EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 12th April 2022 commencing at 09:30 via MS Teams

	AGENDA		**Lead:**	**Time:**
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Hero of the Month Award	A	Chair	0930 - 1000
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 08.02.22	B	Chair	
4.	Matters Arising	C		
5.	Board Committee Chair's Feedback	D	Committee Chairs	
6.	Chief Executive's Report	E	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Integrated Performance Report Month 11 (February) 1. Chief Executive Summary 2. Quality and Safety 3. Our People – Our Staff 4. Access and Responsiveness 5. Financial Control and Capital Development	Assurance	F	CEO CND MD COO CPO CFO	1000 - 1115
8.	Ambulance Handover	Assurance	G	COO	
9.	Learning from Deaths Q2	Assurance	H	MD	

BREAK

STRATEGY

					Time:
10.	Board Assurance Framework Q4	Assurance	I	DS	1130 - 1140

GOVERNANCE AND ASSURANCE

					Time:
11.	Maternity Update • Ockenden – One Year On	Assurance	J	ADO	1140 - 1215
12.	Review of Governing Documents: • Scheme of Delegation • Standing Financial Instructions • Standing Orders	Approval	K	CFO	
13.	Annual Self Certification	Assurance	L	DS	
14.	Delegation of approval of Annual Report and Accounts 2021/22	Approval		DS	

ITEMS FOR INFORMATION

				Time:
15.	Use of Trust Seal	M	Chair	1215 - 1230
16.	Questions from members of the public (15 minutes maximum) • The Board welcomes questions from the public on matters covered by the Board agenda		Chair	
17.	Date of Next Meeting: Tuesday 14th June 2022		Chair	

Steve Phoenix
Chairman
22nd March 2022

Key:	
Chair	Trust Chair
CEO	Chief Executive
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
DEF	Director of Estates and Facilities
DS	Director of Strategy
CFO	Chief Financial Officer
CPO	Chief People Officer
MD	Medical Director
ADO	Associate Director Operations and Governance, Maternity and Children's Services

Hero of the Month Awards

Meeting information:		
Date of Meeting:	12th April 2022	Agenda Item: 1.3
Meeting:	Trust Board	Reporting Officer: Steve Phoenix, Chair

December 2021

Rachel Cottingham, Matron, Egerton Ward, Conquest Hospital

Rachel was nominated by Nikita Rodda, who said:

"Rachel is the matron on Egerton ward and the ward is a credit to Rachel and all the hard work she puts in. I have been working with Rachel for over 7 years and she is the most patient staff member I have ever met!

She is always at work early and always the last one to leave from the day shift. She is always approachable, and has been known to have a queue of staff waiting to ask her questions. She always has the patients' best interests at heart, and works hard to make sure her staff are following the latest and most up to date training.

Rachel's knowledge and skills are very apparent when you work with her; she always makes time for students and new members of staff, as well as for existing members of staff, helping with anything we have a problem with. She's always there to help, and you would struggle to find a better matron than Rachel."

January 2022

Amy Collis, Head of Nursing, Emergency Department, Eastbourne Hospital

Amy was nominated by Karen Burke, who said:

"As a department we have had numerous Heads of Nursing but Amy has been by far the best. She works so hard, always going above and beyond her role and dedicating herself to her team and department.

She is well respected by us all and has the ability to make us all feel valued and appreciated no matter how much stress and pressure she is under. She arranges regular awards and incentives for us all to keep morale high and this gives us all a massive boost.

Not only does she work many hours in her managerial role but she also works extra hours in the Emergency Department, particularly when there are staffing issues. I can't express enough how much Amy does for us all and I genuinely have no idea how she takes it all on.

She is also continually improving our department in both big and small ways and I feel so strongly that Amy should receive some recognition for all that she does as I feel that she deserves this more than anyone. The past two years have been particularly tough on our department during the pandemic and yet Amy is always smiling, supporting and encouraging each and every one of us."

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 8th February 2022 at 09:30 video conference via Microsoft Teams

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

Non-Voting Directors:
Mr Steve Aumayer, Chief People Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Mr Richard Milner, Director of Strategy, Inequalities & Partnerships
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Ms Ruth Agg, Speak Up Guardian
Mr Stuart Green, Associate Director of Communications and Engagement
Ms Dominique Holliman, Speak Up Guardian
Ms Katherine Murray, Consultant Anaesthetist
Mr Peter Palmer, Acting Company Secretary
Mr Josh Graham, Assistant Company Secretary (minutes)

001/2022 **Chair's Opening Remarks**
Mr Phoenix welcomed everyone to the meeting.

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

Ms Lynette Wells, Director of Corporate Affairs
Chris Hodgson, Director of Estates and Facilities

ii. **Hero of the Month**
Mr Phoenix reported that Dr Galena Doneva had won the Trust's Hero of the Month Award for November 2021.

002/2022 **Declarations of Interest**

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

003/2022 **Minutes**

The minutes of the Trust Board meeting held on 14th December 2021 were considered. Mrs Churchward-Cardiff highlighted some minor amendments which were corrected.

Subject to the amendments, the minutes were agreed as an accurate record. The minutes were signed by the Chair and would be lodged in the Register of Minutes.

004/2022 **Matters Arising**

There was one formal matter arising from the meeting on 14th December 2021:

071/2021 – Mrs Carruth to confirm whether staff are required to relinquish electronic devices before entering the mortuary.

Mrs Carruth explained that there was no national guidance available about whether staff should hand over electronic devices before entering the mortuary, and that she was unaware of any NHS Trust that required staff to do this. ESHT used a number of processes to maintain mortuary security.

004/2022 **Board Committee Chair's Feedback**

i. Strategy Committee

Mrs Churchward-Cardiff explained that developing seamless community integration pathways had been a key focus of the Clinical Strategy that was brought through the Committee. The importance of the Digital Strategy being developed into a widely adopted way of working, rather than a discrete document, was foregrounded throughout its development. The Estates Strategy took a pragmatic view of long term planning that would require considerable investment. Mr Milner added that once the Integrated Care Board (ICB) had taken form and outlined its perspective on place, this would feed into community integration proposals and inform updates to strategies updates moving forward.

Mrs Webber asked whether a timeline had been devised for developing the community care business plan and integrating it with acute services. Mrs Churchward-Cardiff advised that the matter had been discussed by the Strategy Committee; this was a large piece of work with a wide scope. Priorities such as frailty provision and skill mix would need to be incorporated. As such, a definitive timescale was not yet in place, but the business plan would be an ongoing item on the Strategy Committee's agendas before final approval.

The Board noted the report.

ii. Audit Committee

Mr Patel highlighted that several audits had been suspended due to operational pressures. However, this would not impact upon a meaningful audit opinion being delivered by auditors before the end of the year.

It was noted that an additional off-cycle Audit Committee meeting would take place in February as some key individuals were unable to bring papers in January.

The Board noted the report.

iii. Quality and Safety (Q & S) Committee

Mrs Fadero noted that the Committee had commended the Executive leadership's risk management work during the Covid pandemic. Despite these challenges, an ongoing commitment to quality and safety had kept the Trust in a strong position.

One area of concern was the increase in pressure ulcers, and the reasons for this were being closely investigated. The Committee had taken assurance that everything possible was being done to identify relevant factors and make any necessary changes.

Progress had been made against recommendations made as a result of the Ockenden Report. Like other services, Maternity had been affected by staff absences as part of the wider context of pandemic-related challenges.

The Board noted the report.

iv. Finance and Investment Committee

Mrs Webber reported that it was anticipated that the Trust would achieve a balanced financial position by year-end, which was of great credit to the Finance and Operations teams. Delivering high quality and safe care within a tight financial envelope was challenging but being achieved.

She noted that financial pressures would increase significantly in 2022/23 and planning was already underway around to understand how the Trust could meet its financial targets.

The Committee had approved a £600k investment to upgrade digital hardware as part of the ongoing update cycle. Spend approval was also granted for improvements to Westham Ward, with a particular focus on infection prevention and control (IPC).

Mrs Webber advised that significant work was being undertaken to ensure that the full capital programme was delivered in year. Mr Reid noted that there was

an element of risk in delivering a back-loaded capital plan and emphasised the scale of financial challenge for the coming year.

The Board noted the report.

v. People and Organisational Development (POD) Committee

Ms Williams explained that the Workforce Dashboard had been a strong focus at the recent Committee meeting. This included reflection on staff wellbeing and the retention work in place to make them feel supported. Results from the recent trainee survey were encouraging and Ms Williams thanked all those who had participated.

A strong culture of feedback had been established through the work of the Freedom to Speak Up Guardian team. A report would continue to be brought periodically to the Board.

Mr Phoenix thanked Mrs Kavanagh, the outgoing chair of the POD Committee, for all her hard work and contributions to the progress that had been made under her stewardship.

The Board noted the report.

005/2022 **Chief Executive's Report**

Mrs Chadwick-Bell reported that the winter period had been exceptionally busy for the organisation, with lots of time and resource being spent preparing for the anticipated Omicron surge. Thankfully, the number of hospitalisations had not reached anywhere close to those in the second Covid wave and were more aligned with those from the first wave. Although staff sickness had reduced, those affected by the need to self-isolate had remained high. Despite this, it had been possible to maintain most services and deliver safe staffing levels. Mrs Chadwick-Bell added that staff had worked incredibly hard and thanked them for their fantastic efforts. Tribute was also made by Mrs Chadwick-Bell to all the Trust's voluntary workforce.

It had been possible to continue with much planned care activity despite significant numbers of Covid cases and recovery was starting to come into clear focus.

Mrs Chadwick-Bell thanked colleagues who had supported in setting up vaccination hubs at Eastbourne and Conquest or helped in delivering vaccines. She noted in particular the work from Mr Aumayer and his team who ensured progress was at the rapid pace needed. Some staff had been redeployed, with appropriate training that met all NHSE requirements, despite the tight timescales.

In partnership with the Clinical Commissioning Group (CCG), joint consultations around the cardiology and ophthalmology transformation plans were ongoing. Some public meetings had already been held and the process was due to

conclude on 11th March. It was vital to gather as much feedback as possible until then.

The Trust was due to take ownership of the private Spire Hospital from 1st April, which would be renamed Sussex Premier Health. It was planned that all private patient services, as well as some NHS work, would be brought through the facility. Acquisition of the unit would bolster efforts to recruit and retain clinical staff and would offer patients greater choice. Any profits made by the venture would be reinvested into the Trust's clinical services.

The cardiology catheterisation laboratory at the Conquest Hospital was being refurbished, with construction due to finish in early February. New equipment would then be installed so the laboratory would be fully operational by mid-April. Other Estates work continued, including the final stages of the Emergency Department (ED) extension at Conquest. This would be completed by early April and support clinical teams.

Several projects were underway at Eastbourne to maximise operational use of key spaces:

- Reconfiguration of the ED
- Implementation of a new recovery area to support day surgery and elective throughput
- Redevelopment of Westham Ward to have dedicated 'red' and 'green' zones

The Trust's three-year capital plan was being developed and would be brought through Board subcommittees before returning to the full Board meeting for approval.

Mrs Manson asked how much engagement there had been with the cardiology and ophthalmology consultations so far, as well as what the anticipated timeline was once consultations had finished. Mrs Chadwick-Bell confirmed that interim information from the engagement sessions which had taken place was due imminently. The data would be received and collated by Opinion Research Services, who were acting independently from EHST and the CCG, before a final report was published in March. Mr Milner noted that no site preference had been proposed for cardiology (unlike ophthalmology), and therefore a stakeholder workshop would take place soon after the consultation which would develop the recommendations to be brought to the East Sussex Health Overview and Scrutiny Committee (HOSC) in April. Early indications were that there was general agreement with the models of care proposed for both cardiology and ophthalmology. The site preference of individuals who had provided feedback on where cardiology services should be based was closely linked to where they lived.

The Board noted the Chief Executive's Report.

006/2022 **Integrated Performance Report (IPR) for Month 9**

Mr Phoenix noted that November (Month 8) data (instead of December/Month 9) was included in the IPR slides. The correct data was not available in time to be circulated, but Executives would refer verbally to some M9 updates in order that the Board was apprised of the latest data.

i. Quality and Safety

Mrs Carruth reported that local prevalence of Covid during November was already escalating before the Omicron variant emerged at the end of the month. There were a few outbreaks on wards linked to the new variant, but these had been very well managed by clinical and operational teams. Cases of Omicron significantly increased during December and it became clear it was a much more infectious variant of the virus. Due to the successful vaccination programme, this did not translate into more people becoming critically ill or dying.

The recent national easing of Covid restrictions had presented challenges, with some visitors refusing to follow Infection Prevention and Control (IPC) protocols. Communications and signage had been updated to reiterate that requirements such as mask wearing would remain in the Trust regardless of any changes in wider society.

There had been 47 clostridium difficile cases reported for the year by the end of November, against an internal limit of 38. This was followed by nine cases in December and January, which meant the Trust was close to its annual limit. Discussions had been held at both regional and national level around using antibiotics more widely within the community to support admission avoidance. There had been no MRSA bloodstream infections during the year to date.

A root cause analysis was underway around the increase in pressure ulcer damage reported during November and the results would be presented to the Q&S Committee. Initial findings suggested that some out of hospital incidents were potentially attributable to care or nursing homes rather than ESHT, so some data would be revalidated. There was further work to be done around preventing pressure damage within patients' homes and recording when patients with capacity declined treatment or advice. The Pressure Ulcer Review Group had determined that the four main clusters of pressure damage during the year were aligned with Covid outbreaks. It was theorised this could be because strict IPC requirements restricted patient movement.

Additional capacity had been required in the Trust over recent months, which had stretched the nursing workforce. This was compounded by staff needing to self-isolate because of Covid. Despite gaps occasionally appearing, quality metrics remained strong and data collection for the next Nursing Establishment Review took place in November as planned. Mrs Carruth commended the incredible achievements of staff in highly challenging circumstances.

During November, there was a reduction in open complaints. Furthermore, response times improved, and this was sustained throughout December and January. This contributed to NHS Friends and Family Test recommendation scores that were higher than the national average across all areas. ESHT received over 2,200 plaudits during November, as well as seven reviews (all four or five star) on the NHS website. A small number of complaints were reopened across several divisions. However, there were no discernible themes across these or specific concerns to escalate.

The Patient Experience Report had been expanded to include even more detail and had been taken to the Q & S Committee. A divisional focus on associated metrics continued within performance reviews.

Mrs Churchward-Cardiff asked what was being done to keep people safe who were in the ED for significantly longer than anticipated. Mrs Carruth explained that in such scenarios there was a system of regular huddles within the department. Patients were regularly checked in terms of vital signs, hydration, and comfort. Although ED was not the best place for patients to be situated for more than a few hours, mitigations were in place for the rare occasions that targets were not met.

It was noted by Mrs Churchward-Cardiff that only 16% of patients were being discharged before midday against a target of 30%, and she asked what was causing the shortfall. Mrs Argent explained that although Polegate was the discharge area at EDGH, it was also a bedded ward under winter escalation plans. At Conquest, patients were placed in the live discharge lounge but issues with transport partners had at times impeded outward flow. There was therefore a need to prioritise patients according to factors such as journey time and crew member availability. These challenges were being assessed to determine where improvements could be made. Mrs Argent added that for Pathway 0 patients (individuals returning to their usual residence with no ongoing care needs) ESHT was exceeding national targets but discharging earlier in the day would be an area of focus moving forward.

Dr Walker advised that the Summary Hospital-level Mortality Indicator (SHMI) was 97 for both November and December. Over the same period, the Risk-Adjusted Mortality Index (RAMI) fell from 86 to 84. This meant ESHT was ranked 23rd out of 124 Trusts. Crude mortality levels had also fallen once Covid-related deaths were discounted. The depth of coding differences between Conquest and EDGH were being investigated to establish why mortality index disparities continued.

Dr Walker reported that ESHT was asked at short notice in December to establish a Covid Medicines Delivery Unit (CMDU) to fulfil a national requirement. Recent research had suggested certain drugs prevented or reduced the risk of death or need for hospitalisation in the event of Covid infection when delivered within the first five days after contracting the virus. This benefit was enhanced further for patients classified as especially vulnerable to the virus. Those within the category who became infected underwent triage to determine which

medications should be prescribed. The main drug deployed was a neutralising monoclonal antibody, delivered though an intravenous infusion at the Conquest CMDU. None of the patients treated needed to be admitted to hospital and experienced highly positive outcomes overall. Some oral medications were also being utilised and an even more effective version would soon be available. This would take pressure off the intravenous units. Dr Walker commended the many staff who had worked extremely hard to make the unit a success.

Mrs Webber requested further context around the sepsis mortality rate. Dr Walker advised that sepsis was always amongst the main causes of death, but the numbers had declined significantly following the Sign-Up to Sepsis campaign. A graph would be included in the next report to indicate trends over time. **DW**

Mr Reid asked whether there was data to show how overall mortality, including Covid-related, differed from previous years. Dr Walker reported that crude mortality for the current year was 1.3%, compared to 1.6% in the previous year. In the past, the level had at times been over 2%. However, this was just one possible way of considering mortality and assessment of risk factors for death in people admitted to hospital through various routes provided a better comparator between NHS trusts.

Mrs Fadero asked whether there were ICS-level conversations about quality reporting through IPRs and whether this fed into a national picture. Dr Walker advised that mortality data in that regard was not available, but NHS Improvement had begun assessing outcomes across different surgical specialities. This meant some comparator data was being provided as part of a broader trend of performance dashboards for various specialties across a trust. A number of metrics fed into these but not all of them were directly related to quality. Once this data became more expansive and meaningful, it would be summarised at Board meetings moving forward.

Mr Phoenix added that the ICS' emergent leadership had indicated a desire for a more collaborative approach to subcommittee reporting and so areas of focus for maximum impact need to be agreed. Mrs Carruth advised that Chief Nurses across the ICS had been liaising about developing useful comparisons and benchmarks. Mental health services (especially those for young people) had been earmarked as an area where a joined-up approach could have substantial positive impact.

ii. <u>Our People – Our Staff</u>

Mr Aumayer reported that the workforce had been challenged by increasing numbers of escalation beds and hospital attendances. This was exacerbated by specific challenges caused by Covid-19, including staff self-isolation and ward outbreaks.

In what had been a difficult time for many, Mr Aumayer praised colleagues' dedication, resilience and flexibility. A patient-facing reserve workforce had been

created through the new Ward Support Worker role. Over 100 staff members who were usually not patient-facing had been trained to help on wards as needed, in areas other than direct care.

Over the last month, staff sickness levels had increased. Some of this was linked to Omicron but usual winter illnesses were also a factor. On the previous Friday, 163 of the 455 staff absences for health reasons had Covid. This meant 5.7% of the workforce was unavailable due to illness. Taking into account the further 66 staff who were self-isolating, total staff sickness absence was 6.5%. Although these numbers presented challenges, they were much lower than in the previous month and compared well with other NHS Trusts.

Substantive staffing levels were broadly similar in December to those in November. A slight increase in the vacancy rate was linked to creation of new roles. Workforce turnover continued to slowly increase and was now at 10.6%. The figure reduced to 10.1% when planned leave was discounted but this was still above the target of 9.9%. A renewed focus on staff wellbeing and retention was underway to help address the trend.

The number of temporary work shifts requested in the previous month was the highest seen during 2021/22. Filled shift rates remained relatively static compared to the month before. Mr Aumayer advised that fill rates were, in the short term, likely to be below the Trust target; demand for shifts outnumbered the available workforce due to illness levels. The site teams were commended for ensuring that services continued to function safely and effectively despite these challenges.

Two Covid vaccination hubs (one on each acute site) had been set up in less than a week after a request made to the Trust during the latter part of December. These were closed in January, having contributed to booster vaccination targets being met across Sussex. Mr Aumayer thanked all those whose hard work made the hubs a success.

At the end of January, the government advised they were reconsidering the legislation that made it mandatory for staff working in Health and Social Care to have the Covid-19 vaccine. Following this announcement, the Trust had paused formal conversations with unvaccinated staff, but had continued to encourage and support colleagues in taking up the offer of the Covid-19 vaccination, as it remained the best way to protect patients, service users, staff, families and friends. Mr Aumayer acknowledged that this was a contentious issue and thanked all staff those who had come forward for vaccination. He also thanked colleagues who had supported delivery of a large and challenging programme.

504 colleagues who were completing in-scope roles were not vaccinated or had not provided the Trust with information about their vaccination status, despite requests to do so. There were also 77 staff who were in-scope and had declined to have the vaccine, but overall compliance was 93.4%. The Trust continued to seek the vaccination status of new applicants to roles and had decided not to

offer positions to those who refused to be vaccinated whilst national guidance was being clarified.

Mr Aumayer thanked Mrs Kavanagh for her contribution as chair of the POD Committee to its continuing achievements.

Given the high levels of staff sickness and the need for many people to work additional hours, Mrs Manson asked whether there was a risk around holiday accruals as the end of the financial year approached. Mr Aumayer responded that staff were encouraged to use leave throughout the year, and this was closely monitored. A large influx of leave requests was not anticipated over the coming months.

Mrs Manson asked whether any staff who had declined the vaccine or not provided their vaccine status had made complaints to their respective line managers. Mr Aumayer confirmed there had been some outspoken individuals on what was often an emotive subject. However, the Trust had not been told by any staff that they had accepted the vaccine against their will to maintain employment and no significant issues were apparent.

In response to a question from Mrs Churchward-Cardiff about whether disagreements around vaccines had affected team cohesion, Mr Aumayer reported that drop-in sessions for those hesitant to be vaccinated had been used successfully to answer questions in a compassionate and supportive way. There was no evidence to suggest disharmony amongst teams around the vaccines and a mature approach was being taken.

Mrs Churchward-Cardiff asked whether the new rota planning tools were improving compliance around approval rates. Mr Aumayer advised that the Trust's eight-week rota planning had markedly improved and had reached its highest level since January 2020. Moreover, six-week rota compliance had progressed from between 30-40% in recent weeks to just over 50% in the latest data. The high level of staff sickness over had the past few months had been an obstacle to further progress but this remained an area of high priority for ESHT.

In response to a question from Mrs Kavanagh about staff morale, Mr Aumayer reported that early indicators from the staff survey put ESHT amongst the top 20% of Trusts in this area. Mrs Carruth added that face-to-face and social interaction between staff had understandably been limited by the Covid pandemic, but risk assessments around resuming some of these important relationship-building activities were ongoing.

iii. Access and Responsiveness

Ms Abigail Jago (Deputy COO for Planned Care from 7th March) was welcomed to the meeting by Mrs Argent.

Mrs Argent thanked teams across the Trust for their hard work and support. As well as specific initiatives such as Winter Sparkle and the national operation reset

in January, there was enormous effort involved in managing day-to-day operations under a variety of pressures. Teams were working well together, and technology was being innovatively applied to ensure patient safety.

The ED remained extremely busy but ESHT retained a strong position. In December, the Trust was ranked 34th out of 113 for ED performance and at times during January was best in region.

The Livi system had been implemented since the previous Board meeting. During its first seven weeks (up to 23rd December), a full 12-hour, seven days per week rota of GPs was established. 623 referrals from NHS 111 had been redirected, alongside 126 patients from the front door, to a GP appointment via Livi. In real terms, 606 patients avoided having to wait in ED across both acute sites. Furthermore, 84% of these patients did not need to return for further treatment. Overall, results from the rollout were extremely pleasing and would continue to be monitored.

E-Consult would go live on 11th March and facilitate patient self-check-in at the front door. Another pilot scheme to redirect appropriate patients to community pharmacies with an electronic referral would soon be rolled out.

During December and January there had been an increased number of patients who were unable to attend for elective procedures. Despite elective performance being hampered by staff shortages, EHST had been ranked 25th out of 111 for referral to treatment (RTT) standards.

ESHT remained one of the only Trusts in the region to have no patients waiting over 78 weeks and had delivered the faster diagnostic standard again in December. Although cancer performance had not yet reached the national target, performance had been in line with agreed recovery trajectories.

Mrs Argent reported that ESHT had been selected to pilot the Palantir (Foundry) project, which aimed to better manage and understand waiting lists. Members of the data quality team from Chelsea and Westminster Hospital, who ESHT was partnered with on the project, had provided support based on their experience of going through the process. Resource to validate waiting lists had also been secured and would help to ensure data was as ‘clean’ as possible. This was reinforced by critical reflection on administrative process and data validation exercises already in use by the Trust.

Work with local authorities and other system partners to expedite discharges and onward care for patients continued. This was supplemented by admission avoidance strategies, such as virtual wards. Mrs Argent paid tribute to the work of all the Trust’s community teams who supported discharge and ongoing care.

During Winter Sparkle, the average length of patient stays had reduced, and more patients were discharged on Pathway 0 (P0). The national ask was for 50% of patients to be discharged on P0 but there were many days when the Trust exceeded 90%.

With a gradual return to more normal working practices expected, attention had been given to reinvigorating the Trust's community programmes. This involved coordinating plans across the East Sussex system and determining a strategic approach to out-of-hospital requirements for the next 18 months. An audit to assess the current landscape, identifiable trends, complexity and acuity had been proposed and would help assess seasonal variability and how new ED standards would affect requirements. A focus on the complete patient pathway, whilst building on the lessons learnt during the pandemic, was the next step for ESHT and its partners.

Mrs Churchward-Cardiff noted a general trend since the Covid pandemic of more people presenting at ED and asked whether this was expected to become an established pattern. Mrs Argent explained that the community programme reset audit would help to identify whether systems that were in place or soon to be implemented influenced patient behaviours. There was also additional capacity to redirect those coming to the front door to the most appropriate setting and ensuring availability of a streaming nurse was integral to that process. The Trust liaised with primary care providers through a variety of forums to discuss emerging developments. If a patient was seen through Livi, their care record would be updated to ensure GPs were aware of all necessary information.

Mrs Webber highlighted that lots of investment had been made into ED to help in meeting targets but lots of the challenges seemed to be more around flow. Although ED was something that ESHT had full control over, it was potentially not where solutions ultimately needed to come from. The crux of the issue was people attending inappropriate settings and not being able to put them in the right ones. Mrs Argent responded that she felt finances were being spent in the best way and having resource to redirect patients at the front was part of the new ED standards. A whole pathway approach was increasingly the objective and investment within ED would help to future-proof provision. Close collaboration with local authority colleagues and initiatives such as virtual wards would drive this progress further. Within acute settings, social admission lounges were being explored. These would be conducted by Allied Health Professions (AHPs) to provide rapid input to patients without clinical needs. Mrs Chadwick-Bell added that without being able to start from scratch and invest in the community, the pragmatic approach adopted by ESHT was correct. Transitions between health and social care continued to be discussed frequently at a system level. Mr Milner emphasised the importance of considering factors which ESHT could not control and developing a governance model that could weave together services across organisations.

Mrs Kavanagh noted that some cancer metrics were proving challenging to improve and asked what was being done to improve pathways. Mrs Argent reported that ESHT had never stopped operating on cancer patients during the Covid pandemic and maintained as many procedures as possible. Individual waiting lists were being reviewed to identify where flow could be improved, with achievement of faster diagnostic standards being key to expediting cancer pathways. Covid had slowed down treatment for some patients who did not wish

to isolate before surgery under Covid protocols, or had caught the virus shortly before operations. Mrs Argent summarised that ESHT was aligned with trajectory and on the road to recovery for cancer services.

Mrs Webber commented that the report potentially suggested escalation wards might be driving demand for more escalation because they further stretched the workforce and increased length of stay. Mrs Argent advised that ability to discharge was the main challenge rather than the wards themselves. Double up packages of care, as required by some patients, potentially took longer to procure and this caused backlog in the system. With seasonal variation, escalation wards would need to be stepped down. Maintaining an ongoing awareness of the situation within the community would help clinicians to start making different decisions at the front and therefore streamline the full pathway.

Mrs Fadero thanked Mrs Argent for her report and asked what changes would make the most difference for patients on the urgent pathway. Mrs Argent advised that any changes would need to be linked into the new urgent care standards. It was important to ensure that there were a number of options for patients presenting at the front door, rather than them automatically being brought onto hospital pathways. Virtual wards and the prevention of readmission would also greatly improve patient experience and outcomes.

iv. Financial Control and Capital Development

Mr Reid anticipated that the Trust would reach a break-even position at the end of 2021/22. Mr Reid explained that changes to the way the Trust was funded for 2022/23 would present a significant challenge to the organisation. The funding would be based on a pre-covid 2019/20 staffing establishment baseline; since then, the Trust had appointed 532 more whole time equivalent (WTE) employees. Many of these additional staff were brought in to improve community services and help manage during the pandemic.

£15m of efficiency savings had been targeted for 2021/22 and this had almost been achieved. Most of these efficiencies were non-recurrent, and a fundamental re-evaluation of benchmark position would be required moving into 2022/23.

A clear plan of capital delivery had been formulated for 2021/22 but there had been challenges as a result of some funding moving from the previous financial year, as well as a late influx of capital received during November and December. There was a plan to draw down cash through February in the region of between £7m and £8m and this would improve the Trust's capital position. This amount would be dependent on either last-minute finalisation of work, or agreement of vesting certificates to underpin the year-end position.

Mr Reid summarised that the Trust was in a reasonable position to secure a balanced year-end position but underlying concerns about funding for the next year against a 2019/20 baseline remained. Within the rules for the 2022/23 national funding agreement, money directly allocated Covid-related costs would be reduced by 57% and this would put further strain on finances.

Mr Phoenix noted that should the balanced position be delivered as forecast, it would be the third successive year of the Trust delivering on its financial obligations. Achieving this had been challenging but was a significant achievement. He went on to ask what the next steps would be to improve the capital position in the time remaining until year-end. Mr Reid emphasised that it was not necessarily about getting spend agreed but receiving the relevant assets and finishing associated pieces of work to the satisfaction of a vesting certificate. He added that the funding went beyond estates and included streams of work around digital and equipment purchases. The £7-8m of capital spend as previously mentioned would be reviewed in detail to ensure it was deliverable. Mr Reid agreed that the action plan would be shared with non-executive directors once drafted over the coming days.

The Board reviewed the integrated performance report and considered the adequacy of controls and actions

007/2022 **Board Assurance Framework (BAF) Update**

Mr Milner thanked colleagues who had reviewed risks within their own areas of the Trust to feed into the BAF. The document provided a detailed approach to considering risks that would significantly impact upon delivery of the Trust's in-year objectives if realised.

Moving into 2022/23, the Trust would be implementing a new set of strategies and so it was an appropriate time to consider whether the risks noted were the right ones to focus on and the controls in place.

Mrs Webber reported that BAF 6 was an area of responsibility for the F&I Committee and had been discussed at the most recent meeting. This BAF considered delivery of both in-year and future finance. As a blended risk, the positive expectation of 2021/22 and the anticipated financial challenges of 2022/23 were both hidden. It therefore could make sense to split in-year and future finance into two separate BAFs. Mr Milner agreed that correct segmentation of risks was just as important as the risks themselves.

008/2022 **ESHT Strategic Direction to 2025/26**

Mr Milner noted that the supporting strategies which made up the overarching Trust strategy had already been approved by the appropriate Board subcommittees. They were presented with a recommendation that the Board formally approve them and endorse the approaches outlined for achieving the Trust's overarching strategic aims over the next five-to-six years.

A paper would be brought to the Strategy Committee at the end of the month around how these strategies would tie together and the best way to evidence they were informing work done by the Trust.

Mrs Kavanagh asked how the Clinical Strategy was expected to align with the ICS' approach, once finalised. Mr Milner explained that ESHT was working with the ICS to assess how the Trust impacted upon outcomes and noted that the ICS Strategy and Vision 2025 paper was primarily focused in this respect. The core statements which made up ESHT's Clinical Strategy were formulated to address the outcome areas described in Vision 2025 and ensure consistency across the system. Mrs Chadwick-Bell added that the NHS and healthcare systems were in a state of flux and so any strategy document drafted would likely need to be updated as new elements emerged.

Mrs Webber commended the Digital Strategy and took reassurance from the document. She asked whether the strategy was sufficiently ambitious as some of the impacts for patients and colleagues had seemingly already been realised. Many staff had also expressed that standardisation was of particular benefit to them, but this was not an explicit objective within the strategy. Mr Reid responded that ensuring Trust-wide access to a single patient record was central to the Digital Strategy and standardisation. Mrs Webber added that more basic aspects such as ensuring meeting rooms used the same equipment were also something staff had indicated as important in simplifying their roles.

Mrs Manson praised the overarching strategy and four enabling strategies as a step change for the Trust. She asked how the Board would receive assurance moving forward that progress was being made against each of the strategies. Mrs Chadwick-Bell advised that a wider conversation around assurance would take place at the Strategy Committee. Further investment would be made in the transformation team to support delivery of the objectives and provide enhanced programme oversight. Mr Phoenix added that scrutiny by subcommittees of the Board would also be important. It was noted by Mr Milner that a strong steer was coming from the ICB around how delivery transformation would come together, and so internal priorities would need to be aligned with this, and especially around place. Mrs Fadero emphasised the importance of participating in the process as much as possible and leading as appropriate.

Mrs Churchward-Cardiff observed that it was important to demonstrate the benefits of being an integrated trust and the enhanced ability that afforded to change pathways. Mr Phoenix agreed and added this would need to be done as much by highlighting success to date as by explaining what would happen in future.

Following the recommendation for approval at the Board Committees, the Board approved the four enabling strategies.

009/2022 **ESHT Green Plan**

It was noted by Mr Phoenix that the Green Plan had been reviewed by various subcommittees. Mr Milner reported that the plan detailed how the Trust would reduce its carbon footprint. The Care Without Carbon framework had been consulted extensively, in partnership with Sussex Community NHS Foundation Trust. This would also be adopted within the ICS.

The plan would help ESHT to achieve the NHS net zero carbon targets for 2040 - 2050. The Trust had also committed to a specific aim of reducing its carbon footprint by 57% by 2025. Various workstreams would feed into this and annual updates would come to the Board.

A third round of Public Sector Decarbonisation (PSD3) funding had become available and ESHT had made a substantial bid to support its Green Plan.

Mrs Churchward-Cardiff stated that she would welcome more detailed targeting in the plan. Mrs Webber and Mrs Manson agreed that a clearer sense of what success would look like, as well as how it should be measured, would be helpful.

It was highlighted by Mrs Churchward-Cardiff that single-use items were increasingly used by the Trust, but this did not feed into overall environmental objectives. Accordingly, there was perhaps scope to deploy more reusable equipment in an IPC-secure way. It was also noted that lots of emissions derived from the NHS supply chain and would need to be addressed at a national level. Mr Phoenix confirmed these points would be brought to Mr Hodgson, who was unable to attend the meeting, as well as Mrs Kavanagh's on how Trust leaders would be held accountable for the Green Plan.

Mrs Kavanagh asked whether staff and patient travel to Trust sites was considered within the plan. She continued to say that winning over hearts and minds was vital to success. Mr Phoenix noted that emissions from travel would likely have gone down as a result of the Covid pandemic, but it was not necessarily something the Trust could influence significantly. Mrs Kavanagh agreed that it was more challenging to make changes on the patient side but suggested that travel plans for staff were something which could be explored. Mr Reid confirmed the plan did encourage a reduction in staff and patient travel where appropriate, but details of how emission targets would be met needed further development.

The Board approved the Green Plan.

010/2022 **Speak Up Guardian Report**

Ms Holliman reported that around 40 – 60 freedom to speak up (FTSU) conversations were held quarterly. More of these took place with members of the registered nurse and midwife teams than any other group, in alignment with the national data.

The number of individuals from ESHT choosing to speak up anonymously was significantly lower than the national average. Furthermore, fewer people than the national average cited detriment for having spoken up. Ms Holliman commented that this provided assurance around staff at EHST's sense of psychological safety and indicated a positive culture of speaking up.

Most referrals had been during in the first quarter of the year when the Covid pandemic began. Some areas of concern raised in this period included personal protective equipment (PPE), redeployment and isolation protocols. The pandemic also meant the Guardians were less visible than usual, as IPC guidance stipulated minimal movement between clinical areas. Later in the reporting period, issues such as behaviour and conduct began to take on greater prominence. Ms Holliman noted that workforce fatigue was likely a contributory factor to this development.

Most who spoke to the Guardians had also done so previously. Reporting channels were generally being used correctly to escalate concerns before reaching FTSU level. Bullying and harassment rates were higher than the national average. Addressing this was a key priority for the Trust, with work around staff engagement and wellbeing being developed even further. Data and soft intelligence were being triangulated by a dedicated work group to support this process.

Ms Holliman thanked all staff who had spoken up. Messaging to colleagues would be reinforced about the benefits of raising concerns and providing robust feedback. She emphasised that speaking up was of huge benefit to the Trust so must be continually encouraged. Ms Agg added that a refreshed top-down model to promote FTSU was under development.

Ms Agg advised that the Guardians role also involved supporting leadership in responding when concerns were raised to them and promoting local resolution. Listening to staff and involving them in developing solutions, whenever possible, was integral to giving them agency. All national reporting requirements had been met in a timely manner. Data was fed into a public network to make comparisons between organisations. Although there was not specific guidance to make judgments, both under and over-reporting to the Guardians were potential causes for concern.

There was an overall reduction in patient safety concerns raised, which meshed with information received through staff surveys and incident reporting. There was clear evidence to suggest staff reported any clinical worries. Further assurance was offered by the quick responses to concerns on the occasions they were raised, and the feedback of staff involved. Mrs Manson highlighted that the 2020 data showed five patient safety concerns being raised, but sixteen were recorded for 2021 (9.2% of all cases), which did not in isolation suggest these levels had declined. Ms Holliman explained that the data cited the number of conversations which reached Guardian level rather than all concerns raised. Ms Agg added that patient safety concerns were low compared to national averages and made up a relatively small proportion of overall reporting. It was agreed that the Guardians would review the data with Ms Manson and Ms Carruth, who also raised a query, outside the meeting.

Mrs Chadwick-Bell thanked the Guardians for their comprehensive report and explained that she met regularly with them to discuss general themes that emerged from speaking up. She added that 20% of ESHT staff reporting they

felt harassed, bullied, or abused at work was not acceptable, despite it being in line with the national picture. The Trust had ambition to be recognised as an exemplar in how to reduce and address these concerns. Further work and conversations would be required to achieve this step change. Ms Holliman added that a reset of the culture around interactions was vital to achieve this goal.

Mr Aumayer noted that the most recent staff survey results showed the proportion of staff who said they would feel secure raising concerns about unsafe clinical practice was high compared to other organisations. This was also one of the scores which saw the highest rise and would potentially lead to an overall increase in referrals.

Mr Patel noted that the largest category for FTSU referrals was Systems and Processes. He asked whether further insight could be provided into how changes were brought about in these situations and whether any harm was coming to patients as a result. Ms Agg explained that Systems and Processes was a broad grouping, but mainly comprised of staff work-related issues like flexible working or annual leave so did not impact directly on patient safety. It was emphasised that ESHT had clear policies for these areas, but people often came to the Guardians wanting support. Concerns of these nature were discussed before being fed through appropriate channels to achieve a resolution.

In response to a question from Mr Patel, Ms Holliman confirmed that data could be filtered by site and area to establish where more attention was needed. Colleagues working in Organisational Development provided support when emerging themes were identified by the metadata. Mrs Chadwick-Bell added that close focus was paid to areas where multiple concerns had been raised, whilst maintaining strict confidentiality.

Mrs Webber thanked Ms Agg and Ms Holliman for their report. She commented that she would like to see more focus on how speaking up was directly influencing improvements at ESHT. Further assurance could then be provided by monitoring actions over time and assessing their impact. It was suggested that this aspect could potentially be a separate paper for private Board. Ms Agg explained that the Guardian role was primarily around sharing intelligence they received with the Executive team, rather than directly resolving wider issues. Learning from referrals was, however, integral to the FTSU process and input was fed into daily meetings as well as policy application. Mrs Chadwick-Bell added that assurance needed to come through HR committees. FTSU information also had to be triangulated with other data to form a complete picture.

The Board reaffirmed its promotion of speaking up as everyday business.

The Board received assurance that effective speaking up arrangements were in place to ensure learning and continual improvement.

011/2022 **Gender Pay Gap**

Mr Aumayer explained that the paper detailed the 2021 gender pay gaps within ESHT and was presented to the Board in line with legal requirements. It would subsequently be uploaded to the Trust's website.

Gender pay reporting related specifically to the differences in average pay between men and women within the workforce. It was also noted that the NHS Agenda for Change determined how people were paid, except for very senior managers and medical staff. Salary was strongly linked to length of service, which inevitably led to certain unintended anomalies.

On average, men were paid 21.5% more than women and this had remained relatively static since 2021. Medical and dental staff primarily accounted for this disparity. Agenda for Change pay was almost an inversion of this, as were bonus payments and hourly rates.

Bonus payments were linked exclusively to medical and dental staff through the Clinical Excellence Awards (CEA). The number of men receiving bonuses remained significantly higher than the number of women (75% to 25%) but had decreased each year of the previous three. Dr Walker noted that ESHT had over 200 non-locum consultants and all should have received a bonus under CEA in March 2021 under pandemic requirements to spli the bonus fund allocation equally between staff. Therefore, the data only referring to 96 individuals being given a bonus would be reviewed by Mr Aumayer.

To address the gender pay disparity within medical and dental teams, a women's consultant network had been formed. This network would soon hold its second meeting and aimed to support female consultants with progressing their careers. However, Mr Aumayer emphasised that length of service and overall numbers of staff held a huge influence over rates of pay. Therefore, a step change could not be achieved quickly.

Whether pay gaps existed between different ethnic groups was also closely monitored. A report was recently completed that demonstrated no pay disparity between ethnicities within consultant staff groups. However, there were some areas where ethnic minority colleagues earned more than white staff and vice versa.

It was noted that nurses from ethnic minority backgrounds earned on average 12% less than those from a White background. This could be accounted for by the proactive approach ESHT took around international recruitment, with 16% of nurses (321) being appointed from abroad. Average length of service for these colleagues was typically lower and this impacted on pay received.

Mrs Churchward-Cardiff asked whether pay parity would be achieved if CEAs were discounted and Mr Aumayer confirmed it would. Average length of service, though, would mean that the broader picture did not change markedly. Once again, national regulations limited the response ESHT could make. In response

to Mrs Churchward's question around what could be done, Dr Walker advised that ESHT could further encourage female consultants to apply for CEAs. Data from across the NHS suggested women were less likely to put themselves forward in this area. It was expected that CEAs would be more evenly distributed moving forward, following major national discussions.

The Trust Board noted and accepted the contents of the report.

012/2022 **Ockenden Actions – Verbal Update**

Mrs Carruth advised that maternity services were regularly discussed at the Q&S Committee to provide assurance. A full report around Ockenden actions undertaken by ESHT would be brought to the April Board meeting in public, and thereafter on a quarterly basis.

Following the Ockenden report of December 2020, the Trust completed a multidisciplinary benchmark against the 39 recommendations. Around 300 documents were submitted in July 2021 to support the declaration made by the Trust in February of that year. NHS England gave an initial assessment in response that ESHT challenged. Following this, the Trust was regraded to a higher rate of compliance.

The position at the time of the meeting was that 34 of 39 actions were completed, with assurance provided. Five actions remained in progress at various stages, with oversight from Q&S and regular maternity assurance meetings. Mrs Fadero added that areas such as maternity feedback and patient voice were considered in detail through Q&S to ensure full compliance could be achieved as soon as possible. She thanked Mrs Carruth and her teams for their focus and work in this area.

The Board noted the contents of the report.

013/2022 **Charity Annual Report and Accounts**

Mr Reid summarised that the first part of the paper outlined levels of spend over the previous nine months and the second formally confirmed that the annual accounts could be signed off.

It was noted by Mrs Manson that a significant amount of income was received in 2021 from NHS Charities Together which would not continue moving forward. Most Trust charity fundraising activities had been suspended due to the pandemic and so some spend was restricted.

In reply to Mrs Churchward-Cardiff's question about the relatively small financial contribution made by the Trust lottery, Mrs Manson confirmed it would be further promoted through social media. However, a standalone website for the charity (not a subdomain of the main ESHT website) would first need to be created to comply with requirements.

Mrs Manson confirmed in response to Mrs Webber's point around the need to spend funds held by the charity that efforts were being made to do so. Fund holders were being encouraged to use finances available to them, as these individual balances were often higher than that of the general fund which the Charity Committee directly controlled. An investment advisor had also been appointed.

The Board noted the contents of the report and that the accounts were submitted at the end of January after approval at the Charity Committee.

014/2022 **Use of Trust Seal**

The Board noted that the Trust Seal had not been used since the last Board meeting.

015/2022 **Questions from members of the public**

Mr Phoenix reported that questions received from Mr Campbell (including those outstanding from the December meeting) would be responded to in writing.

Mr Campbell asked whether specific concerns raised during the cardiology and ophthalmology transformation consultations would be addressed in Board papers, along with proposed solutions. Mr Phoenix advised that an independent process needed to be followed, but the range of concerns would be collated by the independent group once this had concluded.

In response to Mr Campbell's question about whether putting back the effective date for ICS to July would impact upon ESHT's operations in the first quarter of 2022/23, Mr Phoenix confirmed this was not anticipated.

Mr Phoenix reported that although questions received and their answers had not been put on the Trust's website from the previous meeting, this process would resume moving forward.

Ms Walke asked about the position of the midwifery-led unit (MLU) at Eastbourne and whether it was open for overnight stays. Mrs Chadwick-Bell reported that the MLU was not open at the time due to staffing pressures and the prioritisation of home births, but there was no strategic intent to keep it closed.

In reply to Ms Walke's query about when the cut off time was for new mothers to be discharged from Conquest, Mrs Carruth advised she would speak to colleagues and come back to Ms Walke with an answer.

Ms Walke enquired about the five Ockenden recommendations for which the Trust had not yet evidenced compliance and Mrs Chadwick-Bell assured these would be addressed in the paper brought to Board in April.

Ms Walke requested reassurance around the cardiology reconfiguration proposals, with reference to the specialist cardiac teams that were to be based

on each acute site and travel considerations. Ms Chadwick-Bell advised that any specific questions or concerns would need to be fed through the formal consultation channels and a response could not be given outside of these. Travel for staff and patients had been factored into the consultation and would continue to be a key focus.

Ms Walke asked about current patient visiting policy within the Trust and whether a booking system was still in effect. She also requested confirmation around the rules for accompanying those having operations who had been isolating in preparation. Mrs Carruth reported that the Trust had taken the decision at the end of December to further restrict visiting because of high Covid case numbers in the local area. Visiting was continuing but mainly only by exception. It was planned to gradually ease restrictions over the coming week so more patients could be visited more often, subject to IPC compliance. Digital visiting also remained in place. Ms Walke added that she knew of some people who had been visited by hospital chaplains and suggested that this service could be more widely publicised.

016/2022 **Date of Next Trust Board Public Meeting**

The next meeting of the Trust Board would be on Tuesday 12th April 2022 at 0930

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Meeting of the Board on 8th February 2022.

Questions from Mr Colin Campbell.

1. Given the limitations of on-line meetings and the probable absence of face to face public meetings, can a Frequently Asked Questions' (FAQ) page be created on the Trust website listing the questions submitted and the responses given at the meetings held to date?

   Any responses to questions submitted to the Board are sent directly to the member of public who asked the question as soon as answers have been collated. They are also included within the Board papers for the following meeting, and so are already available on the Trust's website.

2. Could an update be given either in the Board papers or at the Board meeting of the concerns raised during the public consultation process to date and how the Trust would address any concerns raised? For example, the primary concern identified in the survey of ophthalmology patients was transport to and from their treatment site. Will the Trust be prepared to offer a specific solution addressing this concern other than a general reference to eligibility for non-emergency patient transport services?

   The consultation is independently led but the concerns raised will be collated by the independent group at the end of the process and taken into consideration.

3. Given that the ICS effective date has been put back to the 1st July 2022 what impact will this delay have on the Trust's operations for the 1st Quarter of 2022/2023?

   It is not expected that this would impact upon operations at this time.

4. Within the Minutes of the previous meeting it was noted that my questions would be responded to in writing but nothing has been received to date. When can these responses be expected and why were they not included in the Minutes of the previous meeting?

   Apologies for the delay in responding to the questions, which was due to staff absence. The answers have now been sent.

5. Despite existing to serve the needs of the people of East Sussex, why is there no core strategy within each of the individual strategy documents addressing the needs of patients who require the services of the Trust?

We have recently recruited a Head of Health Inequalities who will be addressing issues relating to how we support improve patient engagement and involvement.

6. Why is there no Patient Strategy document included in the suite of strategy documents included in the Board papers to state clearly and enumerate how the other strategies will deliver a better standard of care for the residents of East Sussex? In particular how the often utilised phrase of "Health Inequalities" will be analysed into measured deliverables?

   It is not uncommon for NHS trusts not to have a "patient strategy" in the sense described. Indeed, as the recent legislative proposals accept, organisation–led approaches to improving patient outcomes are often partial and/or unsustainable.

   The focus on improving patient outcomes, therefore, is better articulated through a system-wide document. We understand that Vision 2025 does this job very well.

   For that reason, we have oriented our strategic plans in line with the priority is contained in that document

7. There is apparently no mention made of any feedback from the multidisciplinary committee managing on issues encountered and solutions achieved. Does this mean there are no possible areas or processes identified for improvement?

   We are unsure what this question refers to as we do not have a multidisciplinary committee at ESHT.

8. Given the roll-out of Voice Over Internet Protocol services by BT in Eastbourne does the Digital Strategy include a project for the provision of dedicated devices programmed for use only via a digital gateway to the Trust that could be supplied to patients and enable direct communication and remote monitoring with minimal digital education required for patients.

   A number of solutions are being introduced, including:

   a. *Personal Health care record (PKB) which will allow patients to interact with their healthcare record and to feedback to clinical teams if on a specific pathway. Further information can be found at https://www.esht.nhs.uk/my-health-and-care-record/*

   b. *Virtual wards, where we are already using a number of simple to use technologies to support the remote monitoring of patients including Oxygen Levels, Pulse, Blood Pressure etc. This means that patients do not have to attend outpatient clinics, or come in to hospital as they can be monitored at home.*

   The Digital Strategy is to continue to build on these innovations over the coming years.

9. The item labelled Trust Balance Sheet should be re-labelled Trust Assets and Liabilities as the other side of the Balance Sheet is not shown.

   This is correct, although the "financed by" section of a balance sheet is normally only included at the year-end external reporting. We will review the wording.

10. Despite the volume of statistical data included in the Board papers there appears to be no reported measure of Quality of Healthcare within the Trust's operations and yet, given the pressures that are going to exist for at least the next three years, should it not be the primary goal of the Trust to establish, publish and deliver a comprehensive quality of integrated healthcare that is accepted as a common goal across the Trust? The Balanced Scorecard is inadequate.

    The Trust submits a great deal of data – qualitative and quantitative – into the ICS on a regular basis. Given the earlier answers regarding a more holistic understanding of health improvement and outcomes at a system level, the answer to this question will be better addressed by ICS colleagues.

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 8th February 2022 Trust Board Meeting

Agenda item	Action	Lead	Progress
006/2022 – Integrated Performance Report (IPR) for Month 9	Dr Walker agreed to include a graph within the next IPR report that showed sepsis mortality trends over time.	**DW**	Graph included within month 11 IPR

Audit Committee Summary of meeting held on 24th March 2022

Data Quality – Audit Recommendations Update
Applications had been received for a Data Quality Lead and an appointment would be made by June. This role would provide support and assurance about a wide range of data quality metrics in the organisation, and would develop a Trust data quality strategy.

Emergency Preparedness, Resilience and Response (EPRR)
ESHT complied substantially with EPRR core standards at the end of 2021. A target had been set of full compliance being achieved within 12 months (around September/October 2022). Developing more robust business continuity measures would be a key part of the process.

Draft Annual Governance Statement (AGS) for 2022/23 and Annual Self Certification
A draft version of the AGS was presented to the Committee for comment. The finalised AGS would be included in the Annual Report. The Annual Self-Certification checklist to confirm that ESHT could meet its obligations under licence would be brought to the Board in April.

Board Assurance Framework (BAF)
A refresh of the BAF to incorporate internal audit recommendations had been discussed. Committee members noted that they liked the current format of the BAF, and asked that any changes added value to the document for Committees and the Board. Consultation would take place with chairs of the Board subcommittees, before an updated BAF was presented to Committees and the Board in Q1 22/23.

Review of Accounting Policies
Following an annual review which considered any changes to approach at national and local level, no significant changes were made to the Trust's accounting policies.

Tenders and Waivers
Discussion took place around how best to manage waivers where the tender process could not meaningfully be followed because suppliers declined to submit quotes. It was agreed that the Standing Financial Instructions would be updated to delineate the correct policy in these scenarios.

Information Governance Update
A report detailing progress through the DSPT toolkit was presented. A process was underway to clarify who was responsible for key areas of data. These individuals would then have opportunity to share their perspectives on the Datix migration to ensure a relatively seamless transition.

Internal Audit
A schedule had been put in place to resume suspended audits (these were suspended due operational pressures related to Covid). It was agreed that more benefit realisation assessments should take place, beginning with a review of Nervecentre's implementation. The Committee approved the 2022/23 workplan that was proposed.

External Audit Report
The external audit plan highlighted five areas that would be given specific consideration: management override of controls; valuation of land and buildings; fraud in revenue consideration; fraud in expenditure recognition and validity of capital payables. The plan was agreed by the Committee.

Anti-Crime Specialist (ACS) Service Progress Report
Proactive work had begun around contract management and charitable funds. No new referrals had been received since the previous meeting. The ACS work plan for 2022/23 was formally approved.

Paresh Patel
Chair – Audit Committee

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

Introduction
Since the Board last met a POD Committee meeting was held on 17 March 2022. A summary of the items discussed at the meeting is set out below.

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

Workforce Report
An update was provided on the workforce report highlighting that the Trust was in an extremely challenging position due to the COVID infection and staff sickness.

Staff Sickness
Currently 216 staff members were off with COVID; in wave 2 it was 237; given the current trend the Trust is expecting to exceed this number in the next 2 to 3 days. In terms of sickness numbers, COVID equates to 42% of sickness within the Trust. The impact of this staff sickness has had a great impact on the Trust's ability to deliver services.

Patients
- Currently 112 patients with COVID
- 145 exposed beds, 9 of which are empty that cannot be used
- 250 patients not meeting the criteria to reside
- 120 medically ready to discharge patients
- 60% of bed base unavailable for non-COVID patients

Mandatory Training & Appraisals
Mandatory training and appraisals had not improved since the previous month. The Trust recognised how difficult it has been for staff dealing with today's pressures.

TWS & Recruitment
The bank and agency rates remained challenged due to sickness levels. SA highlighted that neighbouring Trusts were experiencing similar pressures in the system. Discussions were underway on creating additional capacity.

It was noted that the Recruitment Team had been working extremely hard during this pressured time. Their focus had been relentless in bringing people in quickly and the work that they are doing alongside the TWS team and Volunteers to keep going was incredible.

Board Assurance Framework (BAF)
The BAF detailed the quarter 4 update. The ratings for BAF 4 and 5 had not changed since quarter 3 and there were no new risks added from the risk register. The recruitment risks had been amalgamated under a single risk.

Moving forward into the next financial year improvements to the BAF were being discussed. The detail would be made clearer to present the risk appetite differently.

Deep Dive: Creating a Culture of Inclusion & Involvement

Health & Wellbeing

An update was provided on health and wellbeing highlighting that the focus had been on supporting the emotional, psychological and mental wellbeing of staff.

It was noted that it was becoming normalised to talk about mental health and people feel more willing and able to speak up when they are not feeling ok.

EDI Workforce

An update was provided on EDI Workforce highlighting that there were 4 priorities in place with a suite of projects each. A smart objective had been linked to the current work plan for the next 3 years.

An EDI Toolkit had been co-produced with workforce colleagues. The Toolkit had been trialled within the medicine division and had received positive feedback.

Retention

Retention levels within ESHT were 11.1% against a national average of between 8.5 – 12%. However, workforce data showed that the turnover of Trust staff had been increasing since March 2021 and that the latest turnover rate was the highest in the last two years. The increase in turnover, in the last year, was driven by an increase in voluntary resignations; the top three reasons cited as being due to Work Life Balance, Relocation and Retirement.

The Retention Model sets out the dozen demands for psychological safety alongside established interventions within the Trust that are already contributing to the retention of staff at ESHT. Further triangulation and data gathering is required to understand other causes of staff turnover.

Guardian of Safe Working Report (Nov/Dec/Jan)

This quarterly report was for November 2021 to January 2022 therefore some of the issues and discussions may have changed since then. NMI highlighted that the format of the report had slightly changed to express the issues felt to be relevant.

Most exception reports had been from the most junior doctors, the foundation doctors F1 and F2; It is important to listen to our staff about feeling safe at work.

The most common risks and concerns were unfilled gaps on some rotas, heavy workloads and missed breaks; work in place to resolve these concerns.

Carys Williams
Chair of POD Committee
March 2022

Quality and Safety Committee Report – 17 March 2022 Meeting

- Patient Safety and Quality Group – staffing challenges impacting fill rates but quality metrics holding despite this. Interoperability of systems raised as a concern and the Committee will receive a report from the Digital Steering Group regarding progress and mitigation so that impact on quality, and quality or safety risks can be considered.

- Diabetes major amputations – increase in major amputation rates. This was expected and reflected nationally. System-wide review planned along with reinforcement of referral criteria for primary care.

- Pressure Ulcer Deep Dive – no specific themes had arisen from a review of the increase in pressure ulcers in November 2021. Committee received assurance regarding learning and actions and noted the need for shared responsibilities across the system.

- Urgent & Emergency Care Patient Story – learning from this and similar incidents has resulted in better information for patients when being discharged home.

- Infection Prevention & Control Board Assurance Framework – new version of the BAF had involved significant change and now included winter planning and seasonal illnesses. Trust assessing against requirements.

- Quality & Safety Exception Report – Feb 22 data. Improvement in open Serious Incident investigations and governance team working with the Divisions to close outstanding amber investigations. Implementation of the new Patient Safety Incident Response Framework progressing – report will be presented at the April 22 meeting.

- Maternity - Ockenden Progress Report – continued progress.

- SSNAP – Progress Report and Latest Data – Expect an improvement in rating for next data return.

- GIRFT – Relaunch of programme noted, and revised reporting arrangements noted.

- CQC Maternity Survey – creditable results and a slight increase in response rate on 2019.

- Covid-19 Recovery – assurance received regarding 104-day cancer wait breaches with Trust meeting trajectory.

- High Level Risk Register and Board Assurance Framework – taken and noted slight reduction in risks and no new risks for the BAF.

Amanda Fadero, Chair
25th March 2022

Strategy Committee Report – 24th February 2022 Meeting

The strategy committee last met on 24th February and considered the following updates:

Electronic Patient Record Business case

This was due to be presented to the Sussex ICS Digital Board in March, and had been developed in collaboration with NHS LPP, NHSX and Channel Freda. The case would fit within a three-year financial plan, included existing revenue and was match funded by NHSX at 15% of the upfront investment costs.

After discussion about running costs, timelines and integration/compatibility with other systems in use, the Committee was assured that the business case met Trust objectives and included ICS collaboration to fit with integrated data set development. Accordingly the Committee supported the proposed business case

Sussex System Governance

This paper set out the proposed governance structures for the Sussex ICS, starting from July 2022 and would be shared at the Trust Board Seminar on 8th March. The proposed division of responsibilities between the Health & Care Assembly and the Integrated Care Board were described along with the proposed committees and their functions. There is a proposed role for a Lead Executive for Place and that ESHT would seek to work closely with this role alongside all provider organisations to ensure joined up care across East Sussex. There was discussion regarding the relationship between the statutory body chief executives and the Executive lead for Place. It was agreed that ESHT already worked in a place-based model and that this way of working was therefore well-established.

An executive committee had been established by the ICS that recognised five key workstreams:

- Children's Urgent Care
- Planned Care
- Mental Health
- Community / Primary Care
- Health and Inequalities

Place Development – National Support Programme

The Committee received a summary of the programme and noted that East Sussex had been put forward for this on behalf of the Sussex system. The work would last for approximately 12-14 weeks and deliverables would focus on governance structures, resourcing and potential models for health and care collaboration.

Implementing the Strategy: Next steps and approach

The Committee was provided with an overview of how the Trust planned to provide assurance that delivery against strategic priorities would align with Trust transformation programmes. The presentation focused on three main areas:

1. Key Strategic Milestones.
2. Benefits Emerging.
3. Assessment of risks to progress.

Discussion covered managing potential derailers, operational challenges, capacity and capability and how the Trust would ensure that end targets were being met. It was agreed that it would be helpful if the workstream leads could attend the Strategy Committee in the future to deliver programme updates to members. The Committee commended the programme and suggested aligning the various building blocks to allow for a more robust process.

New Hospitals Programme - Cohort 4 National Briefing

A summary was received on the national programme that was being developed with 48 other Trusts within the New Hospital Programme (NHP). ESHT was awaiting feedback on the Strategic Outline Case (SOC) which was anticipated in spring / summer of 2022. This programme was part of Cohort 4 and included incorporating the standardisation and learning from previous schemes within the programme developments. This included mandated outcomes, guidelines and standards that would require modern methods of construction including net zero carbon standards, digital, design, procurement and operational outcomes. The commercial approach would include a centralised commercial strategy to maximise the benefit and value for money across the national programme.

Jackie Churchward-Cardiff, Strategy Committee Chair

23rd March 2022

Chief Executive Report

Meeting information:			
Date of Meeting:	12th April 2022	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell, CEO

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:

Introduction

Firstly, I would like to thank all staff for their ongoing dedication and hard work since the last Trust Board. I hear stories on a regular basis of outstanding things our staff have done, and this makes me proud of the services we offer our population.

We were delighted to welcome Julian Kelly, NHSE Chief Finance Officer, Hannah Hamilton, Regional Chief Finance Officer and Acosia Nyanin, Regional Chief Nurse to Conquest on 18th March 2022. Thank you to the A&E, MacDonald and Gardner teams who supported the visit.

Improving the Health of our Communities

ESHT moving to a smoke free site from 1 April

East Sussex Healthcare NHS Trust will be a smoke free Trust from 1st April 2022. Smoking, vaping or using e-cigarettes will not be allowed anywhere on any Trust site, including outside areas or in vehicles to protect the health of the people using and working in our services. Smoking is also prohibited in private vehicles while on trust property. Our smoke free policy applies to all patients, visitors, staff, volunteers and contractors.

We know that smoking is the single greatest cause of preventable ill health. As a healthcare provider we have a responsibility to promote healthy lifestyles, reduce smoking prevalence and protect everyone from the dangers of second-hand smoke.

Stopping smoking is single most beneficial thing you will ever do for your health. It's never too late to quit. Support for anyone who wants to quit smoking or stop while receiving treatment is available across our trust. Patients can also be referred to the East Sussex Stop Smoking Service, One You East Sussex, for further support. People who attend a stop smoking service are four times more likely to quit smoking successfully.

Every patient is asked about their smoking history to help us give them better care. Many patients use their admission as an opportunity to stop smoking and improve their health. Patients who let us know that they would like to stop smoking at any point during their stay or treatment, can be put in touch with the stop smoking nurse and offered nicotine replacement therapy (NRT). People that wish to stop smoking are strongly advised to also

seek support from local community smoking services to ensure they get all the support necessary to help them to quit. Support to stop smoking is also available from GPs.

Collaborating to Deliver Care Better

MSK Services

Musculoskeletal Services (MSK) in parts of East Sussex are delivered through SMSKPE in the Eastbourne and High Weald area and this will continue over the next year. NHS Sussex is working together to agree a more consistent model of services across East Sussex but in the meantime the current contract arrangements have been extended for a year. I am pleased to announce that from 1st April 2022 ESHT will be replacing Sussex Partnership on the Board of Directors for the SMKPE service which will offer benefits of integrated working and service development for East Sussex. Both myself and Damian Reid will take up the posts on the Board.

Maternity Ockenden Report

Many people will have seen the news about the Maternity Service Review at The Shrewsbury and Telford Hospital NHS Trust. The Ockenden final report was published on 30th March 2022 and the Trust will be reviewing this in detail and ensuring that the recommendations within the report will be implemented where they are not already in place.

Shaping Place in East Sussex

The National Programme on Place Development has begun in earnest, with two workshops to consider:

1. Working together and relationship building across Sussex provider organisations; and
2. Potential models of integrated care from ICSs elsewhere and how these might apply in East Sussex.

Empowering our People

Staff Survey

Without our staff none of what we do would be possible and the pandemic has had an impact on our staff both within and outside of the work environment. The staff survey results have been published for 2021 and we will be reviewing the report in more detail as a Trust Board, but also with the divisional and corporate leadership teams in order to agree a set of priorities for the year. The national picture reflects one where results in general have declined but ESHT has remained on a good position with the People Promise scores remaining in line with the scores of similar organisations. I'm pleased to say that the support for work life balance score is higher than average, but there are 3 areas which are of concern; compassionate culture; negative experiences and flexible working.

Staff Car Parking

The Government have announced that free car parking in hospital car parks for NHS staff, introduced during the pandemic, will come to an end on 31st March 2022. It is not the Trust's intention, as approved by the Trust Board, to reinstate the staff car parking charges that were in place prior to the pandemic. Instead we are looking to introduce a new parking permit scheme with a small annual administration fee – this proposal has been discussed with JSCC and we will provide an update in due course.

Ensuring Innovation and Sustainable Care

From 1st April 2022 the private healthcare services at the Conquest site have been transferred from Spire to being part of the Trust. We extend a warm welcome to our new colleagues who have moved across into ESHT. Sussex Premier Health is the new brand name for all private activity completed across the Trust. Members of staff working within our Trust wide private service provision will moved into a new operational divisions and will be led by Amanda Rogers (current Spire Hospital Director) and report into the Chief Operating Officer. It is important to note that whilst Sussex Premier Health does not draw from NHS resources, the profits will be reinvested back into the Trust. It also helps with recruitment and retention of Consultants and other healthcare professionals.

There has been a lot of hard work undertaken over the past year to prepare for the transfer of services, the assets previously transferred in April 2021 and I'd like to take the opportunity to thank everyone who has been involved, but with special thanks Simon Dowse and Hayley Barron who have been leading the service transfer.

We are currently in the process of developing our annual business plans and these will come to a future Board meeting, outlining the key priorities for 2022/23, although key areas of focus will be:

- wellbeing of our staff
- transformation and productivity of our services
- living with Covid and recovery of services
- developing integrated working across health and social care both within East Sussex and where appropriate across Sussex
- financial sustainability

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period February 2022 (Month 11)

Content

East Sussex Healthcare NHS Trust

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

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 (2021/22), 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

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target / Limit	Last month	This Month	Variation	Assurance
Patient Safety Incidents	M	937	909	Common Cause	
Serious Incidents	M	2	2	Common Cause	
Never Events	M	1	1	Common Cause	
Falls per 1,000 bed days	5.5	5.4	5.5	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	1	2	Common Cause	Consistently Missed
MRSA Cases	0	0	1	Concern	Inconsistent
Cdiff cases	<5	5	6	Common Cause	Inconsistent
MSSA cases	M	0	2	Common Cause	
RAMI	94	84.4	83.5	Improvement	Consistently Hit
SHMI (NHS Digital monthly)	0.99	0.97	0.98	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	85%	85%	Concern	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	85%	85%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last month	This Month	Variation	Assurance
Complaints received	M	29	33	Common Cause	
A&E FFT Score	M	96%	90%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	94%	100%	Common Cause	
Out of Hospital FFT Score	M	97%	99%	Common Cause	
Outpatient FFT Score	M	99%	99%	Common Cause	

Our Performance	Target / Limit	Last month	This Month	Variation	Assurance
A&E 4 hour target	>95%	78.8%	72.8%	Concern	Consistently Missed
A&E Non Admitted	M	85.7%	80.4%	Concern	
A&E > 12 hours from arrival to discharge	M	123	238	Common Cause	
A&E waits over 12 hours from DTA	0	0	0	Common Cause	Consistently Hit
UTC 2 hour	>98%	75.2%	69.9%	Concern	Consistently Missed
Cancer 2ww	>93%	98.0%	96.0%	Common Cause	Consistently Hit
Cancer 62 Day	>85%	69.9%	70.5%	Common Cause	Consistently Missed
62 day Backlog	M	155	127	Common Cause	
104 day Backlog	M	29	21	Improvement	
RTT under 18 weeks	>92%	68.8%	66.5%	Concern	Consistently Missed
RTT 52 week wait	0	78	68	Improvement	Consistently Missed
RTT Total Waiting List Size	36,833	37,278	38,442	Concern	Inconsistent
Overdue P2	M	262	217	Common Cause	
CHIC wait times < 13 weeks	>75%	87.1%	84.0%	Common Cause	Consistently Hit
Diagnostic <6 weeks	<1%	19.7%	15.5%	Improvement	Consistently Missed

Our People	Target / Limit	Last month	This Month	Variation	Assurance
Establishment (WTE)	M	7,846.4	7,840.3		
Vacancy Rate	<5%	8.8%	8.0%	Concern	Consistently Missed
Staff Turnover	<9.9%	11.1%	11.1%	Concern	Consistently Missed
Retention Rate	>92%	91.4%	91.4%	Concern	Inconsistent
Sickness - Absence % (rolling 12 mths)	<4.5%	5.3%	5.4%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	19.2	19.5	Concern	Consistently Missed
Staff Appraisals	>85%	76.6%	75.7%	Common Cause	Consistently Missed
Statutory & Mandatory Training	>90%	89.5%	88.5%	Improvement	Consistently Missed

Our Productivity	Target / Limit	Last month	This Month	Variation	Assurance
4 hour theatre sessions	M	321	429	Common Cause	
Average Cases per 4 hour session	M	2.5	2.4	Improvement	
Clinic run rate	M	82.2%	80.2%	Improvement	
Non Face to Face Outpatients	>25%	30.2%	28.9%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.6	2.7	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	4.1	4.3	Common Cause	Consistently Missed

East Sussex Healthcare NHS Trust

Chief Executive Summary

The Trust along with the majority of providers continues to see services stretched, impacted by Covid and staff sickness. Due to the highly infectious transmission of the omicron BA.2 variant which appears to be the most common in East Sussex, we have seen services severely impacted ; which include our emergency departments, patient flow, discharge, elective activity and workforce. Despite this we continue to deliver the full range of services.

Key Areas of Success

- The Trust is placed 45 out of 113 Trusts for the 4 hour emergency care standard which is just above the national average. Achieving just over 75% against the 95% standard. This is a decrease from the previous month and is indicative of our limited ability to discharge patients with challenged access to social care beds. Although this remains a key area of improvement with enhanced actions in place
- Cancer performance saw an improvement in February. With the 28 day Faster Diagnosis Standard (FDS) being met, and the >62 and >104 day backlogs both being reduced, over and above expectation and trajectory
- Our elective performance also saw a further improvement. Further reducing our >52 week waiting patients and achieving the H2 elective target. Delivering 91% of clock stops compared to 2019/20 baseline. With the ask being to deliver 89%
- The Trust's YTD favourable of £9m is driven by H1 pay award (£4.3m), ERF (£6.9m) partially offset by lower divisional income (£3.4m). Covid position continues to support the trusts overall financial position with an effective YTD contribution of £17.2m (£23.2m income)
- Our financial efficiency target of £14.7m looks to deliver in on plan for year end
- Quality indicators are showing that our staff continue to provide consistent levels of care

Key Areas of Concern

- Although an improving picture for workforce with successful recruitment campaigns to fill substantive posts, the Trust continues to rely on temporary workers to address increased activity demands and the increase in staff sickness due to the Omicron variant which has increased pay cost variance to £11.8m
- The Wellbeing of our workforce remains a key priority as the continued pressure is affecting staff
- Our Medically Ready for Discharge (MRD) numbers continue to rise and impacts our ability to discharge patients to the right care setting remains challenged. A Discharge and LoS programme is being rescoped with a back to basics approach including board round, roles and responsibilities, Work is ongoing with system partners as part of this programme.
- The increased challenge in delivering the financial position for next year
- Child Development Assessment waiting times, for which the aim to reduce to no more that 52 weeks, currently routine appointment average wait times are over 60 weeks and increasing due to lack of capacity

Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

Quality and Safety

February 2022 data

COVID - 19
The prevalence of COVID in the local population remained considerably higher than the national position. At time of writing the Omicron BA.2 variant is now the most common in East Sussex and has been shown to be highly infectious with vaccination providing protection against serious illness but not necessarily preventing transmission. The average number of positive inpatients increased from 70 to 100 with no significant increase in critical care requirement. The impact on staff has also been significant which the Chief People Officer (CPO) will discuss in more detail.

Infection Control
As predicted, unfortunately the year end position for CDIFF cases exceeded the internal limit. The limit was exceeded in the first two quarters of 2021 and despite incidence returning to within limits for Q3 and 4 it was not possible to recover the position. All specimens were ribotyped, with Post Infection Reviews (PIR's) underway and no evidence of any outbreaks.

Incidents
Two Serious Incidents (SI's) were reported in February 2022, one was a Never Event relating to high strength Midazolam and the other SI related to Maternity and is being investigated by Healthcare Safety Investigation Branch (HSIB). The number of open SIs is under review and work will commence to enable the older ones to be closed over the forthcoming weeks/months.

Pressure Ulcers
A deep dive regarding November was reported to the Patient Safety & Quality Group (PSQG) and the Quality & Safety Committee (QSC) in March. Two Category 3 pressure ulcers were reported in February and are subject to root cause analysis investigations. Work is underway to try and obtain more granular data to focus quality improvement efforts.

Falls
Work is underway with Business Intelligence to try and obtain more detail regarding incidents reported as Falls with a paper discussed at QSC regarding assisted or controlled falls.

Patient Experience - Complaints/Friends & Family Test (FFT)
Teams have continued to work through the backlog of complaints from wave 2 of COVID, with just 8 overdue complaints at the end of February. FFT submissions still remain lower than pre-COVID but recommendation rates are still very high ranging between 89.8% and 100% for A&E, Inpatient areas, Maternity and Outpatients. It is hoped that a digital option for FFT will be available in April which will give patients the option to provide feedback in other ways.

Mixed Sex Accommodation
The Trust's commitment to minimising mixed sex accommodation has been reviewed and updated and will be uploaded to the Trust website by 31 March 2022.

Nursing & Midwifery Staffing
The requirement for significant additional inpatient bed capacity continues with the additional pressure of increased staff absence due to the very high prevalence of COVID-19 in the local population.

Nurse staffing in February remained very stretched in most areas which may have had an impact on some of the key quality metrics (or indirect care such as documentation, discharge planning etc) and on staff wellbeing due to the sustained pressures.

The ward Nursing Establishment Review is almost complete with a slight delay awaiting benchmarking data.

The first cohort of the 'New to Care' Health Care Support Worker (HCSW) role commenced induction at ESHT. Additional clinical facilitator support will enable the successful on-boarding of this new staff co-hort.

Mortality
Both SHMI and RAMI indices of mortality remain better than peers. SHMI has reduced this month and RAMI remains in the top quartile across NHS England Acute Peers.

Author(s)

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

David Walker
Medical Director

Actions: Work ongoing with BI colleagues re: more granular data being made available

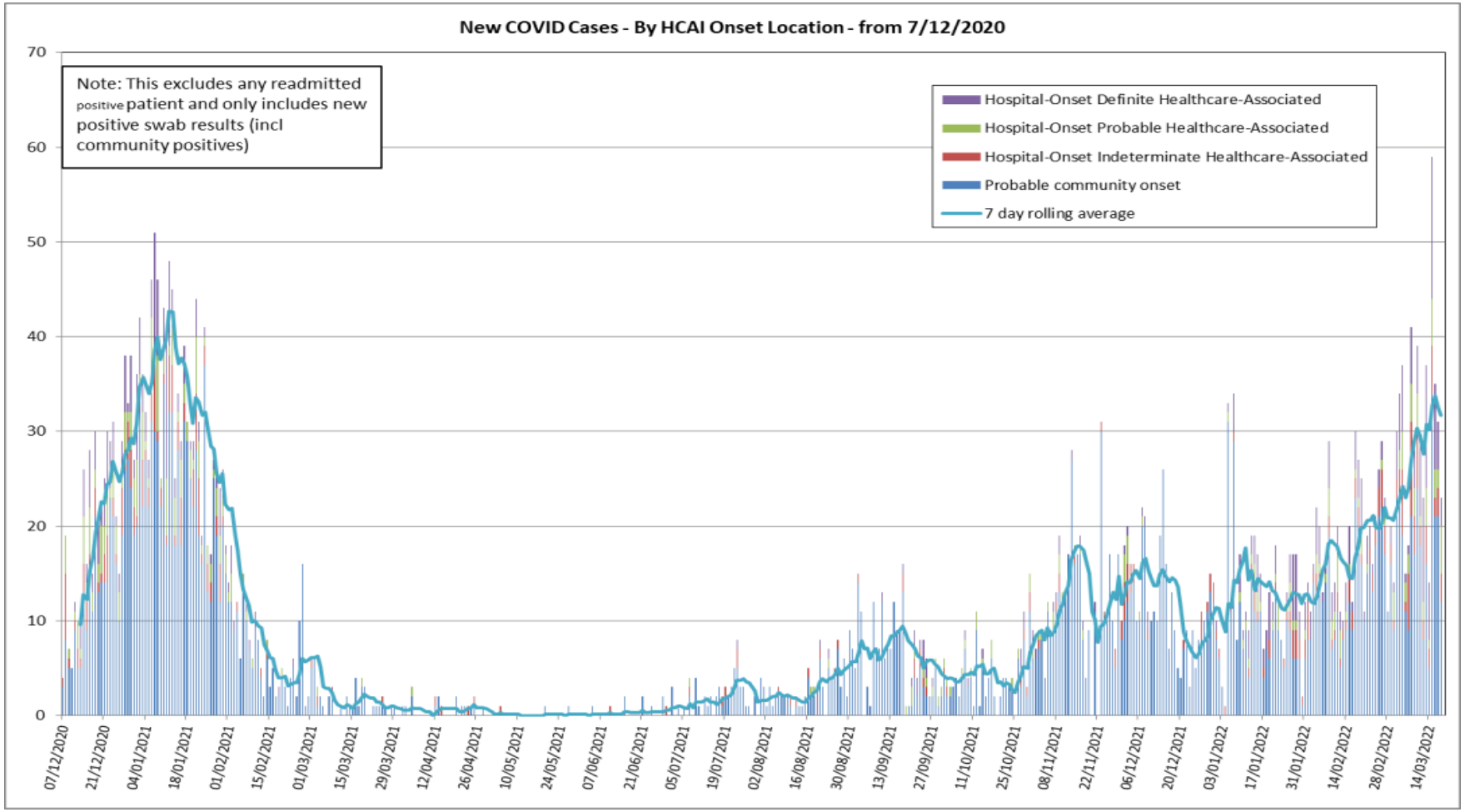
COVID-19

East Sussex Healthcare NHS Trust

Quality and Safety

Prevalence

The prevalence of COVID in our local community remained higher than the national average for another month. As at 17th March 2022, COVID prevalence was highest in Hastings at 1,097/100,000 and Eastbourne at 937/100,000 compared with an England rate of 660/100,000. The number of COVID positive patients at ESHT also increased during this time.



Outbreaks and Serious Incident Investigations

There were 10 outbreaks of COVID during February mirroring large numbers of outbreaks in trusts elsewhere in the South . As Omicron BA.2 increased in prevalence in Sussex during February, a greater number of wards had more than one bay affected as part of an outbreak. A greater number of staff were/are also reporting sickness due to COVID. Outbreak control measures and reporting have been in line with trust and national requirements with DIPC oversight.

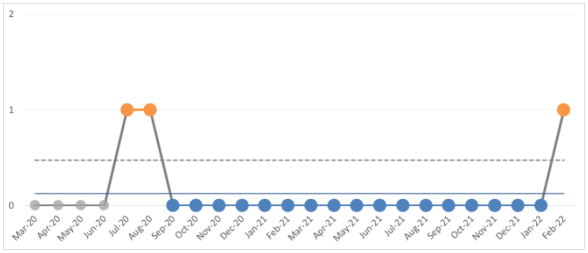
Safe Care - Infection Control

East Sussex Healthcare NHS Trust

Author: Lisa Redmond – Head of Infection Control & Deputy DIPC

Quality and Safety

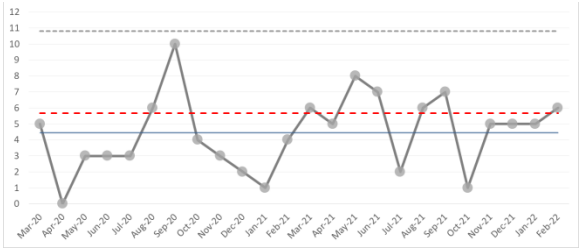
MRSA cases



Variation: Normal
Current Month: 1

MRSA bacteraemia (MRSA)
There was one MRSA bacteraemia reported in February. Source found to be Osteomyelitis. Assessed as an unavoidable infection. Patient has a history of MRSA.

CDIFF cases

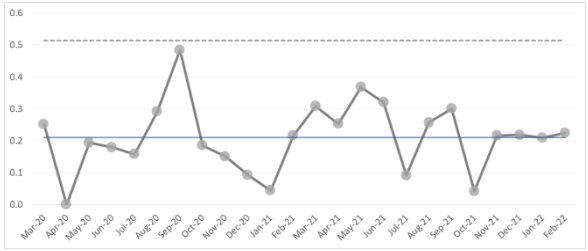


Limit: 5.66
Variation: Normal
Current Month: 6

Clostridium Difficile Infection (CDI)
For the month of February, 6 cases of CDI were reported against a monthly limit of 5. Four cases were reported as HOHA (Hospital Onset Healthcare Associated) and 2 cases reported as COHA (Community Onset Healthcare Associated). There is no evidence of any outbreaks.

The year end position was 65 cases against an internal limit of 58 with Post Infection Reviews underway reporting to Trust Infection Prevention Control Group (TIPG) and QSC. Unfortunately high numbers in Q1 and Q2 made it very difficult to recover the position.

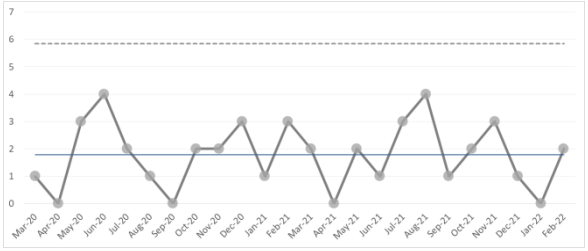
CDIFF per 1000 bed days



Variation: Normal
Current Month: 0.2

National reporting of CDI per 1,000 bed days remains suspended to reflect organisations need to flex bed numbers during the pandemic.

MSSA



Variation: Normal
Current Month: 2

<u>MSSA</u> bacteraemia
There were 2 Trust attributable MSSA bacteraemias reported in February. One assessed as potentially avoidable relating to line infection. Line removed and patient treated with antibiotics.
Second case of an unknown source. Patient treated with antibiotics.

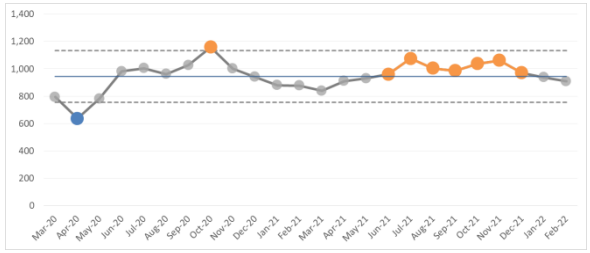
Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

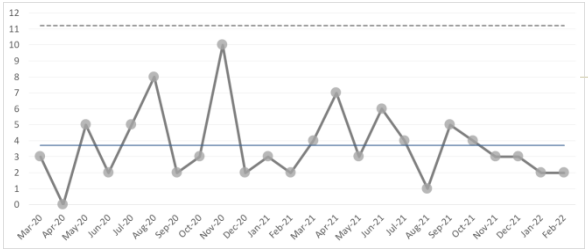
Author:	**Margaret England – Head of Governance**
Status Report	Of the 909 incidents reported – 777 were **ESHT only** incidents with: • Severity 1 None/Near Miss - 577 • Severity 2 Minor - 187 • Severity 3 Moderate - 12 • Severity 4 Major - 0 • Severity 5 Catastrophic – 1 (HSIB ref) **Top four locations**: Patients Home - 49 Emergency dept Conquest – 42 Acute Medical Unit Eastbourne - 34 Emergency dept EDGH – 30 **Top categories:** Slips Trips and Falls - 123 Diagnosis and Diagnostic Services - 110 Medication Errors and Other Medication Related Incidents - 96 Antenatal, Labour and Post Natal Care - 66 **There was 1 Never Event and 1 SI reported in February 2022 :** • 1 x Mis-selection of high strength Midazolam during conscious sedation – Never Event • 1 x Maternity SI reported referred to HSIB.
Challenge & Risk:	Work is underway to reduce the number of open SIs. As discussed at QSC there is slow progress with the Implementation of PSIRF*, particularly re: education within divisions relating to formal investigation methodology. The Trust is required to recruit Patient Safety Partners. Further national guidance is anticipated in Spring/Summer 2022 - a meeting with an early adopter site in the South is imminent. *Patient Safety Incident Response Framework
Actions:	Meetings have been arranged with each SI investigator to expedite closure. HSIB investigation training will become available but places are limited & divisions are being asked to identify staff in readiness for booking.

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



Variation Normal
Current Month: 909

Serious Incidents (SIs) (Incidents recorded on Datix)



Variation: Normal
Current Month: 2

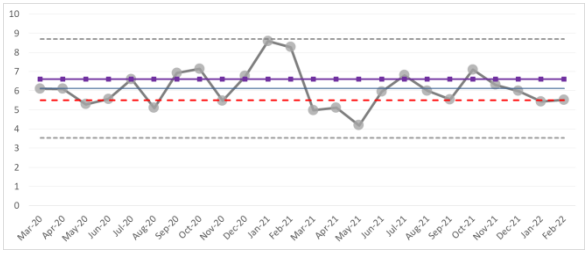
Safe Care – Falls

East Sussex Healthcare NHS Trust

Quality and Safety

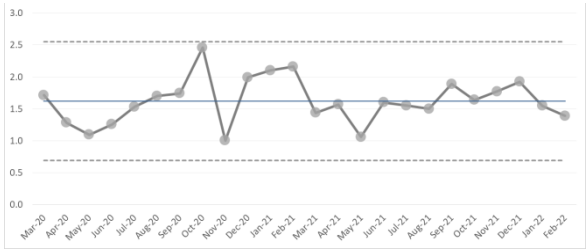
Total Falls Per 1,000 bed days

RCP National Average: 6.6
(RCP – Royal College of Physicians)
Variation: Normal
Current Month: 5.5



Falls with Harm Per 1,000 bed days

Variation: Normal
Current Month: 1.4



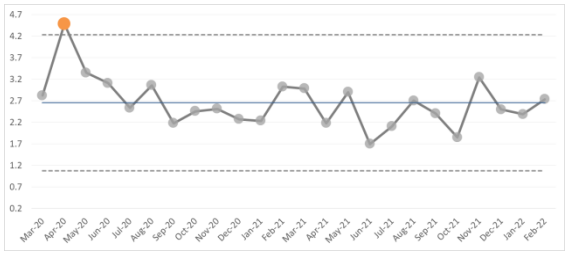
Author:	**Margaret England – Head of Governance**
Status Report	The falls rate per 1,000 bed days was the same with the rate remaining below the last RCP average. There were no severity 4 falls reported during Feb. **Top reporting locations were:** • Irvine Unit • Glynde Ward • Jevington Ward • Macdonald Ward • Acute Medical Unit
Challenge & Risk:	The continued significant additional capacity open and it's impact on nurse staffing is likely to have an impact on falls especially for higher risk patients many of whom require enhanced observation (1:1 care) or two staff to help with mobility. More granular data is required for incidents reported as falls but not necessarily so, especially in rehab areas. This includes faints/syncopal events and those patients assisted to the floor. There will be a focus on areas with the highest rates of "true" falls to see what else can be done in terms of prevention noting the ongoing workforce challenges.
Actions:	• Recruitment continues for surge areas and resulting vacancies on other wards due to internal movement of staff. • Report went to QSC re: controlled and assisted falls

Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

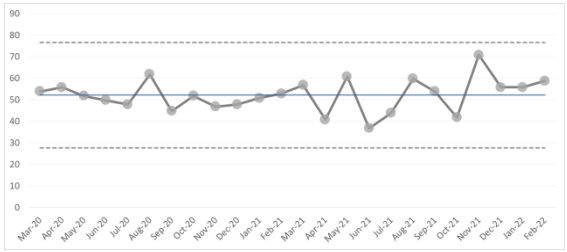
Quality and Safety

Pressure Ulcers (PUs) Per 1,000 bed days (Grade 2,3,4)



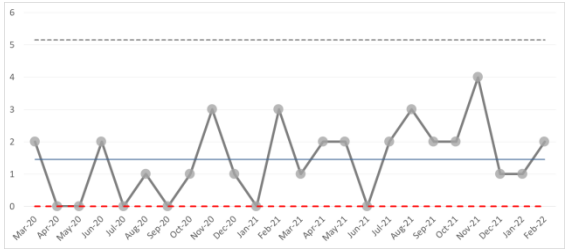
Variation: Normal
Current Month: 2.7

Pressure Ulcers Category 2 (inpatient and community)



Variation: Normal
Current Month: 59

Pressure Ulcers Category 3&4



Variation: Normal
Current Month: 2

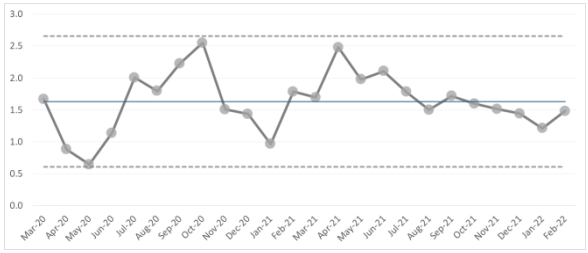
Author:	**Tina Lloyd, Assistant Director of Nursing - Corporate**
Status Report	A deep dive was undertaken into the increases in cases (esp. Cat 2 damage) in November 2021 including a cluster of cases in the community setting. The findings & recommendations were reported to the Patient Safety & Quality Group and the Quality & Safety Committee in March 2022. No specific themes or concerns were noted. Despite the ongoing & significant increase in bed numbers, occupancy & staffing shortfalls, the rate of PUs reported remains largely static, which is a credit to our hardworking teams. Two category 3 PUs were reported in February; one in the community setting and one at the Conquest. Both are subject to full Root Cause Analysis (RCA) investigations and will report to the PURG. Of those audited, the compliance of completed PU assessments was a steady 95.1%%.
Challenge & Risk:	Sustained, increased operational pressures associated with the ongoing requirement for additional surge and escalation wards, service demands in response to Covid 19 & significant staff sickness continue to challenge all areas.
Actions:	Review of PU reporting to separate damage that occurs in our bedded units from in the community setting. This was a recommendation from the Deep Dive of category 2 damage which occurred in Nov and will help detect trends in the different care settings in future (care homes and patients own homes) and where there were no contributory lapses.

What patients are telling us?

East Sussex Healthcare NHS Trust

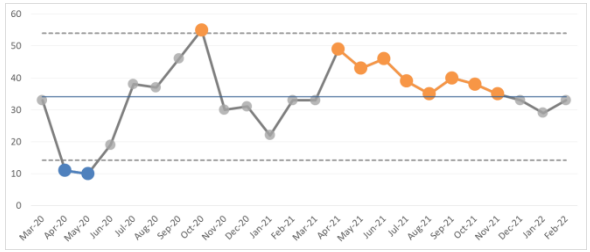
Quality and Safety

Complaints Received per 1,000 bed days



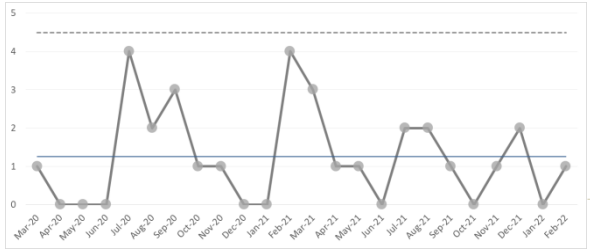
Variation: Normal
Current Month: 1.5

Total Complaints Received



Variation: Normal
Current Month: 33

PHSO contacts



Monitoring
Variation: Normal
Current Month: 1

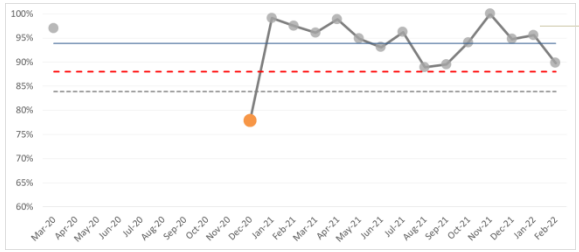
Author:	**Amy Pain- Patient Experience Lead**
Status Report	There were 69 open complaints at the end of February, which is an increase of 3 compared to January. In February, the top three primary complaint subjects were: • Standard of Care =16 (January =15) • Communication =6 (January= 3) • Patient Pathway =5 (January =5) **Top complaint locations:** • Emergency Departments totalled 6 (CQ =2 & EDGH =4) • Acute Assessment Unit (2) • Frailty Unit (2) The remaining complaints were spread over 22 other locations. The Trust received one contact from the Parliamentary & Health Service Ombudsmen (PHSO) in February. This was to confirm that following receipt of our files, they would not be investigating a case they had previously been considering. 616 Patient Advice & Liaison Service (PALS) contacts were received in February which is an increase compared to January (550 contacts). In February, compliance with the three day acknowledgment standard for new complaints was 100%. Compliance with complaint response times deteriorated in February due to ongoing operational/clinical and workforce pressures. The overall response rate for February was 38%. For 35 working days = 36% and 50 working days = 50%. The January overall response rate was 78%. The trust received 1,719 compliments in February and 33 complaints. 11 complaints were reopened in February as complainants were unhappy and/or had additional questions/concerns. There was 8 overdue complaints at the end of February - the oldest complaint was 23 days overdue.
Challenge & Risk:	Ongoing operational/workforce pressures affecting response times.
Actions:	Ongoing monitoring and discussions in divisional Integrated Performance Report Meetings.

What patients are telling us?

East Sussex Healthcare NHS Trust

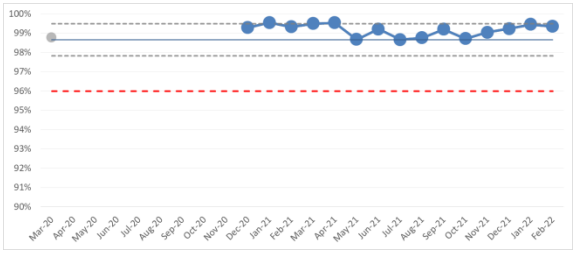
Quality and Safety

F&FT – A&E Score



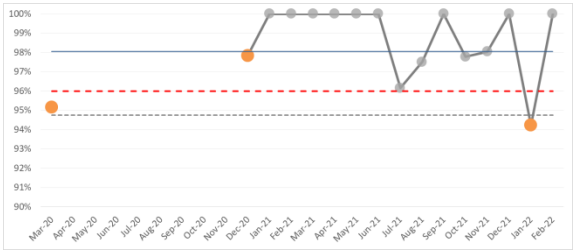
Variation: Normal
Current Month: 89.8%

F&FT – Inpatient Score



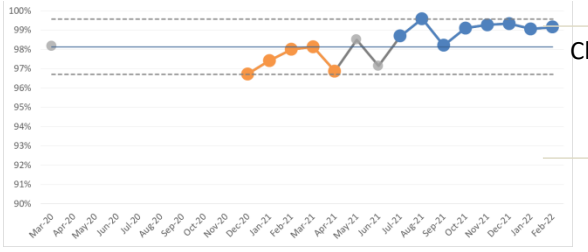
Variation: Improvement
Current Month: 99.5%

F&FT – Maternity Score



Variation: Normal
Current Month: 100%

F&FT – Outpatient Score



Variation: Normal
Current Month: 99.2%

Author: **Amy Pain - Patient Experience Lead**

Status Report

The total number of Family & Friend Tests (FFT) surveys returned in February was 1,914, this is a small increase compared to January =1,837. Response rates were affected by the sustained pressures.

The positive recommendation rates for February, compared to the most recent data released by NHSE (January) continue to be higher than the national average as follows:

Inpatient - 99.34% (national average in January 94%)
A&E – 89.80% (national average in January 80%)
Maternity - 100% (national average in January 94%)
Outpatients – 99.15% (national average in January 93%)

February's top scoring questions:

- Were you always treated with kindness? 99.66% (593 responses)*
- Did you feel the staff responded appropriately to any questions or concerns you raised? 97.14% (591 responses)
- Did all staff have a smiling and friendly approach? 98.65% (592 responses)

*November ,December and January reported this question within the top 3.

February lower scoring questions were the same as November, December and January:

- Do you know who to contact if your condition deteriorates? 90.11% (566 responses)
- Did you feel involved in decisions about your discharge from hospital? 94.53% (585 responses)
- Were you given enough notice about when you were going to be discharged from hospital? 95.52% (580 responses)

Challenge & Risk:

Both A&E's continued to face considerable pressures with crowding and longer waits at times.
With the launch of the new software InPhase , it is hoped the offer of completing the survey on a digital platform will increase the response rate.

Actions:

To work with clinical areas to encourage the completion of surveys and to identify areas for improvement and share positive feedback.

Effective Care – Nursing & Midwifery Workforce

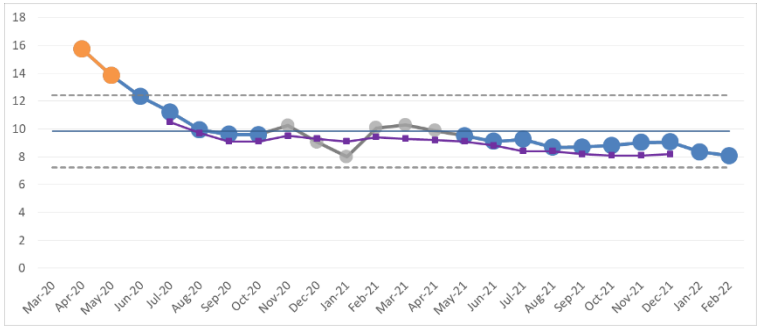
East Sussex Healthcare NHS Trust

Quality and Safety

Author: **Angela Colosi, Assistant Director of Nursing – Corporate**

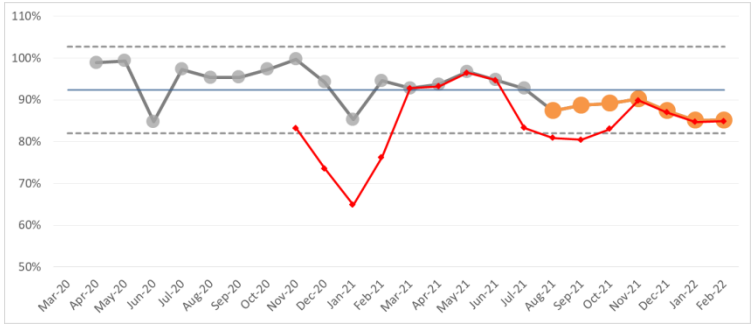
Status Report

CHPPD (Trust)



National Median: 8.2
Variation: Normal
Current Month: 8.1

Staff Fill Rate (total)



Current Month: 85.1%
Incl. escalation: 84.9%

*CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight.

Care Hours per Patient Day (CHPPD*)

December 2021's national benchmark data (latest available) reported peers as 7.9 and national median at 8.2 with ESHT at 9.1. ESHT's CHPPD shows a stable trend with overall rate of 8.1 in February 2022. Work is ongoing to determine if all trusts report in the same way as this affects peer and median comparison.

Higher acuity areas skew the overall average e.g. Critical Care EDGH @46.1, CCU @14.1, Paeds @ 12.3 and Special Care Baby Unit (SCBU) @17.8.

Ward level breakdown is discussed in the Safer Staffing report at Patient Safety & Quality Group with some significant variation across wards and units with 20 out of 37 areas under 8.0 in February.

Staff Fill Rate

February's fill rate against the planned budgeted establishment for nursing overall was 85.1% noting some variation across wards. Bays on various wards were closed in the month due to COVID. Significant surge and additional escalation capacity remained open for medical patients on Devonshire, Glynde, Polegate, Murray and Littlington, with an extra bay open on Seaford and beds in SDEC at EDGH.

The fill rate including the escalation areas was 84.9% (red line) but this only represents the additional unfunded Polegate beds (30) which were also affected by Covid. It is not possible to separate the additional beds used on existing wards such as Murray, Seaford, SDEC etc. Therefore the additional staffing on these areas may artificially over state the fill rate. Additional duties created are also not currently included in this data so it does not include the extra Infection Prevention & Control (IPC) requirement for 'red' areas and 1:1 interventions. There is a gap between the top & bottom line on the chart on the left during the summer months as Devonshire and Glynde were unfunded at that time.

Challenge & Risk:

Staff absences continued to be high through February 2022 and at the time of writing this report.

Ensuring appropriate skill mix is a challenge when there are such high numbers of supernumerary staff that need support.

Actions:

- Continued international nurse and 'New to Care' HCSWs recruitment
- Twice daily staffing reviews to ensure risk is mitigated as much as possible.

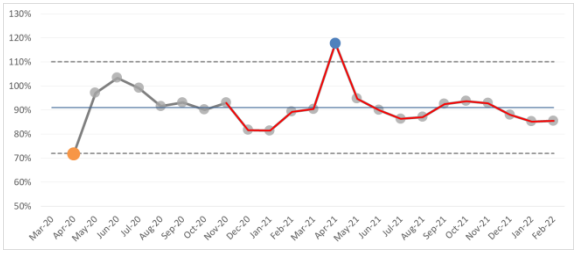
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

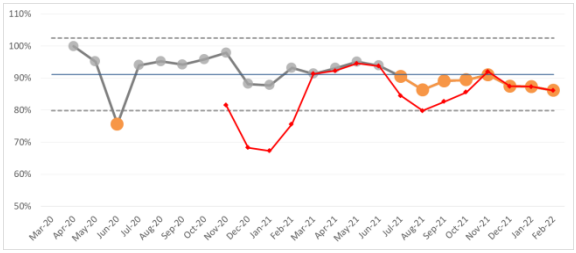
Staff Fill Rate (Bexhill)

Variation: Normal
Current Month: 85.5%
Incl. escalation: 85.5%



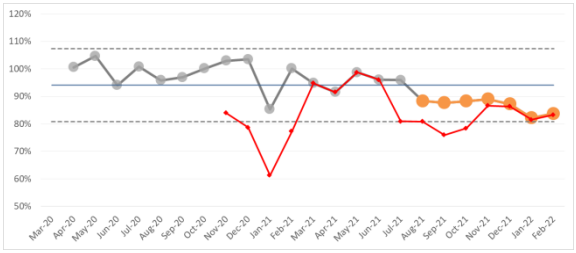
Staff Fill Rate (Conquest)

Variation: Normal
Current Month 86.1%
Incl. escalation:86.1%



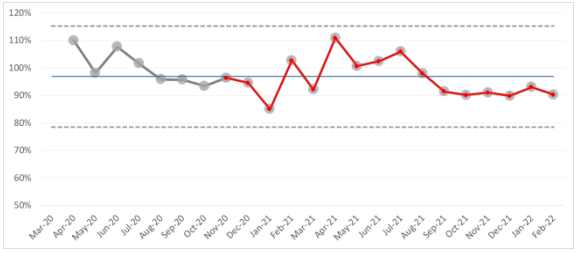
Staff Fill Rate (Eastbourne DGH)

Variation: Normal
Current Month: 83.8%
Incl. escalation: 83.3%



Staff Fill Rate (Rye Memorial)

Variation: Normal
Current Month: 90.3%
Incl. escalation: 90.3%



Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	EDGH and Conquest acute hospital data does not fully represent the impact of the extra areas that are open as only Polegate at EDGH is captured as an extra unfunded area for February with funding available for Glynde and Devonshire as Winter surge until the end of March 2022. In addition, Murray ward escalation beds are also funded (as part of the ward) and therefore not included in the red line. Fill rates at Bexhill remained stable during February and Rye has also remained relatively stable. There were/are no escalation beds at either community hospital now as they are funded for 54 and 19 beds respectively to facilitate rehabilitation and care of patients who are non weight bearing.
Challenge & Risk:	As the majority of additional capacity is at EDGH, the fill rates are lower there with daily challenges in most areas. With the workforce so stretched, it is very difficult for staff to be able to undertake all of the clinical and non clinical elements of care such as indirect care, complaints, RCA investigations, some elements of documentation and certain aspects of flow/discharge.
Actions:	The additional twice daily staffing meetings were re introduced when staffing was most challenged in February and these are ongoing. Corporate senior nurse support is offered with difficult decisions on best use of staffing resources with competing clinical demands.

Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

Author:	**Vikki Carruth, Chief Nurse**
Status Report	Amongst other metrics, the reporting of Red Flags (via SafeCare) by nursing staff has increased/improved since the SafeCare Lead Nurse has been in post and will now be included in a more detailed Safe Staffing for Nursing report presenting to the Q&SC going forward. There are **9 Red Flag categories** including; • Nurse in Charge cover • 2 RNs or less on duty • Shortfall in RN time • Skill mix concerns • Vital signs not assessed or recorded • Missed intentional rounding • Unplanned omission in medications • Delay in providing pain relief • ED specific category re ENP cover In addition, more information regarding; • RN skill mix • Unfilled duties • Bank and Agency usage • Annual Leave management and • Total Unavailability will also be provided in the new, updated report.
Challenge & Risk:	The process for booking International Nurse their places to sit their Objective Structured Clinical Examinations (OSCEs) post induction causes delays in them gaining full UK registration which means that they remain as supernumerary members of staff.
Actions:	Continued education and compliance sessions supported by the SafeCare Lead Nurse and Heads of Nursing. Divisions to ensure that required additional shifts are sent in plenty of time for TWS to be able to source staff to fill the shifts. Escalation to the national team to support timely booking of OSCEs for the International Nurse recruits.

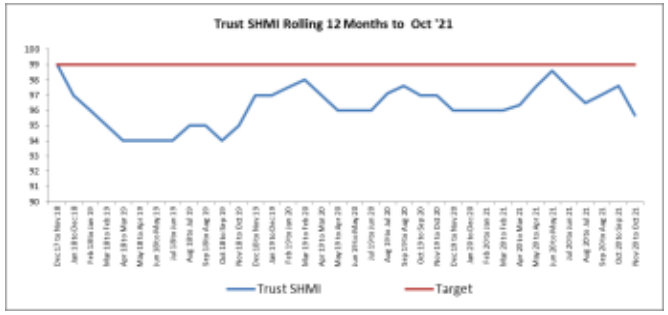
Effective Care - Mortality

East Sussex Healthcare NHS Trust

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

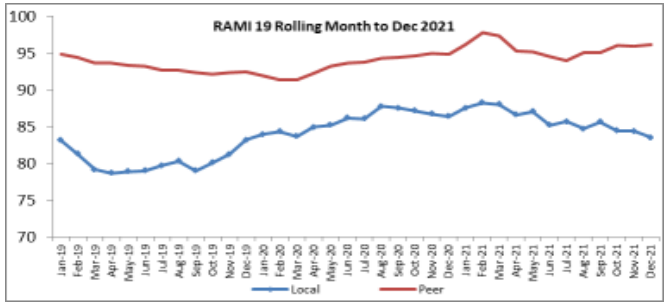
Summary Hospital Mortality Indicator (SHMI)

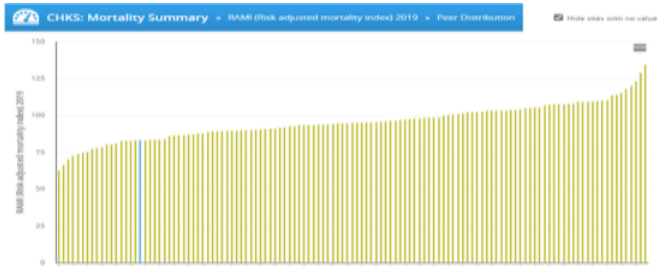
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – November 2020 to October 2021 is showing an index of 0.96. SHMI remains higher at Conquest .
- RAMI 19 – January 2021 to December 2021 (rolling 12 months) is 83 compared to 86 for the same period last year. December 2020 to November 2021 was 84.
- RAMI 19 was 84 for the month of December and 85 for November. Peer value was 103 for December.
- Crude mortality without confirmed or suspected covid-19 shows January 2021 to December 2021 at 1.41% compared to 1.57% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 77% for January 2022 deaths compared to 72% for December 2021 deaths.

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





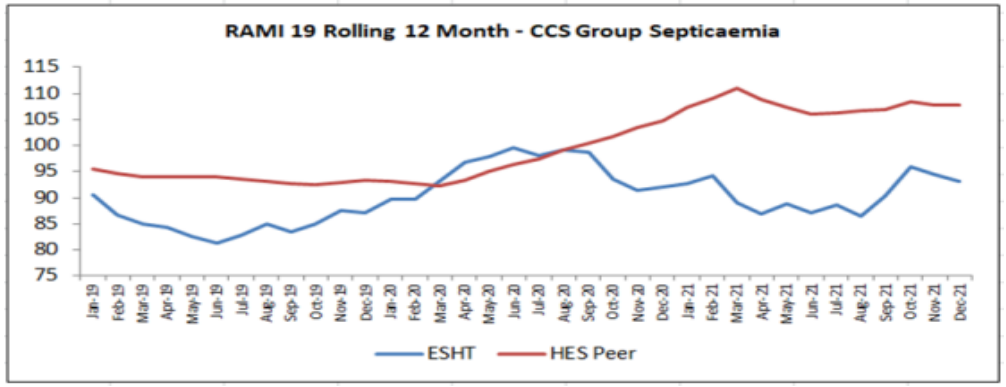
RAMI v Peer

This shows our position nationally against other acute trusts - currently 18/123

***February 2022 Main Cause of In-Hospital Death Groups (ESHT)**

Sepsis/Septicaemia	29
Pneumonia	21
Cancer	14
Heart Failure	11
COVID-19	10
Community-acquired Pneumonia	7
Cerebro-vascular Incident	6
Myocardial Infarction (MI)	5
Bowel Obstruction	3
Dementia	3
Hospital-acquired Pneumonia	3
Liver Disease	2
Acute Kidney Injury (AKI)	1

There were 10 COVID-19 related deaths in February and 14 in January.



There are:

29 cases which did not fall into these groups and have been entered as 'Other not specified'.

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

Our People – Our Staff

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

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Vacancy rate** has reduced by 0.8% to 8.0%. **Current vacancies** are showing as 604.2 ftes **Monthly sickness** has reduced by 0.4% to 6.6%	**Annual turnover** unchanged at 11.1%, reflecting 715.4 fte leavers in the rolling 12 months **Annual sickness** has increased by 0.1% to 5.4%. **Mandatory Training** rate has reduced 1.0% to 88.5% **Appraisal** compliance has reduced by 0.9% to 75.7%	 **Steve Aumayer** Chief People Officer

Overview:

Although the monthly sickness rate fell by 0.4% in Feb, to 6.6%, this is still a historically high level of sickness (rate in Feb 21 at the tail end of Covid #Wave 2 was 4.0%) and thus the annual sickness rate has increased to its highest level, in the last two years, of 5.4%. Moreover, the impact of Omicron appears to be continuing with a new peak in staff absences, on 11th Mar, of 196 staff absences due to Covid. Covid sickness has been trending at an average of 133 headcount since the start of Mar compared to an average of 116 for Feb.

Substantive staff numbers increased this month due to successful recruitment, including New to Care, Healthcare Support Workers. Overall, there were 118.1 fte starters and 50.1 fte leavers, a net impact of +68.0 ftes. The Trust turnover rate remained at 11.1%. One of the noted reasons for leavers is end of fixed term contracts. If we remove those planned leavers, our turnover rates reduce to 10.6% for this year.

Our vacancy rate continues to reduce, as vacancies are filled, down this month by a further 0.8% to 8.0%, which equates to 604.2 fte vacancies, a reduction of 61.7 since last month. Vacancy rates are highest amongst Additional Clinical Services staff (largely healthcare assistants & therapy helpers) at 15.4% (259.3 fte vacancies) and Registered Nurses & Midwives at 11.9% (280.8 fte vacancies). Medical & Dental vacancy rate was 9.5% (67.8 fte vacancies)

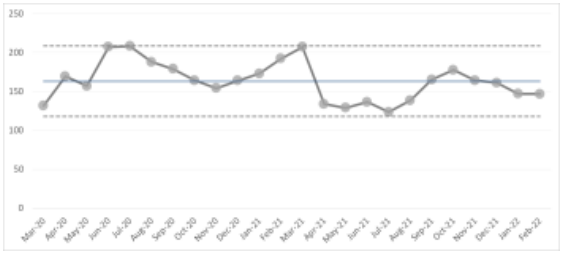
The Trust reliance on temporary workers remains high due to activity demands and the increase in staff sickness due to the Omicron variant. Agency & bank supply are unable to respond to the level of demand; neither Tier 1 or Tier 2 agencies have been able to respond. Off-framework supply is minimal. An additional 3 Framework agencies have been engaged

The requirement for mandated staff vaccines remains on hold pending further consultation.

Workforce – Contract type

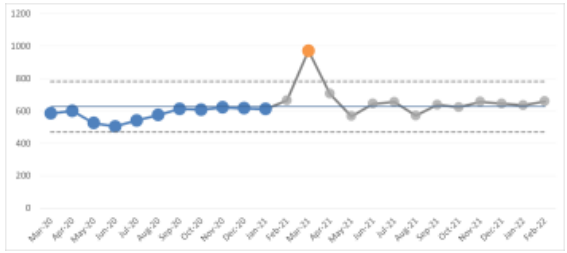
East Sussex Healthcare NHS Trust

Agency FTE Usage



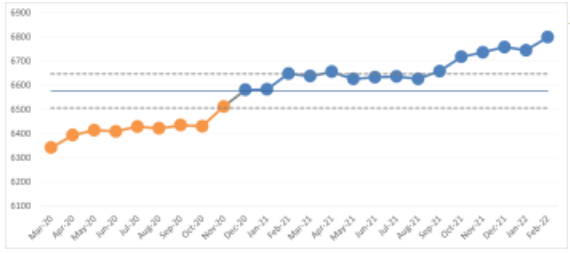
Current Month: 146.7

Bank FTE Usage



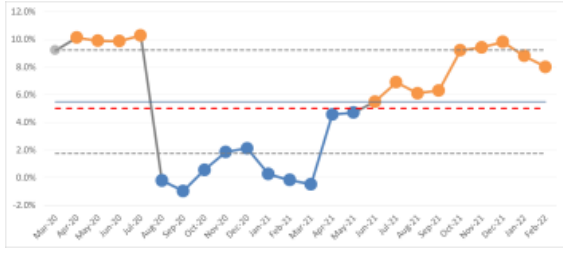
Current Month: 658.9

Substantive FTE Usage



Current Month: 6,798.8

Vacancy Rate



Target: 5%
Current Month: 8.0%

Author: Greig Woodfield

Status Report: Substantive usage increased 54.2 ftes and bank usage increased by 23.6 ftes whilst agency fte usage decreased by -0.2 ftes. Vacancy rate reduced by 0.8% to 8.0% due to successful recruitment. .

Demand has continued to remain high for Feb across all work groups, particularly Nursing, HCA and Emergency Medicine.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	67.8	64	56.2	80
Reg Nurse	280.8	159.2	128.6	75
Addit Clin Serv	259.3	156.6	97.8	58
AHP	10.2	91.1	51.4	60
Prof, Sci, Tech	-5.3	1	4.6	79
Healthcare Scs	3.6	25.2	12	54
A&C	14.6	99	62.7	57
Est & Ancillary	7.8	28.3	47.2	72
Trust	**604.2**	**624.4**	**460.5**	**66.87**

Challenge & Risk: Unestablished escalation wards and additional services remain a significant pressure for TWS and has contributed to the increase in agency use within the nursing group.

Patient Safety & Quality - agency & bank supply are unable to respond to the level of demand; neither Tier 1 or Tier 2 agencies have been able to respond. Off-framework supply is minimal.
Financial - increase in cost due to the increase of procurement of high cost framework and off framework agencies

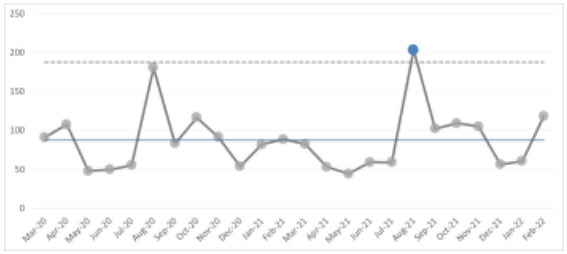
Actions: Data is now available at roster level which means that services can analyse and review spikes in demand. This is currently limited to Agenda for Change but is due for roll out to Medical & Dental rosters in the next month

TWS continues to run an active recruitment campaign with c200 applicants in pipeline .Focus for the next month is increasing bank staff numbers to address the demand. An additional 3 Framework agencies have been engaged

Workforce - Churn

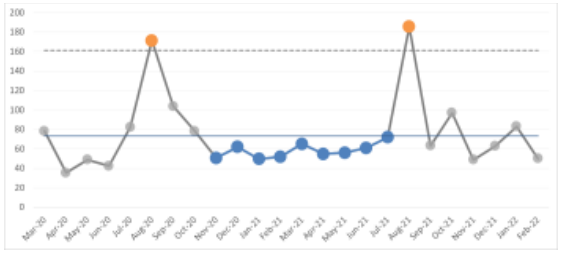
East Sussex Healthcare NHS Trust

Starters FTE



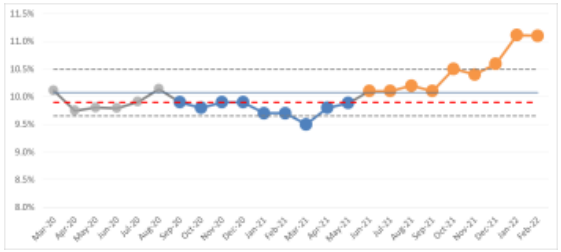
Current Month: 118.1

Leavers FTE



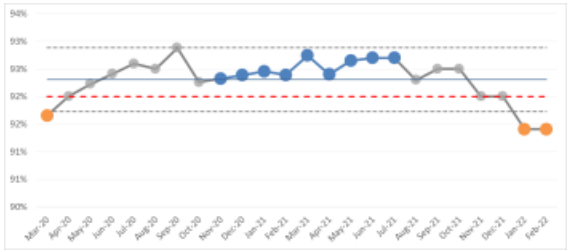
Current Month: 50.1

Annual Turnover Rate



Target: 9.9%
Current Month: 11.1%

Retention Rate



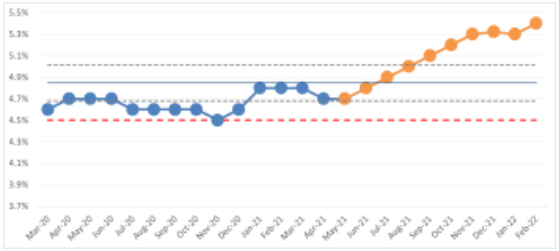
Target: 92%
Current Month: 91.4%

Author:	David Moulder & Greig Woodfield
Status Report	The Trust starters & leavers monthly net total as at Feb 22 is +67.9 with 118.1 starters fte and -50.1 leavers fte. Over the last 12 months there was 1,052.5 Starters fte & -899.4 leavers fte giving a net total of 153.1. The Trust turnover rate is unchanged at 11.1%. There were 715.4 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) is also unchanged at 91.4%.
Challenge & Risk:	Staff peak retirement usually occurs in Dec or Mar, however, we may see an increase in this due to Covid pressures. Recruitment activity continues to remain high year on year with c.700 actions currently underway on TRAC. Activity around Health Visitors/CHIC/Spire, New to Care and Kickstart programme Covid /Travel restrictions continue to effect some international travel which impacts on overall Trust Time To Hire (TTH). Some delays still remain with visa applications at source countries due to volume. Despite success with continued targeting of "hard to recruit" posts, areas of focus remain e.g. Consultants for various posts; Cardiology,, Acute Medicine, Respiratory and Care of the Elderly. Recruitment activity focused around Theatre ODPs. Sonographers, Radiographers Dietitians and Community Nurses as well as UTC and A&E
Actions:	There is a strong pipeline of international nurses in place. A further 34 nurses arrived in Feb with an additional cohort of c20 due in Mar and April There will also be c6 Radiographers due. Sonographers sourced through two agencies with interviews on the 22nd Mar Continued campaigns with external recruitment agencies to provide Theatre ODPs. Hard to recruit medical posts are with Medacs and other additional agencies, as required. Targeted phased approach to filling medical posts. Major campaigns for CHIC UTC and Emergency Medicine are underway. Scoping of Trac functionality being examined to reduce overall Trust TTHT

Workforce - Sickness

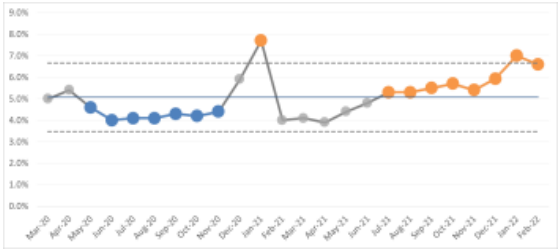
East Sussex Healthcare NHS Trust

Annual Sickness



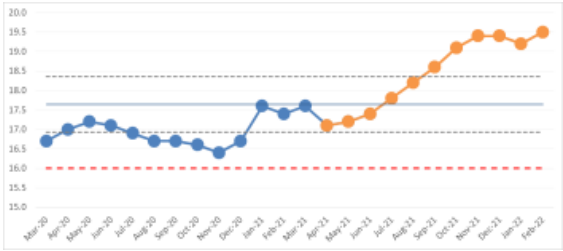
Target: 4.5%
Current Month: 5.4%

Monthly Sickness



Current Month: 6.6%

Average sickness Days per FTE



Target: 16
Current Month: 19.5

Author:	David Moulder, Julie Hales
Status Report	Monthly sickness % for Feb reduced by 0.4% to 6.6%. This is higher than the monthly rate for Feb 21, however, and, consequently, the annual sickness rate has increased by 0.1% to 5.4%, the highest it has been in the last two years. There has been a worrying increase in Covid sickness in the w/c 7th Mar. Hitting a new peak, for wave #3 of 196 staff on 11th Mar. (compared to a peak of 237 for wave #2 on 22nd Jan 21). Overall, there were 497 staff absent due to all types of sickness, another new peak for this wave (compared to a peak of 540 for wave #2 on 22nd Jan). Covid sickness has been trending at an average of 133 headcount since the start of Mar compared to an average of 116 for Feb. Sickness average is 19.5 days per fte, an increase of 0.3 from last month.
Challenge & Risk:	Higher levels of Covid absence and isolating staff have given cause for concern with the more highly infectious Omicron variant putting further pressures on staffing.
Actions:	Although VCOD is no longer to be enforced, the Trust encourage managers to hold informal conversations with unvaccinated staff. Occ Health continue to offer short term psychological interventions and ensure support is available. We are identifying trends and targeting support; looking at reasonable adjustments ensuring managers are fully trained in supporting attendance. Utilising training available along with TRIM practitioners to prevent longer term stress and anxiety.

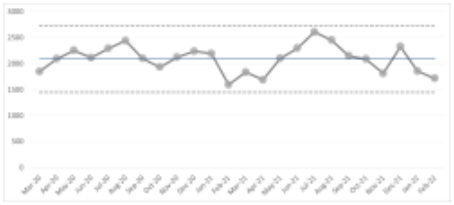
Workforce - Sickness

East Sussex Healthcare NHS Trust

Author: David Moulder; Julie Hales

Status Report

Anxiety/Stress/Depression



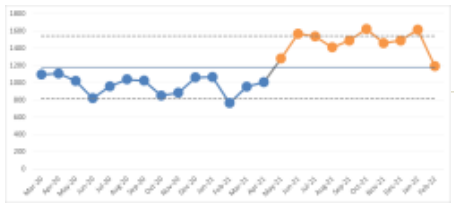
Back Problems

Chest & Respiratory Problems

Cough, Cold & Flu

Gastro-intestinal Problems

Other MSK problems



Reason		fte Days Lost +/-	Total fte Days Lost
Anxiety, stress & depression	▼	-139.8	1,713.6
Back problems	▲	+36.2	665.9
Chest & respiratory	▼	-866.3	4,709.5
Cold, cough & flu	▼	-107.8	624.3
Gastrointestinal	▼	-58.14	582.6
Other MSK problems	▼	-424.1	1,187.8
Other reasons	▼	-569.6	3,244.3
All reasons	▼	-2,129.5	12,728.0

Challenge & Risk:

The high level of Chest & respiratory illnesses is reflective of the high levels of Omicron sickness; staff in many cases are remaining off for longer periods. Whilst the guidelines for isolation are now a reduced number of days, the availability of staff continues to cause an increased pressure on the remaining staff.

Actions:

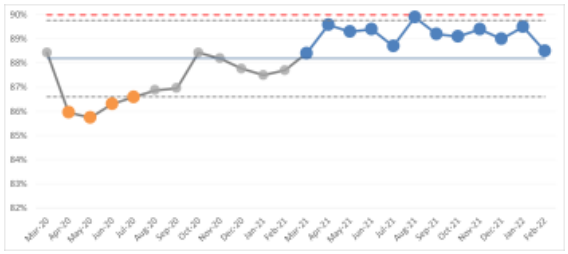
Whilst we have seen a decrease in absence due to stress & anxiety, the continued pressure for staff is a concern. Wellbeing conversations are being launched in Mar in line with the NHS People Plan and this, in turn, will give a more holistic view of the wellbeing of our staff.

As absence with Long COVID continues we are now moving colleagues to follow the Trust Attendance Management procedure and where appropriate longer phased returns, potential for redeployment or Ill Health Retirement is considered.

Workforce - Compliance

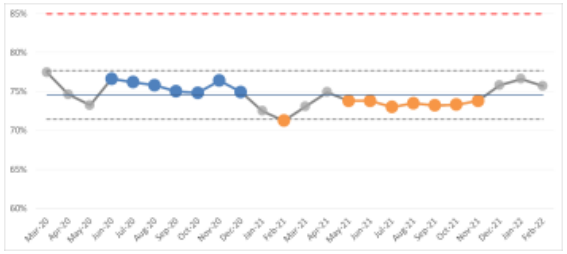
East Sussex Healthcare NHS Trust

Mandatory Training Compliance



Target: 90%
Current Month: 88.5%

Appraisal Rate



Target: 85%
Current Month: 75.7%

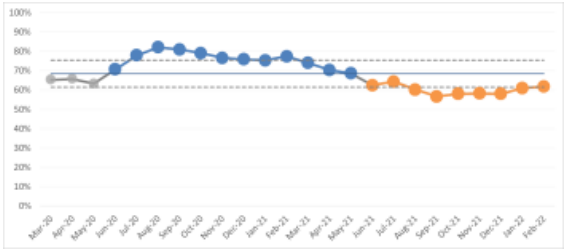
Author:	Dawn Urquhart
Status Report	Compliance for this month disappointingly fell by 1.0% to 88.5% and is perhaps an indicator of the continued service pressures that are affecting the Trust. Appraisal compliance also decreased by -0.9% to 75.7%. A specific ED OSCE Bootcamp has been developed and will be implemented next month with the next cohort of over 30 International Nurses. This has been a collaborative initiative between Integrated Education and ED Senior personnel. In addition, discussions will commence with the Community team to explore a Community Bootcamp. An immediate issue is resolving how International Nurses in the cohort can secure UK driving licenses. We have undertaken three New to Care Inductions and have supported approximately 20 New to Care HCSW's to work in the Trust. With NHSE/I funding we have recruited one additional Band 6 Clinical Educator and will be interviewing two potential HCSW educator assistants to support them. A meeting has taken place with the UoB following the end of the consultation on the withdrawal of the University from the Eastbourne campus .
Challenge & Risk:	The full impact of the withdrawal of the UoB has yet to be fully scoped and will impact on cohort size, placements, funding, travel & local recruitment Lack of capacity, nationally, to support the OSCE exams. Taken with the decision by the NMC to withdraw temporary registration soon and the mandatory requirement that International Nurses need a full time role within 8 months, is causing real concern that the system is not coping. Ongoing impacts of the operational status of the Trust (including future Covid outbreaks) will continue to impact on Trust CST/Appraisal compliance for the rest of the year impeding the Trust in achieving the 90% target.
Actions:	The issue of the OSCE capacity has been escalated to the NMC and at NHSE/I national meetings regarding international Nurses as a significant concern. We will be meeting with the UoB again in late Mar 22. We are working to the Trusts COVID footprint to begin the offer of more face to face education and training.

Workforce – Job Planning

East Sussex Healthcare NHS Trust

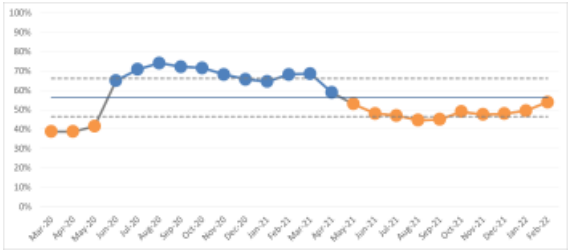
Consultant eJob-Planning Fully Approved Rate

Current Month: 61.8%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 53.9%



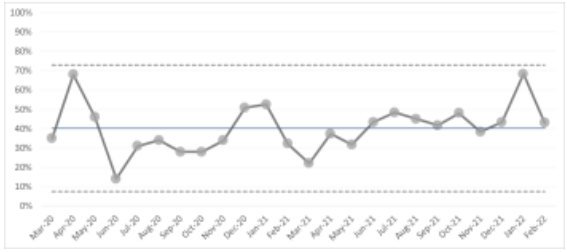
Author:	Joanne Penfold
Status Report	The overall medical job plan approval rate is 60%. 160 of 259 Consultants have a completed eJob Plan (61.8%) and 55 of 102 SAS Doctors have a completed eJob Plan (53.9%).
Challenge & Risk:	We are currently in the review period for job planning from Jan-Mar and Specialties are being encouraged to review job plans as part of their business planning process, with a view to starting the job plans on the 1st Apr 22.
Actions:	A new version of the job planning software is being launched by Allocate. This will have additional features, and benefits for users. Allocate are providing training at the point of the version release, and the Job Planning team will provide sessions to key users.

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

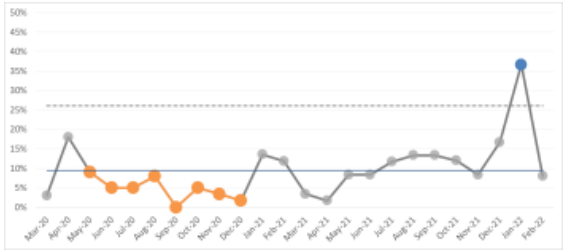
6 week Nursing Management Roster Approval Rate

Current Month: 43.0%



8 week Nursing Management Roster Approval Rate

Current Month: 8.0%



Author:	Penny Wright; David Moulder
Status Report	Roster approval rates at 6 & 8 weeks have reduced in Feb. Jan. For the roster starting on 24th Jane, 43% of rosters had been approved at 6 weeks before the go live date which is a 25% reduction on the previous month, whilst 8% had been approved at 8 weeks prior to commencement which is a reduction increase of 29%.
Challenge & Risk:	There are opportunities to improve effective planning to, in turn, drive efficient deployment of staff. Lower roster approval rates are linked with late requests for TWS support. This means probability for filling shifts becomes lower and has implications for patient safety and staff morale.
Actions:	The new Nursing Deployment dashboard continues to be shared with senior nurse leaders and is updated and issued fortnightly.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Summary

East Sussex Healthcare NHS Trust

Access and Responsiveness

	Positives	Challenges & Risks	Author
Responsive	The Trust achieved the Elective Recovery target in February. Delivering over 91% of RTT clock stop activity compared to the 2019/20 baseline, with the target being 89%. There were no reported 78 or 104 week waiting patients and the Trust continued to reduce the amount of patients waiting over 52 weeks. The Trust continues to deliver > 100% of diagnostic activity compared to 2019/20. And although not yet compliant with the DM01 standard, this is a steadily improving month on month and anticipated to deliver substantively when the Community Diagnostic Centre opens in August. The 28 day Cancer FDS standard will again be achieved in February. The backlog of patients over 104 days is ahead of the Trust's internal trajectory	ED Performance: February was another challenging month for our emergency departments. Treating an overall average of 75% of our patients within the 4 hour standard. Workforce challenges remain, as well as high levels of exit blocks throughout our wards. Low discharges and limited access to social care beds Escalation Wards: The Trust is working on introducing virtual wards and remote monitoring to help reduce the use of escalation wards and increase flow. But currently, we are still utilising all escalation beds which is stretching workforce further and because of challenges in the social care market, hindering our ability to discharge patients on pathways 1 – 3. This impacts on our workforce, ability to create flow and stream patients through from our emergency departments efficiently Cancer: The Trust did deliver against the 28 day FDS standard and has reduced the number of patients on the 104 backlog. However, we are still not compliant with the 62 day standard and this needs to continue to be a focused piece of work for divisions to deliver this target Community Paediatrics: Demand continues to outweigh capacity and results in a growing waiting list. This is a key risk for the Trust which we are actively trying to address with the introduction of a Paediatric Hub at EDGH and a review of pathways. As well as recruitment to doctor and child development nursing posts to fill the capacity gap.	 **Tara Argent** Chief Operating Officer

Actions:

- Ambulance Awareness Week
- 2022/23 planning submission preparation
- Elective Hub bid – business case
- Focus on discharge and LoS
- Recruitment to urgent care model

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

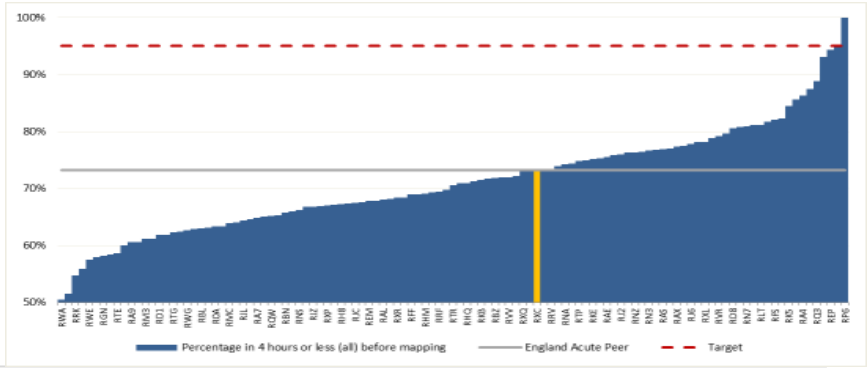
*NHS England has yet to publish all February 2022 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

February 2022 Peer Review

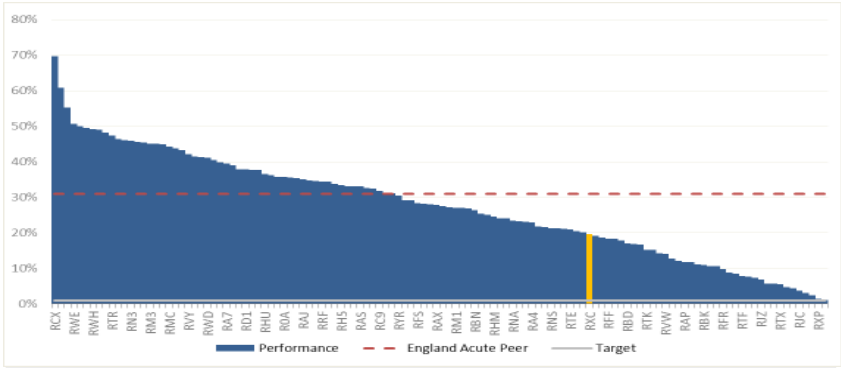
National Average: 73.3% ESHT Rank: 45/113



Planned Care – Diagnostic Waiting Times

January 2022 Peer Review*

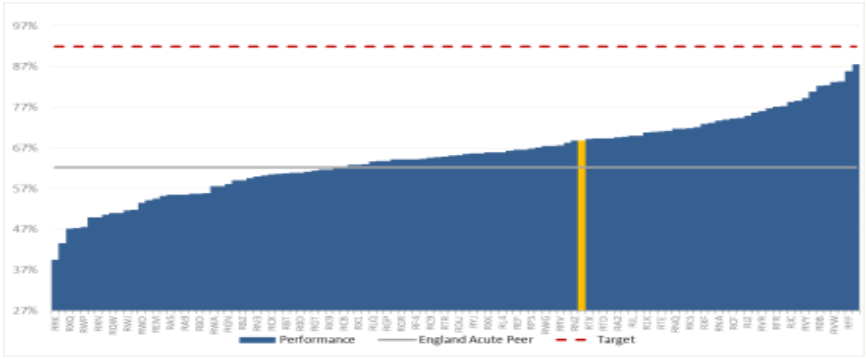
National Average: 31.0% ESHT Rank: 38/122



Planned Care – Referral to Treatment

January 2022 Peer Review*

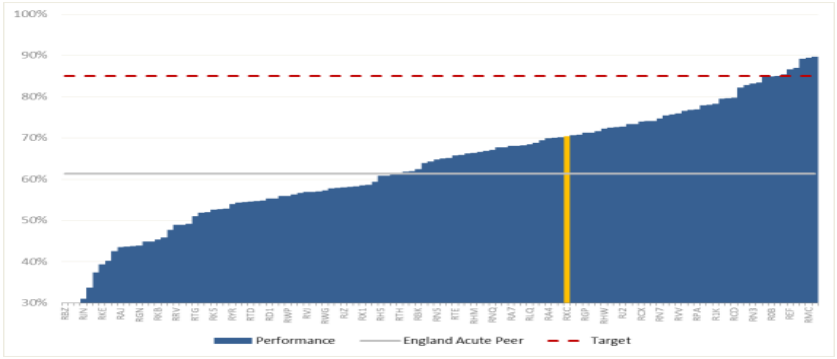
National Average: 62.3% ESHT Rank: 39/112



Cancer Treatment – 62 Day Wait for First Treatment

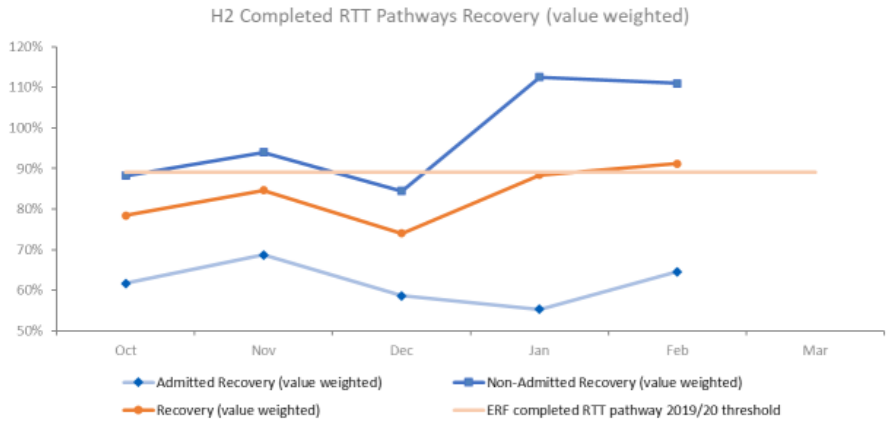
January 2022 Peer Review*

National Average: 61.3% ESHT Rank: 41/122



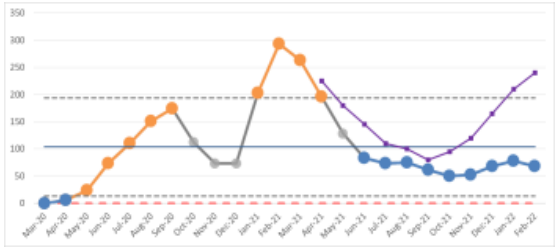
Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust



RTT 52 Week Waiters

Target: 0
Trajectory: 240
Current Month: 68



The Trust surpassed the ask to deliver 89% of clock stop activity against the 2019/20 baseline in February, delivering 91% of completed RTT pathway activity. External support for validation of the RTT PTL started in January with Source Group, which is assisting the delivery of this target. From week ending 27.2.22 Source had validated 6710 pathways with 2855 pathways removed from the RTT PTL, a removal rate of over 42.5%.

The Trust continues to robustly manage its elective PTL and long waiters, with zero patients waiting over 78 weeks or 104 weeks respectively. The Trust has consistently declared a position below the agreed trajectory for the volume of patients waiting over 52 weeks and is proactively working towards eliminating 52 week breaches by June 2022.

Patient Initiated Follow Up (PIFU) remains a focus of the Trust as we move into 2022/23 as it is recognised that this will help to support outpatient delivery. PIFU has been adopted across 13 specialties and PIFU numbers are increasing weekly. The Outpatient Transformation team continue to work with specialties to support the adoption and conversion of patients on to a PIFU pathway. Validation of the Follow-up database starts in April. The validation work will not only help reduce the number of overdue follow-ups but will also support specialties to increase PIFU numbers exponentially, with the validation work identifying patients that are suitable to be moved on to the agreed PIFU pathways.

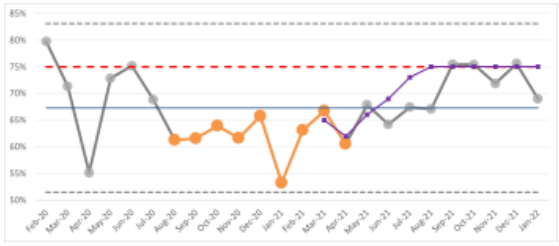
Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust

Access and Responsiveness

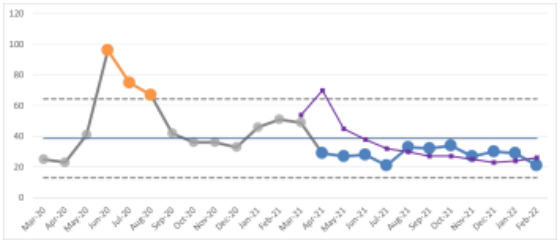
28 Day FDS(Faster Diagnosis Standard)

Target: 75%
Trajectory: 75%
Current Month: 68.9%



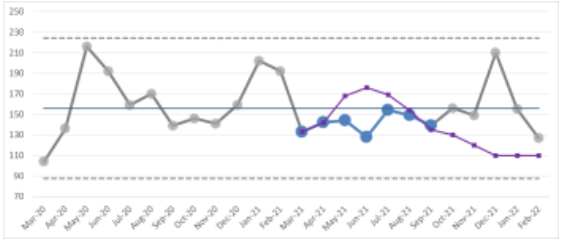
Cancer 104 Day Backlog

Target: Monitor
Trajectory: 26
Current Month: 21



Cancer 62 Day Backlog

Target: Monitor
Trajectory: 110
Current Month: 127



Timely diagnoses is key to supporting our patients and improving outcomes. The Trust achieved the FDS in September, October and December. Despite the continued challenges relating to Omicron cancellations by patients and staff the Trust has recovered its position and will achieve FDS in February.

Despite the continued increase in the volume of 2ww referrals received compared to 19/20 figures, and the impact on both workforce and patient availability as a result of Covid, the Trust has seen a reduction in recent months of both the number of patients waiting over 62 days and those waiting over 104 days. The 104 day backlog is meeting trajectory and the number of patients waiting over 62 days, whilst higher then is wanted, is at the lowest level it has been in 21/22.

There are significant challenges to sustain a continual reduction of patients waiting over 62 days, however the Deputy COO for Planned Care will work with the Divisions to achieve the target of having the same number of waiters in February 2020 levels (or less) by March 2022.

The Trust maintains a continuous focus on reducing Cancer waiting times with daily review of all long waiters, and all pathways over 104 days reviewed at least weekly by the senior leadership team to ensure all possible actions are being taken. The Trust holds regular 'Cancer weeks' to maintain the focus on delivering cancer targets and continues with insourcing in both Radiology and Endoscopy to support delivery of the FDS.

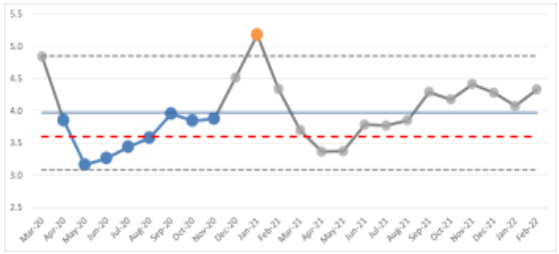
Patient Care- Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

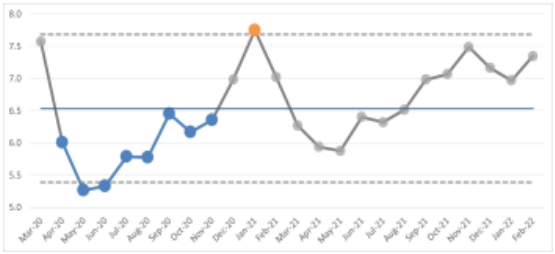
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 4.3



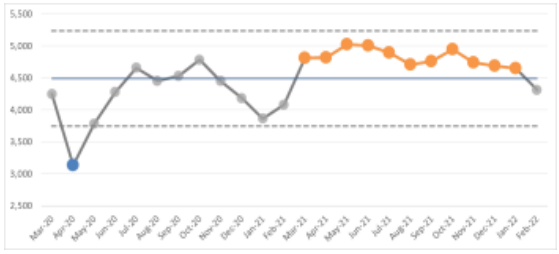
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 7.4



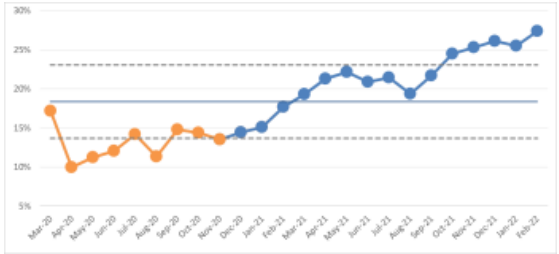
Non Elective Spells

Target: Monitor
Current Month: 4,312



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 27.4%



In February the Trust continued to see increased pressure on acute admissions presenting with a higher acuity and an increase Covid positive patients which impacted flow.

Additional escalation capacity was created on wards that would normally be ring-fenced for elective patients. This increased the bed base to support the additional activity but at the same time placed further pressure on the workforce and in-turn can lead to extended length of stays.

Following a period of improved Length of stay . February data is showing a sudden increase which could be attributed to high number of Covid cases and staff sickness that the Trust started to experience from mid-February onwards.
The Trust has continued to embed a number of initiatives and outcomes from the January 'Perfect Week', for example:

- Daily review of all patients not meeting the Criteria to Reside (CTR) with ASC
- Utilisation of doctors assistants to support flow, and focus on weekend discharges, where able
- Weekly reviews
- Complex discharge panel, including medical staff
- Continue performance on P0 (Regional leader)

There has now been agreement to progress with an integrated discharge to assess model with ESHT and ASC which will support the discharge of P1 patients through Crisis response / JCR

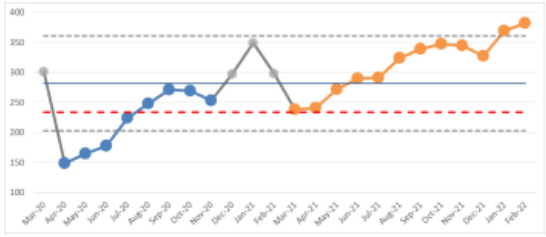
ESHT continues to build on its increased utilisation of its Same Day Emergency Care (SDEC) units (27.4% in February). SDEC is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.

Patient Care - Flow

East Sussex Healthcare NHS Trust

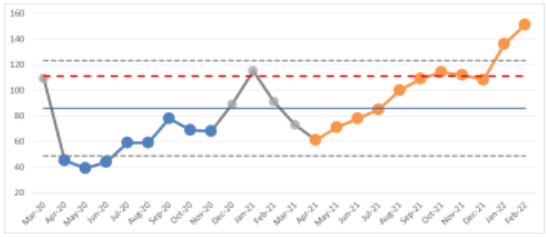
Adult inpatients in hospital for 7+ days (Acute)

Target: Monitor
Current Month: 382



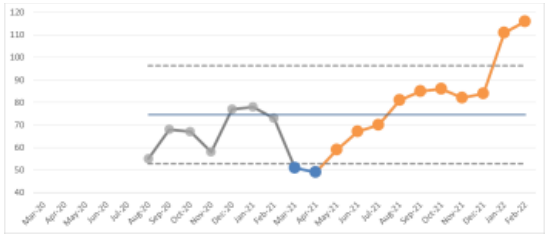
Adult inpatients in hospital for 21+ days (Acute)

Target: Monitor
Current Month: 151



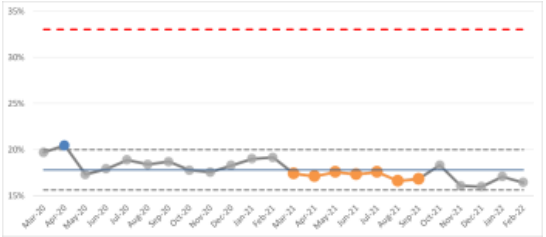
MRD on Pathways 1 -3

Target: Monitor
Current Month: 116



Patients discharged before midday %

Target: 33%
Current Month: 17.0%



In February the Trust saw a further increase in demand compared to January which has increased the number of patients on all pathways (0 to 3) experiencing extended lengths of stays.
Continued challenges are:
Pathway 1: There are challenges in expediting discharges as a result of reduced capacity in the private sector, as well as limited capacity in ESHT and Adult Social Care responsive services.
Pathway 2: There is increasing demand for bedded rehab; bed modelling shows a 39 bed gap for East Sussex residents.
Pathway 3: There is limited daily available D2A capacity to facilitate hospital discharge due to challenges with increasing LoS in D2A beds. This has resulted in an increased need to access spot purchase D2A beds which take longer to source and put an increased challenge on an already pressurised system.

As part of the Trusts reset approach, a Discharge & LoS programme has been implemented with objectives that link to national targets and objectives whilst also supporting Trust and system flow.

There are initially 9 areas / objectives as part of this programme of works:

1. Sense check against national guidance and benchmark against upper quartile organisations
2. Pathway 1 focused support with Crisis Response support (Home First)
3. Review lessons learnt from recent MADE events, Perfect Week and operational reset objectives
4. Criteria led discharge: Focus on nurse led discharge and an objective to increase weekend discharges
5. Embed Non Criteria to Reside (NCTR) tracking through Nerve Centre
6. Discharge to Assess (D2A) planning post March 2022
7. Develop further opportunities from the use of our Discharge Hubs and look to transition the hubs into 'Transfer of Care' Hubs
8. Implementation of TW3 (That Was the Week That Was) that can monitor data on the number of patients in brokerage awaiting POC/placement or LoS of patients in D2A beds
9. A working group focusing on Bedded Rehab Capacity. This is currently linking in with Optimum Rehab Bed Modelling (ESHT local prioritisation, and bed modelling tool has been adopted nationally as an exemplar and launched as NHS Foundry)

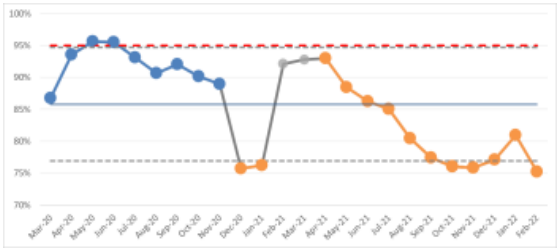
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

Access and Responsiveness

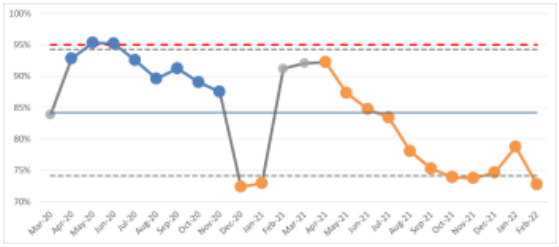
A&E Performance
(Local System)

Target: 95%
Current Month: 75.2%

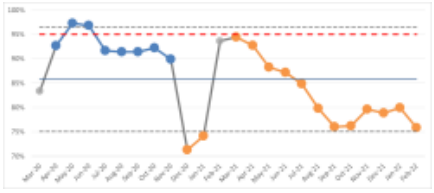


A&E Performance
(ESHT Total Type 1 & 3)

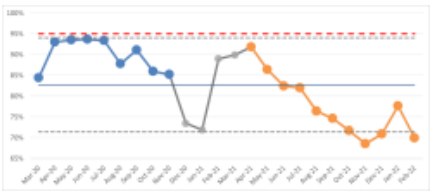
Target: 95%
Current Month: 72.8%



CONQ

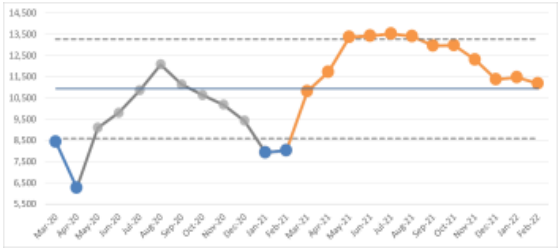


EDGH



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

Target: Monitor
Current Month: 11,173



There has been notable decrease in performance against the 4 hour urgent care metric Flow during February and is still significantly below the required standard, this is directly related to a high level of exit block as a result of a low number of discharges and poor access to social care funded beds. The impact of this continues to provide a direct challenge to the front door with a negative impact on patient safety. However this position is reflected regionally and nationally as the demand for urgent care increases and the ability to discharge is also reducing.

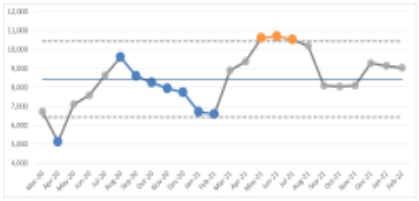
The Urgent Care leadership team continue to explore new ways of working to respond to the challenges of demand.

Urgent Care – Front Door

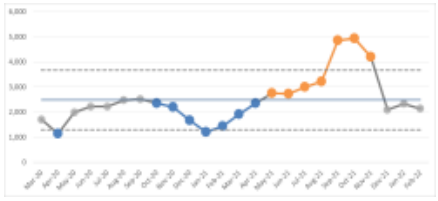
East Sussex Healthcare NHS Trust

Access and Responsiveness

ESHT Total Type 1

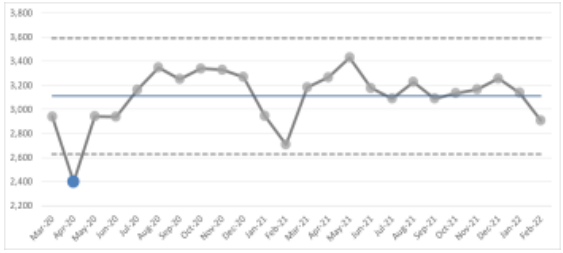


ESHT Total Type 3



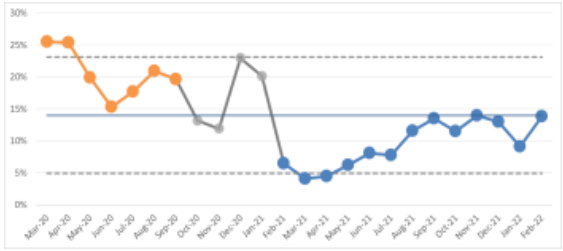
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 2,907



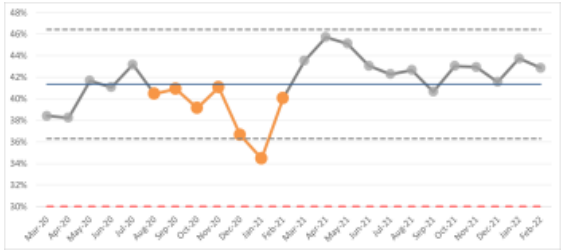
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 13.9%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 42.9%



The ratio between type 3 and type 1 attendances has stabilised following a number of changes to pathways, further work will be undertaken in the following months to increase type 3 attendances again however this is dependant on recruitment of appropriate staffing.

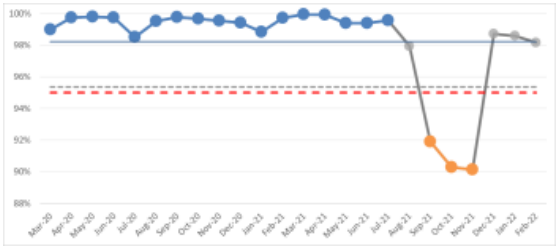
Conveyances have decreased however compliance to handover within 15 minutes remains a concern with a declining performance, this decline is directly triangulated to poor flow secondary to exit block.

Urgent Care – UTC

East Sussex Healthcare NHS Trust

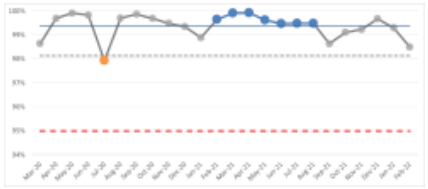
UTC 4 hour standard
(Visit complete within 4 hours)

Target: 95%
Current Month: 98.2%

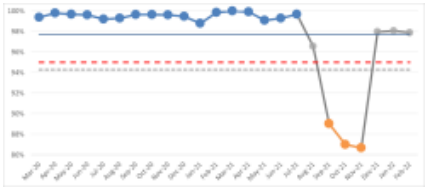


Recruitment to the Urgent Treatment Centre has improved with an increase in paramedic practitioners and General Practitioners and this increase in staffing alongside the 111 stream being managed by LIVI has enabled the UTC to return their focus back to the 4 hour urgent care standard.

CONQ



EDGH



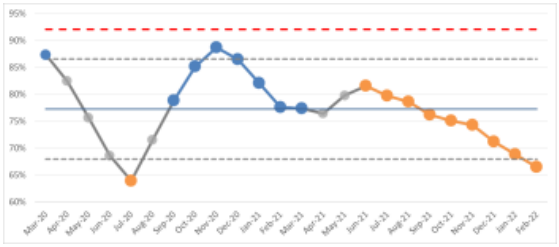
Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

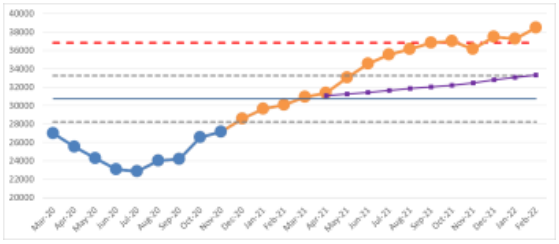
RTT Incomplete Standard

Target: 92%
Current Month: 66.5%



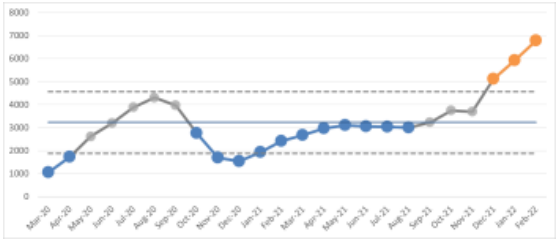
RTT Total Waiting List Size

Target: 36,833 (Sep-21)
Trajectory: 33,310
Current Month: 38,442



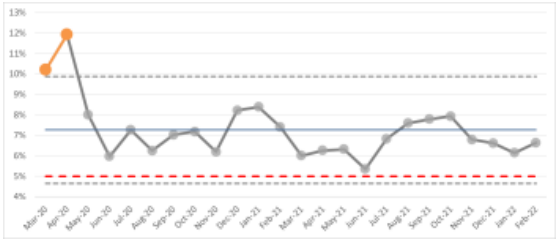
RTT 26 Week Waiters

Target: Monitor
Current Month: 6,777



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 6.6%



Although reported on, the RTT 18 weeks constitutional standard is not a standard that Trusts are currently being monitored on as the focus is currently on recovery and reducing waiting times. In January the Trust achieved 66.5% against the RTT standard and was placed 39 out of 112. None of the 112 Trusts achieved the 92% ask.

The volume of patients on the RTT waiting list continues to far exceed the expected trajectory and whilst there has been a sustained reduction in the number of our longest waiting patients the volume of patients waiting over 26 weeks has significantly increased for the third consecutive month.

Patients waiting over 52 weeks, and those with the potential to reach 52 weeks, are being closely monitored to ensure plans are in place to facilitate these patients being treated and removed from the PTL

There has been an increase in the percentage of cancellations on the day attributed to an increase in sickness levels. Cancellations on the day are only made when all other options have been exhausted. Any patients who is unfortunately cancelled on the day will be offered a new date with 28 days of the cancellation and we are fully compliant with this.

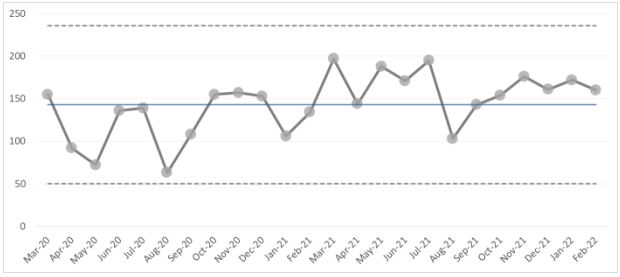
Paediatric Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

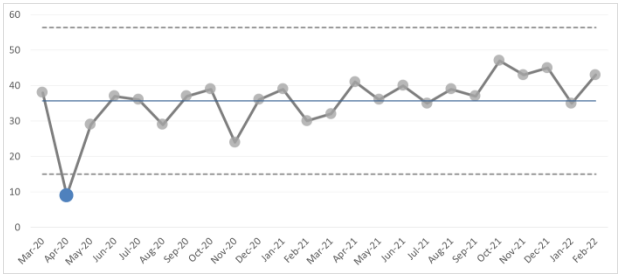
Total Referrals

Target:
Variation : Normal
Current Month: 160



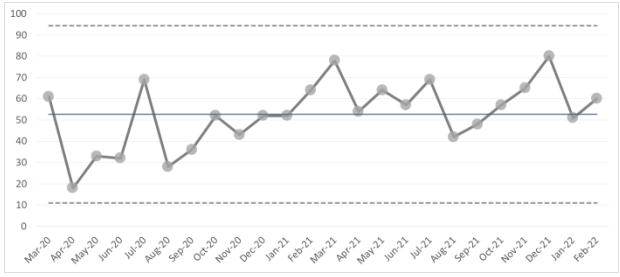
Under 5: Waiting time to first Appt of children seen in month

Target:
Variation : Normal
Current Month: 43 weeks



5-16 : Waiting time to first Appt of children seen in month

Target:
Variation : Improvement
Current Month: 60 weeks



Demand for Community Paediatrics continues to outstrip capacity, with the service having received 160 referrals in February despite only being commissioned for 800 referrals a year.

The number of children waiting for a new Child Development Clinic appointment continues to increase month on month. Pre-school children, safeguarding welfare, and looked after children are prioritised but there is still a long wait time for an appointment. The average wait time has risen to 43 weeks for children under 5 has weeks and 60 weeks for children between 5-16 years old.

Measures to address issues have been put in place . A 'Paediatric Hub' including 4 additional rooms was set up on the EDGH site and is working well with good feedback from staff. PIFU pathways are being developed to support overdue follow-ups and provide additional clinic capacity.

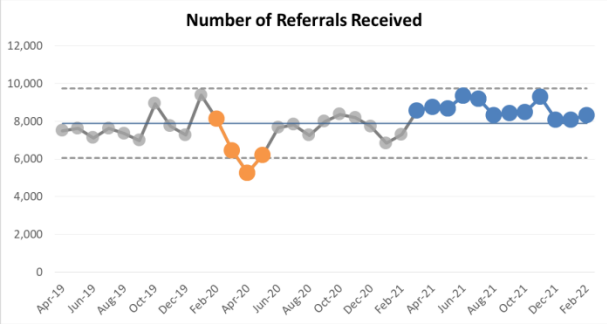
Workforce difficulties remain challenging, with difficulties in recruitment, in line with a national shortage, and attrition from the existing workforce as a result of retirements and sickness. Work is ongoing to support the recruitment of both Doctors and Child Development Nurses, looking at how best to meet the service needs.

Adult Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust

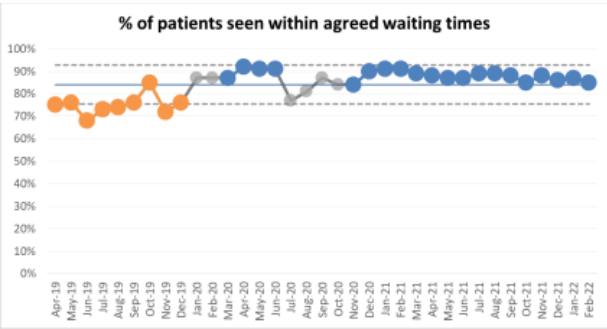
Number of Referrals Received (Planned

Current Month: 8,314



% of Patients seen within agreed waiting time targets (Planned)

Current Month: 85%



Urgent Community referrals	Sussex	ESHT	SCFT
Total Number of Referrals	12,749	9,341	3,048
Number of 2 hour Referrals	7,727	6,846	1,041
Met 2 hour target	**67.5%**	**74.5%**	**13.2%**

Data Source: Monthly UCR Dashboard prepared by P&BI
Data provided by ESHT and extracted from SCT_Datawarehouse
Data shown represents past 6 months (June – November 2021)
Not every referral received requires a 2 hour response
Planning target to achieve 70% of 2 hour crisis response demand within 2 hours from the end of Q3

Adult services are also observing an overall increase in the referral numbers as well as the acuity and complexity compared to 19/20 activity levels.

All community adult services have been recovered, apart from some elements of group activity due to IPC guidance. However full restoration has been more of a challenge due to the shift in the number of type of caseload.

Services remain challenged in terms of staff vacancies, gaps as a result of addressing and managing winter pressures/Omicron, access to clinic space and the increasing complexity of patients requiring community services, however measures have been taken to address waiting list sizes and reduce wait times. These measures include data validation, use of the text reminder service to reduce DNA rates, staff recruitment (both clinical and non-clinical) and expansion of non F2F appointments to improve clinic utilisation.

Particular areas of concern with adult community services are:
District nursing which has a high vacancy factor and sickness levels.
Community rehabilitation (JCR) has seen a significant increase in referrals against their rebasing number Urgent patients are being prioritised resulting in patients with long term conditions and those living with complex disability having significant delays at which point their needs are escalating.

Dietetics have long waits for specific pathways due to the increase in referrals and staffing gaps further compound the issue. SALT have seen an increase in referrals over and above community rebasing causing issues with being able to respond to non-urgent referrals in a timely way.

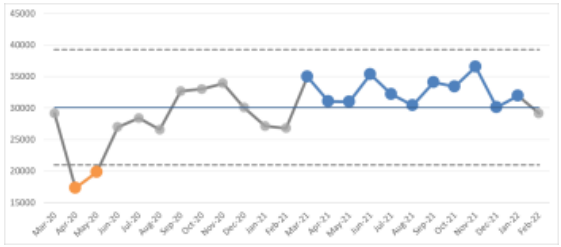
Regionally ESHT have been recognised for achieving above 70% performance target for the 2 hour response.

Planned Care – Outpatient Delivery

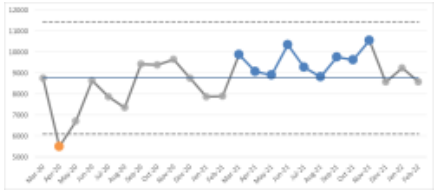
East Sussex Healthcare NHS Trust

Outpatient Total Activity
(New and Follow-up)

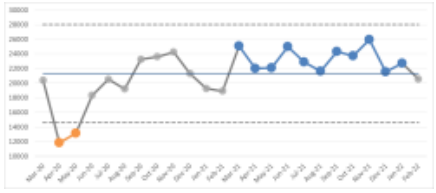
Target: Monitor
Current Month: 29,142



New

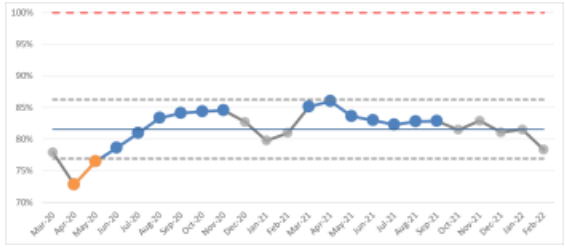


Follow-up



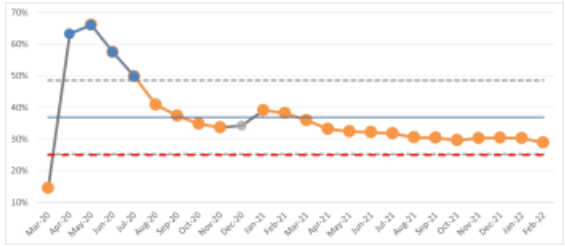
Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 78.3%



Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 28.9%



Outpatient activity has decreased across both New and Follow-up appointments. High sickness levels impacting both our workforce and patient availability has been a significant factor influencing this downward trend.

Outpatient utilisation also decreased in February, impacted by an increase in the volume of DNAs (Did Not Attends); difficulty backfilling short notice cancellation and short notice clinic changes that resulted in blocked slots rather then cancellations in order to accommodate more complex patients who required longer clinic appointments.

The text reminder service is switching back in during March following resolution of the technical issues that had delayed its restart and should support better utilisation and a reduction in DNAs.

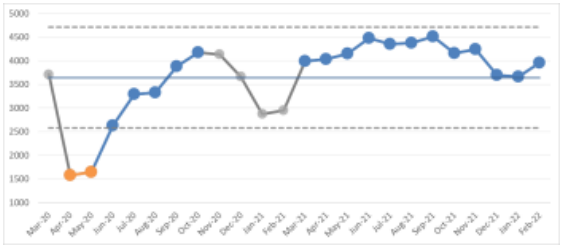
We continue to deliver over 25% of our outpatients activity in a non Face to Face setting and we do not anticipate this position altering significantly.

Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

Access and Responsiveness

Elective Spells
(Day case and Elective IP)

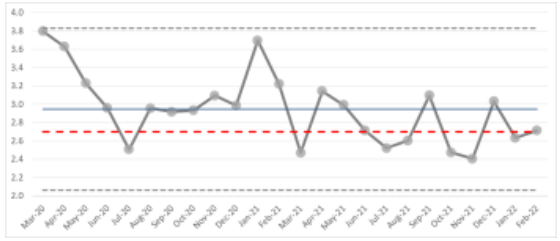


Target: Monitor
Current Month: 3,954

Day case

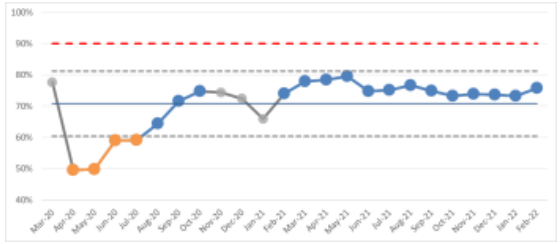
Elective IP

Elective Average LoS
(Acute)



Target: 2.7
Current Month: 2.7

Theatre Utilisation



Target: 90%
Current Month: 75.8%

Despite the continuing challenges, largely due to the impact of Omicron absence on both staff and patients, as well as other seasonal factors, the volume of elective spells increased in February. Theatre activity was prioritised over OP activity to support the treatment of cancer, urgent case and long waiters.

The Elective length of stay did rise in February but was within target. The rise can be attributed to an increase in the volume of Elective IP treated in the month.

Divisions continue to undertake regular review to balance elective priorities to support the delivery of elective activity whilst ensuring we are treating patients with the highest clinical priority.

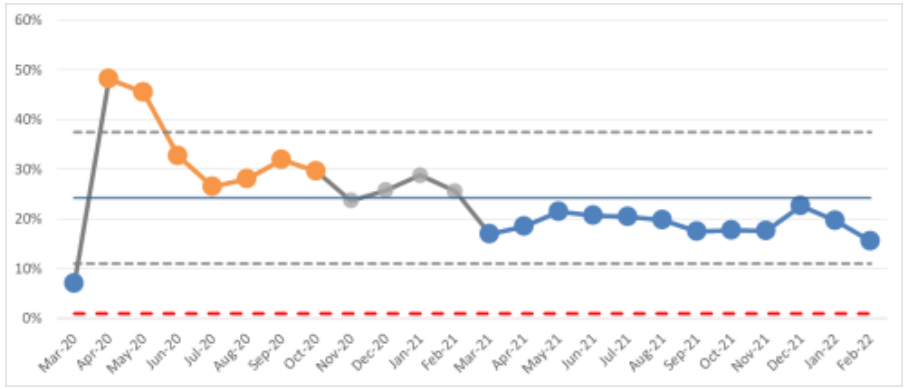
The Trust is currently working with Palantir to implement a new waiting list management and booking tool to aid in improved Theatre utilisation. This will be delivered through effective booking with a single view of all patients on the waiting list. Clinicians will be able to easily review patients on their waiting list which will support ongoing reprioritisation of patients, aiding productivity whilst ensuring we are treating the sickest patients first. Part of this work also includes a cleanse of data which will also support ongoing waiting list management.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

Diagnostic Standard

Target: < 1.0%
Current Month: 15.5%



Diagnostic performance, whilst not where we would like it to be, is improving month on month. Performance continues to be affected by a growth in referrals coupled with workforce challenges in recruitment and retention that are impacting on our ability to deliver DMO1. Regular review of the DMO1 position and trajectory is taking place to allow for early action and mitigation measures to be put into place to aid DMO1 recovery.

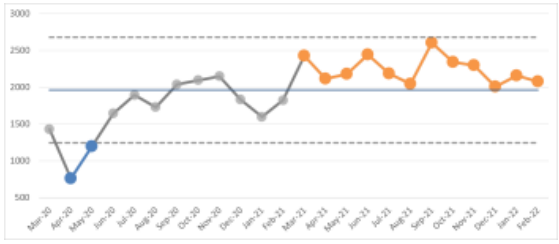
Insourcing continues across Radiology; Endoscopy and Cardiology which is supporting a reduction in our longest waiters in these modalities and provides additional activity to help meet the increase in demand we are experiencing. Currently we are delivering 104% of 19/20 activity across all DMO1 reportable areas.

Cancer Pathway

East Sussex Healthcare NHS Trust

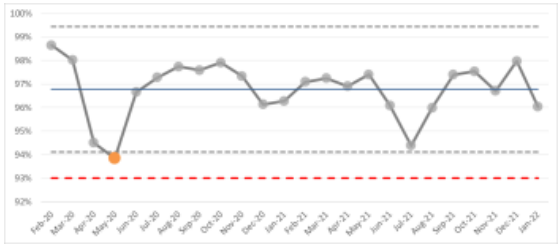
Two Week Wait Referrals

Target: Monitor
Current Month: 2,075



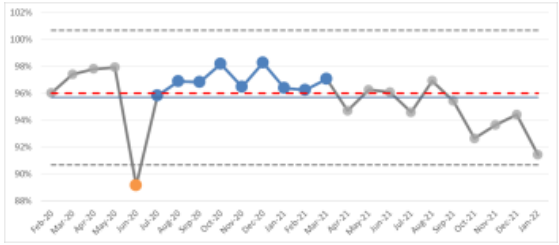
Cancer 2WW Standard

Target: 93%
Current Month: 96.0%



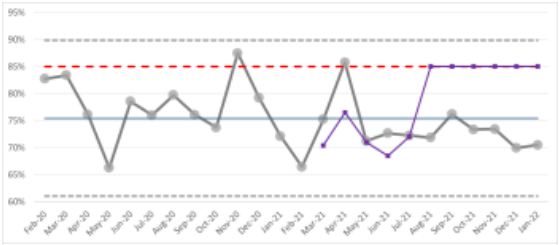
Cancer 31 Day Standard

Target: 96%
Current Month: 91.4%



Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 70.5%



The Trust continues to experience an increase in the volume of 2ww referrals with over 2000 referrals per month in 21/22. This has impacted on all phases of pathways including diagnostics, clinical admin and divisional tumour site services.

Continued focussed efforts in reducing the backlog back to the trajectory was very positive and at the end of February the Trust has over achieved and has met the February 2020 position in advance of the target at the end of March 2022. We continue to regularly review long waiting patients (> 62 days) with additional Patient Tracking Meetings which were implemented in February.

Activity remains a challenge due to cancellations by patients and staff due to covid, however it is expected that the FDS standard will achieve in February and the 62 day performance will improve, compared to December and January.

The Trust were proud to achieve the best in the country performance for the Lower GI FDS in January which has been commended by the Surrey and Sussex Cancer Alliance and ICS.

Developments and transformation projects continue to be progressed to support the pathways, improve performance, and patient experience

Financial Control and Capital Development

Our Income and Expenditure

Our Income and Activity

Our Expenditure and Workforce, including temporary workforce

Cost Improvement Plans

Divisional Summaries

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

Exec summary

East Sussex Healthcare NHS Trust

	RAG	YTD actual (£m)	YTD var (£m)	Commentary
Income	G	496.9	9.0	• YTD favourable of £9.0m driven by H1 pay award (£4.3m), ERF (£6.9m) partially offset by lower divisional income (£3.4m)
Pay	R	(322.9)	(11.8)	• Pay cost variance has remained consistent with M10 at £11.8m, driven by use of temporary staff at higher unit cost partially offset by WTE usage below budget. • Temporary staff costs are £43.3m YTD, this was particularly high in month due to covid driven sickness • The Trust is using 527 (8%) more staff than in 19/20
Non-pay	R	(169.9)	(3.1)	• Non-pay costs now exceed budget mainly driven by tariff excluded drugs and devices above plan by £2.6m, some of this is offset by higher tariff drug income. Costs in month were low due to reduction in elective activity as a result of the covid wave.
Covid	G	(5.9)	6.0	• Covid position continues to support the trusts overall financial position with an effective YTD contribution of £17.2m (£23.2m income).
Surplus/deficit	G	(0.3)	0	• The in-month surplus is £0.4m taking the cumulative position to a £0.3m deficit in line with plan. The Trust is expected to recover this position over the rest of the half.
Efficiency	G	11.9	0.6	• Full year identified efficiency is £14.4m against an indicative plan of £14.7m. Whilst the gap to year end target has reduced to £0.3m. We are confident of delivering the in year positions and as such have RAG rated as Green
Capital	A	20.6	7.1	• Capex of £20.6m is £7.1m behind plan, this needs to be carefully monitored against the capital allocation. • Current forecast is to spend £34.7m against a plan of £34.7m. Remains material risk to delivery with significant amounts to be spent in M12
Risk & Mits	G	n/a	n/a	• We have identified £0.4m of net risk (after probability weighting – to present a reasonable worst case) against mitigations of £1.0m suggesting that based on current information the Trust will deliver a balanced position or small surplus.

Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Act	Plan	Var	Act	Plan	Var
Income						
Contract income	42,018	41,573	445	430,061	424,436	5,625
Divisional	2,717	3,474	(758)	34,777	38,266	(3,490)
ERF	-	-	-	10,469	3,567	6,902
Covid - block	1,785	1,785	-	23,168	23,168	(0)
Covid - variable	638	638	-	7,416	7,416	-
Total Income	**47,157**	**47,470**	**(313)**	**505,891**	**496,853**	**9,037**
Operating Expense						
Pay						
Permanent	(25,517)	(27,910)	2,393	(279,590)	(292,390)	12,800
Temporary	(4,135)	(1,645)	(2,490)	(43,340)	(18,695)	(24,645)
Total pay	**(29,652)**	**(29,555)**	**(97)**	**(322,930)**	**(311,086)**	**(11,844)**
Non-pay						
Drugs	(894)	(1,087)	193	(11,380)	(11,065)	(315)
TEDD	(3,571)	(3,644)	74	(40,405)	(37,800)	(2,604)
Clinical supplies	(3,400)	(3,284)	(116)	(36,031)	(34,681)	(1,350)
Purchased services	(1,261)	(800)	(461)	(10,942)	(8,757)	(2,185)
Finance costs	(1,826)	(2,078)	251	(20,580)	(22,857)	2,277
Other	(5,096)	(5,340)	244	(50,571)	(51,585)	1,014
Total non-pay	**(16,049)**	**(16,234)**	**185**	**(169,909)**	**(166,745)**	**(3,163)**
Covid exp - block	(376)	(603)	227	(5,930)	(11,947)	6,017
Covid exp - variable	(638)	(638)	-	(7,416)	(7,416)	-
Total Expense	**(46,714)**	**(47,029)**	**315**	**(506,184)**	**(497,193)**	**(8,991)**
Surplus/(Deficit)	**443**	**441**	**2**	**(294)**	**(340)**	**46**
Memo:						
WTE (worked)	7,490	7,840	(350)	7,329	7,676	(347)

I&E position

The in-month surplus is £0.4m in line with plan (YTD deficit of £0.3m). The Trust is deliver a balanced position by year end.

Income

- YTD favourable income position £9.0m driven by:
  - of ERF being £6.9m ahead of plan, all driven from H1 performance;
  - the effect of the back dated pay award for H1 of £4.3m included in contract income;
  - Overperformance in TEDD of c£1.3m;partially offset by
  - Divisional income under-performing due to the impact of COVID on the Trust's ability to bill for third party rents, car parking and other services provided.
- M10 income is below plan by £0.8m this is driven by underperformance in divisional income.

Expense

- The Trust has a YTD £11.8m adverse pay position, this has remained consistent with M10.
- Underlying overspend is due to the Trusts reliance on temporary staffing solutions to deliver the elective recovery and increased emergency care levels that are currently being delivered.
- WTE usage is significantly below plan, it is therefore the use of agency and bank is therefore driving the overspend on pay.
- The £3.1m adverse non-pay variance is due to the increased effort in delivering the elective recovery, increased emergency care activity and the costs of delivering health care under a COVID regime.
- Covid block expenditure is £5.9m which is £6.0m better than plan with Covid Block Income recognised at £23.2m meaning there has been an effective contribution of c£17.2m YTD.

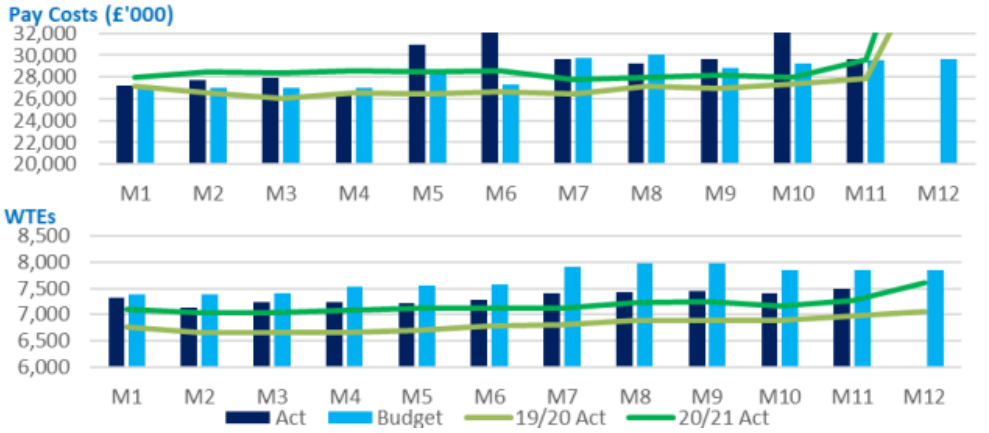
Pay costs

East Sussex Healthcare NHS Trust

Pay analysis

All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(7,107)	(59)	*(7,397)*	(4,408)	(7,238)	797	(7)	*740*	17	798
Nursing	(12,467)	(78)	*(11,098)*	3,864	(11,917)	3,507	(274)	*3,180*	(322)	3,386
AHP	(4,058)	239	*(3,836)*	749	(4,008)	1,103	(45)	*1,017*	(20)	1,097
Admin	(3,395)	191	*(3,495)*	350	(3,516)	1,279	(39)	*1,252*	(9)	1,287
Other	(2,626)	(389)	*(2,028)*	(12,398)	(2,679)	804	14	*774*	(13)	760
Total	**(29,652)**	**(97)**	**(27,854)**	***(11,844)***	**(29,357)**	**7,490**	**(350)**	**6,963**	***(347)***	**7,329**

Temporary	Pay costs (£'000)					WTE				
	H1 Ave	Jan	Feb	PY	YTD	H1	Jan	Feb	PY	YTD Ave
Bank	**(1,416)**	**(1,868)**	**(1,802)**	**(1,549)**	**(16,797)**	**424**	**447**	**497**	***462***	**442**
Medical	(385)	(371)	(412)	(435)	(4,380)	30	29	31	*28*	31
Nursing	(281)	(366)	(372)	(243)	(3,614)	57	80	78	*43*	68
AHP	(97)	(120)	(119)	(183)	(1,136)	18	17	17	*30*	18
Admin	(68)	(90)	(56)	(65)	(591)	16	4	5	*4*	13
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(830)**	**(947)**	**(959)**	**(926)**	**(9,721)**	**121**	**130**	**131**	***104***	**130**
Locum	**(1,223)**	**(1,510)**	**(1,136)**	**(1,080)**	**(13,906)**	**103**	**110**	**91**	***88***	**104**
WLI	**(264)**	**(213)**	**(230)**	**(309)**	**(2,883)**	**25**	**21**	**24**	***13***	**25**
Total Temp	**(3,732)**	**(4,539)**	**(4,126)**	**(3,863)**	**(43,307)**	**673**	**708**	**742**	***667***	**701**



Note: Due to the impact of Covid, the 19/20 equivalent has been used as the prior year comparator with inflation applied

Pay analysis

- Note the costs and WTE's exclude those included in covid costs.
- M11 pay costs are higher in line with budget.
- Overall the in month spend of £29.7m is £2.0m higher than inflation adjusted 19/20 comparator with covid costs over and above that.
- YTD all staffing groups other than nursing & AHP's are overspending. Nursing underspending due to the significant increase in the budget for H1 & H2 and recruitment lagging behind this.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive. A more detailed analysis is set out demonstrating this was included in the M5 finance report.

PY comparison

- Pay (£) is overall is above the inflation adjusted 19/20 and 20/21 comparator although the underlying related activity trends are quite dissimilar (covid and non-covid). The spike in month five is caused by the reallocation of covid costs and M6 from pay award.
- When compared to 19/20 in particular costs are materially higher in 21/22.

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month Plan £'000	In Month Actual £'000	In Month Var £'000	Ytd –M11 Plan £'000	Ytd –M11 Actual £'000	Ytd –M11 Var £'000	Full Year Rec £'000	Full Year NR £'000	Full Year Total £'000	Full Year Target £'000	Full Year Gap £'000	Schemes #
Medicine	45	45	-	618	618	-	15	648	663	1,948	(1,285)	3
Emergency Care	42	42	0	209	209	0	13	249	262	538	(276)	5
DAS	202	204	3	2,167	2,230	63	215	2,223	2,437	2,273	164	9
Core Services	60	42	(18)	394	401	7	442	65	507	1,695	(1,188)	14
CHIC	48	48	0	1,007	1,007	0	363	693	1,056	1,056	0	5
WCSH	7	7	-	511	511	-	21	973	993	997	(3)	8
Estates & Facilities	288	288	0	1,426	1,427	0	375	1,095	1,471	823	648	6
Corporate	17	123	105	739	953	214	234	779	1,013	806	208	20
ERF	-	-	-	958	1,413	455	-	1,413	1,413	-	1,413	-
Trustwide	765	1,095	330	3,825	3,095	(730)	1,590	3,000	4,590	4,590	-	2
Total	**1,473**	**1,893**	**420**	**11,854**	**11,864**	**10**	**3,268**	**11,138**	**14,405**	**14,725**	**(319)**	**72**
Unidentified	*114*	*-*	*(114)*	*(630)*	*-*	*630*	*-*	*-*	*319*	*-*	*319*	*-*
Total	**1,587**	**1,893**	**306**	**11,224**	**11,864**	**640**	**3,268**	**11,138**	**14,725**	**14,725**	**(0)**	**72**
Movement from last month	*(162)*	*63*	*225*	*2,217*	*1,893*	*(324)*	*(1)*	*316*	*(319)*	*-*	*(319)*	*1*

Overview

- The Divisions have delivered £1.9m in month 11 and £11.9m YTD.
- In the month variance is positive due to small over-achievements for DAS with increased SEES activity and vacancy slippage in Corporate, plus the recovery of the Trust-wide CCG income scheme.
- The YTD variance is largely due to the increased SEES activity and vacancy slippage in Corporate.
- The target for the year is £14.7m, £14.4m has been identified, including £3m contingency and £1.6m income recovery. The remaining gaps stands at £0.3m and there is confidence that this will be delivered before the end of the year.
- There is a high proportion (77%) of non-recurrent schemes, this is expected during a transition back to BAU working patterns, with budgeting and the funding regime making it hard to recognise items (such as the ERF over-performance) as recurrent.

Risks

The main risk to delivery is:

- The reliance on non-recurrent savings will create a pressure for 2022/23 unless recurrent savings are found to replace these.

Next Steps

- Work with the divisions to develop robust plans for the rest of the year, targeting run-rate reductions;

Capital

East Sussex Healthcare NHS Trust

SCHEME	TRUST LEAD	YTD			Full year			RAG
		Plan	Actual	Var	Plan	F'cast	Var	
		£'000	£'000	£'000	£'000	£'000	£'000	
Fire Compartmentalisation	EST	1,125	905	(220)	1,250	1,447	197	
Backlog Maintenance	EST	5,955	3,041	(2,914)	6,996	4,851	(2,145)	
Cath Lab Replacement CONQ	EST	1,315	623	(692)	1,315	800	(515)	
ED and DSU - EDGH	EST	567	323	(244)	2,200	1,300	(900)	
Emergency Department CONQ	EST	2,175	2,035	(140)	2,549	2,882	333	
Medical Equipment	EME	1,309	1,680	372	1,527	997	(530)	
Paediatrics	EST	200	48	(152)	200	180	(20)	
Respiratory Ward - Westham	EST	250	181	(69)	250	450	200	
Respiratory Ward - Baird	EST	250	5	(245)	250	5	(245)	
Energy Centre EDGH/CONQ	EST	535	764	229	535	907	372	
BFF Enabling/Transformation	EST	2,798	1,851	(947)	3,019	2,705	(314)	
ICU Covid-19 adaptations	EST	200	2	(198)	400	100	(300)	
Triple Breast	EST	200	281	81	200	200	-	
Temporary Accommodation	EST	1,423	1,307	(116)	1,423	1,270	(153)	
Digital	DIG	3,380	1,733	(1,647)	3,800	4,164	364	
Minor Capital	FIN	1,237	1,283	47	1,400	1,400	-	
Reserves and Unplanned Urgents	FIN	663	-	(663)	750	-	(750)	
Other	FIN	218	167	(51)	218	295	77	
Donated	FIN	-	312	312	-	-	-	
Assumed Slippage	FIN	(4,327)	-	4,327	(5,283)	-	5,283	
Original planned Capital		**19,471**	**16,542**	**(2,929)**	**22,999**	**23,952**	**953**	
Digital Aspirant/Transformation	DIG	1,200	519	(681)	1,600	1,289	(311)	
Digital Pathology - PathNetwork 7	DIG	632	24	(608)	903	600	(303)	
Community Diagnostics Centre	EST	1,161	146	(1,015)	1,786	1,786	-	
Radiology Imaging Network	DIG	529	170	(358)	1,322	1,280	(42)	
Imaging and Pathology networks	DIG	-	-	-	85	85	-	
ICS Digital - Shared Care Record	ICS	1,976	1,313	(663)	2,767	2,767	-	
Robotic Process Automation (TIF)	DIG	269	-	(269)	150	170	20	
E-Triage (TIF)	DIG	630	-	(630)	408	357	(51)	
Da Vinci Robot (TIF)	THE	700	977	277	700	700	-	
Upgrade Theatres (TIF)	THE	495	508	13	1,400	1,120	(280)	
CT Scanner (TIF)	RAD	620	-	(620)	550	550	-	
Digital (TIF)	ICS	-	-	-	1,260	1,260	-	
Diagnostics Equipment (TIF)	RAD	-	405	405	885	885	-	
Other national programmes		-	-	-	717	717	-	
Additional Capital		**8,210**	**4,062**	**(4,149)**	**14,533**	**13,566**	**(967)**	
Capital Position		**27,681**	**20,604**	**(7,078)**	**37,532**	**37,518**	**(14)**	
Headroom/(Gap) to allocation					**-**	**14**		

Capital

- The planned Capital allocation for 2021.22 was originally £24.2m. This now totals £37.5m. Comprising a core allocation of £23.0m and additional capital from national programmes of £14.5m.
- The capital position at the end of month 11 totals £20.6m of actual expenditure. This compares to the revised plan of £27.7m meaning there is unplanned slippage of £7.1m.
- The total plan is for capex of £37.5m with a forecast expenditure of £37.5m We have tested these forecasts against an understanding of where the projects are in terms of delivery phase and therefore this represents our best view based on the information we currently have available.
- Despite good progress there is c£17.0m capital to recognise in M12, this is clearly a significant ask:
  - We have orders raised for (in excess of) the required total, acknowledging that to be recognised we need to have the asset in place;
  - As noted we have, in the first 10 days or so of March recognised £5.0m;
  - We are working to get stage of completion certificates for estates projects up to year end, some projects lag in terms of invoices on the system and recognised by a couple of months;
  - for medical equipment we either expect delivery or a credible vesting certificate to be obtained and our procurement team are closely monitoring; and
  - We are expecting a catch up of ICS and other IT projects with capitalisation of staff an invoices received for partners (council and CCG) who host most of the staff but have not invoiced so far this year.
- The risk around interruption of estates works due to clinical priority or covid remains but appears to be reduced. The most significant risks are now relating to the additional capital largely in Digital areas.

Assets and Liabilities

East Sussex Healthcare NHS Trust

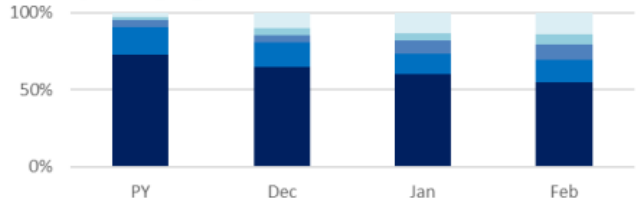
Trust Assets and Liabilities

	Dec	Jan	Feb	Change
	£'000	£'000	£'000	£'000
Non-current assets	**259,556**	**260,732**	**263,206**	**2,474**
Inventories	6,328	5,375	5,732	357
Trade and other receivables	18,310	18,650	19,809	1,159
Cash and Cash equivalents	61,602	64,180	79,407	15,227
Current Assets	**86,240**	**88,205**	**104,948**	**16,743**
Trade and other payables	(45,529)	(49,932)	(58,525)	(8,593)
Other liabilities	(9,190)	(9,376)	(4,751)	4,625
Current Liabilities	**(54,719)**	**(59,308)**	**(63,276)**	**(3,968)**
Non-current liabilities	**(5,889)**	**(2,939)**	**(2,939)**	**-**
Total assets employed	**285,189**	**286,690**	**301,939**	**15,249**

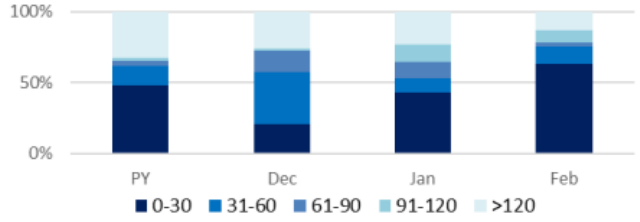
BPPC

Trade	93.1%	93.4%	93.6%	0.1%
NHS	99.6%	99.6%	99.6%	0.0%

Trade Payables Ageing



Trade receivables Ageing



Balance sheet

- The balance sheet shows a broadly consistent position overall with the previous month (as would be expected with a break even I&E position), total assets deployed have reduced driven by the in month deficit.
- There have been a number of movements relating to timing of payments (e.g. trade payables and receivables), in particular with payables falling translating into additional cash balance in month. The balance sheet has been affected by an early month end close for Feb.
- The Trust continues to hold very significant cash balances, this has increased by £15.2m by draw down of capital PDC (£14.8m) for the additional allocations of which significant sums have not yet converted into cash out the door and fully reflected in fixed asset increases.

Trade Payables and Better Payment Practice Code (BPPC)

- BPPC performance has improved again in February and is a result of the on-going work of the financial services team to increase performance, particularly around non-NHS payables.
- An Decrease in month of £0.2m on the creditor position reducing the purchase ledger total to £9.9m.
- 80% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.
- Additional analysis is provided in the appendix

Trade Receivables

- The sales ledger balance at the end of February is £15.9m which is a increase on the previous month of £7.9m.
- The increase is mainly due to an early ledger close in February which resulted in a number of large invoices with East Sussex CCG and Health Education England showing as outstanding. £7.3m was paid by these two debtors and cleared from the 0-60 day position on 24 February 2022 but is not reflected.
- The number of invoices on the sales ledger at the end of the month has increased by 39 to a total of 1,504.
- The invoices noted above impact the ageing profile with a higher % in the 0 -30 days.
- Additional analysis is provided in the appendix

Risks and mitigations

East Sussex Healthcare NHS Trust

	Gross value £'000	Risk adjusted %	Net value £'000	Prior month £'000	Description
H2 Efficiency Programme	1,514	0%	-	151	Trust plan is predicated on delivery of £4.7m of efficiency compared to H1 run rate. Reducing expenditure by that qunatum in four months remaining will be extremely challenging. Further progress has been made and we anticipate being able to deliver broadly in line with plan however there does remain some risk
SMSK	TBC	n/a	TBC	-	The transaction to take on management of the SMSK programme could result in the Trust taking on liabilities, this is being worked through
Funding assumptions	2,000	20%	400	957	Whilst funding has been secured, the bids related to specific services or activity outputs. A number of these have not been delivered (due to 3rd covid wave, delays in recruitment or other operational pressures), there is a significant risk that these amounts are looked to be recovered in full or part. We have recognise the majority of the potential liability within the position and the risk has therefore reduced
Total Risk	**3,514**		**400**	**1,109**	
ESHT contingency contribution	3,080	0%	-	616	ESHT has contributed £3.1m to ICS contingencies however this will not be needed to be drawn on
Independent sector usage	800	0%	-	160	Based on current activity levels additional income will not be received for independent sector usuage
Additional short term measures	2,500	40%	1,000	1,000	If the risks materialise over and above the mitigations set out above the Trust will take further action to reduced spend on elective activity and/or divert more bid funding to close the gap
Total mitigation	**6,380**		**1,000**	**1,776**	

Ambulance Handover

Meeting information:	
Date of Meeting: 12th April 2022	Agenda Item: 8
Meeting: Trust Board	Reporting Officer: Tara Argent

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: ……SECAMB……			
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

Ambulance handover is the point where the ambulance service deliver their patient to the Emergency Department (ED). The national standard for this is that the time from "handbrake on" on the ambulance to the point that the crew have given a meaningful clinical handover to the ED doctor or nurse and the patient is on ED furniture (chair/trolley) should be less than 15 minutes.

Nationally there is an increased focus on ambulance handover performance as EDs across the country have been so full that they have been unable to take a handover and ambulances have been delayed. This means that they are not then available to attend 999 calls.

NHS England have asked that all Trust Boards are fully sighted on Trust Ambulance Handover times and the actions being taken to ensure timely handovers. This paper is written to give the Board an understanding of our current performance and the actions we are undertaking.

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

For Public Board

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

For information

SUMMARY

To respond to the National ask and to support our ED, South East Coast Ambulance Service NHS Foundation Trust (SECAmb), and most importantly, our local population, the Trust have identified that there is a need to keep space (cubicles) available for ambulance handovers at all times. On average, both sites receive 2 to 4 ambulances per hour.

The standards set for our region are:

65% of ambulances to handover within 15 minutes.
95% of ambulances to handover within 30 minutes.
100% of ambulances to handover within 60 minutes.

We currently hold, on both sites, an average of 6 to 8 vehicles per day for longer than 30 minutes each. This is from a total number of 55 to 60 arrivals per day.

SECAmb record the number of minutes past 15 minutes that each ambulance waits. This is called “Lost Time”.

At Eastbourne DGH we currently lose approx. 660 minutes per day in total.

At Conquest Hospital we currently lose approx.. 600 minutes per day in total.

Both sites offload around 45% of ambulance arrivals within 15 minutes.

Both sites offload around 90% of ambulance arrivals within 30 minutes.

It is worth noting that despite not achieving the current standards, the Trust remains one of the better performers across the region, and indeed nationally, are in the top half of performers which gives some indication of the challenge across the country.

The table below gives the national position with the Trusts of most concern at the top. ESHT is circled.

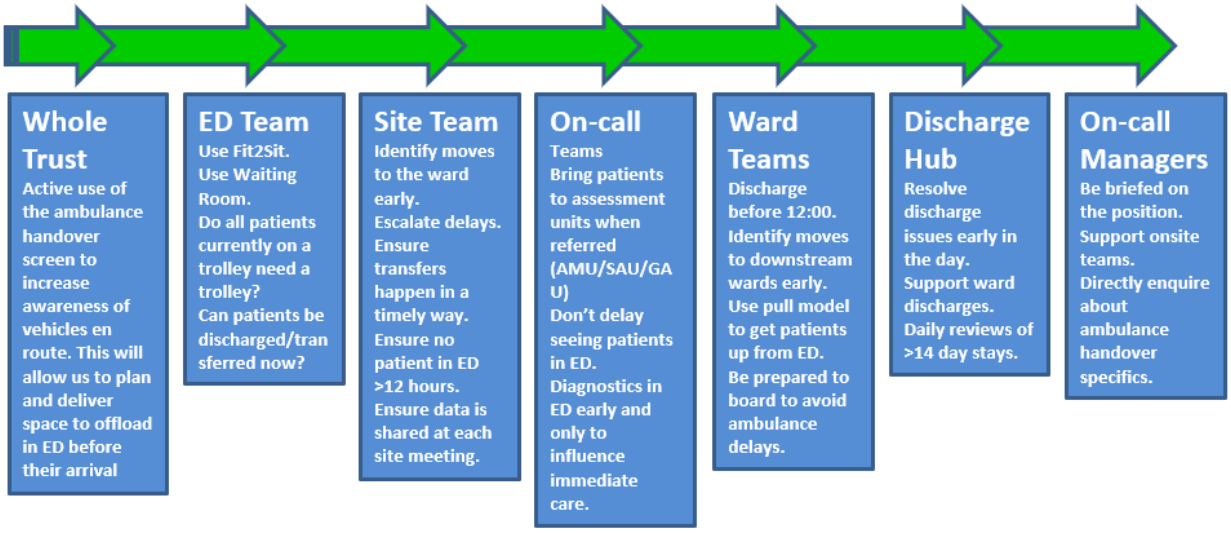
Code	Name	Number 30-60 minutes	Share of ambulance arrivals 30-60 minutes	Number 60+ minutes	Share of ambulance arrivals 60+ minutes	Share of ambulance arrivals 30+ minutes
RK9	University Hospitals Plymouth NHS Trust	154	15%	507	49%	64%
RTE	Gloucestershire Hospitals NHS Foundation Trust	184	15%	556	46%	62%
RA7	University Hospitals Bristol and Weston NHS Foundation Trust	201	14%	568	40%	54%
RN3	Great Western Hospitals NHS Foundation Trust	99	12%	292	37%	49%
RVJ	North Bristol NHS Trust	161	16%	317	32%	48%
RA9	Torbay and South Devon NHS Foundation Trust	132	16%	229	28%	45%
RGN	North West Anglia NHS Foundation Trust	469	26%	478	27%	53%
REF	Royal Cornwall Hospitals NHS Trust	13	1%	247	27%	28%
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	150	10%	384	26%	37%
RCX	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	111	14%	193	25%	39%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	189	17%	270	24%	41%
RWP	Worcestershire Acute Hospitals NHS Trust	286	14%	477	24%	38%
RWE	University Hospitals of Leicester NHS Trust	349	19%	446	24%	42%
RQW	The Princess Alexandra Hospital NHS Trust	140	19%	164	23%	42%
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	373	23%	358	22%	45%
RGP	James Paget University Hospitals NHS Foundation Trust	109	13%	179	21%	34%
RD1	Royal United Hospitals Bath NHS Foundation Trust	139	14%	208	21%	35%
R0D	University Hospitals Dorset NHS Foundation Trust	164	10%	341	20%	30%
RXW	The Shrewsbury and Telford Hospital NHS Trust	364	26%	289	20%	46%
RWA	Hull University Teaching Hospitals NHS Trust	242	15%	314	19%	34%
RJE	University Hospitals of North Midlands NHS Trust	500	22%	440	19%	41%
RHU	Portsmouth Hospitals University National Health Service Trust	267	14%	348	19%	33%
RWD	United Lincolnshire Hospitals NHS Trust	408	23%	336	19%	41%
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	195	11%	326	18%	28%
RRK	University Hospitals Birmingham NHS Foundation Trust	1067	23%	813	17%	40%
RAJ	Mid and South Essex NHS Foundation Trust	418	14%	450	16%	30%
RBN	St Helens and Knowsley Teaching Hospitals NHS Trust	162	15%	156	15%	30%
RNZ	Salisbury NHS Foundation Trust	70	13%	74	14%	28%
RWH	East and North Hertfordshire NHS Trust	266	24%	139	13%	36%
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	160	14%	118	10%	24%
RF4	Barking, Havering and Redbridge University Hospitals NHS Trust	411	21%	200	10%	31%
RLQ	Wye Valley NHS Trust	113	13%	83	10%	23%
RL4	The Royal Wolverhampton NHS Trust	191	11%	161	10%	21%
RNA	The Dudley Group NHS Foundation Trust	312	20%	142	9%	30%
RNS	Northampton General Hospital NHS Trust	232	19%	116	9%	28%
RAL	Royal Free London NHS Foundation Trust	459	26%	167	9%	35%
RJC	South Warwickshire NHS Foundation Trust	136	19%	62	9%	28%
RP5	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	270	16%	144	9%	25%
RTR	South Tees Hospitals NHS Foundation Trust	100	10%	86	8%	18%
RYR	University Hospitals Sussex NHS Foundation Trust	550	18%	254	8%	26%
RKB	University Hospitals Coventry and Warwickshire NHS Trust	493	33%	106	7%	40%
RBL	Wirral University Teaching Hospital NHS Foundation Trust	72	8%	65	7%	15%
R0A	Manchester University NHS Foundation Trust	330	11%	202	7%	18%
RC9	Bedfordshire Hospitals NHS Foundation Trust	200	11%	120	7%	18%
R1K	London North West University Healthcare NHS Trust	403	19%	140	7%	26%
RXP	County Durham and Darlington NHS Foundation Trust	227	12%	126	7%	18%
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	169	15%	73	7%	22%
RFR	The Rotherham NHS Foundation Trust	124	13%	63	6%	19%
RDE	East Suffolk and North Essex NHS Foundation Trust	337	14%	147	6%	20%
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	223	19%	71	6%	25%
RBZ	Northern Devon Healthcare NHS Trust	80	14%	34	6%	20%
RVY	Southport and Ormskirk Hospital NHS Trust	114	17%	37	6%	23%
RX1	Nottingham University Hospitals NHS Trust	205	10%	117	6%	15%
RNN	North Cumbria Integrated Care NHS Foundation Trust	125	11%	60	6%	17%
REM	Liverpool University Hospitals NHS Foundation Trust	209	9%	119	5%	15%
RJ6	Croydon Health Services NHS Trust	73	6%	59	5%	12%
RXQ	Buckinghamshire Healthcare NHS Trust	113	13%	45	5%	18%
R1H	Barts Health NHS Trust	555	19%	150	5%	24%
RWG	West Hertfordshire Teaching Hospitals NHS Trust	167	14%	59	5%	19%
RN5	Hampshire Hospitals NHS Foundation Trust	117	8%	74	5%	13%
RM3	Northern Care Alliance NHS Ft	217	8%	130	5%	13%
RMC	Bolton NHS Foundation Trust	117	12%	46	5%	16%
RJ7	St George's University Hospitals NHS Foundation Trust	224	18%	58	5%	22%
RWJ	Stockport NHS Foundation Trust	151	14%	50	5%	18%
RJN	East Cheshire NHS Trust	37	8%	20	4%	13%
RTF	Northumbria Healthcare NHS Foundation Trust	197	14%	55	4%	18%
RPA	Medway NHS Foundation Trust	155	11%	55	4%	14%
RXK	Sandwell and West Birmingham Hospitals NHS Trust	290	15%	75	4%	18%
RFF	Barnsley Hospital NHS Foundation Trust	136	14%	35	4%	18%
RVR	Epsom and St Helier University Hospitals NHS Trust	125	10%	44	3%	13%
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	137	14%	31	3%	17%
RH5	Somerset NHS Foundation Trust	89	10%	28	3%	13%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RXC	East Sussex Healthcare NHS Trust	112	8%	42	3%	11%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RJZ	King's College Hospital NHS Foundation Trust	252	11%	62	3%	14%
RGR	West Suffolk NHS Foundation Trust	51	6%	23	3%	9%
RAP	North Middlesex University Hospital NHS Trust	92	7%	33	3%	10%
RAS	The Hillingdon Hospitals NHS Foundation Trust	194	21%	24	3%	24%
RAE	Bradford Teaching Hospitals NHS Foundation Trust	43	3%	33	2%	6%
RGT	Cambridge University Hospitals NHS Foundation Trust	124	11%	28	2%	13%
RTG	University Hospitals of Derby and Burton NHS Foundation Trust	333	15%	51	2%	18%
RJ2	Lewisham and Greenwich NHS Trust	95	5%	45	2%	7%
RA2	Royal Surrey County Hospital NHS Foundation Trust	55	7%	15	2%	10%
R0B	South Tyneside and Sunderland NHS Foundation Trust	197	11%	35	2%	13%
RD8	Milton Keynes University Hospital NHS Foundation Trust	91	11%	16	2%	13%
RXF	Mid Yorkshire Hospitals NHS Trust	221	13%	31	2%	15%
RHW	Royal Berkshire NHS Foundation Trust	115	10%	21	2%	12%
RQ3	Birmingham Women's and Children's NHS Foundation Trust	51	14%	6	2%	15%
RA4	Yeovil District Hospital NHS Foundation Trust	48	9%	8	1%	10%
RBT	Mid Cheshire Hospitals NHS Foundation Trust	64	7%	12	1%	9%
RRV	University College London Hospitals NHS Foundation Trust	58	7%	9	1%	9%
RTK	Ashford and St Peter's Hospitals NHS Foundation Trust	99	9%	12	1%	10%
RWW	Warrington and Halton Teaching Hospitals NHS Foundation Trust	30	4%	8	1%	5%
RBK	Walsall Healthcare NHS Trust	93	7%	13	1%	8%
RVV	East Kent Hospitals University NHS Foundation Trust	212	8%	23	1%	9%
RH8	Royal Devon and Exeter NHS Foundation Trust	108	8%	12	1%	9%
RJ1	Guy's and St Thomas' NHS Foundation Trust	150	12%	10	1%	13%
RVW	North Tees and Hartlepool NHS Foundation Trust	10	1%	6	1%	2%
RWY	Calderdale and Huddersfield NHS Foundation Trust	85	6%	11	1%	7%
RWF	Maidstone and Tunbridge Wells NHS Trust	202	13%	12	1%	13%
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust	58	7%	6	1%	7%
RCF	Airedale NHS Foundation Trust	16	2%	4	1%	3%
RAX	Kingston Hospital NHS Foundation Trust	8	1%	5	1%	1%
RDU	Frimley Health NHS Foundation Trust	108	4%	13	1%	5%
RCD	Harrogate and District NHS Foundation Trust	10	2%	2	0%	2%
RR7	Gateshead Health NHS Foundation Trust	22	3%	3	0%	3%
RLT	George Eliot Hospital NHS Trust	99	15%	2	0%	16%
RFS	Chesterfield Royal Hospital NHS Foundation Trust	78	8%	3	0%	8%
RN7	Dartford and Gravesham NHS Trust	29	3%	3	0%	3%
RTP	Surrey and Sussex Healthcare NHS Trust	128	10%	3	0%	10%
RHM	University Hospital Southampton NHS Foundation Trust	82	4%	4	0%	5%
RXR	East Lancashire Hospitals NHS Trust	217	13%	3	0%	13%
RR8	Leeds Teaching Hospitals NHS Trust	106	4%	3	0%	4%
RK5	Sherwood Forest Hospitals NHS Foundation Trust	48	4%	1	0%	4%
RNQ	Kettering General Hospital NHS Foundation Trust	217	18%	0	0%	18%
RYJ	Imperial College Healthcare NHS Trust	202	12%	0	0%	12%
RTH	Oxford University Hospitals NHS Foundation Trust	146	9%	0	0%	9%
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	110	7%	0	0%	7%
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	30	2%	0	0%	2%
RKE	Whittington Health NHS Trust	0	0%	0	0%	0%

ESHT ACTIONS FOR IMPROVEMENT

In response to the need for improvement the Trust is taking the following actions:

- Regular reporting and oversight of performance through the Trust Board
- Daily reporting of the position through Site Meetings
- Including ambulance handover performance within the IPR process
- "Ambulance Awareness Week"
    - Briefings from Board to Ward
    - Daily PDSA reviews and improvements
    - Refining response
    - Monitoring Ambulance inbound screen
- Cultural change to a pre-emptive model rather than reactionary
- Monthly face-to-face "confirm and challenge" meetings with SECAmb to improve flow
- Refreshing SECAmb pathways into Gateway Areas (SDEC, AMU, SAU)
- Confirming and a developing "Right Site, First Time" approach for SECAmb specialty arrivals
- Deliver 4 hour, 12 hour and Clinically Ready To Proceed standards
- Implement new written escalation plan

Overall Trust Aim
Ensure sufficient space (approx. 2 trolleys at any one time) to take ambulance handover ideally within 15 minutes; always within 30 minutes. To not lose more than 120 minutes of cumulative handover delays through the day.



It is worth noting that 98% of our ambulance delays are caused by there being no physical space for the vehicle to offload the patient in the ED. It remains essential therefore that the Trust continues to drive improvement in the four hour and proposed twelve hour standards and is successful in implementing the new "Clinically Ready to Proceed" standard. These will help to ensure that there is always space in the ED for arriving ambulances to handover.

East Sussex Healthcare NHS Trust

Mortality Report – Learning from Deaths: 1st April 2017 to 30th September 2021

Meeting information:			
Date of Meeting:	12th April 2022	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer:	Dr David Walker

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

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

Summary:

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

The attached board report on "Learning from Deaths" is a requirement in the Care Quality Commission review. All deaths in hospital are reviewed by our team of Medical Examiners and any cases requiring further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.

The current "Learning from Deaths" report details the April 2017 – September 2021 deaths, recorded and reviewed on the mortality database.

The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths going to inquest, SIs, Amber reports, complaints and "low risk" deaths are all reviewed for completeness.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process, in order to mitigate any risk.

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

N/A

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

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

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard September 2021-22

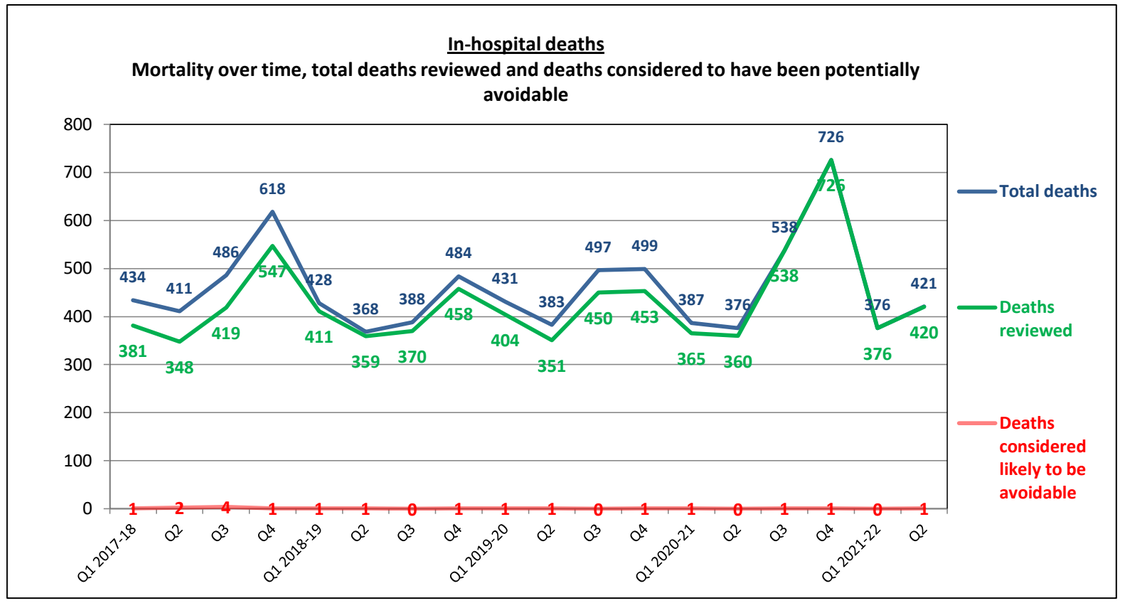
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 28/02/2022)

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

Time Series:	Start date	2017-18	Q1	End date	2021-22	Q2

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
158	129	158	128	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
421	376	420	376	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1292	2027	1291	1989	1	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	100.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	50.0%	This Quarter (QTD)	1	50.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	33.3%	This Year (YTD)	2	66.7%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Data above is as at 28/02/2022 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 3 care concerns expressed to the Trust Bereavement team relating to Quarter 2 2021/22 deaths. These were not taken forward as complaints however, one relates to a quarter 2 Serious incident.
Complaints - Of the complaints closed during Quarter 2 2021/22 relating to 'bereavement', two have overall care ratings of 'poor care' on the mortality database. These cases were discussed at the Mortality Review Audit Group, one was considered to be a 'probably avoidable' death and the other 'possibly avoidable'.
Serious incidents - There were 3 severity 5 Serious incidents raised in Q2 2021/2022, two of these relating to ward outbreaks of COVID. They were discussed at the Mortality Review Audit Group and not considered to be avoidable deaths.
As at 28/02/2022 there are 515 April 2017 - September 2021 deaths, still outstanding for review on the Mortality database.

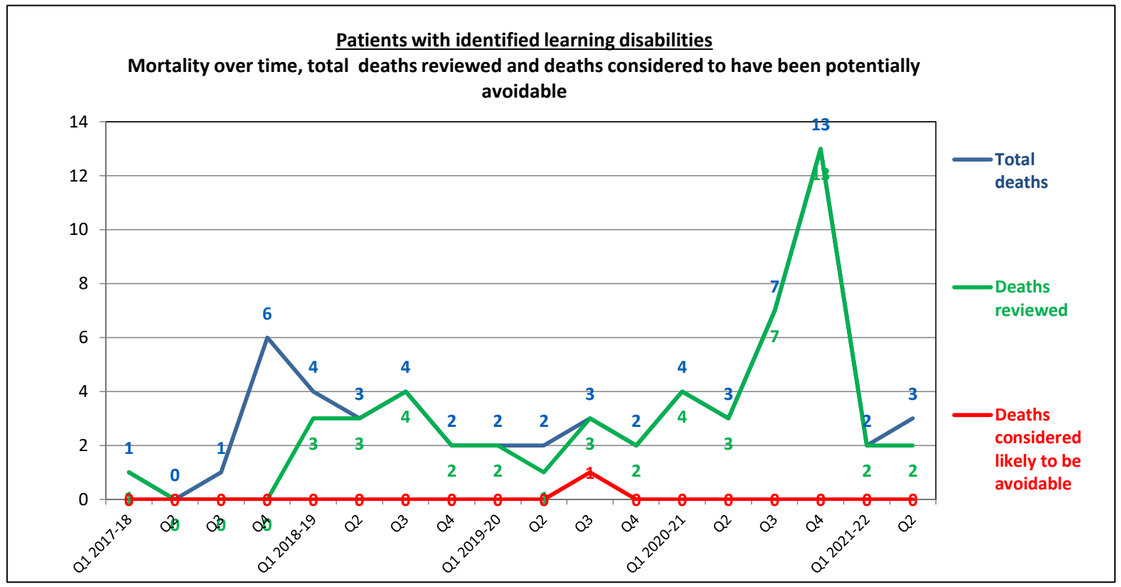
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 28/02/2022)

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

Time Series:	Start date	2017-18	Q1

End date	2021-22	Q2

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	1	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	27	7	27	0	0



The LeDeR (learning disability mortality review) programme is now in place and the deaths of patients with a learning disability are being reviewed against the new criteria externally. Feedback from these external reviews is now being received by the Trust.
These deaths are also reviewed internally by the Acute Liaison Nurse for Learning Disabilities, who enters the review findings on the mortality database.

Board Assurance Framework Q4

Meeting information:			
Date of Meeting:	12th April 2022	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 update report on the BAF essentially fulfils two functions; firstly to provide an overview of the overarching risks to the delivery of the Trust's strategic objectives/aims for 21/22. The second function is to report to the Board the position of the risk at 21/22 YE for assurance, this being the Q4 update.

The controls, assurances and actions relating to each area of the BAF are outlined in the document, with all existing risks on the BAF having been reviewed and progress updated/signed off by the responsible ED. Target risk levels and target dates for all areas of the BAF have been updated to reflect the Trust's current position.

- The score for BAF 6 – Financial Sustainability has been reduced from 12 to 4 as a result of the large degree of confidence that the Trust will operate within its available resources during 2021/22.
- No new risks have been added to the BAF in this quarter.
- Individual risks that had previously been included on the BAF relating to Trust vacancies are now included under the overarching risk 2054 - Recruitment to Trust Vacancies (substantive)

Annual Committee Review of the BAF for 21/22

Risks have been presented and reviewed on a quarterly basis to their lead Committees. The Trust Board also receives and reviews the BAF on a quarterly basis and movement of the risks over the past two years is set out in the table below:

Ref	RISK SUMMARY	Monitoring Committee	Objectives Impacted					Inherent risk	Current position (Residual risk)								Change	Risk appetite	Target rating	Target date
									2020/21				2021/22							
									Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
BAF 1	Safe care - sustained and continuous improvement	Q&S	✔					20	9	9	12	16	12	12	12	12	◄►	Low	6	Mar-23
BAF 2	Restoration and Recovery - ongoing impact of Covid19	Q&S	✔	✔	✔	✔	✔	20	16	16	20	20	16	16	16	16	◄►	Low	8	Mar-23
BAF 3	The Trust's performance against access standards is inconsistent	Q&S	✔	✔				20	12	16	20	20	16	16	16	16	◄►	Low	6	Mar-23
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16	16	16	16	16	16	16	◄►	Moderate	12	Ongoing
BAF 5	Protecting our staff	POD			✔			16	12	12	12	12	12	12	12	12	◄►	Low	9	Ongoing
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12	12	4	12	12	12	4	▼	Moderate	8	Mar-22
BAF 7	Investment required for IT, medical equipment and other capital items	F&S	✔				✔	20	16	16	12	12	12	16	16	16	◄►	Moderate	12	Mar-23
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	16	12	12	16	16	16	16	◄►	Moderate	8	Mar-23
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	16	16	16	16	16	16	16	◄►	Low	12	Mar-23

The BAF in 2022/23

We have begun detailed conversations with the Executive risk owners to review current risks; whether they will remain appropriate for 22/23 and to assess whether new risks need to be added or some may need to be removed. The descriptions of existing risks will also be reviewed to ensure that these describe the risks on the BAF as fully as possible and are proportionate and appropriate for 22/23.

The Board has already seen how the Executive team plans to use the 'assurance radar' to identify whether we are comfortable that the BAF identifies no Trust-level risks around patient strategy and experience, and whether the Trust is comfortable with the number of red rated risks included on the BAF. Additional risk categories including strategic/system risks, patient experience/engagement and health inequalities are being considered for inclusion on the 22/23 BAF.

We have engaged with our internal auditors TIAA on their annual review of the BAF and recommendations from this will be considered once available. Early conversations have been helpful about additional aspects the Trust could consider to strengthen the BAF further as we look at the 22/23 BAF. Board members will see these aspects in the Q1 2022/23 BAF is presented in August.

The governance process for approving the BAF will remain the same moving into 22/23 with Board sub-Committees reviewing the areas of the BAF that they lead on, Audit Committee reviewing the full BAF and then further review and sign off by the Trust Board.

It is important to note that there are practical scheduling challenges with the BAF, as it is updated on a quarterly basis (every three months) and the Audit Committee and the Board meeting in public take place on bi-monthly basis. This leads to the BAF being discussed at consecutive Board meetings and we remain committed to minimising the impact of this disparity.

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

All risks on the Register are aligned to a Group or Committee for monitoring and challenge.

People and Organisational Development Committee 17th March 2022
Quality and Safety Committee 17th March 2022
Finance and Investment Committee 24th March 2022
Audit Committee 24th March 2022

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

The Board is asked to review and note the Corporate Risk Register and BAF and consider the risks identified and the actions in place to manage the risks.

Board Assurance Framework (BAF)

Quarter 4 2021/22

East Sussex Healthcare NHS Trust

1. Overview and BAF updates

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.

The rating for BAF 6, financial sustainability, has been reduced from 12 to 4 due to increased assurance about the Trust's 2021/22 financial position.

No new risks have been added to the BAF in Q4. Please note that individual risks that had previously been included on the BAF relating to Trust vacancies are now included under the overarching risk 2054 - Recruitment to Trust Vacancies (substantive).

All existing risks on the BAF have been reviewed and progress updated where appropriate.

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	16	12	12	12	12	◄►	Low	6	Mar-23
BAF 2	Restoration and Recovery - ongoing impact of Covid19	Q&S	✔	✔	✔	✔	✔	20	16	16	20	20	16	16	16	16	◄►	Low	8	Mar-23
BAF 3	The Trust's performance against access standards is inconsistent	Q&S	✔	✔				20	12	16	20	20	16	16	16	16	◄►	Low	6	Mar-23
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16	16	16	16	16	16	16	◄►	Moderate	12	Ongoing
BAF 5	Protecting our staff	POD			✔			16	12	12	12	12	12	12	12	12	◄►	Low	9	Ongoing
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12	12	4	12	12	12	4	▼	Moderate	8	Mar-22
BAF 7	Investment required for IT, medical equipment and other capital items	F&S	✔				✔	20	16	16	12	12	12	16	16	16	◄►	Moderate	12	Mar-23
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	16	12	12	16	16	16	16	◄►	Moderate	8	Mar-23
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	16	16	16	16	16	16	16	◄►	Low	12	Mar-23

- 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	16	16	16	16	16
BAF 3 - The Trust's performance against key access standards is inconsistent	16	16			
BAF 4 - Sustainable Workforce	16	16	16		16
BAF 5 – Protecting our Staff	12				
BAF 6 - Financial Sustainability				4	4
BAF 7 - Investment required for IT, medical equipment and other capital items	16				16
BAF 8 – Investment required for estate infrastructure – buildings and environment	16				16
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:	Chief Nurse & DIPC/ Medical Director	**Lead Committee:**	Quality and Safety Committee		**Date of last Committee review:**	Mar-22

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	◀▶
	12/06/20	1884	Delayed surgical treatment	20	16	◀▶
	24/09/20	1913	Increased waiting times due to cancellations as a result of Covid-19	16	16	◀▶
	03/12/20	1942	Risk of insufficient acute beds during winter	20	16	◀▶
	11/03/21	2035	Nervecentre recording error for patient alerts	16	16	◀▶
	12/07/21	2055	Radiology equipment breakdowns (Bexhill)	20	15	◀▶
	12/07/21	2056	Radiology equipment breakdowns (Conquest)	20	20	◀▶
	12/07/21	2057	Non-Compliance with NaDIA (Inpatient Diabetic Foot Pathway)	20	16	◀▶

BAF Risk Scoring								
Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	ESHT has now entered the next phase of Covid with a new VOC, presenting different challenges to those seen in the second wave. Infection control requirements are impacting both clinically and operationally, even with the small numbers of Covid positive patients, impacting on capacity, staffing, flow and performance. Challenges are likely to be sustained in the medium to longer term. The Trust is continuing to see ongoing multiple Covid outbreaks with high local prevalence still at time of writing with subsequent acquisitions, albeit a much reduced incidence of immediate harm to patients as a result.	**Likelihood:**	2	Sept-22
Consequence:	3	3	3	3		**Consequence:**	3	
Risk Level:	12	12	12	12		**Risk Level:**	6	

Cause of risk:	• Covid-19 impacting the Trust's ability to provide safe and effective care • Impact of significant additional capacity being required and subsequent and significant effect on	**Impact:**	Failure to provide safe and effective care may result in: • Sub-optimal patient outcomes and experience • Impact on our registration and compliance with regulatory bodies

	workforce and at times quality • Clinical governance systems and systems for learning from incidents and other quality metrics may not be consistently applied and effective		
Current methods of management (controls)	A. Robust governance process, to support quality improvement and risk management; including undertaking Root Cause Analysis where there are incidents and sharing learning, B. Audit programme in place and reviewed by clinical effectiveness C. Mortality reviews to share learning D. Independent medical examiner scrutinising deaths to identify any quality concerns E. Quality Improvement strategy in place and improvement hub established QSIR improvement utilised and training programme in place F. 'Excellence in Care' audit and reporting programme rolled out to in-patient areas to facilitate clinical areas in assessing themselves against Trust wide standards of care G. Patient tracking lists, use of nerve centre and MDT meetings in place H. Daily safe staffing monitoring and establishment reviews to ensure safe, effective and efficient skill mix		

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Oversight of excellence in care at ward and service level (F) • Health Assure being utilised by wards and services as depository for CQC evidence (A) • Divisional management of risk and control framework (A) • Quality improvement champions in place and projects in train (E) • Daily clinical review of patients on waiting list (G) • Nerve centre in use for monitoring real time bed state (G) • Daily monitoring of staffing levels (H)	• 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:
• Improvements required in discharge particularly regarding information and communication to care homes • Please 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 4 Progress Report**	**BRAG**
1.	Programme of work in place to improve discharge pathway and quality of discharge	COO	Ongoing	• Multi-professional Discharge Improvement Group paused during wave 3 and now restarted. • Workstreams in place to Perfect Discharge which is a Quality Account priority.	
2.	Mitigating actions to minimise the risk to patients of safety alerts not being visible to staff accessing Nerve Centre	COO/CFO	Ongoing	• Staff are checking patient alerts on alternate system • Matter raised with Head of Digital who has escalated to software provider • Interface from PAS to Nerve Centre is built. • Formal Testing is underway and then the interface will be put into live. • Need to backload the historical warnings	
	Refer to BAF 2 for additional actions related to Covid-19 pandemic				

Risk Summary

BAF Reference and Summary Title:	**BAF 2: Restoration and Recovery**				**Strategic Objectives Impacted**	
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 Committee	**Date of last review by Committee:**	Mar-22	

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	27/11/20	1937	EMU birth centre environment	15	15	◄►
	03/12/20	1942	Insufficient acute beds during winter	20	16	◄►

BAF Risk Scoring

Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4		Risk level decreased due to the lessening impact of Covid-19 on the delivery, restoration and recovery of services. Likelihood of further wave reduced from 'certain' to 'high probability'.	**Likelihood:**	2	Mar-23
Consequence:	4	4	4			**Consequence:**	4	
Risk Level:	16	16	16			**Risk Level:**	8	

Cause of risk:	2021 recovery (H1&2) is being overseen at an ICS level against the national 2021/22 priorities and operational planning guidance. There is an expectation that ESHT will deliver the national ask of 95% in H2, also that the Trust starts planning against the operational guidance for 22/23, which has been delayed to the end of April due to the current COVID response levels. As expected the Trust has seen an increase in the Omicron variant and this has impacted staffing levels available to deliver elective sessions. There is an additional impact on the increase in the number of beds having to be closed due to contacts/outbreaks – encroaching on the elective bed base as a result. Additional capacity has been opened and the Trust is working as part of the ICS to utilise IS and Cancer	**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 • failure to meet constitutional and contractual standards • damage to Trust's stakeholder relationships and reputation

	capacity at QVH to maintain urgent elective procedures for Skin. It is recognised regionally and nationally that the impact is on the elective programme and the Trust delivered 85% in November for admitted activity. The trust continues to deliver against OP activity and Day Case but along with the rest of the country the inpatient elective programme has been impacted. The trust remains with 0 patients waiting over 104 weeks and 1 patient over 78 weeks which is being planned in conjunction with the patient availability.		
Current methods of management (controls)	A. Compliance with 95% in H2 B. Working to national guidance on activity requirements C. Estates space utilisation being reviewed taking account of requirements for recovery of safe services whilst maintaining social distancing ongoing D. Identifying areas where improvements have been made e.g. such as virtual out-patient appointments and maximising these opportunities E. Utilisation of capacity in private providers where available during H2 F. Elective Access meeting with oversight of Trust level PTL profile and long waiters including cancer and private patients G. The Trust is asked to support system partners to smooth the Sussex waiting list profile and the number of patient waiting over 78 week		

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:	• Weekly system operations and surge group meeting in place and all decisions logged and risks monitored (F) (G) • Elective Access, Urgent and Community Care Boards and associated governance arrangements in place (A) (B) (C) (D) (E) (F) • Update report covering concerns/ key actions / positive assurance and decisions presented to Executive Team (A) • Weekly Elective Access meeting overseeing re-starting of services and interdependencies (E) (F) • Performance against National Standards (A) (B)	• Reporting on Restoration and Recovery presented to Trust Board in IPR (A) • Linking into system wide recovery approach, via System Recovery Board (B) (G) • Digital infrastructure improved; hardware available to facilitate home working (C) • HR Support for staff related Covid-19 issues including risk assessment and track and trace (F) • Divisional tracking through Elective Access meeting against trajectories that are in development (A) (F) • ICS Planned Care Leads meeting (F)	• Internal audit plan will include aspects of the management of Covid-19 (G) • Oversight by NHS Improvement through submission of sitrep information and oversight meetings (A) • ICP/ICS risk and recovery group (A)(G) • Planned Care Board (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 4 Progress Report**	**BRAG**
1.	Seasonal bed modelling in progress and mitigations being identified	COO	End of April 22	• Escalation waterfall and triggers presented to Execs and NEDS – via board drop in session and IMT – being embedded into EPRR / BC documentation	

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 national operating guidance KPIs**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee	**Date of last review by Committee:**	Mar-22	
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	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	5	4	4		Risk level reduced due to the impact of the second wave of Covid-19 had on restoration and recovery of services. Impact moved to "highly probable" and consequence "major". Additional capacity for endoscopy introduced in August which will help address the diagnostic backlog for routine and cancer patients.	**Likelihood:** 2	Mar-23
Consequence:	4	4	4			**Consequence:** 3	
Risk Level:	20	16	16			**Risk Level:** 6	

Cause of risk:	Increased demand for services and diagnostics year on year. This has been further impacted by the reduction of patient presentations to GPs during the pandemic, leading to a growing unidentified need, and to reluctance on the part of some patients to engage with treatment plans during the pandemic period.	**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, diagnostics and RTT - pathway review in line with 28/62 days - identifying digital opportunities to proactively manage patient care - Alliance decision to be confirmed re AI digital tracking - Contact with individual patient and agreeing individual approaches to mitigating concerns - Contact with GPs / CCGs / Primary Care Networks etc.

	D. Working closely with the Cancer Alliance on improvement actions such as: - Straight to test pathway - Faster diagnostic standard E. Addressing Histology turnaround times and implementation of the Faster Diagnostic Standard F. Development and implementation of additional diagnostic capacity with the Community Diagnostic Centre roll out in Bexhill

Assurance Framework – 3 Lines of Defence – mapped to controls A-E			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Clinical oversight and review of RTT and cancer PTL weekly (B) (C) (D) • Day to day oversight of A&E performance (A) • Ongoing 'Cancer Week' focussed MDT PTL meetings on six week basis (E) (D) (B)	• Policy and procedures for MDT reviews strengthened and continually reviewed (C) • Divisional IPR meetings in place (A) (C) • Cancer Board, Urgent Care and Elective Access with oversight of metrics (A) (C) (D) (E) • Review by Quality & Safety Committee (A) (C) • IPR reports to Trust Board (A) (C) • Cancer Access Meeting (weekly) (C) (D) (E) • System Access Policy and PTL changes commencing with ENT (A) (B) (C) (D)	• Oversight by NHS Improvement through submission of sitrep information and oversight meetings (C) • System Recovery Board (A) (C) (E) • Admin and clinical validation of DM01 PTL and diagnostic codes to prioritise patients (A) (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 4 Progress Report**	**BRAG**
1.	System and Trust recovery trajectories for DM01 / Admitted / Non-admitted for H1	COO	End Mar 2022	• Elective Access and Cancer Access Meetings oversee performance • Trust cancer Board	

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:	Chief People Officer	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	Mar-22	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	07/07/21	2054	Recruitment to Trust Vacancies (substantive)	16	12	◄►
	25/11/21	2079	Construction Project Manager Vacancies	16	16	◄►

BAF Risk Scoring								
Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention likely to be a risk especially following Covid-19 pressures.	**Likelihood:**	4	Ongoing
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	16	16	16	16		**Risk Level:**	12	

Cause of risk:	• Recognised national shortages in some staff groups • Geographical location • Continued pressure in a number of clinical areas • Lack of opportunity for career development • Pandemic may have a detrimental impact on staff retention. • Changes to national educational programmes especially GP training. From August 2022 GP trainees will have to spend 24 months in the community leading to a reduction in the current hospital based posts. This will affect ED, Medicine, Paediatrics, O&G and Psychiatry. • South Thames Foundation School splitting apart new Foundation School being created for HEEKSS; expectation ready for August 2022, could impact on smooth allocation of FY doctors in August 2022. • Staff leave NHS employment as result of mandated vaccinations affect all areas.	**Impact:**	Failure to maintain workforce stability gives rise to risk of: • Increased workforce expenditure due to agency requirements • Detrimental impact on patient care and experience • Failure to comply with regulatory requirements and constitutional standards • Detriment to staff health and well-being • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas

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 efficiency 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 and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Exit interview programme I. Use of bank and agency if required with authorisation process in place J. Range of wellbeing support available and being further developed K. We continue to look for opportunities to thank our colleagues and celebrate the success of the work they do through the Pride of ESHT awards, thank you cards, regular meals, Hero of the Month Awards, Winter Sparkle Campaign L. Real focus on retention particularly on understanding why people may want to leave the trust.

Assurance Framework – 3 Lines of Defence – mapped to controls A-K			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H)(D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas e.g. consultants in Histopathology, Radiology, Neurology and Acute medicine.(A) (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Workforce efficiency metrics (D) • New AHP /HCSW initiatives rolled out Jan 2022(C) • Continued International Nurse recruitment.c30 each month Jan/Feb/March 2022.Cohorts planned for rest of Financial year 2022(A) • Additional Headhunter Agencies engaged for hard to recruit Medical Posts (A) • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • HR develop policies, strategies and support for all staff reference mandated vaccinations – through HRBP roles.	• 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 and Attraction Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Trust vacancy rate increased to 6.9% in August 2021. (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I) • Wellbeing offering enhance (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy being developed (A)(B)(C)(D)(E)(F)(I)(K) • Planned 3-6 month recruitment campaign to be scoped and rolled out early March 2022 (A)	• 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 4 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers ,Sonographers, gastro and endoscopy	CPO	Ongoing	• Between Aug 21 and Dec 21 a further 87 international recruits joined the Trust of which 4 were radiographers. • Medacs recruitment agency have sourced 2 sonographers are due to start before April 22 • International nurses successfully placed in Gastro (4) endoscopy (5) and critical care. • 180 international nurses and 9 radiographers recruited to date January 2022. • Further 34 Nurses due to arrive February 2022 and an additional cohort of c40 in March. • Planned 20 every other month during 2022/2023.	
2.	Kickstarter and other local outreach initiatives	CPO	Ongoing	First cohort of 9 commenced Feb 2022 following full Induction and now on placement. 2nd cohort due.	
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	CPO	Ongoing	• SCP: 2 currently on programme. • PA: We continue to have only 3 PA in post in the Trust; more work to be done within the Trust to promote the role. A Day in the Life initiative with a video to raise profile of new roles - starting with PA role, discussed with Comms. • Anaesthetic Associates: Theatres Service are considering this role. Education, Clinical Lead, Practice Educator to meet with the GMC/HEE lead Dr Nigel Penfold	
4.	People Strategy	CPO	Ongoing	Final Strategy agreed by Trust Board. Implementation commenced. Communications team finalising the document for publication.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 5: Protecting our Staff**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk to staff health, welfare and morale if we do not undertake and act upon risk assessments to ensure a safe working environment and effective support for wellbeing**					
Lead Director:	Chief People Officer	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	Mar-22	
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	16/07/21	2059	Impact of Violence and Aggression on staff wellbeing	16	12	◄►

BAF Risk Scoring								
Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	3	3	3	Significant work has been undertaken in conducting and acting upon risk assessments for Covid-19. There is also a robust programme of work in place to support wellbeing of staff and manage violence and aggression however there is still more that can be done. As Covid levels reduce, pressures are being replaced by recovery and other emerging operational challenges.	**Likelihood:**	3	Ongoing
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	12	12	12	12		**Risk Level:**	9	
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 e.g. Covid-19, violence and aggression and work related stress.				**Impact:**	Adverse impact on staff health and wellbeing. Risk of increased absences and therefore inability to deliver on services; possible closure of services and adverse impact on patient experience and reputational risks.		
Current methods of management (controls)	A. Systems and processes in place to risk assess staff to reduce the risk from infection of COVID 19. Managers are required to complete a risk assessment to identify measures that need to be put in place to enable a member of staff to remain safe at work. If this cannot be achieved managers need to consider deploying their staff member to a different area or working from home if need be. B. Training for managers to have compassionate conversations about risk assessments with vulnerable staff C. 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. D. Working with the ICS to develop a system wide strategy and policy on violence prevention 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 (e.g. TRiM, MHFA) G. Targeted support for implementing TRIM in ED departments through a dedicated resource for a period of three months H. Range of wellbeing/pastoral support available and being further developed across all professional groups I. Development of Health and wellbeing Conversations for all colleagues which will be implemented in April 2022							

	J. Violence and Aggression action plans developed following the 2020/21 staff survey results K. Ongoing National vaccination programmes L. Workforce Efficiency and Availability Reviews M. Workforce Strategy

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:	• On Line Covid risk assessment process implemented to be undertaken by line manager and retained on personnel file. (A) (C) • Completion of risk assessments to be recorded on ESR. (A) • Appropriate PPE provided (A) • Promoting wellbeing support available and training to line managers (G) • DME monitor/reviews confidential trainees in difficulty register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs (I)	• Occupational Health and Health and Safety Team support and audit of risk assessments and datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) (H) (I) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Local Security Management Specialist advice and support (D) • Oversight and monitoring by Health and Safety Steering Group (D)	• 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) • Audit of Covid-19 staff risk assessments undertaken by TIAA, providing reasonable assurance (A) • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust

Gaps in control/assurance:

- The Covid-19 pandemic and recovery has impacted some of the progress in supporting staff with incidence of violence and aggression
- Need to develop a single software solution to support staff who are lone/community working
- Need to ensure that staff have access to appropriate well-being support during and following the Covid-19 pandemic

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Managers and staff to review existing Covid risk assessments to ensure they reflect latest risk profiles and ensure appropriate mitigations are in place in line with Trust/national guidance.	CPO	Ongoing	Audit completed by internal auditors, providing assurance about compliance and completion of staff risk assessments. Good compliance with completion but need to ensure assessments are reviewed and updated, including reviewing and implementing effective mitigation if required. Providing guidance regarding vaccination.	
2.	People Strategy	CPO	Ongoing	Final Strategy agreed by Trust Board. Implementation commenced. Comms finalising the document for publication.	

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 21/22 or not complying with Covid financial guidance and audit breaches**					
Lead Director:	Director of Finance		**Lead Committee:**	Finance and Investment Committee	**Date of last review by Committee:**	Mar-22

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	22/07/21	2060	Delivery of 21/22 Financial Plan	**20**	12	◄►

BAF Risk Scoring								
Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**3**	**1**	The financial position for H1 of 2021/22 is assured, with an agreed H1 settlement despite ERF targets increasing. In M8 additional funding was agreed, providing some assurance that H2 should be delivered.	**Likelihood:**	**2**	Mar-22
Consequence:	**4**	**4**	**4**	**4**		**Consequence:**	**4**	
Risk Level:	**12**	**12**	**12**	**4**		**Risk Level:**	**8**	

Cause of risk:	The Trust has agreed a block contract and agreed Covid payments for the first half of 2021/22. The financial envelope and position for H2 has been finalised in M8. Delivery is being closely managed through H2 as the current Covid pressures are adding to the system challenge.	**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 has been updated with divisions B. Transformation programmes in place to realise benefits of cost effectiveness C. 21/22 budgets have been updated to reflect nursing establishment changes. In 22/23 there will be a need to complete a specialist nurse review and nursing and A&E reviews. D. There will be an ongoing review of process following the previous year of IMT Covid controls. E. Monthly benchmarking of Covid costs within ICS and agreement to only charge excess costs to Covid reclaim system F. The organisation is starting to develop the efficiency plan for 22/23		

Assurance Framework – 3 Lines of Defence - aligned 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:	• 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 Efficiency Committee and Finance & Investment Committee (A) (B) (C) • 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 4 Progress Report	BRAG
1.	Agree CIP plan for 2021/22: 2% in H1 and 3% in H2	Chief Finance Officer	Complete	The CIP £14.7m target 2021/22 target has been identified, £10.8m of the delivery is non-recurrent.	
2.	Monitor delivery of any activity above the elective threshold to maintain this within additional ERF funding	Chief Finance Officer	Complete	No penalties have applied	
3.	Maintain staffing controls through establishment control, including vacancy panel	Chief People Officer	Complete	Workforce efficiency metrics in place and regularly monitored	
4.	Capital controls: • Agree and manage within an updated capital plan for the year • Develop controls to forecast and deliver capital projects in line with Trust agreed limits	Chief Finance Officer	Complete	Capital controls were independently reviewed in Month 9 by RSM. There is some risk remaining as a significant amount of capital is planned in the final two months of the year.	
5.	Capital funding: • Additional capital was agreed through the TIF process during November 21 - January 22.	Chief Finance Officer	Complete		
6.	Trust focus on developing a CPI and capital for 22/23	Chief Finance Officer			

Risk Summary						
BAF Reference and Summary Title:	**BAF 7: Capital Investment**				**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 Investment Committee	**Date of last review by Committee:**	Mar-22	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	12/02/14	1152	Obsolete medical devices	20	12	◄►
	25/09/15	1360	Cardiac catheter lab breakdowns	16	12	▼
	27/05/20	1879	Capital sustainability	20	20	◄►
	01/02/21	2027	Trust Compute Resources for the Virtual infrastructure	20	9	▼
	02/07/21	2051	Potential failure of digital backup hardware components	16	16	◄►
	12/07/21	2055	Radiology equipment breakdowns (Bexhill)	20	15	◄►
	12/07/21	2056	Radiology equipment breakdowns (Conquest)	20	20	◄►
	02/11/21	2075	Datix risk management system no longer fit for purpose	20	12	▼

BAF Risk Scoring

Quarter	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4	4	4	Due to in year controls, currently expecting to limit IT and medical equipment spending to £4.5m for the year.	Likelihood:	3	Mar-23
Consequence :	4	4	4	4		Consequence:	4	
Risk Level:	12	16	16	16		Risk Level:	12	

Cause of risk:	Insufficient capital to meet significant backlog maintenance	Impact:	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care. Clearer reporting of any slippage against plan. Annual capital for digital is limited to £3.5m, plus £1m for equipment, so some risk to demonstrating matched funding for an EPR project, with a potential impact on achieving digital maturity over next five years if the capital position does not return to £4.5m for digital and £1m for equipment in 2022/23.

Current methods of management (controls)	A. Significant work was undertaken to deliver the capital plan. However in future there will be clearer reporting of any slippage against plan. B. Essential work prioritised with estates, IT and medical equipment

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 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.	Chief Finance Officer	End Mar 2021	Completed	**Complete**
2.	To develop clearing escalation and reporting of slippage of capital plans	Chief Finance Officer	End Sept 2022	By September 2022 a two year capital plan will have been developed and shared with the ICS.	
3.	Radiology equipment: Bexhill Friends / potential funding over the next year with phasing to be agreed. Also potential funding through the Community Diagnostic Hub	Chief Finance Officer Director of Strategy, Inequalities & Partnerships	End Mar 2022 Oct 2022	£1m ring-fenced from capital budget for equipment. Prioritisation through Sim Beaumont. Overall improvement as CDC has been secured	**New**

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 Investment Committee	**Date of last review by Committee:**	Mar-22	

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	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	◄►
	09/05/17	1621	Loss of Electrical Services (Power and Lighting) to Critical Clinical Areas	20	16	◄►
	27/11/20	1937	EMU birth centre environment	15	15	◄►
	29/12/20	1949	Insufficient air ventilation could contribute to Covid-19 cross infection	16	16	◄►
	03/08/21	2065	Lack of suitable premises for community midwifery service	15	15	◄►
	25/11/21	2079	Construction Project Manager Vacancies	16	16	◄►

BAF Risk Scoring								
Quarter	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	The Six facet survey indicates significant backlog maintenance. Whilst £12m of backlog was eradicated in 20/21 with external capital support, the backlog inflationary pressures are outstripping the available internal capital.	**Likelihood:**	2	Mar-23
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	16	16	16	16		**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	A. 2020/21 capital plan reprioritised to ensure that it is fit for purpose post COVID-19.		

methods of management (controls)	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 e.g. automatic fire detection. emergency lighting and firefighting equipment

Assurance Framework – 3 Lines of Defence- linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (B) (C) (D)	• Oversight by Finance and Strategy Committee (A) (B) • Simulated patient safety exercise undertaken on Seaford ward in June 2019 to support refinement of evacuation plans (D) • Estates and Facilities IPR (A) (B) (C)	• Capital business cases reviewed by ICS (A) (C) • The Trust has been named as part of the HIP Programme (Phase 2) and developing strategic outline case to secure significant funding over the next 5-10 years (A) • NHSI funding confirmed in order to facilitate additional fire compartmentation works, but is being delayed by Covid-19 bed pressures (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 with appropriate levels of investment required to identify pressures and requirements
- Need to recommence fire infrastructure work impacted by Covid-19 (restarted in AMU in FY21/22 Q3)
- Building works delayed due to impact of Covid-19 and Brexit. Position slowly improving, but will continue in short-term
- Some areas inadequately ventilated (standalone HEPA fans being used where appropriate as short-term mitigation)

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 4 Progress Report	BRAG
1.	Developing "Building for Our Future" full business case and project board being established	Chief Executive	End Mar 2021	• Programme Director in place. • Governance structure in place. • SOC submitted late March 21 – awaiting DH/NHP review	
2.	Aiming to resume fire compartmentation works at DGH in Autumn 2020	Director of Estates	End Mar-2024	• Now that the Maternity Day Unit has become available the 1st phase of the refurbishment plan has now been completed Sept '21 (SDEC). • Winter escalation plan delayed works scheduled for the rest of FY21/22, so now limited fire compartmentation works have been agreed to be undertaken in EDGH AMU over Oct-Dec' 21.	

3.	Comprehensive trust-wide plans for improving ventilation being developed	Director of Estates	End Mar-2022	• Draft report sent to TIPCG in April 2021 and progress updated being reported bi-monthly as appropriate. • Can only be fully mitigated upon completion of BFF programme due to the significant level of investment required to minimise the risk	
4.	6 facet survey update	Director of Estates	End Apr-2022	6 facet survey update being undertaken in FY21/22 Q3/A4 with report being made available in FT22/23 Q1 to inform future backlog strategy	

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Infrastructure**				**Strategic Objectives Impacted**	
					SO1 ✓	SO2 ✓	SO3	SO4	SO5 ✓
Risk Description:	A large-scale cyber-attack could shut down the IT network and severely limits the availability of essential information and access to systems for a prolonged period which would impact the Trust's ability to deliver its strategic objectives					
Lead Director:	Chief Financial Officer		**Lead Committee:**	Audit Committee	**Date of last review by Committee**	Mar-22
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	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**21/22 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	There are a number of robust controls in place, but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda. Whilst the risk is still 16, lots of work has been done to increase the robustness of the Trust Cyber security posture, but due to an evolving threat landscape new threat arise that need new and further remediation.	**Likelihood:**	4	Mar-23
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	16	16	16	16		**Risk Level:**	12	
Cause of risk:	Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website.				**Impact:**	A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.		
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. Ongoing Education campaign to raise staff awareness F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary H. Continual Network monitoring for abnormal activity / behaviour I. Vulnerability scanning, to identify vulnerabilities and remediate							

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) (H) (I)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with organisations within the Sussex ICS (G) • Regular quarterly security status report to IG Steering Group and Audit Committee (D)	• Cyber security testing and exercises e.g. senior leaders participated in IT / Cyber exercise in a box provided by GCHQ (Oct-21) (E) • Trust to date has had no ransomware attack (A) (B) (C)(H)(I) • TIAA internal audit (Feb-22). (D) • Assurance given for our DSTP submission (Jun 21) (D)
Gaps in control/assurance:			
Obtain Cyber Essentials Plus to provide assurance on reliability and security of systems and information. Continue with patching programme and address points raised by internal audit			

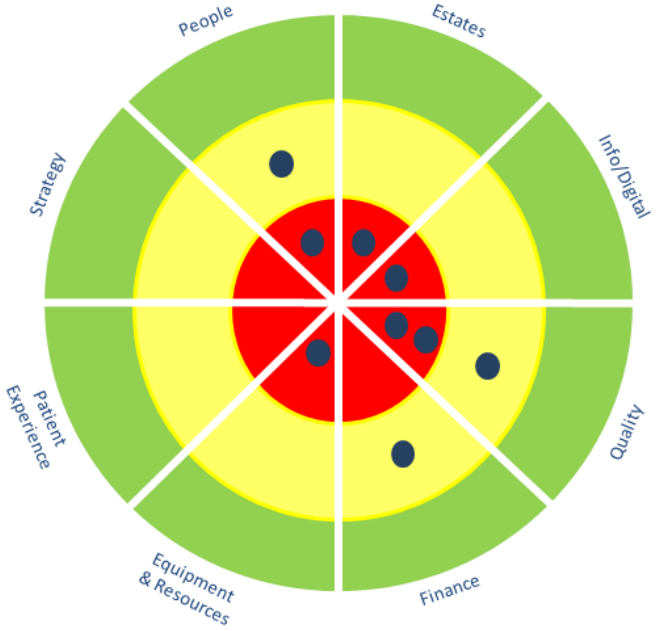
Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Cyber Essential Plus framework.	Director of Finance	March 2023	Scope of Cyber Essentials has now change and this is a much larger piece of work. Good progress has been made on removing end of life mobile devices.	
2.	Improved Backup environment including immutable copies	Director of Finance	May 2022	Equipment now ordered awaiting implementation.	
3.	New Cyber awareness Campaign	Director of Finance	March 2022	• Campaign is developed and now anticipated to take place in March 2022 • Malware email campaign carried out August 2021 with good results and will be carried out each year.	
4.	Medica devices with network connectivity asset list	Director of Finance	June2022	Cylera installed and now running network audit.	
5.	Server level firewall	Director of Finance	March 2023	Trend Micro host-based firewall installed and in the pilot stage of deployment.	

2. Planning for FY 22/23 BAF risks

Board members are aware that we have made significant improvements to our BAF and, looking forward, we are keen to continue this mindful that 22/23 brings additional challenges. We now have a clear set of Trust strategies, the aims/objectives of which will drive the Trust's direction over the coming five years at least. These aims/objectives have been shaped by an understanding of our operating context and we also have annual priorities as set out in the Annual Planning Guidance that we need to ensure the Trust aims to deliver this year.

We therefore need to ensure that we have captured adequately all the relevant information on the risks to the delivery of the Trust's aims/objectives and urgent priorities. As we move into the new FY 2022/23 this is a sensible point at which to review and refresh our BAF. The figure below shows an approach known as the "assurance radar" and, as an Executive Team, we are looking to use this to prompt our own thinking about how we shape the 22/23 BAF and this will be coming as part of the Q4 YE summary.

(NB: The figure below shows our current BAF controls and risk parameters covered)



Denotes the residual risk level (where we believe the risk level remains once the control has been implemented

*Baker Tilly: Board Assurance, A Toolkit for Health Sector Organisations

Considering our current BAF using this approach, two immediate questions appear:

1) Are we comfortable that our BAF identifies no Trust-level risks around patient experience or strategy?

2) Given the dots represent our residual risks (i.e. post- controls) are we comfortable with two-thirds of our BAF risks remaining red?

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

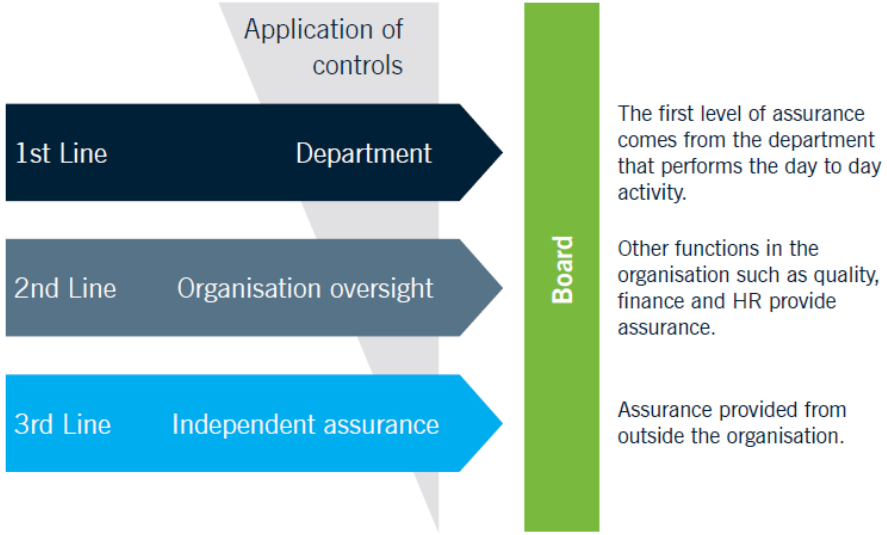
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		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 – One Year On

Meeting information:			
Date of Meeting:	12th April 2022	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer: Brenda Lynes Executive Sponsor: Vikki Carruth	

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

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

Summary:

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

This report is the scheduled Trust Board update on maternity services. Its purpose is to provide assurance to the Board regarding the service's progress with completing the actions generated by the recommendations of the Ockenden Report[1] and the Morecambe Bay Report[2] whilst also including ESHT's maternity workforce plans and any other related matters.

Detailed reports are also discussed at each meeting of the Quality and Safety (Q&S) Committee, and are presented on a quarterly basis to the Trust Board. This report has also been discussed at the Maternity Assurance meeting (Internal Performance Review) on 23rd February 2022 and at a Private Trust Board meeting on 8th March 2022 with some updates since.

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

Maternity Assurance (IPR) – 23rd February 2022
Private Trust Board Meeting - 8th March 2022

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

The Board is asked to receive assurance that the majority of the recommendations from the Morecambe Bay and Ockenden reports have either been completed, or are progressing, and a timeframe for completion of the service's work force plans is in place.

[1] The Report of the Morecambe Bay Investigation (publishing.service.gov.uk)
[2] OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk)

Ockenden

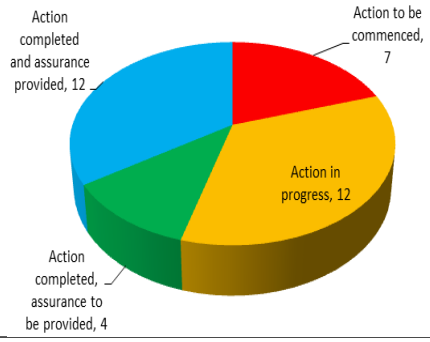
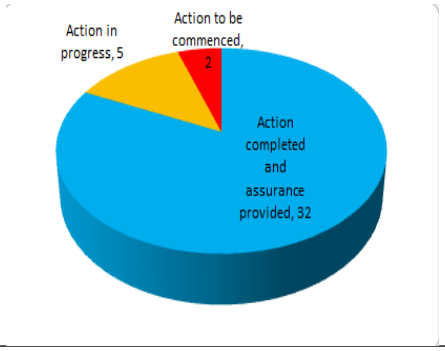
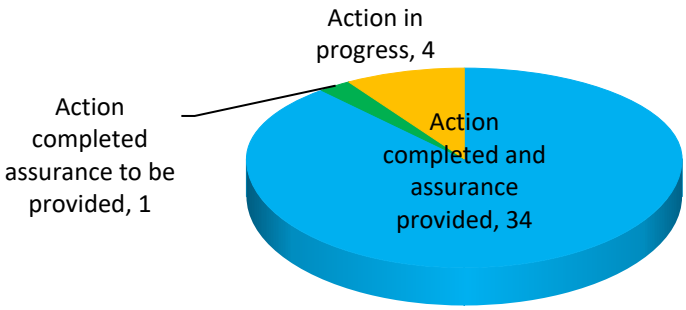
The Ockenden Report was published in December 2020 following a review of maternity services at Shrewsbury and Telford NHS Trust. During June/July 2021, there was a requirement for Trusts to submit evidence to an online portal to support the declared position against recommendations made in February 2021. This resulted in the uploading of over 300 documents. The initial assessment of evidence by NHSE returned a completion rate of 50%. Following challenge of this by the service, re-assessment by NHSE resulted in 70% compliance. The service still assesses compliance as higher and have signposted the assessors to the submitted evidence. A meeting is planned for 8th April 2022 between the Maternity Safety Champions and the Regional Midwifery Officer to review the evidence which the service considers to be compliant.

The service was unable to provide evidence for the following recommendations at the time of submission:

Recommendation	Reason for non-submission of evidence
Audit of compliance of external review of serious cases.	No cases during the initial timeframe for upload. Any/all cases now are discussed with the Local Maternity and Neonatal System (LMNS) Quality and Safety Group and lessons shared.
Evidence of consultant led ward rounds 7 days a week.	Not yet recruited to full capacity, therefore, not yet in place - not able to audit.
Evidence of education funding spending.	Was not captured at the time. This data is now captured 21/22 and available via the trust Integrated Education team and the Maternity Governance/Quality Improvement team.
Maternity services are involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. Pathways have been across the LMNS and the first joint clinic commenced at University Sussex Hospital in January 2022.	Omitted in error, now submitted.
Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	Personalised Care and Support plans are in place (included in evidence). Unable to complete audit until BadgerNet was in place. BadgerNet now in place (Antenatal care from August 2021/Intrapartum care from November 2021) – audits to commence in April 2022 to allow for sufficient data capture from bookings.
An audit of 1% of notes demonstrating compliance which shows how women are enabled to participate equally in all decision-making processes and to make informed choices about their care.	Unable to complete within timeframe. (Audit in 3/12 now BadgerNet is in place) Once discussed and agreed with woman/birthing person all notes are published to the person's own Badger Notes (App) – audit in April 2022.

An audit of 5% of notes demonstrating compliance with "*Care out of Guidance"*, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	Evidence of "*Care out of Guidance"* planning discussions and outcomes, full audit not completed in timeframe due to handheld notes. Audit planned for April 2022 from BadgerNet/Esearcher
Evidence of establishment reviews 6 monthly for all staff groups and evidence considered at board level.	Midwifery workforce papers included, other staff groups omitted in error – now submitted.

In January 2021, ESHT maternity services completed a multidisciplinary benchmarking process against the report's recommendations. The Trust continues to make good progress in completing recommendations.

June/July 2021. First review of the recommendations	**October 2021 position. Some actions have been separated for clarity resulting in more actions**
	
Latest Position	
	

Remaining actions:

Recommendation	Progress	RAG	Timeframe
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.	LMS TOR review completed. Quality and Safety forum frequency increased to allow for quality and safety review. Clinical Effectiveness midwife recruited, commenced in post 14/3/2022 Further work needed to fully embed learning.		Priority of Clinical Effectiveness midwife will be to improve embedding of learning from incidents and investigations. Work plan will be developed by June 2022.
Consultant presence on ward rounds day and night seven days a week.	4 x permanent consultant posts out to advert Cover at present is day and night ward rounds 5 days (Monday – Friday). Weekend day ward rounds are attended, with the two evening ward rounds to be job planned in once new recruits commence.		Interviewed x February 2022 – 2 posts recruited to, in post by June 2022 Further x 2 posts, interviews June 2022
Review of maternity website and necessary improvements.	IT lead and midwife for clinical support identified, work to start March 2022. Maternity Voice Partnership (MVP) Gap analysis performed. Immediate improvements actioned.		Communications team are working with a midwife to review and update the maternity website with any necessary improvements. Anticipate completion by Q3 2022/23
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.	Interim post in place, for review May 2022		Q1 2022/23

Morecambe Bay

The Morecambe Bay report was published in 2015. The Investigation was established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents including the deaths of mothers and babies in maternity services provided by what became, the University Hospitals of Morecambe Bay NHS Foundation Trust. The investigation was completed by Dr Bill Kirkup.

There were a total of 44 recommendations. 18 applied to NHS Trust Maternity services, the remaining actions were to be actioned by the wider NHS and selected stakeholders.This ESHT benchmarking work has been completed by the management team. Of the 18 actions for the service, self-assessment has concluded that the service is compliant with 15.

The three remaining actions are:

Recommendation	ESHT self-assessment and progress	RAG	Timeframe
Trusts should admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but the length of time to bring to light the failures.	ESHT has a robust Governance and Duty of Candour process. Families are involved in Perinatal Mortality Review Tool (PMRT) and SI/RCA reports. HSIB include family opinions. There is shared learning of outcomes from investigations across the service and the system. Historic round table review of SIs is planned (delayed by Winter and Omicron wave). Further work needed to embed actions and audit compliance.		Clinical Effectiveness midwife recruited, start date 4.4.22 – this will increase Governance capacity to allow for this work. Work plan expected Q1 of 2022/23
Trusts should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience.	ESHT has good levels of recruitment historically. This has been impacted by Covid, with a vacancy factor of 3.5% currently. Recruitment and Retention Strategy lead post being recruited at present. There are bi-annual Board reports regarding workforce. BirthRate+ final report and regional workforce lead meeting output to inform workforce strategy.		Workforce strategy development Q2 of 2022/23
Trusts should improve the physical environment of the delivery suite particularly including access to operating theatres, an improved ability to observe and respond to all women in labour and en-suite facilities. Arrangements for post-operative care of women also need to be reviewed.	At ESHT, upgrade of the postnatal environment within the Obstetric Unit is underway. Dedicated bereavement suite completed in May 2021. Second theatre and Midwife Led Unit (MLU)/Community hub is included in ESHT Building for the Future (BFF) plans with draft business plans in progress.		Physical upgrades to Mirlees and postnatal area April/May 2022 Community hub – draft business case in progress Second theatre is currently part of BFF – further discussions underway to support planned Caesarean Sections in main theatres

Maternity Workforce plans

- Obstetric workforce plans are reviewed by the Clinical Lead for Obstetrics, Chief of Division and the Associate Director of Operations.

- Anaesthetic workforce plans are in place and reviewed by the Surgical Divisional leads.

- Midwifery workforce planning is to be confirmed following the receipt of the final BirthRate+ (BR+) report expected imminently and following a workforce review by the regional workforce advisor. The BR+ team are recalculating requirements based on a 25% - 26.4% uplift (as opposed to the current funded 21%) as BR+ consider this to be the correct uplift due to training/study requirements. This is currently being recalculated. The current vacancy rate is 3.5%. A workforce plan is expected to be completed by Q2.

- The service has recently received notification from the LMNS of two successful funding bids for 2022/23. The bids were for ongoing funding for the Maternity Transformation Lead and a deputy who will support with individualise training and cross-skilling of midwifery staff in preparation for the introduction of further Continuity of Care teams.

- A further funding bid has been submitted to NHSE/I for a Clinical Support Practice Assessor post. If successful, the post-holder will work collaboratively with the Recruitment and Retention Lead, Maternity Transformation Lead and Maternity Education team to provide ongoing individualised support and targeted intervention for student/apprentice midwives, early career midwives and those who are more advanced in their career to promote retention, career progression and cross-skilling.

- Staffing levels remain of concern due to absence (maternity leave/ increased sickness/ retirement leave/ Covid sickness and isolation) impacting on our ability to staff the service on a day to day basis. The internal Maternity Escalation Policy is frequently activated, staff report being tired and morale is low. The Eastbourne Midwifery Unit birth services have been suspended since 10th December 2021, this suspension remains in place at the time of writing this report. Suspension is reviewed by the Senior and Executive team on a weekly basis with a view to reopen as soon as staffing levels allow.

- Intrapartum care elements of the Continuity of Carer teams suspended from 20th December 2021 recommenced on 21st March 2022

Maternity Perinatal Quality Surveillance Update

The Maternal Clinical Quality Surveillance Report is a dashboard to systematically review quality indicators for Trust Maternity Services in response to the Ockenden Report. The dashboard is reviewed monthly by the Divisional Governance Trust Quality and Safety Committee. The report is communicated to the Local Maternity and Neonatal System (LMNS) Board monthly, any issues are reported to the Integrated Care System (ICS) Quality Group. Issues that have not been covered in this report to date include:

- Perinatal Mortality Review Tool (PMRT) – a tool to support standardised perinatal mortality reviews across the NHS – concerns raised by parents regarding that ESHT have one obstetric theatre available. Exploration of using main theatres for elective caesarean sections is underway, with a second theatre being part of Building for the Future.

Severity 3 Incidents

1. Never Event – retained swab at caesarean section – investigation underway

2. IT issues restricting access to portable devices on labour ward – now resolved

- FFT feedback score 94.23% positive – one 'poor' and one 'very poor' rating

Maternity Voices Partnership (MVP) feedback

- Lack of antenatal education – action – working with the local County Council to develop Service and online bite sized videos have been produced to share with service users
- Lack of midwifery consistence in the antenatal period – this has been impacted by workforce absence – every attempt to provide consistency in care. Antenatal pathways are a key action within the 2022 Business Plans for Maternity Services
- Requests for open visiting – to be reviewed in line with Trust review on visiting – not currently possible due to Covid risk assessments and hierarchy of controls
- Pressure on the postnatal ward impacting on care – impacted by workforce absence, mitigations in place to support staffing levels as previously described

NHSE self-assessment tool

- This tool is benchmarking against CQC 'Outstanding' maternity services. Initial benchmarking completed, to go through Trust Governance process and discussion within the next Board report

Ockenden - Final Report

The Ockenden Final report was published on 30th March 2022. NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate and Essential Actions (IEA's) which every Trust, ICS and LMNS Board must consider and then act on the reports findings. An initial gap analysis is underway with support from the LMNS. The requirement is to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well -trained workforce
3. Learning from incidents
4. Listening to families

A fuller local report will be provided at the next Board meeting.

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

Meeting information:			
Date of Meeting:	12th April 2022	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	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. Changes to the documents are highlighted below.

Full versions of the updated Standing Orders, 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 21.02.22

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

The Trust Board is asked 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 Acting Company Secretary, with input from the Head of Procurement.

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

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
P9 2.4.1	Amended 'Chairman may appoint one of their number, who is not also an executive director, to be Vice-Chairman'	'Chairman may appoint **any Member of the Board, who is also a Non-Executive Director,** to be Vice-Chairman'
P20 4.8.4.1	Added information about the Capital Sub Committee	-
P21 4.8.6	Added information about the Strategy Committee	-

Standing Financial Instructions

Throughout the SFIs, the following replacements have been made

- 'OJEU threshold' has been replaced by **The Public Procurement Threshold**
- 'EU threshold' has been replaced by **The Public Procurement Threshold**

Page Number and Reference	Detail	Replaced with
P14 3.1.5	Replaced 'Director of Finance'	Chief Financial Officer
P22, 7.2	Replaced 'EU Directives' and 'Directives by the Council of the European Union'	'The Public Contracts Regulations 2015 Legislation' in both instances
P22 7.5.1	Added 'All competitive tendering must be undertaken in conjunction with the Procurement team'	
P28 7.6.8	Director of Estates and **Capital Development**	Director of Estates and **Facilities**

P30/31 7.8	Made clear distinction between processes for approvals for 'Within Current Budget' and for 'New Spend' and defined these terms	-
P31 7.8	Removed requirement for use of Trust Seal for spend within budget of over £1m	
P31 7.8	Added approval of Executive Directors for any new spend over £500,000	-
P31 7.8	Additional wording added	**If there is any doubt about whether proposed expenditure falls outside of the £138,760 inc VAT then please seek advice from the Procurement team.**
P32 7.11	Replaced 'EU Directives'	The Public Contracts Regulations 2015
P33 7.15.2	Replaced '**supplies** officer'	**Purchasing** officer
P39 10.2.4 c	Replaced 'EU public procurement'	The Public Contracts Regulations 2015
P40 10.2.6 b	Replaced 'EU on public procurement'	The Public Contracts Regulations 2015
P43 13.1.2 a and d	Amended 'Capital **Review** Group'	Capital **Resource** Group
P43 13.1.2 f	Amended 'submitted to the Trust Board for'	'submitted to the Trust Board for **approval**'
P43 13.1.2 g	Additional wording added	**Details of any forecast overspend should be recorded within the minutes of the CRG meeting where the matter was discussed.**
P44 13.1.6	Included detail of process for gaining approval for overspend of capital process	Flowchart added.
P57 22.1.1	Amended £50,000 excluding VAT	**£70,000** excluding VAT
P57 22.2.1	Amended 'Tenders from **£50,000** excluding VAT'	**£70,001** excluding VAT **to the Public Procurement Threshold**
	For tenders from £70,001 excluding VAT and the Public Procurement Threshold: Minimum of **4** invitations to tender **with at least 3 received** (**where such number of suppliers exist**)	Minimum of **3** invitations to tender.
	For tenders above the Public Procurement Threshold: Minimum of **6** invitations to tender **with at least 4 received** (**where such number of suppliers exist**)	Minimum of **4** invitations to tender with at least **3** received (where such number of suppliers exist)
P57 22.2.2	£50,000	£70,000
P57 22.2.3	£50,000	£70,000

P58, 22.3.1	Amended values for requiring competitive quotations: Up to £10,000 £10,001 to £50,000	 **Up to £25,000** **Above £25,000 to £70,000**
	Number of quotations required for between **£25,000 to £70,000** Minimum of **3** suppliers invited to submit written quotations	 Minimum of **2** suppliers invited to submit written quotations
P58 22.4.2	For tenders £1-**£50,000** For tenders above **£50,000**	For tenders £1-**£70,000** For tenders above **£70,000**
P60 Annex 1	Addition of simplified Capital and Revenue Process	
P62 Annex 2	Updated Waiver form included	

Scheme of Delegation

Page Number and Reference	**Detail**	**Replaced with**
P29 21.3 and 21.6	Changed the NHS **Litigation Authority**	NHS **Resolution**
P30 and 31 and 3, 4	Updated authorisations for spending in line with SFIs, making clear distinction between spend 'Within Current Budget' and 'New Spend' Updated thresholds in line with SFIs Updated number of written quotations required in line with SFIs Amended 'the prevailing **EU Threshold'**	 The prevailing **Public Procurement Threshold**

NHS Provider Licence Conditions - Annual Self-Certification

Meeting information:			
Date of Meeting:	12th April 2022	Agenda Item:	12
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? No	

Summary:

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

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

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

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

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

The evidence to support this self certification has been reviewed by Executive Directors and the Audit Committee.

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

Executive Directors Meeting, 28th March 2022
Audit Committee, April 2022

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD

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

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

The self-certification template (below) will then be signed off and published on the Trust website by the end of June deadline. In the event of a CQC/regulatory inspection this information would be shared with the relevant body.

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

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

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

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

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

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

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

A

FT4 Annual Corporate Governance Statement

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

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

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	• The Trust ensures capability at Board level though a process of annual assessment of Board and Committee effectiveness • The Board receives presentation of the Integrated Performance Report (IPR) at each meeting in public, setting out key quality, financial and workforce information. • The accuracy of data presented to the Board is assured through internal checks and internal audit verification. • The Board has met virtually during the pandemic. Meetings in public take place on a bi-monthly basis, and any member of the public can join these virtual meetings. Meetings are also recorded and put onto the Trust's website to ensure that they are as accessible as possible. • Public engagement events have taken place about the future of Cardiology and Ophthalmology services in the Trust to ensure that public opinion is heard and considered as decisions are made. • A robust governance system ensures that issues are escalated as appropriate through the organisation, and to the Board and its sub-Committees as appropriate.

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	**Sufficient in Number** • Demand and supply workforce modelling draws together service activity, the workforce size and shape with occupational coded roles to meet the demand and triangulate with Finance to ensure it is financially viable and sustainable • Gap and risk analysis is undertaken throughout the Business Planning process and monitored through the governance structure e.g. Board meetings, sub-Board Committee and appropriate Groups. These meetings are recorded and minuted with Terms of Reference and 'purpose' being reviewed annually as a minimum • Staff Group national guidance safer staffing are utilised where appropriate to determine the skill mix and size of the resource pool against specific requirements e.g. ward based nursing use Shelford for the establishment reviews which take into consideration acuity, bed occupancy, shift types. There are also recognised staffing models for AHP's, Emergency Department, Birth Rate Plus and Community Nursing. Where we do not have a safer staffing model, guidance from the Royal Colleges are utilised for best practice • During periods of high demand (Winter escalation) or low supply (Covid absence), substantive staff are redeployed as appropriate using the 4 cross-site operational staffing meetings, supported by a Safercare tool that shows live patient acuity data. Furthermore, ESHT have a robust, skilled temporary workforce bank pool that consistently play a key role as part of our congoing experienced workforce. There are additional opportunities to utilise agency for specialist roles such as Consultants, AHP's in order to deliver service. **Appropriately Qualified** • Specific roles requirement evidence of training and registration through professional bodies such as GMC, NMC, RCN and these form part of the recruitment onboarding due diligence checks • Further checks through recruitment include Occ Health (vaccines), DBS at specific levels dependent on role, ID checks (Right to Work), references, visa

			• As well as vocational training and coaching, colleagues are supported through defined career pathways through Integrated Education and NHS Leadership Programmes

APPENDIX ONE

Compliance with the Provider Licence Conditions

SECTION 1: GENERAL CONDITIONS

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

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

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

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

SECTION 2 PRICING

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

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

SECTION 3: CHOICE AND COMPETITION

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

SECTION 5: CONTINUITY OF SERVICES

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

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

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

SECTION 6: NHS FOUNDATION TRUST CONDITIONS

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

Use of Trust Seal

Meeting information:	
Date of Meeting: 12th April 2022	Agenda Item: 14
Meeting: Trust Board	Reporting Officer: Steve Phoenix, 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 Trust Seal was used to seal the following documents between 25th January 2022 and 30th March 2022:

Sealing 76 – Viapath Analytics LLP, 25th January 2022
Two year extension of agreement for various testing services and a connectivity solution for ESHT pathology.

Sealing 77 – Currie and Brown, 15th February 2022
Agreement for EDGH Emergency Department and Day Surgery Unit Works.

Sealing 78 – Asterisk Limited, 22nd March 2022
Five year lease for Units 10 & 11 Brampton Road and deed of surrender for former lease.

Sealing 79 – NHS Property Services, 22nd March 2022
Deed of surrender for Level 2, Creche Building, EDGH.

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 that the Trust Seal was not used 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	February 2022

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
Audit Committee	Annual Review	February 2022

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	9 Feb 21	ESHT Trust Board
v1.12	Feb-22	Nov-22		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 – Feb 2022 v 1.12

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 NHS Resolution or self insure for some or all of the risks (where discretion is allowed).
21.5	Chief Financial Officer	Where the Board decides to use risk pooling schemes or commercial insurers the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.
21.6	Chief Financial Officer	Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures to cover these arrangements.
21.7	Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible.

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:		
	For spend within current budget:		Authorised Budget Signatory and Purchasing and Supplies Buyer
	a) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	
	b) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
	c) **£70,001** excluding VAT to **The prevailing Public Procurement Threshold**– invite 3 written quotations.	Head of Procurement together with Chief Financial Officer	Authorised Budget Signatory and Head of Procurement
	d) **Above the prevailing The Public Procurement Threshold**up to **£500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
	e) **£500,001** to **£1,000,000**	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
	f) **Over £1,000,000**	Executive Directors' Meeting	Chief Financial Officer or Chief Executive

For new spend		Authorised Budget Signatory and Purchasing and Supplies Buyer
g) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	
h) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
i) **£70,001** excluding VAT to **the prevailing The Public Procurement Threshold**– invite 3 written quotations.	Head of Procurement together with Chief Financial Officer	Authorised Budget Signatory and Head of Procurement
j) **Above the prevailing The Public Procurement Threshold**up to **£500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	Chief Financial Officer or Chief Executive
k) **£500,001** to **£1,000,000**	Finance and Investment Committee	Finance and Investment Committee
l) **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 **£50,001 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 **£500,001** to **£1,000,000**	Finance & Investment Committee	N/A
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

	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)	<u>Establishments</u>		
	i) Additional staff to the agreed establishment with specifically allocated finance	Director for appropriate budget or General Manager	Manager responsible for budget
	ii) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	N/A
f)	<u>Pay</u>		
	i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Director for appropriate budget or General Manager	Authorised Budget Signatory
	ii) Authority to complete and authorise positive reporting forms	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iii) Authority to authorise overtime	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iv) Authority to authorise travel and subsistence expenses	Director for appropriate budget or General Manager	Authorised Budget Signatory
	v) The approval of merit awards and discretionary points to Consultant and Associate Specialist staff	Remuneration and Appointments Committee of the Board	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) Leave – all arrangements should be made in accordance with Trust policy		
i) Approval of annual leave	Manager responsible for the budget	N/A
ii) Annual leave – approval of carry forward (up to maximum of 5 days or in the case of Ancillary and Maintenance staff as defined in their initial conditions of service)	Manager responsible for the budget	N/A
iii) Annual leave – approval of carry over in excess of 5 days	Director for appropriate budget or Associate Director of Operations	N/A
iv) Special leave arrangements		
▪ adoption leave ▪ bereavement leave ▪ paternity leave ▪ urgent domestic distress/crisis ▪ carers leave	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget
v) Leave without pay	Director for appropriate budget or Associate Director of Operations 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 and authorised signatory	Deputy Company Secretary and Authorised Signatory
24. Management and Control of Computer Systems		
a) Financial Data	Chief Financial Officer	Senior Finance Manager Capital Systems Manager
b) Other Data	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	February 2022

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
Audit Committee	Annual Review	February 2022

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	09.02.21	ESHT Trust Board
	April 2022, v1.10	Nov 2022		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 Chief Financial Officer to enable budgets and annual plans to be compiled.

3.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.7 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities:

a) the amount of the budget;
b) the purpose(s) of each budget heading;
c) individual and group responsibilities;
d) authority to exercise virement;
e) achievement of planned levels of service; and
f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by Executives.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year end position (Income Statement);
(ii) movements in working capital (Statement of Financial Position);
(iii) movements in cash and capital (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 The Public Contracts Regulations 2015 Legislation Governing Public Procurement

The Public Contracts Regulations 2015 Legislation promulgated by the DHSC prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reserve eAuctions.

7.4 Other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the NHSI 'Capital Regime, Investment and Property Business Case Guidance' and 'Estatecode' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with relevant Department of Health guidance

7.5 Formal Competitive Tendering

7.5.1 General Applicability

All competitive tendering must be undertaken in conjunction with the Procurement team.

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services, Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to tendering procedures.

7.5.3 Exceptions and Instances where Formal Tendering need not be applied

Formal tendering procedures need not be applied where:

a) the estimated expenditure or income is, or is reasonably expected to be, less than £70,000 (excluding VAT) over the life of the contract;

b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

c) regarding disposals as set out in SFI 15;

d) where the requirement is covered by an existing valid contract;

e) where supply of goods or services is through NHS Supply Chain unless the Chief Executive or nominated officers deem it inappropriate for reasons of cost or availability. The decision to use alternative sources must be documented;

f) where the Trust can utilise framework agreements through a direct award or further competition to achieve Value for Money. These may include but not be limited to Crown Commercial Services, NHS Commercial Solutions and the other NHS Hubs, NHS Shared Business Services, Health Trust Europe, Pro5;

g) for construction works under the provision of the DoH ProCure21+/P22 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 The Public Procurement Threshold for Goods & Services and is for the renewal of maintenance services under an original supplier contract to provide equipment or IT and the Chief Financial

Officer and Head of Procurement is satisfied that the procurement arrangements conform to current statute and deliver value for money;

l) where payment is less than the current The Public Procurement Threshold for Goods & Services and is for the renewal of software license agreements under an original supplier contract to provide software licenses and the Chief Financial Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money;

m) where payment is less than the current The Public Procurement Threshold for Goods & Services and is for the purchase of replacement equipment parts under an original supplier contract to provide medical equipment and the Chief Finance Officer and Head of Procurement are satisfied that the procurement arrangements conform to current statute and deliver value for money

7.5.4 Formal tendering procedures may be waived in the following circumstances:

a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

b) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

c) where specialist expertise is required and is available from only one source;

d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and evidence of the decision making process and cost / benefit analysis documented;

f) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society of England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

g) where allowed and provided for in the Capital Regime, Investment and Property Business Case Approval Guidance.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure (except in circumstances outlined in 7.5.3 (d) above)

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.5 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 7.1, 7.5.3 and 7.5.4 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than **three** firms/individuals (unless demonstrated to be a restricted market), having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.6 Building and Engineering Construction Works

Competitive Tendering should not be waived for building and engineering construction works and maintenance (other than in accordance with relevant guidance) without DHSC approval.

7.5.7 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in Standing Financial Instructions for which formal tendering procedures are not used and which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to Tender

i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

ii) All invitations to tender shall state that no tender will be accepted unless:

a) accompanied by a statement from the prospective supplier / contractor that provides assurance that they are compliant with the Bribery Act 2010.

iii) Every tender for goods, materials, services or disposals shall embody

such of the NHS Standard Contract Conditions as are applicable.

iv) Every tender for building or engineering works (except for maintenance work, when the Estatecode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with the Estatecode guidance. When the content of the work is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institution of Mechanical Engineers and the Association of Consulting Engineers, (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

v) All individuals involved in the evaluation of tenders will make a formal declaration of any interests they have along with any gift or hospitality received regardless of the provider.

7.6.2 Receipt, Safe Custody and Record of Formal Tenders

(i) Formal competitive tenders shall be returned: - electronically via the Trust's nominated e-portal provider;

(ii) When tenders are received in electronic format the e-portal will automatically record the date and time of receipt of each tender. This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

7.6.3 Opening Formal tenders (Electronic Format)

(i) The e-tendering portal will automatically close at the date and time stated as being the latest time for the receipt of tenders, the e-tendering portal shall be closed to further tender submissions, and the project will be locked for evaluation.

(ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iii) A designated procurement officer shall electronically open the submitted tenders through the e-tendering portal.

(iv) The e-tendering portal will record the date and time the tender submissions are opened.

(v) A tendering register shall be maintained on the e-tendering portal, to show for each set of competitive tender invitations dispatched:

a) The name of all firms' individuals invited;

b) The names of firms individuals from which tenders have been received;

c) The date the tenders were opened;

d) The person opening the tender;

(vi) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing, should be dealt with in the same way as late tenders (paragraph 7.6.5 below).

7.6.4 Admissibility

i) If for any reason the Procurement officer is of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 Late Tenders

i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. uploaded in good time but delayed through no fault of the tenderer.

ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the process of evaluation and adjudication has not started.

iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

7.6.6 Acceptance of Formal Tenders (See Overlap with SFI No. 7.7)

i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

ii) The most economically advantageous tender (MEAT), the lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons (for example, evaluation criteria) shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;

b) understanding of client's needs;

c) feasibility and credibility of proposed approach;

d) ability to complete the project on time;

e) result of the "quality" aspect of any mini-competition in conjunction with the tender price

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive

iv) The use of these procedures must demonstrate that the award contract was:

a) not in excess of the going market rate/price current at the time the contract was awarded;

b) the best value for money was achieved; and

v) All tenders should be treated as confidential and should be retained for inspection.

7.6.7 Tender Reports to the Trust Board

Reports to the Trust Board will be made in exceptional circumstance basis only.

7.6.8 List of Approved Firms

a) Responsibility for Maintaining List

Tender lists for building and engineering works will be compiled by the Director of Estates & Facilities from "Constructionline" the Trust's approved list of Contractors.

b) Building and Engineering Construction Works

i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Tender documentation will require confirmation that companies on the tender list confirm that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not unlawfully discriminate, harass or victimise any person because of colour, nationality, ethnic or national origins, religion or belief, sex, gender reassignment, age, disability, sexual orientation, pregnancy or maternity, civil partnership or marital status and will comply with the provisions of the Equality Act 2010 and the Gender Recognition Act 2004 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.6.9 Exceptions to Using Approved Contractors

a) If in the opinion of the Chief Executive and Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the "constructionline" list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on "constructionline"), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote. The Trust should also seek written confirmation from the potential contractor that they are compliant with the Bribery Act 2010.

b) An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.6.10 Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced 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 £25,000 but not exceed £70,000, excluding VAT**.**

7.7.2 Competitive Quotes

(i) Where possible requests for Quotations over £25,000 excluding VAT shall be logged using an e-tendering portal
(ii) Quotations should be invited from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
(iii) Where possible, quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which

case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iv) All quotations should be treated as confidential and should be retained for inspection.

(v) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) Where the goods or services are purchased through charitable funds /donations from Leagues of Friends, provided that they are below the UK Public Procurement Threshold and a value for money evaluation has been undertaken.

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer .

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

(Please note that the UK Public Procurement Threshold (for supplies and services – £138,760 inc VAT)

Within Current Budget (within the budget approved by the Board for the appropriate financial year)

Value of The Public Procurement Threshold	Manager responsible for the Budget
From The Public Procurement Threshold to £500,000 excluding VAT	Executive Directors and Director responsible for the Budget Budget

From £500,000 to £1,000,000 excluding VAT	Chief Financial Officer and Chief	Executive
Value of £1,000,000 or above excluding VAT	Chief Financial Officer and Chief	Executive

New Spend (not included within a budget approved by the Board for the appropriate financial year)

Value of The Public Procurement Threshold	Manager responsible for the Budget	
From The Public Procurement Threshold to £500,000 excluding VAT	Executive Directors and Director responsible for the Budget	Budget
From £500,000 to £1,000,000 excluding VAT	Business Development Group (Revenue) and/or Capital Resource Group (Capital), Executive Directors and Finance & Investment Committee	and/or Capital and Finance & Executive
Value of £1,000,000 or above excluding VAT	Business Development Group (Revenue) and/or Capital Resource Group (Capital), Executive Directors, Trust Board and Common Seal of the Trust and Finance & Investment Committee	Executive

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

If there is any doubt about whether proposed expenditure falls outside of the £138,760 inc VAT then please seek advice from the Procurement team.

7.9 Instances where Formal Competitive Tendering or Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a) the Trust shall use the NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented;
b) if the Trust does not use the NHS Supply Chain the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

7.10 Private Finance for Capital Procurement (See Overlap with SFI No. 13.2)

The Trust should normally market-test for PFI (Private Finance Initiative Funding) when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
b) Where the sum exceeds delegated limits, a business case must be referred to NHSI for approval or treated as per current guidelines.
c) The proposal must be specifically agreed by the Board of the Trust.
d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance Requirements for all Contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) The Trust's Standing Orders and Standing Financial Instructions;
b) The Public Contracts Regulations 2015and other statutory provisions;
c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;
d) such of the NHS Standard Contract Conditions as are applicable;
e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations are invited.
g) In all contracts made by the Trust, the Board shall endeavor to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Healthcare Services Agreements (See Overlap with SFI No. 8)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 2014 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts.

However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable by law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.14 Disposals (See Overlap with SFI No 15)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;
b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
d) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
c) Evaluation team, comprising normally a specialist officer, a purchasing officer and a Chief Financial Officer representative.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15.6 Applicability of SFIs on Tendering and Contracting to Charitable Funds (See also SFI section 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 The Public Contracts Regulations 2015rules where the contract is above a stipulated financial threshold); and

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Financial Officer;

c) state the Trust's terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Financial Officer.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made. All leases must be assessed prior to entry and classified as either operating or finance leases under IFRS. Authority to enter into finance leases requires written approval from the Chief Financial Officer .

b) contracts above specified thresholds are advertised and awarded in accordance with The Public Contracts Regulations 2015;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the DHSC;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable, and also notify the details of all such hospitality offered or received, for entry in a register maintained for that purpose by the Chief Executive.

The national guidance contained in HSG 1993/5 'Standards of Business Conduct for NHS Staff' is shown as to Standing Orders 6.2.

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order except for those specifically excepted by the Chief Financial Officer in financial procedures, and purchases from petty cash or on purchase cards;

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or

urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order';

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Chief Financial Officer and;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer ; and

l) petty cash records are maintained in a form as determined by the Chief Financial Officer .

10.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained with ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

Payments to local authorities and voluntary organisations made under the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

11. EXTERNAL BORROWING

11.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the DHSC. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer .

11.3 The Chief Financial Officer must prepare detail procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the DHSC.

11.5 Any applications for short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer . The Board must be made aware of all short term borrowings at the next Board meeting.

11.6 All applications for long-term borrowing must be consistent with the plans outlined in the current Trust business plan and be approved by the Trust Board.

11.7 INVESTMENTS

11.7.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

11.7.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.7.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12 PLANNING FRAMEWORK

12.1 The Chief Financial Officer shall ensure that members of the Board are aware of the operational planning and contracting guidance issued by the regulator. The Chief Financial Officer should also ensure that the guidance is followed by the Trust.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation, where applicable of commissioner support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every capital expenditure proposal in excess of £100,000 excluding VAT the Chief Executive shall ensure:

a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the combined Business Development Group (BDG) and Capital Resource Group (CRG).

b) for every capital expenditure proposal in excess of £250,000 excluding VAT the business case is also required to be submitted to the Executive Director's meeting for approval.

c) for all projects over £500,000 excluding VAT a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Investment Committee for approval.

d) for all projects over £500,000 excluding VAT the Project Director will be required to co- ordinate and complete a monthly capital monitoring return to the Business Development Group (BDG) and Capital Resource Group (CRG) showing performance against budget.

f) for all projects over £1,000,000 excluding VAT 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 CRG for approval before any further expenditure is committed:

i. where the scheme value is £250k or less excluding VAT – 10% of the approved scheme value
ii. for other schemes up to £1m excluding VAT – the higher of 5% or

£25k

Details of any forecast overspend should be recorded within the minutes of the CRG meeting where the matter was discussed

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:

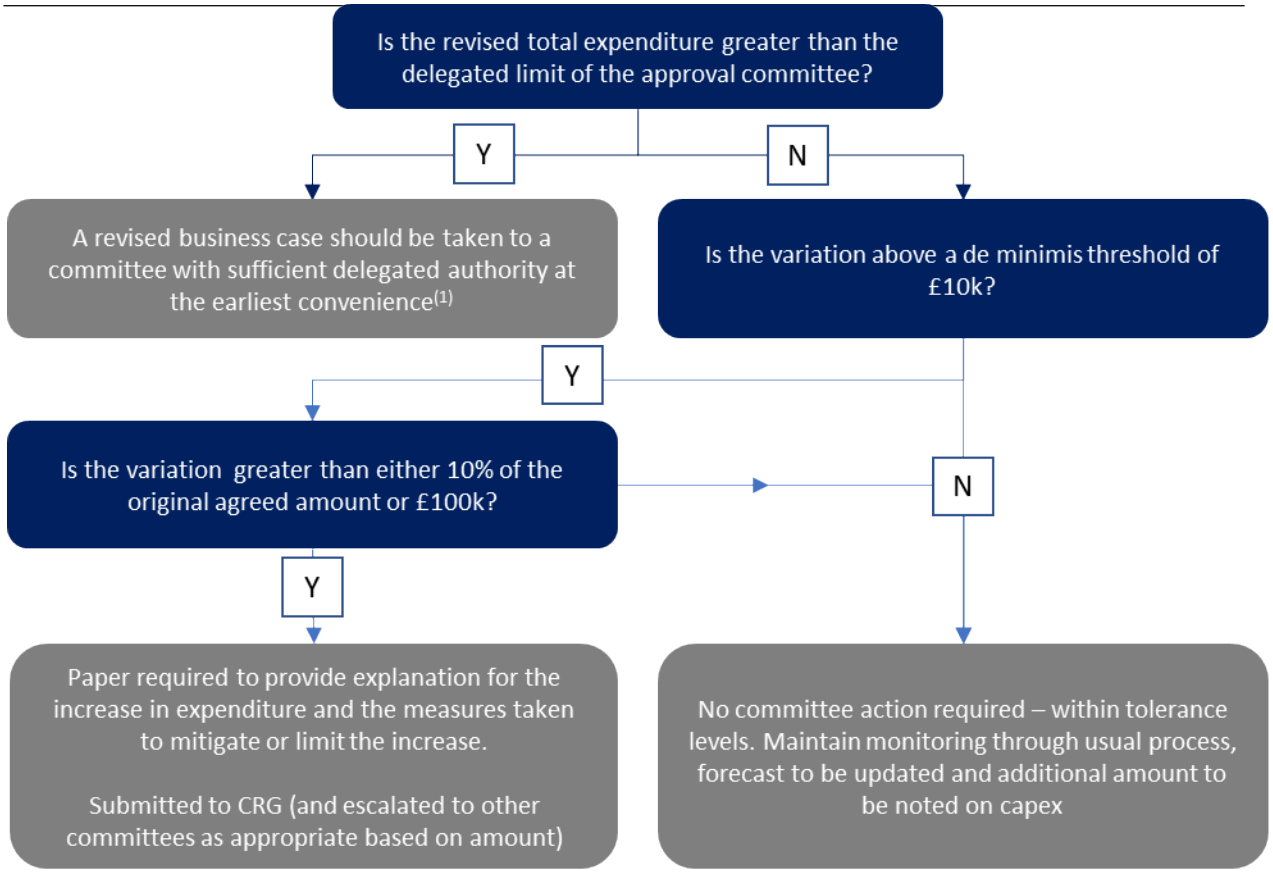
a) specific authority to commit expenditure;
b) authority to proceed to tender;
c) approval to accept a successful tender.

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.

13.1.6 Capital schemes will be monitored through local and Committee review processes. Variances to capital schemes should be discussed and approved at the CRG and the F&I Committee as appropriate at the earliest opportunity following awareness that it is likely that a scheme will overspend.

The flowchart below sets out the process that should be followed for any expected overspend of capital schemes :



(1) At this point this triggers the project should be considered unapproved and where possible expenditure should not be committed until approval is received. If the project is live or timing is critical and delay until a meeting cycle is not possible this should be brought to the attention of the Deputy Director of Finance and the Head of Financial Services immediately and an appropriate action plan will be developed (for example chair's action or extraordinary meeting of appropriate committee).

13.2 Private Finance

13.2.1 When the Trust proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) The proposal must be specifically agreed by the Board.

c) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DHSC body and/or treated as per current guidelines.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Regime, Investment and Property Business Case Approval Guidance as issued by the DHSC.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of land and buildings will be at "fair value" on the balance sheet date. Under the requirements of IFRS, the Modern Equivalent Asset valuation method will be adopted.

13.3.7 The value of each asset shall be depreciated according to the useful economic life of the asset. The Trust will use commonly available and appropriate indices for the revaluation of assets or take advice from independent experts. The Chief Financial Officer will ensure that a review of all asset lives will be undertaken annually.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer .

13.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

13.4.6 Where practical, assets should be clearly and securely marked as Trust property.

13.4.7 Trust assets and facilities are to be used for official Trust purposes only, unless approval for private use has been given by the Chief Executive.

14. STORES

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stocktake; and

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to the Head of Procurement by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer . The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of estates stock, fuel oil and coal of a designated Estates Manager.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Director of Estates and Facilities. Wherever practicable, stocks should be marked as health service property.

14.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Procurement shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 15 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt of the goods against the delivery note.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations (Disposal of Surplus Goods/Equipment Procedure) and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer ;

b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.1.5 Land and buildings formally planned for closure and/or disposal shall be valued and referred to the Chief Financial Officer prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The Chief Financial Officer shall prepare a report at least annually to the Audit Committee detailing all losses reported by number and amount with detail for those over £1,000

15.2.3 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive.

Where a criminal offence is suspected, the Executive Directors must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Directors must inform the DHSC Counter Fraud Services in accordance with the Secretary of State's directions and the Local Counter Fraud Service.

15.2.4 The Chief Financial Officer must notify the External Auditor of all frauds and suspected frauds.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, at an estimated value in excess of £10,000, the Chief Financial Officer must immediately notify:

a) the Board, and

b) the External Auditor.

15.2.6 The Audit Committee shall approve the writing-off of losses.

15.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

15.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16. INFORMATION TECHNOLOGY

16.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to Data Protection and Computer Mis-use legislation.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

16.2 The Chief Financial Officer shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.3 The 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 **£70,000 excluding VAT**.

22.2 Invitation to Tender

22.2.1 The number of invitations to tender and tenders required to be received will be as follows:

VALUE	TENDERS
Tenders above **£70,000 excluding VAT** to The Public Procurement Threshold	Minimum of 3 invitations to tender
Tenders above The Public Procurement Threshold	Minimum of 4 invitations to tender

22.2.2 If the required number of tenders is not received, it will be at the discretion, as to whether to proceed with the contract, of:

- the Chief Executive **or** the Chief Financial Officer above **£70,000 excluding VAT** to The Public Procurement Threshold; and

- the Chief Executive **and** the Chief Financial Officer from The Public Procurement Threshold to £1,000,000.

22.2.3 For the purpose of determining the above limitations of **£70,000 excluding VAT**, The Public Procurement Threshold and **£1,000,000 excluding VAT** in circumstances where tenders are invited at any one time for a number of works, which are to be carried out simultaneously or sequentially by one contractor, the total cost may not exceed the appropriate financial limit.

22.3 Financial Limits – Competitive Quotations

22.3.1 The number of quotations required will be as follows:

VALUE	TENDERS
Up to **£25,000 excluding VAT**	Minimum of 1 written quotation (where this may be impractical, 1 verbal quotation may be obtained and the reasons for this documented)
Above £25,000 to **£70,000 excluding VAT**	Minimum of 2 suppliers invited to submit written quotations

22.4 Waivers to Standing Orders

22.4.1 Standing Orders on Competitive Tendering may be waived under certain circumstances and will require the completion and authorisation of a waiver form.

22.4.2 The waiver authorisation limits are:

i) For tenders **£1 - £70,000 excluding VAT** , the Head of Procurement

ii) For tenders above **£70,000 excluding VAT** to **The Public Procurement Threshold**, the Head of Procurement and the Chief Financial Officer or the Chief Executive.

iii) For tenders from **The Public Procurement Threshold up to £500,000 excluding VAT** Head of Procurement, the Chief Financial Officer and the Chief Executive.

iv) For tenders from **£500,000 to £1,000,000 excluding VAT** the Audit Committee

v) For tenders above **£1,000,000 excluding VAT** the Trust Board

22.4.3 Any waiver request must be submitted on the requisite form and, after authorisation, must accompany the requisition sent to the Head of Procurement.

22.4.4 The Chief Financial Officer will establish and maintain a register of Waivers to Standing Orders.

22.5 Expenditure Authorisation

22.5.1 All requisitions that result in an order for goods and services must be approved in accordance with the following financial limits:

VALUE	RESPONSIBILITY
Value to The Public Procurement Threshold	Budget Holder/Budget Manager
From The Public Procurement Threshold to	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 Public Procurement Threshold are available from https://www.legislation.gov.uk/uksi/2021/1221/regulation/3/made

CAPITAL AND REVENUE PROCESS

This document sets out the processes for spending:

1. revenue within budget
2. capital within budget, within the Capital Resource Limit (CRL) and included in the annual capital plan

If any procurement with suppliers is required, then it is essential that any contracts are agreed within authorised limits and following appropriate processes.

If spend is not in budget then it shall be escalated to Executive Directors. Any spend must be included within annual plans.

Key contacts if you require further advice

Finance:
Matt Backler, Deputy Finance Director

Procurement:
Angela Alletson, Head of Procurement

Business Development:
Mike Farrer, Strategy , Innovation and Planning Team

For detailed information on processes, please refer to the following overarching ESHT corporate governance documents:

- Standing Financial Instructions (SFIs)
- Standing Orders
- Schedule of Matters Reserved to the Board and Scheme of Delegation

Process for up to £50k (if within total budget):

1. Division has idea for a business case
2. Log plan with **Capital Team** (capital) **Business Development Team** (revenue) who will assign a reference number, and signpost any additional requirements (CAPEX, liaison with procurement etc.). Cases that are both capital and revenue will need to be logged with both teams.
3. Complete Service Change Proposal
4. Complete Quality / Privacy / Equality Impact Assessment (QIA/PIA/EIA) if required
5. If the plan impacts on a **single division only**, present Service Change Proposal (with reference number) to Integrated Performance Review (IPR) who can approve or reject if funding has been identified
6. If the plan impacts on **more than one division**, present Service Change Proposal (with reference number) to IPR who can approve or reject if funding has been identified then present to Business Development Group (BDG) for logging, noting and socialising with other divisions.

Additional process for between £50k to £500k (please follow steps 1-4 above, then):

5. Present Service Change Proposal to IPR who can approve production of business case
6. Business case to be produced with sign off from relevant corporate areas
7. Present Business Case to BDG (revenue) or Capital Resource Group (CRG) (capital) who can recommend a direction of travel. If the business case has both revenue and capital implications it will need to be presented to both groups.
8. Present Business Case to Executive Directors' Meeting for approval

Additional process for between £500k to £15m:

9. Present Business Case to Finance and Investment Committee for approval if between £500k - £1m
10. Present Business Case to Trust Board for approval if over £1m
11. Submit to NHSE/I for approval if over £5m, or over £15m for capital property investments

Waiver of Standing Orders

Reason for Request to Waive Standing Orders:	Please Tick
1 Competitive tenders/quotations were sought insufficient responses returned	
2 Only provider of goods/services	
3 Genuine reason for continuity or compatibility	
4 Risk where timescales/urgency genuinely exceed time required to competitively tender/obtain quotes	
5 Chief Financial Officer /Deputy Director of Finance	
6 Retrospective expenditure - goods/services have already been received	
7 Quotes/tenders not obtained due to clinical/technical preference	
8 Market tested and most economical providers not selected	
9 Agency expenditure exceeding the NHSI allowable price caps	

Full written details and justification must be provided in the "Supporting Information" section on the reverse of this form before this waiver request will be considered for approval.

The current limits set by East Sussex Healthcare NHS Trust under which competitive quotations/tenders are required are defined in the Standing Financial Instructions. These are as follows:

Up to £25,000 (ex VAT)	-	1 Verbal quotation
£25,001 to £70,000 (ex VAT)	-	Minimum of 3 invitations to quote.
£70,001 (ex VAT) to The Public Procurement Threshold	-	Minimum of 3 invitations to tender.
Above The Public Procurement Threshold	-	Minimum of 4 invitations to tender with at least 3 received.

The waiver authorisation limits are:

- For quotations £25,001 to £70,000 the Chief Executive, Chief Financial Officer or Head of Procurement.
- For tenders £70,001 to The Public Procurement Threshold the Chief Financial Officer or Chief Executive.
- For tenders from The Public Procurement Threshold to £1,000,000 the Chief Executive and Chief Financial Officer.

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: _____

Conflicts of interest/subsequent measures taken: _____

CERTIFICATION BY SENIOR BUSINESS MANAGER		HEAD OF PROCUREMENT VERIFICATION **PRIOR** TO APPROVAL BY A DIRECTOR	
Signature:	Date:	Signature:	Date:
Title:	Department:		

APPROVAL OF WAIVER

I/We hereby approve this waiver

Signatures authorising the waiver of Standing Orders.

Signature:	**Signature:**	**Signature:**
Designation:	**Designation:**	**Designation:**
Chief Executive	**Chief Financial Officer**	**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	February 2022

Multi-disciplinary Evaluation/Approval

Name	Title/Speciality	Date:
Audit Committee		November 2011
Audit Committee	Annual Review	November 2012
Audit Committee	Annual Review	6 November 2013
Audit Committee	Annual Review	12 November 2014
Audit Committee	Annual Review	4 November 2015
Audit Committee	Annual Review	23 November 2016
Audit Committee	Annual Review	22 November 2017
Audit Committee	Annual Review	28 November 2018
Audit Committee	Annual Review	28 November 2019
Audit Committee	Annual Review	28 January 2021
Audit Committee	Annual Review	21 February 2022

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	9 Feb 21	Trust Board
1.12	Apr-22	Nov-22		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 any Member of the Board, who is also a Non-Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him/her. If, in exceptional circumstances due to illness or any other cause, the Chairman is unable to appoint a Vice-Chairman, then another non-executive director will assume the office of Vice-Chairman.

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

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

2.5 **Appointment and Powers of Senior Independent Director**

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

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

2.6 **Appointment 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 be a member of the Audit Committee.

4.8.4.1 **Capital Sub Committee**

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

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

4.8.5 **People and Organisational Development Committee**

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

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

4.8.6 **Strategy Committee**

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

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

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

The removal is subject to the following conditions:

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

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

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

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

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

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

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

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of business conduct policy

7.4.1 Trust Policy & National Guidance

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.