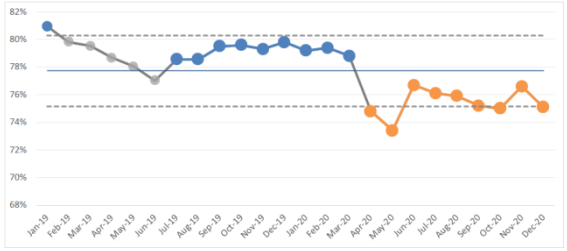
Mandatory Training Compliance

Current Month: 87.9%



Appraisal Rate

Current Month: 75.1%



- The overall mandatory training compliance rate has reduced slightly by 0.3% to 87.9%, reflecting the initial impact of the second Covid wave.
- Many subjects have remained static but annual topics (Fire Safety and Information Governance) have been most affected. That said Deprivation of Liberties compliance has increased by 5.4% this month. Learning & Development communicate with Divisional Governance Leads to identify any staff out of date and who are in a position to update their training, offering support with Library/IT space where practical given the huge pressures all areas are currently working under. A general communication will also be developed and sent out with the support of Communications
- Trust appraisal compliance rate has decreased this month by 1.5%. Learning & Development are working with the Governance Leads to ensure all completed appraisals are recorded on ESR whilst understanding that the current pressures will impact capacity for completion of appraisals. Continued support is being offered to Divisions through webinar training updates and via Teams.
- Following advice from NHS England, the decision was taken to cancel all appraisals for doctors for the 2020-21 appraisal year.

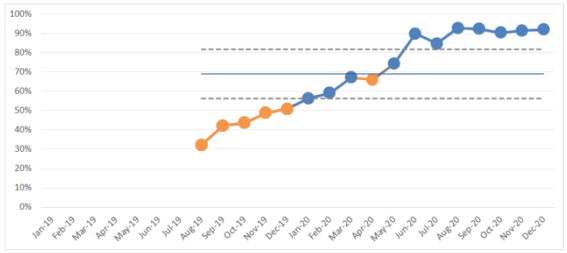
Workforce – Job Planning

East Sussex Healthcare NHS Trust

Quality and Safety

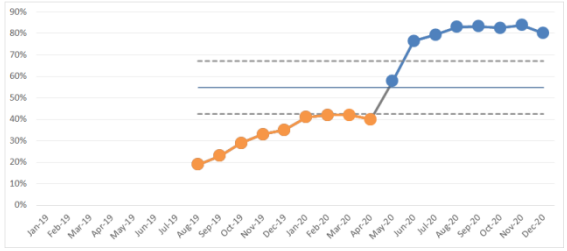
Consultant eJob-Planning Fully Approved Rate

Current Month: 91.8%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 80.0%



- As of 8th January 2021, 224 of 244 consultants (91.8%) and 80 of 100 SAS grades (80.0%) had fully approved job plans.

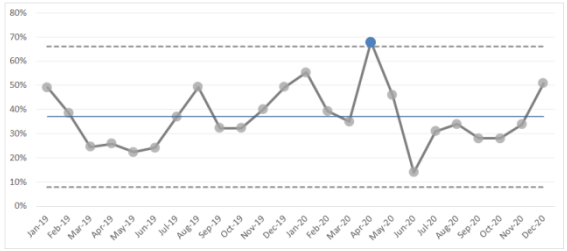
- Overall Trust compliance rate is 88.4%.
- Diagnostics Anaes & Surgery compliance rate is 93.4%
- Medicine compliance rate is 80.7%
- Women & Children compliance rate is 78.3%
- Urgent Care compliance rate is 73.9%.

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

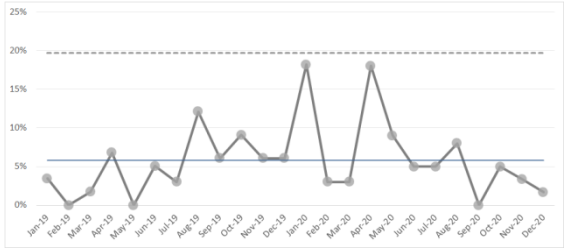
6 week Nursing Management Roster Approval Rate

Current Month: 50.8%



8 week Nursing Management Roster Approval Rate

Current Month: 1.7%

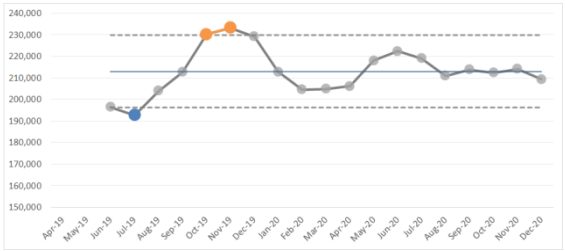


- The following charts show the % of approved rosters as at 6 & 8 weeks prior to commencement.
- For the period commencing 30th Nov ’20, 51% of rosters had been approved at 6 weeks before commencement and 2% had been approved at 8 weeks prior to commencement. This compares to 34% at 6 weeks and 3% at 8 weeks for the previous roster period.
- Monthly reports are produced and sent to Assistant Directors of Nursing and compliance is monitored at the Safer Staffing meeting. During the pandemic, some rostering has been shorter term due to the changing ward footprint.

Workforce – Salary Overpayments

East Sussex Healthcare NHS Trust

Salary Overpayments



Current Month: £209,413

- Outstanding debts as of Dec 20 totalled £209,413 against a 12 month average of £208,541.
- New debt added in December equated to £15,272, from 19 new cases
- There are currently 261 cases in all; 62 relating to current staff and 199 for leavers
- The most common reason for debts is late notification of leaving (33% of cases)
- HR Workforce are looking at introducing a simpler web based staff changes form which should be easier for managers to use
- Finance are reviewing the controls on salary sacrifice schemes which can cause overpayments

Access and Responsiveness

Delivering the NHS Constitutional Standards

Our front door - Urgent Care

How our patients flow through the hospital

Our Cancer Services

Our Out of Hospital Services

We will operate efficiently & effectively

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

Summary

East Sussex Healthcare NHS Trust

Author

Tara Argent
Chief Operating Officer

Access and Responsiveness

Positives

Our response to the Covid-19 pandemic has led to significant changes in the way non-elective and elective care is being delivered. This has been driven by our clinical colleagues ensuring safety, maintaining patient experience within the context of change whilst delivering effective outcomes of care.

The provision of diagnostic services continues and patients are being booked in accordance with the national guidance and clinical prioritisation. Patients are being contacted to ensure that they feel safe to attend their appointments.

The Trust has held several Cancer Recovery focus weeks with all services, these are to review all patients on the waiting list. This has supported the continued reduction of the 62 day backlog in addition the Trust achieved the National Cancer Standard in November at 87.5% this should be acknowledged and recognised, however with the second wave of the COVID pandemic , the Trust performance in December will be circa 79%. We continue to treat our urgent and cancer patients in line with the clinical prioritisation and are planning a further Cancer focus week in February to ensure that the actions are in place to recover.

The Trust RTT performance position is ranked 2^{tnd} out of 111 providers in the country in November. For Elective Care, the priority is to continue to treat P1 and P2 patients based on clinical urgency and within the available capacity in the Trust and the Independent Sector.

Trust continues to monitor and report those patients waiting longer than 52 weeks for elective surgery. The Trust is currently reporting 235 patient waiting over 52 weeks although a large percentage of this is due to patient choice. The harm review policy and process is in place for any patient waiting longer than 62/104 days (Cancer) and 52 weeks (RTT).

Challenges & Risks

As we did in the first wave we are changing the way we provide many services to provide care to the people who most need it, and to keep our patients and colleagues safe.

Thank you to our hard working teams who are being flexible and innovative. But some of these are very difficult decisions
Since the beginning of the pandemic we have increased critical care and general bed capacity, for example by converted surgical wards into medical wards to support more patients.

Following National guidance we have made the very difficult decision to reschedule some routine operations – to allow us to focus on caring for Covid-19 patients, emergency care, cancer care and diagnostics. This has also impacted on the ways in which we deliver some of our services and of course presents us with the challenge of planning for recovery, as a Trust we have demonstrated that we can do this following the first wave. We will take the lessons learnt and start to plan for the coming months.

The past few months have been particularly challenging for our Emergency Departments and we have seen the impact that the COVID pandemic has had on our performance in December we reported 72.6% This was against a national average of 80.3% and positioned ESHT, 86th out of 115 reporting organisations. A significant amount of work across the ICS has been undertaken to avoid admissions and conveyances and the Trust have responded to the needs of the patients.

Our DM01 (Diagnostic 6 week standard) services have been negatively affected during the pandemic as a result of displaced activity whilst prioritising clinically urgent and Covid-19 activity.

We have to acknowledge that RTT performance has declined in December (86.5%) due to the P3 and P4 activity being suspended as part of the pandemic response. Phase 4 recovery will be to comply with the elective access standards and ensure that the Trust recovers reducing the number of patients waiting for elective surgery.

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

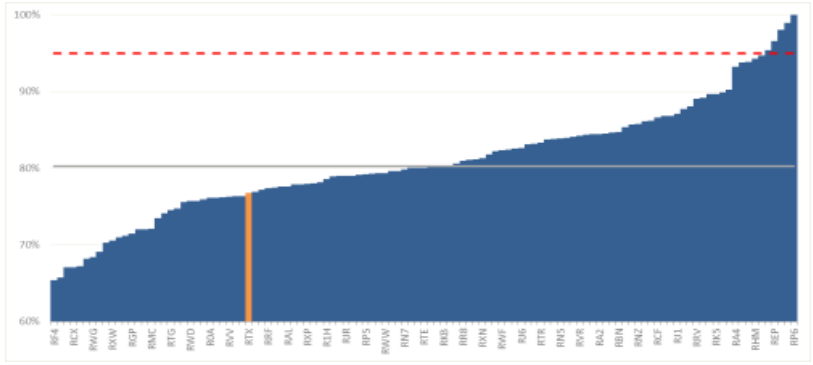
*NHS England has yet to publish all December 2020 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

December 2020 Peer Review

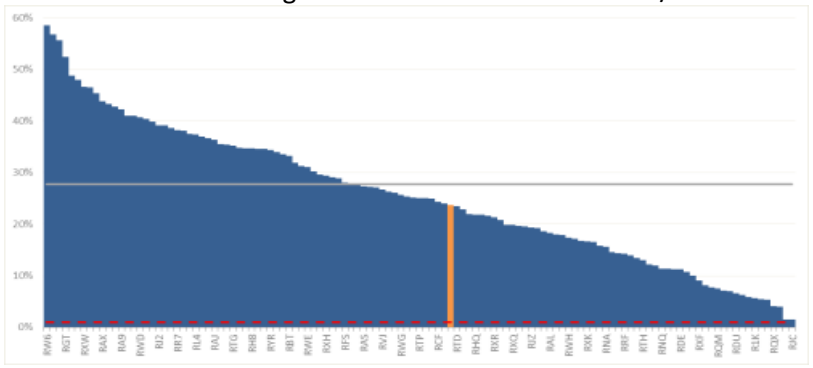
National Average: 80.3% ESHT Rank: 86/115



Planned Care – Diagnostic Waiting Times

November 2020 Peer Review*

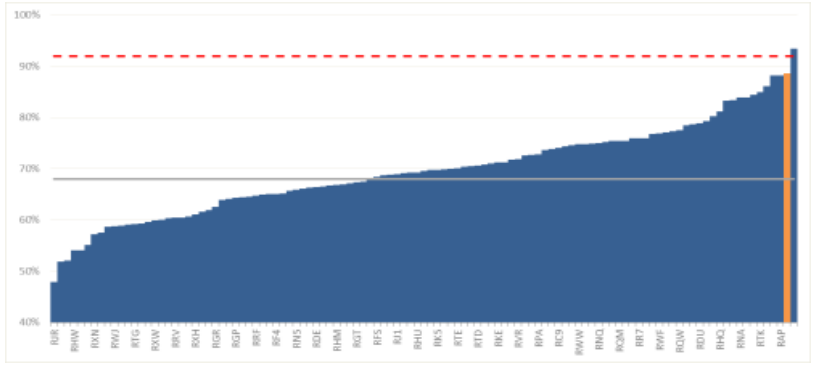
National Average: 27.8% ESHT Rank: 56/121



Planned Care – Referral to Treatment

November 2020 Peer Review*

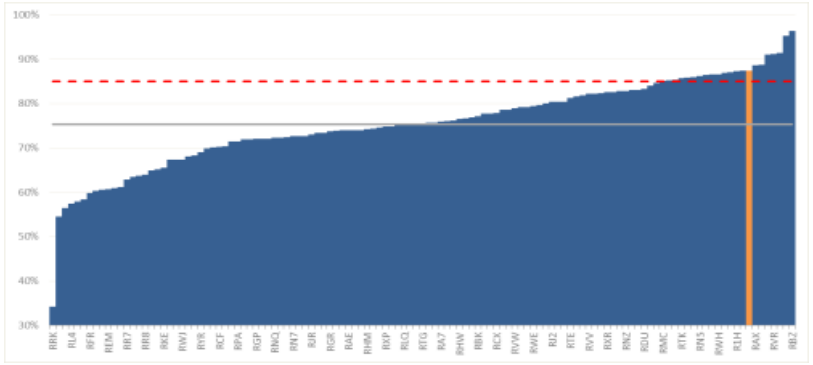
National Average: 68.0% ESHT Rank: 2/111



Cancer Treatment – 62 Day Wait for First Treatment

November 2020 Peer Review*

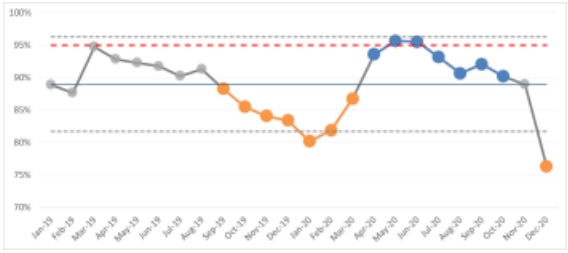
National Average: 75.3% ESHT Rank: 8/121



Urgent Care – Front Door

East Sussex Healthcare NHS Trust

A&E Performance
(Local System)



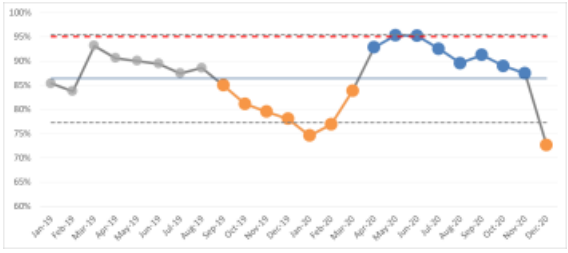
Target: 95%
Current Month: 76.3%

From 1st December to the 31st December 2020, the A&E Performances (including Walk in Centre Numbers) were:

Trust 76.3% – CQ 75.8% – EDGH 76.8%

An overall decrease of 12.6% from the previous month.

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



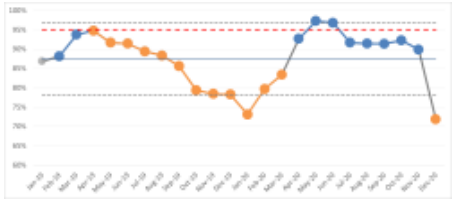
Target: 95%
Current Month: 72.6%

From 1st December to the 31st December 2020, the A&E Performances (Type 1 and Type 3 only) were:

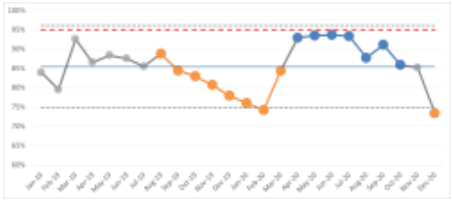
Trust 72.6% – CQ 71.8% – EDGH 73.4%

An overall decrease of 14.9% from the previous month.

CONQ



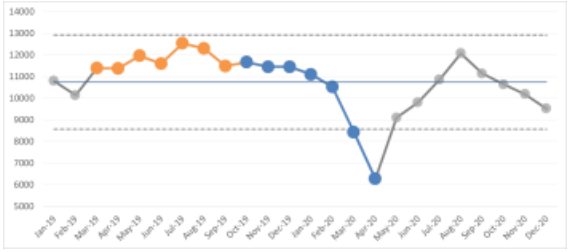
EDGH



For Conquest, the highest breach reason in December was “No Bed Available” with 329 breaches.

For EDGH, the highest breach reason in December was “No Bed Available” with 422 breaches.

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



Target: Monitor
Current Month: 9,518

In December 2020 there were 9,518 attendances in total, 4,701 for Conquest and 4,817 at EDGH.

The total number of attendances for December 2019 was 11,447 (16.9% more than this year).
For Conquest it was 5,677 and EDGH it was 5,770.

Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1

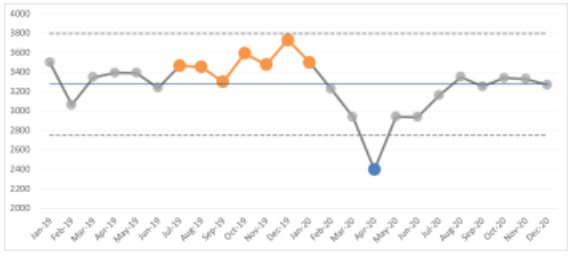
ESHT Total Type 3

Types of A&E service:
Type 1: Consultant led 24 hour service with full resus facilities.
Type 3: Other type of A&E/minor injury units/Walk-in-Centres/Urgent Care Centre.

In December 2020, there were 7,773 Type 1 attendances and 1,733 Type 3 attendances.

Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,269

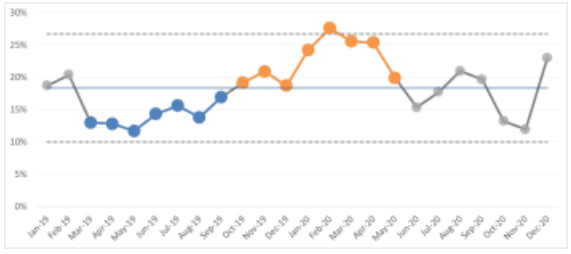


In December 2020, there were 3,269 conveyances in total.

The total number of conveyances for December 2019 was 3,729 (12.3% more than this year).

Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 23.0%

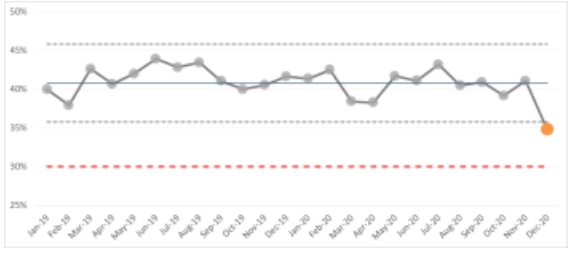


In December 2020, the percentage of conveyance handovers over 30 minutes were 23.0%.

The percentage of conveyance handovers over 30 minutes for December 2019 was 18.7% (4.3% less than this year).

Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 34.8%



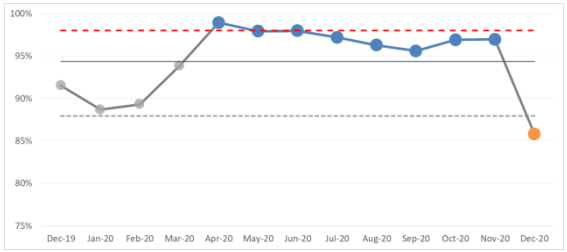
In December 2020, the SDEC performance was 34.8%.

The SDEC performance for December 2019 was 41.6% (6.8% more than this year).

Urgent Care – UTC

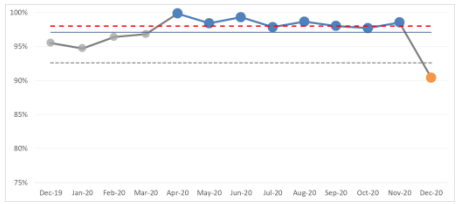
East Sussex Healthcare NHS Trust

UTC 2 Hour Standard
(Treatment start within 2 hrs)

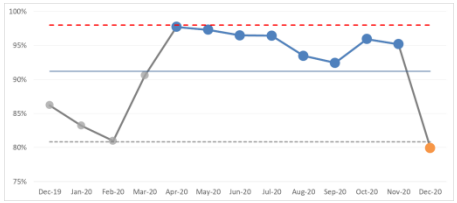


Target: 98%
Current Month: 85.8%

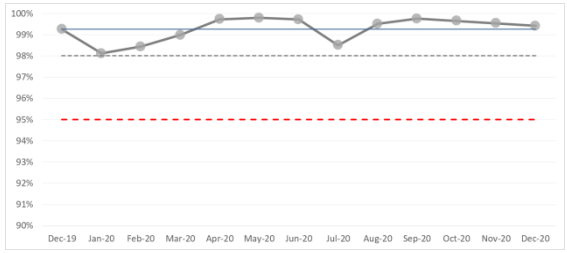
CONQ



EDGH

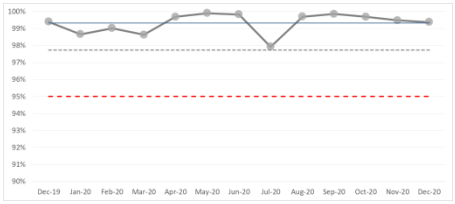


UTC 4 hour standard
(Visit complete within 4 hours)

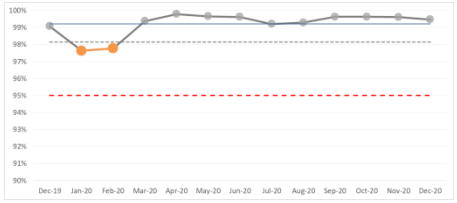


Target: 95%
Current Month: 99.4%

CONQ



EDGH



UTC GP Front Door Model agreed.

Processes are now in place to report UTC attendances.

Continuing to receive high numbers of referrals from 111 especially OOHs. Deep dive completed work continues with 111 to ensure other non-ED pathways are sign-posted to rather then ED first priory option unless ED appropriate or Bookable appointments.

From November 2020 to December 2020 Comparison.

2 Hour
TRUST – 11.2% decrease (97.0% to 85.8%)
CONQ – 8.1% decrease (98.5% to 90.4%)
EDGH – 15.2% decrease (95.2% to 79.9%)

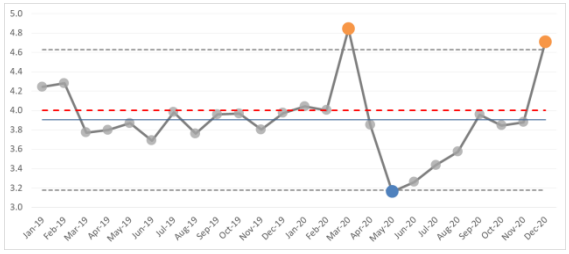
4 Hour
TRUST – 0.1% decrease (99.5% to 99.4%)
CONQ – 0.1% decrease (99.5% to 99.4%)
EDGH – 0.1% decrease (99.6% to 99.5%)

Urgent Care - Flow

East Sussex Healthcare NHS Trust

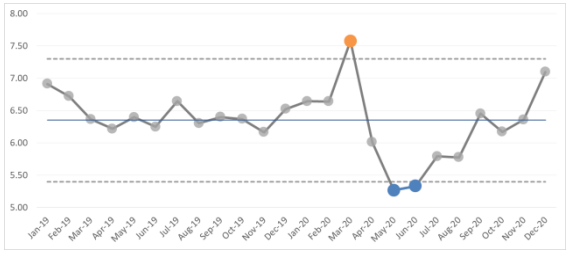
Non-elective Length of Stay (Acute)

Target: 3.60
Current Month: 4.71



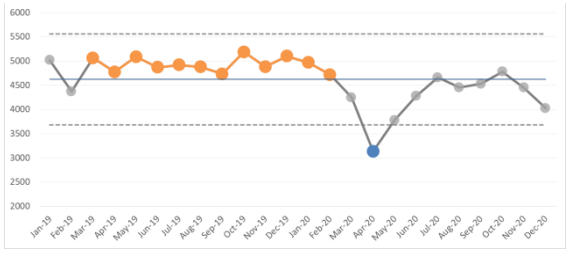
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 7.1



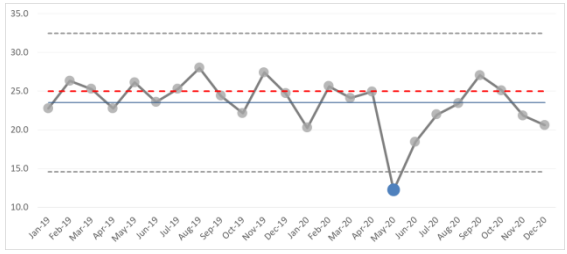
Non-elective Spells

Target: Monitor
Current Month: 4,028



Intermediate Care Units Average LoS (Community)

Target: 25.0
Current Month: 20.6



The Discharge Hub continues working 7 days per week on all medically fit patients on pathways 0 – 3. Out of hospital staff are supporting the hub due to redeployed staff returning to substantive roles.

NEL length of stay increased from 3.88 to 4.71 from November to December 2020.
NEL length of stay excluding zero length of stay increased from 6.36 to 7.10 from November to December 2020.

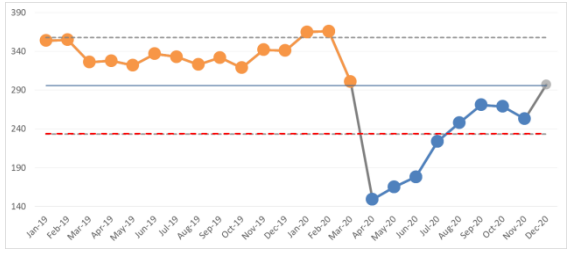
Urgent Care - Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

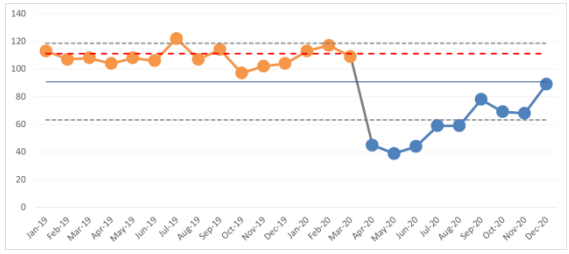
Adult inpatients in hospital for 7+ days (Acute)

Target: 234
Current Month: 297 (Daily Avg.)



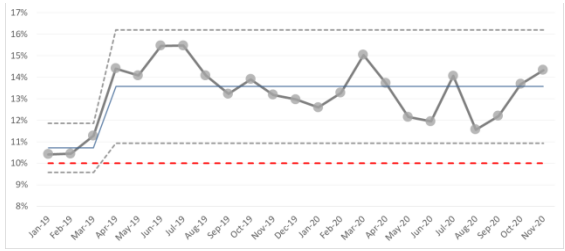
Adult inpatients in hospital for 21+ days (Acute)

Target: 111
Current Month: 89 (Daily Avg.)



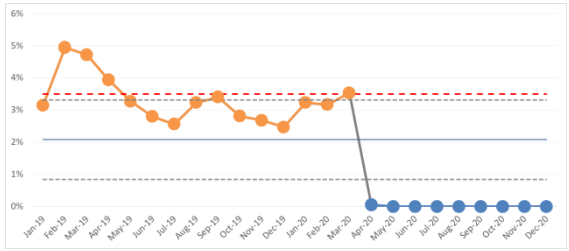
Emergency Re-Admissions within 30 days

Target: 10%
Current Month: 14.3% (Nov-20)



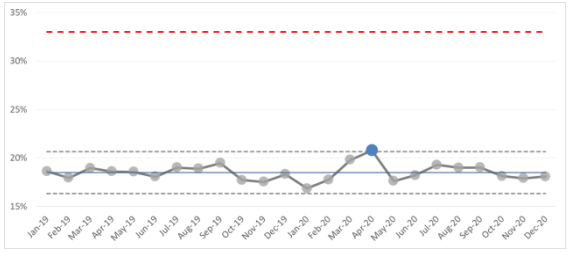
Delayed transfer of care (National Standard)

Target: 3.5%
Current Month: 0.0%



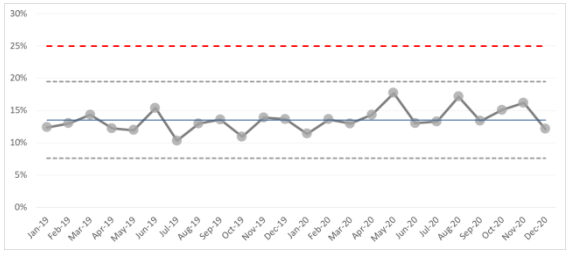
Patients discharged before midday %

Target: 33%
Current Month: 18.1%



Patients discharged on weekend day

Target: 25%
Current Month: 12.1%



The stranded patient numbers has seen an increase from 253 to 297, for the trust. 21 day (LLOS) patients has increased to 89 in December from 68 in November.

Patients discharged before midday has slightly increased in December from November, whereas the percentage of weekend discharges has decreased.

The established emergency readmission rate metric uses finance flags to exclude readmissions in cases where either the initial admission or readmission was an ambulatory tariff. The tariff was discontinued for 19/20, so there has been a step change in the readmission rate because ambulatory admissions are no longer identified as exclusions.

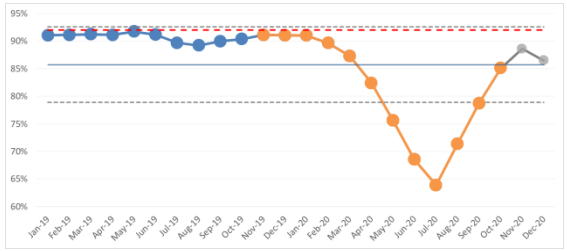
Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

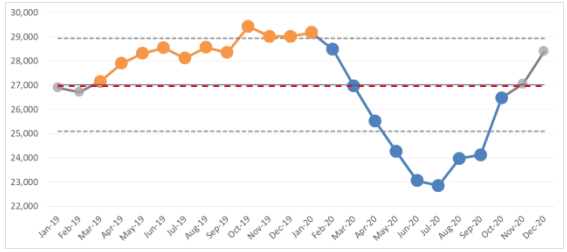
RTT Incomplete Standard

Target: 92%
Current Month: 86.5%



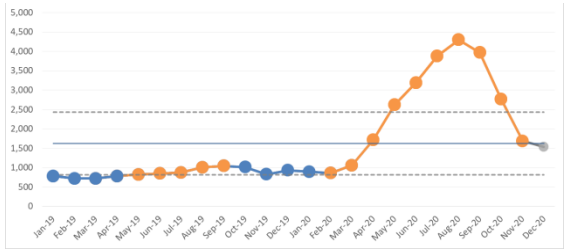
RTT Total Waiting List Size

Target: 26,965
Current Month: 28,401



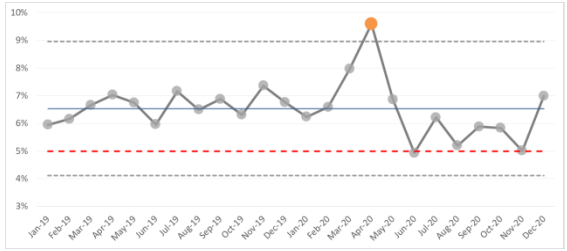
RTT 26 Week Waiters

Target: Monitor
Current Month: 1,535



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 7.0%



Since July 2020, the Trust has demonstrated a positive and steady road to recovery of the 18 week standard. The second wave of the pandemic in early December has clearly impacted on this recovery with performance reducing by 2.1% compared to November.

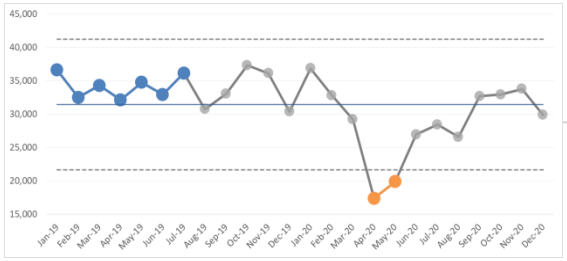
Due to the pressures on both staff and bed resources, all elective providers where instructed by NHSE to limit elective activity to Priority 1 & 2 patients in December. This instruction has remained in place in January and will continue into February. This has obviously impacted on our performance which we expect to see reduce to circa 80% in January.

Planned Care – Outpatient Delivery

East Sussex Healthcare NHS Trust

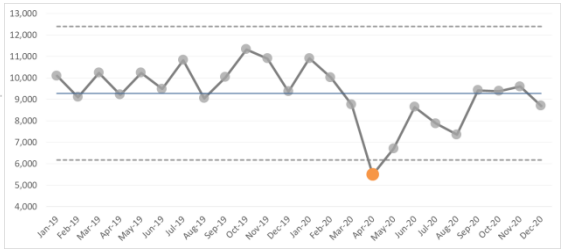
Access and Responsiveness

Outpatient Total Activity
(New and Follow-up)

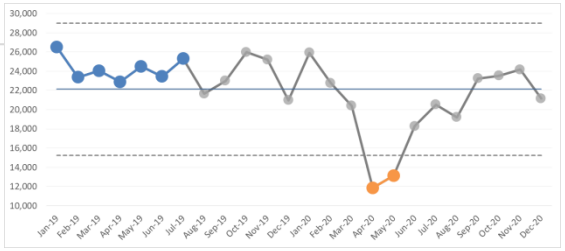


Target: Monitor
Current Month: 29,857

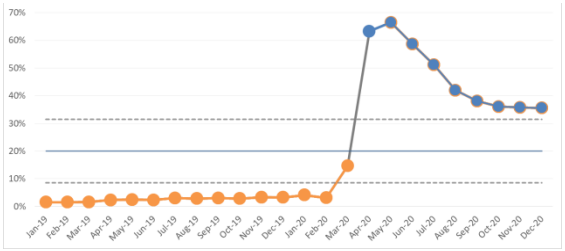
New



Follow-up

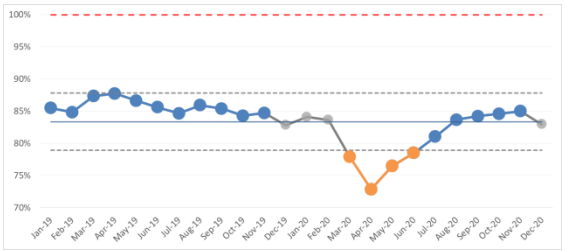


Non Face to Face Outpatients Activity
(Activity %)



Target: Monitor
Current Month: 35.5%

Outpatient Utilisation
(XX1 and Non XX1 Clinics)



Target: 100%
Current Month: 83.0%

Outpatient activity and clinic utilisation has reduced in December, partly due to the seasonal trend but also as part of the National guidance to, where possible, covert clinics to non-face to face.

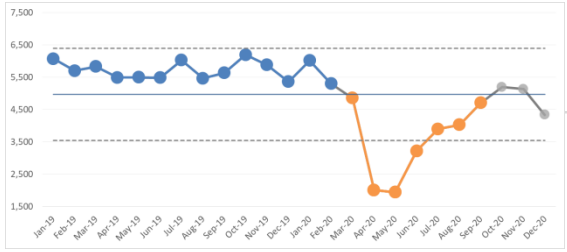
Through our recovery & transformation programmes we are continuing to focus on maintaining a high level of virtual activity (25% new OPAs & 60% FU is target). In key specialties there are a range of rapid improvement initiatives to support the requirements of Phase 3 which will transfer into Phase 4.

Planned Care – Admitted Delivery

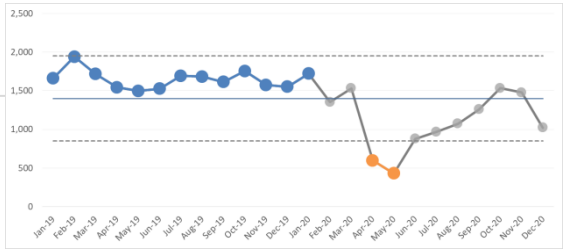
East Sussex Healthcare NHS Trust

Elective Spells
(Day case and Elective IP)

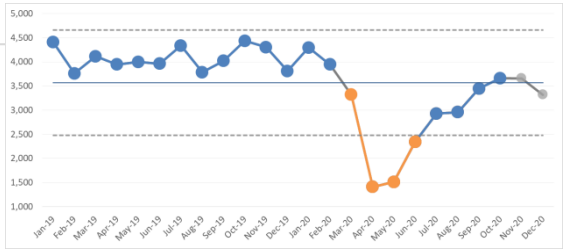
Target: Monitor
Current Month: 4,339



Elective IP

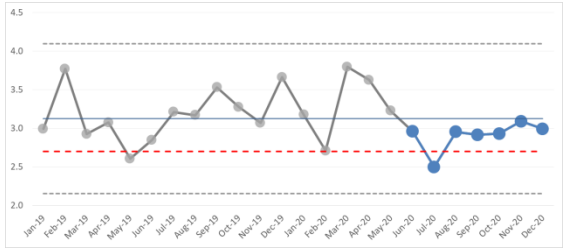


Day case



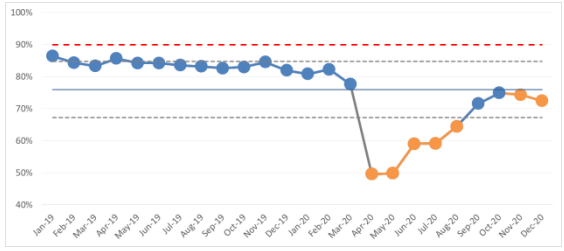
Elective Average LoS
(Acute)

Target: 2.7
Current Month: 3.0



Theatre Utilisation

Target: 90%
Current Month: 72.4%



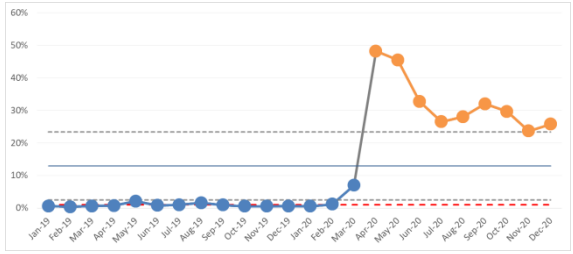
Follow a number of months of hard work to recover elective activity to pre-covid levels, the impact of the second wave in December has clearly presented a worsening position.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

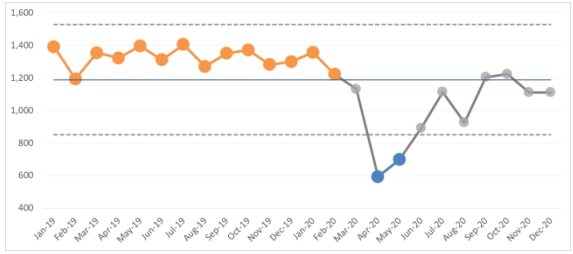
Diagnostic Standard

Target: < 1.0%
Current Month: 25.7%



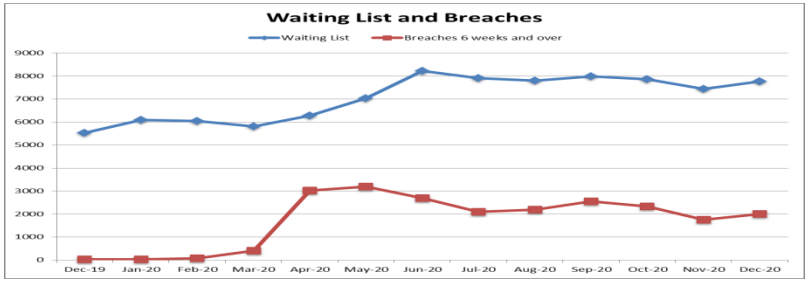
Endoscopy Demand
(Waiting List Additions)

Target: Monitor
Current Month: 1,111



Decembers DM01 performance declined slightly by 2.1% whilst the waiting list size was reported at 7,762, of which there were 1,998 breaches.
This was made up of : 532 Magnetic Resonance Imaging, 411 Computed Tomography, 152 Non-Obstetric Ultrasound, 58 Urodynamic, 242 Colonoscopy, 108 Flexi Sigmoidoscopy, 11 Cystoscopy, 5 Audiology and 479 Gastroscopy.

In the run up to December most modalities were back to achieving pre-Covid activity levels, although the greatest challenge that they all face is the clearance of the backlog patients that built up during wave 1 of the pandemic.



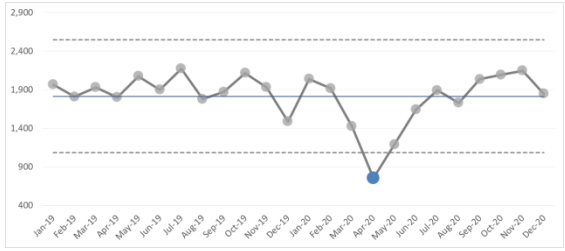
Breach Rates	Trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Magnetic Resonance Imaging		1.26%	1.40%	3.24%	10.57%	61.58%	48.91%	26.40%	15.14%	16.52%	14.84%	22.96%	22.56%	27.41%
Computed Tomography		0.00%	0.21%	0.15%	8.49%	48.76%	44.80%	36.44%	32.32%	35.71%	41.41%	37.64%	22.89%	23.39%
Non-obstetric ultrasound		0.58%	0.27%	0.57%	1.89%	41.25%	28.81%	11.70%	7.76%	11.66%	21.12%	7.70%	3.97%	7.13%
Barium Enema		--	--	--	--	--	--	--	--	--	--	--	--	--
DEXA Scan		--	--	--	--	--	--	--	--	--	--	--	--	--
Audiology - Audiology Assessments		0.00%	0.00%	0.00%	0.00%	33.04%	91.79%	77.48%	97.32%	98.61%	71.43%	100.00%	--	1.67%
Cardiology - echocardiography		--	--	--	--	0.00%	--	--	--	--	--	--	0.00%	--
Cardiology - electrophysiology		--	--	--	--	--	--	--	--	--	--	--	--	--
Neurophysiology - peripheral neurophysiology		--	--	--	--	--	--	--	--	--	--	--	--	--
Respiratory physiology - sleep studies		--	--	0.00%	0.00%	--	--	0.00%	0.00%	0.00%	--	--	0.00%	--
Urodynamics - pressures & flows		7.69%	6.67%	0.00%	56.00%	100.00%	87.50%	76.47%	70.83%	54.55%	73.53%	64.29%	84.78%	73.42%
Colonoscopy		0.00%	0.27%	0.29%	3.08%	35.14%	50.57%	49.22%	47.54%	40.90%	35.18%	32.28%	37.18%	43.60%
Flexi sigmoidoscopy		0.00%	0.00%	0.00%	4.82%	30.19%	44.65%	57.79%	53.14%	55.21%	57.30%	56.80%	55.28%	59.02%
Cystoscopy		0.00%	0.00%	0.00%	28.57%	86.96%	57.14%	58.82%	48.72%	46.03%	28.00%	35.71%	20.93%	26.83%
Gastroscopy		0.44%	0.37%	0.39%	7.10%	38.86%	50.89%	47.50%	54.88%	54.53%	54.93%	56.95%	57.50%	61.81%
Total		**0.60%**	**0.57%**	**1.21%**	**6.97%**	**48.17%**	**45.48%**	**32.73%**	**26.48%**	**28.08%**	**31.98%**	**29.63%**	**23.68%**	**25.74%**
Surgery		0.66%	0.62%	1.32%	7.30%	50.08%	44.58%	28.91%	19.86%	22.45%	27.50%	24.24%	16.76%	18.71%
Medicine		0.15%	0.28%	0.30%	4.86%	36.19%	49.92%	49.57%	51.67%	49.27%	47.71%	48.11%	50.00%	54.79%

Cancer Pathway

East Sussex Healthcare NHS Trust

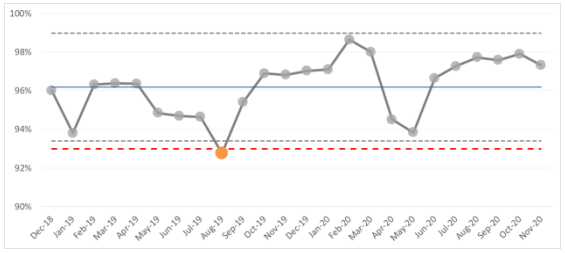
Two Week Wait Referrals

Target: Monitor
Current Month: 1,849



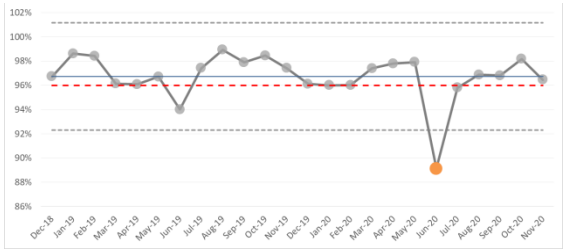
Cancer 2WW Standard

Target: 93%
Current Month: 97.3%



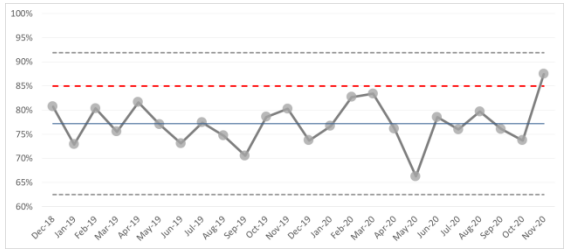
Cancer 31 Day Standard

Target: 96%
Current Month: 96.5%



Cancer 62 Day Standard

Target: 85%
Current Month: 87.5%



The Trust has continues to meet the 2 week wait cancer standard and will report compliance for December and January.

As part of the Trusts activity restoration programme, there has been a focused drive to address some of the challenges that Cancer services have had to face. As part of the Trusts recovery planning, out trajectory predicted recovery of the 62 day standard by the end of November 2020. The Trust is pleased to report that this was achieved as planned with a final position of 87.5%. This is the first time that the Trust has achieved this since April 2014.

Novembers performance placed ESHT, 8th out of 121 reporting organisations and the performance was 125 higher than the national average.

Due to the pandemic second wave in December, it is unlikely that we will be able to build on Novembers success. Although every effort is being made to continue providing cancer services during the pandemic, the Trust has seen a decline in activity due to operating restrictions along with a higher number of patients declining appoints through 'Patient Choice'.

November saw the highest 2ww referral rate for over a year with 2,147 referrals. Although this reduced in December, it is too early to suggest that this is related to the pandemic or if it is the normal seasonal impact.

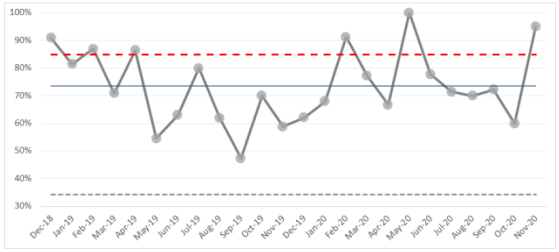
- 2WW Standard: 48 breaches out of 1800 patients first seen.
- 31 Day Standard: 7 breaches out of 198 treatments.
- 62 Day Standard: 19 breaches out of 151.5 treatments.
- For November there were no breached patient pathways directly impacted by Covid-19. However, this is expected to increase going forward as a result of the increase in Covid cases and patient choice relating to the updated national guidance/restrictions e.g. patients reluctance to attend.

The Trust reported 3.5 treatments on or over 104 days, 1.5 of these were shared treatments with other Trusts (Brighton & GSTT) and there were 5 individual patients in total.

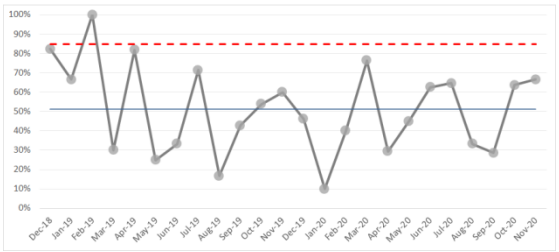
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

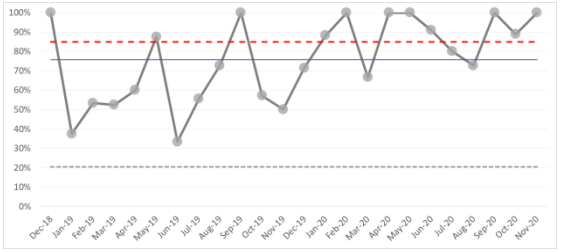
Breast



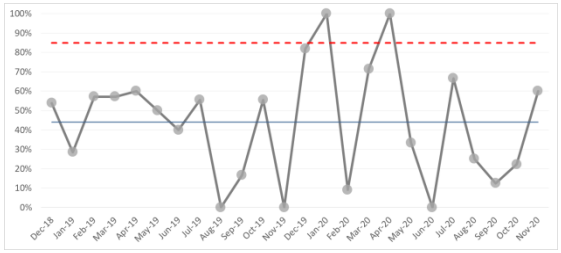
Gynaecology



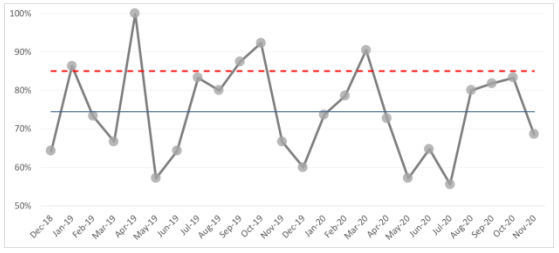
Haematology



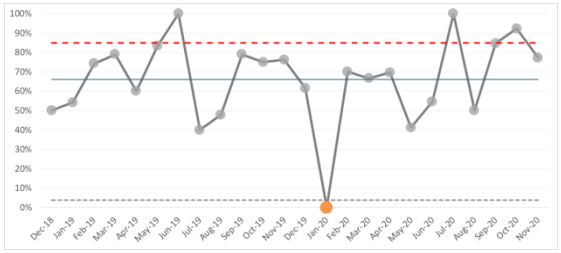
Head & Neck



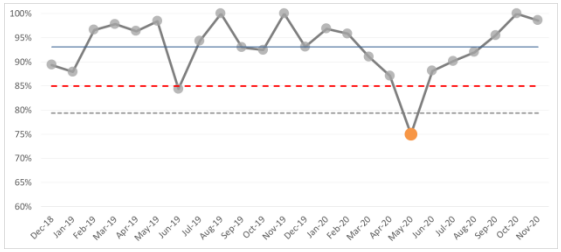
Colorectal



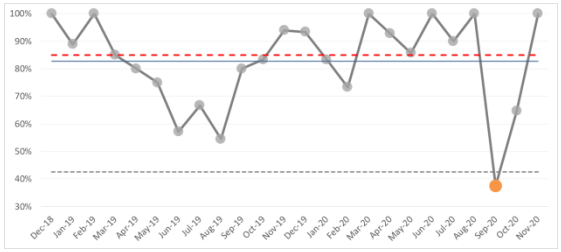
Lung



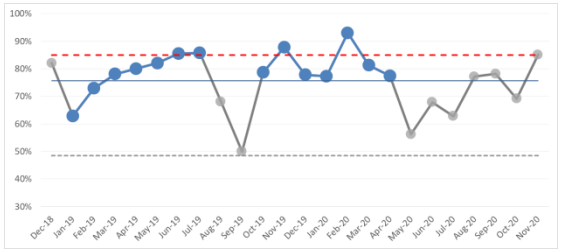
Skin



Upper GI



Urology



Financial Performance

Trust Financial Performance

Statement of Financial Position

Workforce Expenditure

Non Pay Expenditure, Efficiencies & Capital

Receivables, Payables & Cash

Divisional Financial Performance

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

Finance Report Summary - Month 9

Income YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Contract/Block Income	288,933	301,386	300,898	(488)
Divisional Income	37,407	32,385	19,621	(12,764)
Pre Top-Up Income	**326,340**	**333,771**	**320,519**	(13,252)
FRF/Block Top-up	8,588	28,353	28,353	0
COVID-19 Expense Claim	0	0	16,112	16,112
COVID-19 Income Claim	0	0	8,822	8,822
Top-up Income	**8,588**	**28,353**	**53,287**	24,934
Total Income	**334,928**	**362,124**	**373,806**	11,682

The Trust's income is above plan £11.7m YTD. This is mainly due to the block top up and retrospective true-up of £24.9m. Without these element the Trust's income would be £13.3m adverse due to the NHSE/I planning assumptions. The Elective Incentive Scheme, where income can be withheld should the agreed activity levels not be reached has been applied in accordance with NHSE/I instructions. This is estimated to be £27k for months 6 to 9.

Operational Deficit YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Permanent	(197,032)	(221,718)	(215,306)	6,412
Temporary	(26,316)	(20,743)	(35,854)	(15,111)
Total Pay	**(223,349)**	**(242,461)**	**(251,160)**	(8,699)
Non Pay Costs	(118,411)	(122,125)	(125,103)	(2,978)
Operating Costs	**(341,760)**	**(364,586)**	**(376,263)**	(11,677)
Operational Deficit	**(6,832)**	**(2,462)**	**(2,456)**	**5**

The Trust is reporting actual deficit of £2.4m against planned deficit of £2.5m YTD which is £5k better than plan. The Trust operating costs are £11.7m over plan but is offset with COVID-19 expense claims. Pay expenditure is £8.7m YTD above plan and non-pay £3m. Both of these variances are due to the Trust's response to and the impact of COVID-19. Factors leading to the deficit are due to the loss of non-NHS income which is not reclaimable and providing services which had commenced prior to the COVID-19 financial regime.

COVID-19 Claim YTD

	Qtr 1	Qtr 2	Qtr 3	YTD
Pay	3,285	4,158	3,699	11,142
Non-pay	2,234	1,190	1,546	4,970
Planning Assumption	3,589	3,500	0	7,089
Loss of Income	135	79	0	214
(Loss)/Surplus Adjustment	(229)	1,748	0	1,519
Total	**9,015**	**10,674**	**5,245**	**24,934**
Amounts Validated	8,768	6,290	8,744	23,802
Residual Risk	**(247)**	**(4,384)**	**3,499**	**(1,132)**

The Trust's COVID-19 recovery claim of £24.9m YTD covers increased operating costs due to COVID, a planning assumption gap and non-patient care income losses. The retrospective true-up cost adjustment is no longer applicable. The Trust has been allocated a COVID-19 block fund of £11m for quarters 3 and 4 and a pass through COVID-19 cost of £1.4m.

Workforce

	Pr Year Actual WTE	Plan £k	Actual WTE	Variance WTE
Permanent	6,935	6,646	6,533	113
Temporary	175	421	507	(86)
Total Pay	**7,111**	**7,067**	**7,040**	27

The Trust has used 27 FTE above plan in M9. The Trust has used 113 substantive FTE above plan and reduced temporary workforce by only 86 FTE. Many of these relate to pre-COVID-19 service developments and the requirement to run red and green areas. It is still expected that there will be a rise in recruitment into substantive posts in the coming months leading up to year-end to replace the some of the temporary staffing arrangements.

Agency Spend YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Medical	3,182	1,478	3,255	(1,778)
Nursing	1,706	819	2,235	(1,416)
AHP's	1,105	1,356	1,468	(112)
Admin	516	342	487	(145)
Other	221	13	51	(38)
Total	**6,729**	**4,007**	**7,496**	(3,489)

Agency spend is above plan by £3.4m YTD, and this overspend is largely driven by Medical and Nursing agency spend. This is mainly due to the Trust's response to delivering the COVID-19 response including having staff for red and green areas and service developments as well as covering vacancies & absence.

Non-Pay Spend YTD

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Drugs	35,836	31,768	34,895	(3,127)
Clinical Supplies	28,088	28,215	25,180	3,035
Purchased Services	8,111	8,205	7,320	884
Other	24,427	31,764	33,993	(2,229)
Finance Costs	21,951	15,745	18,755	(3,010)
Total	**118,411**	**115,698**	**120,144**	(4,446)

Non-pay spend is adverse to plan by £4.4m YTD. This is largely due to increased revenue effects of capital expenditure above plan and increasing other costs such as CNST premiums. There is a netting off effect between drug costs and clinical supplies, but these have both been rising with activity.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	91,328	89,228
Year End Forecast	2,100	2,100	2,100	0

The cash balance remains high as the cash has been received in advance of the period it relates to causing a higher than usual cash balance. Work is being performed to reduce the cash balance. NHSE/I will be issuing unwinding of cash guidance shortly which will be reviewed and implemented.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	25,050	25,163	(113)
Year End Forecast	46,152	48,259	(2,107)

At M9 the CRL forecast is £46.2m as additional bids require formal approval from NHSE/I and COVID funding is awaiting approval. Should approval be granted the forecast CRL would increase to £53.6m. This consists of internally generated depreciation of £13,834k, plus other external funding including; year 2 of fire £6m; Building For Our Future (including HIP2/seed) £10,375k; emergency capital bids of £5.25m; A&E winter £3.7m; critical infrastructure funds (CIF) £8.27m; Digital bids of £1.65m; Adopt & Adapt £0.6m; Oxygen £1.0m; Perkin Elmer £0.3m; and COVID bids £2.5m. The Trust is slightly behind plan YTD as scheme phasing has materialised at a different pace to the plan largely due to the impact of COVID and final decisions on scheme requirements.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	80.33%	93.69%	78.87%	91.02%
NHS Invoices	89.56%	87.22%	87.11%	95.18%

80% of trade invoices were paid within 28 days which equates to 94% of the total value paid in month. This is in line with the performance last month in invoices paid within the target of 28 days.

90% of NHS invoices were paid within contract or within 28 days of receipt which was 87% of the total NHS invoices paid. This is a 10% reduction in the number of NHS invoices that were paid within the 28 day target last month.

Divisional Performance

Division	In the Month Plan FTE	In the Month Actual FTE	In the Month Variance FTE	In the Month Plan £k	In the Month Actual £k	In the Month Variance £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Outturn Plan £k	Forecast Outturn Actual £k	Forecast Outturn Variance £k
Diagnostics, Anaesthetics & Surgery	1,714.42	1,730.99	(16.57)	(10,260)	(9,848)	412	(91,637)	(87,113)	4,524	(122,417)	(122,417)	0
Medicine	1,381.99	1,412.28	(30.29)	(6,167)	(6,140)	27	(55,855)	(55,611)	243	(74,880)	(74,880)	0
Urgent Care	343.63	333.45	10.18	(1,791)	(1,671)	120	(15,247)	(16,257)	(1,010)	(20,620)	(20,620)	0
Out of Hospital Care	1,087.99	1,068.80	19.19	(4,500)	(4,518)	(18)	(39,358)	(38,583)	775	(52,844)	(52,844)	0
Women's, Children's & Sexual Health	718.86	696.15	22.71	(3,263)	(3,170)	93	(29,288)	(27,749)	1,538	(39,081)	(39,081)	0
Estates & Facilities	713.49	683.38	30.11	(2,503)	(2,809)	(306)	(21,821)	(24,861)	(3,040)	(29,329)	(29,329)	0
Corporate	589.85	601.46	(11.61)	(3,595)	(3,483)	113	(31,266)	(30,496)	770	(42,052)	(42,052)	0
Central	516.93	832.56	(315.63)	31,205	30,672	(533)	282,010	278,214	(3,796)	375,191	375,191	0
Total	**7,067.16**	**7,359.07**	**(291.91)**	**(874)**	**(965)**	**(91)**	**(2,462)**	**(2,456)**	**5**	**(6,034)**	**(6,034)**	**0**

Productivity & Efficiency

	Plan £k	Actual £k	Variance £k
YTD	**1,241**	**1,242**	**1**
Full Year	**3,001**	**3,001**	**-**

The Trust has an internal plan that slightly exceeds the plan submitted to regulators to allow for some contingency. The Trust has a YTD over-performance of £1k. This is driven by an overachievement on outpatients, however this is offsetting underperformance in diagnostics and LoS.

Key Risks

Key Risk 1 — The amended financial regime is based on the average income for months 8 to 10 plus a 3.2% inflator. This has the potential to create cost pressures as the block contract is based on a period of time and not on forecast outturn.

Key Risk 2 — Continued recruitment to vacant posts and service developments which commenced prior to the amended financial regime could lead to expenditure commitments higher than the funding allows in the block funding for 2020/21.

Key Risk 3 — The Trust is required to submit plans to deliver 90% or 100% activity levels. This will incur additional costs. Should we not achieve these activity trajectories then there is a potential for reductions to our block

Key Risk 4 — The Trust will receive a revised block value. It is unclear at this stage whether or not this will resolve our block income gap or the income

Mitigations

Mitigation 1 — An expenditure forecast will be undertaken to understand both the financial opportunities and challenges and put in place early mitigation for the challenges.

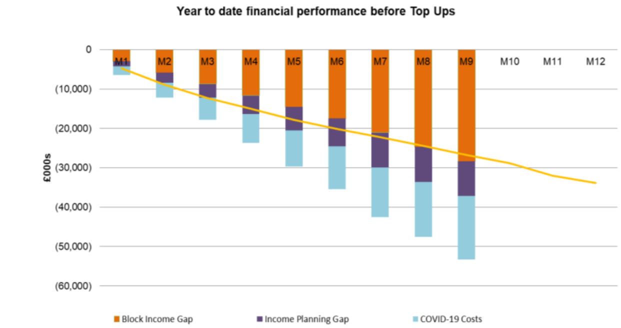
Mitigation 2 — An update of the Trust's financial plan is being undertaken based on month 1 as a benchmark to monitor pay spend and permanent recruitment

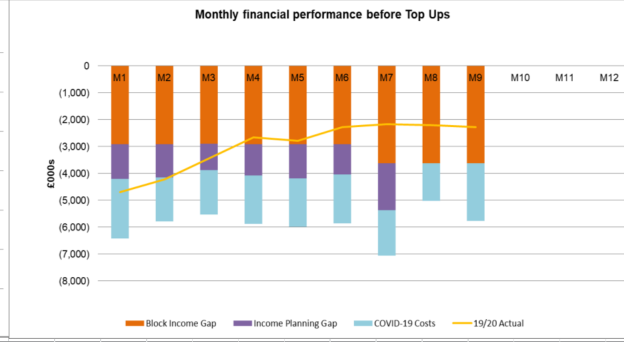
Mitigation 3 — The focus will continue to be on productivity and efficiencies to ensure that we meet the required activity trajectories, manage our costs to avoid the risk of a reduced block contract.

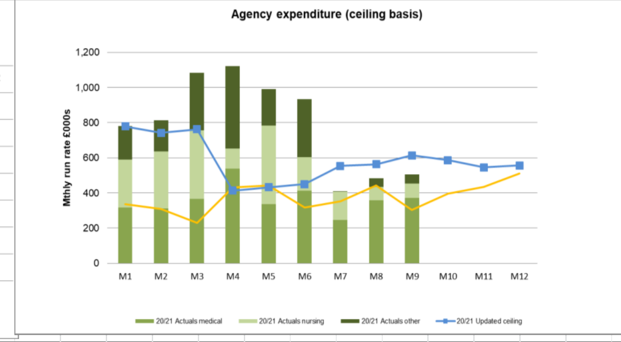
Mitigation 4

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

Finance Analysis





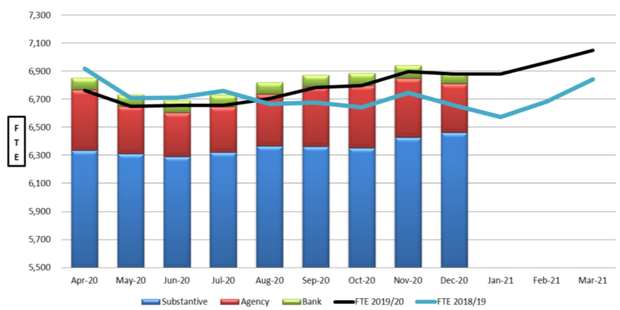


For month 9, the trust is reporting a deficit pre-top up & True up of £51.6m. This is currently due to Block Income Gap of £28.3m, COVID income claim of £8.8m, and COVID-19 related expenditure additionality of £16m

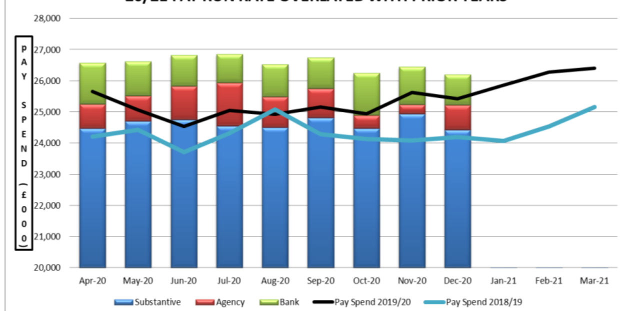
In month the trust is reporting a deficit pre-top up & True up of £5.7m. This is currently due to Block Income Gap of £3.6m and COVID-19 related expenditure additionality of £2.1m. The increasing deficit run rate is due to higher expenditure related to COVID-19 in M09 and also as a result of restoring 'normal' activity levels. Ideally, the block income gap should track the 19/20 actual trajectory.

This shows an increase in runrate from previous month and is inline with the phase restore & recover planning. It is key that the Trust continues to focus on cost control as it has a block contract in place until March 2021. NHSE/I are encouraging providers to restore their non-patient income back to 19/20 levels.

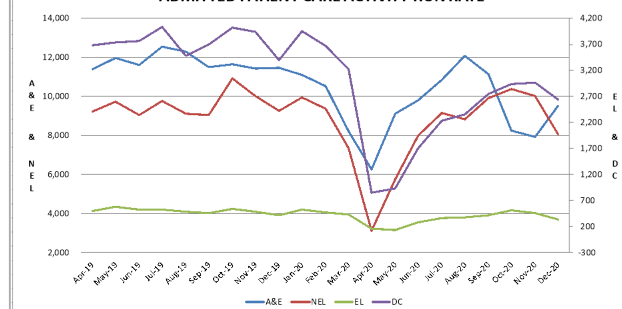
2021 FTE RUN RATE OVERLAYED WITH PRIOR YEARS



20/21 PAY RUN RATE OVERLAYED WITH PRIOR YEARS



ADMITTED PATIENT CARE ACTIVITY RUN RATE

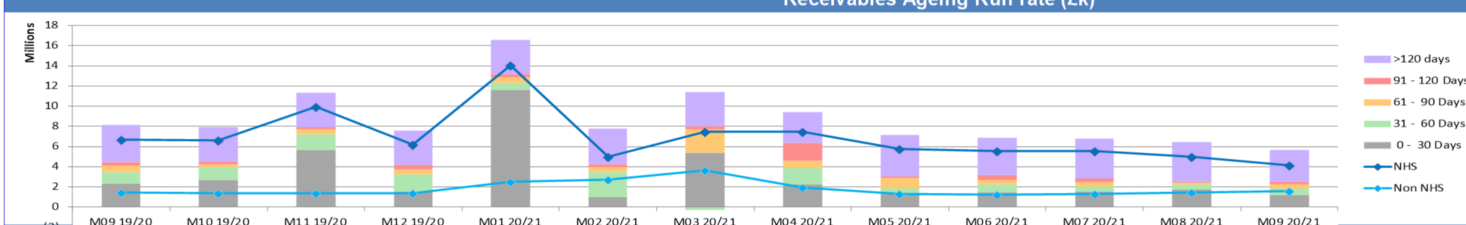


The FTE run rate for 2020/21 is higher than both 18/19 and 19/20. This demontrates the Trust's investments prior to the pandemic and current financial regime. The trend appears to represent an increase as activity recovers.

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

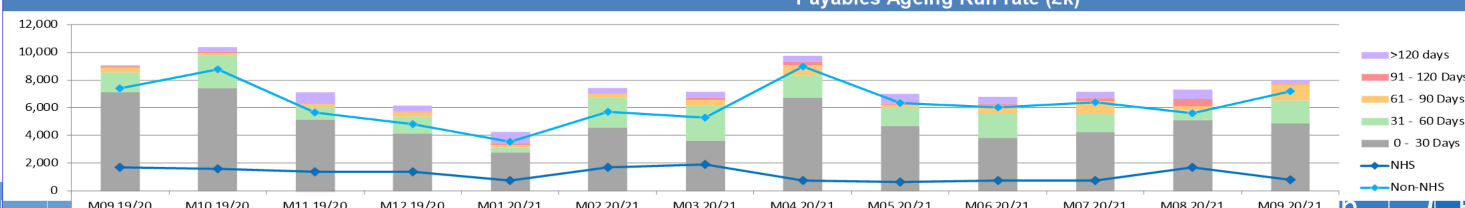
Admitted patient care (excluding Critical care) shows a deep decline in April and consitent recovery thereafter. As at M9, A&E is 83% of prior year activity, NEL at 87%, Elective at 81% and Daycases at 78%. The expectation is all these are to reach 90% by January. However, the increased COVID-19 demand is likely to inhibit the Trust's ability to achieve this target.

Receivables Ageing Run rate (£k)



The sales ledger balance at the end of December is £5.7m which is a reduction on the previous month of £0.7m. This reduction is reflected in 101 fewer invoices held on the sales ledger at the end of the month. The position reflects an improvement in aged debt (invoices > 30 days) of £0.2m. 78% of the total debt owed to the Trust is due and is aged over 30 days. Most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.
There are NHS invoices currently being disputed relating to; prior year market rent recharge from NHSPS £0.955m; SLA year-end settlement 2018/19 £0.281m and delayed discharges £0.092m.

Payables Ageing Run rate (£k)



An increase in month of £0.7m on the creditor position increasing the purchase ledger total to £8.0m. The number of invoices on the system increased by 838. Aligned to the total purchase ledger increase, the value of debt owed to suppliers (aged > 30 days) also increased by £0.9m. Balances that are aged and not ready for payment reflect invoices that are awaiting authorisation or the receipting of the goods/services received.
90% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs and forecasts to pay £5.0m per week. Actual payment runs depend on the level of invoices on the system that are system ready to be paid and due for payment.

M7 to M12 Run Rate

The M9 run rate is £875k deficit (£1k over the M9 plan)

	M7 Outturn £000	M8 Outturn £000	M9 Outturn £000	M10 Plan £000	M11 Plan £000	M12 Plan £000	Total £000
Planned monthly surplus/(deficit)	(833)	(754)	(874)	(1,178)	(1,031)	(1,364)	(6,034)
Acutal monthly surplus/(deficit)	(831)	(750)	(875)				(2,456)
Variance from planned monthly deficit	**2**	**4**	**(1)**				**5**
Planned Income pre COVID-19 and top up	35,897	35,854	35,760	35,583	35,715	35,254	214,062
Actual Income pre COVID-19 and top up	36,094	36,301	37,347				109,742
Income Variance	**197**	**448**	**1,587**				**2,232**
Planned expenditure (pay and non-pay)	(40,352)	(40,352)	(40,432)	(40,530)	(40,535)	(40,404)	(242,605)
Actual expenditure (pay and non-pay)	(40,548)	**(40,674)**	**(41,844)**				(123,065)
Expenditure Variance	**(196)**	**(322)**	**(1,412)**				**(1,929)**
Planned COVID Income (including pass through)	2,143	2,143	2,143	2,143	2,143	2,143	12,856
Actual COVID Income (including pass through)	1,688	1,409	2,149				5,246
COVID Income Variance	**(455)**	**(734)**	**7**				**(1,182)**
Planned COVID Expenditure	(2,142)	(2,142)	(2,142)	(2,142)	(2,142)	(2,145)	(12,855)
Actual COVID Pay Expenditure	(1,246)	(1,032)	(1,421)				(3,699)
Actual COVID Non-Pay Expenditure	(441)	(377)	(728)				(1,546)
COVID Expenditure Variance	**(455)**	**(733)**	**7**				**(1,181)**
Actual block income top up	3,622	3,622	3,622				10,866
Monthly deficit pre income top up	(4,453)	(4,372)	(4,497)				(13,322)
Operational Deficit	**(831)**	**(750)**	**(875)**				**(2,456)**
Improvement/Deterioration of deficit compared to prior month		**2**	**(5)**				

Statement of Financial Position - Month 9

	Year to date				Forecast Outturn		
	19/20 Actual (£m)	20/21 Plan (£m)	20/21 Actual (£m)	Variance (£m)	20/21 Plan (£m)	20/21 Outturn (£m)	Variance (£m)
Non Current Assets							
Property, Plant and Equipment	229.5	232.7	243.7	10.9	252.6	275.1	22.6
Intangible Assets	2.4	2.1	2.6	0.4	2.3	2.5	0.2
Other Assets	3.0	9.4	3.1	(6.4)	8.8	3.1	(5.7)
Total Non Current Assets	**234.9**	**244.3**	**249.3**	**5.0**	**263.7**	**280.7**	**17.0**
Current Assets							
Inventories	7.3	6.6	7.0	0.4	6.6	6.6	0.0
Trade and Other Receivables	47.3	41.3	21.2	(20.0)	37.6	50.5	12.9
Cash and Cash Equivalents	2.1	10.5	91.3	80.8	2.1	2.1	0.0
Non Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**56.8**	**58.4**	**119.6**	**61.2**	**58.4**	**59.2**	**12.9**
Current Liabilities							
Trade and Other Payables	(28.8)	(32.3)	(54.9)	(22.6)	(32.5)	(47.5)	(15.0)
Borrowings	(234.1)	(4.9)	0.0	4.9	(5.3)	0.0	5.3
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions	(0.4)	(0.4)	(0.3)	0.1	(0.4)	(0.3)	0.1
Other Liabilities	(1.4)	(2.2)	(42.7)	(40.5)	(2.2)	0.0	2.2
Total Current Liabilities	**(264.6)**	**(39.8)**	**(97.9)**	**(58.1)**	**(39.8)**	**(47.8)**	**(7.4)**
Non-Current Liabilities							
Borrowings	(1.8)	(22.4)	0.0	22.4	(27.1)	0.0	27.1
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Provisions	(2.8)	(2.0)	(2.8)	(0.8)	(1.8)	(2.8)	(1.0)
Total Non Current Liabilities	**(4.6)**	**(24.5)**	**(2.8)**	**21.6**	**(28.9)**	**(2.8)**	**26.1**
Total Assets Employed	**22.4**	**238.4**	**268.1**	**29.7**	**253.4**	**289.2**	**48.5**
Financed By							
Public Dividend Capital	162.6	387.5	411.5	24.0	388.6	435.6	46.9
Income & Expenditure Reserve	(230.5)	(246.8)	(233.7)	13.1	(245.6)	(236.6)	9.0
Revaluation Reserve	90.2	97.7	90.2	(7.5)	97.7	90.2	(7.5)
Total Tax Payers Equity	**22.4**	**238.4**	**268.1**	**29.7**	**240.7**	**289.2**	**48.5**

Summary & Next Steps

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

Capital Programme Summary - Month 9

YTD Capital Programme Performance	Original Plan £000	Revised Plan £000	CRG Plan £000	YTD Plan £000	Actual Expenditure £000	Variance to YTD Plan £000
Brought Forward	-	-	-	-	-	-
Estates	3,559	3,559	7,748	600	2,093	1,493
Backlog Maintenance	2,783	2,783	1,820	1,325	1,614	289
Digital	1,975	1,975	3,248	850	1,342	492
Medical Equipment	3,667	3,667	3,774	3,638	2,870	(768)
Finance	1,500	1,500	1,500	750	1,125	375
Unplanned urgents	545	350	1,592	400	350	(50)
Fire compartmentalisation	6,020	6,020	4,000	4,520	4,316	(204)
Medical Equipment Bid	4,000	1,250	1,250	-	273	273
Building For Our Future (HIP2)	4,230	10,375	9,758	3,285	3,616	331
Integrated Theatres	250	-	-	250	-	(250)
Track4Safety barcode implementatio	1,500	-	-	-	-	-
General Provision	301	-	-	-	-	-
Cardiology Cath Labs	3,250	2,000	2,000	3,250	136	(3,114)
Local Health Care Record	-	1,452	1,452	-	1,119	1,119
Breast Screening Mobile Units	-	26	26	26	26	-
Clinical Ward Internal Courtyards	-	3,858	3,858	1,800	230	(1,570)
Energy Centre Conquest	-	450	450	450	-	(450)
Energy Centre EDGH	-	822	722	720	341	(379)
Helipad area	-	-	-	-	-	-
Temporary Accommodation	-	3,140	3,240	2,071	1,855	(216)
COVID-19	-	1,115	1,115	1,115	902	(213)
CYBER SIEM Solution	-	220	220	-	100	100
A&E Winter	-	3,700	3,700	-	1,215	1,215
Oxygen	-	1,024	1,024	-	978	978
Perkin Elmer	-	323	334	-	323	323
Adopt & Adapt	-	630	630	-	339	339
Hummingbird	-	2,000	2,000	-	-	-
COVID-19	-	1,374	259	-	-	-
Total Owned	**33,580**	**53,613**	**55,720**	**25,050**	**25,163**	**113**
Donated	1,000	1,000	1,000	1,000	124	(876)
Less donated Income	(1,000)	(1,000)	(1,000)	(1,000)	(124)	876
Total	**33,580**	**53,613**	**55,720**	**25,050**	**25,163**	**113**

Capital Resource Limit (CRL)	£k
Planning CRL	**34,580**
2020/21 Opening CRL	**13,834**
Fire Compartmentation	6,020
Building For Our Future (HIP2)	10,375
Local Health Care Record (LHCRE)	1,452
Breast Screening Mobile Units	26
COVID-19 reimbursement (PY)	1,115
Critical Infrastructure Funds (CIF)	8,270
Oxygen (Tranche 1)	630
A&E Winter	3,700
Cyber SIEM solution	100
Adopt & Adapt	630
Closing Working CRL	**46,152**
Business cases (NHSE/I yet to be appro	**5,250**
Oxygen (Tranche 2)	**394**
COVID-19 20-21 Pending bids	**1,374**
Cyber bids awarded	**120**
Perkin Elmer (awaiting MOU)	**323**
Forecast CRL	**53,613**
Overplanning/(underplanning) margin	**2,107**

Capital Commentary

At the end of December the forecast CRL is £54.613m however the working capital is £46.152m as reduced bids of £5.75m need formal approval from NHSE/I and COVID funding is awaiting approval.
CRL is the maximum that can be spent on capital purchases in year however actual permitted expenditure is determined by the capital departmental expenditure limit (CDEL) and this is based on actual depreciation in year, loan repayments and asset disposals.
The Trust has a £2.107m overplanning margin which will be managed on a monthly basis by the CRG.

NHSE/I Consultation - Integrating Care: Next steps to building strong and effective integrated care systems

Meeting information:			
Date of Meeting:	9th February 2021	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Richard Milner

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

This brief paper notes the ICS formal response to the NHSEI consultation paper on integrated care, published in late November 2020. It also considers the response provided from East Sussex County Council to the NHSEI paper.

At a simple level, it can be read as a paper for information, which it undoubtedly is. However, upon review of the key themes from both responses, there are messages for ESHT in terms of our tactical approach and how we ensure that we reflect this new direction into our 5-year plan.

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

- Executive Directors Meeting 20th January 2021
- Strategy Committee, 21st January 2021

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

Paper for information only.

1. Summary

This paper is presented for information to ensure that Non Executives have sight of the ICS paper written in response to the NHSEI consultation paper (*Integrating Care: Next steps to building strong and effective integrated care systems*) issued in late November 2020.

2. Background

The paper ostensibly concerned the two options for the legislative basis and future structure of the Integrated Care System. Individual organisations were able to respond if it was felt appropriate. However, having reviewed the collective response of the ICS and, having fed into the discussions regarding the final direction of the content in the ICS letter, it was felt that ESHT's position was consistent with the view set out in the ICS letter.

3. Content

The response letter is built around the four questions posed in the consultation paper and notes the considerable levels of collaboration already evident across the ICS and at place level. In support of the progress made to date the response letter refers to the previous restructuring of the county's commissioning function into three CCGs from the previous eight.

It makes the point that this collaboration has been built from the ground up and has involved a range of organisations. Were a statutory ICS role and function be preferred, the letter reiterates the need to ensure that decision rights at the existing levels need to be respected. Aligned with this point, the need for further clarity as to the relationship and the role of Health and Wellbeing Boards and Overview and Scrutiny arrangements is also requested.

On the point that Option 2 (which removes the CCG function in essence) drives greater potential for collaboration, the letter concludes that irrespective of the preferred option, it is important that NHSEI takes account of the challenge that the deadline of April 2022 would create for all involved; not least the sensitivity of a new model working alongside existing governance structures. The letter also calls for a more standardised approach (covering e.g. resource allocation, performance management and patient engagement) to take ICSs forward collectively – mindful that not all start from the same place. The letter also notes that further clarity around financial governance and how place/systems need to evolve would support a coherent transition to a new model. It also recognises the need to ensure lay involvement – but that this need not impede effective and timely decision-making.

Finally, on the straightforward point regarding specialist commissioning returning to local control, the letter is supportive of this function coming to the ICS.

4. Response from East Sussex County Council

The supportive response from ESCC CEO Becky Shaw reflects the strong partnership that exists between local government and the NHS, of which ESHT has been and continues to be a strong element.

As expected, the ESCC perspective welcomes the retention of a strong local focus and emphasises a desire that the further iteration of the ICS model seeks to enhance partnership working and the capital/trust that already has been built, noting the benefits of subsidiarity in terms of resource allocation and decision making. It also emphasises stakeholder engagement to build further with local communities, an area where local government has traditionally always been strong.

On the final question regarding the move of specialist commissioning more local, ESCC is helpfully clear that it sees this as key in enabling the development of population-specific, integrated care budgets. It emphasises the need for pace of execution, in order that place based arrangements for local decision-making and use of available resources (including freedom to delegate significant budgets) can maximise their impact on local communities.

ESCC adds that this integrated approach offers the opportunity to explore further strategic commissioning on an increasingly integrated basis for the range of services and providers working at place level to minimise inequalities around access to care.

5. Next steps

At a formal level, the response will come via the ICS so there is no action to take in that regard. More generally, key themes and messaging that can be drawn from both the direction of the consultation and the responses to it are that;

- The co-ordination of Trusts across Sussex will strengthen in the short-medium term via the ICS and so the Trust's approach of supportive engagement with all aspects of the ICS must continue
- The local authority remains absolutely committed to integrating health and care in order to minimise health inequalities, evidenced by their input to Vision 2025, and this strong partnership needs to be maintained and developed further
- The change in mindset required in some parts of NHS Trusts to realise this new direction (above) cannot be underestimated given the historical emphasis placed on Trusts to operate on a largely autonomous basis and within an internal marketplace
- The embedding of this new direction into the Trust's 5-year plan, therefore, will be best supported by a renewed emphasis on organisational development and the values/capabilities required of us to succeed in this rapidly changing environment

england.legislation@nhs.net

Sussex Health and Care Partnership
36-38 Friars Walk
Lewes
East Sussex
BN7 2PB

8 January 2020

Dear colleagues

Response to "Integrating care - Next steps to building strong and effective integrated care systems across England"

The Sussex Health and Care Partnership, our Integrated Care System, welcomes the opportunity to comment on the legislative proposals set out in the document published by NHS England and Improvement (NHSE/I) on 24 November 2020. We have collaboratively inputted to our response as a system and individual statutory organisations may also respond separately

The Sussex system was awarded ICS status in April 2020 as it has been recognised as one of the most improved systems within the country for financial, quality and performance standards. This improvement has been based on the strong partnerships that we have in place and a streamlined commissioning footprint following the merger of our CCGs into three new organisations. Coordination of system improvement and transformation requires system partners to work together to agree and deliver a co-ordinated programme of service and underpinning digital transformation, to provide high quality services closest to where they are needed and secure the long-term sustainability of the system.

In our ICS this includes delivering our Sussex Strategic Delivery Plan, approved by Governing Bodies, Trust Boards and Health and Wellbeing Boards in September 2019, and our restoration and recovery programme from Covid-19. We are also continuing this work through the development of our Vision 2025, to support our transformation of health and care services for all the patients and communities in the area. We have Collaborative Networks and Enabling Programmes in place and Partners across health and care are working together to deliver system transformation. Our place based teams, led by the West Sussex, East Sussex and Brighton and Hove Partnership Executives, are integral to bringing that operational performance knowledge and accountability together for the local population.

Whist we have made significant progress together we are committed to further integration, strongly support the direction of travel set out in the document, and would offer the following responses to the specific consultation questions posed:

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We support the proposals and recognise the benefits that a statutory ICS could bring. However, we would wish to continue the journey of collaborative decision making across our partnership in way that recognises the importance of ensuring decision making and accountability are as close to the local populations as possible. Our system is moving in this direction as we are starting to make decisions at PCNs, Place and ICS level. In creating a statutory ICS we will need to be clear about which decisions are reserved and those that would be taken at each of those levels.

We welcome the permissive nature of the document but caution that if it is too freeform then it may be not be helpful to national bodies and/or organisations that work across multiple ICSs. The other important issue to highlight, given we have strong working relationships with our two county councils and unitary city council, is being clear about how local authorities are engaged and able to commit to joint working at place level within the framework of their existing statutory responsibilities and their local democratic accountability. We would therefore welcome further clarity regarding the relationship between these proposals and other statutory partnership arrangements such as Health and Wellbeing Boards and Overview and Scrutiny arrangements, and the current statutory framework for local government..

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We believe that all the aspirations in this question are completely consistent with the ambitions of our ICS. We do however, see risks and benefits in both option 1 and option 2. Option 1 would be the next logical step for an ICS and we were already having moving to a model where we make decisions together. However, we do recognise the limitations of Option 1, as in a “pure” partnership model a level of uncertainty remains especially with respect to those key decisions that benefit the system to the detriment of one partner. Option 2 could make decision making much clearer and if this option is the preferred end state that the Government through Parliament wishes to achieve, we believe we should move to this model quickly and in one step. We feel that this also gives Clinical Commissioning Groups (CCGs), greater certainty about their future whilst recognising the valuable contribution these organisations have made to the NHS.

Regardless of which option is preferred, the timelines for implementation by 1 April 2022 are very challenging whilst also dealing with current operational pressures within the NHS and the ongoing response to the pandemic. So to achieve this change by the start of 2022/23 there would need to be a reasonable expectation as to what could be realistically be achieved and delivered, in this respect within the NHS in both 2021/22and 2022/23.

We believe there would also need there to be some national principles that applied to all systems in a standardised way so that there would be limited opportunity for variance that could undermine the direction of travel. For example we would expect

national principles and guidelines on resource allocation, performance oversight, and the importance of public and patient involvement. We would also expect that the 2021/22 NHSE/I planning guidance was in line with these principles in order to start moving systems forward consistently recognizing that all ICSs are at differing levels of maturity.

A successful transition would require recognition that the new system would be working in shadow alongside existing statutory organisational accountabilities and we would need the Centre to be sensitive to this operating reality. However, we would expect a clear emphasis on system by default and for the ICS to be the principal point of interaction with the regional arms of national bodies. For the new statutory ICS to be successful there would also need to be absolute clarity as to the role of the ICS, a merged NHS England and Improvement, Health Education England, CQC, and public health and the continuing accountabilities of partner organisations, particularly in the circumstance where system decisions may be in the interests of all partners. It is key that the responsibilities and accountabilities between those national bodies and a statutory ICS are explicitly clear to remove ambiguity and duplication and so that there can be transparency for public accountability purposes. Our experience would support the concept of “thinner” regional teams. Our overall message would be to avoid muddled accountabilities.

There would need to be further work at a national and regional level that recognises how Collaboratives and Places are held to account is likely to be different according to which option we go forward with, and it would be helpful if this were explicitly recognised in any future guidance as to how Provider Collaboratives are expected to develop.

Finally, to help system governance development and transition, early indications of the governance framework expected of an organisation created out of option 2 would be very helpful.

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

It is really important that the membership of an ICS is built around the functions that it will be responsible for, both those which are devolved with in the NHS and those which are pooled between system partners.. Giving ICSs some discretion regarding their governance arrangements will be important to enable them to tailor their approach to meet the particular needs of their communities. This freedom should be set within a clear framework of principles for good governance, which would include the requirement for strong, independent lay input.

An ICS that is well led would be working to ensure all relevant partners are engaged effectively around decisions and issues in which they have an interest. Therefore a System Oversight Framework would need to be developed that ensure the engagement of non-statutory stakeholders is captured. We should however be clear about the distinction between engagement and decision making by distinguishing between those organisations responsible for making decisions at ICS level and those

bodies who participation is necessary and desirable to inform effective decision making.

We would also recommend strengthening and utilising existing relevant mechanisms for engagement of stakeholders to ensure their voice continues to be built into decision making at a Place and Collaborative level.

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We feel that this would be the next logical state for more integrated commissioning, but we would expect that the directly commissioned services that are delegated to an ICS should be capable of being commissioned at an ICS level, or by more than one ICS working together. In relation to specialist commissioned services, we would support the delegation of this commissioning to an ICS or to more than one ICS working collaboratively together (dependent on scale). For this delegation to work effectively, national bodies would need to be clear (including in future policy developments) about the appropriate population size for the delivery of that commissioned service. This direction of travel will also require significant engagement and development with providers to help transformation of the provider system which supports their emerging roles within an ICS, at place and at a level, for example to consider conflict of interest, and leadership and management development.

We hope that you find these reflections helpful and we look forward to the next steps being taken forward. As ever, we would be happy to be involved in any further conversations to inform the next steps or detail of these proposals.

Yours faithfully

Adam Doyle
ICS Leader

Bob Alexander
ICS Independent Chair

On behalf of the Sussex Health and Care Partnership

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

Meeting information:			
Date of Meeting:	9th February 2021	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Lynette Wells/Damian 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?	

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 and proposed revisions are outlined in the attached paper. The review was originally due to be undertaken in November, but it was decided to defer this to January so that a thorough update of the documents could be undertaken.

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 January 2021

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

The Board is asked to accept the Audit Committee recommendation to approve the proposed changes to the Standing Orders, Standing Financial Instructions 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.

All of the documents were subject to a full review, and as a result job titles, statutory bodies, levels of delegation, legislation and other non-material changes have been made throughout the documents to bring them up to date.

All of the documents were cross-referenced to ensure that they did not contradict each other.

Key changes were:

- Standardising and updating the thresholds for business cases, capital investment, waivers, tenders, contract approvals to:

  i. From £1 - £35,000 excluding VAT: Head of Procurement

  ii. From £35,001 excluding VAT to EU Threshold: Head of Procurement and the Chief Financial Officer or the Chief Executive.

  iii. From EU Threshold up to £500,000: Head of Procurement, the Chief Financial Officer and the Chief Executive.

  iv. From £500,000 to £1,000,000: F&I Committee (for tenders and contracts) / Audit Committee (waivers).

  v. Above £1,000,000: Trust Board

- Business cases of between £10,000-£50,000 now require 3 quotations when formal tendering processes are not adopted. Previously this was from £7,500- £50,000 and this change brings the Trust in line with other NHS organisations.

Other material changes proposed to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation are detailed below.

Standing Orders

Page Number and Reference	Detail	Replaced with
P5 Introduction	Removed reference to the Trust operating in schools	-
P9 2.1	Changed 'The Board shall have not more than 11 and not less than 8 members'	'The Board shall have not more than 11 and not less than 8 **voting** members'
P9 2.4.1	Changed 'If…. the Chairman is unable to appoint a Vice-Chairman, then the Senior Independent Director will assume the office of Vice Chairman'	'If…. the Chairman is unable to appoint a Vice-Chairman, then **another Non-Executive** Director will assume the office of Vice Chairman'
P10 2.5.1	Changed 'the Board of Directors may appoint a member of the Board… to be Senior Independent Director'	'the **Chairman** may appoint a member of the Board… to be Senior Independent Director'
P12 3.1	Added reference to holding Board meetings using an online platform under 3.1.1 and 3.1.6	-
P17 3.16.1	Changed 'The public and representatives of the press to attend all meetings of the Trust (Board)'	'The public and representatives of the press **may** attend all **public** meetings of the Trust (Board)'

Standing Financial Instructions

Page Number and Reference	Detail	Replaced with
P8, 1.2.4 and 1.2.5	New additions to SFIs	
P10, 2.1.1	Duties of Audit Committee rewritten and strengthened	
P12, 2.3.5 and 2.4.1	New additions to SFIs	
P14, 3.1.2	New addition to SFIs	
P15, 3.2.2	Additional wording added	**'Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by Executives.'**
P15, 3.3.1	Contents of monthly financial reporting to Board rewritten.	
P16, 3.4.1	New addition to SFIs	
P22, 7.5.3 and 7.5.4	Guidance for where tendering need not be applied and where it may be waived rewritten and strengthened.	
P25, 7.6.2 ii	Additional wording around recording of formal tenders added	**'This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.'**
P25, 7.6.3	Section completely rewritten to provide additional information about process.	

P26, 7.6.6. ii	Added wording	**'The most economically advantageous tender (MEAT),'**
P28, 7.7.1	Thresholds for requirement of 3 quotations when formal tendering processes are not adopted changed from between £7,500-£35,000	Now between £10,000-£50,000
P44, 13.1.2	Threshold for Board approval of business cases was previously those over £500,000	Changed thresholds for approval to: - Execs, over £250,000 - F&I Committee, over £500,000 - Board over £1,000,000
P60-62	Updated in line with changes to other governing documents	

Scheme of Delegation

Page Number and Reference	Detail	Replaced with
P4 The Board – Strategy, Plans and Budgets, 4	Updated Board needing to 'Approve Final Business Cases for Capital Investment over £500,000' (these would be approved by the F&I Committee)	'Approve Final Business Cases for Capital Investment over £1,000,000'
P5 The Board – Policy Determination, 1	Removed 'Policies so adopted shall be listed and appended to this document by the Director of Corporate Affairs'	
P9, 1.3.1.7	Removed delegated approval by Board for procedure for declaration of hospitality and sponsorship	Approval by **Audit Committee**
P10, 1.3.2.5, number 6	Amended 'appoint Non-Executive Board members to an Audit Committee of the Main Board'	'appoint Non-Executive Board members to an Audit Committee **and any other Sub-Committees** of the Main Board'
P11, 1.3.2.8	Amended 'Declaration of conflict of interests'	'**All members of the Board are required to make annual** declarations of conflict of interests **and fit and proper persons.**'
P12, 3.1	Amended 'Call meetings'	'Call **Board** meetings'
P15, 3.1.6	Changed 'Ensure adequate training…'	'Ensure adequate **financial** training…'
P18, 9.1.1	Changed 'Establish a Remuneration and Appointments Committee'	'Establish a Remuneration Committee'
P18, 9.1.3	Changed 'Report in writing to the Board its advice and its bases about remuneration of directors and senior employees'.	'Produce an annual report for the Board'
P22, 13.1.2	Threshold for Board approval of business cases was previously those over £500,000	Changed thresholds for approval to: - Execs, over £250,000 - F&I Committee, over £500,000

		- Board over £1,000,000
P28, 21.3	Removed final sentence 'Decisions to self-insure should be reviewed annually.'	-
P29, 4	Strengthened approval of waivers.	- EU Threshold to £500k – Executive Directors' Meeting - £500k to £1,000,000 – F&I Committee - Over £1,000,000 - Board

East Sussex Healthcare NHS Trust Charitable Fund Annual Report and Account 20/21

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

The Trust's charity, East Sussex Healthcare NHS Charitable Fund (ESHTCF), has recently completed its annual return to the Charity Commission. The annual report and accounts are presented for the Board's information.

Highlights of the year include:

- A key change was made to the way in which the Charity was administered. Previously, each of the voting members of the Trust Board was automatically made a Trustee of the Charity. Across the NHS it is common for the NHS Trust to be the sole corporate Trustee and we brought ESHTCF in line with other organisations by making East Sussex Healthcare NHS Trust (ESHT) the sole Trustee on 3 March 2020.
- This will enable us to change the way that we oversee the Charity. We have invited staff from different areas of the organisation to join our Charity Committee meetings, to enable us to hear different perspectives whilst considering individual bids and the future strategy of the Charity.
- Karen Manson, one of our Non-Executive Directors, became Chair of the Charity in March 2020.
- The charity received income of £369,000 during 2019/20, approving 425 bids.

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

- Charity Committee, 7th October 2020

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

- The Board is asked to review and note the ESHTCF annual report and accounts.

East Sussex Healthcare
NHS Trust

East Sussex Healthcare NHS Trust Charitable Fund

Annual Report and Accounts

Year Ended 31 March 2020

Registered Charity Number 1058599

WHAT **MATTERS** TO YOU
MATTERS TO US ALL

Contents

Trustee's Report

Report of the Trustees for the Year Ended 31 March 2020

The Trustees are pleased to present the annual report together with the financial statements of the Charity for the year ended 31 March 2020.

The annual report and financial statements comply with the Accounting and Reporting by Charities: Statement of Recommended Practice applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015), the Charities Act 2011 and the UK Generally Accepted Accounting Practice.

Chair's Report

As Chair of the East Sussex Healthcare NHS Trust Charitable Fund (ESHTCF), I am pleased to welcome you to the 2020 Annual Report and Accounts. We hope you find this a useful guide to the important role our Charity plays in supporting NHS patients, their carers, families and staff.

A key change was made to the way in which the Charity is administered during the year. Previously, each of the voting members of the Trust Board was automatically made a Trustee of the Charity. Across the NHS it is common for the NHS Trust to be the sole corporate Trustee and we brought ESHTCF in line with other organisations by making East Sussex Healthcare NHS Trust (ESHT) the sole Trustee on 3 March 2020. This will enable us to change the way that we oversee the Charity. We intend to invite staff from different areas of the organisation to join our meetings, to enable us to hear different perspectives whilst considering individual bids and the future strategy of the Charity.

The Charity's work is only possible thanks to the generous support of patients, staff and local people. Thanks to your efforts, we received £369,000 of income over the last year. Key highlights of our year include provision of:

- The Annual Staff Awards which recognised the valuable contribution that staff make to the organisation;
- Support for LGBT+ initiatives across the Trust;
- A scalp cooling system to help limit hair loss for patients undergoing chemotherapy;
- State of the art microscopes for the haematology team; and
- Refurbishment of an external play area for children.

I would like to take this opportunity to thank those individuals who have served as Trustees during the year and to welcome those who will play an important role in the future.

I would also like to thank all of our supporters – including everyone who has helped raise money for the Charity or given their energy, time and skills to make a difference during this financial year. I hope that, like me, you will be inspired by our plans to help and want to be part of our story. Your donations made this work possible and your future donations are the key to our continued success.

If you would like to donate, details about how to do this are on page 24.

On behalf of the many patients who have benefitted from your generosity, thank you for your continued support.

Karen Manson
Chair

Our Objectives and Activities

East Sussex Healthcare NHS Trust Charitable Fund (ESHTCF) was formed in October 1996 and is registered with the Charity Commission, the Registered Charity Number is 1058599.

At 31 March 2020 the Charity had 143 unrestricted funds, linked to specific wards and specialities. Within the unrestricted funds there are 5 quality funds linked to Bexhill Hospital, Community Services, Conquest Hospital, Eastbourne District General Hospital and an overarching Trust fund. These funds are used to fund Trustwide initiatives as well as bids specific to particular locations.

The Charity also had 11 restricted funds, which include the South East Orthopaedic Training Fund, supporting junior doctors training to become orthopaedic surgeons at the Brighton and Sussex Medical School, and the Eastbourne District General Hospital Scanning Equipment Fund which is for the benefit of the Intensive Care and Radiology Department.

The Charity's main purpose is to raise funds and receive donations in service to its objective of providing benefit to the patients of ESHT. This benefit may come in a variety of forms, including:

- improving clinical services;
- enhancing the experiences of patients;
- purchasing equipment that will improve the care given to patients;
- enabling services to be given to patients in innovative ways;
- training staff; and
- improving the welfare of staff where there is a clear benefit to patients in doing this.

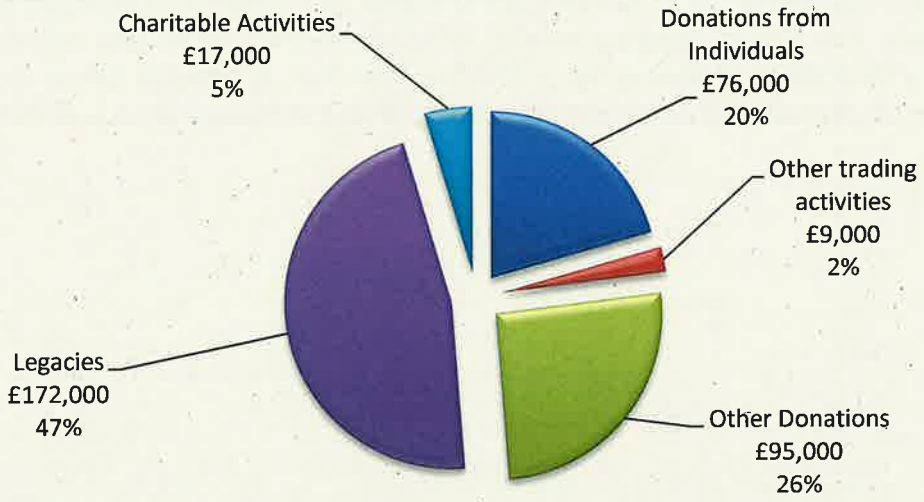
From 1 April 2019 to 2 March 2020 the Trustees were legally responsible and from 3 March 2020 the Corporate Trustee is legally responsible for the overall management and decision making of the Charity, ensuring that it operates in compliance with the Charities Act 2011.

Financial Review

During 2019/20 ESHTCF received income of £369,000 from donations, legacies, investment income and training activities. This year, the Charity has undertaken proactive fundraising as well as receiving unsolicited donations from the public. The Charity utilises the services of a fundraising manager who raises money for the unrestricted quality funds and supports members of staff and the public who wish to raise money for ESHTCF.

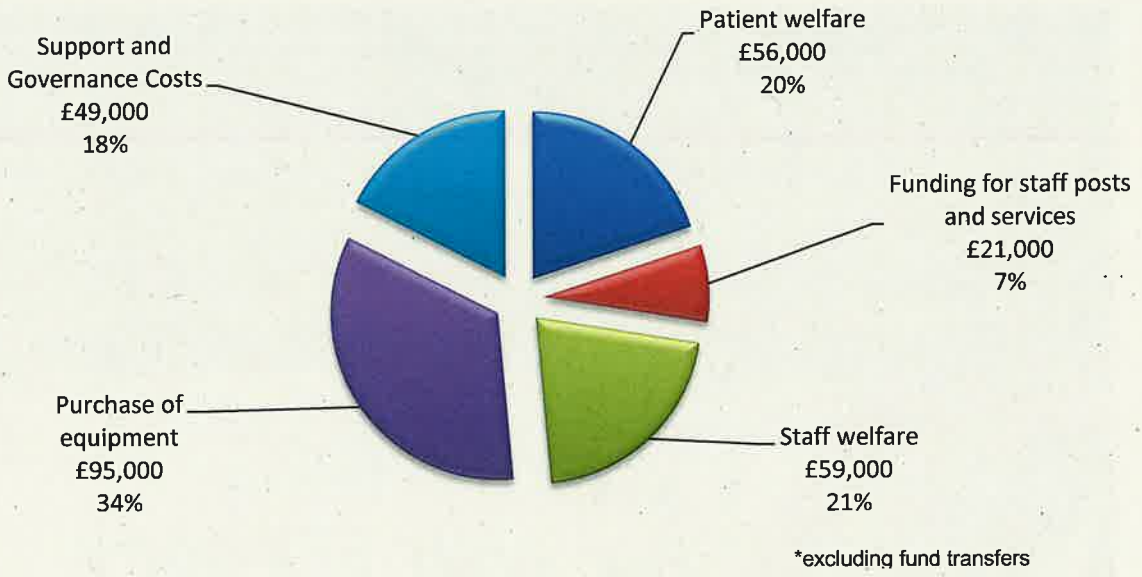
ESHTCF promotes itself by advertising in wards and public areas throughout the Trust and by making it as easy as possible for donations to be made. It also benefits from 50% of the ticket value of the East Sussex Healthcare Lottery, a common brand lottery managed by Sterling Management Centre. The lottery is promoted throughout East Sussex in medical settings such as walk in centres and GP surgeries, and in March 2020 had just over 1,000 tickets in play. Winners can receive up to £25,000 for matching their 6-digit numbers.

Donations we received



ESHTCF spent £280,000 during the year on charitable activities, as shown below. This was funded from: £369,000 income receipts.

Money we spent*



*excluding fund transfers

The Charity suffered a £219,000 net loss on investment and as a result drew £143,000 from Reserves to continue to deliver its Charitable Activities.

In 2018/19 the Postgraduate Education Fund held by the Charity was transferred to ESHT with the exception of £2,000. This remaining balance was transferred in 2019/20.

On 3 March 2020 the Trustees approved that the South East Orthopaedic Training Fund could be transferred to the University of Brighton (UoB) once UoB has accepted the terms of transfer. The Charity has not received UoB's formal acceptance during the year 2019/20 and as a result no transfer has been made in this financial year.

Reserves

ESHTCF hold reserves that are considered to be needed to fund planned expenditure. The Charity acknowledges that charitable donations received need to be spent on patient and staff amenities wherever possible and should not be used to build up reserves.

The reserves of the Charity at 31 March 2020 consisted of £1,502,000 unrestricted funds and £341,000 restricted funds. The Charity regularly reviews all funds held to ensure they remain active and where appropriate, a fund which is inactive for a period greater than 18 months will be closed and the funds transferred to the most relevant quality general fund to ensure that they are spent in a timely manner.

Reference and Administration Details

Registered Charity Number: 1058599

Address of Charity:
St Anne's House
729 The Ridge
St Leonards-on-Sea
East Sussex
TN37 7PT

Banker:
Lloyds Bank plc
2 City Place
Beehive Ring Road
Gatwick
West Sussex
RH6 0PA

Solicitors:
Bevan Britten
Kings Orchard
1 Queen Street
Bristol
BS2 0HQ

Auditor:
Grant Thornton LLP
2nd Floor
St John's House
Crawley
RH10 1HS

Trustee Arrangements:
Until 3 March 2020, voting Board members of the Trust become Trustees of the Charity upon their appointment to the Board, ceasing this role when they left the Board. From 3 March 2020, this was changed to make ESHT the sole Trustee of the Charity. The Trustees confirm that they have referred to the Charity Commission's guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities.

The Trustees of ESHTCF during the year, 1 April 2019 to 3 March 2020 were as follows:

Chairman:

Steve Phoenix	Chair (to 3rd March 2020)

Non-Executive Directors:

Jackie Churchward-Cardiff	Non-Executive Director
Miranda Kavanagh	Non-Executive Director
Karen Manson	Non-Executive Director (Chair from 3rd March 2020)
Barry Nealon	Non-Executive Director
Nicola Webber	Non-Executive Director

Executive Directors:

Dr Adrian Bull	Chief Executive
Vikki Carruth	Director of Nursing
Joanne Chadwick-Bell	Chief Operating Officer
Jonathan Reid	Director of Finance (to 31 March 2020)
Dr David Walker	Medical Director

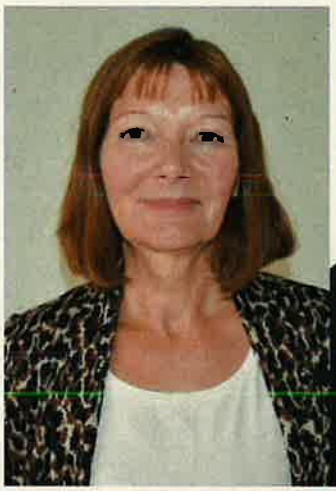
From 3 March 2020 to 31 March 2020 and to date, the sole Corporate Trustee was East Sussex Healthcare NHS Trust. Karen Manson took over as Chair of the charity from 3rd March 2020.

Steve Phoenix
Chairman

Dr Adrian Bull
Chief Executive

Jackie Churchward-Cardiff
Non-Executive Director

Miranda Kavanagh
Non-Executive Director



Karen Manson
Non-Executive Director
(chair of charity from 03.03.20)

Barry Nealon
Non-Executive Director

Nicola Webber
Non-Executive Director

Vikki Carruth
Director of Nursing

Joanne Chadwick-Bell
Chief Operating Officer

Jonathan Reid
Director of Finance
(to 31/03/20)

Dr David Walker
Medical Director

Highlights

During 2019/20 the Charity approved 425 bids, totalling over £383,000. This was an increase compared to the 371 bids approved the previous year. Bids that were approved included:

- The Annual Staff Awards which recognised the valuable contribution that staff make to the organisation;
- Funding to allow both medical and non-medical Trust staff to improve their knowledge and skills;
- Support for LGBT+ initiatives across the Trust;
- State of the art microscopes for the haematology team;
- Supplies for End of Life Care Comfort Boxes for patients;
- Grants to patients to enable them to have an improved end of life experience while remaining living in the community. Grants included:
    - Support for day-to-day living costs due to loss of income;
    - Travelling costs to undertake specialist treatment; and
    - Short breaks for terminally ill patients and their families.
- Refurbishment of an external play area for children;
- Funding to enable staff to attend transgender training;
- Equipment, including an Ophthalmoscope, an Exophthalmometer and a Slit Lamp to enhance the service offered by the Ophthalmology team at EDGH;
- Internal cameras to increase the security on maternity wards;
- Reminiscence Interactive Therapy Activities (RITA) software for patients on MacDonald Ward;
- Environmental enhancements to aid patients with dementia on Irvine Unit;
- A festive event to thank the Trust's volunteers for their hard work during 2019;
- Spirometry machines, to help assess children with cystic fibrosis;
- Replacement benches to provide outdoor seating for patients and staff at EDGH;
- Reclining chairs to enable relatives of End of Life Care patients to stay overnight at the bed side;
- A scalp cooling system to help limit hair loss for patients undergoing chemotherapy; and
- The curator for the Arts in Healthcare project, which is designed to enhance patients' experience when they visit the Trust's hospitals:
    - Provides professional management of the artworks displayed throughout the Trust;
    - Facilitates events where artists work with therapists and patients; and
    - Organises the provision of music across the Trust.

Governing Document

ESHTCF's governing document is the Model Declaration of Trust as registered with the Charity Commission. This provides that the Trustees shall hold the funds on trust to apply the income and, at their discretion so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly, or mainly, for the services provided by ESHT, Hastings and Rother Clinical Commissioning Group (CCG) and Eastbourne, Hailsham and Seaford CCG.

Structure, Governance and Management

Under the provisions of the Charities Act 2011, the Charity Commission has agreed that ESHTCF should be treated as a single Charity for the purposes of Part 4 of the Act for registration and of Part 8 of the Act for accounts.

The Charity had five registered non-trading subsidiary charities as at 31 March 2020:

- East Sussex Healthcare NHS Trust Ward Fund;
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund;
- East Sussex Healthcare NHS Trust Education Fund;
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund; and
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund.

The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is the pooling scheme fund for holding all funds.

Trustees' Meetings

The Trustees should meet at least four times a year in order to consider any bids for over £5k and to review the management of the Charity. Reports presented to Trustees include information about income and legacies, expenditure, investment performance, and fund balances.

A number of factors, including a clash with a CQC inspection and the onset of the Covid-19 pandemic meant that Trustees only met on three occasions in 2019/20, with attendance as follows:

Name and Position	Attendance at Trustee's meetings
Steve Phoenix Chairman	2/3
Dr Adrian Bull Chief Executive	3/3
Jackie Churchward-Cardiff Non-Executive Director	2/3
Miranda Kavanagh Non-Executive Director	3/3
Karen Manson Non-Executive Director	3/3
Barry Nealon Non-Executive Director	0/3
Nicola Webber Non-Executive Director	2/3
Vikki Carruth Director of Nursing	2/3
Joanne Chadwick-Bell Chief Operating Officer	3/3
Jonathan Reid Director of Finance	3/3
Dr David Walker Medical Director	2/3

Governance

The Trustees delegate responsibility for the day-to-day management of the charitable funds to the Director of Corporate Affairs and the Director of Finance. The Director of Corporate Affairs is responsible for:

- the administration and governance of the funds;
- ensuring that spending is in accordance with the objectives and priorities agreed by the Trustees;
- ensuring that the criteria for spending charitable monies are fully met;
- arranging meetings of the Trustees; and
- management of the Fundraising Manager.

The Director of Finance is responsible for:

- ensuring that full accounting records are maintained;
- ensuring the accounts of Charitable Funds show a true and fair view of the year's activity;
- ensuring there is a system of control for all transactions related to expenditure and income;
- ensuring that there is robust oversight of the accounting records; and
- ensuring the accurate reporting of the in-year position to both Trustees and fund holders.

The principal officer overseeing the day-to-day financial management and accounting for the charitable funds for the accounting period 1 April 2019 to 31 March 2020 was the Director of Finance, Jonathan Reid.

The principal officer overseeing the day-to-day administration and governance for the charitable funds for the accounting period 1 April 2019 to 31 March 20120 was the Director of Corporate Affairs, Lynette Wells.

Financial Management

Expenditure budgets for administration, governance and fundraising costs are approved by the Trustees at the start of the financial year and are monitored throughout the year.

The Charity manages its Charitable Activity spending through appointed fundholders for the individual funds. These fundholders manage the funds on a day-to-day basis with agreed authorisation limits, and in accordance with the Trust's Standing Financial Instructions and Orders. Each fund holder receives a quarterly financial statement of their fund which details income, expenditure and fund balances for the period.

The Charity receives expenditure applications from staff throughout the year which are authorised by the fundholder and submitted to the Assistant Company Secretary, who reviews all applications to ensure that they meet the objectives of the Charity for quality, value for money and patient benefit. Where an application exceeds £5,000 the fundholder is required to present the application to the Trustees' for approval. Where any expenditure is considered inappropriate, feedback is given to the fund manager.

The Charity does not directly employ any staff; the Charity enjoys and values the services of volunteers, but is not wholly dependent on them. The Charity is not financially dependent upon the support of any individuals, corporations or specific classes of donors. No funds are held by the Charity on behalf of individuals.

Investments and Investment Policy

The Charity aims to enhance the value of its funds through sound investment.

Money is invested through CCLA Investment Management Limited and M&G Securities Ltd, with the aim of obtaining a return higher than the FTSE All Share Index (dividends reinvested). During the year, investments were held in the following proportions:

Fund	2019/20	2018/19
Fixed Interest Funds	21%	18%
CCLA Property Fund	27%	24%
M&G Securities Ltd Equities Investment Fund	52%	58%
Total investments	**100%**	**100%**

The total value of the investment portfolio at 31 March 2020 was £2.17m. The return on investment during the year was a decrease of 9% (2018/19 increase of 6%) compared to a 22% decrease (2018/19 increase of 2%) in the FTSE All Share Index. The total investment income from the cash holdings produced interest of £10 (2018/19 £8).

Risk Management

The major risks to which the Charity is exposed have been identified and reviewed with systems established to mitigate them. The Charity relies on and benefits from the financial controls framework of ESHT.

The most significant risks identified were:

1. possible losses from a fall in the value of the investments; and
2. reputational damage leading to a sudden and dramatic fall in donations

Both risks have been carefully considered and mitigating procedures put in place. Regular review of the investment policy ensures that both spending and firm financial commitments remain in line with income. Both income and expenditure are monitored by the Committee on a quarterly basis in order that any trends can be identified at an early stage in order to avoid unforeseen calls on reserves.

Future plans

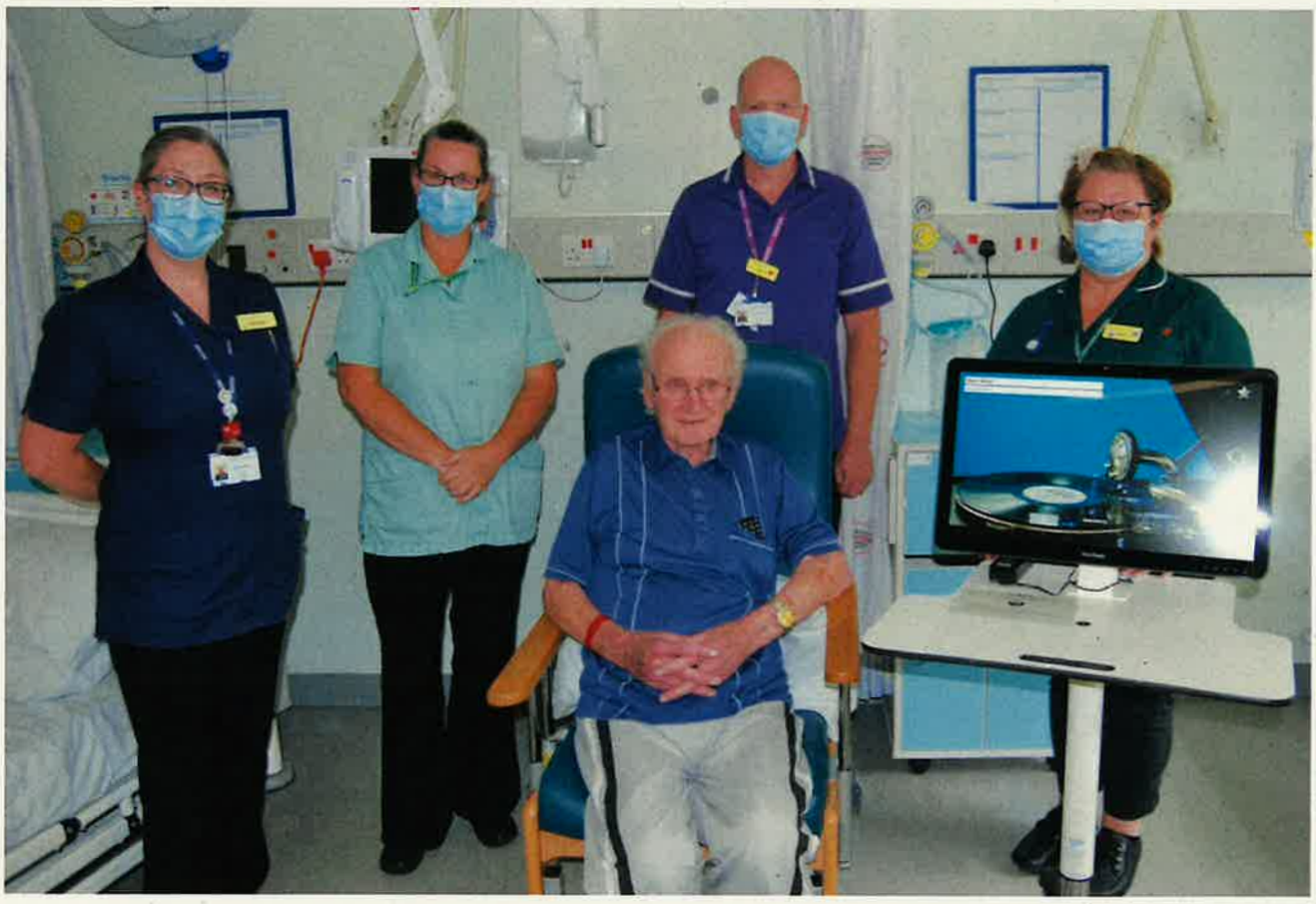
In accordance with Charity Commission directives, it is the Charity's intention to expend funds for the benefit of both staff and patients.

The Charity has changed the manner in which it is overseen moving from individual Trustees to a single corporate Trustee. This will allow the Charity in 2020/21 to change the makeup of its Committee and the intention is that staff from clinical, HR and other areas of the Trust will be invited to join in order to help develop the Charity's future strategy. Karen Manson, one of the Trust's Non-Executive Directors will be taking up the role of the Charity's Chair.

The Charity will also be looking at how it can aid the Trust's response to the Covid-19 pandemic which began in March 2020 continuing into the next financial year. This will include the responsible distribution of money so generously raised by members of the public, support for frontline and other staff in the organisation and for our community.

Fundraising will continue with the aim of increasing the amount of general funds that are available, and also in support of specific fundraising projects for wards and clinical areas.

We will continue to work hard to support the needs of our patients, staff and carers, enhancing the care that they are able to receive from the NHS. We are hugely grateful for the support that we receive from our donors and our local population; their support makes everything that we do possible. Your support makes these plans possible and to help us please do consider making a donation (see page 24).



Statement of Trustee's Responsibilities

The Trustees are responsible for preparing the Trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Charity law requires the Trustees to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of the resources of the Charity for the year. In preparing those financial statements the Trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP FRS 102;
- make judgements and accounting estimates that are reasonable and prudent;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business; and
- ensure the financial statements comply with the Trust Deed.

The Trustees are responsible for keeping accounting records that are sufficient to show and explain the Charity's transactions and disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011 and regulations made thereunder. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Approved by the Trustees on 20th January 2021 and signed on their behalf by:

Signed:

Karen Manson
Chair

Independent examiner's report to the corporate trustee of East Sussex Healthcare NHS Trust Charitable Fund

I report on the accounts of East Sussex Healthcare NHS Trust Charitable Fund (the "charity") for the year ended 31 March 2020, which are set out on pages 15 to 25.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011; and
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met, or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Basis of independent examiner's statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as corporate trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement above.

Respective responsibilities of corporate trustee and examiner

The charity’s corporate trustee is responsible for the preparation of the accounts. The charity’s trustee considers that an audit is not required for this year under section 149(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 149 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 149(5) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

This report is in respect of an examination carried out under section 149(3) of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

Darren Wells

Darren Wells, Director

Grant Thornton UK LLP
Chartered Accountants

London

21 January 2021

Statement of Financial Activities for the year ended 31 March 2020

	Note	2019/20 Unrestricted Funds £000	2019/20 Restricted Funds £000	2019/20 Total Funds £000	2018/19 Total Funds £000
Income and endowments from					
Donations	2.1	143	37	**180**	**275**
Legacies	2.2	6	166	**172**	**68**
Charitable activities	2.3	17	-	**17**	**20**
Total income		**166**	**203**	**369**	**363**
Expenditure on Charitable activities					
Patient welfare		(65)	(1)	**(66)**	**(70)**
Funding for staff posts and services		(11)	(18)	**(29)**	**(16)**
Staff welfare		(66)	(6)	**(72)**	**(162)**
Purchase of equipment		(113)	-	**(113)**	**(268)**
Spend on charitable activities		**(255)**	**(25)**	**(280)**	**(516)**
Fundraising		(9)	(2)	**(11)**	**-**
Transfer to East Sussex Healthcare NHS Trust		(2)	-	**(2)**	**(97)**
Total expenditure	**4**	**(266)**	**(27)**	**(293)**	**(613)**
Net gains/(losses) on investments	7.1	(194)	(25)	**(219)**	**127**
Net income/(expenditure)		**(294)**	**151**	**(143)**	**(123)**
Net movement in funds	**6**	**(294)**	**151**	**(143)**	**(123)**
Reconciliations of funds					
Fund balances brought forward at 1 April		1,796	190	**1,986**	**2,109**
Fund balances carried forward at 31 March		**1,502**	**341**	**1,843**	**1,986**

All gains and losses recognised in the year are included in the Statement of Financial Activities.

Balance Sheet as at 31 March 2020

	Note	2019/20 Unrestricted Funds £000	2019/20 Restricted Funds £000	2019/20 Total Funds £000	2018/19 Total Funds £000
Fixed assets					
Investments	7	1,994	175	**2,169**	2,388
Total fixed assets		**1,994**	**175**	**2,169**	2,388
Current assets					
Debtors	8	1	-	**1**	-
Cash and cash equivalents		123	263	**386**	453
Total current assets		**124**	**263**	**387**	453
Liabilities					
Creditors falling due within one year	9	(616)	(97)	**(713)**	(855)
Net current liabilities		(492)	166	**(326)**	(402)
Total net assets		**1,502**	**341**	**1,843**	1,986
Funds of the Charity					
Unrestricted		1,502	-	**1,502**	1,796
Restricted		-	341	**341**	190
Total funds	10	**1,502**	**341**	**1,843**	**1,986**

The notes at pages 17 to 24 form part of these accounts.

Approved and authorised for issue by the Trustees on 20th January 2021 and signed on their behalf.

Karen Manson
Chair
Date: 20th January 2021

Damian Reid
Financial Trustee
Date: 20 Jan 21

Statement of Cashflows for the year ended 31 March 2020

	Note	2019/20 Total Funds £000	2018/19 Total Funds £000
Cash flows from operating activities:			
Net expenditure for the reporting period		(143)	(123)
Adjustments for:			
(Gains)/losses on investments	7.1	219	(127)
(Increase)/decrease in debtors		(1)	38
Increase/(decrease) in creditors		(142)	515
Net cash used in operating activities		**(67)**	**303**
Change in cash and cash equivalents in the reporting period		**(67)**	**303**
Cash and cash equivalents at 1 April 2019		**453**	150
Cash and cash equivalents at 31 March 2020		**386**	**453**

Notes to the Accounts

1. Accounting Policies

1.1. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments at market value. The financial statements have been prepared in accordance with the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011, and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The Trust constitutes a public benefit entity as defined by FRS 102.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

1.2. Income Recognition

All income is recognised and included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement: control over the rights or other access to the economic benefit has passed to the Charity.
- Probable: it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity.
- Measurement: the monetary value or amount of both the income and the costs to complete the transaction can be measured reliably.

Income from legacies are accounted for as incoming resources once the receipt of the legacy becomes probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled or are within the Charity's control to fulfil.

1.3. Expenditure Recognition

The accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

Support and Governance costs are accounted for on an accruals basis and are recharges of appropriate proportions of the ESHT costs, audit or independent examination fees, fund raising consultancy, support for the accounting software and Trustee Indemnity Insurance.

Support and Governance costs are apportioned across all funds based on the average fund balance for the year.

In 2018/19 the Postgraduate Education Fund held by the Charity was transferred to ESHT with the exception of £2,000. This remaining balance was transferred in 2019/20 (Note 10.1).

All items of expenditure under £5,000 are treated as revenue.

1.4. Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. The major funds held within these categories are disclosed in note 10.

1.5. Investment Fixed Assets

Investment fixed assets are shown at bid price, which is used to measure fair value for accounting purposes of shares that are traded in an active market. The investments are valued at closing unit prices and the net gains and losses on revaluations and disposals are included on the Statement of Financial Activities.

1.6. Gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Gains and losses on investments are calculated as the difference between sales proceeds and opening fair value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between fair value at the year end and opening fair value (or date of purchase if later).

1.7. Pooling scheme

An official pooling scheme, the East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is operated for investments relating to the following funds:

- East Sussex Healthcare NHS Trust Ward Fund
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund
- East Sussex Healthcare NHS Trust Education Fund
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund

The Scheme was registered with the Charity Commission on 17 March 1998.

1.8. Related Party Transactions

The Trustees of the ESHTCF are the Chairman, Executive and Non-Executive Directors of East Sussex Healthcare NHS Trust acting in an individual capacity.

ESHT is the major recipient of funds of the Charity and received grants from the Charity totalling £233,000 during the year (2018/19 £434,000).

ESHT charged a management fee to the Charity of £47,000 (2018/19 £56,000) to recharge administrative costs and services provided.

The Charity owed ESHT £537,000 at 31 March 2020 (£607,000 31 March 2019).

None of the members of ESHT Board, senior staff or parties related to them were beneficiaries of the Charity. None of the Trustees or other members of ESHT Board has received honoraria, emoluments or expenses in the year.

1.9. Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

1.10. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments.

1.11. Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt. There are no amounts which are owed in more than a year.

2. Details of Income

2.1. Donations

	Unrestricted Funds	Restricted Funds	Total 2019/20	Total 2018/19
	£000	£000	£000	£000
Donations from individuals	74	2	**76**	132
Other trading activities	9	-	**9**	8
Other	60	35	**95**	130
Grants	-	-	**-**	5
Total voluntary income	**143**	**37**	**180**	**275**

2.2. Legacies

L Rondelli	5	-	**5**	-
E Lewis	-	10	**10**	-
A E Wood	-	156	**156**	-
J E M Billings	1	-	**1**	-
J Sowerby	-	-	**-**	1
U Burton	-	-	**-**	9
M G Tookey	-	-	**-**	58
Total legacies	**6**	**166**	**172**	**68**

2.3. Charitable Activities

Training courses	17	-	**17**	20
Total charitable activities	**17**	**-**	**17**	**20**

3. Analysis of charitable expenditure before allocation of Support and Governance Costs

	Unrestricted Funds	Restricted Funds	Total 2019/20	Total 2018/19
	£000	£000	£000	£000
Arts in Healthcare	21	1	**22**	26
Other patients welfare and amenities	34	-	**34**	33
Patient welfare total	**55**	**1**	**56**	**59**
Funded staff posts and services	-	12	**12**	-
Clinical supervision for Cancer teams	9	-	**9**	13
Funding of staff posts and services total	**9**	**12**	**21**	**13**
Support to staff training	29	3	**32**	48
Annual Staff Awards and retirement gifts	4	-	**4**	27
Other support to staff welfare and amenities	23	-	**23**	61
Staff welfare total	**56**	**3**	**59**	**136**
Purchase of equipment	95	-	**95**	235
Fundraising	9	2	**11**	-
Transfer to East Sussex Healthcare NHS Trust	2	-	**2**	97
Total charitable expenditure	**226**	**18**	**244**	**540**

All charitable expenditure is classified as grant funded activities

4. Analysis and Allocation of Support and Governance Costs

	2019/20 Total Funds £000	2018/19 Total Funds £000
Administration fee	24	27
Preliminary fundraising expenses	-	13
Total support costs	**24**	**40**
Independent Examiner's fee	2	3
Indemnity insurance	-	1
Governance fee	23	29
Total governance costs	**25**	**33**
Total support and governance costs	**49**	**73**

The support costs and governance costs attributable to charitable activities is apportioned based on the total expenditure for the year for each charitable activity as shown in the table below.

	2019/20 Grant funding of activities £000	2019/20 Support and Governance Costs £000	2019/20 Total Funds £000	2018/19 Total Funds £000
Allocation of support and governance costs	Note 3			
Patient welfare	56	10	66	70
Funding for staff posts and services	21	8	29	16
Staff welfare	59	13	72	162
Purchase of equipment	95	18	113	268
Active continuing funds	**231**	**49**	**280**	**516**
Fundraising	11	-	11	-
Transferred funds	2	-	2	97
Total allocated	**244**	**49**	**293**	**613**

Grants paid in year to ESHT £233,000 (2018/19 £434,000), Grants paid to individuals in year £8,000 (2018/19 £8,500).

5. Examiner's remuneration

The Independent Examiner's remuneration of £1,800 exclusive of VAT (2018/19 £1,800) related solely to the independent examination with no other additional work undertaken.

6. Changes in Resources Available for Charity Use

	2019/20 Unrestricted Funds £000	2019/20 Restricted Funds £000	2019/20 Total Funds £000	2018/19 Total Funds £000
Net movement in funds for the year	(294)	151	**(143)**	(123)
Net movement in funds available for future activities	**(294)**	**151**	**(143)**	**(123)**

7. Analysis of Fixed Asset Investments

7.1. Fixed Asset Investments

	2019/20 Total £000	2018/19 Total £000
Market value at start of period	2,388	2,261
Net gain on revaluation and sales	(219)	127
Market value at end of period	2,169	2,388
Historic cost at end of period	1,203	1,174

7.2. Market Value

	31 March 2020 £000	31 March 2019 £000
Investments in a Common Deposit Fund or Common Investment Fund		
CCLA Investment Management Fixed Interest Funds	415	400
CCLA Investment Management Property Fund	585	570
M&G Securities Fixed Interest Investment Fund	39	39
M&G Securities Equities Investment Fund	1,128	1,377
Total	2,167	2,386
Cash held as part of the investment portfolio	2	2
Total	2,169	2,388

All units are held within the UK.

8. Analysis of Debtors

	Balance 31 March 2020 £000	Balance 31 March 2019 £000
All falling due within one year		
Trade debtors	1	-
Total debtors	1	-

9. Analysis of Creditors

	Balance 31 March 2020 £000	Balance 31 March 2019 £000
Falling due within one year		
Accruals and deferred income	176	248
Other creditors	537	607
Total creditors	713	855

10. Analysis of Funds

10.1.

	Balance 31 March 2019	Income	Expenditure	Transfers	Gains and Losses	Balance 31 March 2020
	£000	£000	£000	£000	£000	£000
Unrestricted funds	**1,796**	**166**	**(264)**	**(2)**	**(194)**	**1,502**
Arts in Healthcare	1	1	(1)	-	-	**1**
Conquest Equipment	3	-	-	-	-	**3**
South East Coast Orthopaedic Training	171	-	(11)	-	(12)	**148**
Lewes Victoria Hospital	15	-	-	-	(2)	**13**
EDGH Scanning Equipment for Intensive Care and Radiology	-	156	(2)	-	(9)	**145**
Maternity Bereavement Suite	-	22	-	-	(1)	**21**
Conquest Courtyards	-	10	(1)	-	(1)	**8**
Youth Volunteering Project	-	12	(12)	-	-	**-**
Kipling Music	-	2	-	-	-	**2**
Total Restricted Funds	**190**	**203**	**(27)**	**-**	**(25)**	**341**
Total Funds	**1,986**	**369**	**(291)**	**(2)**	**(219)**	**1,843**

10.2. Details of the Restricted Income Funds

Name of fund	Description
Arts in Healthcare	The promotion of the initiative for the provision of Arts in Healthcare
Conquest MRI Scanner	The fund held for the purchase of a MRI Scanner at Conquest Hospital
Conquest Equipment	The fund held for the purchase of Equipment at Conquest Hospital
South East Orthopaedic Training	To provide training for junior doctors in surgical skills
Lewes Victoria Hospital	The fund held for the benefit of Lewes Victoria Hospital
EDGH Scanning Equipment for Intensive Care and Radiology	The funds held for the purchase of Scanning Equipment for Intensive Care and Radiology at Eastbourne District General Hospital
Maternity Bereavement Suite	The fund held for the refurbishment of the Maternity Bereavement Suite
Conquest Courtyards	The fund held for the benefit of the Conquest Courtyards
Youth Volunteering Project	The fund held for the development of youth volunteering opportunities
Kipling Music	The fund held to provide interactive music sessions to Kipling Ward
COVID-19	The fund held to enhance the well-being of NHS Staff, volunteers and patients impacted by COVID-19

11. Funding Commitments

As at 31 March 2020 the Trustees had not made commitments other than those shown as creditors, Note 9.

12. Trustee Indemnity Insurance

	2019/20 Amount	2018/19 Amount
	£000	£000
Trustees' indemnity insurance	-	1
Total	**-**	**1**

Ways in which to support our Charity

There are many ways you can support our Charity.

Donations can be made in the following ways:-

Direct into bank account
Bank: Lloyds Bank
Sort code: 30-92-86
Account number: 00460039
Account name: East Sussex Healthcare NHS Trust Charitable Fund
Reference: Please state the General Fund

By post
Cheque to East Sussex Healthcare NHS Trust Charitable Fund

Please write on the back of the cheque which fund you would like to donate to, e.g. General Fund, and send to:

Charitable Funds
St Anne's House
729 The Ridge
St Leonards-On-Sea
East Sussex
TN37 7PT

By a donation on our 'Just Giving' site
www.justgiving.com/esht

As well as making a general donation, you can also open a page in celebration of and in memory of a loved one. If you are a group or an organisation who is interested in raising money on behalf of the Charity, we would love to hear from you too.

For more information and for support if you are holding your own event, please contact:

Mike Eastwood, Charity Manager
East Sussex Healthcare NHS Trust Charitable Fund
Email: mike.eastwood@nhs.net

Gift Aid
Gift Aid is a simple, government initiative which allows us to increase the value of your donations at no extra cost to you. For every pound you give to us we can get an extra 25 pence from HM Revenue and Customs helping your donation go further to help patients and their families. The only condition is that you are a UK tax payer. When making a donation simply let us know that you wish to Gift Aid your donation, to do this all we need is your name and address.

Use of Trust Seal

Meeting information:			
Date of Meeting:	9th February 2021	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Chair

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

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

Summary:

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

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

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

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

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

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

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

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

Not applicable.

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

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

East Sussex Healthcare
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	Chief Financial Officer
Signature & Date	November 2019

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
Audit Committee	Annual Review	November 2019
Audit Committee	Annual Review	January 2021

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 Nov.17	ESHT Trust Board
v 1.9	Dec-18	Nov 2019	4 Dec 18	ESHT Trust Board
v.1.10	Dec-19	Nov 2020	3 Dec 19	ESHT Trust Board
v.1.11	Jan-21	Nov 2021		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 very senior managers.
	The Board	**Strategy Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Final Business Cases for Capital Investment over £1,000,000 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3-year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer for losses and special payments. 12. Approve proposals for action on litigation on behalf of the Trust. 13. Review use of NHS risk pooling schemes (CNST/RPST).

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
	The Board	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	The Board	**Audit:** 1. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report of the Audit Committee.
	The Board	**Annual Reports and Accounts:** 1. Receipt and approval the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for charitable funds.
	The Board	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary to the Board. 3. Receive reports from Chief Financial Officer on financial performance against budget and business plan and other Directors on activity, workforce, quality and safety. 4. Receive reports from the Chief Financial Officer on actual and forecast income from SLA's 5. Receive assurance on compliance with the appropriate regulations within the Health and Social Care Act 2008 and the related Care Quality Commission outcomes

DECISIONS/DUTIES DELEGATED BY THE BOARD TO THE CHAIRMAN, CHIEF EXECUTIVE AND COMMITTEES

Section 1

Reference		**Decision/Duties Reserved to the Chairman and Chief Executive**
	Chairman	1. Appoint the Vice Chairman 2. Appoint the Senior Independent Director 3. Appointment and dismiss committees (and individual members) that are directly accountable to the Board. 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
	Chief Executive	1. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2)

Reference	**Committee**	**Decision/Duties Delegated by the Board to Committees**
	Audit Committee	The current terms of reference, including powers delegated by the Board, are available from the 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 Chief Financial Officer	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	Chief Executive	Ensure effective management systems that safeguard public funds and the 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	Chief Financial Officer	Operational responsibility for effective and sound financial management and information.
15	Chief Executive	Primary duty to see that Chief Financial Officer discharges this function.
16	Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

Section 1

Reference	Delegated To	Accountable Officer Memorandum – Duties Delegated
17	Chief Executive	Promote the observance of all staff of the Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by the Secretary of State.
18	Chief Executive and Chief Financial Officer Medical Director Chief Nurse and Director of Corporate Affairs	Chief Executive, supported by Chief Financial Officer , Medical Director, Chief Nurse 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	Audit Committee	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of the Code of Conduct and Accountability, and other ethical concerns.
1.3.1.9 & 1.3.2.2	All Board members	Subscribe to the Code of Conduct and Accountability.
1.3.2.4	Board	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	Chairman and Non-Executive Directors	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 and any other sub-Committees of the main Board; and 7. advise the Secretary of State on the performance of Non-Executive Board members.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.5	Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	Non-Executive Directors	Non-Executive Directors are appointed by the NHS Appointments to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	Chairman	All members of the Board are required to make annual declarations of conflict of interests and fit and proper persons.
1.3.2.9	Board	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Ref	Delegated To	Standing Orders – Authorities/Duties Delegated
1.1	Chairman	Final authority in interpretation of Standing Orders.
2.4	Chairman	Appointment of Vice Chairman and Senior Independent Director.
3.1	Chairman	Call Board meetings.
3.7	Chairman	Chair all Board meetings and associated responsibilities.
3.9	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings.
3.11	Chairman	Having a second or casting vote.
3.12	Board	Suspension of Standing Orders.
3.12	Audit Committee	Audit to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
3.13	Board	Variation or amendment of Standing Orders.
4.1	Board	Formal delegation of powers to sub-committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub-committees may be approved by the Chief Executive).
5.2	Chairman & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chairman and Chief Executive after having consulted at least two Non-Executive Directors.
5.3	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	All	Disclosure of non compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	The Board	Declare relevant and material interests.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Reference	Delegated To	Standing Orders – Authorities/Duties Delegated
7.2	Director of Corporate Affairs	Maintain Register(s) of Interests.
7.4	All staff	Comply with national guidance contained in NHS England's 'Standards of Business Conduct Policy' for NHS staff
7.4	All	Disclose relationship between self and candidate for staff appointment.
8.1/8.3	Director of Corporate Affairs	Keep seal in safe place and maintain a register of sealing.
8.4	Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
1.1.1	Chief Financial Officer	Training and communication programme for staff on SFIs.
1.1.3	Chief Financial Officer	Approval of all financial procedures.
1.1.4	Chief Financial Officer	Advice on interpretation or application of SFIs.
1.1.6	All Members of the Board and all Staff	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible
1.3.4	Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the system of internal control.

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 & Chief Financial Officer	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.3.6	Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	Chief Financial Officer	Responsible for: a) Implementing the Trust's financial policies and co-ordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and the wider organisation; e) Design, implementation and supervision of systems of internal financial control; and f) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
1.3.8	All members of the Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, SFIs and financial procedures.
1.3.9	Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income is made aware of these instructions and their requirement to comply.
2.1.1	Audit Committee	Provide independent and objective view on internal control and probity.
2.1.2	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3	Chief Financial Officer	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed).
2.2.1 c)	Chief Financial Officer	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.

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 Chief Financial Officer and in accordance with NHS Internal Audit Manual and best practice.
2.4.1	Audit Committee	Ensure cost-effective external audit.
2.5.1 2.5.2	Chief Executive & Chief Financial Officer	Monitor and ensure compliance with Secretary of State's Directions on fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.
2.6.1	Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on HNS security management including appointment of the Local Security Management Specialist.
3.1.1	Chief Executive	Compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain: ▪ a statement of the significant assumptions on which the plan is based; ▪ details of major changes in workload, delivery of services or resources required to achieve the plan. ▪ detailed financial templates, accompanying finance narrative and operational/strategic narrative
3.1.3 & 3.1.4	Chief Financial Officer	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.7	Chief Financial Officer	Ensure adequate financial training is delivered on an on going basis to budget holders.
3.2.1	Chief Executive	Delegate budgets to budget holders
3.2.2	Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
3.3.1	Chief Financial Officer	Devise and maintain systems of budgetary control.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
3.3.2	Budget Holders	Ensure that: a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.
3.3.3	Chief Executive	Identify and implement cost improvements and income generation activities in line with the Business Plan.
3.6.1	Chief Executive	Submit all statutory and other monitoring returns required of the organisation.
4.1	Chief Financial Officer	Preparation of annual accounts
4.3	Director of Corporate Affairs	Preparation of annual report
5.1.1	Chief Financial Officer	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements).
6	Chief Financial Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
6.2.3	All employees	Duty to inform Chief Financial Officer of money due from transactions which they initiate/deal with.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.5.3	Chief Financial Officer	Report waivers of tendering procedures to the Audit Committee.
7.6.2	Chief Financial Officer	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.4	Chief Executive & Chief Financial Officer	Where one tender is received will assess for value for money and fair price.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.6.6	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.
7.7.4	Chief Executive & Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Chief Financial Officer .
7.15	Chief Financial Officer	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
8.1	Chief Financial Officer	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
8.3	Chief Financial Officer	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
9.1.1	Board	Establish a Remuneration Committee.
9.1.2	Remuneration Committee	Take decisions under delegated authority on the remuneration and terms of service of the Chief Executive, other officer members and very senior managers to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements. Monitor and evaluate the performance of individual very senior managers. Oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
9.1.3	Remuneration Committee	Produce an annual report for the Board.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
9.2.2	Chief Executive	Approval of variation to funded establishment of any department.
9.4.1 & 9.4.2	Chief Financial Officer	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 9.4.2).
10.1.1	The Board	Approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer
10.1.2	Chief Financial Officer	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.2.3	Chief Financial Officer	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and regularly reviewed; a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds; b) Be responsible for the prompt payment of all properly authorised accounts and claims; c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; d) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; e) Instructions to employees regarding the handling and payment of accounts within the Finance Department; f) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.2.4	Appropriate Executive Director	Make a written case to support the need for a prepayment.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
10.2.4	Chief Financial Officer	Approve proposed prepayment arrangements.
10.2.4	Budget holder	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Financial Officer if problems are encountered).
10.2.5	Chief Financial Officer	Authorise who may use and be issued with official orders.
10.2.6	Managers and Officers	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer .
10.2.7	Chief Executive Chief Financial Officer	Ensure that Standing Financial Instructions are compatible with Department of Health requirements re building and engineering contracts. Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
11.1	Chief Financial Officer	The Chief Financial Officer will advise the Board on the Trust's ability to pay dividend on 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 Chief Financial Officer).
11.3	Chief Financial Officer	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	Chief Executive or Chief Financial Officer	Be on an authorising panel comprising one other member for applications for short term borrowing.
11.7.2	Chief Financial Officer	Will advise the Board on investments and report, periodically, on performance of same.
11.7.3	Chief Financial Officer	Prepare detailed procedural instructions on the operation of investments.
12.1	Chief Financial Officer	Ensure that Board members are aware of the Financial Framework and ensure compliance.
13.1.1 & 13.1.2	Chief Financial Officer	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans; b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.1.2	Chief Financial Officer	For every capital expenditure proposal over £100,000 a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the Capital Review Group (CRG). b) for every capital expenditure proposal in excess of £250,000 the business case is also required to be submitted to the Executive Directors' Meeting for approval. c) for all projects over £500,000 a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial and TW Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Investment Committee for approval. d) for all projects over £500,000 the Project Director will be required to co- ordinate and complete a monthly capital monitoring return to CRG showing performance against budget. e) for every capital expenditure proposal in excess of £500,000 the business case is also required to be submitted to the Combined Business Development Group (BDG) and Capital Review Group (CRG) for approval before any further expenditure is committed. f) for all projects over £1,000,000 the business case will be submitted to the Trust Board for approval g) where any scheme is forecast to overspend by more than the following amounts the Project Director will be required to report reasons to the CAG for approval before any further expenditure is committed: i. where the scheme value is £250k or less – 10% of the approved scheme value ii. for other schemes up to £1m – the higher of 5% or £25k
13.1.3	Director of Estates and Facilities	Assess the requirement for the operation of the Construction Industry Scheme.

13.1.4	Chief Financial Officer	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.5	Chief Financial Officer	Issue procedures governing financial management, including variation to contracts, of capital investment projects and valuation for accounting purposes.
13.2.1	Chief Financial Officer	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	Board	Proposal to use PFI must be specifically agreed by the Board.
13.3.1	Chief Financial Officer	Maintenance of asset registers.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.3.5	Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.7	Chief Financial Officer	Ensure that a review of asset lives is undertaken annually.
13.4.1	Chief Financial Officer	Overall responsibility for fixed assets.
13.4.2	Chief Financial Officer	Approval of fixed asset control procedures.
13.4.4	All senior staff	Responsibility for security of Trust assets including notifying discrepancies to Chief Financial Officer , and reporting losses in accordance with Trust procedure.
14.2	Chief Financial Officer	Delegate overall responsibility for control of stores. Further delegation for day to day responsibility subject to such delegation being recorded.
14.2	Head of Procurement	Responsible for systems of control over stores and receipt of goods.
14.2	Designated Pharmaceutical officer	Responsible for controls of pharmaceutical stocks.
14.2	Designated Estates Officer	Responsible for control of stocks of fuel.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
14.3	Director of Estates and Facilities	Security arrangements and custody of keys
14.4	Chief Financial Officer	Set out procedures and systems to regulate the stores.
14.5	Chief Financial Officer	Agree stocktaking arrangements.
14.6	Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified.
14.7	Head of Procurement/Pharmaceutical Officer	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.7	Head of Procurement/Pharmaceutical Officer	Operate system for slow moving and obsolete stock, and report to Chief Financial Officer evidence of significant overstocking.
14.8	Chief Financial Officer	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	Chief Financial Officer	Prepare procedures for recording and accounting for losses and special payments and informing police in cases of suspected arson or theft.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
15.2.3	Executive Directors	Where a criminal offence is suspected Executive Directors must inform the police if theft or arson is involved. In cases of fraud and corruption Executive Directors must inform the relevant LCFS and CFOS in line with Secretary of State's directions.
15.2.4	Chief Financial Officer	Notify CFOS and External Audit of all frauds.
15.2.5	Chief Financial Officer	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.6	Audit Committee	Approve write off of losses.
15.2.8	Chief Financial Officer	Consider whether any insurance claim can be made.
15.2.9	Chief Financial Officer	Maintain losses and special payments register.
16.1	Chief Financial Officer	Responsible for accuracy and security of computerised financial data.
16.2	Chief Financial Officer	Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
16.3	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 Chief Financial Officer .

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
16. 5	Chief Financial Officer	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. The contract should also ensure rights of access for audit purposes.
16.7	Chief Financial Officer	Where computer systems have an impact on corporate financial systems satisfy himself/herself that: a) systems acquisition, development and maintenance are in line with corporate policies and IM&T Strategy; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) relevant staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
16.8	Chief Financial Officer	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
17.2	Chief Nurse	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
17.6	Departmental managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1.	Chief Financial Officer and Director of Corporate Affairs	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 Corporate Affairs	The Director of Corporate Affairs will arrange for the creation of a new charitable fund where this is required.
19.1	Director of Corporate Affairs	Ensure all staff are made aware of Trust policy on the acceptance of gifts and other benefits in kind by staff.
20	Chief Executive	Retention of document procedures in accordance with Department of Health guidance.
21.1	Chief Nurse	Ensure the Trust has a risk management programme.
21.1	Board	Approve and monitor risk management programme.
21.3	Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks (where discretion is allowed).
21.5	Chief Financial Officer	Where the Board decides to use risk pooling schemes or commercial insurers the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.
21.6	Chief Financial Officer	Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures to cover these arrangements.
21.7	Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible.

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	Director of Corporate Affairs	Deputy Company Secretary
2.	Receiving Hospitality, Gifts and Sponsorship other than isolated gifts of a trivial nature or conventional hospitality Applies to both individual and collective hospitality receipt items	Declaration required in Trust's Hospitality Register – all Trust Directors and Employees	N/A
3.	The keeping of the Interests, Hospitality, Gifts and Sponsorship Register	Director of Corporate	Deputy Company Secretary
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 **£10,000** – one written quotation.	Director for appropriate budget or General Manager	Authorised Budget Signatory and Purchasing and Supplies Buyer
	b) **£10,001** up to **£50,000** excluding VAT– invite 3 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
	c) **£50,000** excluding VAT to **the prevailing European Union Threshold** – a minimum of 3 Invitations to Tender.	Head of Procurement together with Chief Financial Officer	Head of Procurement together with Chief Financial Officer
	d) **Above the prevailing European Union Threshold** up to **£500,000** – a minimum of 4 Invitations to Tender with at least received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer
	e) **£500,000** to **£1,000,000**	Finance and Investment Committee	Finance & Investment Committee
	f) **Over £1,000,000**	Trust Board	Trust Board and Common Seal of the Trust

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:		
a) For quotations	Chief Executive.	Head of Procurement
b) For tenders **£50,000 excluding VAT** to the **EU threshold**	Chief Executive or Chief Financial Officer	N/A
c) For tenders from the **EU threshold** up to **£500,000**	Chief Executive and Chief Financial Officer	N/A
d) For tenders from **£500,000** to **£1,000,000**	Finance & Investment Committee	
e) For tenders above **£1,000,000**	Trust Board	N/A
5. Opening electronic Tenders and Quotations	Procurement Department	N/A
6. Attestation of Sealings in accordance with Standing Orders	Chairman/Chief Executive	Executives
7. The keeping of a register of Sealings	Director of Corporate Affairs	Deputy Company Secretary
8. Implementation of Internal and External Audit Recommendations	Chief Financial Officer	Manager responsible for service.
9. Management of Budgets - Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.	Budget Manager
b) At service level	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads

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) For the totality of services covered by a Divisional Triumvirates or Corporate Leaders	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.
10. Capital Schemes		
a) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Director for appropriate budget.	N/A
b) Financial monitoring and reporting on all capital scheme expenditure	Chief Financial Officer	Deputy Chief Financial Officer
c) Granting and termination of leases	Director for appropriate budget.	N/A
11. Authority to open Bank Accounts	Chief Financial Officer	N/A
12. Management of the Investment of Charitable Funds within the approved investment strategy	Chief Financial Officer	Monitored by the Charity Committee
13. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Financial Officer	Manager responsible for the budget together with the Chief Financial Officer
b) Price of NHS Contracts – charges for all NHS Contracts, be they block, cost per case, cost and volume, or spare capacity	Chief Financial Officer	Head of Contract Income
14. Authorisation of Sponsorship deals	Director of Corporate Affairs	Director for appropriate budget or Associate Director of Operations
15. Personnel and Pay		
a) Authority to fill funded post on the establishment with permanent staff	Director for appropriate budget or General Manager	Manager responsible for budget

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b)	Authority to appoint staff to post not on the formal establishment	Chief Executive (approval at Executive Directors' meeting)	N/A
c)	The granting of additional increments to staff within budgets	Chief Executive	Manager responsible for budget with the Chief People Officer
d)	All requests for upgrading/re-grading shall be dealt with in accordance with Trust Procedure	Chief Executive	Payroll Manager
e)	Establishments		
	i) Additional staff to the agreed establishment with specifically allocated finance	Director for appropriate budget or General Manager	Manager responsible for budget
	ii) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	N/A
f)	Pay		
	i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Director for appropriate budget or General Manager	Authorised Budget Signatory
	ii) Authority to complete and authorise positive reporting forms	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iii) Authority to authorise overtime	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iv) Authority to authorise travel and subsistence expenses	Director for appropriate budget or General Manager	Authorised Budget Signatory
	v) The approval of merit awards and discretionary points to Consultant and Associate Specialist staff	Remuneration and Appointments Committee of the Board	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) <u>Leave – all arrangements should be made in accordance with Trust policy</u>		
i) Approval of annual leave	Manager responsible for the budget	N/A
ii) Annual leave – approval of carry forward (up to maximum of 5 days or in the case of Ancillary and Maintenance staff as defined in their initial conditions of service)	Manager responsible for the budget	N/A
iii) Annual leave – approval of carry over in excess of 5 days	Director for appropriate budget or Associate Director of Operations	N/A
iv) Special leave arrangements		
▪ adoption leave ▪ bereavement leave ▪ paternity leave ▪ urgent domestic distress/crisis ▪ carers leave	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget
v) Leave without pay	Director for appropriate budget or Associate Director of Operations 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 Associate Director of Operations	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 Chief People Officer	N/A
ii) Return to work part-time on full pay to assist recovery	Director for appropriate budget or General Manager together with Chief People Officer	Manager responsible for the budget
iii) Extension of sick leave on full pay	Chief People Officer together with Chief Executive	N/A
i) Study Leave (Medical staff included in para 14.g.vi) above		
i) Any Study leave outside the UK	Chief Executive	Medical Director or Chief Nurse
ii) All other study leave (UK)	Chief People Officer, Director for appropriate budget or General Manager	Training Officer or Manager responsible for the budget
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) within Trust policy limits – currently £10,000.	Chief People Officer or Chief Financial Officer	Payroll Manager or Head of Financial Services
k) Grievance Procedure		
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure	Chief People Officer	Manager responsible for the budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
l) Renewal of Fixed Term Contract	Manager responsible for the budget	N/A
m) Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief People Officer	N/A
n) Redundancy	Chief People Officer together with Chief Financial Officer . Approval is required from the Remuneration Committee.	N/A
o) Ill Health Retirement Decision to pursue retirement on grounds of ill health	 Manager responsible for the budget together with Chief People Officer	 Manager responsible for the budget together with Personnel Manager
p) Dismissal	Director for appropriate budget with Chief People Officer	N/A
16. Engagement of Agency Staff		
a) Booking of Bank, Agency or Locum Staff – limited to total delegated staffing budgets	Director for appropriate budget or General Manager	Manager responsible for the budget
b) Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget
c) Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure)	Chief Executive	Director for appropriate budget
17. Engagement of Professional Consultancy Services		
a) Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget

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
18. Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods and Services		
a) Non-Pay Expenditure for which a specific budget has been set up and which is subject to funding under delegated powers of virement.		
i) Value to the 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 Chief Financial Officer	N/A
c) Commitments/orders exceeding 12 month period	Chief Financial Officer or Chief Executive	Manager responsible for the budget
d) Variations to contract for goods and services	Director for appropriate budget or General Manager.	Manager responsible for the budget together with Purchasing and Supplies Department Senior Buyer

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 Category Manager
ii) AND the variance is >£1,000 }		
19. Petty Cash Disbursements		
a) Expenditure up to £50 per item	Director for appropriate budget or General Manager	Authorised Budget Signatory
b) Reimbursement of patients monies held up to £100	Hospital Cashier	N/A
c) Pay advances up to £50	Payroll Manager or Payroll Team Leader	Senior Payroll Clerk
d) Urgent exceptional payments in excess of the above limits	Head of Financial Services	N/A
20. Management and Control of Stocks		
a) Pharmaceutical Stocks	Chief Financial Officer	Designated Pharmaceutical Manager
b) Theatres	Chief Financial Officer	Theatres Manager
c) Estates	Chief Financial Officer	Estates Manager
d) Eastbourne Hospital Services	Chief Financial Officer	Manager responsible for budget
e) General	Chief Financial Officer	Manager responsible for budget

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
21. Sale and Disposal of Assets (Excluding land and/or buildings) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
a) with current/estimated purchase price < £50,000	Chief Executive	Manager responsible for the budget
b) with current purchase new price > £50,000 (Note: Tender Procedure SFI 7.)	Chief Executive	Manager responsible for the budget together with Head of Procurement
22. Losses, Write-off and Compensation		
a) Losses and cash and cash equivalents due to theft, fraud overpayment and others	Chief Executive and Chief Financial Officer	N/A
b) Fruitless Payments (including abandoned Capital Schemes)		
i) Up to £100,000	Chief Executive and Chief Financial Officer	N/A
ii) Over £100,001	Audit Committee	N/A
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Other	Chief Executive and Chief Financial Officer	N/A
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Chief Executive and Chief Financial Officer	N/A
Special Payments		
e) made under legal obligation	Chief Executive and Chief Financial Officer	Director of Corporate Affairs

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
f) Extra Contractual payments to contractors	Chief Executive and Chief Financial Officer	N/A
g) Ex-Gratia Payments		
i) Patients' dentures repaired or replaced through the Community Dental service	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	Chief Financial Officer	Trust Solicitor
iv) Other ex gratia claims < £500	Chief Financial Officer	Trust Solicitor
v) Other ex gratia claims > £500	Chief Financial Officer	Director responsible for the budget
h) Payments under the Risk Pooling Scheme for Trusts up to the Policy Excess:		
i) Liabilities to Third Parties Scheme for Public and Employees Liability	Director of Corporate Affairs	Trust Solicitor
ii) Property Expenses Scheme	Director of Corporate Affairs	Trust Solicitor
i) Settlements on termination of employment – to a limit of £50,000	Chief Executive and Chief Financial Officer and Chief People Officer. Approval is required from the Remuneration Committee.	N/A
j) Other, except cases of maladministration	Chief Executive and Chief Financial Officer	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
23. Expenditure on Charitable Funds		
a) All expenditure up to £5,000 per request but excluding training and hospitality requests	Director and authorised signatory	Deputy Company Secretary and Authorised Signatory
b) All other expenditure	Director	Deputy Company Secretary
24. Management and Control of Computer Systems		
a) Financial Data	Chief Financial Officer	Senior Finance Manager Capital Systems Manager
b) Other Data	Medical Director as Caldicott Guardian	Relevant Service Manager
25. Review of Trust's compliance with Data Protection Act 1998	Medical Director as Caldicott Guardian	Director of Corporate Affairs
26. Review the Trust's compliance with the Access to Health Records Act	Medical Director as Caldicott Guardian	Director of Corporate Affairs
27. Retention of Records	Director of Corporate Affairs	Trust Solicitor
28. Insurance Policies	Chief Executive and Chief Financial Officer	Director of Corporate Affairs
29. Risk Management	Chief Nurse	Risk & Patient Safety Manager
30. Monitor proposals for contractual arrangements between the Trust and NHS commissioners of healthcare	Chief Financial Officer	Head of Contract Income
31. Maintenance and Update on Trust Financial Procedures	Chief Financial Officer	Technical Accountant

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
32. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Chief Operating Officer	Accommodation Manager
b) Extensions to existing agreements/licences c) Letting of premises to outside organisations d) Approval of rent based on professional assessment	} Chief Executive and/or responsible Director }	} } } N/A }
33. Reporting of Incidents to the Police or Local Counterfraud service		
a) Where a criminal offence is suspected	Director responsible for the service or department	Each Trust Employee
b) Where a fraud is involved	Chief Financial Officer	Each Trust Employee
34. Patients and Relatives		
a) Overall responsibility for ensuring that all complaints are dealt with Effectively	Chief Nurse	Assistant Director of Nursing
b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	Director for appropriate budget or Associate Director of Nursing	Relevant Service Manager
c) Management of litigation relating to complaints	Director of Corporate Affairs	Trust Solicitor
35. Relationships with Press		
a) General Enquiries	Director of Corporate Affairs	Communications Team
b) Emergency	On-call Director	On-call 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
36.	Facilities for staff not employed by the Trust to gain practical experience		
	Professional Recognition, Honorary Contracts, and Insurance of Medical Staff	Chief People Officer	Clinical Tutor, Post-Graduate Medical Education and HR Manager
	Work experience students	Chief People Officer	Manager responsible for the budget
37.	Review of fire precautions	Director of Estates and Facilities	Nominated Fire Manager
38.	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Chief Nurse	Health and Safety Manager
39.	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Estates and Facilities	Estates Manager and Waste Manager

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 Trust

STANDING FINANCIAL INSTRUCTIONS

Written/Produced By:	Title/Directorate	Date:
Daniel Boyd	Head of Financial Services	November 2012

Doc ID 922

Person Responsible for Monitoring Compliance & Review	Chief Financial Officer
Signature & Date	January 2021

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Audit Committee		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
Audit Committee	Annual Review	November 2019
Audit Committee	Annual Review	January 2021

Ratification Committee

Issue Number (Administrative use)	Date of Issue & Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
	Nov 2012, v1.1	Oct 2013	Dec 12	ESHT Trust Board
	Nov 2013, v1.2	Nov 2014	30.11.13	ESHT Trust Board
	Nov 2014, v1.3	Nov 2015	26.11.14	ESHT Trust Board
	Nov 2015, v1.4	Nov 2016	03.12.15	ESHT Trust Board
	Nov 2016, v1.5	Nov 2017	14.12.16	ESHT Trust Board
	Nov 2017, v1.6	Nov 2018	28.11.17	ESHT Trust Board
	Nov 2018, v1.7	Nov 2019	04.12.18	ESHT Trust Board
	Nov 2019, v1.8	Nov 2020	03.12.19	ESHT Trust Board
	Jan 2021, v1.9	Nov 2021		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 Scheme of Delegation; and
   - 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 Director of Corporate Affairs.

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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 Chief Financial Officer to affect these SFIs.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer .

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 FAILURE TO COMPLY WITH SFIs and SOs IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.

1.1.6 **Overriding Standing Financial Instructions** –
If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non- compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Trust's Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

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

b) 'Board' means the Board of the Trust;

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

d) 'Budget Holder' means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

e) 'Chief Executive' means the chief officer of the Trust;

f) 'Chief Financial Officer ' means the chief financial officer of the Trust;

g) 'Executive Director' means a member of the Trust who is an officer;

h) 'Funds held on trust' shall mean those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the National Health Service Act 2006 and the Health and Social Care Act 2012. Such funds may or may not be charitable;

i) 'Legal Adviser' means the properly qualified person appointed by the Trust to provide legal advice;

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

k) 'Non-Executive Director' means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of the Membership and Procedure Regulations;

l) 'Trust' means the East Sussex Healthcare NHS Trust;

m) Any reference to an act should be taken to include any subsequent legislation.

1.2.2 Wherever the title Chief Executive, Chief Financial Officer , or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term 'employee' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Any employee of the Trust who solicits or accepts any gift or consideration of any kind from contractors or their agents or from any organisation, firms or individual, as an inducement or reward for doing or refraining from doing anything in his official capacity, or for showing favour or disfavour to any person in his official capacity shall be liable to dismissal and to prosecution. All dealings shall be in accordance with "Standards of Business Conduct for NHS Staff."

1.2.5 Powers not defined by Standing Orders or these SFIs shall be exercised on behalf of the Trust by such officers as the Chief Executive designates, within such limits and subject to such conditions as the Chief Executive shall prescribe.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of Matters Reserved to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as Accountable Officer to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board and employees and all new appointees are notified of and understand their responsibilities within these instructions.

1.3.7 The Chief Financial Officer is responsible for:

a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

d) the provision of financial advice to other members of the Board and the wider organisation;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding unplanned financial losses;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer .

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Trust's Board shall establish an Audit Committee which will provide an independent and objective view of internal control by:

(a) concluding upon the adequacy and effective operation of the organisation's overall internal control system. In particular it is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust;

(b) reviewing the establishment and maintenance of effective systems of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives;

(c) ensuring that there is an effective internal audit function, including the Counter Fraud function, establishment by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;

(d) reviewing the work and findings of the external auditor and consider the implications of management's responses to their work.

(e) receive a report on tenders and waivers and framework direct awards that exceed £250k (cumulative if a supplier is awarded more than one contract for the same project);

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care. (via the Chief Financial Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.2 Chief Financial Officer

2.2.1 The Chief Financial Officer is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities not involving fraud or corruption (for cases involving suspected fraud or corruption see paragraph 15.2.3);

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover;

i) a clear opinion on the effectiveness of internal control;
ii) major internal (financial) control weaknesses discovered;
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 Chief Financial Officer and designated auditors are entitled without necessarily giving prior notice to require and receive;

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case they shall have a duty to safeguard that confidentiality);

b) access at all reasonable times to any land, premises, members of the Board or employees of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of the Board and employee's control; and

d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) fraud and other offences,
ii) waste, extravagance, inefficient administration,
iii) poor value for money or other causes.

e) Internal Audit shall also independently verify the Assurance Framework in accordance with guidance from the Department of Health.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning; cash, stores, other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

2.3.3 The Audit Manager/Director of Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Chief Financial Officer . The reporting system for internal audit shall be agreed between the Chief Financial Officer , the Audit Committee and the Audit Manager/Director of Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years.

2.3.5 The Audit Manager shall report direct to the Director of Operational Finance who shall refer audit reports, under agreed reporting arrangements, to the appropriate designated officers. Recipients of an audit report shall send a written response within two weeks stating the action to be taken in response to the audit recommendations. Failure to take any necessary action within a reasonable period shall be reported to the relevant Executive Director.

2.4 External Audit

2.4.1 The external auditor is appointed and paid for by the Trust. The Audit Committee must ensure that the Trust receives a cost efficient service. Should there be a problem which cannot be resolved by the Audit Committee, then this should be discussed with the external auditor and if appropriate referred to the Board for resolution. In exceptional circumstances the issue may be referred to NHSI if it cannot be resolved.

2.5 Fraud and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the Secretary of State's Directions on fraud and bribery.

2.5.2 In line with their responsibilities, the Board shall monitor and ensure compliance with the provisions of the Bribery Act 2010. Senior officers (including non-board level managers) can be individually held criminally liable for the Trust's bribery offences.

2.5.3 All suspicions of bribery should be reported to the Trust's Local Counter Fraud Specialist. Detailed guidance can be found in the Trust's Counter Fraud & Bribery Policy.

2.5.4 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.5 The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work with staff in the Directorate of Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.5.6 The Local Counter Fraud Specialist will provide a written report, at least annually to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources and is in accordance with the guidance issued by NHSI.

The annual plan content and the number of submissions are defined by NHSI. The plans usually contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

(c) detailed financial templates, accompanying finance narrative and operational/strategic narrative.

3.1.2 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and the delivery of a balanced budget.

3.1.3 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the annual business plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared as far as is reasonably practicable within the limits of available funds; and

e) identify potential risks and the means of mitigating such risks.

3.1.4 The Chief Financial Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Board. As a consequence the Chief Financial Officer shall have the right of access to all budget holders on budgetary related matters.

3.1.5 All budget holders must provide information as required by the Director of Finance to enable budgets and annual plans to be compiled.

3.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.7 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement;

e) achievement of planned levels of service; and

f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by Executives.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year end position (Income Statement);
(ii) movements in working capital (Statement of Financial Position);
(iii) movements in cash and capital (Cash Flow Statement);
(iv) capital project spend and projected outturn against plan;
(v) explanations of any material variances from plan;
(vi) Cost Improvement Programme Report;
(vii) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, activity and workforce budgets;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer ;

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 Contract Income

3.4.1 The Chief Financial Officer of the Trust will:

(a) periodically review the bases and assumptions used for compiling budgets and ensure that these are reasonable and realistic;

(b) periodically review contract income and all other sources of income to ensure the Trust is obtaining all the funds due;

(c) prior to the start of each financial year submit to the Trust's Board of Directors for approval a report showing the total expected contract income received and the proposed allocation including any sums to be held in reserve; and

(d) regularly update the Trust's Board of Directors on significant changes to contract income and the uses of such funds.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 13)

3.6 Monitoring Returns

3.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSI within agreed timescales.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Chief Financial Officer, on behalf of the Trust, will:

a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

b) prepare and submit annual financial reports to the Secretary of State certified in accordance with current guidelines; and

c) submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care (DHSC).

4.2 The Trust's annual accounts must be audited by the appointed auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting, (see 1.3.2). The document will comply with the DHSC group accounting manual (GAM) .

5. BANK AND OFFICE OF PAYMASTER GENERAL ACCOUNTS

5.1 General

5.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account DHSC guidance/directions. In line with 'Cash Management in the NHS', Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and Government Banking Service (GBS) Accounts

5.2.1 The Chief Financial Officer is responsible for:

a) GBS and bank accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds;

c) ensuring payments made from GBS or bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken); and

e) monitoring compliance with DHSC guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of GBS and bank accounts which must include:

a) the conditions under which each GBS and other bank account is to be operated;

b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No bank account may be opened for official monies without the approval of the Chief Financial Officer .

5.4 Tendering and Review

5.4.1 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The Chief Financial Officer is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow NHSI's and the Department of Health's guidance in setting prices for NHS contracts e.g. "National Tariff Payments System."

6.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the DHSC Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures. (See Section 15).

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Chief Financial Officer is responsible for:

a) approving the form of all receipting books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such records;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Cash income may be exchanged for Payable Orders for Petty Cash and Patients Money. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer .

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. TENDERING AND CONTRACTING PROCEDURE

7.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No 3.12 Suspension of Standing Orders is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the DHSC prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reserve eAuctions.

7.4 Other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the NHSI 'Capital Regime, Investment and Property Business Case Guidance' and 'Estatecode' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with relevant Department of Health guidance

7.5 Formal Competitive Tendering

7.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services, Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to tendering procedures.

7.5.3 Exceptions and Instances where Formal Tendering need not be applied

Formal tendering procedures need not be applied where:

a) the estimated expenditure or income is, or is reasonably expected to be, less than £50,000 (excluding VAT) over the life of the contract;

b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

c) regarding disposals as set out in SFI 15;

d) where the requirement is covered by an existing valid contract;

e) where supply of goods or services is through NHS Supply Chain unless the Chief Executive or nominated officers deem it inappropriate for reasons of cost or availability. The decision to use alternative sources must be documented;

f) where the Trust can utilise framework agreements through a direct award or further competition to achieve Value for Money. These may include but not be limited to Crown Commercial Services, NHS Commercial Solutions and the other NHS Hubs, NHS Shared Business Services, Health Trust Europe, Pro5;

g) for construction works under the provision of the DoH ProCure21+/P22 framework;

h) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members where the Head of Procurement and Chief Financial Officer is satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

i) where a statutory payment can only be made to a specific statutory body (eg rates), authorisation of the bodies considered in this category will be determined by the Chief Financial Officer and Head of Procurement.

j) where payment is to another NHS body and the Head of Procurement and Chief Financial Officer is satisfied that the procurement arrangements conform to current statute and deliver value for money;

k) where payment is less than the current OJEU threshold for Goods & Services and is for the renewal of maintenance services under an original supplier contract to provide equipment or IT and the Chief Financial Officer and Head

of Procurement is satisfied that the procurement arrangements conform to current statute and deliver value for money;

l) where payment is less than the current OJEU threshold for Goods & Services and is for the renewal of software license agreements under an original supplier contract to provide software licenses and the Chief Financial Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money;

m) where payment is less than the current OJEU threshold for Goods & Services and is for the purchase of replacement equipment parts under an original supplier contract to provide medical equipment and the Chief Finance Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money

7.5.4 Formal tendering procedures may be waived in the following circumstances:

a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

b) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

c) where specialist expertise is required and is available from only one source;

d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and evidence of the decision making process and cost / benefit analysis documented;

f) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society of England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

g) where allowed and provided for in the Capital Regime, Investment and Property Business Case Approval Guidance.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure (except in circumstances outlined in 7.5.3 (d) above)

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.5 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 7.1, 7.5.3 and 7.5.4 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than **three** firms/individuals (unless demonstrated to be a restricted market), having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.6 Building and Engineering Construction Works

Competitive Tendering should not be waived for building and engineering construction works and maintenance (other than in accordance with relevant guidance) without DHSC approval.

7.5.7 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in Standing Financial Instructions for which formal tendering procedures are not used and which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to Tender

i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

ii) All invitations to tender shall state that no tender will be accepted unless:

a) accompanied by a statement from the prospective supplier / contractor that provides assurance that they are compliant with the Bribery Act 2010.

iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

iv) Every tender for building or engineering works (except for maintenance work, when the Estatecode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with the Estatecode guidance. When the content of the work is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institution of Mechanical Engineers and the Association of Consulting Engineers, (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

v) All individuals involved in the evaluation of tenders will make a formal declaration of any interests they have along with any gift or hospitality received regardless of the provider.

7.6.2 Receipt, Safe Custody and Record of Formal Tenders

(i) Formal competitive tenders shall be returned: - electronically via the Trust's nominated e-portal provider;

(ii) When tenders are received in electronic format the e-portal will automatically record the date and time of receipt of each tender. This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

7.6.3 Opening Formal tenders (Electronic Format)

(i) The e-tendering portal will automatically close at the date and time stated as being the latest time for the receipt of tenders, the e-tendering portal shall be closed to further tender submissions, and the project will be locked for evaluation.

(ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iii) A designated procurement officer shall electronically open the submitted tenders through the e-tendering portal.

(iv) The e-tendering portal will record the date and time the tender submissions are opened.

(v) A tendering register shall be maintained on the e-tendering portal, to show for each set of competitive tender invitations dispatched:

a) The name of all firms' individuals invited;

b) The names of firms individuals from which tenders have been received;

c) The date the tenders were opened;

d) The person opening the tender;

(vi) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing, should be dealt with in the same way as late tenders (paragraph 7.6.5 below).

7.6.4 Admissibility

i) If for any reason the Procurement officer is of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 Late Tenders

i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. uploaded in good time but delayed through no fault of the tenderer.

ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the process of evaluation and adjudication has not started.

iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

7.6.6 Acceptance of Formal Tenders (See Overlap with SFI No. 7.7)

i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

ii) The most economically advantageous tender (MEAT), the lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons (for example, evaluation criteria) shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value

for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time;
e) result of the "quality" aspect of any mini-competition in conjunction with the tender price

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive

iv) The use of these procedures must demonstrate that the award contract was:

a) not in excess of the going market rate/price current at the time the contract was awarded;
b) the best value for money was achieved; and

v) All tenders should be treated as confidential and should be retained for inspection.

7.6.7 Tender Reports to the Trust Board

Reports to the Trust Board will be made in exceptional circumstance basis only.

7.6.8 List of Approved Firms

a) Responsibility for Maintaining List
Tender lists for building and engineering works will be compiled by the Director of Estates & Capital Development from "Constructionline" the Trust's approved list of Contractors.

b) Building and Engineering Construction Works

i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Tender documentation will require confirmation that companies on the tender list confirm that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not unlawfully discriminate, harass or victimise any person because of colour, nationality, ethnic or national origins, religion or belief, sex, gender reassignment, age, disability, sexual orientation, pregnancy or

maternity, civil partnership or marital status and will comply with the provisions of the Equality Act 2010 and the Gender Recognition Act 2004 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.6.9 Exceptions to Using Approved Contractors

a) If in the opinion of the Chief Executive and Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the "constructionline" list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on "constructionline"), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote. The Trust should also seek written confirmation from the potential contractor that they are compliant with the Bribery Act 2010.

b) An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.6.10 Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced 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 to exceed £10,000 but not exceed £50,000, excluding VAT**.**

7.7.2 Competitive Quotes

(i) Where possible requests for Quotations over £10k shall be logged using an e-tendering portal

(ii) Quotations should be invited from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
(iii) Where possible, quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
(iv) All quotations should be treated as confidential and should be retained for inspection.
(v) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) Where the goods or services are purchased through charitable funds /donations from Leagues of Friends, provided that a value for money evaluation has been undertaken.

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer .

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

£10,000 to £50,000	Manager responsible for the Budget and Head of Procurement
£50,001 to value of EU Threshold	Head of Procurement and Chief Financial Officer
From EU Threshold to £500,000	Trust Executive and Director for the Budget
From £500,000 to £1,000,000	Finance & Investment Committee
Value of £1,000,000 or above	Trust Board and Common Seal of the Trust

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 Instances where Formal Competitive Tendering or Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a) the Trust shall use the NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented;
b) if the Trust does not use the NHS Supply Chain the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer .

7.10 Private Finance for Capital Procurement (See Overlap with SFI No. 13.2)

The Trust should normally market-test for PFI (Private Finance Initiative Funding) when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
b) Where the sum exceeds delegated limits, a business case must be referred to NHSI for approval or treated as per current guidelines.
c) The proposal must be specifically agreed by the Board of the Trust.
d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance Requirements for all Contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) The Trust's Standing Orders and Standing Financial Instructions;
b) 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.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Healthcare Services Agreements (See Overlap with SFI No. 8)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 2014 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts.

However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable by law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.14 Disposals (See Overlap with SFI No 15)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

d) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer representative.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15.6 Applicability of SFIs on Tendering and Contracting to Charitable Funds (See also SFI section 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 (if any);
- NHS Standard Contract;
- the provision of reliable information on cost and volume of services;
- the NHS Service and Financial Framework (SaFF);
- the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing partnership arrangements;
- that contracts are based on integrated care pathways; and
- The NHS Constitution which has the force of law.

8.2 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast contractual income. This will be supplemented by reports on profitability of individual services based on the costing activity in line with latest guidance.

9. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD AND EMPLOYEES

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting, (see NHS guidance contained in the Higgs report).

9.1.2 The Committee will:

a) provide assurance to the Board around the process for appointing and dismissing all executive directors of the Board, including the chief executive;

b) agree the remuneration package, including performance related pay and other terms of service of the Chief Executive, including the scheme for performance related pay and any other benefits;

c) with the Chief Executive, agree the remuneration packages, including the scheme for performance related pay and other terms of service (including severance terms of applicable) of the executive directors and very senior managers;

d) review and agree the grading and remuneration package of any Director post that falls vacant, prior to the vacancy being advertised; and

e) monitor the system to evaluate the performance of the Chief Executive, the executive directors and other senior employees.

9.1.3 The Committee shall report in writing to the Board on an annual basis.

9.1.4 The Trust will remunerate and pay allowances to the Chairman and Non-Executive Directors in accordance with instructions issued by the Secretary of State for Health.

9.1.5 All employees are required as part of their conditions of service to comply with the Trust's and national guidance notes on 'Standards of Business Conduct for NHS Staff'.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or a nominated officer .

9.3 Staff Appointments

9.3.1 Employees may only be engaged, re-engage, or regraded, whether on a permanent or temporary basis, and agency staff may only be hired and changes in any aspect of remuneration can only be made:

a) within agreed policies and procedures; and

b) within the limit of approved budgets and the funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief Financial Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

9.4.2 The Chief Financial Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee and officers;

h) procedures for payment by cheque, bank credit, or cash to employees and officers;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash;

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust; and

n) premature retirement proposals.

9.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Chief Financial Officer 's instructions and in the form prescribed by the Chief Financial Officer ; and

c) notifying termination of employment in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer .

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

10.2.2 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Chief Financial Officer will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of Board members/employees (including specimens of their signatures) authorised to certify invoices.

ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

c) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the 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 Chief Financial Officer ;

c) state the Trust's terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Financial Officer.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made. All leases must be assessed prior to entry and classified as either operating or finance leases under IFRS. Authority to enter into finance leases requires written approval from the Chief Financial Officer .

b) contracts above specified thresholds are advertised and awarded in accordance with 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 DHSC;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii) conventional hospitality, such as lunches in the course of working visits;

   iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable, and also notify the details of all such hospitality offered or received, for entry in a register maintained for that purpose by the Chief Executive.

The national guidance contained in HSG 1993/5 'Standards of Business Conduct for NHS Staff' is shown as to Standing Orders 6.2.

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order except for those specifically excepted by the Chief Financial Officer in financial procedures, and purchases from petty cash or on purchase cards;

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or

urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order';

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Chief Financial Officer and;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer ; and

l) petty cash records are maintained in a form as determined by the Chief Financial Officer .

10.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained with ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

Payments to local authorities and voluntary organisations made under the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

11. EXTERNAL BORROWING

11.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the DHSC. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer .

11.3 The Chief Financial Officer must prepare detail procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the DHSC.

11.5 Any applications for short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer . The Board must be made aware of all short term borrowings at the next Board meeting.

11.6 All applications for long-term borrowing must be consistent with the plans outlined in the current Trust business plan and be approved by the Trust Board.

11.7 INVESTMENTS

11.7.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

11.7.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.7.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12 PLANNING FRAMEWORK

12.1 The Chief Financial Officer shall ensure that members of the Board are aware of the operational planning and contracting guidance issued by the regulator. The Chief Financial Officer should also ensure that the guidance is followed by the Trust.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation, where applicable of commissioner support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 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 combined Business Development Group (BDG) and Capital Review Group (CRG).

b) for every capital expenditure proposal in excess of £250,000 the business case is also required to be submitted to the Executive Director's meeting for approval.

c) for all projects over £500,000 a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Investment Committee for approval.

d) for all projects over £500,000 the Project Director will be required to co-ordinate and complete a monthly capital monitoring return to the Business Development Group (BDG) and Capital Review Group (CRG) showing performance against budget.

f) for all projects over £1,000,000 the business case will be submitted to the Trust Board for

g) where any scheme is forecast to overspend by more than the following amounts the Project Director will be required to report reasons to the CRG 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 Estates and Facilities shall assess on an annual basis the requirement for the operation of the construction industry scheme in accordance with Her Majesty's Revenue and Customs guidance.

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.4 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 Scheme of Delegation for capital investment management in accordance with 'Estatecode' guidance and the Trust Standing Orders.

13.1.5 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Regulator.

13.2 Private Finance

13.2.1 When the Trust proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) The proposal must be specifically agreed by the Board.

c) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DHSC body and/or treated as per current guidelines.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Regime, Investment and Property Business Case Approval Guidance as issued by the DHSC.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of land and buildings will be at "fair value" on the balance sheet date. Under the requirements of IFRS, the Modern Equivalent Asset valuation method will be adopted.

13.3.7 The value of each asset shall be depreciated according to the useful economic life of the asset. The Trust will use commonly available and appropriate indices for the revaluation of assets or take advice from independent experts. The Chief Financial Officer will ensure that a review of all asset lives will be undertaken annually.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer . This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer .

13.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

13.4.6 Where practical, assets should be clearly and securely marked as Trust property.

13.4.7 Trust assets and facilities are to be used for official Trust purposes only, unless approval for private use has been given by the Chief Executive.

14. STORES

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stocktake; and

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to the Head of Procurement by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer . The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated Estates Manager.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Director of Estates and Facilities. Wherever practicable, stocks should be marked as health service property.

14.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Procurement shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 15 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt of the goods against the delivery note.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations (Disposal of Surplus Goods/Equipment Procedure) and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer ;

b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer .

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.1.5 Land and buildings formally planned for closure and/or disposal shall be valued and referred to the Chief Financial Officer prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The Chief Financial Officer shall prepare a report at least annually to the Audit Committee detailing all losses reported by number and amount with detail for those over £1,000

15.2.3 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive.

Where a criminal offence is suspected, the Executive Directors must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Directors must inform the DHSC Counter Fraud Services in accordance with the Secretary of State's directions and the Local Counter Fraud Service.

15.2.4 The Chief Financial Officer must notify the External Auditor of all frauds and suspected frauds.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, at an estimated value in excess of £10,000, the Chief Financial Officer must immediately notify:

a) the Board, and

b) the External Auditor.

15.2.6 The Audit Committee shall approve the writing-off of losses.

15.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

15.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16. INFORMATION TECHNOLOGY

16.1 The Chief Financial Officer , who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to Data Protection and Computer Mis-use legislation.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

16.2 The Chief Financial Officer shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.3 The 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 Chief Financial Officer :

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.5 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access

for audit purposes.

16.6 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

16.7 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy himself/herself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) authorised staff have access to such data; and

d) such computer audit reviews are being carried out as are considered necessary.

16.8 The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17. PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Nurse is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets, (notices are subject to sensitivity guidance),
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where DHSC instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer .

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. CHARITABLE FUNDS

18.1 The Chief Financial Officer and Director of Corporate Affairs 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 Corporate Affairs shall ensure that all staff are made aware of the Trust policy on acceptance of gifts, hospitality and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health and Social Care Standards of Business Conduct for NHS Staff (See Standing Orders 6.2).

20 RETENTION OF RECORDS

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DHSC guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with the Health Service Circular (1999) 053 shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of records so destroyed.

21. RISK MANAGEMENT AND INSURANCE

21.1 The Chief Nurse shall ensure that the Trust has a programme of risk management, in accordance with current DHSC controls assurance requirements, which must be approved and monitored by the Board.

21.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including: internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured;

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current DHSC guidance.

21.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.4 With three exceptions Trusts may not enter into insurance arrangements with commercial insurers. The exceptions are:

i) Trust may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

ii) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

iii) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

21.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complimentary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

21.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

22. ANNEX – TENDERS AND CONTRACTING – FINANCIAL LIMITS

22.1 Financial Limits – Competitive Tendering

22.1.1 Competitive Tenders will be invited for:

i) the supply of goods, materials and manufactured articles;
ii) the rendering of services;
iii) building and engineering works (including construction and maintenance of grounds) and;
iv) disposals;

where the estimated income/expenditure is expected to exceed **£50,000 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 **£50,001 excluding VAT** to the European Union Threshold	Minimum of 4 invitations to tender with at least 3 received (Where such number of suppliers exist)
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 Chief Financial Officer from **£50,001** excluding VAT to the EU threshold; and

- the Chief Executive **and** the Chief Financial Officer from the EU threshold to £1,000,000.

22.2.3 For the purpose of determining the above limitations of **£50,001** 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 **£10,000**	Minimum of 1 written quotation (where this may be impractical, 1 verbal quotation may be obtained and the reasons for this documented)
£10,001 to **£350,000** excluding VAT	Minimum of 3 suppliers invited to submit written quotations

22.4 Waivers to Standing Orders

22.4.1 Standing Orders on Competitive Tendering may be waived under certain circumstances and will require the completion and authorisation of a waiver form.

22.4.2 The waiver authorisation limits are:

i) For tenders **£1 - £50,000** excluding VAT, the Head of Procurement

ii) For tenders **£50,001** excluding VAT to the **EU Threshold**, the Head of Procurement and the Chief Financial Officer or the Chief Executive.

iii) For tenders from the **EU Threshold up to £500,000** Head of Procurement, the Chief Financial Officer and the Chief Executive.

iv) For tenders from **£500,000 to £1,000,000** the Audit Committee

v) For tenders above **£1,000,000** the Trust Board

22.4.3 Any waiver request must be submitted on the requisite form and, after authorisation, must accompany the requisition sent to the Head of Procurement.

22.4.4 The Chief Financial Officer will establish and maintain a register of Waivers to Standing Orders.

22.5 Expenditure Authorisation

22.5.1 All requisitions that result in an order for goods and services must be approved in accordance with the 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**

Waiver of Standing Orders

Reason for Request to Waive Standing Orders:	Please Tick
1 Competitive tenders/quotations were sought insufficient responses returned	
2 Only provider of goods/services	
3 Genuine reason for continuity or compatibility	
4 Risk where timescales/urgency genuinely exceed time required to competitively tender/obtain quotes	
5 Director/Deputy Director of Finance	
6 Retrospective expenditure - goods/services have already been received	
7 Quotes/tenders not obtained due to clinical/technical preference	
8 Market tested and most economical providers not selected	
9 Agency expenditure exceeding the NHSI allowable price caps	

Full written details and justification must be provided in the "Supporting Information" section on the reverse of this form before this waiver request will be considered for approval.

The current limits set by East Sussex Healthcare NHS Trust under which competitive quotations/tenders are required are defined in the Standing Financial Instructions. These are as follows:

Up to £10,000 (ex VAT)	-	1 written quotation
£10,001 to £50,000 (ex VAT)	-	Minimum of 3 invitations to quote.
£50,001 to European Union Threshold (ex VAT)	-	Minimum of 3 invitations to tender.
Above the EU Threshold (OJEU advert) (ex VAT)	-	Minimum of 4 invitations to tender with at least 3 received.

The waiver authorisation limits are:

- For quotations £10,001 to £50,000 the Chief Executive, Chief Financial Officer or Head of Procurement.
- For tenders £50,001 to EU Threshold the Chief Financial Officer or Chief Executive.
- For tenders from the EU Threshold to £500,000 the Chief Executive and Chief Financial Officer.
- For tenders £500,001 to £1,000,000 the Finance & Investment Committee
- For tenders over £1,000,000 the Trust Board

In accordance with East Sussex Healthcare NHS Trust's Standing Order number 9.5, I request a waiver of the requirement to obtain competitive quotations/tenders in respect of Requisition Number: _____

Name of Supplier: _____

Description of goods: _____

Total price of goods (inc VAT): _____

Department for which goods are required: _____

CERTIFICATION BY SENIOR BUSINESS MANAGER		HEAD OF PROCUREMENT VERIFICATION **PRIOR** TO APPROVAL BY A DIRECTOR	
Signature:	Date:	Signature:	Date:
Title:	Department:		

APPROVAL OF WAIVER

I/We hereby approve this waiver

Signatures authorising the waiver of Standing Orders.

Signature:	**Signature:**	**Signature:**
Designation:	**Designation:**	**Designation:**
Chief Executive	**Director of Finance**	**Head of Procurement**
Date:	**Date:**	**Date:**

Procurement & Supplies use only		
Waiver Register Number:	**Waiver Register Entry By:**	**Date:**

DETAILED SUPPORTING INFORMATION This section **must** be completed in all instances. Insufficient information may result in the waiver being returned unauthorised.		
a) Brief description of goods/services: **b) Justification:**		
Has lowest quotation been accepted?	**Yes / No** (Delete as appropriate)	If "No" – reason for accepting higher quotation:
Will this be the subject of a future, formal procurement competition?	**Yes / No** (Delete as appropriate)	If yes, please state when - if "No", please state reason below:
If previously procured, last price paid (if known):	**£**	If previously procured, please state when (if known):
List alternative providers (if any) and reason for not considering:		
Consequences of non-approval of this waiver:		

Please note:

- **All Trust expenditure is subject to Public Sector Procurement Regulations and transparency rules. The information detailed on this form is subject to audit and challenge.**
- **All breaches to Trust Financial policies will be investigated and reported to the Audit Committee.**

East Sussex Healthcare NHS Trust

ADMINISTRATIVE GUIDANCE NOTES

STANDING ORDERS

Written/Produced By:	Title/Directorate	Date:
Dr Amanda Harrison	Director of Strategic Development and Assurance	October 2011

Person Responsible for Monitoring Compliance & Review	Director of Corporate Affairs
Signature & Date	January 2021

Multi-disciplinary Evaluation/Approval

Name	Title/Speciality	Date:
Audit Committee		November 2011
Audit Committee		November 2012
Audit Committee		6 November 2013
Audit Committee		12 November 2014
Audit Committee		4 November 2015
Audit Committee		23 November 2016
Audit Committee		22 November 2017
Audit Committee		28 November 2018
Audit Committee		28 November 2019
Audit Committee		28 January 2021

Ratification Committee

Issue Number (Administrative use only)	Date of Issue & Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
1.2	Nov-11			Trust Board
1.3	Nov-12		Dec-12	Trust Board
1.4	Nov-13		30 Nov 13	Trust Board
1.5	Nov-14		26 Nov 14	Trust Board
1.6	Nov-15		3 Dec 15	Trust Board
1.7	Nov-16	Nov-17	14 Dec 16	Trust Board
1.8	Nov-17	Nov-18	28 Nov 17	Trust Board
1.9	Nov-18	Nov-19	4 Dec 18	Trust Board
1.10	Nov-19	Nov-20	3 Dec 19	Trust Board
1.11	Jan-21	Dec-21		Trust Board

FOREWORD

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

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

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

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

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

5. Where reference is made to other documents, these are available from the Director of Corporate Affairs

INTRODUCTION

Statutory Framework

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

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

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

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

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

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust takes into account the rights and pledges set out in the NHS Constitution which has the force of law

NHS Framework

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

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

The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

Delegation of Powers

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

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

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive or Company Secretary).

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

1.2.1 **'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.

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

1.2.*3* **'Board'** means the Chairman, Officer and non-officer members of the Trust collectively as a body.

1.2.4 **'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.

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

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

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

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

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

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

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

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

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

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

1.2.15 **'Membership, Procedure and Administration Arrangements Regulations'** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

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

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

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

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

1.2.20 **'Company Secretary'** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

1.2.21 **'SFIs'** means Standing Financial Instructions.

1.2.22 **'SOs'** means Standing Orders.

1.2.23 **'Trust'** means the East Sussex Healthcare NHS Trust.

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

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

1.2.26 **The 'Regulator'** means NHS Improvement or successor body.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

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

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

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

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

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

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

2.2 Appointment of the Chairman and Members of the Trust

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

2.3 Terms of Office of the Chairman and Members

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

2.4 Appointment and Powers of Vice-Chairman

2.4.1 Subject to SO 2.4(2) below, the Chairman may appoint one of their number, who is not also an executive director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him/her. If, in exceptional circumstances due to illness or any other cause, the Chairman is unable to appoint a Vice-Chairman, then another non-executive director will assume the office of Vice-Chairman.

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

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

2.5 **Appointment and Powers of Senior Independent Director**

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

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

2.6 **Appointment of Associate Non-Executive Directors**

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

2.7 **Joint Members**

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

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

(i) either or both of those persons may attend or take part in meetings of the Board;
(ii) if both are present at a meeting they should cast one vote if they agree,
(iii) in the case of disagreements no vote should be cast.
(iv) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.10 Quorum.

2.8 **Role of Members**

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of

Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

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

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

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

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

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

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

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

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

2.9 **Corporate Role of Board**

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

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

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

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

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

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

2.11 **Lead Roles for Board Members**

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

3. MEETINGS OF THE BOARD

3.1 **Calling Meetings**

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

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

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

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

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

3.1.6 Before each public meeting of the Board a public notice of the time and place of the meeting, or details of the online meeting, and the public part of the agenda, shall be displayed at the Trust's principal office at least three clear days before

the meeting. (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a)).

3.2 **Notice of Meetings and the Business to be transacted**

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

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

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

3.3 **Agenda and Supporting Papers**

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

3.4 **Petitions**

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

3.5 **Notices of Motion**

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

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

3.6 **Emergency Motions**

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

3.7 Motions: Procedure at and during a meeting

3.7.1 Who may propose?

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

3.7.2 Contents of motions

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

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

3.7.3 Amendments to motions

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

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

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

3.7.4 Rights of reply to motions

a) Amendments

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

b) Substantive/original motion

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

3.7.5 Withdrawing a motion

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

3.7.6 Motions once under debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;

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

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

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

3.8 **Motion to Rescind a Resolution**

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

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

3.9 **Chairman's Ruling**

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

3.10 **Quorum**

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

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

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

3.11 **Voting**

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

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

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

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

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

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

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

3.12 **Suspension of Standing Orders**

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

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

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

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

3.13 **Variation and Amendment of Standing Orders**

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

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

3.14 **Record of Attendance**

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

3.15 **Minutes**

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

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

3.16 **Admission**

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

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

3.16.2 **General Disturbances**

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

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

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

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

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

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

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

3.17 **Observers at Trust Meetings**

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

4. APPOINTMENT OF COMMITTEES AND SUB COMMITTEES

4.1 **Appointment of Committees**

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

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

4.2 **Joint Committees**

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

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

4.3 **Applicability of Standing Orders and Standing Financial Instructions to Committees**

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

4.4 **Terms of Reference**

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

4.5 **Delegation of powers by Committees to Sub-Committees**

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

4.6 **Approval of Appointments to Committees**

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

4.7 **Appointments for Statutory functions**

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

4.8 **Committees established by the Trust Board**

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

4.8.1 **Audit Committee**

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

terms of reference will be approved by the Trust Board and reviewed on at least an annual basis.

4.8.2 **Remuneration and Appointments Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, a remuneration and appointments committee will be established and constituted.

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

4.8.3 **Quality and Safety Committee**

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

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

4.8.4 **Finance and Investment Committee**

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

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

4.8.5 **People and Organisational Development Committee**

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

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

4.8.6 **Other Committees**

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

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

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees and Officers

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

5.2 Emergency Powers and urgent decisions

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

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

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

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

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

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

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

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

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS, REGULATIONS AND THE STANDING FINANCIAL STRUCTIONS.

6.1 **Policy Statements General Principals**

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

6.2 **Specific Legislation, Policy and Guidance**

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

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

- NHS Constitution Health Act 2009;
- Bribery Act 2010
- Fit and Proper persons regulations

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

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

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

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

i) Directorships, including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

ii) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

iii) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

iv) A position of authority in a charity or voluntary organisation in the field of health and social care.

v) Any connection with a voluntary or other organisation contracting for NHS services.

vi) Research funding/grants that may be received by an individual or their department:

vii) Interests in pooled funds that are under separate management.

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

7.1.3 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.
(See overlap with SO 7.3)

7.2 **Register of Interests**

The Director of Corporate Affairs will ensure that a Register of Interests is established to record formally declarations of interests of Board or committee members. In particular the Register will include details of all directorships and other relevant and material interests as defined in SO7.1.2) which have been declared by both executive and non-executive Board members, as defined in Standing Order 6.5.

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

7.2.3 The Register will be available to the public and the Director of Corporate Affairs will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

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

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

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

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

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

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

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

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

iv) **Exception to Pecuniary interests**

A person shall not be regarded as having a pecuniary interest in any contract if:-

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

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

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

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

7.3.2 **Exclusion in proceedings of the Trust Board**

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

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

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

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

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

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

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

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

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is –

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

(b) at a meeting of a Committee –

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

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

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

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

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

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

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

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

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

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

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

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

(4) <u>Conditions which apply to the waiver and the removal of having a pecuniary interest</u>

The removal is subject to the following conditions:

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

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

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

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

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

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

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

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of business conduct policy

7.4.1 Trust Policy & National Guidance

All Trust staff and members of must comply with the Standards of Business Conduct for NHS staff (HSG(93)5), the Bribery Act 2010, and the Trust's Interests, Hospitality, Gifts and Sponsorship Policy (see SO 6.2) and any amendment thereto

7.4.2 Interest of Officers in Contracts

(i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO6.5/7.5) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable.

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

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

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

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

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

7.4.4 **Relatives of Members or Officers**

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

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

8. CUSTODY OF SEAL, SEALING AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

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

8.2 Sealing of Documents

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

8.3 Register of Sealing

The Director of Corporate Affairs shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of Documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director. The Director of Corporate Affairs may act as a counter signatory if required.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease,

contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.