East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 14th February 2023

Time: 09:30 – 12:30

Venue: Holy Cross Priory, Lewes Road, Cross-in-Hand, Heathfield TN21 0DZ

	Item	Lead	Action	Time
1	**Welcome and apologies**	Chair	Information	09:30
2	**Staff Recognition**	Chair	Information	09:35
3	**Declarations of Interest**	Chair	Information	
4	**Minutes of the Trust Board Meeting in public held on 13th December 2022**	Chair	Approval	09:40
5	**Matters Arising**	Chair	Approval	
6	**Board Committee Chairs' Feedback** • Updated ToRs for Audit & F&P Committees	Committee Chairs	Assurance / Approval	09:45
7	**Chief Executive's Report**	CEO	Information	09:55
	Quality, Safety and Performance			
8	**Integrated Performance Report, Month 9 (December)** 1. Chief Executive Summary 2. Quality & Safety 3. Our People 4. Access and Responsiveness 5. Financial Control and Capital Development	 CEO CND/CMO CPO WD CFO	Assurance	10:05
	Break (15 mins)			
9	**Maternity Overview, Quarter 3**	DM	Assurance	11:30
10	**Learning from Deaths, Quarter 1**	CMO	Assurance	11:45
	Strategy			
11	**ICP Strategy Update**	CEO	Assurance /Information	11:50
12	**Industrial Action (verbal)**	CPO	Assurance	

13	**2023/24 Business Planning – Guidance and approach**	CFO	Information	
Governance and Assurance				
14	**Board Assurance Framework, Quarter 3**	CS	Assurance	12:10
15	**EPRR Update**	WD	Assurance	
16	**Annual Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation**	CFO / CS	Approval	
Items for Information				
17	**Use of Trust Seal**	Chair	Information	
18	**Questions from Members of the Public**	Chair		12:30
19	**Date of Next Meeting** Tuesday 11th April 2023	Chair	Information	
20	**Close**	Chair		

Steve Phoenix
Chairman
10th January 2023

Key:	
Chair	Trust Chair
CEO	Chief Executive
CND	Chief Nurse and DIPC
WD	Winter Director
CFO	Chief Finance Officer
CS	Chief of Staff
CPO	Chief People Officer
CMO	Chief Medical Officer
DM	Director of Midwifery

Board Meetings in public: Etiquette

As we return to face-to-face meetings, we thought it helpful to offer a reminder of the things that we know contribute to productive meetings and show respect to all members in the room:

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

Board Meetings in public: 2023

Month	Location	Timing	Any other information
11th April	Grange Room The Locker Room College Road, Eastbourne BN21 4JJ	09.30 – 12.30	
13th June	Cornwallis Room Horntye Park Sports Complex Bohemia Road Hastings TN34 1EX	09.30 – 12.30	
8th August	St. Mark's Church Hall Green Lane Bexhill TN39 4BZ	09.30 – 12.30	
12th September	**ESHT AGM**		Details to be confirmed.
10th October	Uckfield Civic Centre Bellfarm Lane Uckfield TN22 1AE	09.30 – 12.30	
12th December	Cornwallis Room Horntye Park Sports Complex Bohemia Road Hastings TN34 1EX	09.30 – 12.30	

East Sussex Healthcare NHS Trust

1.Staff Recognition

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

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

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

Recommendation	N/A

Executive Summary

Hero of the Month

November 2022

Glyn Hards - Planned Care, Community Nursing Service – CHIC

Glyn was 'New to Role' having worked as a chef. He now works as an HCA and has developed his skills so incredibly well. When Glyn arrived, he had never used a laptop, so his learning curve has been immense. Since he started in July 2022 not only has, he learned how to manage his laptop and he has almost completed his Care Certificate.

I heard a colleague share with him " the patients love you, all I hear is good things about Glyn. There was a particular patient that you visited that would let none of the rest of us take her blood, but she let you."

Given the demands of our service and our significant shortfalls of staff Glyn has managed his development within role through the toughest of times. This represents above and beyond in developing himself and working as part of his team to deliver amazing and good quality care. He demonstrates respect and compassion for his patients, this is heard by the amazing feedback we receive. I want to say to the whole department how impressed I am with Glyn's commitment to his new role, and I cannot wait to see Glyn progress within our team.

December 2022

Kheva King - Estates and Facilities, Bexhill Community Diagnostic Centre - Estates and Facilities Division

Kheva singlehandedly cleared the whole patient carpark at the Bexhill CDC as it was extremely dangerous to everyone. He did it all by himself under the freezing air, without any complaints and with a very happy face! Could have not opened the Centre today without his help and hard work! - Kudos from all of us in CDC!

Long Service Awards

Nov-22					
10 Years' Service		**25 Years' Service**		**40 Years' Service**	
Samuel	Bachellier	Janet	Botting	Maria	Martin
Gwenda	Bull	Gayle	Clark	Helen	Barrow
Kristian	Burfitt				
Graham	Burley				

Joanna	Byers
Paul	Chantler
Charmaine	Creasy
Darren	Cumber
Kyle	Dadswell
Sarah	Dixon
Hope	Dyson
Natasha	Evans
Mark	Fincher
Lisa	Genidy
Elizabeth	Gregory
Arati	Gurung
Christopher	Houry
Peter	Jordan
Paul	Knight
Natasha	Light
Kathryn	Mathis
Philip	Ouston
Gem	Pacheco
Adrian	Playle
Abigail	Radley
Annabelle	Randle
Holly	Richardson
Matthew	Simmonds
Tracy	Simpson
Jennifer	Smart
Allison	Smith
Michael	Sparkes
Wendy	Stevens
Lisa	Stoten
Gary	Wendel
Lianne	Williams
Samantha	Warren

Dec-22						
10 Years' Service			**25 Years' Service**			**40 Years' Service**
Karen	Hall		Silin	Cornelius		Suzanne Goodrum
Christina	Holt		Andrea	Grant		
Madeleine	Honnor		Stuart	Robinson		
Kirstie	Horton		John	Southen		
Michelle	House		Phomena	Sherlock		

	Shelley	Jackson		Pauline	Morris		
	Irma	Jarockiene		Liz	Fresson		
	Benny	Mathew					
	Bibiana	Ortiz					
	Marcia	Planson					
	Ian	Timms					
	Deborah	Tirel					
	Ann	Turner					

Next steps	• Awards are given to staff on a monthly basis, and reported via Trust communications and to each Board meeting • Staff will continue to be recognised and thanked through long service awards

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Minutes

Date: Tuesday 13th December 2022

Time: 09:30 – 12:30

Venue: St. Mark's Church Hall, Green Lane, Bexhill, East Sussex, TN39 4BZ

		Actions
	Attendance: Mr Steve Phoenix, Chairman Mrs Joe Chadwick-Bell, Chief Executive Mr Steve Aumayer, Deputy Chief Executive and Chief People Officer Mrs Jackie Churchward-Cardiff, Vice Chair Mrs Karen Manson, Non-Executive Director Dr Simon Merritt, Chief Medical Officer Mr Damian Reid, Chief Finance Officer Non-Voting Directors Mrs Ama Agbeze, Associate Non-Executive Director Mr Richard Milner, Director of Strategy, Inequalities & Partnerships Mrs Sheila Roberts, Winter Director Mr Frank Sims, Associate Non-Executive Director In Attendance Ms Brenda Lynes, Director of Midwifery Mrs Hazel Tonge, Deputy Director of Nursing Mr Peter Palmer Deputy Company Secretary (minutes)	
	Apologies: Mrs Vikki Carruth, Chief Nurse & Director of Infection Prevention and Control Mrs Amanda Fadero, Associate Non-Executive Director Mr Paresh Patel, Non-Executive Director Mrs Nicola Webber, Non-Executive Director Mrs Carys Williams, Non-Executive Director	
078/ 2022	**Chair's Opening Remarks** Mr Phoenix welcomed everyone to the meeting, noting that this was Mrs Agbeze and Mr Sims' first Board meeting in public since joining the Trust as Associate Non-Executive Directors (NEDs). He reported that Ms Williams had been made a full NED since the previous meeting and welcomed Mrs Roberts to her first Board meeting in public, explaining that she had joined the organisation on a temporary basis as Winter Director. He also reported that Mr Aumayer had been given temporary Board voting rights. These would remain in place until a new Chief Operating Officer was appointed.	

079/ 2022	**Hero of the Month** Mr Phoenix reported that Gregg Wicks, a Porter for Sussex Premier Health had won the award in August, Felicity Parsons from Decham Ward at the Conquest had won in September and that October's winners had been Louise Myeni, Fran Williams & Ella Butler from the Physiotherapy and Occupational Therapy Development Team. He praised the dedication of the many staff who had recently received long service awards.	
080/ 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.	
081/ 2022	**Minutes** The minutes of the Trust Board meeting held on 11th October 2022 were considered and no amendments to the minutes were noted They were agreed as an accurate record, and were signed by the Chair and would be lodged in the Register of Minutes.	
082/ 2022	**Matters Arising** There were three formal matters arising from the meeting on 11th October 2022, two of which had been completed. Mrs Tonge provided a verbal update about the scheduling of patient tests, explaining that as a result of the volume of diagnostic tests undertaken in the Trust it was very challenging to stop any overlap with protected times for patients entirely. However, the Trust would endeavour to minimise clashes.	
083/ 2022	**Board Committee Chairs' Feedback** <u>Audit Committee</u> Mr Reid presented a report from the Audit Committee meeting held on 24th November 2022. He reported that Committee had accepted a recommendation from external auditors about the manner in which the acquisition of Spire Healthcare Limited would be accounted for moving forward, which would be reflected in the 2022/23 accounts. <u>Finance and Investment (F&I) Committee</u> Mr Reid presented a report from the F&I Committee meeting held on 24th November 2022. He reported that the Committee had recognised that as of month seven the Trust was anticipating a break-even year-end financial position. Mrs Chadwick-Bell reported that the name of the F&I Committee would be changing to the Finance and Performance Committee from December 2022, with a standing Committee item reviewing productivity. The change had been made in recognition that the Trust had not yet returned to pre-Covid levels of efficiency. <u>People and Organisational Development (POD) Committee</u> Mr Aumayer presented a report from the POD Committee meeting held on 17th November 2022. <u>Quality and Safety (Q&S) Committee</u> Mrs Manson presented a report from the Q&S Committee meeting held on 17th November 2022. <u>Strategy Committee</u> Mrs Churchward-Cardiff presented a report from the Strategy Committee meeting held on 27th October 2022.	
084/ 2022	**Chief Executive's Report** Mrs Chadwick-Bell reported that the Trust continued to operate in a very challenging environment, as did the entire NHS. She praised staff for the way that they continued to work under pressure, thanking them for all that they did. She reported that the Chancellor of the Exchequer had recently made the 2022 Autumn statement, and that this had contained a number of areas of focus for the NHS, including elective pathways, earlier	

cancer diagnosis and addressing the cancer backlog, improving ambulance response times, performance against the four hour urgent care target, access to primary care and improved efficiency returning to 2019/20 levels. It was important that everyone in the organisation understood how they could contribute to improving these areas.

The Trust continued to focus on reducing the number of patients waiting for over 52 weeks, and on improving productivity and four hour performance. A £500m national discharge fund had been made available, around £16m of which would be used to support discharge in Sussex during the winter. It was hoped that this money would enable rapid improvements to be realised.

Mrs Chadwick-Bell reported that the new Critical Care Sensory Garden had recently been completed at the Conquest, which could be visited by staff, patients (including those in beds) and visitors. She praised the work of staff in fundraising for the garden, noting that it provided a fantastic environment. The Bexhill Community Diagnostic Centre had opened the previous day having recently been approved by the CQC.

A number of senior leadership changes in the Trust were reported. Mrs Roberts had joined as Winter Director until a substantive COO was recruited. Joel Newman had been appointed as Chief of the Specialist Medicine division, Matthew Clark as Chief of the Women's and Children division and Kate Murray had been re-appointed as Chief Clinical Information Officer.

In November, the Trust's payroll services had transferred to the Sussex Health and Care Payroll Hub. She thanked payroll staff who had transferred to the new provider, as well as those who had chosen to take alternative routes. Mr Aumayer reported that November's payroll had gone well, with queries received unrelated to the transfer of the service. Mr Reid noted that a larger payroll structure had been required to ensure future continuity of services.

Mrs Chadwick-Bell reported that flu and Covid vaccination programmes continued in the Trust and thanked vaccination teams for their hard work. She updated on the New Hospital Programme, explaining that the national business case for the programme had been submitted to the treasury for review on 8th December. A visit from the national team was anticipated to the Trust in March.

Executive and Non-Executive Directors had been undertaking a programme of visits to areas across the organisation. Visits were being tracked to ensure that all areas of the Trust were included, with feedback from the visits being captured. Mrs Chadwick-Bell noted that a question had been received from a member of the public about whether volunteers would be visited. She explained that she had already visited Conquest Radio and it was planned that all areas would be visited, including volunteers. She noted that the size of the organisation meant that it would take some time to visit every area.

Mrs Churchward-Cardiff asked how the organisation had managed during the recent snow. Mrs Roberts explained that the Trust had robust plans for managing during deteriorating weather, but the intensity of the recent cold spell had been surprising. Plans would be reviewed to enable the Trust to respond better in the future. She thanked staff for the way in which they had worked to cover services, noting the invaluable support received from the volunteer 4x4 service in getting staff to work.

Mr Sims noted that the Autumn Statement priorities had contained nothing about improving mental health outcomes or the management of patients with mental health issues attending acute providers. He asked whether the winter funding would be used to address these areas. Mrs Chadwick-Bell explained that the Autumn Statement was focussed on improving current performance. The Trust would set clear priorities for the next four months, including increased productivity by working differently, reducing the backlog of long waiting patients, improving four hour performance and increasing elective activity within existing budgets. The Integrated Care Partnership's (ICP) strategy and delivery plan included a greater focus on mental health prevention, self-care and community based care and intervention.

085/ 2022 **Integrated Performance Report, Month 7 (October)**

i. <u>Chief Executive Summary</u>
Mrs Chadwick-Bell explained that there was a continued focus on improving four hour A&E performance as this was a measure of the quality of the whole organisation. A culture change was

required in order to realise this improvement as A&E performance was the responsibility of all the Trust's staff. The Trust had previously greatly improved A&E performance by ensuring that all staff had a common goal, and this would be supported by the Trust's winter plan and improvement plan. Executives received weekly reports on key milestones within the plans, with a back to basics approach being taken to ensure that patients were in the right place at the right time. Improvements to A&E performance would lead to a reduction in the number of incidents reported, improve mortality, improve staff morale and improved patients outcomes and safety.

Additionally, the Trust would focus on improving 60 minute A&E ambulance handover and on reducing the number of patients who waited in A&E for over 12 hours from arrival. Additionally, the number of supersurge beds being utilised was now being tracked at system level. Mrs Chadwick-Bell explained that the Trust was performing well in comparison to many other NHS organisations, with a falling vacancy rate and a forecast breakeven position but that significant challenges remained.

Mrs Manson asked for additional information about the culture change required to improve the four hour target. Mrs Chadwick-Bell explained that the turnover of staff in the organisation meant that not everyone fully understood that patients in A&E were patients of the whole organisation, and that specialities needed to take ownership of their patients even if they were in A&E, responding to calls in a timely manner even when under pressure.

ii. <u>Quality & Safety</u>

Mrs Tonge thanked clinical staff for the incredible work they had done during the recent snow, noting that some nursing staff had stayed in the Trust for more than 24 hours to cover staffing gaps.

She reported that attendances to the hospital continued to increase, along with the number of patients with no criteria to reside (NCTR) which was putting pressure on staff. As a result of this pressure, some quality metrics were reducing, and there had also been an increase in incidents of violence and aggression towards staff.

She reported that the Trust had recently seen an increase in patients with invasive Group A Streptococcal, and had the second highest rate in the South East. The Trust had breached its internal target for clostridium difficile (c.diff) incidents in the previous year and anticipated that it would breach targets again in 2022/23. The increase in c.diff was a national issue, and the Trust had joined a national workshop to share lessons learned and to look at causes. No linkages had been found between the c.diff cases reported at ESHT.

There had been an increase in the number of incidents reported at the Trust, and these were all subject to investigation. Staff were encouraged to report incidents whenever they occurred. Three Serious Incidents had been reported during October, as well as five Grade Four incidents. The rate of falls had slightly increased during the month. Mrs Tonge noted that the data concerning pressure ulcers contained within the IPR was incorrect as this had not been able to be validated prior to publication. There had been three grade three and four pressure ulcers reported rather than five.

There had been an increase in complaints received during October. Key themes identified from Friends and Family Test responses in A&E during the month had been around waiting times, overcrowding and reception and staff check-in.

Staffing remained stretched due to the additional capacity that remained open, which was also impacting on the number of nursing care hours per day. This should ideally be eight care hours per day, but in over half the wards it was less than this with 15 wards under seven hours. Work was being undertaken to address this. An increase in patients with safeguarding issues was being seen and a quality improvement plan was in place, alongside working closely with divisions to identify themes and review cases. Liberty Protection Safeguards would be introduced in 2023 which would have a big impact on the organisation, with a training programme introduced to ensure staff fully understood the changes.

Mrs Churchward-Cardiff noted that 'Office/Administration Area' was the second highest location for safety incidents reported during October and asked why this was. Mrs Tonge agreed to find out the reason for this and feedback to the Board. **VC**

Mrs Churchward-Cardiff asked whether pressure on the organisation was affecting the nursing skill mix. Mrs Tonge reported that there had been an increase in trained nurses filling HCA roles in some areas. Staffing and skill mix on wards was monitored through twice daily meetings and wards always worked to a minimum of two trained staff per ward, reflecting high vacancies and sickness. Mr Aumayer noted that the Trust had very few Band 2 HCA vacancies, but did have a number of band 3 HCA vacancies that divisions had not asked to be filled. Work was being undertaken to fully understand this.

iii. Our People

Mr Aumayer reported that October had been a challenging month for the Trust with very high bed occupancy levels alongside high staff sickness. The sickness rate was the same as it had been in October 2021 once Covid was removed from the figures, although was 1.3% higher than the same period pre-Covid.

October had seen the slowing of a number of adverse trends, including staff turnover, and the Trust had seen an overall increase in workforce of 320 during the year to date. An additional 20 nurses were due to join the Trust before the end of 2023. Mandatory training rates had slightly reduced and were an area of focus as these remained very close to annual targets. Appraisal rates had also reduced and a campaign was being run with divisions to improve this metric. Job planning had increased to 60% and Mr Aumayer praised Dr Merritt for the work he had done in supporting this improvement, noting that a rate of 70% by the end of 2022/23 was being targeted.

Mr Aumayer reported that work had been undertaken to cohort wards, buddying them together to minimise staff having to work on wards which they were unfamiliar with. This had been a successful scheme, and had been well received by staff. Uptake of Covid and flu vaccinations had only been 35% amongst staff in the Trust, which was significantly lower than the previous year. However, many staff had received vaccinations outside the Trust and these vaccinations were not included in reporting.

Nursing staff in Sussex were not currently taking industrial action, and a recent vote by Unison had not met the required threshold for action. Physiotherapists had reached the appropriate threshold, but had voted for action short of strike (work to rule) in 2023. Less than 50% of midwives had voted, so the threshold for action had not been met, but 95% of those who had voted had voted in favour of taking action. Junior doctors were also being balloted with results due before the end of the year. A significant programme of work was in place to prepare for any industrial actions, with plans being developed across the region and system. The Trust was waiting to hear about what strike derogations would be agreed during upcoming strikes by ambulance staff to protect services and patient safety.

Mrs Roberts noted that the Trust would operate a command centre on both days of the ambulance strikes to minimise the impact of the action. Mrs Lynes confirmed that the maternity service had also developed plans for continuity of service during the strikes.

Mrs Churchward-Cardiff asked for the reasons why turnover and retention rates were trending slowly away from targets. Mr Aumayer explained that the top reasons for people leaving the NHS both locally and nationally were retirement or leaving the service completely. A deep dive on retention had recently been presented to the POD Committee, and work was being undertaken with divisions to fully understand any local factors that were driving staff turnover. 25% of the Trust's staff were of an age where they could retire, so this was a key risk for the Trust.

Mrs Manson asked how successful recent HCA recruitment workshops had been. Mr Aumayer explained that they had been very successful, with an increasing numbers of applicants being seen by the Trust as a result. He noted that being able to recruit staff on the day of the workshops had been a key benefit.

iv. Access and Responsiveness

Mrs Roberts explained that discharging patients who no longer required the care of an acute organisation would be the key to improving four hour performance. The benefit of work being undertaken at the Trust's front door and throughout patient pathways would not been seen until discharge was improved. She reported that she was working closely with Dr Merritt and Mrs Carruth to review patients to identify what more could be done to facilitate their discharge prior to the Christmas period. Information had been circulated to colleagues about the service provided by the urgent community response service, along with information about the criteria and method for accessing virtual wards which were now operational, to help improve discharge during this period.

Mrs Churchward-Cardiff asked whether it was possible to include more detailed reporting in subsequent IPRs to enable trends to be identified. Mrs Roberts explained that improvements to the data presented were already planned. Around 34% of the Trust's patients had waited for discharge for over 21 days with no criteria to reside (NCTR), although this figure was reducing. A regional target of 21% of patients had been set, and work was being undertaken with Adult Social Care colleagues to review all long waiting patients to identify what could be done to remove barriers for discharge. Additional work was also being undertaken to improve theatre efficiency and maximise capacity. The elective hub, due to open in 2024, would have a further positive impact on elective work when it opened.

Mrs Manson noted that it was important that staff knew about virtual wards and how to access this resource. Mrs Roberts explained that good communication with staff was vital in realising improvements through virtual wards. Communications messages would be sent out, along with visible leadership and conversations throughout divisions, led by divisional triumvirates. Every way of getting the message to as many staff as possible would be explored. Mr Aumayer reported that the Trust was also reaching out to independent care homes to ensure that they also understood how virtual wards could be accessed, reducing admissions to hospital. Dr Merritt explained that the Trust was aiming to have 60 virtual ward beds by the end of December, with around 15 already in use. He was confident that these additional virtual beds would make a big difference during the busy winter period.

Mrs Manson reported that she had visited the Adult Social Care (ASC) team the previous week and asked about Trust engagement with this team. Mrs Roberts explained that the ASC team had recently recruited additional staff and that the Trust was engaging closely with the team to encourage them to come into hospitals and visit patients on wards. Mrs Chadwick-Bell explained that the Trust had a good relationship with both the local authority and ASC, particularly at a senior level. The working model for ASC had changed to discharge to assess in recent years, and it was important that wards fully understood the changes that had taken place. In addition, work was being undertaken across the region to understand whether the current Sussex discharge model remained correct

Mr Sims asked how the risk associated with longer lengths of stay in hospital for patients were assessed. Mrs Roberts reported that a paper on the risks to patients was due to be presented to the Quality and Safety Committee later on that week. She noted that 80% of patients could be managed to return to their homes safely by the Trust, and that wards would be supported in how they could further improve discharge.

v. <u>Financial Control and Capital Development</u>

Mr Reid explained that the Trust continued to be challenged in returning to productivity levels from 2019/20. Nonetheless, he anticipated that the Trust would deliver its 2022/23 financial position as Emergency Recovery Fund (ERF) clawback would no longer apply, although he noted that £4-5m of Trust reserves would be required to reach this position. The Trust was delivering close to the expected level of productivity but costs had increased substantially due to a number of factors including increased spend on pay due to an increase in staff numbers, usage of temporary staff, the increased cost of utilities, non-elective pressures, and outsourcing of pathology and radiology services. All these challenges would need to be addressed during the development of the 2023/24 annual plan to enable the Trust to reach a sustainable financial position.

Mr Phoenix recognised that the Trust's financial position moving into the following year would be extremely challenging, noting that many other organisations were already in a difficult financial position. He explained that there would be a financial challenge for the entire NHS that would need to be addressed. Mrs Chadwick-Bell noted that credible plans would need to be presented to the F&P Committee and to the Board to demonstrate that the Trust had appropriately planned to meet the financial challenges to come. It was important that clear messaging was sent out to the organisation about what would be required as there was no intention to go back to previous turnaround regimes. However finance, safety and quality metrics all needed to be improved and there were five priority programmes, monitored by F&P and the Finance and Efficiency Committee, that would lead on this. It was important to be open and honest with staff about the issues that needed to be addressed, as colleagues were already working under significant operational pressure.

Mr Sims noted that messaging to staff about any financial reset would be vital and asked how they could be empowered to be part of the process, putting any plans they had into action at local level. Mrs

Chadwick-Bell explained that the financial improvement plan would build on existing financial plans. External support for communicating with staff had been sought. She agreed that it was important that staff owned the improvements, and explained that Executives would have to balance empowering staff with seeking assurance that financial improvements were being achieved.

Mrs Churchward-Cardiff noted that staff numbers had increased by almost 1,300 since before the pandemic and asked whether this increase was fully understood. Mr Aumayer explained that the increase in staff numbers was good for the organisation, but that there were a number of factors that had changed in the Trust during the pandemic. A review of workforce that included current sickness levels, leave, escalation areas and other factors was being undertaken to fully understand how the workforce had changed since before the pandemic. Mr Reid noted that a number of factors had led to the increase in staffing, including the current pressure on the Trust with all escalation areas open, commissioner funded changes and staffing reviews. Mrs Chadwick-Bell reported that a review of nursing staffing had been completed which would be taken to Committees by Mr Aumayer and Mrs Carruth; this had been very helpful in providing the context for increased nursing staffing. Mr Aumayer noted that the vast majority of the increased staffing was clinical staff.

Mrs Manson noted that there was often a tipping point for organisations which were under severe pressure where staff wanted Executives to take control and resolve the biggest issues. Mrs Chadwick-Bell explained that divisions had been clear that they wanted to be able to make decisions for themselves, although with appropriate boundaries and control mechanisms in place.

086/ 2022

Maternity Overview

Mrs Lynes presented a maternity overview, noting that it provided an overview of maternity planning, progress and activity during quarter two 2022/23.

The Kirkup report into maternity and neonatal services in East Kent had recently been published and contained a small number of recommendations. Mrs Lynes explained that this had been a sobering and concerning read which had identified issues that were recognised both within ESHT and across the NHS. All the areas identified in the report were already areas for improvement for maternity services in the Trust.

She reported that the Trust had now fully recruited to maternity consultant roles, with one middle grade vacancy. This allowed for a twice daily ward round to be undertaken, seven days a week. Two continuity of carer teams were maintained, one focussing on deprived patients and the second on home births which were becoming increasingly complex. Midwife sickness rates had improved to around 2.5%, alongside an improving 6.75% vacancy rate.

Mrs Lynes reported that the Healthcare Safety Investigation Branch (HSIB) had recently completed two investigations into stillbirths at ESHT, with no trends noted. The majority of the maternity policies had now been updated in line with national guidance, and access had been improved for staff with a dedicated maternity page on the intranet making them simpler to find.

A thematic review of stillbirths had been undertaken following a cluster between October 2021 and May 2022, which had shown that reduced foetal movements were a factor in 50% of the cases. Improvements had been made as a result of this, including improved communication with patients around reduced foetal movements and the introduction of an urgent pathway to enable patients to report any concerns.

Work was being undertaken to ensure that the voices of all staff in the maternity team were heard when asking for feedback and listening events had been organised to facilitate this, allowing staff to raise concerns and to come together to solve issues. The Trust had a good relationship with the Maternity Voices Partnership which was helping to improve the experience of patients, and work was being undertaken to improve the Friends and Family Test process in maternity to receive more feedback.

Mr Phoenix praised the report, explaining that he had found it to be comprehensive and helpful, highlighting the challenges faced and progress being made. He thanked Mrs Lynes and her team for the work they were doing, noting that 70% of maternity staff had reported being emotionally exhausted in the 2021/22 staff survey. Mrs Lynes hoped that the latest staff survey would show that staff morale had improved.

	Mrs Chadwick-Bell noted that the key question to ask about the Trust's maternity services was whether good outcomes were achieved for families and babies. Strong assurance was being received about the progress being made, but risks still remained that needed to be mitigated on a daily basis. She noted the outstanding work that was being done by Mrs Lynes and her team, and the assurance that this enabled them to provide about the service through a number of different channels. Mrs Churchward-Cardiff hoped that there would be improved staff survey results for the maternity team in 2022/23. She noted concern about the use of community maternity staff in acute units during periods of escalation, and asked that future maternity updates included assurance about these challenges and how they would be addressed moving forward. ***The Board endorsed the CNST/MIS 4 year assurance compliance, noting that this had been subject to external review.***	
087/ 2022	**Learning from Deaths** Dr Merritt reported that a robust process was in place in the Trust where deaths were reviewed to identify whether anything could be learnt. A number of factors were used to identify the deaths that should be reviewed; he noted that compared to national figures, the number of deaths which were considered to have been potentially avoidable was very low and a review would be undertaken to fully understand this. A single death during Q4 2021/22 was considered to have been potentially avoidable and no deaths were considered to have been avoidable. Three cases were considered to have been possibly avoidable but not very likely due to the care received; in all three cases the patient was unlikely to have survived their admission. The review process provided helpful insight into the generally good care that was provided by the Trust. Dr Merritt noted that all deaths concerning any patient with a learning disability were reviewed, and none of these had been found to be avoidable. These cases were also subject to external review by the Learning Disability Mortality Review (LeDeR) programme. Mrs Churchward-Cardiff asked whether the results of all deaths that were considered to have an element of avoidability were fed back to clinical teams. Dr Merritt confirmed that teams were asked to reflect on the feedback, and discussions were held to discuss learning. This was then shared throughout the organisation. He noted that greater detail about the way in which information was shared could be included within the report if required.	
088/ 2022	**Cardiology and Ophthalmology Update** Mr Milner reported that decisions on the future of Cardiology and Ophthalmology services had been endorsed by the Trust Board at August's meeting in public. These endorsements had subsequently been approved by the Integrated Care Board (ICB) in November, and were due to be presented to Sussex Health Oversight Committee (HOSC) for decision later on in the week. He reported that there had been a small amount of local media interest in the decisions, and joint briefings had been issued by Integrated Care System (ICS) colleagues and local MPs. He hoped that there would be a positive response following HOSC's decision. Mrs Churchward-Cardiff asked when, if the changes were approved, capital funding would be received by the Trust to implement the improvements. Mr Milner explained that funding was already included within the Trust's plans, and Mr Reid noted that the ICB would prioritise the allocation of funds to the Trust. Mrs Churchward-Cardiff asked whether HOSC was the last hurdle that needed to be cleared. Mr Milner explained that there was a risk that that the changes would not be voted on, or would be recommended for judicial review, which could delay implementation.	
089/ 2022	**Board Assurance Framework, Quarters 1 & 2 Update** Mr Milner presented an update on the Quarters 1 & 2 Board Assurance Framework (BAF), noting that this had been previously been reviewed by Executives and by the Audit Committee. The report finalised	

	the risks for Q1 and Q2, as well as providing an interim judgement on Q3 risks. The finalised Q3 risks would be presented to Committees before being presented to the Board in February. Mrs Manson asked why it was anticipated that the risk rating for BAF 10 would improve in Q3. Mr Milner explained that the risk concerned a failure to deliver improvement methodology and Charlotte O'Brien had now joined the Trust as Director of Transformation and Improvement. Additionally a piece of work was being undertaken to establish a Quality Improvement (QI) methodology within the organisation, supported by an external consultancy. Mr Sims noted that the preliminary Q3 score for BAF 2, concerning workforce, had increased from 12 to 20. Mr Milner explained that this increase accounted for the risk of potential industrial action. Mr Sims asked about the reducing risk score for BAF 5, concerning Trust finance. Mr Phoenix noted that this reducing score had been discussed by the F&I Committee, and it had been agreed that this concerned the risk to 2022/23 financial performance. He anticipated that this score would increase in Q1 of 2023/24.	
090/ 2022	**Annual Reports** Safeguarding Mrs Churchward-Cardiff noted that a key theme across all of the annual reports presented to the Board was the increasing complexity of safeguarding, and asked how the Trust was managing this. Mrs Tonge explained that a review of the safeguarding team was being undertaken to ensure that they had capacity to manage increasingly complex safeguarding issues. ***The Board noted the annual Safeguarding report.*** Infection Prevention and Control ***The Board noted the annual Infection Prevention and Control report.*** Patient Experience ***The Board noted the annual Patient Experience report.*** Workforce Race Equality Standard (WRES) Mr Phoenix noted that the report had shown significantly improved results over those from previous years. Mr Aumayer explained that the report provided assurance that there was no bias in terms of recruitment, disciplinary processes or access to training with BME staff more likely to access mandatory training than non-BME colleagues. It was overall a very encouraging report on lack of bias for Trust. Mrs Churchward-Cardiff noted that the score for indicator five (the percentage of staff experiencing harassment from patients, relatives or the public in the previous 12 months) was the Trust's highest for five years and asked the reasons for this. Mr Aumayer explained that the results of this indicator were taken from the 2021 staff survey, so was not a recent indicator of progress, but were an uncomfortable result for the organisation nonetheless. He looked forward to seeing the 2022 staff survey results as this had been an area of focus for staff networks and for the Trust as a whole. ***The Board noted the annual Workforce Race Equality Standard (WRES) report.*** Workforce Disability Equality Standard (WDES) ***The Board noted the annual Workforce Disability Equality Standard (WDES) report.*** Gender Earnings Gap ***The Board noted the annual Gender Earnings Gap report.***	

Guardians of Safe Working Hours

Mrs Churchward-Cardiff asked for further information about the exceptions included in the report for breaches of working hours or for educational reasons. Mr Aumayer explained that these were predominantly linked to getting services back up and running post-Covid when junior doctors had worked additional hours as they were not allowed to work on the Trust bank. He noted that the General Medical Council now permitted doctors to work additional hours within their own services under their own supervision and expected to see a reduction in exceptions moving forward.

Mrs Churchward-Cardiff noted concern that the Trust's acting down policy was not being correctly implemented. Mr Aumayer agreed, explaining that the issue was being reviewed to fully understand it.

The Board noted the annual Guardians of Safe Working Hours report.

091/2022 **Use of Trust Seal**

The Board noted one use of the Trust Seal since the last Board meeting.

092/2022 **Trust Board Planner 2023**

The Board noted the 2023 Board planner.

093/2022 **Questions from Members of the Public**

Three questions were asked on behalf of Mr Colin Campbell:

1. *There is no mention in the Visible Leadership section of the Chief Executive's Report whether members of the senior management team or non-executive directors have visited areas of the Trust staffed principally by volunteers? Could this be considered?*

   Mrs Chadwick-Bell reported that she had already visited Conquest Radio and it was planned that all areas of the Trust would be visited, including volunteers. She noted that the size of the organisation meant that it would take some time to visit every area.

2. *The level of over expenditure versus plan in the month on the Temporary Pay line is 300% of the Plan figure, therefore could a breakdown be provided of the various expenditures referred to namely, supernumerary costs, temporary staff and unfunded escalation costs and is this monthly situation likely to re-occur before the end of the financial year?*

   Mr Reid explained that the budget was based on a substantive establishment, which meant that there was only a very minimal temporary budget. In reality there are a large number of vacancies and some of these are covered by bank and agency. Spend on temporary staff is broadly similar to prior year however overall spend on temporary staff has increased by 36% since 19/20.

	18/19	18/19	19/20	20/21	21/22	22/23
	£'000	£'000	£'000	£'000	£'000	£'000
Temporary staff costs YTD M8	28,689	25,559	24,514	32,801	33,861	33,252

   Pay costs attributed to escalation cost centres year to date at month 8 equated to £3.8m compared to a budget of £1.5m. The unbudgeted expenditure is therefore £2.3m. Of this £2.5m is temporary staff costs (with a budget of £0.3m)

Total temporary spend to month 7 was:

Bank		11,232
Agency:	Medical	3,571
	Nursing	3,823
	Allied Health Professionals	808
	Administration	106
Total Agency		8,307
Locum		10,405
Waiting List Initiatives		1,637
TOTAL		31,574

3. *In previous financial years the Trust ran with an average cash balance of £2.5m but is currently carrying £45.4m? Should not any cash surplus to operating requirements be returned to H. M. Treasury?*

   Mr Reid explained that most (if not all) NHS organisations effectively do this as all cash is held in the Government Banking Service. The cash was already therefore part of the consolidated NHS position. It could also be available to improve paying suppliers and could help with funding capital projects above deprecation funding in certain circumstances.

094/ 2022 **Date of Next Meeting**
The next meeting of the Board would take place on Tuesday 14th February 2023 at Holy Cross Priory, Lewes Road, Cross-in-Hand, Heathfield TN21 0DZ.

Signed ……

Position ……..

Date ……

Matters Arising

Agenda Item	Action	Lead	Progress
085/2022 ii – IPR Month 7	'Office/Administration Area' was noted as the second highest location for safety incidents reported during October. The reasons for this to be investigated and fed back to the Board.	Vikki Carruth	Seventeen incorrect result letters were sent by the Child Health Records team in October; there was no harm to any patient as a result of the incorrect letters being sent. The high numbers of incidents reported was due to these being recorded as 17 individual incidents, rather than as a single incident as is normal practice. Administrative processes have been updated to prevent any recurrence.

East Sussex Healthcare NHS Trust

Audit Committee Summary, 26th January 2023

Purpose of the paper	Executive summary attached for Audit Committee meeting that was held on 26.01.2023						
	For Decision		For Assurance	✓	For Information		
Sponsor/Author	Paresh Patel, Chair, Audit Committee						
Governance overview	Trust Board						

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

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

Recommendation	The Board are asked to note the contents of the Executive summary.

Executive Summary

Cybersecurity – Quarterly Update
Improvements in patching, alongside the phasing out of legacy operating systems, meant that compliance around servers and client devices continued to improve each month. The NHS Digital Exposure Score for ESHT was at its lowest ever point and better than any other NHS trust within Sussex.

Review of Corporate Governance Documents
The Trust's corporate governance documents were reviewed and agreed by the Committee. They would be presented to the Trust Board for approval.

Update on new Datix live system rollout and Associated Data Migration
The planned migration to a cloud-based version of the Datix system continued; phase one of the system rollout (risk modules) was forecast to be implemented by April. Further modules, such as the patient administration system, would be rolled out in future phases.

Information Governance Toolkit Update
As at the meeting, 103 evidence items had been submitted against the Data Security and Protection Toolkit (DSPT). Internal auditors were due to begin an assurance audit over the coming weeks against the DSPT.

Tenders and Waivers
The number of waivers being agreed tracked favourably against previous years. A technical waiver (where only one response was received to a tender) was noted, alongside some linked to the innovative Our Care Sussex Integrated Digital Programme.

Review of Losses and Special Payments
The value of losses and special payments was broadly in line with previous years. The main write-off category was once again pharmacy stock that was either out of date or damaged.

External Audit Update
The external audit work programme for the coming year was provided in summary, ahead of the detailed plan being brought to the Committee in March. Regular meetings would take place between members of the Trust's finance team and auditors during June to ensure the review process for ESHT's accounts would be as seamless as possible.

	Internal Audit The following reports had been issued since the last Committee meeting: Final Reports: • Discharges – Advisory • EPRR and Business Continuity – Reasonable Assurance • HFMA Checklist – Advisory • Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Return - Advisory • Board Assurance Framework (BAF) and Risk Management – Reasonable Assurance • ICT: Cyber, Cloud Services – Limited Assurance. • Draft Report: • Absence Management – Limited Assurance. It was agreed by the Committee that the Building for Our Future audit should be deferred until the programme was at a more advanced stage. An audit of External Reviews would replace it in the work programme for the year. **Anti-Crime Specialist (ACS) Service Progress Report** The ACS Fraud Risk Assessment was nearing completion and would continue to be updated as a live document. This would help to further develop proactive anti-crime work that addressed the most current and relevant challenges. The ACS team continued to support the policy ratification group with decision-making. Discussions with ESHT were ongoing around launching a counter-fraud e-learning module for staff and this was soon expected to be available over the coming weeks via the MyLearn system. **Audit Committee Terms of Reference (ToR)** The Committee's ToR were reviewed and agreed by the Committee. They would be presented to the Trust Board for approval.

Next steps	N/A

East Sussex Healthcare NHS Trust

Audit Committee - Terms of Reference

1. Constitution

The Board has resolved to establish a committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Trust Board.

2. Purpose

The Audit Committee will support the Board by critically reviewing governance and assurance processes on which the Board places reliance. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls.

The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.

3. Membership

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members.

One of the members will be appointed Chair of the Committee by the Trust Board Chairman. One member should also be a member of the Quality and Safety Committee and one member a member of the Finance and Investment Committee.

At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee.

Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4. Attendance

Members of the Committee are expected to attend all meetings; if this is not possible then another non-executive director may substitute as outlined in the preceding paragraph.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend the meetings.

At least once a year the Committee should meet privately with the internal and external auditors.

The Chief Executive and other executive directors shall be invited to attend particularly when the Committee is discussing areas that are the responsibility of that Director.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process of assurance that supports the Annual Governance Statement.

The Company Secretary (or their nominee) shall attend the meetings to provide appropriate support and advice to the Chairman and committee members.

5. Quorum

A meeting of the Committee shall be quorate if at least two members are present, one of whom shall be the Chairman of the Committee or his delegated nominee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, may form part of the quorum.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committee's prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Duties

8.1 Governance, Risk Management and Internal control

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

- the information governance system, including requirements under the NHS Information Governance Toolkit and progress in implementing the General Data Protection Regulations (GDPR)

- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.

- the underlying assurance processes, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement

- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service

- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis.

- the Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.

- the Committee will be responsible for forming a panel to procure and appoint both internal and external auditors

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission
- NHS Litigation Authority
- Other regulators and inspectors

- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Standards Committee and the Finance and Investment Committee. In reviewing the work of the Quality and Standards Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Standards Committee on how this function should best be utilised.

8.6 Hosted arrangements

The Committee will review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.8 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.9 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in and compliance with accounting policies and practices.
- unadjusted mis-statements in the financial statements.
- significant judgments in preparation of the financial statements.
- significant adjustments resulting from the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary, or their nominee, and submitted to the Board. The Chair of the Committee shall present a short written summary of Committee meetings to the Board in order to draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

East Sussex Healthcare NHS Trust

Finance & Investment Committee Summary, 26th January 2022

Purpose of the paper	Executive summary attached for Finance & Investment Committee meeting that was held on 26.01.23						
	For Decision		For Assurance	✓	For Information		
Sponsor/Author	Nicola Webber, Chair, Finance & Investment Committee						
Governance overview	Trust Board						

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

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

Recommendation	The Board are asked to note the contents of the Executive summary.

Executive Summary	The Committee reviewed the Board Assurance Framework (BAF) areas for which it has responsibility and recommended review of the risk rating for BAF5 in light of the expected budgetary pressures in 23/24. **M9 Financial Performance and efficiency** The Trust anticipates reaching a balanced financial position at year end, however the Trust's underlying monthly run rate continued to be at a deficit level of c. £1m - £1.5m per month (offset by reserves in 22/23). The run rate was impacted by under performance in the cost improvement plan, in part caused by escalation areas remaining open, operational pressures and ongoing industrial action. The team is focused both on delivering the remaining months of the plan and ensuring that all recurrent schemes are captured. The Committee acknowledged the risk that the run rate presented for 23/24, but noted the collaborative efforts required by finance and operational teams to deliver the anticipated in-year balanced position. **National Productivity Metrics** The Committee noted that NHSE had developed a high level metric to consider productivity which took the real terms change in cost base (RTC) relative to the cost weighted activity (CWA) change. Compared to 2019/20 the Trust was 18.3% less productive (M6 18.5%) which was worse than the national position. Mr Reid explained that this was partly due to cost increases, and activity decreases, but may also be affected by what was, and was not, included in the calculation (for example, community costs). The finance team are focusing on providing meaningful metrics to help the Trust understand service level outliers and change, which will be monitored at F&P. A plan will be brought to the March committee with areas of focus identified (i.e. where it is believed the most material opportunities for productivity improvement may be found). This will support the ongoing work by the Elective Recovery Director and the broader teams in improving efficiency. **M9 Capital** Mr Reid presented the M9 capital update and noted the £2m reduction in the plan, as previously agreed. A capital bid of £650k had been agreed through winter funding to provide a discharge lounge. The committee challenged whether revenue implications had been considered and it was noted that going forward there needed to be clarity of capital and revenue funding for any such bids. In addition, the committee sought

	assurance that delivery of additional work would not impact the delivery of the remainder of the capital plan. Mr Hodgson confirmed that the plan was deliverable, but ambitious. A number of items over £500k were escalated from the CRG, but all were within the year's capital plan or had been previously approved as business cases and therefore were noted. **Five Year Capital Plan** The five year capital plan was presented to committee. This was based on a number of assumptions around central funding. The committee approved the overall capital plan and strategic direction and noted that slippage value was at a manageable level, subject to material changes from the ICB relating to allocation. **23/24 Planning Guidance** The Committee received a summary of planning guidance and an outline of the Trust's approach to planning for 23/24. **Non-Ward Nursing Review** The review considered non-ward nursing levels in relation to the service provided, local and national benchmarks, and activity changes over time (from 2019 to 2022). As phase 1 of the exercise, the paper was the first step in identifying areas for further scrutiny where services appeared to be an outlier in terms of costs relative to activity or benchmarks (or both). It was agreed that the next phase of the work would return to committee in April 2023, which would set out how efficiencies would be generated. It was noted that this work should run concurrently with the productivity analysis discussed earlier and that findings should be considered in tandem to identify correlation and ensure non-nursing elements were also considered. **Virtual Wards – Update** It was noted that recruitment to the virtual wards had taken longer than originally forecast, delaying implementation but that numbers would increase by the year end. Central pressure to roll out at pace was acknowledged. The committee asked for additional cost-benefit analysis to understand the impact of virtual beds on the hospital establishment and patient health / outcomes (including, for example, readmission or admission avoidance, cost of care, length of stay, etc). **Elective Hub Business Case** The Committee received an update on the Full Business Case (FBC) development for the Elective Hub. The FBC is on the agenda for this meeting for approval. The Committee received assurance that inflation was included in the case. It was noted that the clinicians supporting the case were aligned with the delivery of a £2.4m operating surplus by year 4, and that the 'clean' separation of services would facilitate efficiencies and patient flow. The committee approved a capital threshold of between £32m and £34m for the FBC, with an adjustment of the Trust's 5 year capital plan to address the gap between the capital threshold and national funding (£9.5m anticipated gap after VAT reclaim). The Committee recommended Trust Board approval of the FBC within this threshold and noted the risk of the Trust commencing construction prior to FBC approval by NHSE/DHSC. **CCTV and Access Control Framework** A tender award report was presented. It was noted that the current CCTV and Access Control systems at Bexhill and Conquest are at risk of failure and required significant ongoing maintenance. Tenders to replace the systems were invited, and evaluated. The committee was satisfied that the tender process was appropriate and approved the award of the framework to Reliance High Tech for a sum of £1.3m ex VAT.

Next steps	N/A

East Sussex Healthcare NHS Trust

Finance and Productivity Committee - Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Productivity Committee (the Committee). The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Board of directors.

2. Purpose

The Finance and Productivity Committee should provide recommendations and assurance to the Board relating to:

- ***Strategy and development***:
  - Development and oversight of the Trust's Financial and Capital Strategy
  - The process for business case assessments and scrutiny
  - including a review of future financial challenges and opportunities
  - Approve/recommend to Board business cases in line with Standing Financial Instructions (SFIs) and tracking of associated benefits.
  - Understanding the financial risk environment in which the Trust operates including reviewing relevant Board Assurance Framework (BAF) risks, providing assurance on mitigations (requesting plans where relevant) and helping the Board to set the financial risk appetite for the Trust
  - The effectiveness and robustness of financial planning
  - Understanding the capital and market environment in which the Trust operates

- ***Monitoring and assurance***
  - Tracking monthly financial and capital performance against budget, and reviewing and approving changes to forecast if required
  - Monitoring balance sheet risks and the cash position
  - Reviewing productivity and efficiency delivery
  - Undertaking substantial reviews of issues and areas of concern.

3. Membership and attendance

The Committee and the Committee Chair shall be appointed by the Chair of the Board of directors. The membership of the Committee shall be as follows:

- At least three non-executive directors (one of whom shall be a member of the Audit Committee)
- Chief Financial Officer
- Chief Operating Officer
- Chief of Staff
- Director of Estates and Facilities
- Director of Transformation and Improvement
- Senior Medical/ Nursing input as required by agenda
- Associate Director of Digital as required by agenda
- Deputy Director of Finance
- Board Secretary/Nominee

4. Quorum

Quorum of the Committee shall be three members which must include a non-executive director and the Chief Financial Officer (or deputy). Nominated deputies will count towards the quorum.

5. Frequency

Meetings shall be held monthly and at such other times as the Chairman of the Committee shall require.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust. In particular its duties include:

- Reviewing the financial environment in which the Trust operates, and supporting the Board to ensure that its focus on financial and business issues continually improves
- Monitoring the productivity of the Trust, scrutinising the opportunities for improvement and challenging the organisation to increase efficiency as appropriate (with reference to the Trust's broader strategy and values)
- Supporting the Board to understand and secure the financial and fiscal performance data and reporting its needs in order to discharge its duties
- Understanding the market and business environment in which the Trust operates and keeping the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment within which the organisation operates, providing assurance on mitigations (requesting plans where relevant) and helping the Board to agree an appropriate risk appetite for the Trust

- Supporting the Board to agree an annual capital and financial strategy and process
- Supporting the Board to agree an integrated business plan
- Approving or recommending to the Board business cases according to the SFIs
- Ensuring that business cases submitted for approval are in line with the priorities identified in the Trust's strategy
- Receiving assurance and scrutinise the effectiveness of demand and capacity planning.
- Ensuring that the overall financial strategy of the ICS, and any decisions relating to finance made by the ICB, are considered

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to deliver its operational plans

The Committee may as appropriate review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Productivity Committee's own scope of work.

7. Decision making

Every decision put to a vote at a Committee 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 Committee) shall have a second and casting vote.

8. Reporting arrangements

The minutes of the Committee meetings shall be formally recorded by the Executive Assistant to the Chief Financial Officer and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive actions.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. The Chief of Staff will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

January 2023

East Sussex Healthcare NHS Trust

Chief Executive Report

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

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

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

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

Executive Summary

New year / Critical Incident

I'd like to start with wishing everyone a Happy New Year. It was a challenging end to 2022, and those challenges have continued, with a critical incident being declared days into the new year. However our colleagues have showed immense resilience and the ability to adapt quickly to more flexible ways of working, meaning we were able to stand down the critical incident within a few days. Due to the continuation of pressures, and with further industrial action on the horizon, there will be huge focus on helping to maintain patient flow.

COVID-19 / Flu

As you will be aware, we are seeing a significant surge in flu and COVID-19 cases in the county, which is significantly contributing to the high numbers of presentations our Emergency Departments are seeing.

We have reminded staff via several communications routes to ensure that fluid resistant surgical face masks (FRSMs) are being used within all clinical settings for staff, patients, and visitors.

A decision was also made to restrict patient visiting from Thursday 5th January, meaning that visits were permitted in compassionate or exceptional circumstances only. This was lifted on the 17th January. However the restrictions on those accompanying people attending our emergency departments have remained in place. Decisions around visiting and restrictions are never made lightly and are always done with the view of further ensuring the safety of our patients. Full details of the restrictions can be found on our public facing website, as well as the ESHT intranet.

Industrial Action

The Royal College of Nursing (RCN) have confirmed that they plan to take further industrial action on Monday 6th and Tuesday 7th January, with Ambulance services also striking on the 7th.

While last month's RCN strike did have a significant impact on our services – particularly our elective and outpatient care – we were able to make sure we continued to provide urgent and inpatient care.

The Trust and system partners have been working tirelessly to deliver as many safe patient discharges as possible, to create additional capacity to cope with any additional demand on our services during the upcoming strikes.

An Incident Control Centre (ICC) has been, and will continue to be, in operation during the strike days. The ICC monitors the demand across the Trust and assists in assigning resource to areas and services most in need.

There has also been a major focus, including extra staffing resource, on ensuring timely ambulance handovers at the front door. Getting ambulances back out on the roads, as quickly as possible, is of the upmost importance.

As well as all the hard work taking place cross site, our community teams are providing invaluable support by working with patients to try and reduce the number of admissions.

In addition to all the above, we have seen a number of clinically trained staff, currently in non-clinical roles, come back to the floor to provide hands-on help to the services most in need. In addition, staff who are not on strike, but who are working in services which won't be running, will be deployed to derogated services to enable us to deliver safe services to patients.

Everyone's role plays a major part in ESHT being able to continue during these challenging times. What I have witnessed over the last couple of months gives me every confidence that we will continue to stay resilient through any future industrial action. Wellbeing staff will also be on hand during the strike days to further ensure our colleagues are being provided with as much support as possible.

Cardiology & Ophthalmology

The East Sussex Health Overview and Scrutiny Committee (HOSC) met on the 15th of December and has endorsed proposals to improve cardiology and ophthalmology services for the people of East Sussex. The proposals had previously been unanimously agreed by NHS Sussex Integrated Care Board (ICB) at its meeting in public on Wednesday 2 November.

We welcome the HOSC's support for the proposals that will be of great benefit to local people while strengthening and supporting our amazing hospital teams. These proposals will mean significant improvements for local people, meaning they can access treatment faster and enhanced specialist care for both cardiology and ophthalmology.

For Ophthalmology, the proposal is to consolidate services currently provided at Eastbourne District General Hospital (EDGH), Bexhill Hospital (BH) and Conquest Hospital (CQ) into two sites at EDGH and BH.

For Cardiology, the proposal is to create new cardiac response teams at the front door and in the Emergency Departments (EDs) at CQ and EDGH, and to concentrate the most highly specialised cardiac services at EDGH.

These plans are the culmination of a comprehensive programme of work that has considered the best clinical evidence, recommendations from clinical experts and a review and evaluation of feedback from two separate public consultations in which hundreds of people, including service users, carers and their families, as well as a wide range of organisations, took part.

Work will now begin to implement the proposed improvements to cardiology and ophthalmology services, which will provide the very best outcomes for local people.

CQC Maternity report

The Care Quality Commission (CQC) published their report into our Maternity services in January 2023, following their visits in October 2022. This is part of the national maternity inspection programme.

The overall rating for our maternity services at Conquest remains good, whilst at Eastbourne it has been rated requires improvement. Both sites were rated as being good for being well-led, and staff were praised for working well together for the benefit of women, and for managing safety well. It was also noted that services were tailored to meet the needs of the local population.

The CQC identified that we needed to make sure we had the right number of staff available to deliver maternity care safely through core staffing. This is something we have been working on over the last year and we will continue to recruit excellent midwives and other maternity professionals into our teams. Mitigations have been in place to ensure safe staffing and these have been set out in the maternity update paper later to the Board.

Newly published guidance

2023/24 National priorities and operational planning guidance: This guidance was published on 24th December. Briefing slides and a front sheet summary will be presented later in the agenda for this Board meeting.

Delivery plan for recovering urgent and emergency care services: The plan was published on 30th January. Many of the actions are already in place, but we will do an internal gap analysis review to ascertain anything new and summarise accordingly and confirm that associated funding is identified and allocated.

Summary:

A) Increase capacity, to help deal with increasing pressures on hospitals which see 19 in 20 beds currently occupied.

1. Dedicated funding of £1 billion will pay for additional capacity, including 5,000 new beds as part of the permanent bed base for next winter.
2. Over 800 new ambulances, including 100 specialist mental health ambulances, the majority of which will be on the road by next winter.
3. 'Same day' emergency care services will be in place across every hospital with a major emergency department, so patients avoid unnecessary overnight stays.

B) Grow the workforce, as increasing capacity requires more staff who feel supported.

4. More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
5. We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

C) Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

6. Over the next 2 years, and as part of the up to £14.1 billion extra for health and social care, £1.6 billion will be focused squarely on discharge.
7. 'Care transfer hubs' in every hospital ahead of next winter will mean faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
8. This year, new approaches to step-down care will start to be implemented so, for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.

9. New discharge information will be published, with new data collected from this April.

D) Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.

10.Ahead of next winter we will offer more joined-up care for older people living with frailty, including scaling urgent community response, frailty and falls services across the whole country – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.
11.Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 3,000 beds to provide over 10,000 in total by this autumn, allowing staff to care for up to 50,000 patients a month this way over the longer term.

E) Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.

12.By April 2024, urgent mental health support through NHS 111 will be universally available.
13.From this April, new data will allow the public to easily see and compare the performance of their local services. We will also tackle unwarranted variation in performance in the most challenged local systems.

This April, a new clinically-led programme to reduce unwarranted variation will launch, alongside intensive support for those areas struggling the most

Estates Development

Eastbourne Net Zero Carbon Project: The project continues to make good progress with a significant amount of cladding installed on the South and East sides of the hospital. Solar panel enabling works have commenced on the main staff car park and the air and water source heat pumps have been delivered to site.

Eastbourne Elective Care Centre: Enabling wok for the main scheme has commenced with the demolition of the link bridge to the Polegate Ward (clinical services relocated to Friston Ward). Polegate Ward demolition commences on 30th January 2023.

Bexhill Community Diagnostic Centre: The facility was handed over to us in November 2022 by the construction contractor and the first patients attended the centre in December 2022. The CDC was visited by Huw Merriman, MP for Bexhill and Battle, on 9th December 2002 as well as by members of the Trust Board.

Eastbourne Cath Lab: Enabling works for the main construction scheme to replace Cath Lab 1 commenced in December 2022. Main construction commenced in early January 2023.

Visible Leadership

Ensuring visible leadership is of the upmost importance, especially during times of strife. Throughout the last couple of months, both Executive and Non-Executive Directors have paid multiple visits across ESHT sites and services.

Our amazing staff made so much effort to spread festive cheer to patients, visitors and colleagues, and this was noticed and congratulated during many of the visits over the Christmas period.

The Chairman had the honour of presenting December's hero of the month award to a fantastic and well-respected Health Care Assistant from one our community nursing teams.

	One of our Non-Executive Directors returned from a visit with the District Nursing team, full of praise and admiration for the care and commitment to our patients and each other. It has also been really lovely to hear multiple pieces of positive feedback from people about how they feel supported in their roles, and that the Trust continues to have a compassionate approach to how we support our colleagues. These visits are also a place for staff to raise any issues or concerns. This feedback is as essential as the more positive comments, and we need to be informed of such things to enable us to learn and implement change. The approach we take on these visits is one that we hope creates a safe space for our colleagues to speak up about things that perhaps aren't going as well as they should. The openness we have experienced from the visits has been reassuring in that we are delivering on our goal of being a visible and supportive leadership team.

Next steps	*N/A*

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period December 2022 (Month 9)

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 - 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	

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 (ESHT and non-ESHT)	M	1132	1080	Common Cause	
Serious Incidents	M	1	2	Common Cause	
Never Events	M	0	0	Common Cause	
Inpatient Falls per 1,000 Bed days	M	4.8	6.9	Common Cause	
Pressure Ulcers, grade 3 to 4	0	0	0	Common Cause	Inconsistent
MRSA Cases	0	0	0	Common Cause	Inconsistent
Cdiff Cases	<5	13	6	Common Cause	Consistently Missed
MSSA Cases	M	2	4	Common Cause	
RAMI	94	88.3	91.3	Concern	Consistently Hit
SHMI (NHS Digital monthly)	0.99	0.98	0.98	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	89%	86%	Common Cause	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	89%	86%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last Month	This Month	Variation	Assurance
Complaints received	M	39	30	Common Cause	
A&E FFT Score	M	66%	55%	Concern	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	100%	98%	Common Cause	
Out of Hospital FFT Score	M	99%	99%	Common Cause	
Outpatient FFT Score	M	98%	99%	Common Cause	

Our Productivity	Target / Limit	Last Month	This Month	Variation	Assurance
4 hour theatre sessions	M	570	471	Common Cause	
Average Cases per 4 hour session	M	2.4	2.3	Common Cause	
Theatre utilisation	90%	76.7%	72.6%	Common Cause	Consistently Missed
Outpatient utilisation	100%	76.4%	75.6%	Concern	Consistently Missed
Clinic run rate	M	83.7%	81.5%	Common Cause	
Non Face to Face Outpatients	>25%	27.3%	27.7%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.8	3.1	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	5.5	6.1	Concern	Consistently Missed
Non Elective Length of Stay	M	8.9	9.4	Concern	

Our People	Target / Limit	Last Month	This Month	Variation	Assurance
Establishment (WTE)	M	7,986.5	8,163.3		
Vacancy Rate	<5%	7.8%	9.9%	Concern	Consistently Missed
Staff Turnover	<9.9%	13.9%	13.7%	Concern	Consistently Missed
Retention Rate	>92%	89.0%	89.6%	Concern	Consistently Missed
Sickness - Absence % (rolling 12 mths)	<4.5%	6.1%	6.1%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	22.1943	22.3371	Concern	Consistently Missed
Staff Appraisals	>85%	73.5%	73.1%	Common Cause	Consistently Missed
Statutory & Mandatory Training	>90%	86.1%	86.1%	Concern	Consistently Missed

Our Performance	Target / Limit	Last Month	This Month	Variation	Assurance
A&E 4 hour target	>95%	64.4%	58.9%	Concern	Consistently Missed
A&E Non Admitted	M	70.9%	66.0%	Concern	
A&E > 12 hours from arrival to discharge	0	733	1420	Concern	Consistently Missed
A&E waits over 12 hours from DTA	0	0	5	Concern	Inconsistent
Conveyance handover >30 mins	0%	13.3%	25.3%	Concern	Consistently Missed
Conveyance handover >60 mins	0%	1.7%	7.6%	Concern	Consistently Missed
Average daily MRD	M	170	145	Improvement	
Average daily NCTR	M	258	237	Concern	
UTC 2 hour	>98%	70.5%	68.7%	Concern	Consistently Missed
Cancer 2WW	>93%	76.3%	82.8%	Concern	Consistently Missed
Cancer 62 Day	>85%	70.5%	74.8%	Common Cause	Consistently Missed
28 Day General FDS Two Week Wait	>75%	74.5%	76.8%	Common Cause	Inconsistent
62 day Backlog	M	99	128	Common Cause	
104 day Backlog	M	22	27	Common Cause	
RTT under 18 weeks	>92%	54.3%	52.4%	Concern	Consistently Missed
RTT 52 week wait	0	1263	1195	Concern	Consistently Missed
RTT Total Waiting List Size	36,833	55214	53961	Concern	Consistently Missed
Urgent Community Response within 2 hours	>=70%	77.0%	76.2%	Common Cause	Consistently Hit
CHIC wait times < 13 weeks	>75%	83.2%	81.6%	Common Cause	Consistently Hit
Diagnostic <6 weeks	<1%	18.3%	22.6%	Common Cause	Consistently Missed

Chief Executive Summary

East Sussex Healthcare NHS Trust

The Trust moved into December with a number of challenges which impacted on delivering the 4 hour emergency department standard, patients' overall average length of stay, recovery of our elective programme which includes suspected cancer patients awaiting, Our priorities over the past month, in line with our annual objectives has been to focus on elective recovery including cancer, safe and sustainable urgent care; and our workforce, who have experienced (and continue to experience) increased pressure across services. The anticipated rise in infectious illnesses became apparent in the month with an increase in Covid admissions as well as a high prevalence of influenza A and a number of incidences of norovirus. As was the picture nationally for NHS hospital providers.

We continue to focus on the 4 hour standard, bed occupancy, length of stay and elective recovery. We are working collaboratively with our staff and patients alike, system partners and our ICB to ensure that the patients of East Sussex receive timely access to the right care.

There is a balance of risk across all our services. From patients waiting at home for packages of care / community support, to those patients referred in on an elective pathway, to those requiring urgent / emergency care. The Trust is committed to continuously monitoring and balancing these risks and priorities and flexing capacity to meet ever changing and growing demand.

We as a Trust are cognisant of the impact and increased pressure these demands are putting on our staff and we will continue to work productively with teams all across the Trust to support engagement and wellbeing.

Key Areas of Success

- The Trust delivered on the 28 day faster diagnosis standard. Ensuring that over 75% of patients referred in on a suspected cancer pathway received a diagnosis within 28 days of being referred
- There has been a continued reduction in the number of patients residing in an acute bed with a length of stay >21 days
- Trust is reporting a year to date surplus position of £0.1m against a planned deficit of (£0.2m), a favourable variance of £0.3m.
- The number of patients whom have been assessed as medically ready for discharge has reduced again in December

Key Areas of Focus

- Although an improvement seen in the reduction of the number of patients residing with a length of stay (LoS) >21 days, the Trust's LoS and overall bed occupancy will remain areas of focus as we set out our business plans for the coming year
- ED performance just below the national average and is reflective of the length of stay in the emergency departments experiencing a significant increase due to the high bed occupancy and lack of available beds for patients to be pulled through to continue their care with us
- We have seen an improvement in our cancer performance overall and we will be looking to build on this, as well as a Trust focus on elective recovery as we look to reduce wait times, maximise productivity and ensure patients are receiving timely access to care
- Vacancy rates and sickness both saw an increase in December. Although these variations appear to be more a symptom of increase in FTE budget establishment and seasonal illness respectively

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 & Safety - December 2022 Data

COVID – 19

Prevalence of COVID increased once again, peaking towards the end of the month. Management of cases was more challenging as seasonal Influenza A was also at very high prevalence as well incidences of Noro virus. Facemask wearing in clinical settings remains in place for staff and visitors. This has been agreed as an ICS approach for winter and will be kept under review.

Infection Control

Sadly as predicted, the limit for clostridium difficile (CDI) infections was exceeded in December and the Trust has now exceeded the limit for the year. Many Trusts are reporting higher numbers of CDI and reasons are not fully known and will be discussed at a national workshop in December. ESHT is ribotyping each case and the ongoing high numbers of cases do not appear related to outbreaks or cross infection. ESHT is taking part in an improvement collaborative being led by NHSE aiming to understand and reduce this increase.

Incidents

There were two serious incidents reported during December:

- delays in receiving biopsy results
- neonatal death and maternal complications

Pressure Ulcers

After a significant increase in October, the rate of PUs per 1000 bed days amongst hospital patients has continued to reduce and the number reported in the community setting has remained within expected control limits. Zero category 3 & 4 PUs reported in month.

Falls

There were no severity 4/5 falls in December with the Bexhill Irvine Unit reporting the highest number of falls. Several patients had multiple falls, an ongoing indicator of the high numbers of long length of stay patients many of whom are frail, confused, wandersome and high risk. Two patients had four falls each during December. In addition significant supersurge capacity remined open during this time including at BIU with wards exceeding bedded patient numbers on many occasions leading to staffing being very challenged trust wide.

Mortality

Both SHMI and RAMI indices of mortality rolling 12 months, remain better than peers. Trust SHMI has remained the same for this period. Elective SHMI has increased, but remains below our NHS England Acute Peers. RAMI remains in the top quartile.

Patient Experience

2,194 pieces of patient feedback were received in December, 1.36% of feedback was formal complaints (30). Teams continue to work through the backlog with 11 overdue complaints at the end of December. The Patient Experience Team continue to work with the Emergency Department and Maternity teams to try to increase the FFT response rate. December saw just 22 completed surveys across the Emergency Departments with a recommendation rate of 54.55%. Both departments remained under considerable pressure in the month. The Patient Experience & Communication Team continue to look at ways of promoting how patients/carers can leave feedback, with updated posters, website pages and survey questions being reviewed.

Nursing & Midwifery Staffing

The requirement for significant additional inpatient capacity continued throughout December with additional super surge capacity open on three sites and pre-emptive patient placement on many wards. The trust continues to see very large numbers of long length of stay patients most of whom are frail, vulnerable and very dependent. Ward staffing in December remained very stretched in most areas exacerbated by staff sickness. This is likely to have had an impact on key quality metrics especially unwitnessed falls, documentation, communication, discharge planning some delays in providing care and a negative impact on staff wellbeing due to the sustained pressures. The 2022/2023 ward Nursing Establishment Review data collection was completed as planned in September and will feed into business planning. The trust response to Industrial Action including that taken by RCN members will be covered in more detail by our CPO.

Safeguarding

Safeguarding concerns continue to be monitored closely via the weekly tracker. This has shown a decline in concerns about ESHT recently but this may also be as a result of workforce pressures within Adult Social Care so possibly some concerns yet to process. The tracker highlights any themes or hotspots with plans underway regarding improvement work on discharge, communication/documentation/handover esp re: Tissue Viability and assessment of mental capacity. An initial Safeguarding Round Table has been held, with this topic also a focus in upcoming quality summits led by the CNO. Weekly meetings with Divisional ADNs and HON's also continue. Complex cases involving people with learning disabilities where care settings have declined the person's return or a change in funding has left them stranded remains a theme, and a meeting has occurred with the ICB Learning Disability lead to highlight this and consider strategies going forward. Work continues regarding Deprivation of Liberty Safeguards (DoLS) with discussions to ensure staff are prepared for the introduction of Liberty Protection Safeguards (LPS) which will replace DoLS. Work is underway to develop LPS awareness training and a short video clip produced by the Safeguarding Adults National Network is available for staff.
Planned meetings with SPFT to review patients that have been sectioned under the Mental Health Act have been requested to ensure oversight and best practice.
For children and young people, mental ill health and neglect continue to be the predominant themes cited in Children's Safeguarding.

Author(s)

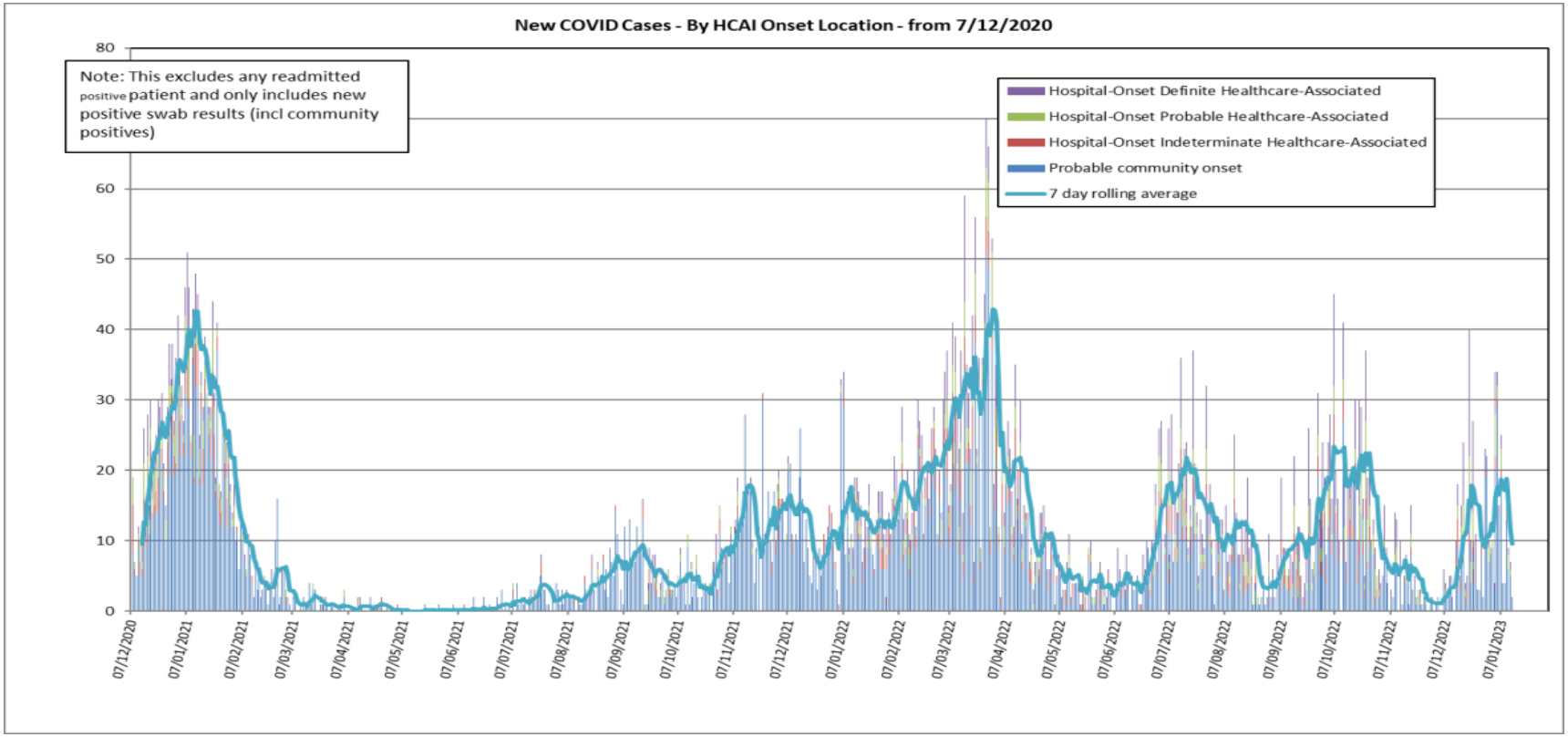
Vikki Carruth
Chief Nurse and Director of Infection Prevention & Control (DIPC)

Simon Merritt
Chief Medical Officer

COVID-19

East Sussex Healthcare NHS Trust

Prevalence of COVID in both community and hospital increased once again in December. Patients presenting with respiratory symptoms are now being tested for COVID, flu and respiratory syncytial virus (RSV) as part of winter preparedness.



Seasonal influenza A also significantly increased during December peaking towards the end of the month during the holiday period. Every effort was made to cohort patients with the same infection together and reduce the risk of exposure to another virus. The IPC winter plan for Sussex was agreed and all escalation actions were implemented.

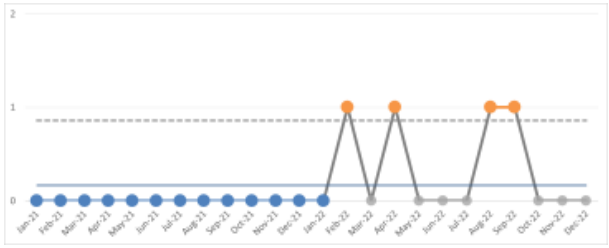
There were two reportable outbreaks of COVID at Rye and Bexhill, an outbreak of flu on Jevington ward and an outbreak of Norovirus on Baird ward, managed as per national guidance.

Safe Care - Infection Control

East Sussex Healthcare NHS Trust
Author: Lisa Redmond – Head of Infection Control & Deputy DIPC

Quality and Safety

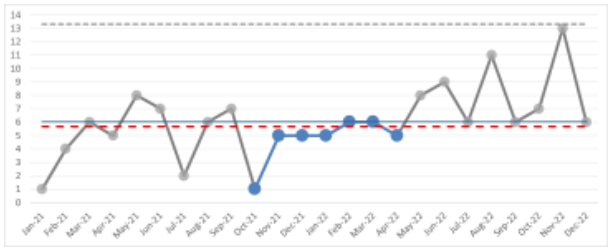
MRSA cases



Variation: Normal
Current Month: 0

MRSA bacteraemia (MRSA)
There were no MRSA bacteraemias to report for December.

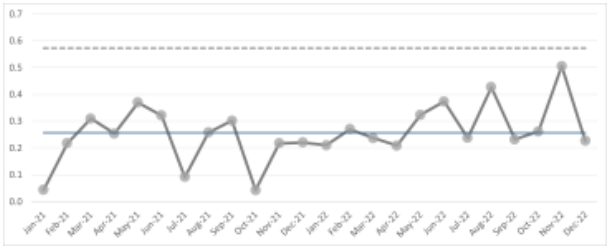
CDIFF cases



Limit: 5.66
Variation: Normal
Current Month: 6

Clostridium Difficile Infection (CDI)
For the month of December, the Trust reported 6 cases of CDI against a monthly limit of 5. Four were reported as Hospital Onset Healthcare Associated and two reported as Community Onset Healthcare Associated. All cases were sent for ribotyping. There was no evidence that cases were as a result of cross infection.

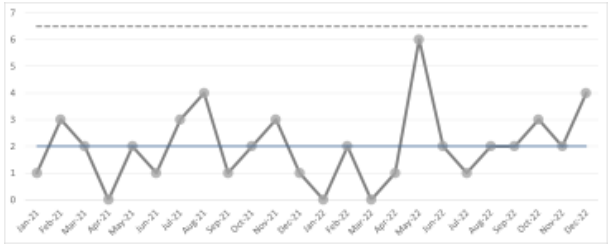
CDIFF per 1000 bed days



Variation: Normal
Current Month: 0.23

The national rate of CDI is not currently included due to flexing of beds with the NHS due to COVID.

MSSA



Variation: Normal
Current Month: 4

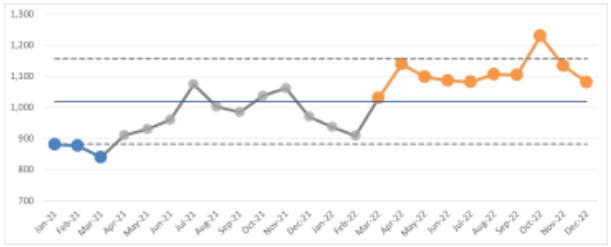
MSSA bacteraemia
Four **MSSA** bacteraemias were reported in December. Two cases were reported as Hospital Onset Healthcare Associated (HOHA), and two cases were reported as Community Onset Healthcare Associated (COHA). None were linked to contributory lapses.

Safe Care – Incidents

Quality and Safety

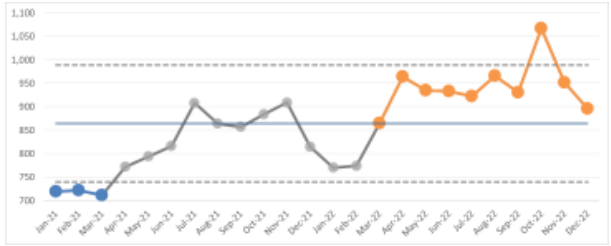
Patient Safety Incidents
(Total incidents ESHT and Non-ESHT)

Variation: Normal
Current Month: 1,080



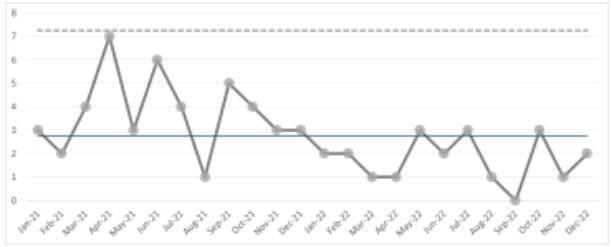
Patient Safety Incidents
(ESHT incidents)

Variation: Normal
Current Month: 896



Serious Incidents (SIs)
(Incidents recorded on Datix)

Variation: Normal
Current Month: 2



Author:	**Margaret England – Head of Governance**
Status Report	There were 1,080 incidents reported (from Datix on 16/01/2022). 896 were **ESHT only** incidents and of these: Severity 1 None/Near Miss - 646 Severity 2 Minor - 234 Severity 3 Moderate - 14 Severity 4 Major - 1 Severity 5 Catastrophic - 1 **Top five reporting locations**: Patients Home - 79 Emergency Unit Eastbourne – 37 Delivery Suite - 37 Emergency Unit Conquest – 36 Irvine Unit Intermediate Care Unit - 33 Acute Medical Unit Eastbourne - 23 **Top reported categories:** Slips Trips and Falls - 219 Medication Errors and Other Medication Related Incident - 101 Antenatal, Labour and Post Natal Care - 75 Diagnosis and Diagnostic Services - 58 Patient discharge and transfers - 57 There were two SI's reported in December. • Core Services – Treatment Delay – there were delays in receiving biopsy results which showed metastatic melanoma. •Women, Children's, and Sexual Health – Maternity/Obstetrics – this case involves a previous neonatal death in Oct with maternal complications. After external roundtable review, declared as SI in Dec.
Challenge & Risk:	On-line, free of charge Healthcare Safety Investigation Branch (HSIB) courses have been made available to divisional staff to book onto to support investigations as part of the PSIRF implementation. Risk that inadequate numbers of staff will be trained by August 2023.
Actions:	The Trust anticipates implementing PSIRF by Aug 2023. ESHT Digital are working with Datix to resolve technical issues with the Datix Cloud IQ implementation.

Safe Care – Falls

Author: **Margaret England – Head of Governance**

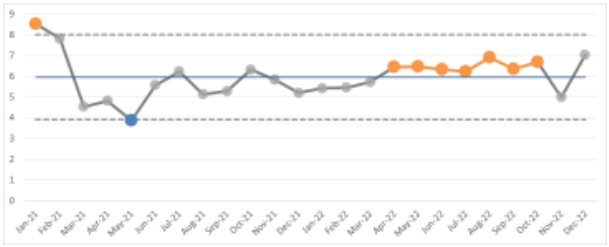
NHS East Sussex Healthcare NHS Trust

Status Report

There were a total of 219 falls in December.

Repeat falls:
- 16 patients had 2 falls each
- 7 patients had 3 falls each
- 2 patient had 4 falls

Inpatient Falls Per 1,000 Bed Days (Acute)

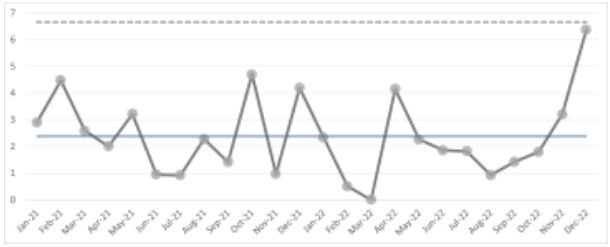


Average: 5.52
Variation: Normal
Current Month: 7.03

Areas reporting the highest numbers of falls during December:
- Bexhill Irvine (Intermediate Care) Unit - 21
- Rye (Intermediate Care Unit) - 14
- Murray Medical escalation Ward (was Gynae) - 12
- Newington Ward - 11
- De Cham Ward - 10

BIU: many patients were at high risk of falling; some had cognitive issues / Stroke patients. Unit had additional surpersurge capacity open during this time in a non bedded area which is felt to have contributed to this significant increase. BIU and Rye are rehab facilities so to avoid deconditioning mobilising is key and may involve more risk.

Inpatient Falls Per 1,000 Bed Days (Intermediate Care)



Variation: Normal
Current Month: 6.37

With widespread supersurge capacity and pre-emptive placement of patients on many wards, this has added to overcrowding and increases the amount of equipment in communal areas making mobilising more challenging for some patients. Murray ward became exclusively medical escalation capacity in the month.

There were no one severity 4 or 5 falls reported during December.

Challenge & Risk:

Significant additional capacity was and is still open on three sites. There were very high numbers of patients not meeting criteria to reside (NCTR) who were medically fit for discharge (MFD), many of whom are frail, confused and dependent with a history of, and increased risk of, harm. Many are confused and prone to wandering and admitted with a history of falls. Work continues regarding harm reviews for these patients including deconditioning with discussions about Safeguarding and Deprivation of Liberties ongoing.

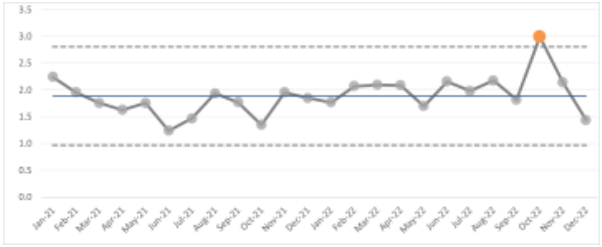
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

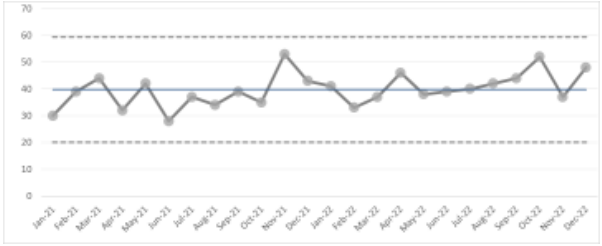
Pressure Ulcers Per 1000 bed days
Inpatients
all categories

Monitoring
Variation: Normal
Current Month: 1.44



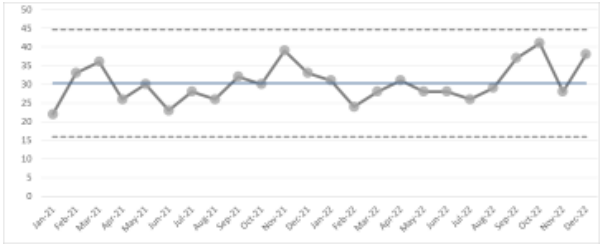
Pressure Ulcers
Non Inpatients
all categories

Monitoring
Variation: Normal
Current Month: 48



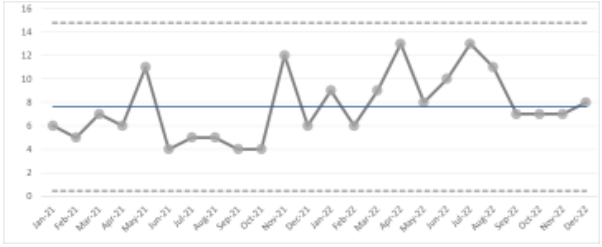
Pressure Ulcers Category
all categories
Patient Home

Monitoring
Variation: Normal
Current Month: 38



Pressure Ulcers Category
all categories
Other care provider

Monitoring
Variation: Normal
Current Month: 8



Author:	**Tina Lloyd – Assistant Director of Nursing**
Status Report:	After an increase in the rate of Pressure Ulcers (PUs) per 1,000 beds days amongst hospitalised patients in October, the rate in November & December has fallen to well within expected control limits (Graph 1). Zero Category 3 or 4 PUs were reported in December. The number of PUs reported amongst patients not in a hospital setting (known to ESHT community services) has remained within expected control limits (Graph 2). Graphs 3 & 4 show a break down of the number of PUs reported in patient's own home and amongst those in other care provider settings, shown for context. The CHIC division works closely with other care providers to review patients at risk and those with PUs, focusing on early intervention with deteriorating patients and planning care together discussions with patients who chose to sit for long periods at home, including sleeping in chairs rather than in their bed.
Challenge & Risk:	Significant additional capacity still open (circa 130 beds) with supersurge capacity and pre-emptive patient placement on many wards. Very large numbers of patients not meeting the criteria to reside (NCTR) and medically ready for discharge (MRD), many of whom are frail, wander some and very dependent. Many patients need 2 staff and/or enhanced observation with increased risk of harms and history of harm prior to admission.
Actions:	Robust planning required to de-escalate and significantly reduce occupancy (and maintain this) and the subsequent additional burden on staffing.

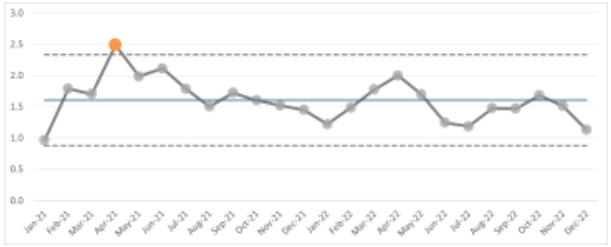
What patients are telling us?

East Sussex Healthcare NHS Trust

Quality and Safety

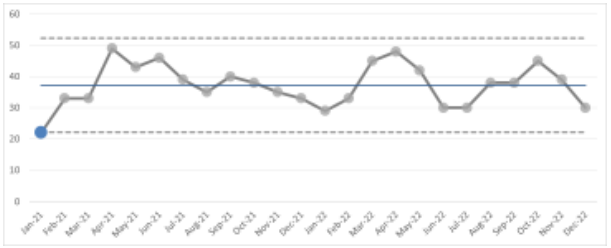
Amy Pain- Patient Experience Lead

Complaints Received per 1,000 bed days



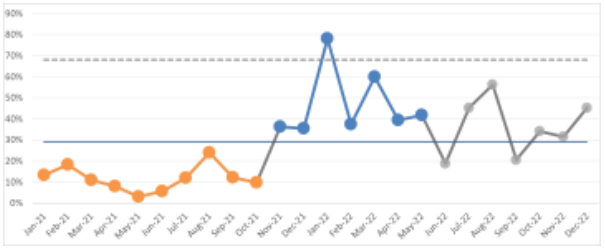
Variation: Normal
Current Month: 1.1

Total Complaints Received



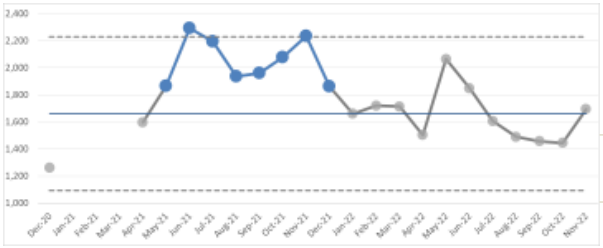
Variation: Normal
Current Month: 30

Complaints Response Times



Monitoring
Variation: Normal
Current Month: 45.3%

Plaudits Received



Monitoring
Variation: Normal
Last available month (Nov-22): 1,693

Status Report

In December ESHT received 2,194 pieces of patient feedback, which is a decrease of 592 compared to November (2,786).
This feedback was made up of:

- 1,679 Family and Friends Test (FFT) surveys completed (of which 1,241 included plaudits)
- 104 plaudits in the form of letters and thank you cards
- 6 positive reviews posted on Healthwatch and NHS websites
- 30 complaints received (November =39)
- 3 reopened complaints (November =7)
- 187 PALS concerns
- 180 PALS advice contacts
- 4 negative reviews posted on Healthwatch and NHS websites
- 1 PHSO outcome contact

The top three primary complaint subjects were:

- Clinical Treatment =9 (Nov=10, Oct= 13, Sept =9, Aug=10, Jul= 8)
- Staff Values & Behaviours = 6 (Nov=3, Oct =4, Sept = 4)
- Communication=5 (Nov =7, Oct= 6, Sept =6, Aug= 8, Jul= 9)

Top complaint locations:

- Emergency Department = 7 (CQ =5 and EDGH =2)
- Outpatient Department =7 (CQ= 3 and EDGH=4)
- Richard Ticehurst Surgical Assessment Unit (2)
- Sussex Premier Health (2)

There were **11 overdue** complaints at the end of December with the oldest complaint 18 working days overdue. These complaints were overdue for various reasons with no specific themes identified.
The overall response rate for the month was 45%. For 35 working days this was 49% and for 50 working days 17%.

The top three primary PALS subjects were:

- Communication = 49
- Appointments = 41
- Patient Care = 24

Top PALS locations:

- Outpatient Departments (EDGH) = 45
- Outpatient Departments (CQ)= 21
- Emergency Department (EDGH)= 15
- Office/ Administration area= 15

Challenge: Ongoing and increasing operational pressures still affecting response times.

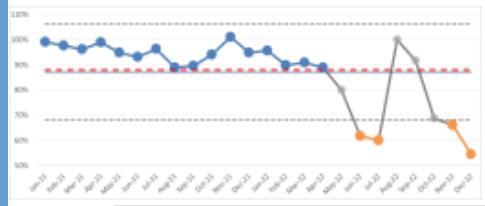
Actions: New style report drafted and will be presented to the Quality & Safety Committee.

What patients are telling us?

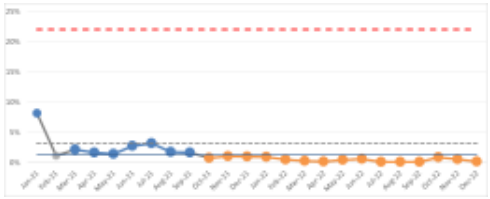
East Sussex Healthcare NHS Trust

Quality and Safety

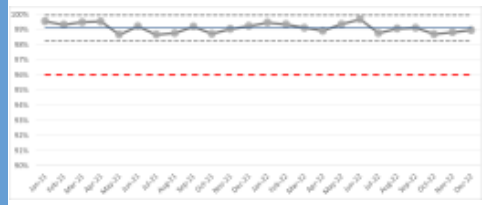
F&FT – A&E Score
Current Month: 54.5%



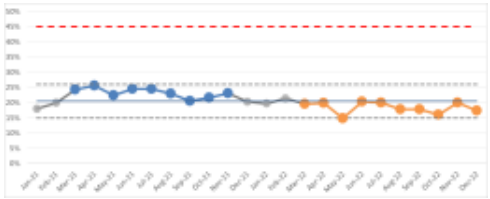
F&FT – A&E Response
Current Month: 0.2%



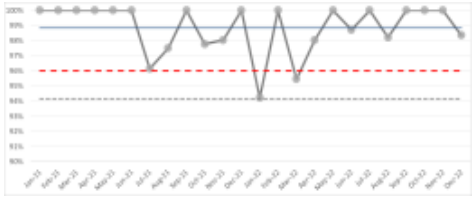
F&FT – Inpatient Score
Current Month: 99.0%



F&FT – Inpatient Response
Current Month: 17.4%



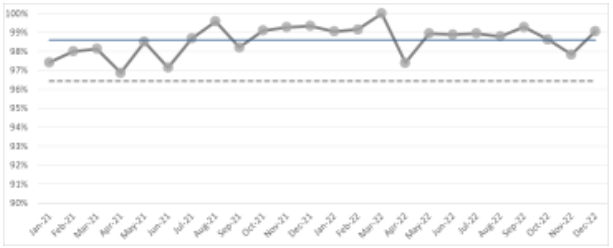
F&FT – Maternity Score
Current Month: 98.4%



F&FT – Maternity Response
Current Month: 29.8%

F&FT – Outpatient Score

Variation: Normal
Current Month: 99.1%



07/02/2023

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

Status Report

The total number of Family & Friend Tests (FFT) surveys returned in December was 1,679 s a decrease compared to November = 2,084.

Response rates continued to be affected by the sustained operational pressures and the Patient Experience team is experiencing long term sickness within the team.

The **positive recommendation rates** for December when compared to the most recent data released by NHS England (November) show that, with the exception of Accident and Emergency (A&E), ESHT continues to be higher than the national average.

A&E	54.55% , nat avg Nov 75% (ESHT resp rate 0.20%)
Inpatient	98.96% , nat avg Nov 94% (ESHT resp rate 17.36%)
Maternity	98.36% , nat avg Nov 93% (ESHT resp rate 29.8%)
Outpatients	99.06% , nat avg Nov 93% (213 surveys)
Community	98.51% , nat avg Nov 92% (268 surveys)

The top three scoring questions on the FFT inpatient survey were:

- Were you always treated with kindness?
- Did you feel the staff responded appropriately to any questions or concerns you raised?
- Did all staff have a smiling and friendly approach?

Themes related to dissatisfaction for the adult inpatient survey were with discharge processes.

Challenge & Risk:

Both A&E's continued to face considerable operational pressures with crowding, longer wait times and patients dissatisfaction with the self check ins, both of which have been recorded as free text on the FFT surveys.
Maternity continues to experience fewer number of surveys completed compared to previous months. The survey questions have been reviewed and streamlined, and promotional opportunities for the completion of FFT are displayed around the unit and on BadgerNet.

Actions:

A review of the process for capturing Out Patient Departments' (OPDs) patient experience is still underway but has been delayed due to staff sickness.

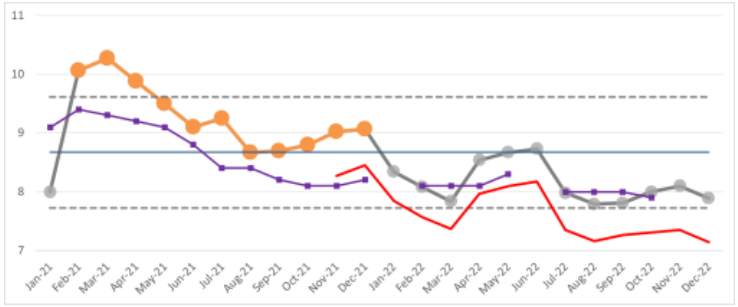
Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

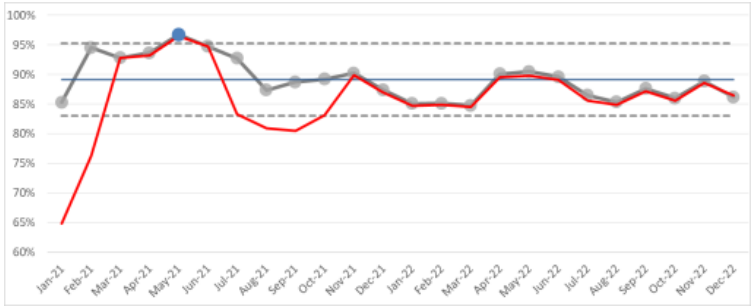
CHPPD (Trust)

National Median: 7.9 (Oct 22)
Level 2 and Level 3 Areas Excluded: 7.1
Current Month: 7.89



Staff Fill Rate (total)

Current Month: 86.2%
Incl. escalation: 86.4%



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

Author: **Angela Colosi Assistant Director of Nursing - Corporate**

Status Report:

Care Hours per Patient Day (CHPPD)
The red line indicates the ESHT CHPPD when level 2 & 3 areas are excluded - Critical Care, SCBU, CCU, maternity and paediatrics. These areas have notably higher CHPPD and therefore skew the average.
Ward level breakdown with registered and unregistered staff split is discussed in the Safer Staffing report that is presented at the Patient Safety and Quality Group with exceptions to the Quality & Safety Committee with some significant variation across areas.
In December, **23 out of 41 areas were under 8.0 CHPPD, with 14 areas under 7 CHPPD**.

Fill Rate
December's average fill rate against the planned budgeted establishment **for substantive wards only** was 86.2% for nursing, noting some variation across wards.
The red line which is the fill rate inclusive of escalation only includes Polegate and Devonshire wards but other escalation beds were open in December. It is not possible to separate out the additional beds used on existing wards such as Murray and the Seaford Annexe. The additional staffing on these areas are therefore not captured within the fill rate including escalation (red line). At time of writing additional supersurge capacity was also open.

Additional capacity remained open for medical patients on Devonshire, Polegate, Murray, Litlington, the Discharge Lounge at CQ, and the Seaford annexe. The fill rate including escalation was 86.4%.
Additional duties created are also not currently included in this data so it does not include the extra staff required for 1:1 enhanced observation. With increased dependency of the patients who are medically ready for discharge the number of patients who require 1 to 1 care can be significant. Supersurge capacity was also opened with approximately 10-15 beds or more on 3 sites.

Challenge & Risk:

- Significant additional and 'supersurge' capacity still open with pre-emptive placement of patients on wards
- Resource to enable staff to undertake mandatory and essential training
- Risk of impact on staff well being from ongoing additional capacity and escalation
- Identifying funding for NER recommendations for in-patient areas

Actions:

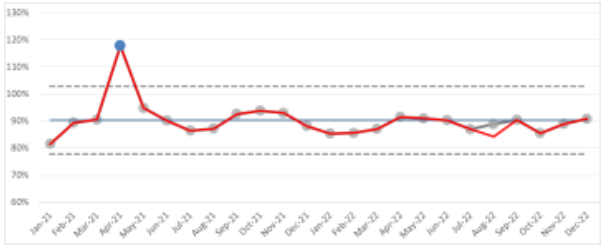
- Twice daily staffing reviews to ensure risk is mitigated as much as possible
- Plans to mitigate risk to patient safety during industrial action are in place.

Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

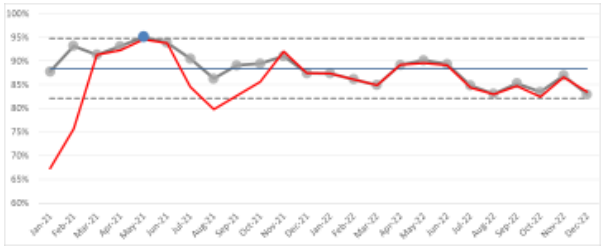
Staff Fill Rate (Bexhill)

Variation: Normal
Current Month: 90.8%
Incl. escalation: 90.8%



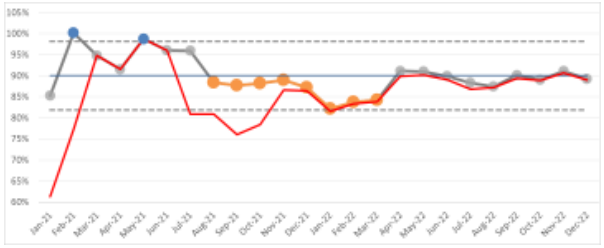
Staff Fill Rate (Conquest)

Variation: Normal
Current Month 82.9%
Incl. escalation: 83.5%



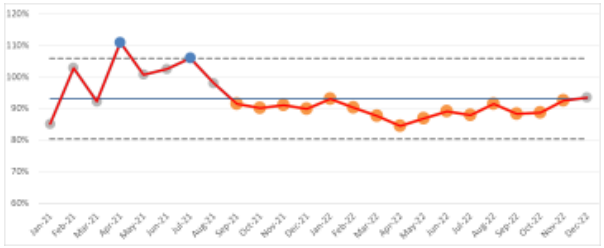
Staff Fill Rate (Eastbourne DGH)

Variation: Normal
Current Month: 89.2%
Incl. escalation: 88.9%



Staff Fill Rate (Rye Memorial)

Variation: Normal
Current Month: 93.4%
Incl. escalation: 93.4%

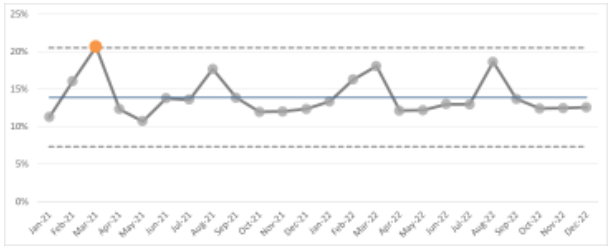


Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report:	Eastbourne & Conquest fill rate data does not fully represent the impact of the additional areas open as only Polegate and Devonshire at EDGH are captured as unfunded areas. In some in-patient areas e.g. Seaford, escalation beds are also funded as part of the ward and therefore not included in the fill rate calculation. Murray ward is now a 28 bedded escalation ward for patients with medical needs. As well as escalation beds additional beds have been opened as part of the risk assessed 'Supersurge beds'. This means that patients are placed into areas on a ward that have not previously been part of the funded bed stock e.g. treatment or MDT rooms. These additional patients are cared for by the substantive staff on that ward. It has also been necessary at times to nurse patients in ward corridors against expected discharges (pre-emptive placement) to ease pressure in the Emergency Department and avoid ambulance handover delays. Fill rates at Bexhill remained stable during October at 90.8% in addition to providing significant staffing support to Rye Memorial Hospital who have ongoing vacancies. Some additional 'supersurge' beds were opened in the Atrium space at Bexhill following a full risk assessment.
Challenge & Risk:	The challenge now is the balance of all of the clinical and non clinical elements of care such as responding to complaints, incident investigations, essential documentation/handover on discharge, ASC assessments and supporting continuous flow. In addition there is a need to ensure compliance with mandatory and essential training to ensure retention of staff. Scrutiny of the availability of nursing staff and identified gaps during the period of industrial action is complete and mitigating plans are in place.
Actions:	• Roster challenge sessions under review by the CNO • International nurses contributing to support worker shifts as part of their induction from the 1st November • Divisional workforce risk assessments have been reviewed.

Effective Care – Nursing Workforce

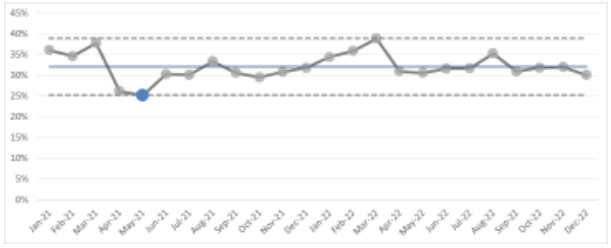
East Sussex Healthcare NHS Trust

Annual Leave (%)



Current Month: 12.6%

Total Unavailability (%)



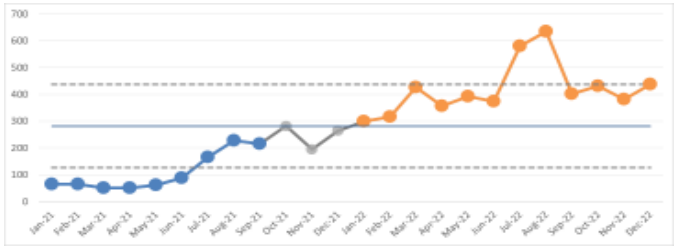
Current Month: 30.0%

Author:	**Angela Colosi Director of Nursing – Corporate**
Status Report	In conjunction with the Assistant Director for Workforce, robust monitoring is in progress to review compliance in relation to the booking of annual leave. The standard is between 11% and 17%. Compliance during December was 12.6% for nursing so within agreed parameters. The Total Unavailability for December was 30.0%, which indicates the total percentage of Registered Nurses (RNs) and Health Care Assistants (HCAs) unavailable to work for various reasons.
Challenge & Risk:	With the issues of industrial action, increased admissions of patients with respiratory conditions (also affects some staff) and adverse weather conditions, plans and processes are in place to ensure safe levels of staffing both in the in-patient areas and in the community setting.
Actions:	• Staffing was especially challenged over the holiday period despite significant and sustained pressures • Industrial action task force meeting Divisional review of business continuity plans and risk assessments • HoNs to escalate staffing issues to Divisional and Corporate ADNs.

Effective Care – Nursing Workforce

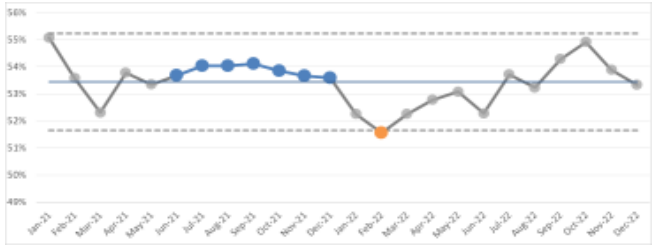
East Sussex Healthcare NHS Trust

Red Flags



Current Month: 438

Registered Skill Mix (%)
(Registered vs unregistered staff)



Current Month: 53.3%

Author:	**Angela Colosi Assistant Director of Nursing - Corporate**
Status Report:	All in scope in-patient areas have now received training from the SafeCare Lead Nurse. The details of the 9 categories are provided in the Safe Staffing report which reports to the Quality and Safety Committee each month. The reporting of red flags is in conjunction with the reporting of patient acuity scoring in in-patient areas which occurs via the SafeCare system three times per day and is now within upper and lower control limits for November. Red flag reporting allows real time mitigation of risk, whereas Datix reporting is for when an incident has occurred. Skill mix for Registered Nursing staff overall was at 53.3% in December.
Challenge & Risk:	Compliance in SafeCare completion continues to improve and is dependant on the right funded staffing establishment being in place as an additional task in scoring of all patients. Skill mix balance is a risk as more new staff (International RNs and 'New to Care' HCAs) are supervised by substantive staff who are also supporting additional patients in the escalation and super surge beds.
Actions:	• Supernumerary time for International Nurse (INs) recruits has been reviewed in line with ICS colleagues and by engaging our INs. It has been agreed that as part of their induction they can be formally rostered/reported as contributing as support workers. • Healthroster compliance sessions continue and are supported by the SafeCare Lead Nurse and Heads of Nursing. • The SafeCare Lead Nurse continues to focus on Healthroster compliance as well as ensuring staff undertake the acuity scoring of patients to determine safe staffing levels accurately and in a timely way.

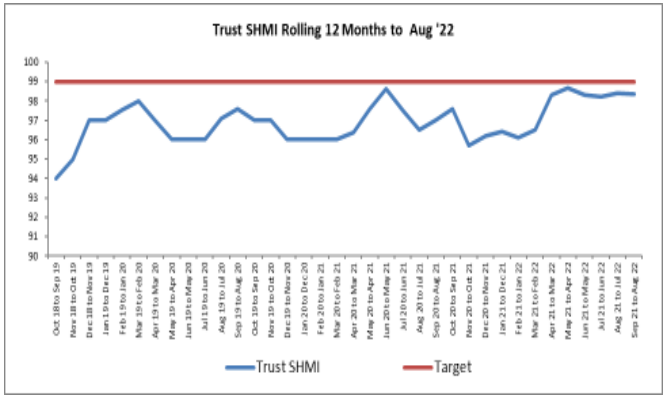
Effective Care - Mortality

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.

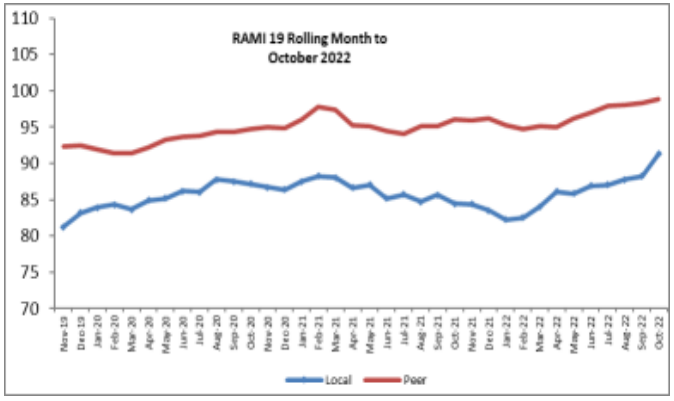
Summary Hospital Mortality Indicator (SHMI)

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

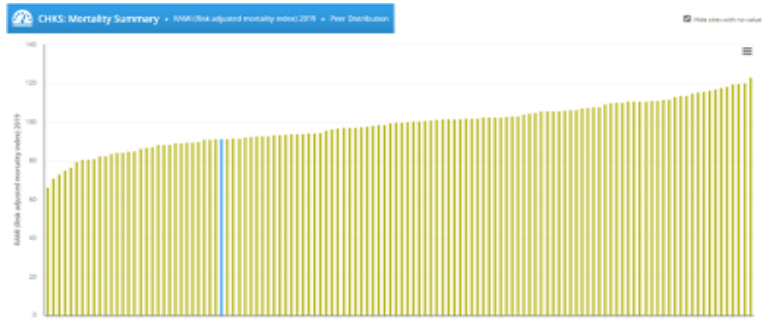


- SHMI – September 2021 to August 2022 is showing an index of 0.98. SHMI remains higher at Conquest
- RAMI 19 – November 2021 to October 2022 (rolling 12 months) is 91 compared to 84 for the same period last year. October 2021 to September 2022 was 88.
- RAMI 19 was 107 for the month of October and 92 for September. Peer value was 104 for October.
- Crude mortality without confirmed or suspected covid-19 shows Nov 2021 to Oct 2022 at 1.64% compared to 1.39% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 41% for October 2022 deaths compared to 36% for September 2022 deaths.

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



RAMI Peer Distribution without confirmed or suspected covid-19



This shows our position nationally against other acute trusts – currently 31/123

Effective Care – Mortality (continued)

East Sussex Healthcare NHS Trust

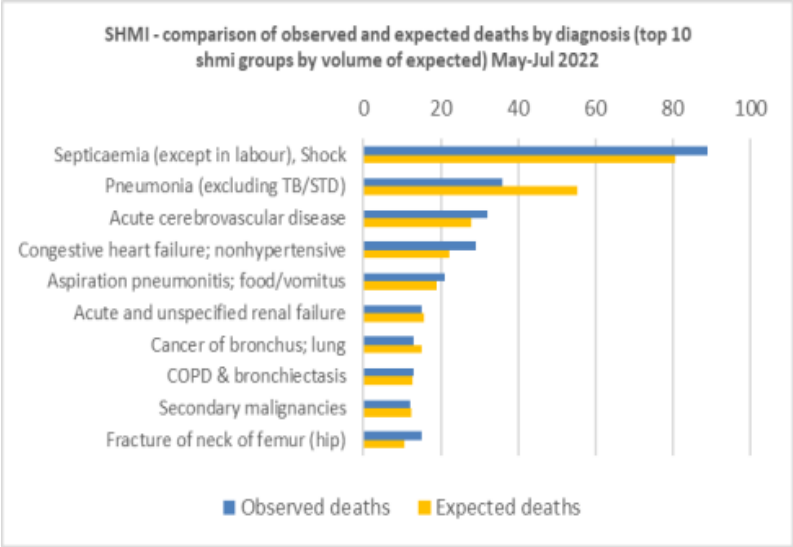
December 2022 Main Cause of In-Hospital Death Groups (ESHT)

Description	Deaths
Pneumonia	32
Sepsis/Septicaemia	27
Cancer	19
Chronic Obstructive Pulmonary Disease (COPD)	14
Cerebro-vascular Incident	13
Heart Failure	11
COVID-19	9
Community-acquired Pneumonia	8
Hospital-acquired Pneumonia	4
Liver Disease	3
Myocardial Infarction (MI)	3
Acute Kidney Injury (AKI)	1
Bowel Obstruction	1
Dementia	1

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

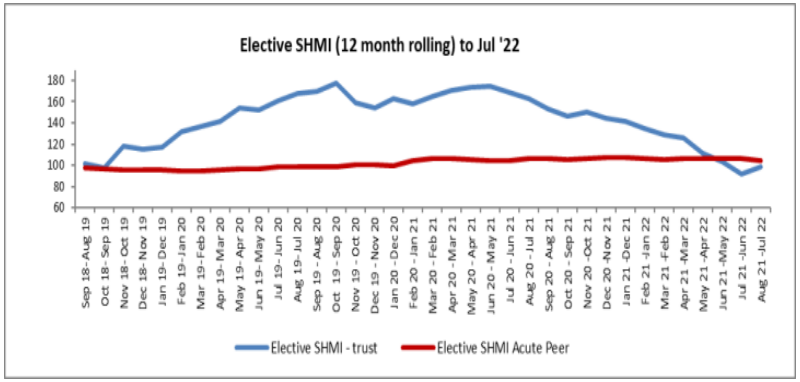
9 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

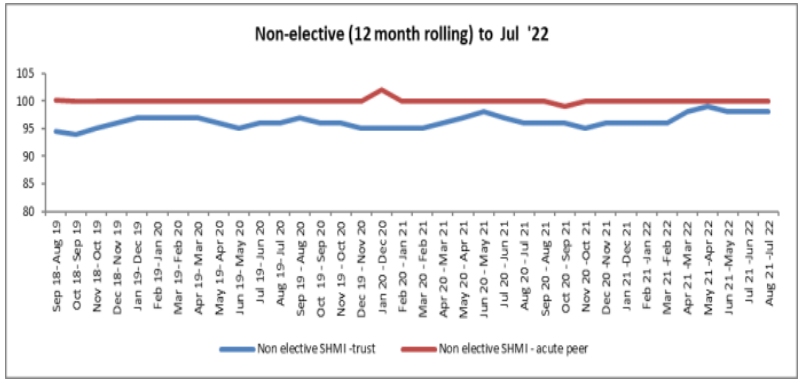
SHMI Diagnosis Main Groups



Summary Hospital Mortality Indicator (SHMI)

Elective and Non Elective Inpatient Trends





Our People

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

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Turnover** has reduced by 0.2% to 13.7%, which equates to 916.3 fte leavers in the last 12 months **Mandatory Training** rate remains unchanged at 86.1%	**Vacancy rate** has increased by 2.1% to 9.9% **Current vacancies** are showing as 784.7 ftes **Monthly sickness** increased by 0.7% to 6.4% **Annual sickness** remains unchanged at 6.1%. **Appraisal** compliance reduced by 0.4% to 73.1%.	 **Steve Aumayer** Chief People Officer

Overview:

Turnover has reduced this month, for the first time since Nov 21. It decreased by 0.2% to 13.7% (916.3 fte leavers in the last 12 months, a reduction of 4.2 fte leavers on last month). Registered Nursing & Midwifery turnover reduced by 0.6% to 12.7% (259.6 fte leavers), Medical & Dental turnover reduced by 0.3% to 13.8% (43.3 fte leavers) and Additional Clinical Services (unregistered nurses & therapy helpers) reduced by 0.5% to 14.1% (211.3 fte leavers). AHP turnover, however, increased by 0.3% to 15.0% (78.7 fte leavers) and Admin & Clerical turnover also increased by 0.3% to 14.7% (204.4 fte leavers). This reduction is despite the fact that Dec is usually a popular month for Age Retirement (along with March, as the end of the financial year). Age Retirement only increased by 2.3 ftes compared to last month

The Trust vacancy rate increased by 2.1% to 9.9% (784.7 fte vacancies, an increase of reduction of 177.9 fte vacancies compared to last month). This large increase, however, is due to a significant increase to the substantive fte budget establishment in Dec (168.4 ftes). This reflects the approved escalation ward funding for posts in Medicine and DAS for Dec 22 – Mar 23, plus additional posts on the Judy Beard Unit, following the successful business case.

The Monthly sickness rate increased by 0.7% to 6.4% (an increase of 2,007 fte days lost to sickness in month) but the Annual sickness rate was unchanged at 6.1%. There was an increase of 966 fte days lost for Chest & Respiratory illnesses as Covid sickness again increased, to a peak of 84 staff off sick on 23 Dec. Since then numbers have continued to reduce, to 34 staff absent for this reason, as at 13 Jan. The most significant increase, however, was in fte days lost due to Cold/Cough/Flu, which increased by 1,399 in Dec to 2,656 (though there will be a seasonal element, this is 147% higher than Cold/Cough/Flu absence in Dec 21, possibly reflecting the loss of immunity during Covid lockdown conditions). Monthly sickness in 2022 never dropped below 5%, in contrast to previous years, with the effect of Covid adding between 0.5% and 3.0% (Mar 22, the height of Wave 3) to monthly sickness rates. Operational HR are reviewing the Attendance Management procedure to provide managers with a clear pathway and understanding of supporting staff but also ensuring appropriate action is taken in a timely manner.

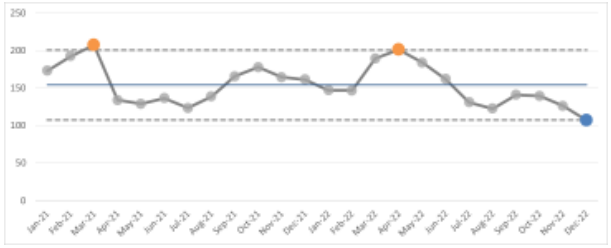
The Trust mandatory training rate was unchanged at 86.1%, whilst the appraisal rate fell slightly by 0.4% to 73.1% reflecting the operational pressures experienced during Dec.

Workforce – Contract type

East Sussex Healthcare NHS Trust

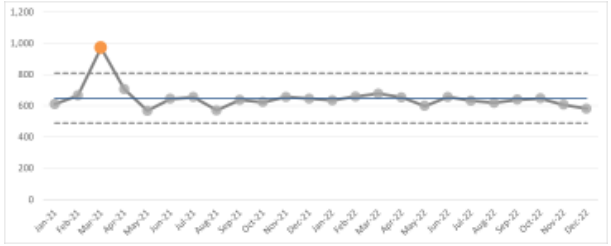
Our People

Agency FTE Usage



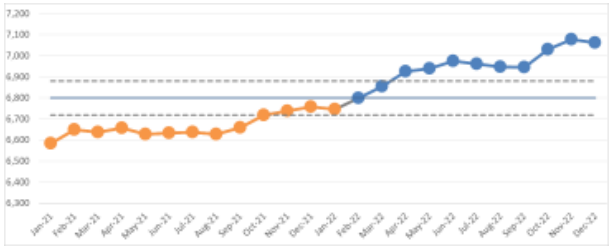
Current Month: 106.9

Bank FTE Usage



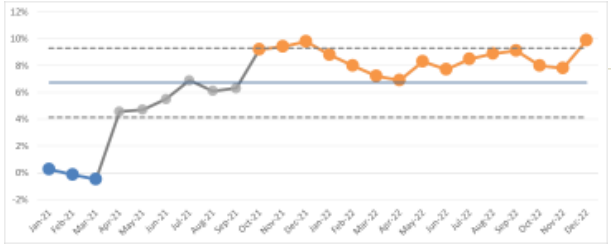
Current Month: 581.8

Substantive FTE Usage



Current Month: 7060.8

Vacancy Rate



Target: 5%
Current Month: 9.9%

Author: **David Moulder, Greig Woodfield**

Status Report

Substantive usage reduced by 17.2 ftes, bank usage reduced by 25.4 ftes and agency usage reduced by 19.2 ftes.

Temporary workforce utilisation was 8.9%, a 0.5% reduction from last month. The Trust vacancy rate increased by 2.1% to 9.9%.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	102.6	61	65.6	84
Reg Nurse	212.0	197.2	125.4	69
Addit Clin Serv	284.1	85	146.6	63
AHP	76.1	114.1	52.4	57
Prof, Sci, Tech	17.0	7	11.4	74
Healthcare Scs	1.4	29.2	4.7	58
A&C	108.3	107.5	76.8	48
Estates & Ancillary	46.0	31.4	42.2	48
Trust	784.7	632.4	525.1	62.62

Challenge & Risk:

There is continued demand for TWS services. Key areas include Midwives, Nurses, Theatre staff, Doctors, AHPs and the Emergency Dept. There is a continuing challenge to provide bank support, with demand still continuing to outstrip supply. Bank fill rate across the Trust is 49%. Medics, Agency and Bank c.60%

Continued actions to reduce agency spend by ensuring adherence to the governance process, whilst under pressure from operations to consider off framework agencies in order to keep up with demand. Working across the ICS to look at standardising rates. Regular meetings established with Medicine to monitor and reduce Agency spend.

Additional Tier 1 & Tier 2 agencies have been engaged to assist with demand. Ongoing activity to increase bank supply, both dual contracts and bank only.

Actions:

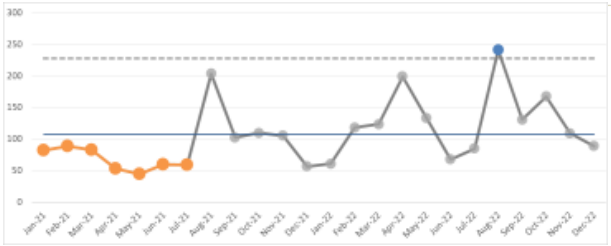
Continued activity to increase the number of candidates on TWS, including communication with colleagues to join the bank as dual contracts, to meet the current demand.
Continued activity to increase the number of additional framework agencies being sourced to assist with both current and future supply. Ongoing activity to increase volunteer numbers across the Trust through taster events now underway.

Workforce - Churn

East Sussex Healthcare NHS Trust

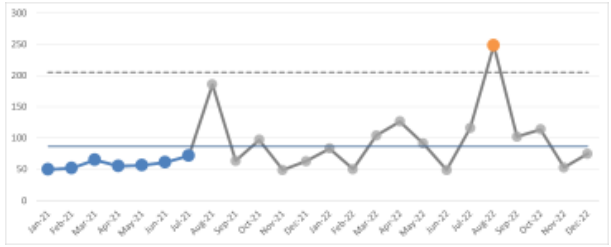
Our People

Starters FTE



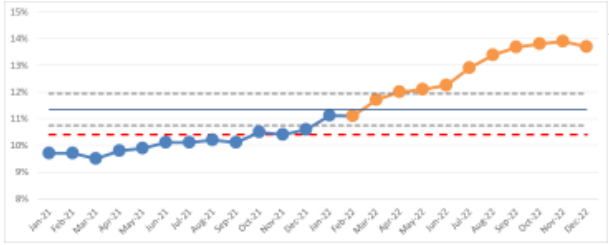
Current Month: 88.6

Leavers FTE



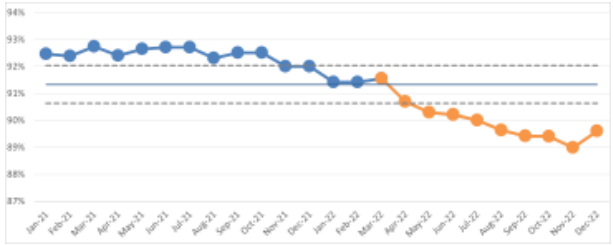
Current Month: 74.6

Annual Turnover Rate



Target: 9.9%
Current Month: 13.7%

Retention Rate



Target: 92%
Current Month: 89.6%

Author: **David Moulder, Greig Woodfield**

Status Report

The Trust starters & leavers monthly net total as at Dec 22 is +9.2 with +88.6 starters fte and -74.6 leavers fte & -4.8 internal changes fte. Over the last 12 months there were +1,546.6 starters fte & -1,196.5 leavers fte & -18.0 internal changes fte giving a net total of +332.1

The Trust turnover rate has reduced by 0.2% to 13.7%, the first reduction since Nov 21. There were 916.3 fte leavers in the previous 12 months, a reduction of 4.2 on last month. The Trust Retention rate (i.e. % of staff with at least one year's service) increased by 0.6% to 89.6%.

Challenge & Risk:

Recruitment activity remains high year on year with increased demand. Currently c700 actions underway on TRAC. Primary areas of activity remain Emergency Medicine, Medical, AHP and HCAs.

There has been some success with continued targeting of "hard to recruit" posts, virtual wards, AHPs and Consultants. Activity remains focused around Community Nurses and AHPs, together with support for CDC together with UTC, Estates & Facilities and A&E.

Sufficient accommodation (and the cost) for International nurses and Radiographers still remains a concern due to lack of rental properties. Airbnb being sourced.

Actions:

There is a dedicated Trust Lead focussing on the retention of staff to gain insight and understanding through direct engagement with staff groups and areas. This will be dovetailed with insight from data to draw up a draft action plan for hot spots.

There is a strong pipeline of international nurses in place. A further 17 nurses, plus 2 Sonographers and 3 Radiographers are due to arrive at the end of Jan. There are planned cohorts for the rest of the financial year. Successful activity against funded NHSE AHP posts, with further activity planned until Mar 2023.

Offers following the open days at both Conquest and Eastbourne are being processed. (c50).

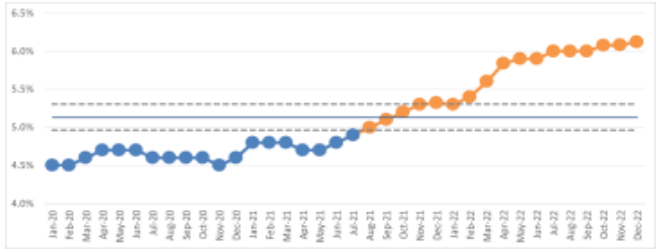
All hard to recruit medical posts are with Medacs and other additional agencies, as required. Additional agencies have been sourced to supplement supply. Targeted phased approach to filling medical posts.

Steps being take to source additional accommodation providers for international nurses.

Workforce - Sickness

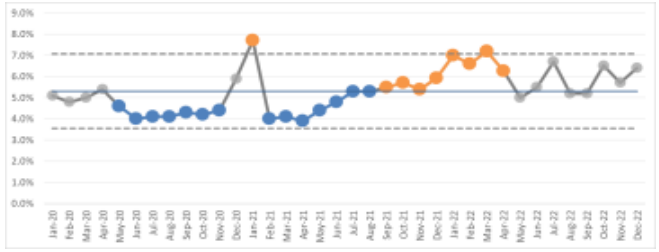
East Sussex Healthcare NHS Trust

Annual Sickness



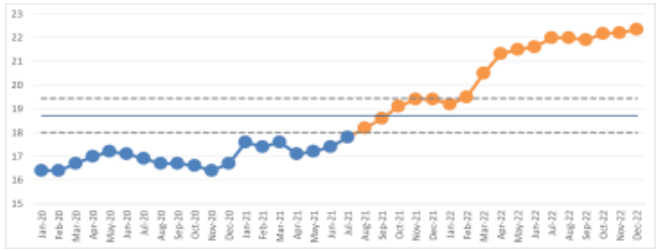
Target: 4.5%
Current Month: 6.1%

Monthly Sickness



Current Month: 6.4%

Average sickness Days per FTE



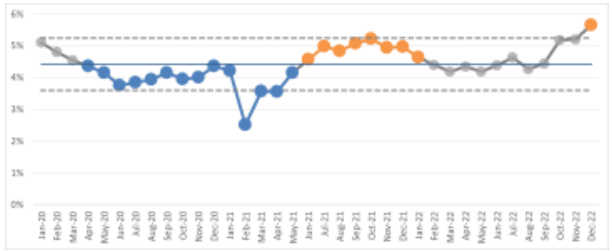
Target: 16
Current Month: 22.3

Author:	**Julie Hales, David Moulder**
Status Report	*n.b. the sickness charts have been amended to show a 3 year period, to illustrate the impact of Covid.* Monthly sickness % has increased by 0.7% to 6.4%, whilst annual sickness rate has remained unchanged at 6.1%. Sickness average days per fte increased by 0.1 to 22.3 days per fte.
Challenge & Risk:	The increase in monthly sickness is largely due to increases in Cold/Cough/Flu, Chest & Respiratory illnesses (Covid) and, to a lesser extent, Anxiety & Stress. The increase in Anxiety & Stress is often noted when there is an increase in Covid.
Actions:	Following the release of the NHSEI Deep dive analysis into the factors affecting non-Covid sickness absence, Operational HR are reviewing the Attendance Management procedure to provide managers with a clear pathway and understanding of supporting staff but also ensuring appropriate action is taken in a timely manner. Operational HR are meeting with managers to ensure appropriate action and support is being put in place for those areas with high sickness levels. All staff on LTS are being supported by managers, HR and Occupational Health.

Workforce - Sickness

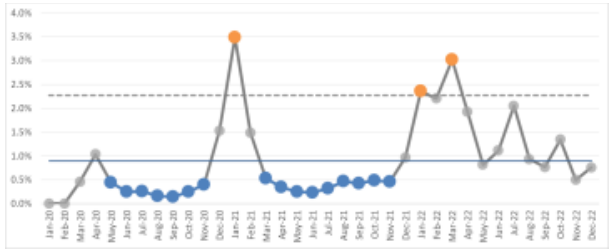
East Sussex Healthcare NHS Trust

Monthly Sickness (Without Covid-19)



Current Month: 5.6%

Monthly Sickness (Covid-19 Only)



Current Month: 0.8%

Author: **David Moulder**

Status Report

New workforce metric agreed to show sickness impact in the month for Covid and non-Covid.

Monthly sickness % (without Covid) increased by 0.4% to 5.6%. This was particularly due to the increase in Cold/Cough/Flu illnesses.
Monthly sickness % (Covid only) has increased in Dec by 0.3% to 0.8%.

The increase in monthly sickness was largely due to seasonal Cold/Cough/Flu, a spike in Covid in Dec and an increase in Anxiety/Stress illness.

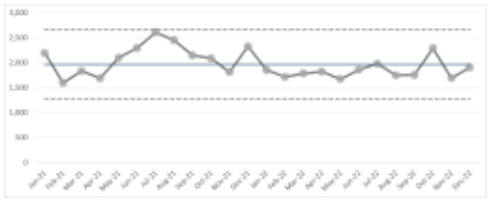
Our People

Workforce - Sickness

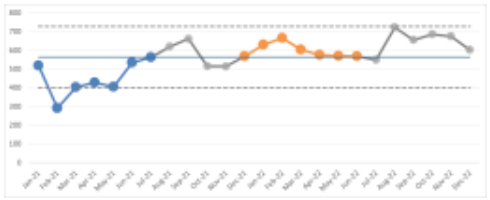
East Sussex Healthcare NHS Trust

Our People

Anxiety/Stress/Depression

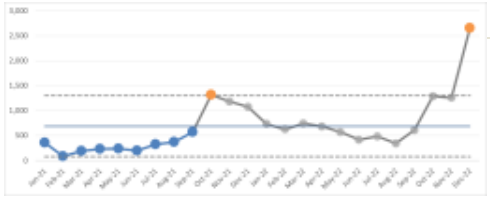


Back Problems

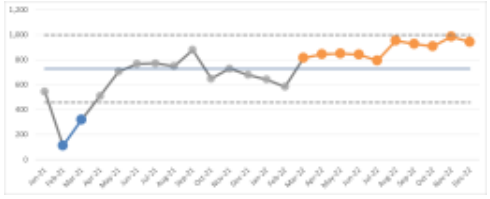


Chest & Respiratory Problems

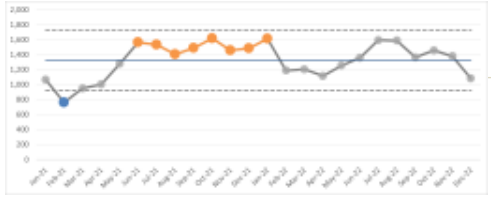
Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



Author: **David Moulder; Julie Hales**

Status Report

Reason		fte Days Lost +/-	Total fte Days Lost
Anxiety, stress & depression	▲	+216.2	1,907.6
Back problems	▼	-72.1	601.9
Chest & respiratory	▲	+966.3	2,700.4
Cold, cough & flu	▲	+1,399.0	2,655.9
Gastrointestinal	▼	-42.1	942.5
Other MSK problems	▼	-298.6	1,081.4
Other reasons	▼	-161.9	4,409.3
All reasons	▲	+2,006.7	14,298.9

Challenge & Risk:

Covid sickness again increased, to a peak of 84 staff off sick on 23 Dec. Since then numbers have continued to reduce, to 34 staff absent for this reason, as at 13 Jan. The most significant increase, however, was in fte days lost due to Cold/Cough/Flu, which increased significantly in Dec (though there will be a seasonal element, this is 147% higher than Cold/Cough/Flu absence in Dec 21, possibly reflecting the loss of immunity during Covid lockdown conditions).

Other MSK problems have continued to reduce, down for the second consecutive month.

Actions:

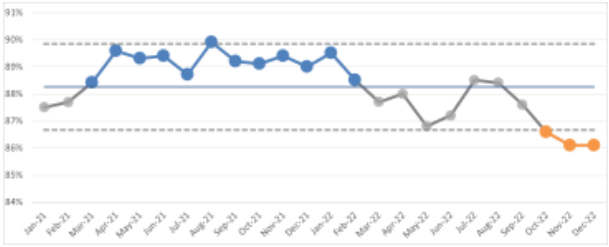
With the increase in both Covid and seasonal Cold and Flu viruses, staff are being encouraged to take up the vaccinations and asked to ensure they wear masks in clinical areas.

Wellbeing interventions are shared on a regular basis with teams and offered bespoke support where required. Wellbeing conversations continue to take place.

Workforce - Compliance

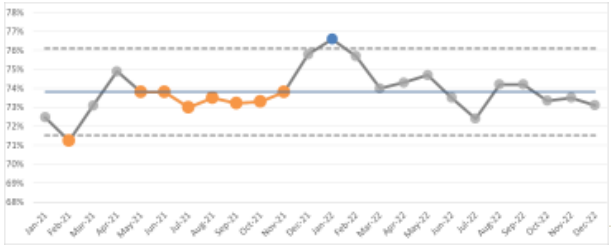
East Sussex Healthcare NHS Trust

Mandatory Training Compliance



Target: 90%
Current Month: 86.1%

Appraisal Rate



Target: 85%
Current Month: 73.1%

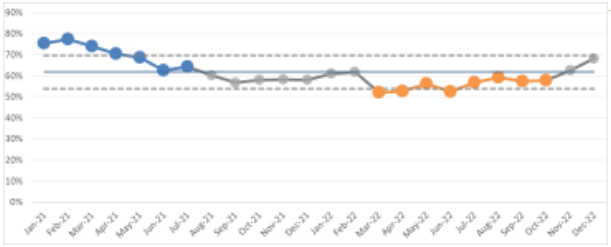
Author:	**Ali Ratcliffe**
Status Report	Current mandatory training compliance (CST) stands at 86.1%, no change from last month. This is a reflection of the ongoing pressures across all services. Areas of concern with the lowest compliance are: Information Governance at 81.2% (down by 0.4% this month), Infection Control at 83.5% (up 0.1%) and Fire Safety at 82.9% (down 0.9%). All modules can be accessed easily through MyLearn and staff can opt to complete the online assessment if confident in their knowledge. Support for colleagues is available through the Technology Enhanced Development Team and both Libraries. Appraisal compliance has reduced slightly by 0.4% to 73.1%.. Appraisal document has been completed in MyLearn but there are some further actions as outlined below.
Challenge & Risk:	The impact of staffing shortages and unprecedented service demand continue to impact on compliance. DNAs continue to be an issue across all taught courses and webinars. OSCE exams – this remains an issue and we continue to escalate to the NMC. Lower appraisal rates represent a risk to the development of staff and subsequent retention rates.
Actions:	Due to the low take up for the Appraisal Pilot in Dec, this will be re-scheduled for Feb and we will work with the Divisions to ensure we have sufficient participants to make this viable and we can gain sufficient feedback to assess the tool and process. Further work will also be required to map all managers/appraisers to the correct staff within MyLearn. Continue to work with HR Recruitment and trainers to deliver increased Induction capacity to meet the needs of all new starters and recruitment drives. From Feb, Oxygen safety will be included in the Clinical Induction programme. The impact of Trust Essential Training has been mapped and discussed with ADNs, and educational colleagues and an update will be presented to PAG of the proposal for the development of a Trust Essential Passport.

Workforce – Job Planning

East Sussex Healthcare NHS Trust

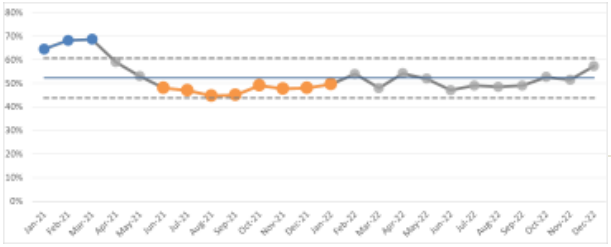
Our People

Consultant eJob-Planning Fully Approved Rate



Current Month: 68.2%

SAS Grades eJob-Planning Fully Approved Rate



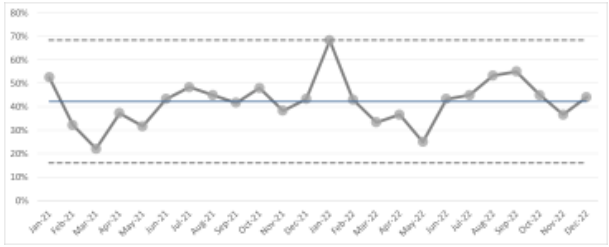
Current Month: 57.7%

Author:	**Penny Wright, Joanne Penfold**
Status Report	Medical job plans increased to a total sign off rate of 66% by the end of Dec. This has fallen slightly since, with the continued push to refresh & improve job plan accuracy. Job plan sign off rate is currently 64%. • 180 of 264 (68.2%) Consultants had a completed eJobPlan • 60 of 104 (57.7%) SAS Doctors had a completed eJobPlan.
Challenge & Risk:	The Chief Medical Officer initiated a big push by all medics to increase the sign off rate to 70% by 24 Dec. The momentum needs to continue to reach a sign off rate of 75% by 20 Jan and 80% by 20 Feb in readiness for job plan renewal by 1st April 2023 for 2023/24. The job planning team are supporting this process.
Actions:	As part of the NHSE Levels of Attainment, a Job Plan Consistency panel will need to be formed. The Extranet job planning page includes guidance for medics and sign off users. Continue to push sign off managers to review and complete the review of the job plans within their respective specialties.

Workforce – Roster Completion

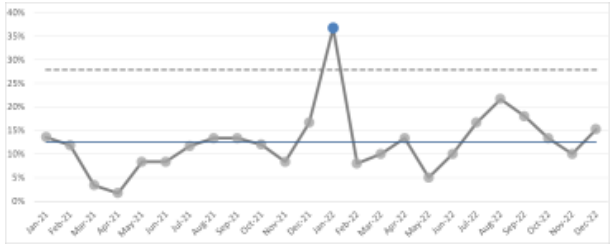
East Sussex Healthcare NHS Trust

6 week Nursing Management Roster Approval Rate



Current Month: 44.1%

8 week Nursing Management Roster Approval Rate



Current Month: 15.3%

Author:	**Penny Wright; David Moulder**
Status Report	For the roster starting on the 28th Nov, 44% of rosters had been approved at 6 weeks before the go live date which is a 7% increase on the previous month. 15% had been approved at 8 weeks prior to commencement which is an increase of 5%.
Challenge & Risk:	Approval rates at 6 weeks prior have improved but are still below 50%. 8 week prior approval is still relatively low. There are some areas that have flagged operational differences that mean 4 week approval cut off for their respective areas, however, this does not follow the guidance provided in Lord Carter's report. Further engagement to refine this is underway.
Actions:	HR to liaise with ADNs to agree level of improvement for next sign off & Corporate Nursing to support through compliance meetings. Rostering Taskforce developing new action plan with agreed deadlines for improvements in sign off, roster quality et al. New roster profiling tool has been developed for ward based nursing. It provides the capability to forecast by individual roster for any time period i.e. half term, Christmas etc. This tool will support the cross-site meetings where site leads report shortfall using the Safecare Wheel but will add insight into what is driving the gap i.e. increased additional duties and/or unavailability planning

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	A further improvement on our Cancer 28 day Faster Diagnosis Standard in November (December's position is not yet finalised) which has seen us achieve above target (75% of patients referred on a cancer pathway to receive a diagnosis within 28 days), delivering 76.8% . We have seen an improvement in performance in December for our Cancer 62 day standard, which remains above the national average. Equally, our trajectory of >62 day reduction is ahead of local plan. The average number of patients on a suspected cancer pathway >62 days is 12%. We as a Trust are reporting 5% The number of patients residing in our beds with a Length of Stay (LoS) >21 days reduced again in December. The 4th consecutive month	Bed Occupancy Rate: The Trust continued to have high bed occupancy levels throughout the month compromising patient flow and the ability to achieve the access targets. Although showing minor improvement, in December, the number of patients in our beds >21 days as a percentage of our overall bed base averaged 28.4% which is above the regional average of 21%. ED Performance: A rise in attendances in our emergency departments, coupled with staffing challenges meant a decline in performance against the 4 hour standard. There continues to be a focus on redirection at the front door as well as addressing staffing gaps in key areas within the Urgent Treatment Centres Electives: The waiting list has continued to rise above trajectory and the wait times in some specialties for a first appointment are a point of concern. The waiting list for elective treatment continued to grow higher than anticipated in December which has impacted on wait times, as well as an increased demand for cancer and urgent capacity. Diagnostics: The DM01 diagnostic standard slipped in December. Cardiology and Audiology notably with challenges. Fortnightly DM01 meetings in place to focus efforts and recovery plans under way	**Sheila Roberts** Winter Executive Director
Actions:	• Business planning to commence. • Set out recovery plans for diagnostic modalities to support delivery of the national DM01 diagnostic target	• Continued review of all long length of stay patients and a focus on timely discharge	

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

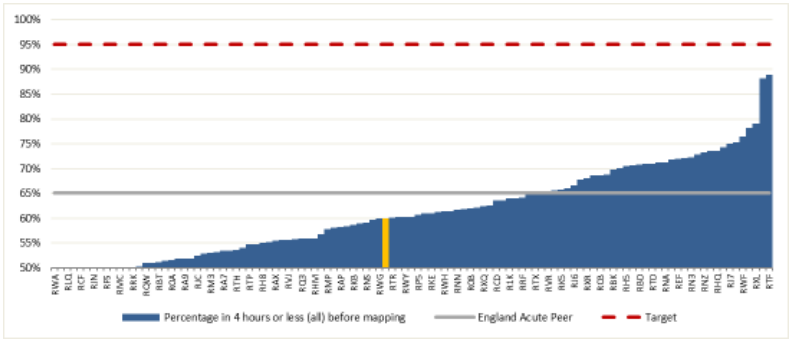
*NHS England has yet to publish all December 2022 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

December 2022 Peer Review

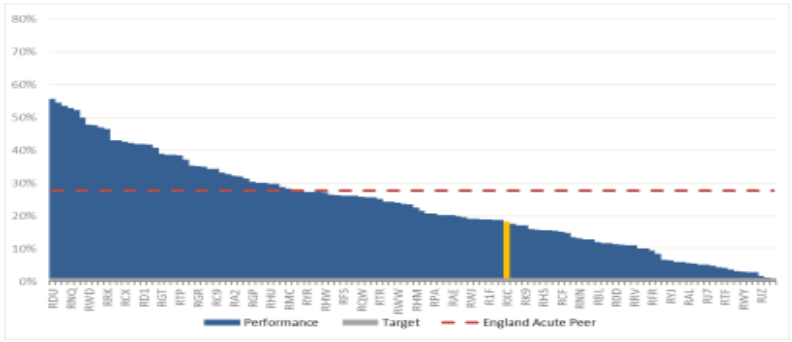
National Average: 65.05% ESHT Rank: 61/112



Planned Care – Diagnostic Waiting Times

November 2022 Peer Review*

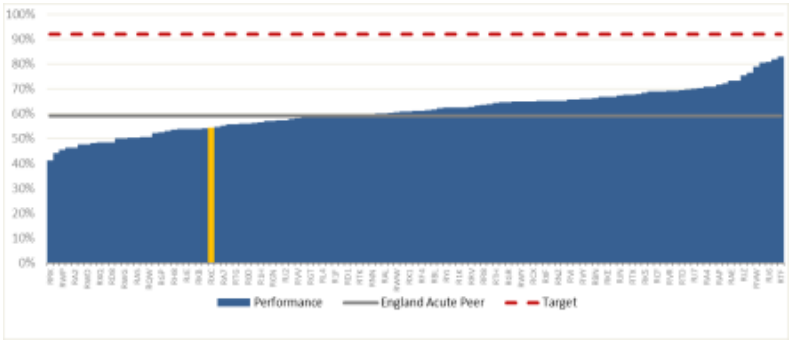
National Average: 27.7% ESHT Rank: 45/120



Planned Care – Referral to Treatment

November 2022 Peer Review*

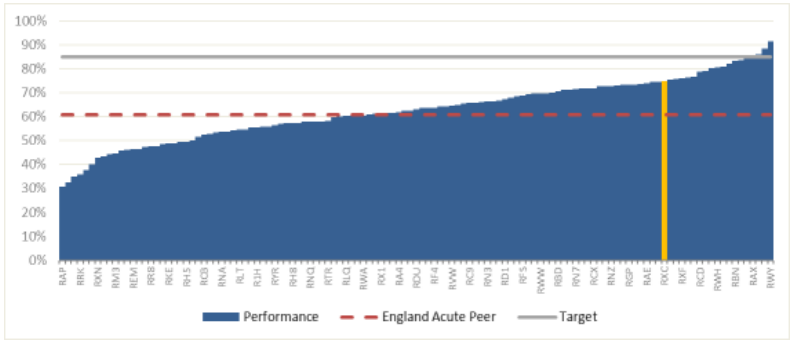
National Average: 59.2% ESHT Rank: 93/119



Cancer Treatment – 62 Day Wait for First Treatment

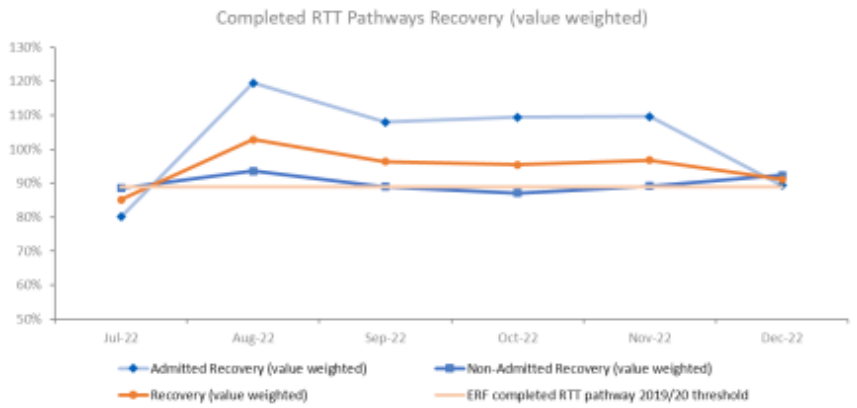
November 2022 Peer Review*

National Average: 60.6% ESHT Rank: 19/121



Planned Care – Recovery KPIs

East Sussex Healthcare NHS Trust



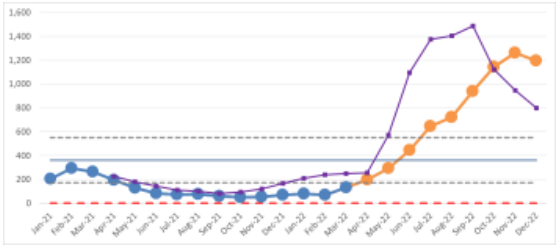
Delivery of 104% of the 19/20 activity baseline continues to be challenging. Admitted activity dropped in December as a result of a reduced activity through poor weather (snow) and an increase in patient choice to defer (at short notice) due to the Christmas and New Year period. Workforce constraints as a result of sickness, planned leave and vacancies are also having an impact for many specialities.

Insourcing for Respiratory commenced in December and the validation work through the utilisation of the Envoy system (text reminders) of the longest waiters without a First Outpatient Appointment (FOPA) has continued; both supporting a reduction in >52 week wait numbers. Despite measures to tackle the long wait position having a sizable impact on the volume of patients >52 weeks, the Trust has not been able to deliver against the 52 week trajectory since October and it is anticipated that there will be further deterioration of the long wait position over the coming months.

The Trust has validated all patients in the 78 week cohort (patients who will otherwise breach by April), in line with the national ask and work is ongoing with services to ensure all patients in this risk cohort will have treatments completed before the end of March 2023. Progress is being monitored on a daily basis and tracked through PTL meetings.

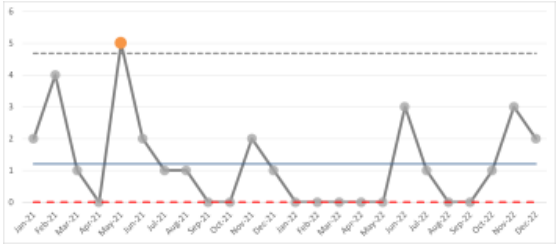
RTT 52 Week Waiters

Target: 0
Trajectory: 799
Current Month: 1,195



RTT 78 Week Waiters

Target: 0
Current Month: 2

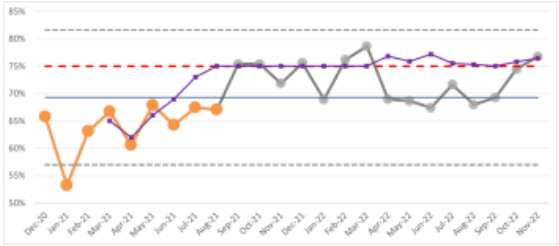


Planned Care –Recovery KPIs

East Sussex Healthcare NHS Trust

28 Day FDS (Faster Diagnosis Standard)

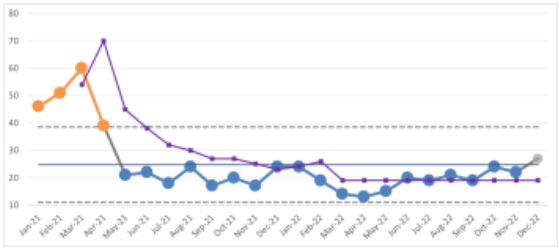
Target: 75%
Trajectory: 76.4%
Current Month: 76.8%



Cancer 104 Days Backlog

Unify 104 Days Backlog (excludes Tertiary patients)

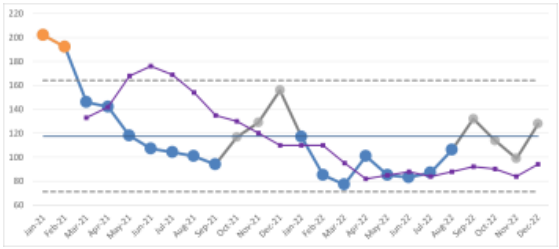
Target: Monitor
Trajectory: 19
Current Month: 27



Cancer 62 Days Backlog

Unify 62 Days Only Backlog (excludes Tertiary patients)

Target: Monitor
Trajectory: 94
Current Month: 128



The Trust achieved FDS in November, for the second time this year, in part as a result of changes with the Breast pathway which have supported FDS compliance.

The trajectory for 62 day and 104 day backlog is continuously monitored in line with the Local Cancer Access Policy.

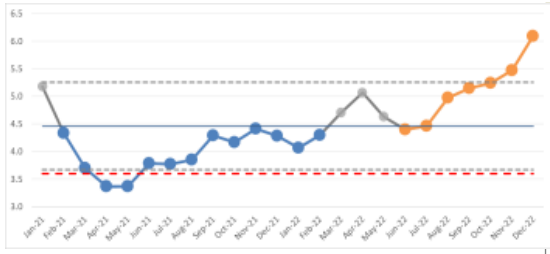
Although the trajectory is over plan at the end of December the Trust remains well below the national average. The number of patients on the backlog has increased and is mainly due to the reduction of activity and increase in patient choice during the Christmas and New Year period.

Long waiting patients are regularly reviewed at twice weekly Patient Tracking Meetings to ensure next steps are in place for completion of their pathway and where possible expedited to reduce any potential delays.

Patient Care- Flow

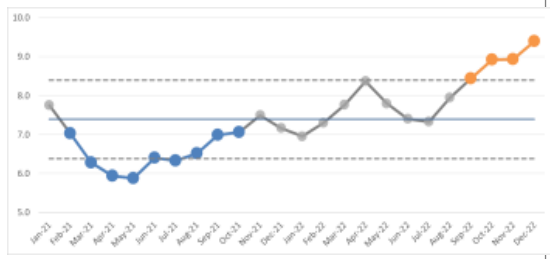
East Sussex Healthcare NHS Trust

Non-elective Length of Stay (Acute)



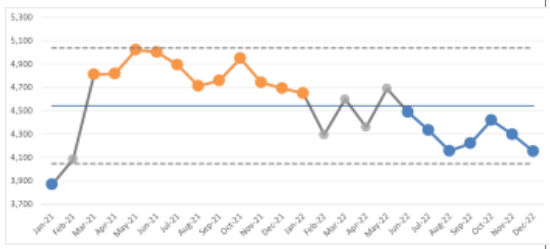
Target: 3.6
Current Month: 6.1

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



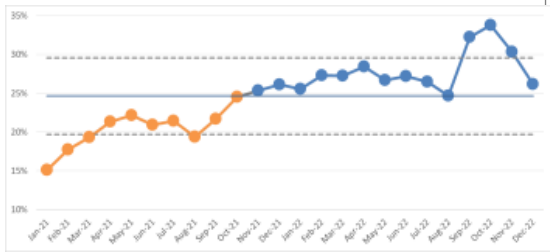
Target: Monitor
Current Month: 9.4

Non Elective Spells



Target: Monitor
Current Month: 4,153

Medical Non Elective Admissions (% SDEC)



Target: Monitor
Current Month: 26.2%

A further rise in the Trusts Non-Elective Length of Stay (LoS) continued in December. It is to be noted that when the hospitals have very high bed occupancy the impact on patient flow is significant. The national aim is to reduce bed occupancy to 92% which ensure effective flow and reduces wait times across the organisation. For much of December, the bed occupancy was tracking at higher than 98% occupancy which will have directly impacted on patient flow.

A contributor to this was the increase in admitted demand and the extended use of escalation wards and 'Super Surge' areas which in turn stretched the workforce and led to increased LoS. The 'Long Length of Stay' weekly review meeting was revisited and reintroduced in November, which is now led by the Winter Director to support reducing LoS. The Trust has also appointed to the post of Associate Director of Operations & Flow with the objective to support the required focus on hospital flow and patient pathway delays.

Utilisation of the system Winter funding has enabled the Trust to develop and strengthen its Discharge Hub team so as to support an improvement programme for reducing LoS.
This includes:

- Recruitment of Discharge Nurses and Discharge Co-ordinators
- Develop Nervecentre assessment to capture reason to reside by clinicians
- Further development of the 'Liveflow' system to enable services to in-reach and assist with discharge opportunities, such as Virtual Ward and Urgent Community Response
- Revised model in development for discharge nurses to screen every admission within 12hrs and all complex discharges to be allocated a name discharge co-ordinator rather than the ward based approach currently used
- Training package for ward staff on discharge process produced for quarter 4 roll out.

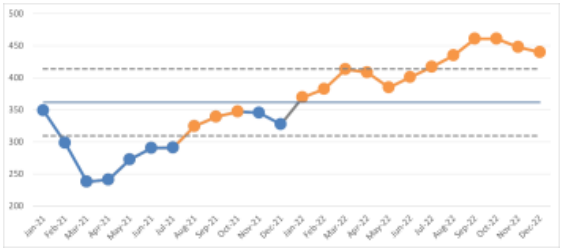
December data shows a further decrease on the utilisation of Same Day Emergency Care (SDEC). Although every effort is made to ringfence the SDEC units, there have been occasions especially over Christmas and New Year when the system was operating at Critical Incident levels, that SDEC had to be used as an escalation overflow beds which reduced the capacity of both units.

Patient Care - Flow

East Sussex Healthcare NHS Trust

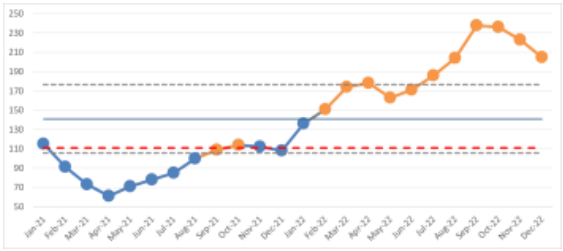
Access and Responsiveness

Adult inpatients in hospital for 7+ days (Acute)



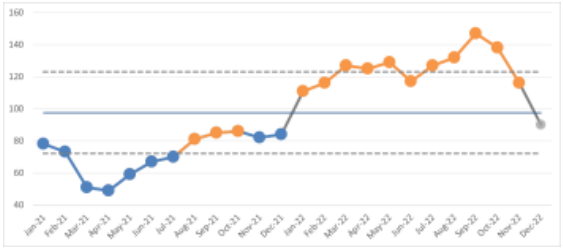
Target: Monitor
Current Month: 440

Adult inpatients in hospital for 21+ days (Acute)



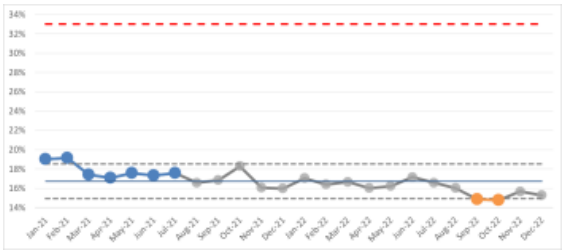
Target: Monitor
Current Month: 205

MRD on Pathways 1-3



Target: Monitor
Current Month: 90

Patients discharged before midday %



Target: 33%
Current Month: 15.3%

December data shows an improving trend of patients in a hospital bed with a length of stay of over 7 and 21 days along with a reduction in MRD patients. A major contributor to this will be the introduction of further Discharge to Assess beds (D2A) across Sussex which were funding through the Winter Schemes initiative. Also, the refocus on Long Length of stay which is now led by the Trust Winter Director.

Patients discharged before midday continue to be 50% below target and it is recognised that the loss of the Discharge Lounges on both sites as escalation areas as being a contributing factor of this.
The Conquest lounge has been used as a Super Surge although as we move out of Critical Incident, the lounged is reverting to its original use. The EDGH lounge has been absorbed into the Polegate/Friston escalation ward arrangement for a number of months. To address this, the Trust has secured capital funding to convert and develop a new Discharge Lounge with the aim to have this ready and available by the start of April 2023.

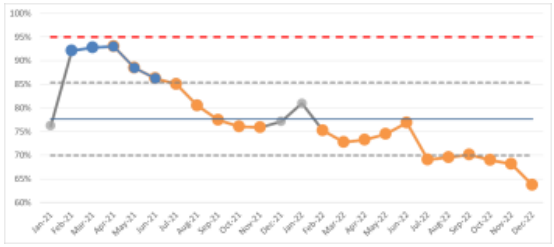
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

Access and Responsiveness

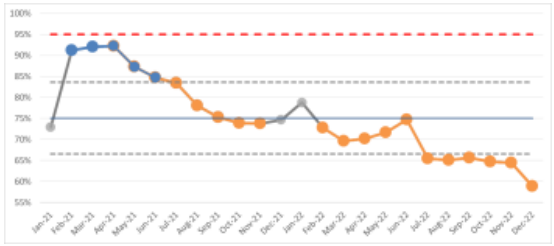
A&E Performance
(Local System)

Target: 95%
Current Month: 63.7%

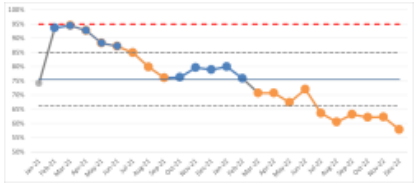


A&E Performance
(ESHT Total Type 1 & 3)

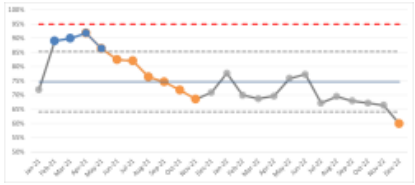
Target: 95%
Current Month: 58.9%



CONQ

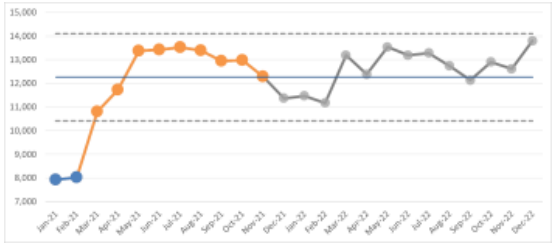


EDGH



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

Target: Monitor
Current Month: 13,798



Attendances have increased in December to the highest level seen by the trust and as a consequence, performance across all metrics decreased.

Embedding redirection and the revised front door model remains the divisional priority in order to decrease demand at triage and to move resources towards extending the service provided by rapid assessment and triage.

Increasing cover in the urgent treatment centre also remains a key element of the divisional plans to improvement performance and reduce overcrowding

Urgent Care – Front Door

East Sussex Healthcare NHS Trust

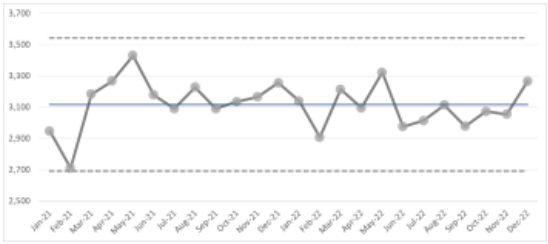
Access and Responsiveness

ESHT Total Type 1 Attends

ESHT Total Type 3 Attends

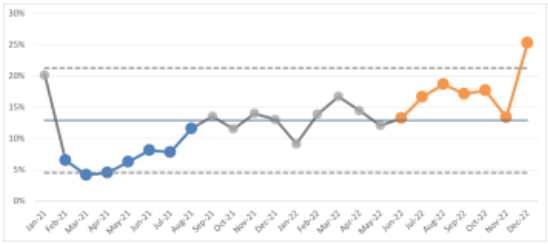
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,265



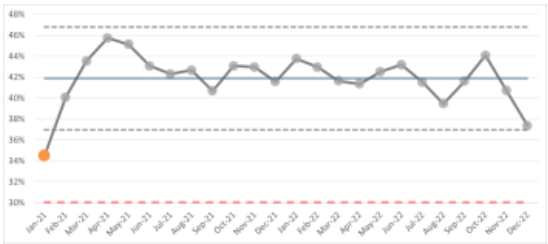
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 25.3%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 37.4%



The increase in attendances mostly occurred in type 1 attendances which corresponds with the increase in ambulance conveyances and collectively represents an increase in acuity and a higher admission rate.

This increase in acuity required additional medical and nursing hours which could not be filled by temporary work force services which is a key contributor to the decrease in performance.

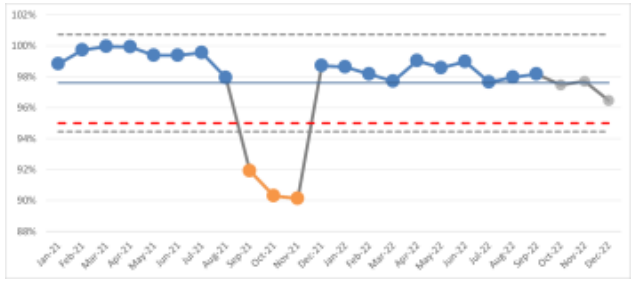
It remains a concern that SDEC activity continues to decrease whilst demand on urgent care continues to increase

Urgent Care – UTC

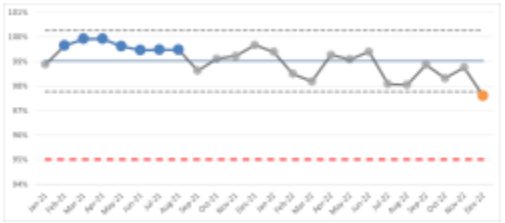
East Sussex Healthcare NHS Trust

UTC 4 hour standard
(Visit complete within 4 hours)

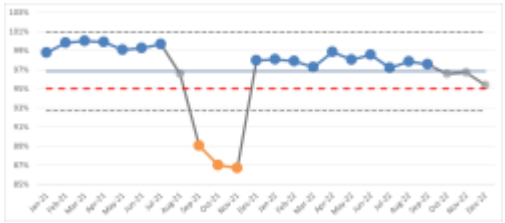
Target: 95%
Current Month: 96.5%



CONQ



EDGH



The increase in activity across all types has also impacted in the urgent treatment centre resulting in a decrease in compliance against the 4hr national standard.

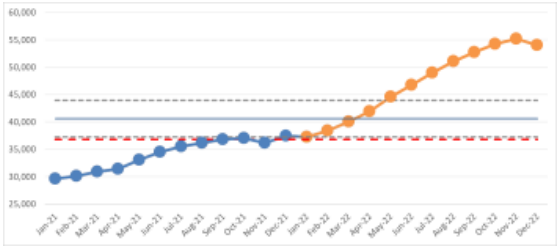
The work on embedding the revised front door model is anticipated to help improve performance but also protect the UTC from any increase in type 1 activity

Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

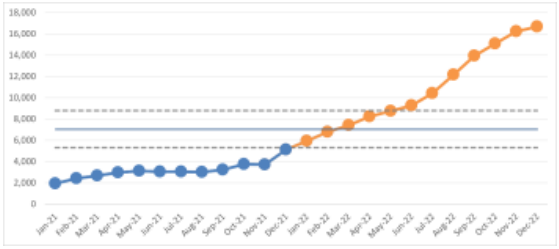
RTT Total Waiting List Size

Target: 36,833 (Sep-21)
Current Month: 54,013



RTT 26 Week Waiters

Target: Monitor
Current Month: 16,695



Cancellations On The Day
(Activity %)

Target: 5%
Current Month: 10.6%

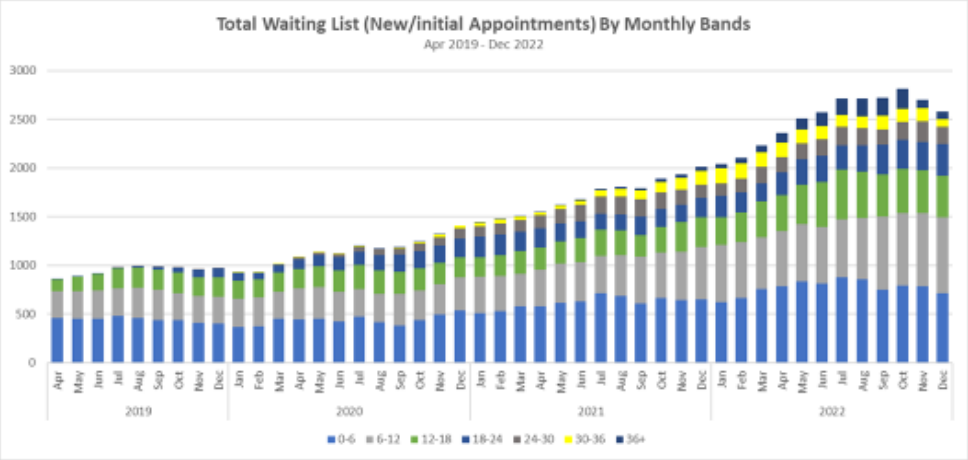
The volume of patients on the RTT waiting list is substantial, and despite a small decrease in December, continues to be above trajectory. The number of patients waiting over 26 weeks continues to rise as a result of the increase in referrals. Referrals have increased on average by 6 per working day compared to 19/20. There has been a decrease in routine referrals but a significant increase in urgent referrals which further impacts routine waiting times for First Outpatient Appointments and recovery of the long wait position.

Patients waiting over 52 weeks, and those with the potential to reach 52 weeks, are being closely monitored through; enhanced PTL validation; pathway redesign; and work to increase both Outpatient and Theatre utilisation. Advice & Guidance and PIFU are areas which continue to be developed and expanded to help address the increase in demand.

There has been a sharp increase in the percentage of cancellations on the day attributed to an increase in sickness levels and the impact of extreme weather in December. On day cancellations continue to go through a robust escalation process before any decision is made to cancel patients. Patients who are unfortunately cancelled get rebooked within 28 days. We are fully compliant with this.

Paediatric Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust

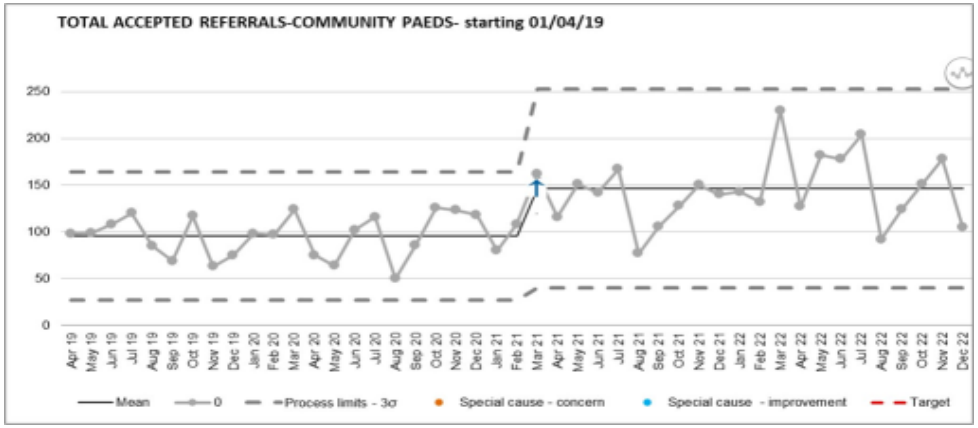


Current Month: 2580
Previous Month: 2699

There was a small decrease on the total number of children waiting for a New/Initial appointment in December, however there has been little change in the volume of patients waiting over 3 years. Average wait times are continue to increase as capacity cannot meet the demand.

The Follow-up backlogs have seen a slight decrease, in part as a result of validation.

Recovery and transformation plans are being progressed to support the service, including recruitment drives, a review of clinic models to support and capture all activity, Saturday WLI lists and validation of waiting lists to ensure accuracy. The outsourcing of 100 ASD assessments to Piscon, funded from CITs budget is also due to commence in early 2023, with appointment start dates from 6.2.2023.



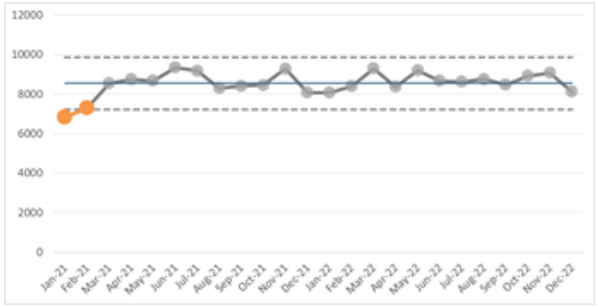
Current Month: 105
Previous Month: 178

Adult Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust

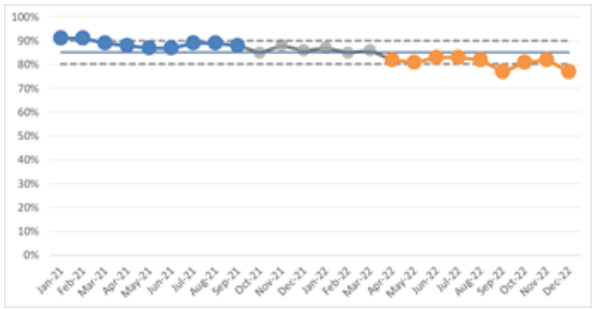
Number of Referrals Received (Planned)

Current Month: 8, 129



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

Current Month: 77%



Sustained increase across number of services since 2019 activity and rebasing of community services leaving an ongoing capacity and demand gap for services, Joint community Rehabilitation, Dietetics, Neurological out patient Physiotherapy and Speech and Language Therapy. Further compounded by increase in complexity of patients for example Podiatry and District Nursing. Continued impact of the legacy of COVID on this group of patients.

There has been a deterioration in the long wait position for Adult Community services, particularly within Neuro OP, with increase in referrals outstripping capacity and referral times increasing accordingly.

Community Non-RTT Waits

Service	Provider	CCG	Wait List	Ave Wait Time	Median WT	>52 wks	>104 weeks
ESHT Bladder and Bowel	ESHT		512	13	11	0	0
ESHT Community Nursing	ESHT		65	0	0	0	0
ESHT Community Stroke and ESD	ESHT		3	0	0	0	0
ESHT Urgent Community Response	ESHT		48	0	1	0	0
ESHT Dietetics	ESHT		1266	16	13	0	0
ESHT Fracture Liaison	ESHT		1627	0	0	0	0
ESHT Frailty Service	ESHT		45	5	3	0	0
ESHT JCR and Falls Prevention	ESHT		1332	9	6	0	0
ESHT MSKt	ESHT		882	8	8	0	0
ESHT Neuro Op	ESHT		405	25	23	28	0
ESHT Orthotics	ESHT		282	6	6	0	0
ESHT Physiotherapy	ESHT		4072	10	10	0	0
ESHT Podiatry	ESHT		1845	14	12	0	0
ESHT Speech and Language Therapy	ESHT		539	15	14	0	0
ESHT Tissue Viability	ESHT		0	0	0	0	0
ESHT Community Respiratory	ESHT		271	14	14	0	0
ESHT Heart Failure	ESHT		0	0	0	0	0
ESHT Community Paediatrics	ESHT		2528	53	43	1049	303

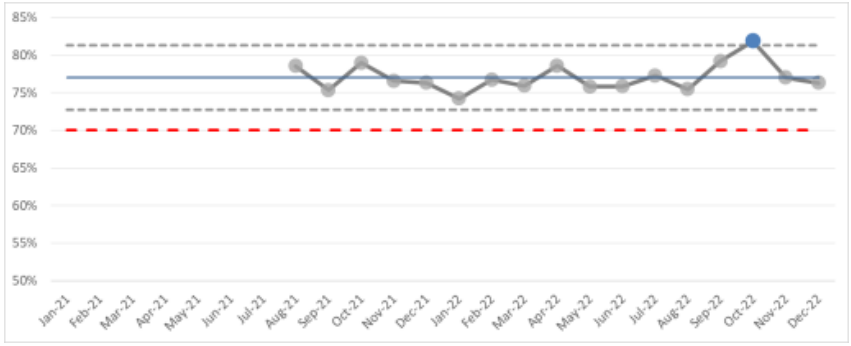
Division	Key
CHIC	
MED	
WAC	

Urgent Community Response

East Sussex Healthcare NHS Trust

Crisis Response Within 2 Hours

Target: 70%
Current Month: 76.3%



The UCR referrals are 1855 against a rebased target of 1200.
2 hour performance 74%

UCR continues to promote the clinical pathways as alternatives to admission with SECAmb.

UCR are also working on implementation of Virtual wards to deliver the Core VW function with an agreed trajectory for increase over time.
Home First – to support patients requiring health and care in order to return home.

Teams in reaching to gateways and wards for proactive identification and discharge

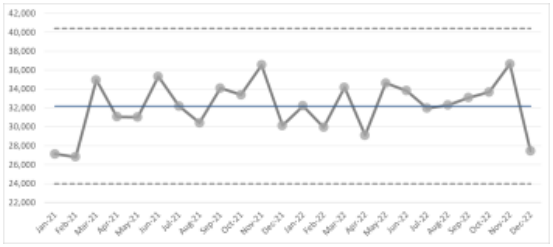
Recruitment at required pace remains most significant challenge to delivering transformation strategies

Planned Care – Outpatient Delivery

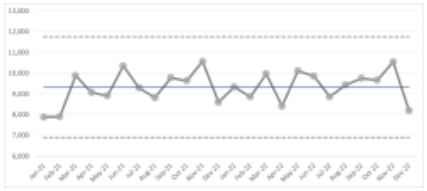
East Sussex Healthcare NHS Trust

Outpatient Total Activity
(New and Follow-up)

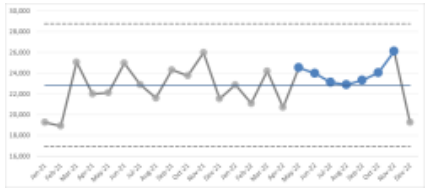
Target: Monitor
Current Month: 27,459



New

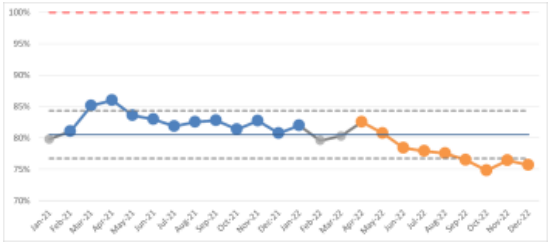


Follow-up



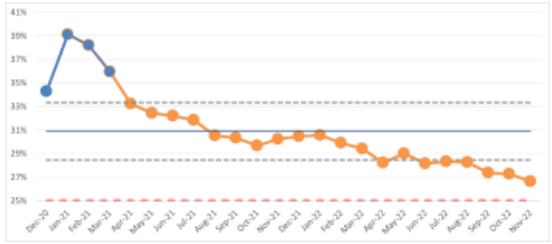
Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 75.6%



Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 26.6%



There was a reduction in outpatient clinics in December due to seasonal pressures which were exacerbated as a result of high sickness and extreme weather which adversely impacted both activity and utilisation.

The deterioration of outpatient utilisation in December is multifactorial; corresponding to a rise in the volume of DNAs as well as difficulties in booking as a result of staffing gaps within clinic admin, and difficulty in contacting patients, compounded further by the postal strike action in November and December.

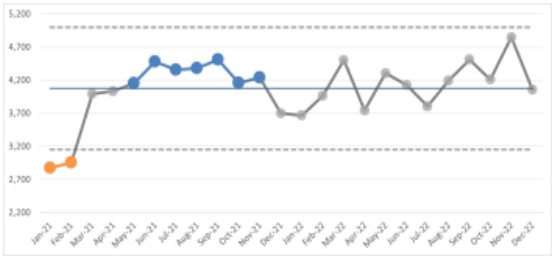
Utilisation remains a key focus point for transformation. The Trust will work with system and national colleagues to introduce best practice to improve performance. This is being addressed as part of the Trust's transformation programme.

Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

Access and Responsiveness

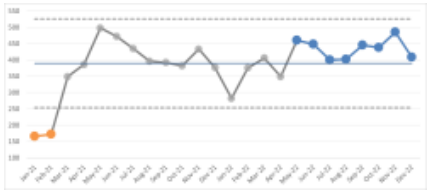
Elective Spells
(Day case and Elective IP)



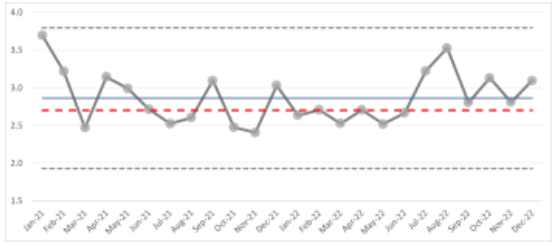
Target: Monitor
Current Month: 4,058

Day case

Elective IP

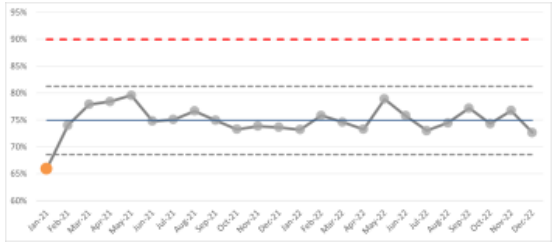


Elective Average LoS
(Acute)



Target: 2.7
Current Month: 3.1

Theatre Utilisation



Target: 90%
Current Month: 72.6%

High sickness levels alongside planned seasonal variances resulted in a reduction in theatre sessions, leading to a decrease in elective activity in December for both day case and Elective IP. Despite the drop in activity December the Trust delivered 97% of 19/20 Elective IP activity, the highest % of 19/20 activity delivered YTD.

Divisions continue to work hard to balance priorities and support the delivery of elective activity, ensuring we are treating patients with the highest priority. The increase in Elective LoS can be attributed to case mix, with an increase in patient acuity across all priority codes.

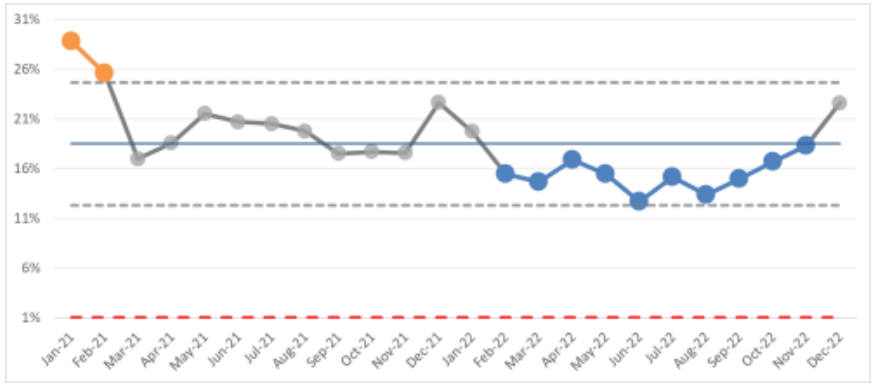
6-4-2 meetings are in place to support Theatre efficiency. It is recognised that further work is needed in some areas to support Theatre utilisation as a whole. Plans are also being progressed to address gaps within pre-assessment capacity that will support better utilisation of Theatres.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

Diagnostic Standard

Target: < 1.0%
Current Month: 22.6%



Although continuously delivering over 120% activity compared to 19/20 baseline, which is the national ask, the Trust is outlying within the system in a number of modalities for our DM01 performance. The Validated December DMO1 performance shows further deterioration, with compliance at 77.4% (down from 81.7% the previous month).

Areas of concern are:

Cardiology: There has been a significant increase in the volume of patients >6 weeks waiting for a echo due to the end of the Community Cardiology contract earlier this year and challenges recruiting the workforce to deliver the capacity internally. Insourcing continues to be in place and the service are looking at utilising additional capacity at CDC within the existing workforce.

Audiology: The service continues to increase activity, but rising referrals have led to a deterioration in breach rates. Additional activity has been agreed to support both audiology and ENT long waits, but support needed for non-ENT referrals.

Endoscopy: Insourcing continues, however colonoscopy is a particular risk as is limited capacity for enhanced sedation.

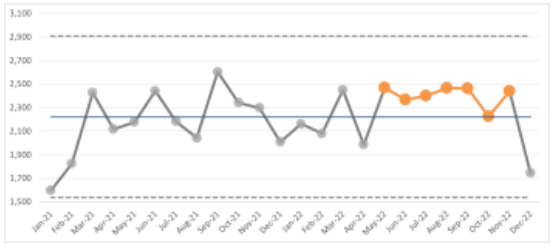
Radiology: It is expected that Radiology, particularly CT and NOUS, should see stronger recovery into 2023 with the opening of the CDC.

Cancer Pathway

East Sussex Healthcare NHS Trust

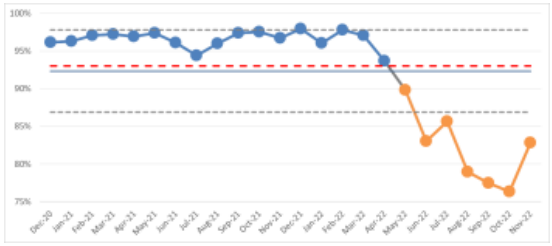
Two Week Wait Referrals

Target: Monitor
Current Month: 1,744



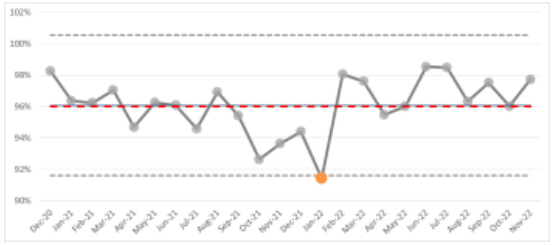
Cancer 2WW Standard

Target: 93%
Current Month: 82.8%



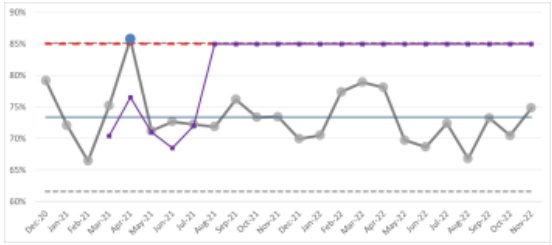
Cancer 31 Day Standard

Target: 96%
Current Month: 97.7%



Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 74.8%



Overall numbers on the cancer PTL have reduced but the Trust continues to experience pressure in all phases of the pathways. There has been an increase in patient choice to defer diagnostics and treatment due to the Christmas and New Year period. Services are exploring all options to increase activity to reduce the backlog and expedite patient pathways.

Turnaround times within pathology (outsourced histology) remains challenged, however, these are closely monitored, tracked and expedited where possible. In order to support cancer pathways and recovery of the 62day standard.

Regular patient tracking meetings are undertaken to ensure patient pathways are expedited where possible and next steps are in place. These meetings are multi-disciplinary and often include clinical team members to support decision making.

Despite the challenges, the Trust improved the position for 62 days and met 28 Day Faster Diagnosis Standard and Breast Symptomatic Standard in November 2022, which is the first time the standard has been achieved this year. It is also expected that the 2ww standard will be met in December.

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

Contents

East Sussex Healthcare NHS Trust

Exec summary

East Sussex Healthcare NHS Trust

£m	RAG	YTD Plan	YTD actual	Var F/(A)	Commentary
Surplus/deficit	G	(0.2)	0.1	0.3	• Trust is reporting a year to date £0.1m favourable position against a planned deficit of (£0.2m), a favourable variance of £0.3m. The Trust's position currently reflects a national request from NHSE/I not to recognise any ERF clawback – YTD against plan this is £2.2m favourable. • M9 did not require a release of reserves to hit this position, how ever this was due to £1.2m of one off benefits in month so the underlying run rate is still above budget. The position ytd has been supported by £4.5m of reserves.
Income	A	431.4	441.0	9.6	• Income is favourable to plan driven by ERF favourable against plan £2.4m, NHSE Drugs £2.6m, ERF £0.6m extra funding £2.6m of revenue reserve release, £0.8m PP overachieving and Winter Vaccs/Virtual Ward income.
Pay	A	(284.7)	(290.7)	*(6.0)*	• Pay cost variance is related to £1.2m of supernumerary costs for overseas/back to care staffing, Unfunded Escalation costs of £2.7m and pressures from Locum/agency usage in Clinical Divisions of £1.5m. • The Trust is using 2% more contracted staff than in 21/22 Mth 12 (excluding SPH)
Non-pay	A	(146.9)	(150.3)	*(3.4)*	• Non-pay costs are higher than budget mainly driven by Utility costs £0.1m, £0.4m Pathology/Radiology outsourcing, Inpulse Ambulance £0.5m, Drugs/HCD £1.0m, Theatres Activity £0.2m and Winter Vaccs £0.6m/VW £0.5m (offset in income).
Efficiency	A	15.6	12.4	*(3.2)*	• The Trust has delivered £0.9m efficiency plan for the month and £12.4m year to date, £1.3m and £3.2m behind plan respectively, £1.3m of this relates to some of the escalation beds being expected to have closed by now, but they remain open, plus unidentified values in the divisions. • The target for the year is £23m. So far £16.3m has been identified, leaving a gap of £6.7m for the Divisions to find, a worsening of £1.3m in the month, largely due to escalation beds remaining open.
Capital	R	20.3	15.4	4.9	• Capex spend of £15.4m which is £4.9m behind plan. FOT remains is an expected underspend of £0.2m
Risk	A	n/a	n/a	n/a	• Risk analysis shows a potential range from £2.5m deficit to a breakeven position downside and upside cases respectively. The base case is showing a slight deficit but not enough materially to change FOT of breakeven to the ICS.

Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	42,775	42,739	*(36)*	384,692	389,717	*5,025*
Divisional	3,961	4,901	*940*	36,728	38,502	*1,774*
ERF	992	1,794	*802*	8,017	11,032	*3,015*
Covid - variable	217	85	*(132)*	1,953	1,756	*(197)*
Total Income	**47,945**	**49,520**	***1,574***	**431,390**	**441,007**	***9,617***
Operating Expense						
Pay						
Permanent	(30,326)	(27,990)	*2,336*	(275,334)	(252,646)	*22,688*
Temporary	(931)	(3,993)	*(3,061)*	(7,966)	(36,170)	*(28,204)*
Total pay	**(31,257)**	**(31,982)**	***(725)***	**(283,301)**	**(288,816)**	***(5,516)***
Non-pay						
Drugs	(902)	(1,299)	*(396)*	(9,500)	(9,866)	*(366)*
TEDD	(3,477)	(3,590)	*(113)*	(31,293)	(33,999)	*(2,706)*
Clinical supplies	(3,946)	(4,297)	*(351)*	(34,963)	(34,325)	*638*
Purchased services	(964)	(1,277)	*(313)*	(8,635)	(8,724)	*(90)*
Finance costs	(2,242)	(2,219)	*23*	(21,061)	(20,722)	*339*
Other	(4,843)	(4,636)	*207*	(40,031)	(41,138)	*(1,108)*
Total non-pay	**(16,375)**	**(17,317)**	***(942)***	**(145,482)**	**(148,774)**	***(3,292)***
Covid exp - block	(90)	(123)	*(33)*	(809)	(1,479)	*(670)*
Covid exp - variable	(223)	(106)	*117*	(2,011)	(1,887)	*124*
Total Expense	**(47,946)**	**(49,529)**	***(1,583)***	**(431,603)**	**(440,957)**	***(9,354)***
Surplus/(Deficit)	**(1)**	**(9)**	***(9)***	**(213)**	**50**	***263***
Memo:						
WTE (worked)	8,110	7,706	*(404)*	7,941	7,677	*(264)*

I&E position

- The month 9 in month position is a breakeven position versus a breakeven plan.
- Year to date the Trust has delivered a favourable £0.1m position, £0.3m favourable to the YTD plan of (£0.2m) deficit.
- There were a number of favourable one-offs (NHSE ERF, oncology SLA and Clinical excellence awards) which meant we did not need to deploy additional reserves in month 9. However, at an underlying level overspend was c£1.0-£1.2m which is a c£0.3m improvement from the prior month.

Income

- The position is favourable YTD by £9.6m, the main drivers being;
  - ERF is still impacted by clawback not occurring, this is an absolute impact of £4.5m and £2.4m favourable versus plan;
  - NHSI Drugs C&V £2.6m
  - Release of reserves into position £2.6m
  - PP Overachieving £1.0m
  - Winter Vaccination Income £0.5m (cost in NP)
  - Virtual Ward Income (costs in pay/NP)

Expense

- The Trust has an in month £0.8m adverse pay position variance, YTD £5.9m which is related to Supernumerary costs for overseas/back to care staffing, temporary staffing and unfunded escalation costs.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget.
- Non-pay costs are higher than budget by £3.3m YTD driven by Utility costs £0.1m, £0.4m Radiology/Pathology outsourcing, £0.5m Impulse Ambulance service, HCD/Drugs £1.0m,Theatres Activity £0.2m and Winter Vaccs £0.6m (offset by income above). £0.6m VW (as above)

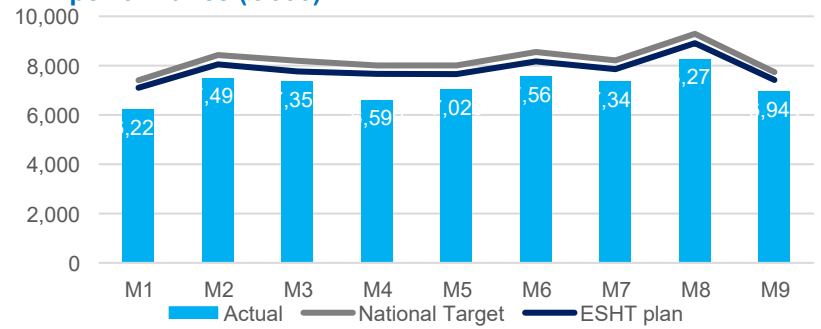
ERF - Trust

East Sussex Healthcare

ERF performance

- The internal plan is £4.5m below national targets (£0.3m per month) this translates into a £3.5m expected full year clawback (at 75%)
- M9 delivery was £0.5m behind plan which would equate to a £0.4m loss of income (YTD £5.8m variance or £4.3m additional clawback).
- National request not to include clawback in the figures means this has not impacted the I&E.
- The main underperforming specialties are Cardiology, T&O, Clinical Haematology, Breast Surgery and Maxillo-Facial.

ERF performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	2,929	2,705	(224)	(7.6%)	27,030	25,176	(1,854)	(6.9%)
Elective	1,457	1,510	53	3.7%	14,763	13,343	(1,420)	(9.6%)
New OP	1,586	1,443	(143)	(9.0%)	15,273	13,603	(1,670)	(10.9%)
OP Procedures	1,449	1,257	(192)	(13.3%)	13,531	12,427	(1,104)	(8.2%)
ERS	-	30	30		-	267	267	
ERF	**7,420**	**6,944**	**(476)**	**(6.4%)**	**70,597**	**64,816**	**(5,781)**	**(8.2%)**
Follow-up	1,321	1,528	207	15.7%	13,408	16,609	3,202	23.9%
Planned care	**8,741**	**8,472**	**(269)**	**(3.1%)**	**84,004**	**81,425**	**(2,579)**	**(3.1%)**

Note: Figures are shown gross before marginal rate at 75%

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Cardiology	671	474	(197)	6,124	4,587	(1,537)
Trauma & Orthopaedics	1,313	1,207	(106)	12,454	10,775	(1,679)
Clinical Haematology	348	258	(91)	2,822	2,298	(524)
Maxillo-Facial Surgery	221	139	(82)	2,002	1,484	(519)
Breast Surgery	207	155	(51)	2,018	1,598	(419)
Urology	652	611	(42)	5,960	6,165	205
Orthodontics	63	24	(39)	452	247	(205)
Ophthalmology	856	819	(37)	8,394	8,212	(182)
Gynaecology	387	355	(32)	3,717	3,835	117
Vascular Surgery	52	25	(28)	407	317	(91)
Respiratory Medicine	157	131	(27)	1,531	976	(555)
Rheumatology	179	155	(24)	1,670	1,323	(347)
ENT	263	242	(21)	2,621	2,182	(439)
Transient Ischaemic Attack	47	29	(19)	462	407	(55)
Gastroenterology	479	461	(18)	4,736	4,226	(510)
Interventional Radiology	64	46	(18)	606	365	(240)
Neurology	101	83	(18)	825	1,045	220
Stroke Medicine	15	6	(9)	132	39	(92)
Paediatrics	129	126	(3)	1,167	1,374	206
Paediatric Epilepsy	2	2	(0)	12	38	26
Palliative Medicine	0	0	(0)	5	3	(3)
Accident & Emergency	-	-	-	8	24	16
Paediatric Diabetic Medicine	-	0	0	-	0	0
Respiratory Physiology	36	36	0	516	397	(119)
Geriatric Medicine	21	22	0	338	196	(142)
Hepatology	2	2	0	16	5	(11)
Anaesthetics	6	7	2	86	88	1
Paediatric Dermatology	-	3	3	-	29	29
Chemical Pathology	5	8	4	51	65	14
Paediatric Surgery	6	9	4	62	87	25
Paediatric Trauma And Orthopaedics	-	4	4	-	50	50
Endocrinology	39	46	7	444	419	(25)
General Medicine	17	37	20	240	122	(117)
Diabetic Medicine	9	29	20	98	138	40
Clinical Oncology	269	293	24	2,585	2,649	64
Acute Internal Medicine Service	-	43	43	-	96	96
General Surgery	688	812	124	6,776	7,241	465
Dermatology	115	245	130	1,259	1,713	455

Pay costs

East Sussex Healthcare NHS Trust

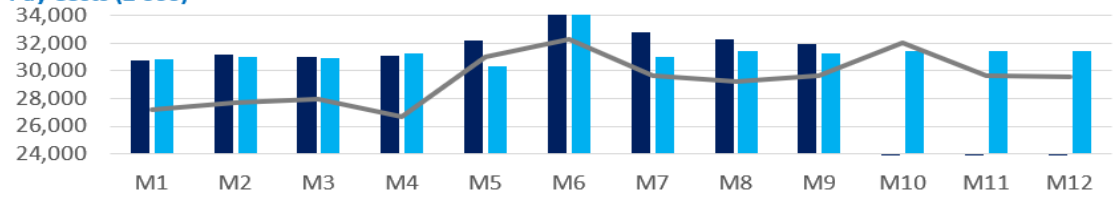
Pay analysis

All staff	Pay costs (£'000) - In Month					WTE				
	Act	*Var*	PY	*YTD var*	YTD ave	Act	*Var*	PY	*YTD var*	YTD Ave
Medical	(7,918)	*(419)*	(7,504)	*(3,493)*	(7,735)	840	*15*	825	*6*	823
Nursing	(13,441)	*286*	(12,187)	*(2,329)*	(13,489)	3,631	*(167)*	3,427	*(66)*	3,640
AHP	(4,177)	*516*	(4,011)	*2,915*	(4,266)	1,122	*(108)*	1,109	*(93)*	1,105
Admin	(3,710)	*400*	(3,742)	*1,998*	(3,785)	1,297	*(117)*	1,291	*(79)*	1,306
Other	(2,736)	*(1,507)*	(3,066)	*(4,607)*	(2,815)	816	*(28)*	792	*(31)*	804
Total	**(31,982)**	***(725)***	**(30,510)**	***(5,516)***	**(32,091)**	**7,706**	***(404)***	**7,444**	***(264)***	**7,677**

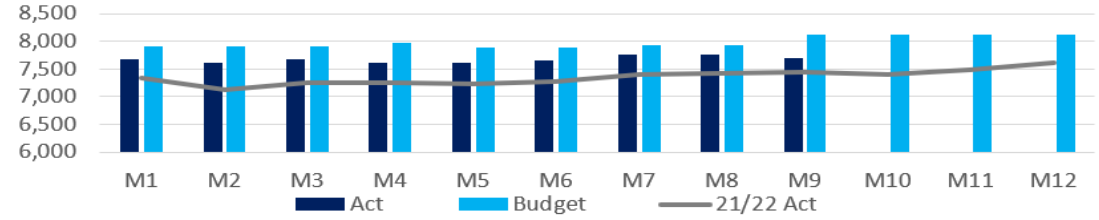
Temporary	Pay costs (£'000)					WTE				
	Oct	Nov	Dec	PY	YTD	Oct	Nov	Dec	PY	YTD Ave
Bank	**(1,592)**	**(1,780)**	**(1,858)**	**(1,550)**	**(14,870)**	**479**	**486**	**485**	**451**	**475**
Medical	(460)	(346)	(361)	(339)	(4,278)	35	34	29	28	36
Nursing	(437)	(375)	(332)	(419)	(4,530)	85	72	63	83	84
AHP	(78)	(74)	(53)	(80)	(936)	16	18	12	19	14
Admin	(1)	(30)	(14)	(164)	(150)	1	1	2	12	2
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(976)**	**(826)**	**(761)**	**(1,002)**	**(9,893)**	**137**	**125**	**106**	**142**	**135**
Locum	**(1,813)**	**2,047**	**(1,050)**	**(1,357)**	**(9,407)**	**87**	**72**	**69**	**119**	**73**
WLI	**(278)**	**(230)**	**(322)**	**(265)**	**(2,183)**	**20**	**25**	**38**	**27**	**26**
Total Temp	**(4,659)**	**(789)**	**(3,990)**	**(4,173)**	**(36,353)**	**723**	**707**	**698**	**740**	**709**

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

Pay Costs (£'000)



WTEs



Pay analysis

- M9 pay costs are higher than budget.
- Overall the in month spend of £32.0m is £1.2m higher than 21/22 comparator with SPH impact (£0.3m) adjusted. Versus month 8 a net £0.3m decrease, aligned to lower agency costs in month plus part effect of central CEA adjustment.
- Nursing & Medical staffing groups are over spending.
- Nursing spending is impacted by the continuation of escalation wards and supernumerary double running costs, and NER pressures.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive.
- M8 Note - Based on updated guidance a proportion of expenditure that was classified as locum has moved to substantive and we have corrected up to the year to date position. This has resulted in £1.8m of YTD budget moving from temporary to permanent giving an in-month negative budget for temporary. There locum expense is showing a negative £2m compared to historical levels of c£2m per month, effectively reducing in-month actual temporary costs by c£4m, this is reclassified into permanent.

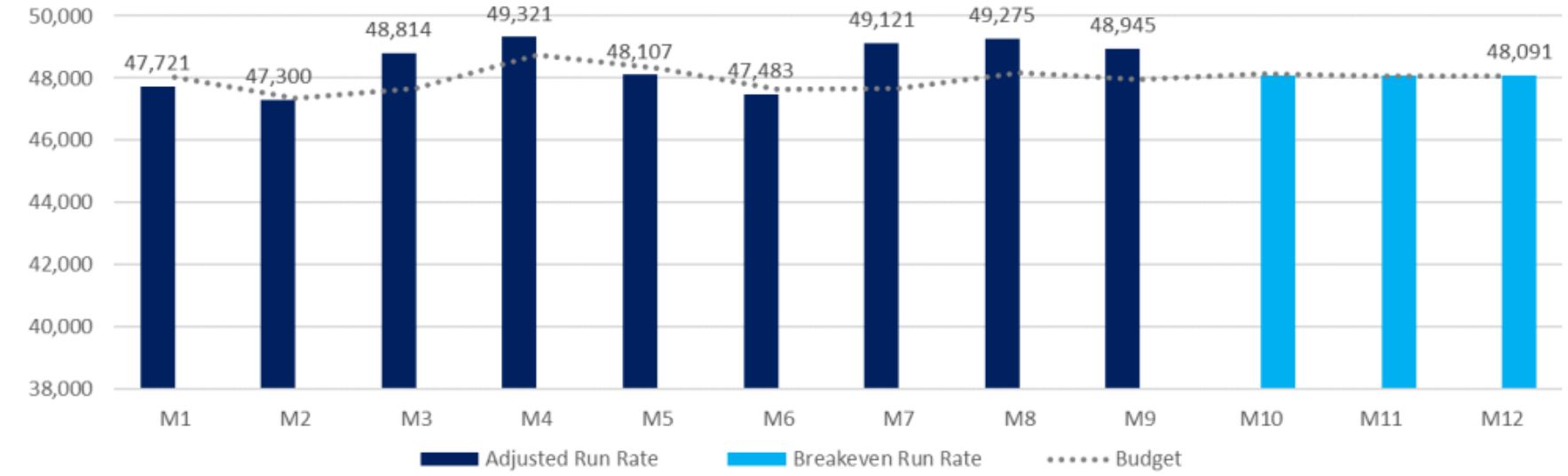
PY comparison

- Pay (£) is overall is above the 21/22 comparator although the underlying related activity trends are quite dissimilar (covid and non-covid).
- When compared to 21/22 in particular costs are materially higher in 22/23.
- Pay FTE is higher than the prior year comparator but this has to be seen as a BAU including COVID vs a high COVID lowered activity baseline.
- Pay FTE includes 90 FTE for SPH so like for like the FTE is 172 fte higher.

Run Rate

East Sussex Healthcare NHS Trust

Underlying run rate



Methodology

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

Run rate

- The graphs shows an decrease in underlying run rate from M9 to M8 of £0.3m (which translates to a variance to budget of £0.3m), non-pay £0.3m partially offset by income ahead of plan. Non-pay continued to be high in M9 but was lower than M8. The analysis has removed net £4.5m of one-off items which whilst don't impact the run rate will still impact the in year financial position.
- Taking the current months run rate and extrapolating gives an overall spend of £583.0m, against a plan of £575.9, an overall gap of **£7.0m** (this adjusts to £2.6m when the one-offs are adjusted for).
- Mitigations are currently being worked through, with some central reserve support expected to be required in M10-12
- Further mitigations will be required from divisional management to ensure progress is made to reduce run rate to the required level by Mar-23, currently around a **£0.9m** reduction per month compared to M9.

Divisional Summary

East Sussex Healthcare NHS Trust

Divisional position

Division	Variance to budget - M9					YTD overall Variance	Run rate analysis (unadjusted)			
	Income	*Pay*	*Non pay*	Overall Variance	WTE		Oct	Nov	Dec	
	£'000	*£'000*	*£'000*	£'000	WTE	£'000	£'000	£'000	£'000	
CHIC	*203*	*126*	*(165)*	164	(75)	*1,471*	(3,556)	(3,733)	(3,618)	▲
Core Services	*61*	*(69)*	*(436)*	(443)	(24)	*(1,273)*	(6,343)	(6,195)	(6,479)	▼
Estates & Facilities	*28*	*23*	*(54)*	(3)	(37)	*(250)*	(3,201)	(3,077)	(3,198)	▼
Medicine	*146*	*(255)*	*297*	187	(50)	*(4,534)*	(8,345)	(8,369)	(7,834)	▲
DAS	*124*	*(273)*	*(156)*	(305)	(7)	*(2,487)*	(8,469)	(8,267)	(8,107)	▲
Urgent Care	*(1)*	*(127)*	*(19)*	(146)	(55)	*(949)*	(2,334)	(2,205)	(2,255)	▼
WCSH	*33*	*206*	*(79)*	161	(65)	*344*	(3,036)	(3,078)	(2,986)	▲
Corporate Services	*118*	*114*	*(452)*	(220)	(69)	*173*	(3,777)	(3,980)	(4,143)	▼
SPH	*210*	*26*	*(118)*	118	(2)	*305*	78	13	2	▼
Central/Trust wide	*8,695*	*(497)*	*324*	8,523	+118	*7,462*	38,197	38,104	40,415	▲
ESHT	***9,617***	***(725)***	***(858)***	**8,034**	(266)	**263**	**(786)**	**(787)**	**1,796**	▲

Division	YTD Variance M9 - Top Level Narrative
CHIC	Vacancies ytd, including 21-22 investment in UCR/EHCH
Core Services	Vacancies ytd in CDC and Pharmacy, non pay outsourcing Path/Rad
Estates & Facilities	Ancillary vacancies and Utility costs ytd
Medicine	Supernumerary posts, Escalation, Cardiology agency, Covid backfill
DAS	Supernumerary posts, Critical Care (Bus Case pending), Theatre Agency
Urgent Care	Supernumerary posts, Agency premium
WCSH	Maternity vacancies, Sexual Health vacs, non pay gen supplies
Corporate Services	Vacancies in Finance/HR/Digital offset by Inpulse Ambulance
SPH	Vacancies and low pay costs v budgeted unit costs. NP offset by income

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd – M8			Full Year					
	Plan	Actual	Var	Plan	Actual	Var	Rec	NR	Total	Target	Gap	Schemes
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	#
Medicine	310	10	(300)	1,974	59	(1,915)	163	124	287	2,912	(2,626)	6
Emergency Care	83	9	(74)	534	34	(500)	63	2	65	783	(718)	11
DAS	326	70	(256)	2,041	1,397	(644)	228	1,329	1,557	3,029	(1,472)	13
Core Services	287	62	(225)	1,518	1,551	33	413	1,540	1,952	2,393	(440)	17
CHIC	166	131	(35)	1,042	1,690	648	26	2,083	2,109	1,539	570	6
WCSH	73	41	(33)	447	375	(72)	18	1,099	1,117	1,172	(55)	6
Estates & Facilities	126	9	(117)	647	380	(267)	105	482	587	1,026	(439)	10
Corporate	138	182	44	764	1,676	912	615	1,471	2,085	1,177	908	10
Trustwide	761	437	(325)	6,597	5,249	(1,348)	6,559	-	6,559	8,964	(2,404)	3
Total	**2,271**	**949**	**(1,322)**	**15,564**	**12,410**	**(3,154)**	**8,189**	**8,129**	**16,318**	**22,994**	**(6,676)**	**82**
Unidentified	-	-	-	-	-	-	-	-	*6,676*	-	*6,676*	-
Total	**2,271**	**949**	**(1,322)**	**15,564**	**12,410**	**(3,154)**	**8,189**	**8,129**	**22,994**	**22,994**	**-**	**82**
Movement from last month	*(58)*	*(494)*	*(436)*	*2,271*	*949*	*(1,322)*	*(1,407)*	*100*	*(1,307)*	*-*	*(1,307)*	*(3)*

Overview

- The trust has delivered £0.9m of efficiencies in the month and £12.4m year to date, this is £1.3m behind the in month plan and £3.2m year to date. This is not a surprise as the planned values have not been delivered for the prior 3 months.
- All areas with the exception of Corporate have not delivered their in month plan.
- The largest in month variance is in Trust-wide and this is due to the escalation beds still being open.
- The divisional plan values in the month represent the phased targets rather than the planned values for schemes that have been approved.
- The target for the year is £23m, this reflects the increase of £2m following the resubmission of the plan in June. So far £16.3m has been identified, leaving a gap of £6.7m for the Divisions to find, a worsening of £1.3m in the month, this is largely due to the escalation beds and any planned value for the rest of the year removed from the forecast.
- 50% of the £16.3m identified is non-recurrent.

Capital

East Sussex Healthcare NHS Trust

Capital Scheme	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Fcast RAG	Full Year Variance £'000
Original							
Digital Programmes	2,970	2,352	(618)	4,500	5,099		599
Total Digital	**2,970**	**2,352**	**(618)**	**4,500**	**5,099**		**599**
Diagnostic Equipment	330	401	71	500	420		(80)
Medical Equipment	1,650	1,499	(151)	2,500	2,000		(500)
Total Medical Equipment	**1,980**	**1,900**	**(80)**	**3,000**	**2,420**		**(580)**
Fire	990	454	(536)	1,500	1,500		-
Backlog	4,455	3,041	(1,414)	6,750	6,750		-
Day Surgery capacity	910	1,350	440	1,400	1,350		(50)
Theatre 5 & 8	185	389	204	280	429		149
CT Scanner	165	9	(156)	250	60		(190)
Westham	88	417	329	150	425		275
Conquest ED	165	234	69	250	305		55
Cath Lab Replacement	1,122	35	(1,087)	1,700	1,500		(200)
Cat 3 Microbiology	33	-	(33)	50	-		(50)
Gynae Footprint	264	158	(106)	400	260		(140)
ICU adaptations Conq	231	41	(190)	350	500		150
Ophthalmology Bex	330	78	(252)	500	750		250
Cardiology Business Case	-	-	-	-	50		50
Friston Paeds	528	247	(281)	800	750		(50)
Decant Ward	231	211	(20)	350	350		-
Ward Refurbishment	825	568	(257)	1,250	1,050		(200)
Total Estates	**10,522**	**7,234**	**(3,288)**	**15,980**	**16,029**		**49**
Business Case Development	264	13	(251)	400	13		(387)
Divisional Small Works	330	2	(328)	500	100		(400)
Minor Capital	429	452	23	650	500		(150)
Unplanned Urgents	330	(9)	(339)	500	88		(412)
Planned slippage/prioritisation	(859)	-	859	(1,110)	-		1,110
Total Finance	**494**	**458**	**(36)**	**940**	**701**		**(239)**
Total Original Planned	**15,966**	**11,944**	**(4,023)**	**24,420**	**24,249**		**(172)**
New							
Community Diagnostic Centre	500	377	(123)	500	500		-
Additional Medical Equipment	**500**	**377**	**(123)**	**500**	**500**		**-**
Building For Our Future	705	350	(355)	1,060	1,060		-
Community Diagnostic Centre	1,791	2,255	464	2,600	2,600		-
Elective Hub EDGH	1,334	301	(1,032)	4,273	4,273		-
Additional Estates	**3,829**	**2,906**	**(924)**	**7,933**	**7,933**		**-**
EPR Match Funding (external)	-	-	-	-	-		-
Diagnostics Digital Capability	-	-	-	1,110	1,110		-
Frontline Digitisation programme	-	-	-	2,200	2,200		-
Additional Digital	**-**	**-**	**-**	**3,310**	**3,310**		**-**
Total Additional Capital	**4,329**	**3,283**	**(1,046)**	**11,743**	**11,743**		**-**
Total Capital	**20,296**	**15,227**	**(5,069)**	**36,163**	**35,992**		**(172)**
PSDS3	16,822	11,648	(5,174)	28,822	28,822		-
PSDS3 Income	(16,822)	(11,648)	5,174	(28,822)	(28,822)		-
Total Grant Capital	**-**	**-**	**-**	**-**	**-**		**-**
Donated Expenditure	660	960	300	1,000	1,000		-
Donated Income	(660)	(754)	(94)	(1,000)	(1,000)		-
Total Donated Capital	**-**	**206**	**206**	**-**	**-**		**-**
Total Capital	**20,296**	**15,433**	**(4,863)**	**36,163**	**35,992**		**(172)**

Capital

- The planned capital allocation for 2022/23 is £36.2m and is made up of the core ICS allocation of £24.4m plus national programmes expected in year of £11.7m.
- Of the additional PDC expected, MOU's have been received for £11.8m. Cash draws will be made once commitments have been made and expenditure incurred.
- The programme includes the public sector decarbonisation scheme which is a government grant funded scheme of £28.8m.
- The capital expenditure incurred to the end of December totals £15.4m compared to a plan of £22.1m meaning the Trust is £6.7m behind initial plan phasing, this is, in the main, driven by Digital(£1.1m), Backlog, Fire, and other estates (£5.3m).
- Expenditure in M9 was largely driven by the following schemes:
  - Medical Equipment £2,277k (includes diagnostic equipment of £401k and equipment for the Community Diagnostics Centre (£377k);
  - Estates works of £10.1m, the main schemes being backlog maintenance (£3,041k), Westham remodelling and refurbishment (£417k), Theatre 5 & 8 upgrade including laminar flow (£389k), Conquest ED project delivering new clinical space and staff area (£234k), and Day Surgery redesign at EDGH (£1,350k);
  - Community Diagnostics Centre £2,632k made up of equipment costs (£377k) and estates costs (£2,255k);
  - Elective Care Centre £301k.
- The current forecast is in line with the revised plan, we believe this now includes the majority of the "bad news" and there should not be further material amounts of slippage. There are £2.2m of amber rated and £0.5m of red rated schemes.
- Digital and medical equipment have brought forward expenditure already as part of the forecast. Following approval at the last meeting to delegate to the CFO the option to trade up to £2m of our allocation in the current year for at least a 50% return in future years, discussions have begun with system partners to this affect.

Assets and Liabilities

East Sussex Healthcare NHS Trust

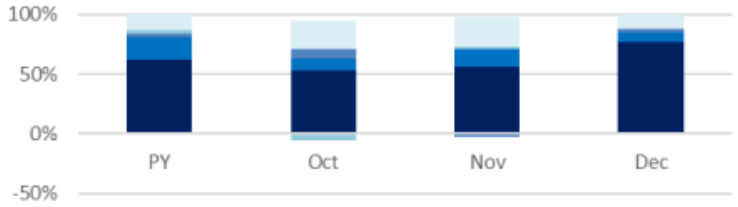
Trust Assets and Liabilities

	Oct	Nov	Dec	Change
	£'000	£'000	£'000	£'000
Non-current assets	**297,136**	**298,014**	**309,660**	**11,646**
Inventories	8,786	8,834	10,004	1,170
Trade and other receivables	27,434	20,242	27,863	7,621
Cash and Cash equivalents	45,403	52,035	52,987	952
Current Assets	**81,623**	**81,111**	**90,854**	**9,743**
Trade and other payables	(44,305)	(44,928)	(49,740)	(4,812)
Other liabilities	(10,583)	(9,815)	(14,581)	(4,766)
Current Liabilities	**(54,888)**	**(54,743)**	**(64,321)**	**(9,578)**
Non-current liabilities	**(12,462)**	**(12,294)**	**(11,570)**	**723**
Total assets employed	**311,409**	**312,089**	**324,623**	**12,534**

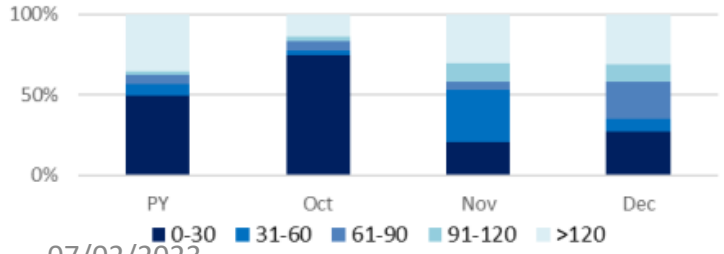
BPPC (Based on invoice count)

Trade	82.3%	83.6%	84.9%	1.3%
NHS	98.5%	98.7%	98.8%	0.1%

Trade Payables Ageing



Trade receivables Ageing



Balance sheet

- Non-current asset values have increased by £11.6m, this is due to the first wave of additions relating to PSDS3.
- Current assets has increased in month by £9.7m. This has predominantly been caused by a increase in trade and other receivables together with an increase in drugs stock.
- Current liabilities has increased in month by £9.6m, Trade and Oher Payables account for £4.8m of the increase the remainder is due to an increase in the level of deferred income.
- The Trust continues to hold very significant cash balances at £53.0m.

Better Payment Practice Code (BPPC)

- Slight improvements in BPPC for Trade and non-NHS in month. The Financial Services team continue to prioritise performance, with non-NHS payables a particular focus. Poor performance is largely due to issues with no purchase orders or delays to receipting of goods and services.

Trade and Other Payables

- An increase in month of £8.1m on the creditor position increasing the purchase ledger total to £15.8m.
- 85% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.
- The majority of aged invoices are stuck in the system due to issues relating to the 'No PO, No Pay' policy.

Trade and Other Receivables

- The sales ledger balance increased by £1.4m in month to a total of £8.6m.
- The ageing profile of debt due has increased by £0.5m in month and now totals £6.2m.

Key risks

East Sussex Healthcare NHS Trust

Risk adjusted forecast outturn

- Risk analysis shows a potential range from £2.5m deficit to a breakeven position downside and upside cases respectively. The base case is showing a expected deficit of £0.3m which is immaterial to the scale of Trust turnover so not seen as a trigger point for changing the forecast.
- The downside position has improved due to one off benefits in Month 9.

	Downside £'000	Base £'000	Upside £'000	Commentary
M9 YTD	**263**	**263**	**263**	
Risks				
ERF value	-	-	-	*The ICB was considering whether the allocation of ERF money was correct. Now been informed there is no adjustment for 22-23.*
Efficiency	(822)	(822)	-	*The shortfall in the efficiency programme is being partially offset by savings in overall expenditure. Divisions continue to work to progress schemes and develop plans to close the gap. Ownership and engagement is high but significant progress will need to be made in the coming weeks to ensure the programme remains on track for full delivery. Mitigations for slippage has been found in some areas.* The current plan is for an improvement in run rate of £0.3m per month in the second half of the year. For **base case** and **downside** we are assuming the current run rate continues and this is not achieved, for upside **case** that this is delivered
Run rate	(2,607)	(1,738)	(869)	*Current levels of temporary staffing, in part due to high levels of sickness, and expenditure growth in areas of activity, notably high cost drugs, are areas of particular concern and are under review* **Base**: Extrapolation of current run rate adjusting for ERF and assumed efficiency updside. **Upside** and **downside** case have been adjusted by 50% of this value.
Winter pressures	(500)	-	-	*Increasing expenditure based on additional operational demand over winter* **Base: Higher runrate in M7-9 reflected in run rate risk and expecting additional funding from ICB for Winter pressures, therefore set at zero for base case.** **Downside**: 500k included for potential risk against funding
Pay award	(849)	-	-	*There is a risk that the full cost is not fully funded. However,it appears H1 has been absorbed within the funding.* **Base Case**: assume continued run rate on pay award abosbed through additional funding **Upside**: Pay award is fully funded **Downside**: based on the theoretical gap identified in the pay workings
Mitigations				
One-off recovery actions	**2,000**	**2,000**	**606**	
Scenario FOT	**(2,515)**	**(297)**	**-**	
Prior month	**(6,062)**	**(2,329)**	**-**	

East Sussex Healthcare NHS Trust

Maternity Overview Report: Q3 2022/23

Purpose of the paper	This report seeks to assure the Board on our progress/response across three areas: 1. The quality and safety of perinatal services, our progress with meeting the perinatal clinical quality surveillance standards and actions to proactively identify/mitigate quality and safety risks/concerns 2. The findings and actions that the maternity team will undertake following the publication this month of the CQC report as part of the national maternity inspection programme 3. The output of the NHS Maternity Services Survey 2022 benchmark report
	For Decision: ; For Assurance: x; For Information:
Sponsor/Author	Executive Director: Vikki Carruth, Chief Nurse Report Author: Brenda Lynes, Director of Maternity Services
Governance overview	The three areas covered in this report were addressed in the January IPR for Maternity Services. Additionally, item 2 relating to the CQC inspection of maternity services has been covered in Executive Leadership Team meetings.

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

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

Recommendation	The Board is asked to: 1. Review the update and progress within maternity and neonatal services during Q3 2022/23 2. Review the overview of the CQC reports following the review of maternity 3. Review the NHS Maternity Services Survey 2022 benchmark report.
Executive Summary	This front sheet seeks to provide the key summary messages for each of the three papers coming as part of this overview. **Quality and safety of perinatal services at ESHT** As part of the Ockenden Report findings, all NHS Trusts are required to update Boards on the quality and safety aspects of our maternity services. The maternity team is looking to focus on improving the workplace culture, with early successes evidenced in new joiners and an improvement in the vacancy rate. The team is also making good progress on compliance with the 7 Ockenden immediate and essential actions (IEAs). **Maternity Inspection Programme**

	Maternity services across England and Wales were included in this national programme and compared with other local reviews, the ratings for this Trust – which stayed the same as the previous inspections in 2017 and 2018 – reflect the hard work of our teams. We recognise the improvements that the CQC has identified and several are already underway, as the report makes clear. In this current challenged environment, the team can be proud of maintaining the overall assessments that each site had in 2017 and 2018 respectively – the last time these services were assessed by the CQC. While the Trust was assessed as performing strongly on the Well Led domain, the Safety domain was felt to require improvement, with specific issues around training and risk assessment of patients driving most of the must-dos. These are all addressed in the action plans. The team is also looking at the longer-term, structural issue of recruitment – specifically to levels that provide for extra cover to free staff to attend training. To support the team in the tracking of progress against the action plan trajectory, we are undertaking a review of the governance process to ensure that the right depth of data and information is made available to ensure we are able to show changes/improvements. **Maternity Services Survey 2022** The CQC also published the maternity services survey in Q3 that looked at the experience of maternity from the perspective of the patient. Overall, across over 90% of indicators, ESHT was seen as performing largely as it had done in 2021 – again, another positive takeaway for the service in a year where many maternity services saw significant dips in patient experience. However, as with the Inspection Report, there were a number of areas where ESHT was performing better than the national average, but other areas – notably around labour/birth – where we can do better. The team has developed an action plan to address this, with reporting being picked up through the division's internal governance process and at the monthly internal performance review.

Next steps	A Q4 follow up and update paper will provide an update of key actions and progress against both the CQC national inspection report and the NHS Maternity Services Survey 2022 benchmark report. As the report also notes, the action plan response re: the inspection report is due back to the CQC by 21/02/23.

Maternity Overview Report: Q3 2022/23

Executive Summary

The Trust Board is requested to note this Q3 report, which covers three discrete sections:

1. It provides **an overview of the quality and safety of our perinatal services**, an overview of our progress in ESHT with meeting the perinatal clinical quality surveillance standards at Trust level, and our actions to proactively identify and mitigate any quality and safety concerns and risks. The report provides an overview of Maternity planning, progress and activity during quarter three 2022/23. This is in line with the National Maternity and Neonatal Safety Improvement programme[1] (MatNeoSip), launched in 2019 aimed to:

    - Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women/birthing people, babies and families across maternity and neonatal care settings in England

    - Contribute to the national ambition set out in the Transformation plan (previously Better Births of reducing rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 2025

    East Sussex Healthcare Trust's Clinical Strategy[2] is aligned to this long-term plan. The ICS through our Local Maternity and Neonatal System and our local Maternity Voices partnership (MVP) are working in partnership to achieve these ambitions. Recommendations made in the final Ockenden report (March 2022), are supportive steps towards this greater ambition. ESHT's dashboard provides data for scrutiny and analysis to provide assurance to the Board surrounding these key areas. This paper provides assurance surrounding the safety of services and we ask ourselves four key questions;

    1. Are we safe against the national safety ambition
    2. Perinatal mortality rates
    3. What is our data telling us
    4. Staff and service users – are staff and service users telling us we are safe

2. It includes **an overview of the recent CQC maternity report as part of the national inspection programme**, Eastbourne report and Conquest report together with our actions designed to meet the must-dos and should-dos.

3. Finally, the report concludes with **an overview of the NHS Maternity services survey** which provides patient-led context around the current operating environment for maternity services across the NHS.

[1] NHS England » Maternity and Neonatal Safety Improvement Programme
[2] Clinical Strategy (esht.nhs.uk)

1. Perinatal quality and safety update

Continuity of carer (CoC) model

As colleagues are aware, the 2017 NHSE five-year forward plan for maternity care (Better Births) required Trusts to identify how it would provide dedicated support from the same midwifery team throughout pregnancy. ESHT continues with the two current midwifery CoC teams, however, will not commit to further rollout until staffing has improved and key requirements are in place. The existing two teams are currently under review to ensure they are meeting key requirements to support those from the most deprived groups and those from women/people from Black, Asian and minority ethnic communities

Healthcare Safety Investigation Branch (HSIB) Referrals for Q3

Since 2021, all HSIB cases accepted for investigation are raised as serious incidents (SIs). During Q3 there were no HSIB referrals, however, sadly a neonatal death declared in October 2022 has been upgraded to a SI following discussions in December 2022. Immediate actions have been developed and a full investigation is currently progressing.

Closed SIs and analysis during Q3

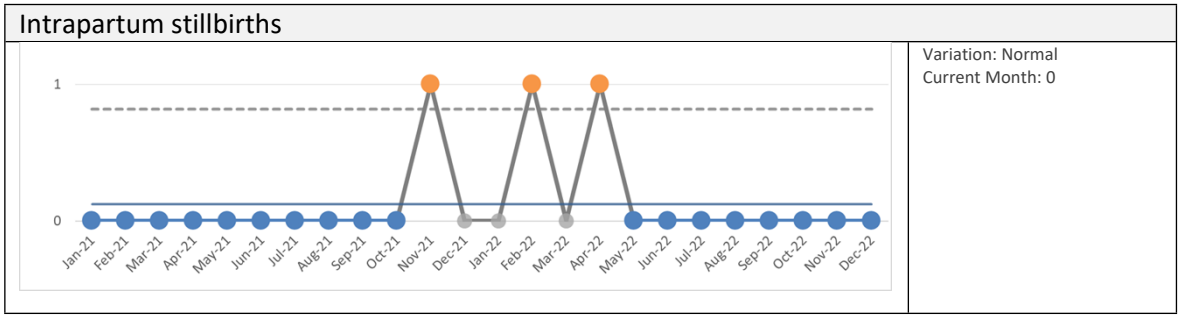
There have been no closed Maternity Serious Incidents during quarter 3 2022/23

Completed HSIB referrals during Q3

Two completed investigations by HSIB during quarter 3 2022/23. Sadly, both cases involved stillbirths, no trends have been noted. Reports have been shared with the respective parents. Tripartite meetings have been held with both parties. Completed safety actions included close support, supervision and retraining of key staff. Scheduling of an appointments audit to ensure robust adherence to national guidance. All actions are reviewed at the Women's Risk meeting on a quarterly basis.

Stillbirth data (Q3)

The table below shows the number of intrapartum stillbirths reported between October 2020 and September 2022:



The national aim is to reduce stillbirths from 5.1/1000 births in 2010 to 4.1/1000 births in 2020, and 2.5 in 2025. The Trust rolling stillbirth rate is currently 4.1/1000 births. The Trust neonatal death rate is currently 1.01/1000 births, which is significantly below ONS data which reported 2.7 neonatal deaths per 1000 births in 2020.

Findings from local Perinatal Mortality Review Tool (PMRT) Reviews

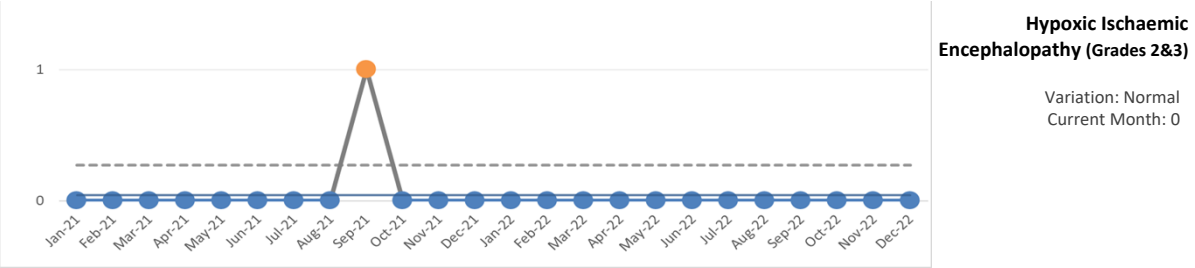
The Perinatal Mortality Review Tool (PMRT) was developed in 2018 by MBRRACE–UK in collaboration with user and parent involvement. The aim is to support high quality standardised perinatal mortality reviews across NHS maternity and neonatal Units.

For the Q3 review, papers were reviewed externally and commented on prior to the meeting. All cases meeting the relevant criteria were reported to MBRRACE within 7 working days. Two cases were reviewed and, while no issues of care were noted, there was an action for Midwives to be reminded of how to use Badgernet software to ensure appropriate grading of risk antenatally.

We are continuing to review how we review SIs in line with the Patient Safety Incident Response (PSIRF) framework, supporting the learning and improvement focus (a move away from "what went wrong" to "how to minimise" SIs in the future).

Neonatal Brain Injury

There have been no cases of neonatal brain injury during quarter 3 2022/23



Maternal Mortality

There were no maternal deaths during Q3

Safe Staffing

Maternity Staffing (workforce)

As of 31 December 2022, the midwifery workforce vacancy rate was 4% (Band 5-7 RM) within the service. This is significant reduction from Q2 9.4%.

We recognise the importance of shoring up our workforce, especially in light of the CQC inspection recommendations (see section 2). A number of developments are already in place:

- A recruitment and retention lead for maternity commenced in post in October 2022
- There are plans in place to consider advanced clinical Midwifery posts for prospective employees and a retention plan is under development.
- A website upgrade is underway with the aim of attracting both staff and birthing people to our services
- ESHT have opened vacancies for our midwives due to qualify from July 2023 onwards
- We have been successful in recruiting a number external midwives into ESHT during the last quarter

Red Flag Incidents

Red flag incidents are recorded using a Birthrate+ web-based application. Compliance is currently 76% (expected 85%) and the HOM is working with staff to improve compliance. There has been a significant reduction in red flags from Q2 (53) to Q3 (36). We are reviewing the causation of this downward shift to understand whether there were conscious decisions made that we can seek to replicate and embed going forward.

Looking at the themes behind the 36 red flag incidents reported during quarter 3, there was a noted delay in commencing of induction of labour (IOL) process, albeit no harm occurred as a result of any delays.

Turning to sickness levels across the service, while we note the rise in December, the trend has been falling significantly since July and, particularly in relation to anxiety and depression, we note a steady reduction.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Sickness Levels (%)	6.9%	5.3%	6.8%	7.3%	4.9%	2.8%	1.1%	1.7%	4.0%
Of which COVID sickness related	2.9%	1.3%	1.9%	2.6%	0.8%	0.0%	0.2%	0.1%	0.8%
Of which anxiety, stress or depression related	1.3%	0.9%	2.5%	3.9%	2.1%	0.8%	0.0%	0.0%	0.2%
% of sickness as long term (28 days+)	46.5%	36.9%	41.4%	41.4%	67.0%	23.2%	0.0%	0.0%	16.8%

Maternity leave peaked in November. Maternity leave is backfilled where possible, however these short-term posts can be difficult to recruit to, the department have a plan to manage maternity leave proactively where possible going forward. Again, this approach forms part of our action plans to address the CQC inspection at section 2.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Maternity Leave	5.8%	6.0%	5.6%	5.7%	6.6%	6.4%	7.2%	8.0%	7.7%

One to one care in established labour is reviewed monthly as part of the Perinatal quality surveillance (PQS) dashboard. The rates of one-to-one care during labour are shown below, demonstrating safe care provision overall.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
1:1 Care in Labour	97%	98%	99 %	96%	99%	98%	96%	96%	100%

MDT Training

Compliance with CTG and fetal monitoring training competency is as follows for quarter 3:

Q3	
CTG compliance	% Compliance
Medics	86%
Midwives	95%
Combined	93.00%

Core competency (PROMPT) training: as of the end of December 2022, combined professional compliance with MDT training is 93%. Again, mindful of the challenges raised in the CQC inspection report, it is important we see this training in the context of other trust mandatory training issues.

Obstetric, Neonatal & Anaesthetic Staffing

Obstetric Workforce

The duties of the Hot Week Consultant guidelines incorporate the principles outlined in the RCOG Workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. Full compliance with the recommendations within the guideline has been demonstrated in a recent audit.

The maternity department remains compliant with the requirement for twice daily consultant ward rounds, 7 days per week. This is monitored monthly via the Patient Quality & Safety meeting dashboard which is shared with the Trust Board and LMNS. The Consultant body for Obstetrics and Gynaecology are currently fully recruited.

Anaesthetic Workforce

Anaesthetic workforce rotas demonstrate compliance with the ACSA standard.

Neonatal Medical Workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. Compliance is under continuous review.

Neonatal Nursing Workforce

The neonatal unit meets the service specification for neonatal nursing standards and uses a specific workforce calculation tool which is reviewed annually.

Culture within maternity services

The most recent staff survey is currently underway. The 2021 survey results have previously been shared and the team is engaged in delivery of the coproduced action plan. The team recognises some of the historical challenges around ways of working, but the new leadership sees this as a key area to develop and are working with the AD for Culture, especially given the importance of effective recruitment as underpinning of the success of the action plans for addressing the CQC inspection issues, especially around the training.

The next Score survey is due to commence in Spring 2023 (date TBC). Listening events continue with staff every 6 weeks. Following initial discussions with the maternity team and HR regarding hearing the voice of staff in multiple ways and hearing the lesser heard voices, many 1:1 discussions have been held with individual midwives to gain deeper insight into concerns and ideas they may have for the service.

Further to this, non-executive directors have joined the Maternity voices partnership in a 15 steps exercise to review maternity services across Eastbourne and Conquest, where the opportunity was also taken for them to speak with individual staff, a full update of this process will be provided in the next Board report.

A welcome event was held for the September intake of newly recruited student Midwives and student listening events have been forward planned.

Robust staff support is offered via generic Trust services, and the Maternity department also offers a number of support processes for staff, examples of excellent practice includes;

- Each midwife within ESHT is allocated to a Professional Midwifery Partner (PMP), this role supports midwives through a continuous improvement process that builds upon personal and professional resilience to enhance the quality of care for women and birthing people and support preparedness for midwives in appraisal and professional revalidation. World café engagement events are being undertaken across the maternity department to assist in understanding from our clinical midwives and maternity support workers perspective, where improvements can be made for staff, this work will form part of our annual business plan.

- Newly qualified midwives are supported through a midwifery preceptorship program. The preceptorship team provide a structured supportive program of work to support department managers to enhance the transition of newly qualified midwives and band 5 & 6 midwives new to East Sussex Healthcare. The preceptorship lead midwives work collaboratively to further develop and facilitate the preceptorship programme to promote the importance of high-quality clinical practice and continuous professional development through clinical teaching, supervision and assessment in order to facilitate the enhancement of a high-quality practice learning experience for all newly qualified midwives. This effective process has celebrated by our new midwives in post.

The service user voice

There is an improvement in the Friends and Family Test (FFT) scores during Q3 with a 25% response rate and 98% noting positive recommendation. We continue to look at ways of increasing this further.

Service user feedback via the Maternity Voices Partnership (MVP)

Positive feedback has included:
- The identification, access and treatment of tongue tie
- Outstanding care from the midwifery team at the Conquest who were noted to have been extremely supportive and friendly
- High quality communication and care with excellent planning when birth at home/EMU were disrupted due to recent ambulance service pressures. The service users felt reassured that they would be cared for as planned but in a different environment

Areas for improvement included:
- Patient care post caesarean section, specifically around caring for baby when still under effects of spinal analgesia, improvement work on the postnatal ward has addressed this concern
- Communication between community midwives and service users re: specific pregnancy symptoms, for which action has been taken with the community teams and Head of Midwifery
- Concerns were raised regarding long waits for antenatal clinic appointments - since October we have set up additional clinics and this is expected to reduce wait times

Progress with Ockenden recommendations / East Kent Report

There is evidence of good progress on the Ockenden 7 Immediate & Essential Actions (IEAs). Our position as submitted to NHSE in April 2022 showed compliance at 82% and this has now risen to 97%. We evidence progress through completed audits, and each has an action plan with delivery monitored at divisional Governance & Accountability meetings and at the monthly Maternity Assurance meeting, led by Executive Directors and through the LMNS. The Trust Maternity website is in the process of being updated. Following the NHSE assurance visit, an action plan is in place to ensure full compliance.

As next steps, the team has benchmarked itself against the final Ockenden 15 IEAs, which build on the first 7 IEA. Compliance is maintained in a database of evidence. Overall, good progress is being made. The Sussex Maternal Medicine Network is now fully functioning.

NHSE/I have advised that the reporting and assurance process against the final IEA's will be combined with the East Kent report. An interim overview and assurance paper was presented at the December Trust Board, local compliance is monitored through governance and accountability meetings and through the LMNS.

NHSE Insight visit

There were 11 actions for ESHT from the final report, all are now nearing completion. *(Appendix A: Ockenden Assurance Insight Visit Report Action Plan).*

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4

CNST incentivises ten maternity safety actions and Trusts that can demonstrate compliance with **all 10** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. This has been reviewed internally through trust governance process and by the chief executive of the ICS, who endorsed the high quality of delivery for all ten safety actions. Final submission to NHS Resolution was completed 01/02/2023 confirmed compliance is expected.

Perinatal Quality & Safety conclusion

Are we safe against the national safety ambition

Our services are managed effectively and safety is maintained clinically, at minimum, a daily review of staffing levels takes place and our escalation plan is activated when required to ensure we maintain safe services. Recruitment and retention review is an ongoing key part of service planning.

We maintain a robust governance process and our data suggests that perinatal mortality rates remain in line with national ambition, local scrutiny of all ESHT cases form part of our governance process.

Our services are well led overall and well managed on a day-to-day basis, staff compliance in line with national requirement for maternity specific training has been maintained. A robust plan of action is underway to ensure Trust targets are met with regards to trust mandatory training. Governance processes remain robust.

2. CQC Maternity Inspection

Background

The Trust was visited by the CQC between 19-20 October 2022 to review maternity services at our EDGH and Conquest sites as part of a national maternity inspection programme. We received a draft report for review in December 2022, with the final report published on 25 January 2023.

Summary of key points (Trust-level)

- The CQC rating for each hospital from the 2019 inspection (CQ - outstanding, EDGH - good) remains unchanged
- Turning to maternity services specifically, both sites have remained overall as they were in their previous inspections. The overall summary for maternity services at EDGH (midwifery-led unit) was requires improvement (this service was previously rated as requires improvement in 2017) and for CQ (obstetrics, delivery, postnatal, antenatal) the overall summary was good, which is the same as the previous inspection in 2018
- The national maternity inspection programme reviewed maternity services against just two of the CQC domains (safe and well-led). Both ESHT sites were rated as requires improvement for safety and good for well-led
- There were a number of "must dos" and "should dos" identified for each site
- The themes emerging from these "must dos" have been summarised into the Report on Actions template (CQC has provided in the documents) and this is referred to hereafter as our action plan
- ESHT is expected to complete this action plan and respond to the CQC by 21/02/2023
- CQ had 4 must dos and 3 should dos. EDGH had 2 must dos and 6 should dos

Key issues: workforce and safety

We note that the comment:

> *"…not always enough staff with the right skills and qualifications to care for women and keep them safe"*

has generated significant reaction from the team. The team acknowledge that workforce pressures have led to risk-assessed contingency plans to support services that mitigate higher risk, but this is a balanced and proportionate response to managing in highly challenged circumstances - not an unsafe service.

In response to this comment, we would observe that:

- At the time the short CQC inspection took place our services were under significant pressure; vacancies rates were higher as were sickness levels (impacted by COVID), vacancy rates have since dropped to c.4%.
- The service has recently changed senior management (as the report recognises), there is significant effort going into strengthening the rigour of basic workforce processes around recruitment and training.

- We are reviewing staffing levels on our maternity units as part of the wider establishment review and it is the ambition of the Midwifery Director to urgently review the clinical team template within maternity to ensure that workforce numbers allow for the additional training required to ensure staff can be released to attend the training and to address the concerns around this highlighted by the CQC report. An initial workforce planning meeting took place on 01/02/23.

- The new leadership team have worked to create an environment where clinical staff want to join from elsewhere, where previous leavers come back to us and where staff commuting to larger Trusts stay local and can develop their career. An example of how this approach is bearing fruit can be seen in the student midwives who wish to come to work with the team after training, 100% of whom were recruited last Autumn. Furthermore, 14 WTE currently training with us and due to qualify from July 23 onwards have expressed an interest in staying at our trust. Recruiting these staff alone would enable an over-recruitment. All these considerations are driving the development of a sustainable workforce plan for the team over 2023/24.

- Alongside this focus on new entrants, the team is also looking at the more experienced members of the team to understand the impact that retirees would have on the capacity of the team and how best this can be mitigated as part of our recruitment and retention planning.

- Additionally, the Midwifery team has agreed a strengthened governance model that enables the review of detailed information and data, which will enable a better understanding of patient risk assessment, rota planning and training statistics.

From detailed reading of the report, it remains unclear what evidence has been relied upon in order to derive the observation around safety. It is not the view of the Chief Nurse, Director of Midwifery and Head of Midwifery that this service is “unsafe” – indeed, as noted in the last paragraph of page seven, contingencies (such as temporarily closing the Midwifery Led Unit and diverting patients to the Conquest maternity service) were put in place precisely to ensure that the service we offered during times of constrained resource were safe.

In the absence of a clear evidence base for the comments on safety in the report, perhaps this short-term reallocation of maternity teams to one site has driven the wording about “not always enough staff…”. As noted, the team is developing a workplan for 2023/24 to address staffing in a way that will both free up teams to attend training and enable cover on both sites.

Findings by site and progress made to date

The report lists an extensive set of both positive and negative findings at each site and makes recommendations that it expects the team to follow up. These recommendations from the CQC are summarised as either must do’s or should do’s and differ by site:

EDGH (Midwifery Led Unit)	
Must do	**Should do**
• Ensure prioritisation score to risk assess women calling the triage line and on arrival in the day assessment unit and which monitors waits • Ensure enough staff to ensure services can run effectively	• Ensure training for level 3 safeguarding meets 90% target • Ensure training compliance for life support, transfusion and mental capacity act aligns with Trust targets • Consider stickers to show equipment has been cleaned • Ensure access to policies/procedures quickly via intranet • Ensure all midwives are trained on how to evacuate the pool • Ensure all staff receive their annual appraisal

It is noticeable that the EDGH site only received two must dos following the inspection, the second of which the CQC report acknowledges is currently a national issue, rather than an ESHT-specific concern.

Regarding the first must do at EDGH, we have already implemented a new triage telephone line which provides day unit staff and service users with live information. The team now use a risk assessment matrix for callers to the triage line. All information from the triage phone call is logged on the BadgerNet IT system. Arrival and waiting times at the day assessment unit are currently logged on a spreadsheet, however this will be moved to BadgerNet shortly (awaiting a BadgerNet network update).

Turning to the Conquest report, while the must dos echo the EDGH issues re: training levels for staff, and the functionality of the triage telephone line, there is no must do regarding staffing levels.

Conquest	
Must do	**Should do**
• Ensure prioritisation risk assessment tool on the triage telephone line in the day assessment unit (DAU) • Ensure those waiting for an assessment in DAU have arrival times noted and are reviewed with observations noted • Ensure medical/midwife staff meeting level 3 safeguarding meets 90% target • Ensure training compliance for life support, transfusion and mental capacity act aligns with Trust targets	• Ensure SOP for DAU and staff are aware • Ensure all medicines are stored safely and securely • Review all incidents within 72hrs

As regards to progress made, the risk assessment tool in use is the same as that in EDGH.

Regarding patients waiting in DAU, the BadgerNet system is currently being updated to include the functionality to provide arrival and waiting times (and when patients are seen by a doctor), in the interim this data is currently recorded on a spreadsheet. The implementation team has a rollout plan for training to support the take-up of this across all our clinical teams. The Birmingham Symptom-specific Obstetric Triage System (BSOTS), that the Q2 maternity overview report mentioned to Board members has been adopted by approximately 70 maternity units in the UK, with implementation imminent within ESHT.

BSOTS enables teams to assess women and birthing people presenting with unexpected pregnancy-related problems or concerns and then allocating a colour code, so staff can see at a glance who needs to be prioritised. An initial early evaluation showed that BSOTS increased the number of women and birthing people seen within 15 minutes of attendance to maternity triage from 38% to 53% and the system also appeared to reduce the time between attendance to medical review for those who required it. It also provides a standardised assessment system across all maternity units nationally.

As regards the training, a concerted effort is now being led by the Divisional Director of Operations with clinicians and the Head of Midwifery for our midwives to ensure these numbers increase as per the Trust target.

Next steps

The Trust is required to complete its action plan and respond the CQC by 21/02/23. The action plan template provided by the CQC reflects only the must dos in the Conquest and EDGH inspection reports. As shown in the progress sections above, several of these areas have already been started by the teams.

The team is keen to ensure that the action plans go further than just the must-do's and address the longer-term structural issues (e.g. workforce) and also the should-dos in the plan. The action plans will be shared with the CQC by 21 February 2023.

3. NHS Maternity Services Survey 2022 Benchmark Report

Methodology

The NHS Maternity Services Survey[3] is a national event commissioned by the Care Quality Commission, with individuals over 16 are invited to participate. The survey is split into three sections antenatal, labour and birth and postnatal care, carried out every 2 years (annually from 2019) and asks women and birthing people a range of questions about their experience of choice and continuity of care in maternity services in hospital. In total 114 (94%) of the 121 participating trusts submitted attribution data.

At a national level the 2022 maternity survey shows that people's experiences of care have deteriorated in the last 5 years. Trend analysis was carried out on 26 evaluative questions on data between 2017 and 2022. Of these questions, 1 showed a statistically upward trend, 4 showed no change and 21 showed a statistically downward trend. Furthermore, of the 21 questions with downwards trends, results for 2022 were at the lowest point for the 5-year period in 10 cases.

Results for 18 of these questions declined during the height of the pandemic (2021). Out of the 18 questions that saw a large decline in experience in 2021, 5 have seen a further decline in 2022 and 6 have stayed level with 2021 results. This indicates that some experiences of maternity services haven't yet recovered to pre-pandemic levels including care during labour and birth and postnatal.

Who took part at ESHT

- 300 pregnant women and birthing people were included, 146 responded (49%), an increase of 12% from 2021 survey
- 41% of respondents gave birth to their first baby, 96% were heterosexual (4% bisexual,1% gay/lesbian)
- Ethnicity: 87% white, 7% Asian,3% multiple ethnic groups,3% other ethnic groups. 7% 19-24, 27% 25-29, 39% 30-34, 27% 35 and over.

ESHT Headline results

Number of questions ESHT performed better, worse, or about the same with most other trusts	
Much better than expected	0
Better than expected	0
Somewhat better than expected	3
About the same	47
Somewhat worse than expected	1
Worse than expected	0
Much worse than expected	0

Comparison with results from 2021	
Statistically significant increase	1
No statistically significant change	41
Statistically significant decrease	2

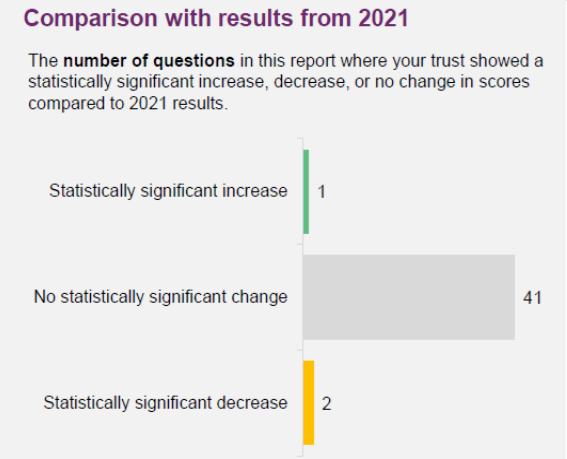
[3] NHS Maternity Services Survey 2022 Benchmark Report

Best and worst performance relative to ESHT Trust average	
Top 5 scores	**Question**
Postnatal care	D2. On the day you left hospital, was your discharge delayed for any reason
Labour & birth	C6. Were you involved in the decision to be induced
Antenatal care	B3. Were you offered a choice about where to have your baby
Care after birth	F12. Were you given information about any changes you might experience to your mental health after having your baby
Antenatal care	B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby
Bottom 5 scores	**Question**
Labour & birth	C5. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour
Postnatal care	D7. Stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted
Labour & birth	C24. During your labour and birth, did your midwives or doctor appear to be aware of your medical history
Labour & birth	C23. After your baby was born, did you have the opportunity to ask questions- about your labour and birth
Labour & birth	C22. Did you have confidence and trust in the staff caring for you during your labour

Benchmarking

This shows how each trust scored for each evaluative question in the survey, compared with other trusts that took part and allows ESHT to compare ourselves against other organisations for antenatal, labour and birth and care in hospital after birth. Overall, for all three areas ESHT remained about the same.

Summary of findings



Conclusion

A plan of action has been prepared by the head of midwifery and Director of Midwifery to improve systems as identified above. This includes a quality improvement program to review the induction of labour pathway, which commenced in November 2022. Partners can stay whilst on the delivery suite and by exception on the postnatal ward where additional support is required. The new electronic records system enables maternity staff to have access to service user's medical records. The Head of midwifery has recently introduced a daily senior clinical walk around the maternity unit, allowing service users access to the senior team for questions, ESHT also have a robust debriefing service available to all. Progress against this plan will be reviewed at the monthly internal divisional governance meeting and internal performance review with the executive team.

Ockenden Assurance & Insight Visit Report
ESHT progress against Action Items
V1.3 January 2023

KEY
Blue - Complete
Green - on target for completion
Amber - unlikely to reach target

	Recommendations	Requirement	Action Required	RAG Status	Lead/Date for completion	In progress/completion comments
1	Trust to work with the LMNS & Region to ensure there is an effective system wide process to attain external reviewer's opinion on all perinatal deaths and neonatal brain injury.	Limited external reviewers. Midwifery reviewer attends: PMRT, professional reviews. SI submitted to external reviewer, L3 discussed at LMNS once complete.	Link with LMNS and central governance to set up a system of external reviewers, including maternity, obstetrics and neonatology, anaesthetics		BL - process agreed for implementation with immediate effect.	Meeting held Oct 22 to discuss implementation of a robust process, database now available with external reviewers by profession. Further meeting with Trust Governance Lead (Margaret England). Agreed to implement review process with external reviewers with immediate effect.
2	The Trust are encouraged to create opportunities that provides the regular contact for the NED & MVP to meet and share ideas.	NED attends bi monthly MVP meetings. To plan regular walkabouts from October 2022	DOM will discuss further opportunities with NED and MVP Chair.		BL - met with NED safety Champion 21/10/22 and agreed annual engagement plan.	Deep dive completed October 2022 with MVP. Annual plan agreed, bimonthly meetings in progress, 15 steps walkabout date TBC.
3	Trust to add the role descriptor for the NED to the Maternity Board ToR and set out the role of individual key members.		BL/DP TORS reviewed, included role descriptors, approved at Maternity Board 9/9/22		BL - completed - available in S drive (maternity Board TOR's)	Completed 9/9/22
4	A robust solution is urgently required to address the current issues around staffing levels and the unsustainable on call cover provided by community midwives .	In progress: full service on call provision, consultation to be launched Dec 22 complete by Feb 23		Target for completion Feb 23	AN - Entire process due for completion Feb 2023	On track for completion by planned date. Listening events completed October/November 2022
5	Trust to specify the timing of the consultant led ward rounds within the 'Duties of the Hot Week Consultant' document in line with the Ockenden recommendations	Ward rounds at 08:30 and 17:30 hrs daily, added to duties of the hot week consultant guideline Sep 22.	Action completed		BL/NR - completed - available-within roles of the hot week consultant guideline	Completed July 2022
6	Trust SOP / Guideline where the specification that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead to be shared with the LMNS and Regional Maternity Team.	Personal Care Guideline contains details. No specific SOP or guideline for complex as whole, have individual guidance dependent on specific complexity - DP/ GC currently working on this guideline Maternal medicine hub guidelines in progress Badgernet provides triggers for midwives booking women and birthing people for referral of varying conditions and referral timings	Action progressing, target completion date: end October 22, approval via governance process by end of Nov 22.	Completed 13.1.23	NM (consultant Midwife) - progressing as planned	Areas of the guidance required review by paediatrics - now completed - guideline scheduled for November Governance & Accoutnabilty Meeting. 10.1.23 AN - update requested as guideline has not yet been ratified. 13.1.23 guideline ratified and published to trust intranet.
7	The Trust to review the guidance on personalised care and include that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. And to specify the minimum expectation on the referral to appointment time with the consultant for women with complex pregnancies.	Currently being updated in line with action 6	Action progressing, target completion date: end October 22, approval via governance process by end of Nov 22.	Completed 13.1.24	NM (consultant Midwife) - progressing as planned	Guideline scheduled for November Governance & Accoutnabilty Meeting. 10.1.23 AN - see above update. 13.1.23 guideline ratified and published to trust intranet.

8	Trust to ensure all staff are aware of and have access to guidelines. Ensure guideline embedded into staff clinical practice	Currently available on the Extranet. Information shared on medical induction. Access covered in mandatory study days annually.	Trust to improve Extranet documentation search function.	Target date Dec 22 - complete see update	Transformation midwife (AN)	Raised through IPR in Oct 22, remains challenging to access guidelines and policies. For further discussion at IPR Nov 22. 1. Setup new 'Maternity policies, guidelines and SOPs' page on the Maternity area on our Extranet, which has direct links to all maternity policies and guidelines and SOPs, under two headings, for ease of use: http://nww.esht.nhs.uk/task/maternity/maternity-policies-guidelines-and-sops/ - staff advised 2. Reviewed SOPs and guidelines for most frequenctly used search terms to improve effectivness of search funcation (GC) 10.1.23 AN - email sent to all staff advising (with illustrations) how to access guidelines on intranet, using key words/phrases.
9	Inclusion of the definition of Antenatal Risk Assessment to be included within the Trust guidance.	In progress	To include in personalised care plan	Completed 13.1.24	Nicky Mason	Guideline scheduled for November Governance & Accoutnabilty Meeting. 10.1.23 AN - uupdate in row 6 above 13.1.23 guideline ratified and published to trust intranet.
10	Trust to continue to work with the LMNS regarding their QI project of reintroducing the My Choices for pregnancy, birth and beyond.	PCSP action taken forward within the WASP training programme. This is personalised care training provided by an external team (12 ESHT applicants MW's and MSW's) on the course.	QI plan to relaunch the PCSP. Posters prepared to put up in staff areas and we VLOG to support staff re discussing PCSP at each contact. To set up procurement order hard copies. Action for : Deputy transformation lead	Target for completion Nov 22.	Interim Transformation lead to commence and complete November 2022 RP/AN	Progressing as planned by Lead Transformation Midwife Xanthe Hayes - new interim lead to complete this action Nov 2022 10.1.23 AN - update: interim transformation lead in post from end October. Has been concentrating on MSW Pathway. Have requested update on progress for this action.
11	Trust to share the link to the 'Useful Information and Leaflets' web page once updated with the Regional Team.	Maternity website is currently being updated as part of digital workstream. Videos completed for updated unit tours specialist discussing roles and services offered, currently being edited. MVP involvement throughout this process	To create QR codes for A/N and inpatient waiting areas for direct access to videos = website access. Leaflets currently being updates. Action for completion Oct/Nov: RP: Maternity Service manager	Target for completion Nov 22.	Interim Transformation lead to commence and complete November 2022 RP/AN	progressing as planned by Lead Transformation Midwife Xanthe Hayes - new interim lead to complete this action Nov 2022 10.1.23 AN - update: Interim transformation lead is no longer involved with development of website. MVP linked with communications team to review structure. Update requested from Rob Toth.

East Sussex Healthcare NHS Trust

Mortality Report – Learning from Deaths 1st April 2017 to 30th June 2022

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

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

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

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

Executive Summary	The current "Learning from Deaths" report details the April 2017 – June 2022 deaths, recorded and reviewed on the mortality database. Learning disability deaths are subject to external review against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process in order to mitigate any risk.

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

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard June 2022-23

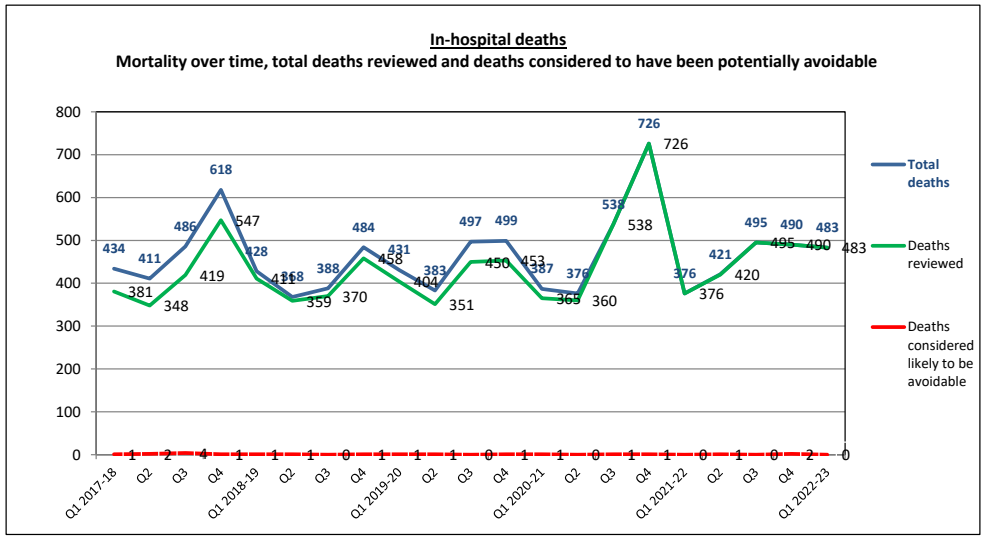
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 12/01/2023)

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	2022-23	Q1

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
140	155	140	155	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
483	490	483	490	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
483	1782	483	1781	0	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	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

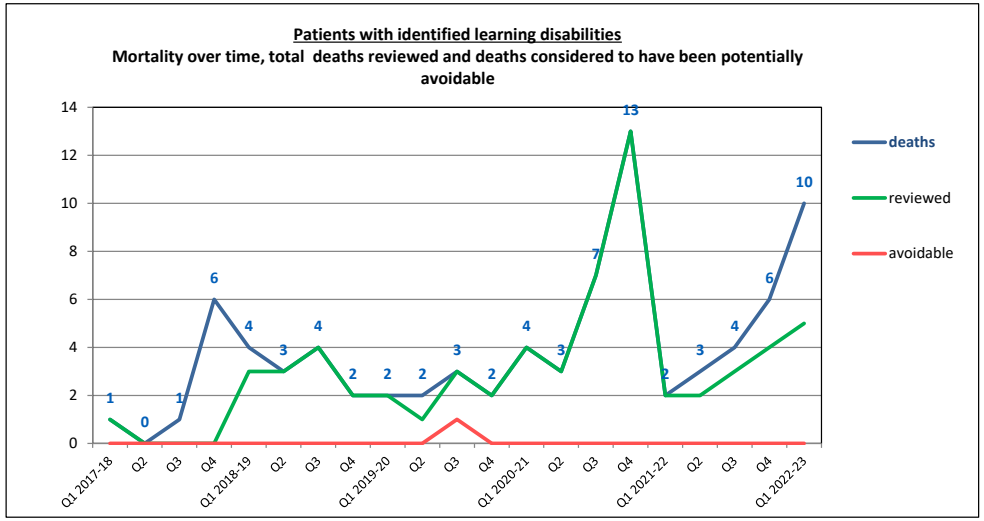
Data above is as at 12/01/2023 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were two care concerns expressed to the Trust Bereavement team relating to Quarter 1 2022/23 deaths. Neither were taken forward as complaints.
Complaints - There was 1 complaint closed during Quarter 1 2022/23 relating to 'bereavement' in hospital. The overall care rating on the mortality database is '4 - good care' .
Serious incidents - There were no severity 5 serious incidents raised in Q1 2022/2023..
As at 12/01/2023 there are 515 April 2017 - June 2022 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 12/01/2023)

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	2022-23	Q1

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	3	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
10	6	5	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	15	5	11	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.

East Sussex Healthcare NHS Trust

ICP Strategy Update

Purpose of the paper	This paper is intended to update the Board on the development of the ICP Strategy and the impact and opportunities it brings for the Trust. The strategy entitled "Improving Lives Together" was approved at the ICP Assembly on 14th December 2022. The Trust Board have previously discussed and endorsed a draft version of this strategy on 13th December 2023.					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Joe Chadwick Bell (CEO, Sponsor), Simon Dowse (Head of Strategy, Author)					
Governance overview	This paper has not been discussed in another forum, however previous drafts of the ICP Strategy have been discussed with Executives, and by the Board. They have also been shared widely across the across the system, including with the East Sussex Health and Social Care Executive, and Health and Wellbeing Board.					

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

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

Recommendation	To note the contents of the ICP strategy "Improving Lives Together", the impact for the Trust and the next steps in terms of developing a Sussex wide Strategic Development plan which form the basis of the East Sussex place-based delivery plan.

Executive Summary	"Improving Lives Together" is attached as an appendix to this paper. The document has been through a number of iterations and has been developed to take into account feedback from a number of different forums. It demonstrates the system have been listening to the views of local people, service users and carers; ensuring the priorities contained within it are aligned to their feedback. The strategy highlights that 'Joined Up Community Working' will be the leading 'thing that will be different' and this links well with the latest views at East Sussex Place regarding the areas that need to be improved upon in the future to support delivery of the 'success factors' that follow in the section. Following approval of this strategy at the ICP Assembly work is underway to develop a Sussex wide strategic development plan. This will form the basis of the three place-based delivery plans and this expectation was discussed at the East Sussex Health and Wellbeing Board on 13th December and the approach to developing this is being agreed by system partners. The strategy summarises the key areas of focus, which will respond to the health and care needs of our Sussex population and will underpin the delivery plans for each of the three places. For the coming year (2023/24) there will be a focus on four areas: • Increasing access to and reducing variability in primary care services • Improving response times to 999 calls and reducing A&E waiting times • Reducing diagnostic and planned care waiting lists • Accelerating patient flow through the system and discharge from hospitals

	To support the development of the place-based delivery plan the East Sussex Health and Care Partnership (of which ESHT is a key partner) will continue to work together, noting that CVD, Respiratory, Frailty, Mental Health and Children & Young People's health are priority areas. There will also be a focus on expanding the integrated community model and agreeing how we collectively work together in our communities, across primary care, community, healthcare, education, social care, mental health and the full range of local voluntary and community and housing organisations, driven by a deeper shared understanding of local needs. Work is underway with partners to refresh the place-based governance structure, ensuring it is fit for purpose, reflects the priority workstreams and is able to support the development of the place-based delivery plan. There are strong relationships across East Sussex Place and as an organisation ESHT are well placed to lead and influence the development and delivery of the place-based plan ensuring it is aligned to our organisational priorities and strategy as well as to those of the ICS.

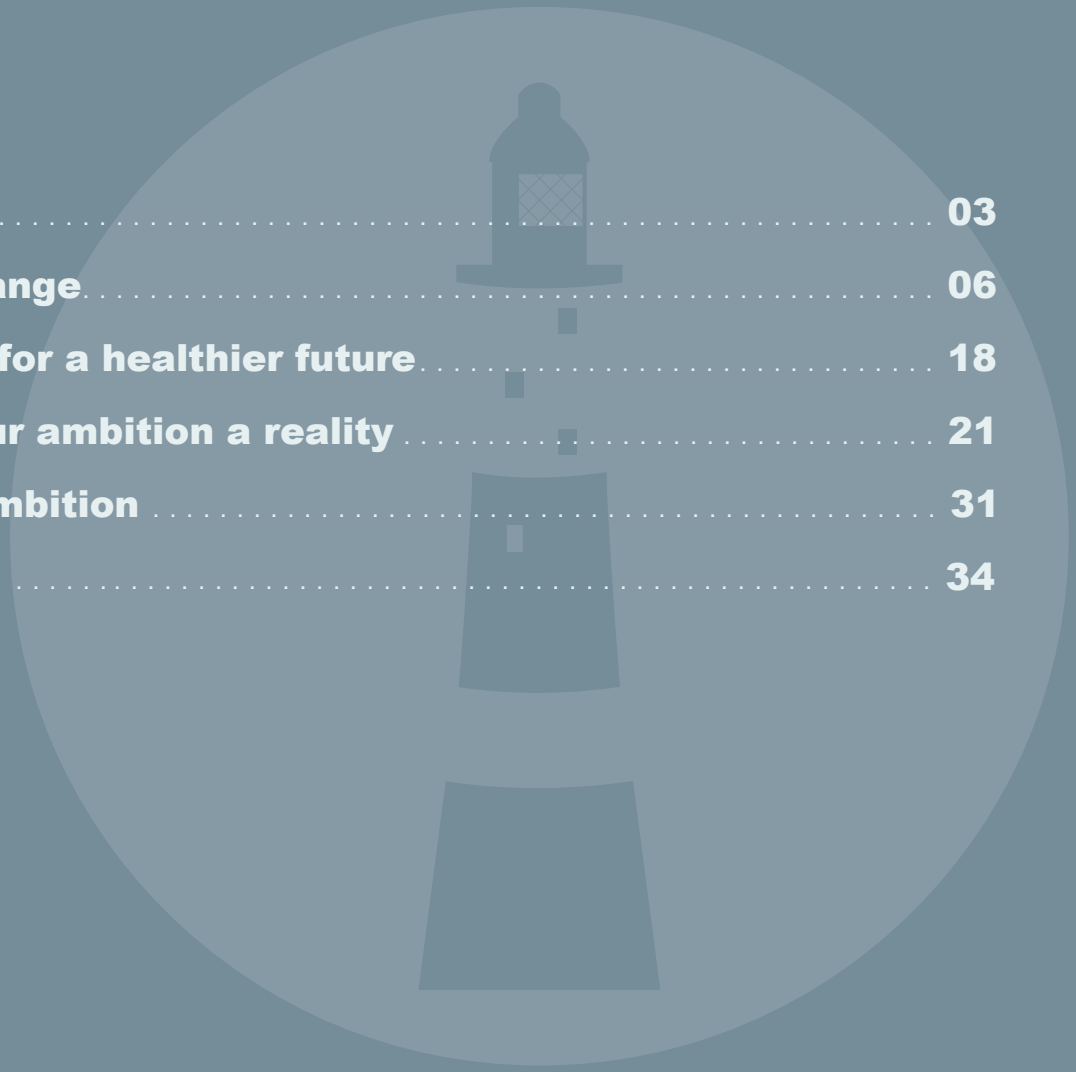
Next steps	To note the contents of the document and the key next step being to engage closely with the development of the East Sussex place-based delivery plan.

Sussex Health&Care

Improving Lives Together

Our ambition for a healthier future in Sussex

Contents



Our ambition for a healthier future

We want to improve the lives of people living across Sussex now and in the future and we will be working differently with our communities to make this happen. We want people to thrive and be the best they can be; to be healthier and feel supported; and have the best possible services available to them when needed.

We know this is not happening often enough at the moment, particularly for those who are the most disadvantaged in our communities.

Not enough people are being supported to live healthier. Too many people are living in poor health. And too many people and their carers are waiting too long for treatment or care. This is despite our dedicated health and care staff working hard every day to give local people the best care they can.

In some areas, this has been the case for many years, but things have been made worse by the impact of the pandemic and the current pressures on people's lives due to the cost-of-living crisis.

A lot of work has already taken place across health and care to make improvements and we have made some progress for our population. But this has still not gone far enough for some people and more needs to be done.

A lot of the issues we face can only be resolved with long-term change. We need to think and work differently to make a bigger difference to local people. And this needs an even greater and longer-term ambition to build on what we have done in the past.

Improving Lives Together represents that ambition.

We are building on the Health and Wellbeing Strategies we have in place across Brighton and Hove, East Sussex and West Sussex that focus on the priorities across our local populations.

In addition to this, we have agreed the areas that will make the biggest positive difference to people's lives that can be best achieved by working across the whole of Sussex. These are:

- **A new joined-up community approach to health and care.**
- **Growing and developing our workforce.**
- **Improving the use digital technology and information.**
- **Maximising the power of partnership working.**

We now have a better opportunity to make our ambition a reality because of the different way we – the organisations responsible for planning, providing, supporting and influencing health and care - are working together.

We will be strengthening how our organisations work formally in partnership across our populations in Brighton and Hove, East Sussex and West Sussex - what we call working at "place". This is where our organisations have already been working to better join-up care and take positive action, co-ordinated through three Health and Care Partnerships whose work is overseen by Health and Wellbeing Boards.

We cannot do this alone though and will be working with local people, our communities, and our staff to make it happen. We will all need to be committed to making the changes we want to make and help support each other to do so.

By working together in this way we can improve lives now and in the future.

Sussex Health and Care Assembly

Who we are

The Sussex Health and Care Assembly is a formal joint committee set up between NHS Sussex, Brighton & Hove City Council, East Sussex County Council and West Sussex County Council. Its membership includes representatives from universities, voluntary and community organisations, Healthwatch, further education, housing and local enterprise, across Sussex. Although each organisation is responsible for decisions about its own priorities and resources, we want to use the approach outlined in Improving Lives Together to keep us focussed on the things we can only achieve well by working together. You can read more information on the Assembly here.

CLICK

About our Health and Wellbeing Boards and Strategies

There are three Health and Wellbeing Boards in Sussex covering Brighton and Hove, East Sussex and West Sussex. They have a statutory role to bring together representation from local government, including borough and district councils, local NHS organisations, Healthwatch and voluntary, community, social enterprise organisations, and other key public services to assess needs and agree plans, focussed on improving health, care and the overall social and economic wellbeing of their populations.

The Health and Wellbeing Board Strategies use local evidence, data and insight to set out the priorities for improving health and wellbeing of their populations, responding to the distinct issues and challenges in these places.

There are three Health and Care Partnerships that support the Health and Wellbeing Boards to deliver these strategies. The additional improvements we want to make in Improving Lives Together aim to support, build on, and accelerate these local priorities.

Brighton and Hove Joint Health and Wellbeing Strategy

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy

West Sussex Joint Health and Wellbeing Strategy

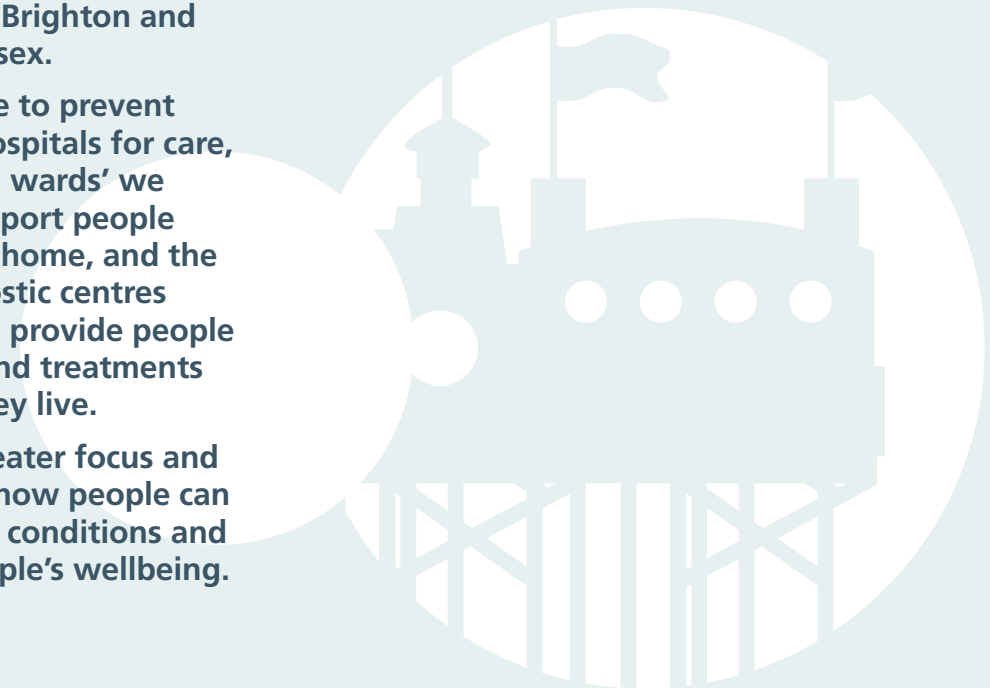

1.
Where we are now:
Why we need to change

The majority of people in Sussex receive good quality support, care and treatment most of the time. Satisfaction rates are still high among those using services and a lot of work has taken place to improve health and care over the last few years that has brought real benefits.

This includes giving people better and quicker access to the right services when they need them. For example:

- **We are creating more appointments at GP practices at more convenient times of the day.**
- **We have improved how people get urgent care by introducing Urgent Treatment Centres at hospital sites and expanding the 111 service.**
- **There has been an expansion of mental health services to include a single point of access service in West Sussex, to go along with that already in place in Brighton and Hove and East Sussex.**
- **More is being done to prevent people going to hospitals for care, such as the 'virtual wards' we are creating to support people and their carers at home, and the community diagnostic centres being rolled out to provide people with tests, scans and treatments closer to where they live.**
- **There has been greater focus and improvements on how people can manage long-term conditions and on supporting people's wellbeing.**

During the Covid pandemic, all health and care organisations and staff worked together, and with our communities, to rapidly do whatever was needed to keep local people as safe and well as possible. Many of these ways of working have been maintained and improved, and the partnership working and learning from the pandemic has continued. We successfully rolled out the biggest vaccination programme in history and to date have delivered more than 3.8m jabs to keep people protected thanks to the efforts of health and care staff, and our partners.



Case study:

Supporting people at home during Covid

The Covid Oximetry at Home (CO@Home) and Covid Virtual Ward services were rapidly rolled out from December 2021 as part of the Sussex response to the pandemic. These supported patients to manage their Covid symptoms at home using simple technologies, that identified deterioration early. Patients were monitored virtually three times a day and clinical questions from doctors and healthcare professionals were sent via a portal, text, email or telephone call. Feedback shows the simple equipment and flexible contact methods made it easy for patients and their carers to monitor and report on their health and worked well for patients with learning difficulties, sensory impairment and mental health conditions, as well as those for whom English is not their first language. Across five months, over 2,100 patients were cared for by the services.

People are telling us things need to change

Despite the good work to improve and maintain high quality health and care, local people are telling us they are not always getting what they need, when they need it.

We are constantly hearing feedback from individuals, communities and staff and we need to listen and respond to what they are saying. A lot of feedback is positive, but we also hear a lot about areas that need to improve. Every person has a different experience and story to tell, but there are common themes people keep telling us:

People say we need to improve access to services

"Getting to see the right service can be slow, inaccessible and makes you reluctant to ask for help. You don't want to bother emergency services which are already stretched and not the correct first point of call, so you just muddle through and feel unwell."

People are finding care disjointed and a confusing 'system'

"Services can be disjointed and appointments often seem unnecessary. Some services could be made much more accessible by being community based."

"My mother has a complex condition, both mental and physical. The biggest challenge has been dealing with all the different teams, being batted around, and no one really taking responsibility. You don't want to have to repeat your situation with each person you come into contact with. You can feel like you're going back to square one."

"I am carer for my husband who has Alzheimer's. I struggle to get help as the whole process from diagnosis is too confusing. You end up feeling you have been left to get on with it."

People need more involvement in their own care

"Someone's health belongs to them, not to the system. A person knows their body and mind best even if they can't diagnose what's wrong. They know what motivates and disincentivises them. A system built around the needs and preferences of an individual is more likely to see that person fully engage with it."

People need more focus on their individual needs

"I think the thing that gets missed is the individual person – what people actually need for them beyond a one size fits all. That's where people fall through the gaps."

People need better access to information

"I know the information I need is out there but I either cannot find or access it. This is a problem that other family members have faced."

People need support for all aspects of their lives

"I think you should be working with local activity and social groups to help get people out in their local community to show that people can help them."

We need to better support our workforce

"Tackling the issues and supporting local people better can only be done if the workforce is sufficient and encouraged, not stressed to the point of leaving the service or becoming ill themselves."

"I work in healthcare and don't really feel I can progress beyond my current role. I've done the same thing for many years and would like to develop and learn new skills but I don't know how best to do it."

How we have engaged with local people

We have collated feedback from local people over the last two years to help shape our ambition. This includes:

Direct feedback from

18,000

people.

500

interviews and direct feedback through partners, including Healthwatch.

1,440

survey responses on our ambition priorities.

800

individual conversations in public engagement events during the summer and autumn of 2022.

Face-to-face and virtual workshops with

420

people.

Online communication that has reached more than

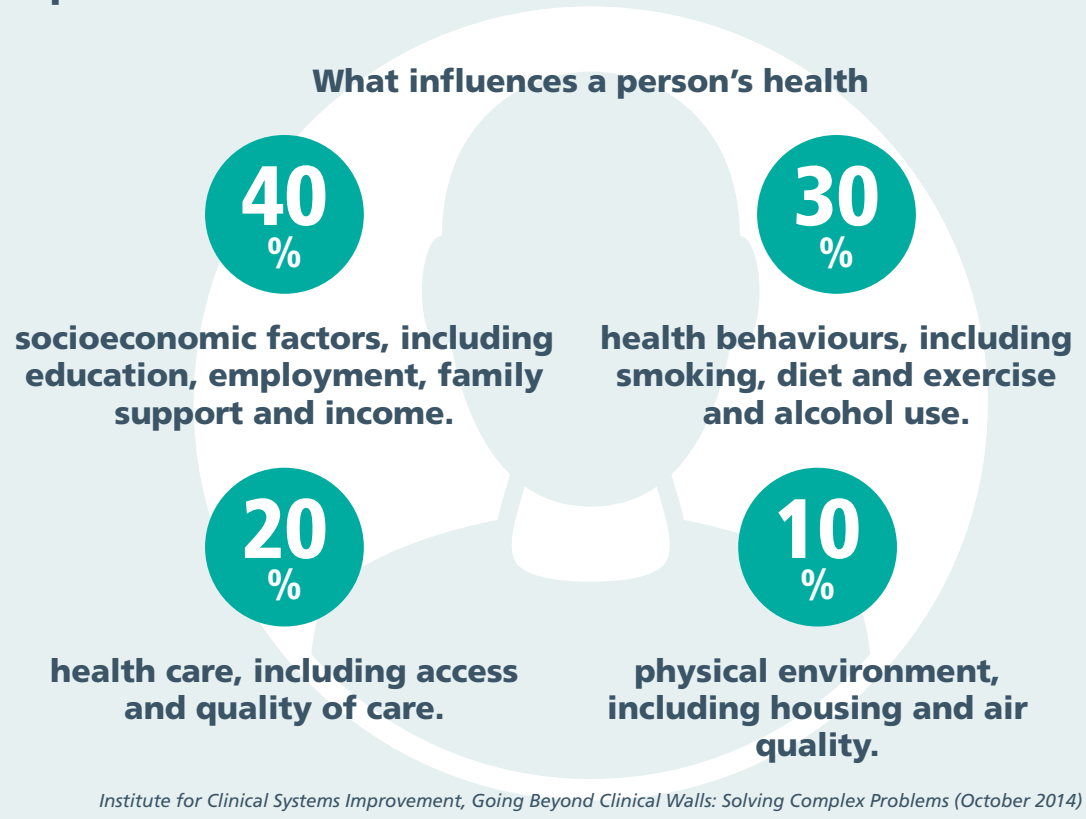
200,000

people across our website, social media and podcasts.

Engagement with communities who experience health inequalities and marginalised groups, working with the voluntary and community sector.

Understanding the reasons behind the need to change

More people living across Sussex now need more support, care and treatment more often and the services currently available cannot keep up. This is causing some people to get sicker, experience delays and is putting staff under more pressure. We need to understand what the reasons are behind this so we can tackle them and make improvements.



Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Across Brighton and Hove, East Sussex and West Sussex, there are unique strengths and challenges, which contribute to differences in the overall health of their populations. This informs the different approaches being taken in the three Health and Wellbeing Strategies and other local plans. There are also common themes across Sussex that we need to tackle and improve.

Different factors affecting health

Many factors influence a person's health and wellbeing, most of which they are unable to control or improve themselves without support. Caring can also have a significant impact on health and wellbeing. 60% of carers report a long-term health condition or disability compared to 50% non-carers (Carers UK analysis of GP Patient Survey 2021). Many different organisations are responsible for influencing these factors and they have not always worked in a joined-up way in the past. To make improvements, we need to consider all the factors and make sure all the organisations are working more closely together.

Growing and ageing population

We have a growing population, with the main reason being that more people are coming to live in Sussex. We also have an ageing population. This means more people are needing more care and support more often.

Brighton and Hove

292,000
people live in Brighton and Hove.

The population is predicted to increase by
3%
by 2032.

There is a younger population with
83%
aged under 60, but the greatest population increase is expected in the 65 and over age group.

East Sussex

559,000
people live in East Sussex.

The population is predicted to increase by
4.1%
by 2032.

There is a higher proportion of people aged 65 years and over compared to other places in the UK and over half the future increase in population is expected to be in this age range.

West Sussex

868,000
people live in West Sussex.

The population is predicted to increase by
5.3%
by 2032.

There is a higher proportion of people aged 65 years and over compared to other places in the UK and over half the future increase in population is expected to be in this age range.

Living with long term conditions

Many people are living with long-term conditions that are affecting their day-to-day lives and need to be better supported to manage their condition. Their carers also need to be supported. The common causes across all our populations are:

- **Respiratory problems**
- **Mental health problems**
- **Lower backpain and joint problems**
- **Cardiovascular disease**

Health inequalities

There are avoidable and unfair differences in health between different groups of people across Sussex that we need to reduce. There are many reasons for 'health inequalities', including disability, employment, where someone lives, income, housing, education, their ethnicity and their personal situation.

People living in more deprived areas have worse health and outcomes and there are big differences in life expectancy across Sussex which matches deprivation. The greatest levels of deprivation in Sussex are along the coast and in South West Crawley.

Brighton and Hove

The difference in life expectancy between the most and least deprived areas is

9.9 years & **7.7 years**

for men **for women**

East Sussex

The difference in life expectancy between the most and least deprived areas is

more than **almost**

11 years & **10 years**

for men **for women**

West Sussex

The difference in life expectancy between the most and least deprived areas is

14 years

for both men and women.
This is the largest differences seen in Sussex.

The impact of Covid and cost-of-living

The Covid pandemic, and the lockdowns we lived through, impacted on people's health and wellbeing in different ways. As a result, we have seen:

- **More children needing support for mental health issues.**
- **Increasing alcohol consumption, smoking and obesity among adults.**
- **Physical and mental wellbeing of older people getting worse.**
- **Waiting times for procedures and treatment growing.**
- **Sicker patients coming into hospital.**
- **Inequalities made worse for some people, including ethnic minority communities.**
- **More health and care staff leaving the profession.**

The current cost of living crisis is also having an impact on people's wellbeing and more are likely to need support and care as a result in future.

Why services cannot keep up with the need

There are a number of reasons services are not always able to keep up with the growing need. These include:

How services are arranged and organised:

Services are currently run by different parts of the NHS, local authorities and other organisations and many people need support and care from more than one service at a time. Services do not always work seamlessly, which means they can sometimes feel disjointed, slow, and people have to repeat their stories many times.

Not enough emphasis on prevention:

The majority of health and care services are focused on treating and supporting people when they become ill. This is often necessary but there is more that could be done to focus on helping to prevent people becoming ill in the first place.

Not making best use of digital:

We have been developing new ways of using digital technology over the last few years to improve health and care services. But we are still not using it in the best possible way and not tapping into all the benefits it could bring.

Limited money and facilities available:

There is a limited amount of public funding available for health and care and this has an impact on investment in services. There is not enough money available to do everything we ideally would want to do, so we have to get the best value out of the funding we have. We are still using ageing buildings in some areas, which can make it difficult to provide high quality care and we need to think differently around how we can best use the buildings and land we have.

Our workforce challenge

When we talk about workforce, we are describing those that keep people safe and who deliver care and support, either through paid employment or volunteering. Working in health and care is incredibly rewarding and those that do want to give the best possible care, in the best possible way. They are currently not always able to do this because of the growing pressure on services and the way some services are run. There are three main issues we need to tackle:

- **Retaining our staff:**

The increasing pressure, and the lasting impact of their efforts during the pandemic, has resulted in some staff being stressed, overworked and tired, which is resulting in more going off sick and leaving health and care professions.

- **Recruitment:**

We are currently not able to recruit enough health and care professionals to cover vacancies in our services and it takes time to train and develop future staff. Housing is also very expensive in some parts of Sussex, which can mean some staff are not able to afford to live locally and makes it more difficult to recruit and keep a local workforce.

- **Development:**

We are not doing enough to support staff to develop new skills which can be used in the best possible way across different teams and services.

Other areas we need to improve

Alongside our commitment to give greater support to our most disadvantaged people and communities, we have agreed three other areas that need particular focus:

Children and young people

Our early years have a big impact on the rest of our lives. More children and young people are needing help and care, and the issues they have are more complicated and severe than they were, but services are not always able to meet this growing need. We have to give more focus on our children, young people and families, to better support them in all aspects of their lives. This includes the environment they grow up, their education, and the support around them. We need to give particular focus to children in and leaving care, those who need support to keep them safe, and young people as they become adults.

Unpaid carers

Unpaid carers play an important role and on average have poorer health than people who are not carers. Over 10% of adults across Sussex say they provide unpaid care to a relative or friend. Many carers do not get the support they need and we need to do more to help them maintain their own health and that of those they are caring for.

People who feel lonely and live in social isolation

The feeling of being alone and a lack of social connections can have major impacts on someone's health and wellbeing. This is an issue for people of all ages, but particularly for our older population, and we can make a big positive difference by giving them more support.

2.

Where we want to get to:

Our ambition for a healthier future

We are taking collective action to respond to what local people are telling us and to tackle and improve the issues.

Our ambition is to improve the lives of people living across Sussex by supporting them to live healthier for longer and making sure they get the best possible care and treatment when needed.

To make this a reality, we have four goals we want to achieve:

- **Improve health and health outcomes for local people and communities, especially those who are most disadvantaged.**
- **Tackling the health inequalities we have.**
- **Working better and smarter, and getting the most value out of funding we have.**
- **Doing more to support our communities to develop socially and economically.**

We will do this by organisations working closer together and differently with and within our communities to support people through each stage of their lives.

We want to:

Help local people start their lives well by:

- Improving mother and baby health and wellbeing, especially for those most in need.
- Creating healthy environments for children, young people and families to grow up in.
- Supporting parents and parent carers.
- Linking health and care up in a better way with education and schools.
- Supporting good mental health for all children and young people.
- Doing more to support the most vulnerable children and young people, including those in and leaving care, and those who need to be kept safe.

Help local people to live their lives well by:

- Supporting people to look after their own health and wellbeing.
- Supporting people to live, work and play in places that promote health and wellbeing.
- Supporting people to know how they can look after themselves better when they have a health issue.
- Supporting people who have physical disabilities, learning disabilities and mental health conditions, to have good health and joined-up care and support, including access to opportunities such as accommodation, housing and employment.
- Ensuring more access to services for people who have traditionally been under-served, for example homeless people and other groups

Help local people to age well by:

- Ensuring fewer older people feel lonely or isolated.
- Helping older people to stay healthy and live independently for longer.
- Reducing the number of older people who suffer falls.
- Helping people receive good quality care at the end of their lives and to die at a place of their choosing.

Help local people get the treatment, care and support they need when they do become ill by:

- Tailoring care to support people in their own homes, or as close to home as possible.
- Supporting the health and wellbeing of carers.
- Giving them access to the most appropriate and best experts and professionals as early as possible that best suits their needs.
- Managing risk factors for long-term conditions.
- Giving greater joined-up care and support for people with long-term conditions and a number of health issues.
- Making sure people only need to use health and care services when they really need to.

Help our staff to do the best job they can in the best possible working environment by:

- Providing more support to them and creating a more diverse, inclusive and healthier working environment.
- Encouraging and supporting more people to go into health and care professions, particularly young people and students.
- Developing our staff to give them the skills they need to work more flexibly and progress their career.

3.

What we will do to get there: Making our ambition a reality

We are not starting from scratch as we look to achieve our ambition. We have our Health and Wellbeing Board Strategies and other pieces of work underway that are making improvements all the time to try to meet the immediate needs of local people.

We will now be building on this with bolder long-term action and change that aims to make a greater positive difference to local people.

This involves developing 'Joined-up Community Working' that will better meet the specific needs of local residents.

To support this, there are three 'success factors' that we need to develop and improve:

- **Growing and supporting our workforce**
- **Improving the use of digital technology and information**
- **Maximising the power of partnerships**

So how will this work and what difference will it make?

Joined-up Community Working

In future, health and care organisations will work in a more joined-up way with and within communities to better understand and respond to their specific needs. Support and services will be shaped around local people, rather than expect them to fit into the 'system'. When we say communities, we mean both the local area people live in and also communities that we know people identify with, such as those with the same interest, beliefs, or way of life.

What will be different?

This will involve a very different way of working to how health and care organisations have often worked with communities in the past. There will be three big differences:

- **Greater joined-up working:** Joined-up Community Teams of professionals and experts will work together across different organisations and within local communities to tailor support, care and treatment to what local people need. This will involve linking up all the services and organisations that influence a person's health, care and wellbeing - including primary care (GP services, pharmacy, dental and eye health services), social prescribing, community, mental health and social care services, hospitals, the full range of support provided by local voluntary and community organisations, and wider services such as public health, schools and lifelong learning institutions, leisure, housing, environment and support for business. When someone needs more specialist care and treatment, they will be better supported to get it as quickly as possible.
- **Different relationship with communities:** We want to change the relationship between health and care organisations, voluntary and community organisations, the staff providing services and those who are receiving care and treatment. We will work with, rather than 'doing to', people and communities to better understand their needs and circumstances, maximise the use of what already works well for them, and find solutions together to issues they face. This will involve greater engagement with local people, community leaders and those with lived experience.
- **Greater involvement of individuals:** Local people will be more involved in, and get more support for, their own health, wellbeing and care. People will be given more support to have the confidence to keep themselves healthy and, if they do become ill, help them manage better themselves so they can carry on living a fulfilled life. There will also be more involvement of, and support for, carers so they can stay healthy themselves and can better support the person they are caring for.

We know every community is different so there will not be a one-size fits all approach, and we will start by specifically focusing on communities who experience the poorest health and have the biggest needs.

As well as changes to how services work, this new way of working will have three differences in how we approach health and care:

- **Greater focus on all aspects of a person's life:** We will be focusing more on all the factors that influence a person's health. This will include doing more to support and contribute to local communities, such as supporting local businesses and employment, working in a more joined-up way with housing and education, the community and voluntary sector, and supporting and working with community groups and local initiatives that encourage healthy living.
- **Greater focus on supporting you to stay healthy:** We want to shift more of our effort, resource and expertise into helping people stay healthy and supporting them to continue to live a fulfilled life if they do have a health issue. This includes more of what we call 'proactive care' which focuses on prevention and not just cure. We will make sure more people get urgent, emergency and specialist care as early as possible when they need it to avoid their condition getting worse.
- **Greater focus on our children and young people:** We will focus more on supporting children, young people, families and parent carers with every aspect of their lives to help them stay healthy and get the support, care, and access to services they need when they need it. This includes more support during the early years, working closer together with schools and further education, and providing more career opportunities.

Bringing our ambition to life:

Case study on Universal Healthcare in Hastings

The local NHS is currently working with councils, community and voluntary organisations and local people in Hastings to design and develop health and care services and support in the future. A project called 'Universal Healthcare' is already underway with a number of community engagement workshops taking place to understand the needs of local people and help shape how they can be better supported in the long term. We intend to be able to start new ways of working from Spring 2023 and this is a good example of the way we want to work with our communities in future.

Our success factors

We have three success factors – workforce, digital technology and information, and partnership working – that need to be improved and developed. Without these, there will not be enough staff and the right expertise to give local people what they need, and services and organisations will not work in the best way.

Growing and supporting our workforce

We want to support our staff and volunteers to do the best job they can by growing and developing our workforce. The number of people working in health and care has grown and we need to carry on increasing staff numbers but recruiting more is not the only answer. We need to also get the best out of the staff we already have.

There are five objectives we want to achieve:

- **Working as 'one team':** We want to create a 'one team' approach across health and care, as well as the voluntary sector, other professionals and volunteers, so they can work together and across different areas to help local people get the support and care they need.
- **A more multi-skilled workforce:** We will support staff to develop new skills and expand the skills they have. This will allow them to work across different disciplines and areas and help staff to have more opportunities to progress in their careers.
- **Creating an inclusive environment:** We want to create a more inclusive working environment that recognises diversity and has a workforce that better represents the population they care for.
- **More recruitment and career opportunities:** We will encourage, and make it easier for, more young people, students, and people who have never considered a career in health and care, to work with us. We will do this by working more closely with local further education, colleges and our universities. We want to employ more local people and we will give greater opportunities for those living in the most disadvantaged areas.
- **Learning culture:** We want to create a culture where people feel valued and supported to develop their skills and expertise. We want to take a 'lifelong learning' approach where people never stop developing their skills throughout their career.

Improving the use of digital technology and information

We will build on the work that has already taken place to improve the use of digital technology. This will help staff make better decisions, work more efficiently and provide better care. It will also help local people access services more easily, to tell their story once and have more involvement and control over their own health and care.

There are five objectives we want to achieve:

- **Connecting services:** We want to connect information better across our different services to help them work in a more joined-up way.
- **Improving technology and sharing data:** We want to support organisations to improve the way they use technology and how they share data to improve the support, care and treatment they provide.
- **Supporting staff:** We want to help staff access the information they need, wherever they are and whenever they need it.
- **Giving local people information:** We want to support local people better to access and manage their own health and care information, care preferences and choice, and the way they wish to interact with those providing services and arranging appointments.
- **Supporting people to use technology:** We want to do more to help people and their carers use and know how to use digital technology that will best suit them and their needs. This will help those who do not have regular access to technology or are unsure how to use it.

Maximising the power of partnerships

In addition to working at a local level across our communities, organisations responsible for influencing health and care will be working more closely together and with other organisations for the benefit of local people.

There are three objectives we want to achieve:

- **More leadership at "place":** We will strengthen how our organisations can work together formally across our populations in Brighton and Hove, East Sussex and West Sussex, focussing on the distinct needs and challenges in our local areas. We call this working at "place" and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care, and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships to increase ways for our staff and volunteers to work together to deliver joined-up care and improve health in our local communities. More information can be found in **section 5** about how each place has made a start with this, and what we plan to do next.
- **Working across Sussex:** Our new Health and Care Assembly will strengthen how key organisations can work together formally on the complex and challenging issues that are shared across Sussex. This is a new way of working and will mean more organisations will be able to contribute to improving health and care.
- **Greater joining-up of the local NHS:** The local NHS will be doing more to join-up services in future. The NHS across Sussex is made up of 1,100 different organisations and we will be supporting them to work in a more effective and seamless way to improve the care and experience of local people.

Our ambition in summary

Our Ambition

Joined-up Communities

Success Factors

- Starting well
- Living well
- Ageing well
- Better care and treatment
- Supported staff

- Joined-up services and teams
- Working with communities
- Greater Involvement of individuals
- Focus on keeping people healthy
- Focus on all areas of people's lives
- Focus on children and young people

- Maximising power of partnerships
- Growing and supporting our workforce
- Improving use of technology and information

How this will benefit local people and staff

Achieving our ambition will bring real benefits to the lives of local people. Here are examples of what this will look like in future, based on the situations of real people living across Sussex.

Emily

Emily, 13, lives with her mum, brother and cat in a block of flats. She used to like doing gymnastics but gave it up last year and now spends most of her spare time chatting to her friends on social media. She has been feeling quite anxious recently, is having more arguments with her mum and is less keen on going to school than she used to be.

What will be different for Emily in future?

- There will be more health and wellbeing support for her at school.
- There will be more opportunities for her and her family to be supported by healthy activities, facilities, groups and services where she lives, both virtually and physically.
- There will be more and quicker access to health, care and wellbeing services if she does become ill or need support.
- She will have more opportunities to make health and care a career choice when she leaves school.

Harpreet

Harpreet, 42, is a mum of two and lives with her husband in an old Victorian terraced house. She is relatively healthy, goes to the gym whenever she can, and hasn't needed to use health and care services for a long time.

What will be different for Harpreet in future?

- She will be better supported and informed to make her feel more confident about what she and her family can do to stay healthy.
- Her family will have more access to healthy activities.
- If she does become ill, she will be able to access the right service for her at a time that is more suitable for her busy life.
- She will be able to access services, and keep better track of her own health, through digital technology, such as her mobile phone.

Dave

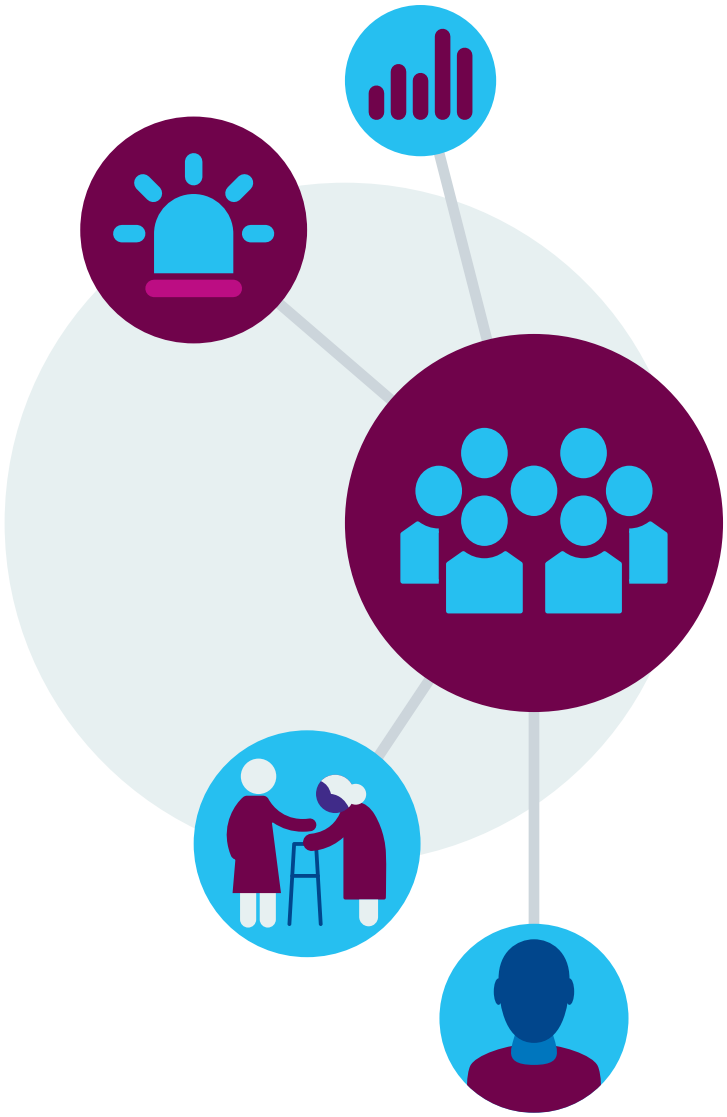
Dave, 82, lives alone and has a number of long-term health conditions. His mobility is restricted, he doesn't go out of his house very often and needs support to travel. He needs care from a number of different professionals and services and his daughter is increasingly helping to look after him.

What will be different for Dave in future?

- He will have a personalised care and support plan in place so she doesn't have to repeat his story and the number of contacts he has with services will be reduced.
- All the health and care professionals supporting him will know his needs and what is important to him.
- His daughter will be treated as one of the team supporting Dave and will also be supported herself as his carer.
- His daughter will be treated as one of the team supporting Dave and will also be supported herself to identify as a carer and get the support she needs to stay healthy and well.
- His condition and health will be regularly reviewed to prevent him from deteriorating.
- If he needs a higher level of care, this will be done in his own home through a 'virtual ward' and Urgent Community Response service.
- He will be supported to have more opportunities to meet other people socially.

4.

How we will get there:
Achieving our ambition



Achieving our ambition will need change, with how health and care organisations, services and teams work, and how communities interact with services and are involved in their own health, care and wellbeing.

We want to achieve our ambition over the next five years and we will not be able to do everything at once, with some things taking longer than others to get up and running. We need to be focused on what we can do and when. We will also need to do it in a realistic way, using the funding, staff and facilities we have available. This is alongside all the work that we continue to do every day to improve and maintain the immediate and short-term support, care and treatment local people need.

This will be a big challenge but we need to be ambitious and bold because just doing what we have always done, or what we are doing now, is not going to make the difference we want and need. This will need a collective effort and everyone will need to play their part.

How we will achieve our ambition is something we will be discussing across organisations, staff, and our communities over the coming months. We will be developing a plan that clearly sets out what actions need to be taken and will be agreeing across organisations how they will need to work differently in the future. We will engage with local people and staff to discuss what will be different for them and how they can play a role in supporting the change.

We will also be setting out how we will measure progress and success to make sure we know whether or not our ambition has become a reality.

How we developed

Improving Lives Together

Improving Lives Together has been developed with input from a large number of people. The Sussex Health and Care Assembly has been established to oversee its development and representatives have been involved in shaping what it looks like and agreeing the areas we want to focus on.

We have engaged with representatives and experts from NHS organisations, public health, social care, voluntary and community organisations, Healthwatch and other people who have an interest and knowledge of health and care.

We have used a significant amount of feedback from local people and communities from engagement carried out over the last two years and have been testing what we are proposing across our communities over the last six months.

Our ambition responds to a number of national strategies, plans and guidelines.

As well as being informed by the Health and Wellbeing Strategies across Brighton and Hove, East Sussex and West Sussex, we have used a range of evidence and supporting information.

This can be viewed here.

5.

Summaries of our place-based working

The following section summarises the key areas of focus and plans in Brighton and Hove, East Sussex and West Sussex. These form the basis of the work we are doing to achieve our ambition.

Brighton and Hove

Brighton and Hove is a coastal city, comprising 290,855 people (ONS estimates). It is the 131st most deprived local authority in England (of 317) according to the 2019 Index of Multiple Deprivation (IMD).

Brighton and Hove is a diverse city. We have:

- A younger population: 83% are aged under 60, however in planning for the future we know the greatest population increase is expected in the 65 and over age group.
- An estimated 11-15% of our residents are lesbian, gay or bisexual.
- An estimated 2,500 transgender residents.
- 19.5% of our population are from a black or minority ethnic group and 20% of the population were born outside the UK (higher than England at 16% and the South East at 14%).
- Over 3,000 known refugees/globally displaced migrants.

Some areas of the city: Whitehawk, Moulsecoomb, and Hollingdean and pockets of Woodingdean fall in the 20% most deprived areas in England. The deprivation experienced in these areas has an impact on life expectancy. There is a life expectancy gap of 9.9 years between men in the most and least deprived areas and of 7.7 years between women in the most and least deprived areas. The gap in healthy life expectancy is wider still, at 14 years between men and 12.5 years between women in the most and least deprived areas. The impact of the Covid-19 pandemic starkly demonstrated health inequalities across the country, including in Brighton and Hove.

We also have high rates of homelessness, substance misuse, alcohol use, smoking and poor mental health. The city has the fifth highest rate of homelessness, the ninth highest rate of deaths related to drugs misuse, and higher than average rates of self-harm and suicide by local authority in England. Of particular concern is the number of people receiving support for multiple compound needs, for example, homelessness, mental health and substance misuse.

Alongside this, however, we have some we have positive health promoting assets – such as access to green space and higher rates of some positive lifestyle behaviours and activity. For example we have high rates of breastfeeding, and more people use outdoor spaces for exercise or health reasons in Brighton & Hove than England (18.3% compared with 17.9%) and are physically active.

Our vision is for everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life. Our Joint Health and Wellbeing strategy, adopted by the Health and Wellbeing Board in 2019, reinforces the wider Integrated Care Partnership strategy and focus on improving outcomes by prioritising prevention and reducing health inequalities throughout the key life stages: starting well, living well, ageing well and dying well.

The Health and Wellbeing Board recognises that most of the building blocks of health are outside of health and care services, for example education and skills, employment, income, housing, environment, leisure and culture and transport. We are making health and wellbeing everyone's business and so the Health and Wellbeing Strategy has adopted a collaborative approach to support partners across the City to take action that improves health and reduces health inequalities.

Brighton and Hove Place Based Plan

The establishment of the Health and Care Partnership Executive Board in January 2020 enables us to continue and build upon the work already started and is now becoming formalised with this Sussex Integrated Care Strategy. The firm foundations of the Board enable us to develop and mature service design, delivery and governance over the coming years. We will seek to embed a philosophy of co-production in all that we do.

The Health and Care Partnership Executive Board have identified the "Plus" Population groups for Brighton & Hove as:

i. Carers, including young carers;

ii. Mental Health Transition in Children and Young People aged 16-25 years;

iii. Globally displaced communities, – those seeking asylum, refugees, vulnerable migrants and;

iv. LGBTQ+ communities.

The Board has developed a Place Bases Plan that includes five priority areas for Brighton and Hove:

1 **Children and Young People:** We will improve and expand access and existing support to children and young people and their families for mental health, emotional wellbeing, autism, ADHD and other neurodevelopmental conditions with a focus population prevention approaches and vulnerable groups. This is underpinned by the Sussex CYP mental health and emotional wellbeing strategy. We will improve early diagnosis and outcomes for children and young people e.g. reducing waiting times and redesign services and pathways to provide seamless transitions for children across all services and for children moving into adult services. We will increase the identification of, and support for Young Carers (5 yrs to 18 yrs), ensuring that the 'carer burden', which is well documented, experienced by Young Carers (YCs) is both recognised and the provision of a range of interventions implemented, aimed at reducing related health inequalities. identify and support young carers

2 **Mental Health:** We will implement the key recommendations of the 2022 Mental health JSNA which will be overseen by the B&H Health and Care Partnership. We will expand our support for people with mental health needs and further develop integrated community mental health services connecting mental health services with community assets. We will do this at local neighbourhood level and develop integrated systems and increase the provision of supported accommodation and support for people with mental health needs, co-occurring disease, and substance misuse services.

3 **Multiple Compound Needs:** We will improve and join up services to better support people with multiple compound needs by delivering a joined up, integrated service model, co-produced for and by people with lived experience. This will include the local delivery of the national drugs strategy, working with the Changing Futures programme, and respond to the Adults with Multiple Compound Needs, Needs Assessment recommendations to deliver joined up care underpinned by a trauma informed care approach

4 **Multiple Long-Term conditions**: We will improve services to people with long term conditions to deliver personalised care, tailored to individual needs, strengths and capabilities. We will aim to better understand the interaction of mental and physical health conditions as a factor to improve outcomes. We will proactively identify and/or support and meet the needs of those at risk of or living with long term conditions, eg: for CVD, stroke, respiratory conditions and diabetes.

5 **Cancer:** We will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and underserved communities where rates of early diagnosis and screening uptake are lower.

Examples of the work already undertaken by the Health and Care Partnership include:

1 The delivery of an outreach model of care to areas of greatest needs e.g., Fibro scanning, targeted lung health checks, twice weekly roving podiatry services.

2 Services targeted at specific communities with known health inequalities e.g. further development of specialist GP Practice services, routine HIV screening at Royal Sussex County Hospital Emergency Department, High Intensity Users programme for people with high A&E attendance.

To further build on our vision and collaboration with health and care services across Sussex and locally at community level, we will have a particular focus on those interventions which can help deliver better outcomes for our priority areas such as:

- Prevention and early detection.
- Supporting communities and building on our community assets approach working with Voluntary and Community Sector services.
- Holistic transformational programmes across the NHS and local authority aimed at supporting communities to thrive.

We will do this together by ensuring we have shared ambitions which will help us to deliver:

- Continuing to work across the city to influence the building blocks of health as well as health and care services, including community engagement to reduce health inequalities.
- A joined-up approach to meeting our population needs as opposed to individual organisations working separately.
- Localised provision to meet the needs of communities, prioritising those with the greatest need.
- Having joint teams and posts that work across all settings.
- A more efficient use of technology to ensure better flows of patient data across health and care services.

East Sussex

Responding to our population health and care needs

The following characteristics of our population significantly drive our local plans for integrated health and care in our communities:

- Our growing and ageing population - by 2026 almost one in four people (24%) will be aged 65-84, and more than 4% of our population will be over 85. Added to this by 2028, around 20,000 more people in East Sussex will be living with two or more long-term health conditions than was the case a decade earlier.
- Increasing numbers of children and young people with Education, Health and Care Plans, some of whom will have complex medical and care needs. There are growing levels of need and complexity in relation to safeguarding for children and young people.

More information about East Sussex, its strengths and challenges and our plans overall can be found in our Health and Wellbeing Board Strategy.

In response, we have worked together to offer joined-up care that can enable more support for complex needs in community settings, across all age groups. For children and young people this has meant:

- An integrated service for 0-5 year olds including health visitors, family keyworkers, communication support workers.
- Multidisciplinary staff teams for youth offending, specialist family service (SWIFT) assessments, young people's substance misuse services, and mental health services for children in care and adopted children.
- An integrated Single Point of Advice and front door joining early help, social care and mental health.
- Developing stronger links between mental health and emotional wellbeing services, and enabling access to shared information.

With more older people, which includes those who are frail and have multiple conditions, East Sussex is likely to have higher health and care needs than other areas of our size. To help with this we have put in place a model of integrated care aimed at supporting independence, reducing avoidable admissions to hospital and improving discharge into community-based care. This includes:

- Health and Social Care Connect – a single gateway for community health and care queries open to staff and the public and operating 24 hours a day, seven days of the week throughout the year.
- Joint Community Reablement – a partnership between Adult Social Care and health providing short-term rehabilitation and packages of care in people's own homes after episodes of ill health or time in hospital.
- Crisis response team – responding to certain health pathways as an alternative service to hospital.
- Discharge to assess – a joint approach to assessing people in short-term beds or their own home rather than hospital.

- Integrated health and social care teams – community nursing and social work services aligned and sometimes co-located, with integrated management arrangements and working with local GP surgeries, care homes and home care agencies.

Alongside key voluntary sector and housing services, and support for carers and families, this joined-up offer of care contributes to enabling people to live independently and well, for as long as possible in their own homes.

How we want to build on this – integrated health, care and wellbeing in our communities

Our next steps as the East Sussex Health and Care Partnership will be to build on these strengths to expand the integrated community model for our population in the following ways:

- Designing and agreeing an approach for working together in our communities across primary care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, driven by a deeper shared understanding of local needs.
- Making sure we keep strengthening our offer of integrated care. For children and young people this is about working with whole families (including through the Family Safeguarding model), and linking ever more closely with early years settings, schools and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care.
- To support improved population health overall and therefore the years of life people spend in good health, we have agreed our model needs to link strongly with the wider services in local areas that impact on social and economic wellbeing as well. This includes leisure, housing and environment services provided by borough and district councils and others.

Our partnership plans to embed hubs in communities to help coordinate access to local sources of support and activities, for example to boost emotional wellbeing and help with loneliness and isolation. We want to develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined-up and personalised care, building on the strengths and assets of individuals, families and communities.
- Greater levels of prevention, early intervention and ways to anticipate health and care needs.
- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.

West Sussex

The West Sussex Health and Care Partnership

The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a Place-based Plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board. Having a place-based partnership allows us to adapt our working to the specific population needs that we have in West Sussex and use our local assets to deliver the solutions.

Partnership working to empower local communities

At the early stages of our partnership formation in 2020, we agreed with our Health and Wellbeing Board to embark on our journey to develop a model of collaboration that brings changes to people directly within their community. This model is our six Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between primary care, district and borough councils, local Public Health, and voluntary sector enterprises.

All six of our Local Community Networks are already up and running and delivering life-changing differences for local people within their communities. As we continue on our partnership development journey, we will maintain our focus on how Local Community Networks can continue to make the positive changes for people who live in West Sussex.

The West Sussex Place-based Plan

The West Sussex Health and Care Partnership Place-based Plan uses evidence from our Joint Health and Wellbeing Strategy to determine local priorities and key areas for change agreed across our partners. Our three local priorities in West Sussex are to tackle health inequality, deliver transformation together and to integrate health and care services for a joined-up experience. In addition to our Sussex-wide priorities, there are six specific priority areas for change that have been identified from the Health and Wellbeing Strategy for West Sussex:

1 **Tackling the wider determinants of health:** Our partnership will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents. This is being done by:

- Delivering our Crawley transformation programme with new models for accessing health and care.
- Tackling the heart of health inequality experienced by communities within West Sussex, using public health data to target resources to close the gaps in health inequalities within communities.
- Building on our commitment to social prescribing to support people with managing their health with help and support.

2 **Addressing health inequalities:** We will have a targeted and focused approach for those with most need and who need additional support. This is being done by prioritising the key health inequality related areas such as heart disease, respiratory illness and cancer and utilising approaches such as tobacco control, targeted cancer screening and health checks to target activity and resources where it is needed most based on local evidence.

3 **Adults Services:** Our strategic objective is to help people 'live the life they want to lead', by remaining independent for as long as possible and maintain a high quality of life. Building on our early models of integrated health and social care, we want to grow our model of care in the community to deliver more health services and care to people in their home-setting and local community, supporting people living with long-term conditions.

4 **Children and Young People:** We will improve the existing support to children and young people so they can have the best possible start to live. This is being delivered through our health priorities set out in our West Sussex Children First programme, improving maternity experiences amongst more deprived people, delivering the best standard health-checks for children who are in care, and developing new services and support for the emotional wellbeing of all young people.

5 **Mental Health:** We will expand our support for people with mental health needs to address the growing need. We aim to deliver the best standard physical health checks for people with mental illness, and to develop sustainable housing solutions for people living with long-term mental illness, linking to our Health, Housing and Social Care Memorandum of Understanding.

6 **Learning Disabilities and Neurodevelopmental Needs:** We will provide greater focus and support for those with a learning disability and neurodevelopmental needs. We are reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support. We want to ensure regular high-standard health checks for people with a learning disability, and we want to create more long-term paid employment opportunities for people with a learning disability.

Sussex Health&Care

Brighton & Hove City Council

East Sussex County Council

west sussex county council

NHS Sussex

December 2022

2023/24 Business Planning – Guidance and approach

Purpose of the paper	To provide a summary of planning guidance. As we have not had detailed allocations or contract discussion with the ICB there is limited further information on the financial position and this will be presented at later meetings.						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	**Sponsor**: Damian Reid (Damian.reid1@nhs.net) **Author**: Mike Farrer (Michael.farrer2@nhs.net)						
Governance overview	Planning approach and guidance has been shared with the executive and DDOs. Headline planning gap shared with Finance and Productivity (F&P) Committee and Trust Board. F&P has reviewed the Trust approach to the planning round at the January meeting.						

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

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

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

Executive Summary

Planning guidance (released end of December)

Key metrics:

- Improving A&E target to 76%.
- Reducing general and acute bed occupancy to 92% or below.
- Eliminate waits of over 65 weeks for elective care by March 2024
- Meeting the 85% day case and 85% theatre utilisation expectations
- Reduce outpatient follow-up activity by 25% against 19/20 levels by March 2024.
- Reducing cancer waiting times and supporting earlier diagnosis
- reducing category 2 ambulance response times to an average of 30 minutes in 2023/24.
- meeting the 70% 2-hour urgent community response standard.

Finance headlines

- Elective activity will operate on Payment by Results (PbR) except OPFU which will be a block. No activity target has been set by the 24/25 target of 130% of 19/20 was reiterated
- Agency costs must be no more than 3.7% of total staff costs
- No longer get main covid funding – message is we are now living with it
- No additional capital was given despite inflationary pressures

Next steps	• Development and consolidation of business plans

East Sussex Healthcare NHS Trust

2023/24 Business Planning

Planning Guidance Summary

System Planning Principles & Approach

East Sussex Healthcare NHS Trust

Systems are required to produce a Strategic Delivery Plan by end of March 2023 which incorporates the requirements of the Operating Plan for 23/24.

CEOs have been asked to endorse the development of the plan under the auspices of the following principles:

- Single Plan for 23/24 (year 1 of the Strategic Delivery Plan which includes the requirements for the 23/24 operation plan).
- **Collective agreement to deliver the core planning targets for A&E, ambulance response times, bed occupancy, elective recovery 65 week waits, productivity and efficiency**
- Focus on recovering services, improving population health and reducing health inequalities
- **Realistic plans** built up from provider plans that align workforce, activity, performance and finance.
- engagement with clinical, quality, finance, workforce, operational and business intelligence colleagues across all partners
- Plan is owned by all system partners
- **Transparency and visibility of the areas which are and are not covered in the plan and the potential risks associated with this.**

National Planning Guidance – Key Messages

East Sussex Healthcare NHS Trust

The 2023/24 priorities and operational planning guidance was published on the 23rd of December 2022, and outlines three key tasks for the coming year:

- Our immediate priority is to recover our core services and productivity.
- Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan.
- Third, we need to continue transforming the NHS for the future.

Planning Guidance Key Points

The planning guidance sets a range of "national NHS objectives" for 2023/24, with expected performance against key operational standards. These include:

- Improving A&E waiting times so at least 76% of patients wait no more than four hours.
- Reducing general and acute bed occupancy to 92% or below.
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties).
- Meeting the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings.
- Reduce outpatient follow-up activity by 25% against 19/20 levels by March 2024.
    - Maximise PIFU pathways where possible.
- Reducing cancer waiting times and supporting earlier diagnosis
    - Continue to reduce the number of cancer patients waiting over 62 days.
    - Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase capacity and improve patient flow to ease UEC pressures;
    - reducing category 2 ambulance response times to an average of 30 minutes in 2023/24.
    - meeting the 70% 2-hour urgent community response standard.

The table below shows the objectives of the planning guidance in more detail, and there is additional information in the annex to this slide deck.

National Planning Guidance – Finance headlines

East Sussex Healthcare NHS Trust

- Elective activity will operate on PbR **except** OPFU which will be a block
  - The 24/25 elective activity target of 130% of 19/20 was reiterated
  - We understand that the Sussex Elective activity target will be 109% in 23/24
- Pretty much everything else will be fixed income
- No longer get main covid funding – message is we are now living with it
- Except testing and vaccinations will continue but will be moving off of pass through during 23/24.
- Agency costs must be no more than 3.7% of total staff costs
- National efficiency ask is apparently 2.2% but doesn't account for non-recurrent support in 22/23 so much higher
- Inflation should theoretically be covered but…
- Some growth funding but will need more detail
- No additional capital was given despite inflationary pressures

East Sussex Healthcare
NHS Trust

Annex 1
National Planning Guidance

Priorities

National Planning Guidance – 23/24 Priorities

East Sussex Healthcare NHS Trust

Area	Objective
Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

National Planning Guidance – 23/24 Priorities

East Sussex Healthcare NHS Trust

Area	Objective
Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

East Sussex Healthcare
NHS Trust

Annex 2
National Planning Guidance

Detail

National Planning Guidance

East Sussex Healthcare NHS Trust

Urgent and Emergency Care

The guidance sets key actions which are designed to increase capacity and improve patient flow to ease the pressures in emergency departments across the country. These include:

• Increasing physical capacity through maintaining the additional 7,000 beds which were funded for this winter and reducing bed occupancy to at least 92%. This also includes increasing the use of virtual wards to 80% by the end of September 2023. £1bn of funding will be incorporated into system allocations to enhance capacity in 2023/24

• Improving timely discharge to ensure medically fit patients can be discharged from hospitals and inpatient units. The Better Care Fund (BCF) should provide £600m in 2023/24 and £1bn in 2024/25 to support timely discharge.

• Increasing ambulance capacity.

• Managing system risk by ensuring all ICBs operationalise clinically led system control centres (SCSs).

As announced in the autumn statement, NHS England will publish an urgent and emergency care recovery plan in early 2023 in collaboration with DHSC and the Department for Levelling Up, Housing and Communities.

National Planning Guidance

East Sussex Healthcare NHS Trust

Elective care and unit prices

NHSE will agree targets with systems for 2023/24 to deliver 30% more elective activity than pre-pandemic levels by 2024/25, and eliminate waits of over 65 weeks by March 2024 (except where patients choose to wait longer or in specific specialties).

The contract default for elective activity which includes ordinary, day and outpatient procedures (but excludes follow-ups) will be to pay unit prices for actual activity delivered. Elective recovery funding will be allocated to systems on a fair shares basis, and provider and system targets will be determined as part of the planning process.

The guidance sets out the key areas of focus for 2023/24:

- Transform outpatient care by reducing outpatient follow-up activity by 25% against 19/20 levels by March 2024
- Increase productivity by meeting the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings.
- Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)

NHS England will allocate £3bn of ERF to ICBs and regional commissioners on a fair shares basis and continue to work with systems and providers to maximise the impact of the three-year capital Targeted Investment Fund put in place in 2022. Further details will be set out in the forthcoming revenue finance and contracting guidance and capital guidance update.

National Planning Guidance

East Sussex Healthcare NHS Trust

Cancer and Diagnostics

The headline objectives for 2023/24 are to reduce cancer waiting times and support earlier diagnosis. To achieve those aims, systems are expected to:

- Implement priority pathway changes for lower GI, skin and prostate cancer pathways to enable earlier diagnosis. This should improve cancer waiting times as two thirds of patients waiting longer than the 62-day target are accessing treatment across these pathways.
- Increase diagnostic capacity for cancer by 25% and treatment capacity by 13% to keep pace with the growth in cancer-related demand.
- Support early diagnosis through an expansion of the targeted lung health check programme as well as other non-symptom specific pathways.

Systems must increase the proportion of patients who attend a diagnostic test within six weeks of referral and deliver sufficient levels of diagnostic activity. The ambition is for systems to maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs.

Systems will be asked to deliver a minimum 10% productivity improvement in pathology and imaging networks by 2024/25 via digital capability enhancements. Following the October 2021 spending review, £2.3bn of capital funding will be made available to systems over 2023/24 and 2024/25 to support diagnostic service transformation..

National Planning Guidance

East Sussex Healthcare NHS Trust

Community health services and primary care

As well as maximising the number of referrals into urgent community response (UCR), the guidance sets out the need to expand direct access and self-referrals to ease the pressure on primary care.

By September 2023, systems should implement direct referral pathways for urgent and elective eye consultations and a range of self-referral routes, including falls response services and weight management services.

The guidance also focuses on improving patient access to GP services by ensuring that appointments can be secured within two weeks, and urgent issues can be seen on the same or next day based on clinical need. Systems are asked to develop plans to improve digital access to GP practices.

The NHS will be expected to deliver 50 million more primary care appointments by the end of March 2024 on 2019/20 levels which will be supported by the recruitment of 26,000 roles through the additional roles reimbursement scheme (ARRS).

ICBs' primary care allocations in 2023/24 will increase by 5.6% given the rise in GP contract entitlements and the increase in ARRS entitlements. Greater use of the community pharmacist consultation service (CPCS) is also intended to redirect lower acuity care away from general practice and NHS 111. NHSE will also publish a recovery plan for general practice access in the new year.

National Planning Guidance

East Sussex Healthcare NHS Trust

Maternity and neonatal services

To achieve improved safety standards across maternity and neonatal services, the planning guidance asks for systems to improve the personalisation of care, and to implement local equity action plans to tackle the inequality of outcomes and experiences of Black, Asian and Mixed ethnic groups. NHSE is also investing an additional £72m above the £93m baselined allocation into the maternity programme in 2023/24 to address the actions highlighted in the Ockenden report.

National Planning Guidance

East Sussex Healthcare NHS Trust

Prevention and health inequalities

The guidance encourages systems to revise plans focusing on prevention and for this to be included in joint forward plans (JFPs). Guidance for JFPs has been published today alongside the planning guidance. JFPs should include revised prevention plans, with particular focus on smoking cessation, cardiovascular disease prevention and diabetes. Plans should reflect the five strategic priorities for tackling health inequalities and enable the delivery of the Core20PLUS5 approach.

Workforce

The guidance asks all systems to refresh system workforce plans to increase productivity, deploy staff more flexibly through digital solutions, improve staff experience and retention via a range of national strategies, ensure there is adequate clinical placement capacity, and implement the Kark recommendations.

NHSE also plans to increase workforce education and training investment in real terms in each of the next two years

Digital

To improve digital capabilities, more providers are expected to operationalise electronic health records and should work towards developing a population health and planning data platform. NHSE will provide targeted funding to enable ICSs to meet minimum digital capabilities and foundations. NHSE will also procure a federated data platform accessible to all ICSs and will improve the functionality of the NHS app.

National Planning Guidance

System working

The guidance expects systems to have local objectives in place which will feed into the national NHS objectives. The review of ICS oversight and governance led by Rt Hon Patricia Hewitt will look to enhance the accountability of systems to ensure the level of oversight systems have is appropriate and proportionate.

Key priorities for the development of ICSs in 2023/24 include:

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.

ICBs will soon be given the responsibility of managing population healthcare budgets, and by April 2023 NHSE will fully delegate pharmacy, ophthalmology and dentistry (POD) services. NHSE and ICBs will work cooperatively via joint committees on the commissioning of specialised services from April 2023, and ICBs will take responsibility for commissioning appropriate specialised services from April 2024. ICBs, in collaboration with NHSE, must also identify three to five priority pathways for specialised service transformation.

National Planning Guidance

East Sussex Healthcare NHS Trust

Mental health, learning disability and autism

Systems must continue to achieve the Mental Health Investment Standard as an absolute minimum. NHSE has also allocated funding to invest in the growth of the improving access to psychological therapies (IAPT) workforce through offering 60% salary support for new trainees in 2023/24, and will also expand services in line with the LTP's ambitions on mental health. The guidance highlights the need to reduce pressure on mental health inpatient care.

Systems should improve performance across autism diagnostic assessment pathways. They are expected to expand the size and improve the accuracy of GP learning disability registers, with an ambition for 75% of people on the registers to be provided with an annual health check by March 2024. NHSE will support ICBs to develop plans to drive improvements in the quality of mental health and learning disability inpatient services, through an alignment and localisation of services, over a three year period.

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF) Update

Purpose of the paper	This paper updates the Committee on the finalised Q3 position of the Board Assurance Framework (BAF) ahead of the finalised Q3 position.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Chief of Staff					
Governance overview	Each BAF risk has been reviewed by the Chief of Staff and the Executive Risk Owner. Collectively the full BAF is reviewed by Executive Directors. Each Board sub-Committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter. As a result of operational pressures, the Strategy, Quality and Safety and People and Organisational Development Committees were cancelled in December/January. The BAF has therefore been shared electronically with members of these Committees for comment. The BAF was reviewed by the Finance and Investment Committee in December, and by the Audit Committee in January.					

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

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

Recommendation	The Board is asked to note the completed Q3 summary position for BAF risks as shared by the Executive risk owners.
Executive Summary	This paper provides a view of the Q3 risk position for each of the BAF risks, following discussions with executive risk owners. The paper summarises the current BAF risk position for all 13 risks setting out the controls/mitigations for each of the strategic risks.
Next steps	The Trust Board is asked to review and approve the Q3 BAF. The Q4 position will be presented to the Board in April.

Board Assurance Framework (BAF) Update

1. Introduction

1.1 The Board Assurance Framework (BAF) supports the Board in focussing on the key risks which might compromise the achievement of the organisation's strategic and in-year 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.

1.2 In this report we are confirming Q3 positions previously reported on a provisional basis to the Committee. We anticipate that we will report the Q4 (YE) BAF risk position to the Audit Committee in March, and to the Trust Board in April.

2. Q3 scores in summary

2.1 Following reviews with all Executive SROs, we have completed assessments for the Q3 summary BAF (see figure 1). Of the 13 BAF risks, 10 show no significant change to the residual risk score for Q3. Two BAF risks show a reduction in residual risk, suggesting the mitigations and controls are showing a degree of effectiveness. However, in the case of the one remaining BAF risk, the residual risk has increased.

Figure 1: BAF Summary for Q3

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

2.3 By way of explanation for BAF risk 10, we recognise that there has been a suboptimal monitoring process to date and wanted to bring to colleagues' attention the progress made. Following further discussions with Q&S Committee members, we have agreed that this risk will reflect the delivery of the continuous improvement methodology – which we recognise is fundamental to the delivery of our transformation/improvement programme (which, in turn, is the "how" of our strategy – hence its importance and inclusion within the BAF).

2.4 Having reviewed both the inherent risk and progress to date we have agreed the trajectory indicated within Figure 1 (greyed out to reflect that this has not yet been agreed through the relevant Committee), and the progress summarised in table 2. A full review of BAF risk 10 was planned to be presented to the Strategy Committee in December, but will now take place in February.

Board Assurance Framework (BAF)

Quarters 3 Update 2022/23

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 Five), aiding the identification of areas of weakness.

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

Between June and July 2022, the Trust Board discussed an updated BAF, agreeing updated BAF risks and the organisation's risk appetite for each. The number of BAF risks for 2022/23 increased to 13, with almost all of them rewritten.

The Trust's Corporate Risk register contains all of the risks in the Trust that are rated as 15 or more. The majority of risks included on the BAF are included on the Corporate Risk Register, which is presented in full to the Audit Committee alongside the BAF.

The Q1 and 2 BAF was presented to the Trust Board in October, with a number of gaps due to decisions about the appropriate oversight Committee remaining to be finalised. Subsequently, these issues were resolved and the final Q1 and 2 BAF, which included interim Q3 updates was presented to Committees in November and to the Trust Board in December.

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

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS
East Sussex Healthcare
NHS Trust

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

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

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

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

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

		Collaborating to deliver care better	Empowering our People	Ensure Innovative & Sustainable Care	Improving the health of our communities
BAF 1	Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture	6			6
BAF 2	Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time		12	12	12
BAF 3	Decline in staff welfare, morale and engagement that impacts standards of care in 22/23		16	16	16
BAF 4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery			16	16
BAF 5	Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23			10	10
BAF 6	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff		20	20	20
BAF 7	Vulnerability of IT network and infrastructure to prolonged outage	16	16	16	16
BAF 8	Failure to develop business intelligence weakens insightful and timely analysis to support decisions			16	16
BAF 9	Failure to transform digitally and deliver associated improvements to patient care			16	16
BAF 10	Failure to maintain focus on improving care				9
BAF 11	Risk of not being able to maintain delivery of safe, high quality effective care due to huge numbers of patients that no longer meet the criteria to reside.	16	16	16	16
BAF 12	Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas	9			9
BAF 13	Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services	12			12

Risk Summary								
BAF Reference and Summary Title:	BAF 1: Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture				Strategic Aims Impacted			
					x			x
Risk Description:	There is a risk that senior Trust resources spend excessive amounts of time focussing on the process aspects of the new System rather than the delivery of service improvements							
Lead Director:	Chief of Staff	Lead Committee:	Strategy Committee	Date of last Committee review:	25/08/22			

BAF Risk Scoring								
Inherent Risk	Residual Risk	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)	Target Date
	Likelihood:	3	2	2		There are two central elements to this risk: 1. With the creation of the new System and Place governance structures, there potentially a far greater call on the time of ESHT senior leaders. The opportunity cost of attending meetings for senior leaders is that other priorities are put at risk. 2. 3. The other priorities being operational/delivery-focused in nature means that the core business priorities in 22/23 have had less focus and direction, because key resources are focused elsewhere and this will impact ESHT ability to deliver these in-year The rationale for the risk level changing from Q1 to Q2 was driven by a reduction in the likelihood; that in order to mitigate elements 1) and 2) above, the Executive Team now frequently monitors/reviews and escalates issues relating to senior attendance at external Committees and meetings. More importantly, the recent restructuring of ED portfolios has enabled clarity on who needs to attend. For Q3 we recognise that this allocation of attendance has improved time allocation, without losing the information that comes from these meetings Hence the likelihood of this risk arising is assessed as the same for Q3 as Q2. The impact/consequence score has not changed (because this is not the variable that controls/mitigations can affect). The approach to tracking this particular risk is active triangulation between the meetings that are going into diaries with the resources being identified by ESHT to ensure effective attendance, hence it is recommended that this risk comes back to StratCom every two months for assurance	Likelihood:	2	Review every two months
	Consequence:	3	3	3			Consequence:	3	
(4x3) 12	Risk Level:	9	6	6			Risk Level:	6	

Cause of risk:	• Creation of new governance forums leading to more meetings for ESHT senior leaders to attend.	**Impact:**	• Internal priorities focused on delivery of ESHT 22/23 priorities may be compromised by the 'right' leaders being at other meetings
Current methods of management (controls)	A. Robust monitoring process via EDs, IPRs enabling teams to flag where pressures arise – either on external commitments or internal presence being compromised to the point where senior leaders' grip on internal priorities is suboptimal		

Assurance Framework – 3 Lines of Defence – linked to control (above)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Teams to consider alternative options/resources to ensure ESHT collaboration is maintained at an appropriate level	• Teams able to escalate to EDs for review/support/mitigation options • EDs to consider alternative resource and appropriateness to the responsibility levels	• EDs to raise with external partners as required where no alternative resource is available
Gaps in control/assurance:			
• None seen currently			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**

Current proactive management means that we are at the target level for this risk. Were meetings to increase, and attendance issues flagged via Executive Directors meeting and/or Divisional IPRs then we would look toward additional actions – including discussions with the relevant partners to seek to manage expectations on attendance.

Risk Summary							
BAF Reference and Summary Title:	BAF 2: Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time			Strategic Aims Impacted			
					x	x	x
Risk Description:	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term						
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee		Date of last Committee review:	15/09/22	

	BAF Risk Scoring								
Inherent Risk	Residual Risk	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
(5x3) 15	Likelihood:	4	4	4		There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention is a clear risk given the ongoing operational pressures being experienced locally and across the NHS. The Trust's age profile presents a specific risk to longer term retention with around 20% of our workforce are at a point where they are technically able to retire. The Royal College of Nurses have voted to take strike action which will impact on our available resources. No action will take place in 2022. UNISON were not successful in their vote for strike action. Additionally, a number of other unions are balloting members The Risk rating may change for Q4 based on the outcome of ballots and information about further RCN action.	Likelihood:	3	Ongoing
	Consequence:	3	3	3			Consequence:	3	
	Risk Level:	12	12	12			Risk Level:	9	

Cause of risk:	Impact:
• Recognised national shortages in some staff groups • Geographical location, demographics and age profile of workforce • Continued operational pressure in a number of clinical areas • Lack of opportunity for career development • Ongoing pressures 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	Failure to maintain workforce stability gives rise to risk of: • Not being able to deliver activity in line with operational needs • Detrimental impact on patient care and experience • Detriment to staff health and well-being • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas • Failure to comply with regulatory requirements and constitutional standards • Detriment to performance and productivity • Increased workforce expenditure due to agency requirements

	2022, could impact on smooth allocation of FY doctors in August 2022. • Industrial action		• Inability to ensure 'great place to work' culture and climate thus frustrating strategies and efforts to attract, recruit, retain, deploy, and develop staff

Current methods of management (controls)	A. Ongoing monitoring of Attraction, Recruitment and Retention Strategy and developing wide range of recruitment methodologies (events, social media, recruitment consultancies, targeted recruitment activity, including a significant overseas recruitment plan) B. Talent management, succession planning, appraisals and development programmes C. Developing new roles and "growing our own" e.g. New to Care D. Workforce efficiency metrics in place and monitored E. Quarterly reviews in place to determine workforce planning requirements. F. Review of nursing establishment 6 monthly as per Developing Workforce Safeguards G. Full participation in HEKSS Education commissioning process and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Stay interview and exit interview programmes I. Use of bank and agency where required J. Focus on retention particularly on understanding why people may want to leave the Trust. K. Use of government initiatives e.g. Kickstart L. Flexible working M. More flexible use of retire and return N. Proactively building our positive reputation as an employer O. Implementation of an industrial action project to mitigate the impact of colleagues taking industrial action P. Assurance is being provided re industrial action preparedness to system and region via self-assessment checklist

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H)(D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas e.g. consultants in Histopathology, Radiology, Neurology 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	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • Three-year Attraction and Recruitment Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Trust vacancy rate increased to 6.9% in August 2021. (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E) • NHS Staff Surveys and Pulse Surveys and benchmarking data (A) (B) (C)

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
	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 (C)(J)(N) • Job plans in place for all doctors (B) • Industrial Action working group and daily resource meetings attached to site meetings (O)(P) • In the event of industrial action, reduction in services to ensure all urgent and derogated services are delivered (O)(P)	• Wellbeing offering enhance (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy 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)	
Gaps in control/assurance:			
• None identified			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers, Gastro and Endoscopy	CPO	Ongoing	• Between April 2022 and December 2022,a total of 105 international recruits joined the Trust of which 2 were Radiographers. • Trust continues to work with external recruitment agencies to assist with recruiting 'hard to fill posts' • Medacs recruitment agency have sourced a further 3 Radiographers and 2 Sonographers due to start before February 2023 • International nurses successfully placed in Paeds (1)for the first time as well as critical care(5).A further 5 are planned for critical care Jan 2023. • Further c12 International Nurses due to arrive January 2023.	G

				• Planned c 20 every other month during 2022/2023.	
2.	Kickstarter and other local outreach initiatives	CPO	Ongoing	• CEO, CPO visit to Project Search areas to promote support for the initiative	G
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	CPO	Ongoing	• SCP :There remain two on programme- one has completed – funding was approved in January 2022 for a member of staff to undertake the SCP course from Anglia Ruskin University and approved HEI by the Royal College of Surgeons. We have requested 3 funded commissioned places in 2023- this was approved with the ADN. For Surgery. • PA Role :We had 8 PA in post however two have since left the Trust- so we have 6 which is an increase of 50% from last year. The lead PA for the Trust has been appointed as a region wide PA Ambassador, a meeting with the ADHR Education and the PA across the Trust on Thursday have resulted in a number of initiatives- 1. Setting up a local PA community of Practice that will link in to the Regional PA form across the ICB's • Membership of Education Steering Group. 3. PA Membership of the Regional Education Leads Forum. 3. Follow up on Day in the Life on Comms 4. Support the ADO in medicine with the creation of a forma Lead PA role- early approach has been made to support with Integrated Education Funding with the wider remit of improving awareness of the PA role across the Trust to include the development of posts that will enhance the ability to recruit from those PA's on placement in the Trust.. • Anaesthetic Associates: DU had an initial meeting with the then College Tutor- Dr Bolton, PE- Gill Miller and invited guest Dr Nigel Penfold. Initial positive engagement however there due to service pressures and more pressing priorities progress has not moved on as much as anticipated. Have agreed with Gill Miler to set up another meeting with the new Service Manager but also the Clinical Director for the service. Have requested date in December/January 2022/2023.	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 3: Decline in staff welfare, morale and engagement that impacts standards of care in 2022/23**				**Strategic Aims Impacted**		
						x	x	x
Risk Description:	**There is a risk that any decline in staff motivation negatively impacts our ability to retain them and also on organisational performance and quality of care.**						
Lead Director:	Chief People Officer	**Lead Committee:**	People and Organisational Development Committee	**Date of last Committee review:**	15/09/22		

	BAF Risk Scoring							
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
(5x4) 20	**Likelihood:**	**4**	**4**	**4**		The Trust is experiencing ongoing levels of activity that, whilst changing in profile, are significantly above those both during and pre-Covid. There is a robust programme of work in place to support the wellbeing of staff. The unpredictable nature of waves of Covid make it impossible to provide certainty to the workforce that activity is stabilising, and when pressure on services will reduce in the future. Elongated industrial action without resolution may further impact on the motivation and morale of colleagues	**Likelihood:** **3**	Ongoing
	Consequence:	**4**	**4**	**4**			**Consequence:** **4**	
	Risk Level:	**16**	**16**	**16**			**Risk Level:** **12**	

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

Current methods of management (controls)

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

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

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• 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) • Deep dive cultural Reviews (P)	• 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 (H)(L)
Gaps in control/assurance:			
• None identified			

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

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	People Strategy	CPO	Ongoing	• People Strategy has been published – this has an established programme of works and is reported quarterly to POD	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 4: A failure to deliver expected income levels and manage costs within a manageable envelope caused by inability to deliver savings**				**Strategic Aims Impacted**		
							x	x
Risk Description:	**There is a risk that failing to meet financial targets for the current year will result in increased regulatory scrutiny and loss of control of autonomous decision making and have an adverse impact on the Trust's reputation.**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee		**Date of last Committee review:**	22/09/22	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	**5**	**4**	**2**		**Likelihood**: It is highly likely given current run rate and operational pressures that the Trust will fail to live within its expenditure budget, however this is potentially partially offset by national guidance on the clawback of ERF. This has had a material positive financial impact in H1, and it is expected to continue in H2. **Consequences**: Whilst the consequences are potentially severe, we are cognisant that the challenges faced by the Trust are common with many NHS providers and therefore the regulatory response will likely be proportionate in that context. Therefore, the consequence has been capped at a 4.	**Likelihood:**	**2**	01/2023
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
	Risk Level:	**20**	**16**	**8**			**Risk Level:**	**8**	

Cause of risk:	• Failure to deliver on the ERF activity plan; • Increased operational pressures and in particular patients not meeting the criteria to reside meaning that we are unable to deliver to the escalation bed plan; • Failure to deliver recurrent efficiencies	**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. Efficiency programme is in place with targets set and monitored at divisional level; B. Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive; C. Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay; D. Staffing controls through establishment control, including vacancy panel;		

Assurance Framework – 3 Lines of Defence – linked to controls (A-D)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Work continues through divisional meetings to both maintain contingency and to strengthen recurrent delivery of overall financial position and the efficiency programme. (A) (B) (D) • Procurement, Temporary Workforce Services and vacancy panel all monitor compliance as appropriate with scheme of delegation and SFI (C) (D)	• Oversight by Efficiency Committee and Finance & Investment Committee (A) • Revised SFIs and SoD (C)	• Internal audit reviews (A) (B) (D) • External audit programme in place (A) (B) (C)
Gaps in control/assurance:			
None identified but need to ensure that the system of internal financial control remains robust.			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Finalise CIP plan for year	Chief Financial Officer	28/02/2023	• At M7 there has been some improvement on CIP delivery.	A
2.	Establish a finance and activity focused accountability session chaired by COO and CFO with each division covering financial performance, activity and efficiency to increase scrutiny, grip and control above the existing IPR process	Chief Financial Officer	30/11/2022	• COO/CFO meetings with divisions happened during month 6 and month 7.	G
3.	Finalise nursing establishment review	Chief Nurse	30/11/2022	• Nurse establishment review was presented to the Trust Board, the principles were agreed. • However, savings have not been finalised.	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 5: Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 2022/23**				**Strategic Aims Impacted**		
						x	x
Risk Description:	**There is a risk that the Trust will be financially unsustainable and be unable meet its long-term financial commitments which may result in increased regulatory scrutiny and loss of control of autonomous decision making and have an adverse impact on the Trust's reputation.**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee		**Date of last Committee review:**	15/09/22	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(3x5)	**Likelihood:**	**2**	**2**	**2**		**Likelihood**: At the end of November 2022, national guidelines have not been finalised for 2023/24. However, initial indications are a national expectation of improving productivity to 2019/20 levels which would be challenging as the Trust continues to be impacted by a degree of covid pressure and NCTR patients. **Consequence**: The longer-term impacts of failing to achieve financial sustainability are severe with potential quality and safety concerns coming from reduced resources as well as likely loss of autonomy to act. As such this has been scored as a 5.	**Likelihood:**	**2**	31/03/2023
	Consequence:	**5**	**5**	**5**			**Consequence:**	**5**	
15	**Risk Level:**	**10**	**10**	**10**			**Risk Level:**	**10**	

Cause of risk:	• Overall constrained NHS financial position; • Change in contract forms meaning that more risk has been passed to providers; • Capacity and funding constraints in social care increasing costs on the Trust; • Apparent significant loss of productivity as a result of the covid pandemic.	**Impact:**	• 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. Efficiency programme is in place with targets set and monitored at divisional level; B. Transformation programmes to be put place to realise benefits of cost effectiveness following on from the Kingsgate review; C. Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive; D. Scheme of delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay; E. Staffing controls through establishment control, including vacancy panel; F. Development of longer-term strategy and service model through the Building for our Future (BFF) programme; G. Monitoring of non-recurrent income and expense to derive underlying position through use of "next year budget" fields in the ledger and run rate analysis in year;

	H. Deep dive into changes since 2019/20 is being undertaken; I. Longer term capital plan to support delivery of sustainable services.

Assurance Framework – 3 Lines of Defence – linked 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:	• Work continues through divisional meetings to both maintain contingency and to strengthen recurrent delivery of overall financial position and the efficiency programme. (A) (C) (E) (G) • Procurement, TWS and vacancy panel all monitor compliance as appropriate with scheme of delegation and SFI (D) (E) • BFF Programme and associated governance (F) • Workforce summit programme (H) • Capital plan set through F&P and board and monitored through F&P and CRG (I)	• Oversight by Efficiency Committee and Finance & Investment Committee (A) (B) (F) (G) • Robust leadership of CIP programme, with strong link to Model Hospital and GIRFT established. (B) • Revised SFIs and SoD (D)	• Internal audit reviews (A) (C) (E) • External audit programme in place (A) (C) (D) •

Gaps in control/assurance:
None identified but need to ensure that the system of internal financial control remains robust and that the organisation is developing a longer term strategy for sustainability

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Establish transformation directorate	Chief Executive Officer	3 June 23	• Director of Transformation in post as of 05.09.22 and will look to establish transformation directorate based on organisational needs and resource	G
2.	Develop and deliver on the transformation programme responding to the key themes identified by Kingsgate and ratified by the executive	Director of Transformation	30 Sep 23	• Review of outcomes undertaken and plan being developed	A
3.	Monitor delivery of planned care through ERF targets but also delivery of the longer-term national requirements	Chief Operating Officer	On-going	• Live production plan in place to monitor activity against locally agreed and national targets	G
4.	Maintain staffing controls through establishment control, including vacancy panel	Chief People Officer	On-going	• Reported to executives on a weekly basis	G
5.	Finalise the five year capital plan and prioritise schemes as required working with internal and ICB stakeholders	Chief Finance Officer	31 Jan 23	• Currently being modelled by ICB finance team for review by Chief Executive group.	A
6.	Progress major national schemes which will support the delivery of sustainable services: • Community Diagnostic Centres • Virtual Wards • Elective Hub • Urgent community response	Chief Operating Officer	30 Sep 22	• All schemes are on track according to their respective program timescales • Elective Hub planning is on track, but is subject to final national approval of funding	A
7.	Review of current bed stock and with a view to establishing longer term requirement	Chief Operating Officer	30 Nov 22	• Bed gap analysis complete for winter 22/23 • Trust focussing on mitigations to address predicted demand • Additional winter bid funding should support delivery through the winter	A
8.	Robust planning process for 23/24 including budget setting, workforce and activity	Chief Finance Officer	31 Jan 23	• An early planning process was started in November 2022 and we are waiting for national guidance to set out overall planning principles prior to finalising (currently forecast to be issued around Christmas week).	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 6: The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff**				**Strategic Aims Impacted**		
						x	x	x
Risk Description:	**There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee	**Date of last Committee review:**	15/09/22		

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	**4**	**4**	**4**		Due to in year controls, currently expecting to limit IT and medical equipment spending to £4.5m for the year.	**Likelihood:**	**2**	Ongoing
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
	Risk Level:	**16**	**16**	**16**			**Risk Level:**	**8**	

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)	• Oversight by Finance and Investment and Strategy Committees (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)

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)*
	• Full inventory of medical devices and life cycle maintenance (B)		

Gaps in control/assurance:

- Longer term capital programme required to identify pressures and requirements
- BFF funding envelope not clear at present

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

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	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	Jan 2023	• BFF SOC was prepared in March 2021 showing backlog would be addressed under BFF plan • Awaiting feedback from NHP team in January 2023 around the option that the Trust can move forward with. Plans will be developed following this.	Jan 2023
2.	Have upgraded capital plans into GANT charts	Chief Finance Officer	March 2023	• By March 2023 a three year capital plan will have been developed and shared with the ICS.	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 7: Vulnerability of IT network and infrastructure to prolonged outage**				**Strategic Aims Impacted**		
					x	x	x	x
Risk Description:	**There is a risk that if part of the infrastructure fails, or we are hit by a cyber-attack, this will create a prolonged outage and the inability to access clinical systems and patient records**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee	**Date of last Committee review:**	15/09/22		

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	4	4	4		There are a number of robust controls in place, but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda. Whilst the risk is still 16, a significant amount of work has been done to increase the robustness of the Trust Cyber security posture, but due to an evolving threat landscape new threats arise that will require new and further remediation.	**Likelihood:**	3	Ongoing
	Consequence:	4	4	4			**Consequence:**	4	
	Risk Level:	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. • Infrastructure Hardware failure, due to unsupported systems or lack of Capital Refresh.	**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 J. Migration of Clinical System to the Cloud K. Strategy of Cloud first, so Software as a service or platform as a service on any new procurements L. Rolling refresh of infrastructure Hardware, LAN, Wi-Fi, Servers, and Client Devices.

Assurance Framework – 3 Lines of Defence – linked to controls (A-L)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Cyber Essential Plus Framework assessment reviewed by division (D) • Day to day systems in place and support provided by cyber security team with increased capacity (A) (B) (C) (F) (H) (I)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with organisations within the Sussex ICS (G) • Regular quarterly security status report to IG Steering Group and Audit Committee (D) • Monthly reporting via NHS Digital on Cyber Exposure score (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 audits throughout 2022/23 (D) • Assurance given for our DSTP submission (Jun 22) (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 3 Progress Report**	**BRAG**
1.	Cyber Essential Plus framework.	Chief Finance Officer	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.	G
2.	Medica devices with network connectivity asset list	Chief Finance Officer	March 2023	• Celera, an auditing tool, has been installed and is now running network audit. Further work required to enable greater visibility	G
3.	Wi-Fi Refresh	Chief Finance Officer	March 2023	• Replace Wi-Fi Networks across community sites underway, Conquest and EDGH complete • Further work required to areas of organisation lacking wi-fi	G
4.	LAN Refresh EDGH	Chief Finance Officer	March 2023	• Replace the Core Network and Fibre connections to the Edge Switches	G
5.	LAN Refresh Conquest	Chief Finance Officer	March 2024	• Replace the Core Network and Fibre connections to the Edge Switches	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 8: Failure to develop business intelligence weakens insightful and timely analysis to support decisions**				**Strategic Aims Impacted**		
						x	x
Risk Description:	**There is a risk that poor quality data input into a complex number of different clinical systems is leading to a lack of assurance on the data reported for operational performance and national and regional reporting.**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee		**Date of last Committee review:**	15/09/22	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	**4**	**4**	**4**		The lack of business continuity plans and quality and assurance of the data used for reporting.	**Likelihood:**	**3**	Ongoing
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
	Risk Level:	**16**	**16**	**16**			**Risk Level:**	**12**	

Cause of risk:	• There are a large number of complex clinical systems used across the Trust • Variable quality of data input into systems • Number of systems can lead to duplication of data entry • Limited assurance available about the data reported outside of the organisation	**Impact:**	• Inability to make clinical decisions • Impact of potentially incorrect data on business planning • Impact of using potentially incorrect data when reporting nationally.

Current methods of management (controls)	A. Local data management policy which includes clear reference to performance data collection, collation and reporting processes; offers a localised point of reference that can provide more clarity to Trust officers than relying solely on national guidance. B. Standard Operating Procedures which assist in ensuring a consistent approach in line with policy by all involved in processes. C. Awareness Training D. Process Mapping E. Responsibilities of all staff groups involved in the process are clearly defined and documented. F. Manual Validation of collected data prior to reporting. G. System Validation – automated checking (such as reasonableness, completeness) of data prior to reporting. H. Developing case for focussed investment in Business Intelligence team

Assurance Framework – 3 Lines of Defence – linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Incidents – there have been incidents (or no incidents) relating to the accuracy of data in this metric. • Process Improvement – processes relating to the collection/collation/reporting of data have been subject to improvement. • Recruitment of Data Quality lead	• Observation/Feels Right – the executive and/or operational lead considers that the reported figures feel correct and are consistent with observations and frontline feedback. • Benchmarking – reported figures for the Trust are comparable with similar organisations. • Business Intelligence Team View – Business Intelligence/Knowledge Management opinion on the accuracy of the data being reported.	• External Review – external organisations (e.g. CQC) have recently reviewed the data and/or data collection processes. • Internal Audit/Granularity – Internal Audit (or another assurance function) has conducted a recent, detailed review of the current process.

Gaps in control/assurance:

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

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

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	EPRR team are undertaking business continuity plan review throughout the organisation.	Chief Operating Officer	September 2022	• Embed ownership of business continuity across the divisions. • Tabletop exercise of hospital evacuation plan undertaken • In process of submitting 2022/23 core EPRR standards	G
2.	Data Quality and Assurance Lead recruited and has started introducing a data quality steering group and framework	Chief Finance Officer	31.03.23	• Review of data assurance started • Data Quality Steering Group now operational and quarterly reporting will be made to the Audit Committee on progress	G

Risk Summary							
BAF Reference and Summary Title:	**BAF 9: Failure to transform digitally and deliver associated improvements to patient care**				**Strategic Aims Impacted**		
							x	x
Risk Description:	**There is a risk that the Trust fails to develop a culture that embraces digital transformation and adoption. This could lead to adverse outcomes for patients and missed efficiency and financial opportunities.**						
Lead Director:	Chief Financial Officer	**Lead Committee:**	Finance and Productivity Committee	**Date of last Committee review:**	15/09/22		

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	4	4	4		**Likelihood**: To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency of investment and resources however, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scales change or recruit to roles. **Consequence**: Long term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions	**Likelihood:**	3	31.03.25
	Consequence:	4	4	4			**Consequence:**	4	
	Risk Level:	16	16	16			**Risk Level:**	12	

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

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

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Digital Steering Group to continue to management and approve any digital activity (A) • Process Improvement - process relating to the prioritisation of project / programmes with digital (C) (E) (F) (G) • Benefits Strategy approved (D)	• Oversight by Finance and Strategy Committee (H) • Digital IPR (A) (B) (F) (G) • Transformation Board (monthly) (F) (G)	• Capital Business cases reviewed by ICS (G) • Interna TIAA audits (A) (B) (D)

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	EPR procurement	Chief Medical Officer	January 2023	• Outline business case and specification completed, and review of invitation to tender being completed • OBC has been submitted, and has passed regional review and frontline digitisation review. It will now go to the national EPRIB Board for approval in January 2023. • Procurement delayed and now due to take place in January 2023	G
2.	Digital transformation business case and roadmap	Chief Finance Officer	March 2023	• Initial work on producing documents has commenced	G

Risk Summary						
BAF Reference and Summary Title:	**BAF 10: Failure to maintain focus on improving care**				**Strategic Aims Impacted**	
						X
Risk Description:	**There is a risk that due to the current context and operational pressures that colleagues are not able to focus on quality improvement.**					
Lead Director:	Executive Director Transformation & Improvement	**Lead Committee:**	Strategy and Transformation Committee		**Date of last Committee review:**	n/a
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	-	-	*New risk for 2023 so no links apply*	-	-	-

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(4x3) 12	**Likelihood:**	**4**	**4**	**3**		The initial risk rating of 12 reflects both the existing resource gap/competencies and a wider lack of clear strategic intent (impacted significantly by COVID. The reduction in Q3 reflects the appointment of a strategic partner who will align leadership around a vision, review KPIs and monitoring and co-develop a continuous quality improvement approach, drawing on their experiences with other Trusts.	**Likelihood:**	**3**	Review every two months
	Consequence:	**3**	**3**	**3**			**Consequence:**	**3**	
	Risk Level:	**12**	**12**	**9**			**Risk Level:**	**9**	

Cause of risk:	• COVID derailing previous model and implementation • People trained under the previous model have been dormant/ inactive as a result of competing priorities • Absence of a clarity of purpose /alignment with strategic aims and framework for delivery	**Impact:**	• No systemic approach to delivering improvements • Persistence of training gaps esp. with senior leaders across the Trust • No clear link between a single approach to improvement and our strategic objectives
Current methods of management (controls)	A. Stocktake via the creation of ED Transformation Improvement B. Provide regular reporting via EDs/StratCom as regards the current transformation programme (including embedding a continual improvement methodology)		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Through reporting to EDs	• Engage strategic partners to capacity build within our teams and clarify approach/model	• Potential for peer review (e.g. via UHSx/ SASH)

Gaps in control/assurance:
• None seen currently

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1	Engage strategic partner to scope the model of improvement and its implementation, aligned with business planning process 23/24	EDTI	Feb - Apr 23	• TBC	A
2	Agree on-going commitment with strategic partner and internal capacity to deliver from within ESHT resources	EDTI	Apr 23	• TBC	A

Risk Summary							
BAF Reference and Summary Title:	**BAF 11: Risk of not being able to maintain delivery of safe, high quality effective care due to huge numbers of patients that no longer meet the criteria to reside.**				**Strategic Aims Impacted**		
					x	x	x	x
Risk Description:	**There is a risk that patients that do not meet the criteria to reside (NCTR) may be exposed to, or suffer, harm (for example deconditioning, falls or particular infections). In addition, there is a risk of patients being cared for in a temporary setting, resulting in potential harms. There is also an ongoing requirement for significant additional capacity requiring significant additional staffing. There is also an impact on the flow of patients, ultimately effecting the emergency departments and elective recovery. This risk focuses on what we want as the culture and standards ('the ESHT way' of improvement), irrespective of the day-to-day challenges that BAF 10 articulates.**						
Lead Director:	Chief Operating Officer / Chief Nursing Officer / Chief Medical Officer	**Lead Committee:**	Quality and Safety Committee		**Date of last Committee review:**	08/09/22	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x4) 20	**Likelihood:**	**4**	**4**	**4**		Evidence on a daily basis of the impact of greater than 50 patients that no longer meet the criteria to reside and the impact that this has on flow and increasing risk to patients and staff. Situation continues with very large numbers of stranded patients and significant extra bedded capacity open now including “supersurge” and critical capacity. In addition in times of extremis it has been necessary to place additional patients on wards pre-empting discharges	**Likelihood:**	**3**	Ongoing
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**	
	Risk Level:	**16**	**16**	**16**			**Risk Level:**	**12**	

Cause of risk:	• Sustained pressure on commercial care home sector resulting in reduced staffing, capacity and acceptance criteria • Closure of care homes across Sussex • Pressures on primary care • Lack of sufficient suitable alternative pathways for patients • Lack of sufficient assessment and treatment capacity in mental health • Lack of sufficient capacity for urgent placement of children at risk • Lack of sufficient suitably trained staff for all capacity that is in use • National removal of discharge to assess funding • Reduction from 113 Discharge to Assess beds to 46 • Increased length of stay in the acute and onward care settings	**Impact:**	• Delays to assessment and treatment • Patients NCTR in inappropriate locations • Poor experience for patients and staff • Risk of harm to patients, e.g. self-harm, harm to others, risk of absconding, violence and aggression • Patients are deteriorating and deconditioning due to length of stay once NCTR • Increase in safeguarding concerns given the huge numbers of vulnerable patients, many of whom have a very considerable length of stay

	• Ongoing negative impact of the pandemic e.g. elective backlog of patients, impact on non-elective patients who have not accessed healthcare as a result of the pandemic		

Current methods of management (controls)	A. Significant additional capacity remains open B. Significant attempts to safely staff all capacity C. Systems in place to identify and escalate NCTR patients D. Ongoing collaborative system working to identify solutions E. Audit of stranded patients undertaken to investigate risks and/or harms F. Weekly long length of stay panel meeting to support expediting discharge of patients with the longest length of stay G. Full capacity protocol, escalation protocol under review. Pre-emptive placement protocol drafted. H. Staff summits planned to ensure whole Trust approach in supporting this work

Assurance Framework – 3 Lines of Defence – linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Robust management of all capacity • Daily management of staffing • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • A robust operational delivery plan, reviewed weekly at Execs' meetings • Daily capture and monitoring of supersurge capacity	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Patient pathway review with adult social care to agree shared risk and ownership • Clear oversight and responsibility of operational delivery and quality and safety • Work being undertaken with Nervecentre to develop capture and monitoring of boarded patients	• Regular meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board • Provider assurance meetings and system clinical quality review meetings

Gaps in control/assurance:
• Gaps in workforce • Lack of suitable physical space for surge capacity • Lack of sufficient equipment for surge capacity • Unable to completely avoid all inappropriate attendances/admissions • Lack of Adult Social Care capacity

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Ensure clinical areas are staffed as safely as possible	COO/CNO/CMO	Ongoing	• Still have significant additional capacity open • Still have gaps in staffing • Escalation waterfall in place with agreed staffing ratios	A
2.	Ensure as far as possible that patients are placed as safely and appropriately as conditions permit	COO/CNO/CMO	Ongoing	• All escalation areas remain open with additional supersurge capacity remaining open and pre-emptive placement of patients when in extremis.	A
3.	Ensure high risk patients are assessed and flagged appropriately	COO/CNO/CMO	Ongoing	• Weekly long length of stay meeting introduced by WD • Weekly high risk patient meeting introduced by CNO	G

Risk Summary									
BAF Reference and Summary Title:	BAF 12: Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas					Strategic Aims Impacted			
						X			X
Risk Description:	There is a risk that an absence of engagement with the wider ICB population health aims and ESHT services evolve without due regard to interdependent priorities								
Lead Director:	Chief of Staff		Lead Committee:	Strategy Committee		Date of last Committee review:	N/A		
Links to Corporate Risk Register:	Date:	Risk Register Number	Title		Inherent Risk Score	Current Risk Score	Change		
	-	-	*New risk for 2023 so no links apply*		-	-	-		

	BAF Risk Scoring								
Inherent Risk	Quarter	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
	Likelihood:	3	3	3		Following the establishment of the health inequalities role, we have undertaken engagement with services, which has found that we have pockets of good engagement within certain specialties that has been well established over time, so this impacts the scale of consequence – hence the shift from 3 to 2 in Q2. The challenge we are aiming to address with this risk is how to systematise/spread good practice across the Trust.	Likelihood:	2	Review every two months
	Consequence:	3	2	3			Consequence:	2	
	Risk Level:	9	6	9			Risk Level:	4	

Cause of risk:	• Challenge to ensuring spread and scalability of good practice • Tracking and prioritising high impact projects/initiatives • Failure to engage with external stakeholders – leads to little/poor insight	Impact:	• Inability to demonstrate how ESHT is "improving the health of our communities" as part of our strategic aims, due to an absence of engagement with community voices • Disconnection with partner organisations at a time when collaboration to redesign and tackle wide-ranging, population health-related issues
Current methods of management (controls)	A. Routine information gathering as part of report collation B. Where significant transformation is taking place (e.g. cardiology, ophthalmology) members of the team have been trained or have experience in establishing meaningful engagement (in line with statutory/legal obligations)		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Through reporting documentation (basic stakeholder analysis) to show engagement approaches	• Teams engage relevant corporate support (health inequalities, communications) to advise and support where engagement is required	• EDs to support prioritisation of team resources to ensure appropriate support is given to most pressing risk areas (e.g. where corporate reputation may be at risk)
Gaps in control/assurance:			
• None seen currently			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Corporate support team(s) to ensure population health priorities feature in service development	Chief of Staff	Q3		A
2.	Development of a governance framework to support engagement with Divisional teams that enables ESHT to track where and how population health issues are being addressed	Chief of Staff	Q4		R
3.	Wider engagement with service users to ensure patient voice features in the operational plans	Chief of Staff	Q4		A

Risk Summary								
BAF Reference and Summary Title:	**BAF 13: Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services**					**Strategic Aims Impacted**		
								x
Risk Description:	**There is a risk that ESHT develops services without adequate involvement of the diverse range of services users and the insight they bring. This may lead to suboptimal patient experience and the potential to create/exacerbate access and responsiveness challenges to groups of patients**							
Lead Director:	Chief Of Staff		**Lead Committee:**	Strategy Committee		**Date of last Committee review:**	25/08/22	
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**		**Inherent Risk Score**	**Current Risk Score**	**Change**	
	-	-	*New risk so no links apply*		-	-	-	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
(5x3)	**Likelihood:**	**4**	**4**	**4**		There is a greater than 50:50 probability that when developing services we do not encourage patient involvement at an early stage, or make it happen. This means that we develop services from an exclusive (NHS) perspective, long on good intent but short on user experience. We fail to take into account the insight of others that may make our services better – more accessible and responsive	**Likelihood:**	**2**	Year end
	Consequence:	**3**	**3**	**3**			**Consequence:**	**3**	
15	**Risk Level:**	**12**	**12**	**12**			**Risk Level:**	**6**	

Cause of risk:	• Organisational silos has led to relevant (corp support) teams not communicating with each another as to what they can offer • Absence of proactive support to planners/operational teams in a timely manner • Poor data stratification means ESHT is unable to identify service users by relevant characteristic	**Impact:**	• New models of care and service design risk failure to optimise or maximise the benefits for patients/users/families • This could lead to a less positive experience for users – and staff, who bear the brunt of user frustration (as opposed to satisfaction) • If user engagement is done at all, the task falls on the service – usually already challenged in transitioning to delivering a different/changed way of working
Current methods of management (controls)	A. Current patient engagement is voluntary (through the volunteers) and management is focused on activity/task-based support B. Patient experience of our services comes through three forums (Complaints (negative), PALS (largely neutral) and plaudits (Friends and Family) so any themes that patients are raising can come through there C. Where we undertake major transformations (e.g. cardiology, ophthalmology) we will engage through formal consultations and our steering groups for these two services contain patient representatives		

Assurance Framework – 3 Lines of Defence – linked to controls (A-C)			
	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:	• If there is a shortage of volunteers to cover key tasks this will typically be managed across the areas concerned	• Wider concerns would be escalated through corporate nursing, as the volunteer function reports via the ADN	• External review on this point could come via HealthWatch or other VCSE sector organisations to offer an objective view

Gaps in control/assurance:

- None of the current controls (A – C) provide adequate assurance as they fail to address the proactive co-ordination and involvement of patients and service users
- We are reliant on patients taking the initiative as regards wanting to be part of any initiative – there is no organisationally-led approach
- Volunteers are a valuable resource, but not have not typically been deployed to support a planning or insight function
- Patient representatives provide extremely helpful, evidence-based insights but are not routinely or systematically part of our development/planning processes

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

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	Co-ordination of Patient Experience Team and Communications team to ensure a process, policy and structure for the oversight and management of patients to ensure a systematised approach across the Trust (managed by the patient experience team)	Chief of Staff	Q3 22/23	Teams aware. Meeting set for September with Head of Health Inequalities, AD for Comms and Patient Experience Manager	A
2.	Communications Team to consider how best to promote this with operational teams and Trust-wide programmes		Q3 22/23	Team linking up with other Trusts to understand good practice examples and materials we might adapt	G
3.	Involvement of the Volunteers Team so that they are aware of the work and can offer their objective assessment of our approach		Q3 22/23	Engagement with the volunteers team has begun, ensure they are involved in the process/policy discussions	G
4.	Ensure that we can segment and show BAME and deprivation data (i.e. by postcode) as regards activity and waiting times		Q4 22/23	The labour intensiveness of the manual extraction, and absence of data systems interoperability has meant this data pull is yet to happen. Current staffing and prioritisation issues to year end are also putting the team under pressure. Discussions to be held with the CFO regarding the potential to prioritise in-year	R
5.	Track the impact and effectiveness of the patient role in our programmes (seek the feedback of participants) to ensure we capture from their perspective as to what's working or not and we can adapt and develop our approach		Q4 22/23	Not yet underway	A

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

BAF 1 - Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶
BAF 2 - Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	21/04/2015	1289	Consultant histopathology vacancies	12	20	◀▶
	19/10/2016	1552	Cardiac physiology staffing	12	16	▼
	03/05/2017	1616	Consultant vacancies in the medicine division	16	20	◀▶
	14/11/2017	1680	Wait times for routine Child Development clinic referrals >24 months	12	16	◀▶
	17/05/2018	1721	Insufficient physiotherapy staffing for neurological outpatient service	15	15	◀▶
	21/12/2018	1772	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	06/09/2019	1830	Failure to meet turnaround times in cellular pathology	12	20	▲
	01/07/2020	1896	Unchaperoned ultrasound examinations	16	16	◀▶
	15/07/2021	2057	Noncompliance with NaDIA inpatient diabetic foot pathway	16	16	◀▶
	12/08/2021	2066	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	25/11/2021	2079	Construction project manager vacancies	25	16	◀▶
	25/11/2021	2080	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	17/03/2022	2091	Reliance on non-qualified and temporary workforce in order to provide 24/7 Covid-19 lab testing service	16	16	◀▶
	28/06/2022	2114	Delays in out of hours patient assessment times	20	16	◀▶
	29/07/2022	2127	Vacancy rate of occupational therapists	20	20	◀▶
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	01/08/2022	2129	International nurses waiting more than 15 weeks for an OSCE place at national test centres	16	16	◀▶
	17/08/2022	2135	Vacancies in radiology and histopathology increasing diagnostic service waiting times	12	15	**NEW**
	25/10/2022	2152	Registered nurse vacancies at Rye	25	20	**NEW**

	01/11/2022	2157	Increased respiratory outpatient waiting times	16	16	**NEW**
BAF 3 - Decline in staff welfare, morale and engagement that impacts standards of care in 22/23						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	29/04/2020	1867	Violence and Aggression Trust wide	16	16	◀▶
	29/07/2022	2127	Vacancy rate of occupational therapists	20	20	◀▶
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	01/08/2022	2129	International nurses waiting more than 15 weeks for an OSCE place at national test centres	16	16	◀▶
BAF 4 - Failure to deliver income levels/manage cost/expenditure impacts savings delivery						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	17/03/2022	2102	Delivery of 2022/23 Financial Plan	20	15	◀▶
BAF 5 - Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	-	-	*New risk so no links apply*	-	-	-
BAF 6 - The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	The risks on the Corporate Risk Register comprise a combination of backlog risk issues that have been raised over the previous 19 years. These are presented in full to the Audit Committee.					
BAF 7 - Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	23/08/2017	1660	Cyber Security	20	16	◀▶
	03/09/2018	1739	Failure of internal communications networks	12	16	◀▶
	01/02/2021	2026	The Disaster Recovery Solution for Critical Systems	16	15	◀▶
	21/03/2022	2092	Unmitigated Software Vulnerabilities	16	16	◀▶
	21/03/2022	2098	Asset management and shadow IT	20	16	◀▶
	21/03/2022	2099	ESHT data centre segregation	20	16	◀▶
	21/03/2022	2100	3rd party and supplier remote access controls	20	16	◀▶
	04/11/2022	2158	Multi Factor Authentication	16	16	**NEW**
BAF 8 - Failure to develop business intelligence weakens insightful and timely analysis to support decisions						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	03/09/2018	1739	Failure of internal communications networks	12	16	◀▶
	05/09/2018	1748	Obsolete business continuity plans	16	16	◀▶

BAF 9 - Failure to transform digitally and deliver associated improvements to patient care						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	25/09/2015	1360	Cardiology Catheter Lab breakdowns	12	16	◀▶
	01/02/2021	2026	The Disaster Recovery Solution for Critical Systems	15	15	◀▶

BAF 10 - Failure to maintain focus on improving care						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	-	-	*New risk so no links apply*	-	-	-

BAF 11 - Risk of not being able to maintain delivery of safe, high quality effective care due to huge numbers of patients that no longer meet the criteria to reside.						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	03/12/2018	1764	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	12/06/2020	1884	Delayed surgical treatment	16	16	◀▶
	24/09/2020	1913	Waiting time for treatment in excess of 52 weeks	16	16	◀▶
	03/12/2020	1942	Risk of insufficient beds during winter	16	16	◀▶

BAF 12 - Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	-	-	*New risk for 2023 so no links apply*	-	-	-

BAF 13 - Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services						
Date: Links to Corporate Risk Register:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change	Date:
	-	-	*New risk for 2023 so no links apply*	-	-	-

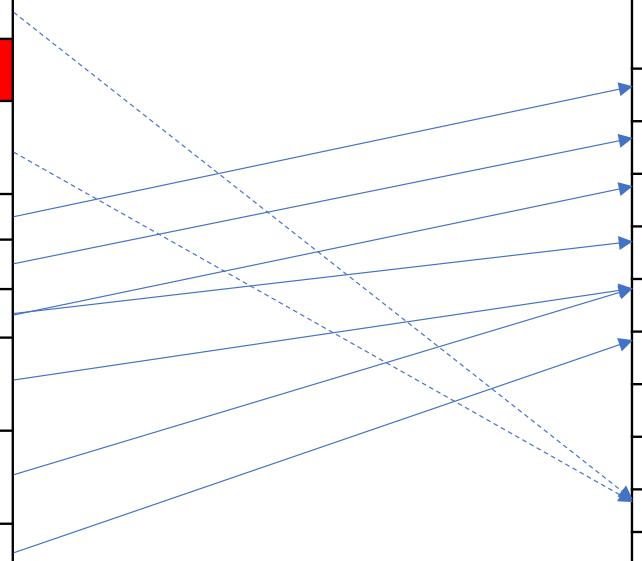
Appendix Two – BAF Summary 2020/21 and 2021/22

Ref	RISK SUMMARY	Monitoring Committee	Objectives Impacted					Inherent risk	Current position (Residual risk)								Change	Risk appetite	Target rating	Target date
									2020/21				2021/22							
									Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
BAF 1	Safe care - sustained and continuous improvement	Q&S	✔					20	9	9	12	16	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

Appendix Three – Tracking BAF risks from 2021/22 to 2022/23

Risks from 21/22 BAF

BAF 1 – Safe care - sustained and continuous improvement
~~BAF 2 – Restoration and recovery Ongoing impact of Covid19~~
BAF 3 - The Trust's performance against key access standards is inconsistent
BAF 4 - Sustainable Workforce
BAF 5 – Protecting our Staff
BAF 6 - Financial Sustainability
BAF 7 - Investment required for IT, medical equipment and other capital items
BAF 8 – Investment required for estate infrastructure – buildings and environment
BAF 9 - Cyber Security



Risks in 22/23 BAF

BAF 1	Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture (NEW)
BAF 2	Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time
BAF 3	Decline in staff welfare, morale and engagement that impacts standards of care in 22/23
BAF 4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery
BAF 5	Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23
BAF 6	Impaired estates/capital limits the ability to provide services & equipment safely for patients/staff
BAF 7	Vulnerability of IT network and infrastructure to prolonged outage including cyber attack
BAF 8	Failure to build business intelligence weakens delivery of insightful and timely analysis to support decisions (NEW)
BAF 9	Failure to transform digitally and deliver associated improvements to patient care (NEW)
BAF 10	Failure to maintain focus on improving care
BAF 11	Inability to ensure patients are treated in the right settings (NEW)
BAF 12	Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas (NEW)
BAF 13	Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services (NEW)

Appendix Four: Risk Matrix

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

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

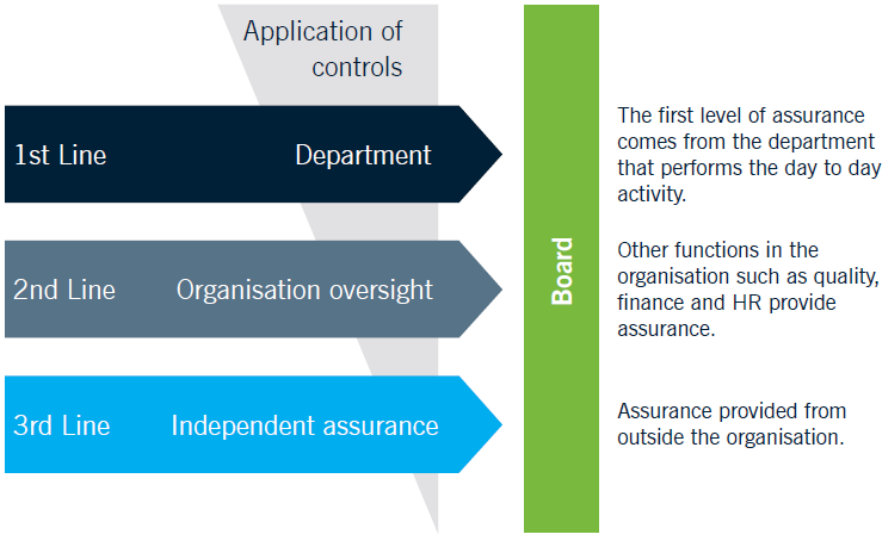
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

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

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

Appendix Five – Three Lines of Defence Assurance Model

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



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

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

East Sussex Healthcare NHS Trust

EPRR Update Report

Purpose of the paper	To update the Trust Board on Emergency Preparedness, Resilience & Response (EPRR) performance at ESHT, as required by the NHSE Core Standards for EPRR.
	For Decision: ; For Assurance: x; For Information:
Sponsor/Author	Sponsor Sheila Roberts (Winter Resilience Director). Report drafted by Kevin Claxton (Head of EPRR) & Garry East Deputy Chief Operating Officer (COO)- Unplanned Care.
Governance overview	This paper comes to the Board (via the Audit Committee), on behalf of the Trust's EPRR Steering Group. EPRR performance also feeds into the Deputy COO's Integrated performance monitoring arrangements.

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

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

Recommendation	The Trust Board is asked to note the contents of this paper as required by the NHSE Core Standards for EPRR.

Executive Summary	To comply with assurance requirements, this report covers the period since September 2022, and includes overviews of: • Training and exercises undertaken by the organisation • Summary of any business continuity, critical incidents and major incidents experienced by the organisation • Lessons identified and learning undertaken from incidents and exercises • The organisation's compliance position in relation to the latest NHS England EPRR assurance process. • An overview of EPRR risks. The paper closes with notable successes and challenges over the recent period.

Next steps	To comply with the Core Standards Assurance, "The Chief Executive Officer (CEO) (must) ensure that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. (Evidence to be submitted includes Public Board Minutes). A further EPRR Update Report will come to the Audit Committee and the Trust Board later this calendar year. Further compliance with EPRR Assurance will take place in the Trust Annual Report (where as required, "the organisation (will) publicly state its readiness and preparedness activities in (its) annual report.")

Introduction.

The Trust continues to recognise and comply with its duties as a 'Category 1 responder' under the Civil Contingencies Act 2004 (CCA2004), and the requirements of the NHS EPRR Framework. Core tasks within the CCA2004 are:

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

EPRR Training and exercises undertaken by the organisation

ESHT has a record of commitment to both internal & external EPRR exercises. However, the ongoing Covid-19 pandemic, operational challenges, a high number of incidents and staffing levels in the EPRR team has restricted level of training taking place.

- The EPRR team staffing has been 2 WTE over much of this period however the team has also been impacted by staff sickness. Very recently the team has been authorised to take on a business support role full time and this will include monitoring the 'Trust Operation centre' role during normal office hours.
- The 'Practical EPRR for On-Call Staff' has now been largely moved to E-learning with the theory aspects of Chemical, Biological, Radiological and Nuclear (CBRN) Training also moving to E-Learning. The team intends to do the same with Major Incident training during 2023, with assistance from the training development team.
- The EPRR team have run monthly 'Major Incident' & practical 'CBRN/Hazmat' courses on both sites and due to EPRR Assurance requirements, have presented a paper to the Trust Education Steering Group, which highlighted a requirement for elements of EPRR Training to be mandatory. This was accepted but it is understood that the Trust has ongoing Executive level discussions regarding mandatory training requirements.
- Unfortunately, due to EPRR team sickness and several Trust incidents, along with the challenges of staff being released for training, a large percentage of training scheduled since September has been cancelled.
- The EPRR team continue to provide practical EPRR training to senior staff on On-call rotas but unfortunately for similar reason to those already mentioned, attendance has been limited. The EPRR team is working with the Winter Resilience Director to identify further dates, utilising Associate Directors of Operations' meetings to try and ensure wider coverage.

The focus for EPRR team going forward is to return to a full training provision. Ideally, the agreement of EPRR training being made mandatory would support the Trust objective to gaining full compliance with EPRR training over the coming year.

Organised exercises also largely ceased due to the pandemic however more recently there has been increased exercise activity:

- Nov 10th 2022 – Exercise Jasper (ICB Incident alerting cascade exercise involving EPRR Team)
- Also, on 10th Nov 2022 The EPRR Team & Trust Digital staff attended a 'Crisis Simulation exercise hosted by the Integrated Care Board at the Amex Stadium, Brighton.
- Nov 14th – 18th 2022 Exercise Artic Willow (NHS E-led exercise on Winter pressures & industrial action, involving EPRR Team and several other staff.
- Nov 23rd 2022– Exercise Lemur – Sussex Resilience Forum Ex on winter power blackouts, attended by EPRR Team and Estates & facilities.

The EPRR team will ensure that the Trust benefits from all multi-agency exercise opportunities, and the additional support that the team currently has in place will result in more internal exercising opportunities during the coming year.

Business Continuity, Critical and Major Incidents

The continuing Covid-19 pandemic response in recent and on-going pandemic waves has seen the Trust's response arrangements combined with the responses to other incidents, (largely managed via the Winter Resilience Director and Deputy COO- Unplanned Care supported by the Trust Operation Centre and EPRR Teams and utilising daily operational bed meetings as the basis for coordination). These have included:

- On-going Avian Flu, Ebola & Mpox response arrangements in Sussex
- Strep A / I-gas outbreak winter 22/23
- Winter operational pressures 22/23
- Ongoing industrial action by NHS & Ambulance staff
- Severe winter weather (snow & ice) December 22.
- Impacts from people arriving in the UK in small boats (including recent Major Incident standby for incident of the Kent coast, December 2022)

Lessons identified from incidents and exercises

In line with the NHS EPRR Framework, the Trust recognises the need to participate in reporting debriefing arrangements, to ensure that learning is identified from both exercises and incidents. The EPRR Team strives to ensure that opportunities are always taken to ensure that lessons are both identified AND learned, and that the Trust participates in available debriefing opportunities, both internally and in the multi-agency arena. The following lessons have been highlighted at ESHT within this period:

- The need to further embed an effective Trust 'incident alerting' and 'staff briefing' system is a recurring theme highlighted in all recent Trust de-briefing processes. The EPRR Team has worked with the Winter Resilience Director's office and with Digital colleagues to place 'Rainbow' with 'WhatsApp, (with which many staff are already familiar from use in the private lives). The ESHT 'EPRR Incidents Alerts' chatgroup is now well-established, and the EPRR Team supports the wide Trust usage of 'WhatsApp' as a means of team communication and information cascade across the Trust.
- Also, because of earlier incident de-briefs, the Winter Resilience Director has supported wider radio usage across the Trust, including in Emergency Departments, and additional radios are now in place in both site offices.
- Additionally, the EPRR Team is assisting Digital, Operational and Estates and Facilities colleagues to develop a workable Business Continuity procedure in the event of the loss of the new Trust landlines at Trust sites which are 'Voice Over Internet Protocol (VOIP) phones.
- In August 2022 the Trust ran an exercise looking at issues raised by the NHS EPRR Assurance 'Deep Dive' into Evacuation & Shelter. Feedback from the exercise will result in an update to the Trust's EPRR response plan for 'Hospital Evacuation' soon.
- Following learning from Business Continuity (BC) incidents and from a tightening of a core standard around ensuring that suppliers have adequate BC arrangements in place, the Trust has agreed that the EPRR Team should have sight of a supplier's BC plans on either contract consideration or renewal. A system has now been agreed, is in place and is working well.

Compliance With NHS England EPRR assurance process

The Audit Committee and Board have previously been made aware that the Trust compliance levels moved from being 'Fully Compliant', to being 'Substantially Compliant' with the EPRR Core Standards Assessment in 2021. In the autumn 2022 process, many core standards were re-written by NHS England, with the evidence requirements being considerably more stringent. The result of this was that many core standards were harder to attain or retain.

Acknowledging the Trust's commitment to a range of ongoing operational responses during the assurance period August-October 22 as highlighted above, the EPRR Team is very grateful for the assistance provided by several colleagues including those from Procurement, Estates & facilities, Communications Team, the Winter Resilience Director's office, and others.

As part of the work required in connection with the assurance round, the Team has reviewed and recently published updates to all its suite of EPRR Plans. Many required minor changes resulting from CCGs being replaced with ICBs, and some required more in-depth reviews, including the Corporate Business Continuity Plan. Additionally, there was greater focus on the need for the Trust to have workable service-level Business Continuity Plans (BCPs) in place across the Trust, and there was a requirement for a (new) BC policy. The EPRR team continues to support key services including (Emergency departments, ESHT

Digital, DAS and others) to develop these plans and puts significant effort into working with service leads to draft BC Plans and offer EPRR advice and support.

As a result, the Trust understands that it has retained its 'Substantially Compliant' status this year. The Trust is awaiting final written confirmation regarding this; however, this was agreed at the Strategic 'Local Health Resilience Partnership' meeting attended by the Deputy COO- Unplanned Care in December 2022. This is a success story for the Trust as we believe that we were the only Sussex provider Trust to retain its status this year.

However, the Team will not rest on its laurels. If the Trust is to progress to full compliance with EPRR Assurance in 2023, we will have to maintain compliance against the current standards and any new standards, as well as attaining compliance in the 3 out of 64 standards that we failed to attain this year. These are:

- CS 3. Governance – EPRR Board Reports – Not attained because reports were not fully presented to Board and published accordingly. To rectify compliance with this standard next year, the EPRR Team have highlighted this to the Trust, to ensure the full reports reach the Board and are published.
- CS 12. Duty to Maintain Plans - Infectious Disease – An updated over-arching plan is to be drafted & signed off in conjunction with Infection Prevention and Control in the coming year, following system wide plans being drafted by the ICB.
- CS 51. Business Continuity – BC Audit – An internal Audit report has been drafted for a 2022 audit; the results of audits & progress of actions are to be reported to Audit & Board.

Actions to attain these standards have also been added to the EPRR workplan which is monitored at quarterly Trust EPRR Steering Group meetings, as well as them being highlighted in this report. Additionally, the Team is committed to progressing the actions identified in the Internal Audit of EPRR & Business Continuity referenced above.

Overview of EPRR Risks

The Trust EPRR risk register is linked to ESHT risk systems, and to the Local Health Resilience Partnership (LHRP) and the Sussex Resilience Forum (SRF) Community Risk registers and is reviewed monthly. Current Risks include 12 risks, the same as the last report. Of these, the top 3 risks as reported to the strategic LHRP meeting in December 22 and also feature on the Trust's Strategic Risk Register with a score of 15 or above. These are:

1. Under-utilised EPRR Training Programme (Risk 1738 – score 16)
2. Failure or degradation of internal communications networks leading to Digital BC incident. (Risk 1739 – score 16)
3. Obsolete Business Continuity Plans (Corporate and service-level) (Risk 1748 – score 16)

Notable Successes

Successes include:

- Maintaining compliance with EPRR Assurance as 'Substantially Compliant'.
- The implementation of the EPRR Business Support post (to include the 'Trust Operation Centre' role).
- Some progress made with delivery of exercising, training and BCPs against a background of continual response and staff shortages.

Notable Challenges

On-going challenges currently include:

- Numbers of incidents and pressures detracting from 'preparedness' work across the Trust
- Recognising the acceptance of EPRR training as 'mandatory training' and finding ways to ensure that operational staff are released for the training.
- Progressing BCP development across parts of the Trust.
- Long term funding (as part of Business Planning) for EPRR Business Support officer post.

Kevin Claxton (Head of EPRR) on behalf of
Garry East (Dep COO) and Sheila Roberts (Winter Resilience Director), East Sussex Healthcare NHS Trust

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

Purpose of the paper	An annual review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation has been undertaken and proposed revisions are outlined in the attached paper. Changes to the documents are highlighted in red for the Board's convenience. Any formatting issues present will be resolved in the final published versions of the documents.					
	For Decision	x	For Assurance		For Information	
Sponsor/Author	Sponsor: Damian Reid Author: Pete Palmer					
Governance overview	This paper was presented to the Audit Committee on 26th January 2023, who endorsed the updated Trust governing documents for approval by the Trust Board.					

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

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

Recommendation	The Trust Board is asked to approved the proposed changes to the Trust's Governing Document, which includes the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Executive Summary

The Trust Board is required to review the Trust's Governing Documents on an annual basis. The documents reviewed are:

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

The review is carried out jointly by the Director of Finance and Deputy Company Secretary, with input from the Deputy Director of Finance and the Head of Procurement.

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

The three existing governing documents were individually updated before being merged into a single document, which also includes a schedule of decisions reserved for the Board, extracted from the Standing Orders. The single document allows for easier cross reference between the Governing Documents.

The content of the document remains the same (albeit updated) from the previous versions seen by the Board. All changes to last year's Governing Documents can be found in red text. 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
P13 3.1.6	Added information clarifying that public notices of time and place of Board meetings could be displayed on line.	-
P20 4.8.4	Changed name of Finance and Investment Committee	Finance and Productivity Meeting
P21 4.8.6	Changed name of Strategy Committee	Strategy and Transformation Meeting

Standing Financial Instructions

Page Number and Reference	Detail	Replaced with
P44 3.7.1	Increased the threshold for approval of business cases and service changes by the F&P Committee from £1m to £2.5m	-
P59 7.8	Increased the threshold for approval of tenders and competitive quotations by the BDG/CRG and Execs for spend within current budget from £1m to £2.5m	-
P72, 13.1.2-13.1.5	Added detailed information about the treatment of replacement and investment capital assets	-
P87 22.2.2	Added requirement that Audit Committee receive updates on a quarterly basis when less than three suppliers respond to invitation to tender	-

Scheme of Delegation

Page Number and Reference	Detail	Replaced with
P112 13.1.2	Added detailed information about the treatment of replacement and investment capital assets, including increased approval thresholds for replacement capital assets of up to £2.5m for Execs and up to £5m for F&P Committee.	-
P120 Section 2, 4k-l	Increased threshold for approval of new spend to £2.5m for F&P Committee	-
P121 Section 2, 4	Increased threshold for authorisation of waivers to £2.5m for Audit Committee	-
P131 Section 2, 23	Added review of charitable fund bids by Executives for spend of over £1k	-

Next steps	If endorsed by the Trust Board the Governing Documents will be updated on the Trust's intranet.

East Sussex Healthcare NHS Trust Governing Documents, incorporating:

- **Standing Orders**
- **Standing Financial Instructions**
- **Scheme of Delegation**

Document ID Number	
Version:	V1.1.1
Ratified by:	Trust Board
Date ratified:	
Name of author and title:	Chief Financial Officer & Chief of Staff
Date originally written:	January 2023
Date current version was completed	January 2023
Name of responsible committee/individual:	Trust Board / Chief Financial Officer & Chief of Staff
Date issued:	
Review date:	January 2024
Target audience:	All Staff
Compliance with CQC Fundamental Standard	N/A.
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	N/A

Written/Produced By:	Title/Directorate	Date:
Pete Palmer	Deputy Company Secretary	January 2023

Doc ID xx

Person Responsible for Monitoring Compliance & Review	Chief Financial Officer / Chief of Staff
Signature & Date	January 2023

Multi-disciplinary Evaluation/Approval

Name	Title/Specialty	Date:
Audit Committee		26th January 2023

Ratification Committee

Issue Number (Administrative use) only)	Date of Issue & Version	Next Review Date	Date Ratified	Name of Committee/Board/Group
1.1	Jan 2023, v1.1	Jan 2024	14.02.23	ESHT Trust Board

Contents

1. Foreword to Standing Orders

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

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

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

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

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

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

.

Introduction

Statutory Framework

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

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

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

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

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

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

NHS Framework

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

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

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

Delegation of Powers

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

Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO.5) the Trust is given powers to 'make arrangements for the exercise, on behalf of the Trust of

any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct'. Delegated Powers are covered in a separate document 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

Interpretation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

'Membership, Procedure and Administration Arrangements Regulations' means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

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

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

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

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

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

'SFIs' means Standing Financial Instructions.

'SOs' means Standing Orders.

'Trust' means the East Sussex Healthcare NHS Trust.

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

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

The 'Regulator' means NHS England or successor body.

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

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

2.1 Composition of the Membership of the Trust Board

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

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

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

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

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

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

2.2 Appointment of the Chair and directors

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

2.3 Terms of Office of the Chairman and Members

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

2.4 Appointment and powers of Vice-Chairman

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

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

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

2.5 Appointment and powers of Senior Independent Director

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

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

2.6 Appointment and powers of Associate Non-Executive Directors

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

2.7 Joint Members

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

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

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

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

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

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

2.8 Role of Members

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

2.8.1 Executive Members

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

2.8.2 Chief Executive

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

2.8.3 Chief Financial Officer

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

2.8.4 Non-Executive Members

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

2.8.5 Chairman

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

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

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

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

2.9 Corporate Role of Board

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

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

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

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

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

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

2.11 Lead Roles for Board Members

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

Part 3 – Meetings

3.1 Calling Meetings

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

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

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

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

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

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

3.2 Notice of Meetings and the Business to be transacted

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

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

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

3.3 Agenda and Supporting Papers

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

3.4 Petitions

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

3.5 Notices of Motion

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

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

3.6 Emergency Motions

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

3.7 Motions: Procedure at and during a meeting

3.7.1 **Who may propose?**

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

3.7.2 **Contents of motions**

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

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

3.7.3 **Amendments to motions**
A motion for amendment shall not be discussed unless it has been proposed and seconded.

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

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

3.7.4 **Rights of reply to motions**

a) 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

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

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

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

3.11 Voting

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

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

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

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

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

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

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

3.12 Suspension of Standing Orders

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

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

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

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

3.13 Variation and Amendment of Standing Orders

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

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

3.14 Record of Attendance

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

3.15 Minutes

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

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

3.16 Admission

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

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

3.16.2 **General Disturbances**

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

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

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

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

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

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

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

3.17 Observers at Trust Meetings

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

Part 4 – Appointment of Committees and Sub Committees

4.1 Appointment of Committees

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

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

4.2 Suspension of Standing Orders

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

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

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

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

4.4 Terms of Reference

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

4.5 Delegation of powers by Committees to Sub-Committees

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

4.6 Approval of Appointments to Committees

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

4.7 Appointments for Statutory functions

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

4.8 Committees established by the Trust Board

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

4.8.1 **Audit Committee**

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

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

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

4.8.2 **Remuneration and Appointments Committee**

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

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

4.8.3 **Quality and Safety Committee**

The Trust Board will establish a Quality and Safety Committee to provide assurance to the Trust Board that the Trust is providing safe and high quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care. It will review whether local and national targets are met and that lessons learned from

incidents, complaints and claims. The terms of reference will be approved by the Trust Board and reviewed on at least an annual basis.

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

4.8.4 **Finance and Productivity Committee**

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

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

4.8.4.1 **Capital Sub Committee**

The Finance and Productivity Committee may establish a capital 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 Productivity Committee.

4.8.5 **People and Organisational Development Committee**

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

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

4.8.6 **Strategy and Transformation Committee**

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

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

4.8.7 **Other Committees**

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

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

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

5.1 Delegation of Functions to Committees and Officers

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

5.2 Emergency Powers and urgent decisions

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

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

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

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

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

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

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

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

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

6.1 Policy Statements General Principals

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

6.2 Specific Legislation, Policy and Guidance

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

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

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

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

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

(i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. 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 6.3)

7.2 Register of Interests

The Associate Director of Corporate Governance in consultation with the Chief of Staff will ensure that a Register of Interests is established to 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 SO 6.1.2) which have been declared by both executive and non-executive Board members, as defined in Standing Order 5.5.

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

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

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

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

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

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

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

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

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

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

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

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

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

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

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

7.3.2 **Exclusion in proceedings of the Trust Board**

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

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

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

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

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

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

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

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

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

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

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that

Committee, the Chairman of the Trust;

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

(3) **Application of waiver**

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

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

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

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

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

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

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

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

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

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

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

The removal is subject to the following conditions:

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

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

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

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

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

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

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

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of business conduct policy

7.4.1 **Trust Policy & National Guidance**

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

7.4.2 **Interest of Officers in Contracts**

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

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

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

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

Appointments

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

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

7.4.4 **Relatives of Members or Officers**

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

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

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

8.1 Custody of Seal

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

8.2 Sealing of Documents

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

8.3 Register of Sealing

The Associate Director of Corporate Governance shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Custody of Seal

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director. The Associate Director of Corporate Governance may act as a counter signatory if required.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease,

contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

Part 9 – Miscellaneous

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

ENDS

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

Standing Order 1.5 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, , which may include members participating by video or telephone." These powers and decisions are set out in this Schedule.

1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1. Approve, including variations to:

- 1.1.1. Standing Orders for the regulation of its proceedings and business.
- 1.1.2. this Schedule of matters reserved to the Trust Board.
- 1.1.3. Standing Financial Instructions
- 1.1.4. Scheme of Delegation, including financial limits in delegations, from the Trust Board to officers of the Trust.
- 1.1.5. suspension of Standing Orders

1.2. Determine the frequency and function of Trust Board meetings, including:

- 1.2.1. administration of public and private agendas of Board meetings
- 1.2.2. calling extra-ordinary meetings of the Board

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation ; and:

- 1.4.1. delegate functions from the Board to the committees
- 1.4.2. delegate functions from the Board to a director or officer of the Trust
- 1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies
- 1.4.4. receive reports from Board committees and take appropriate action in response to those reports
- 1.4.5. confirm the recommendations of the committees which do not have executive decision making powers
- 1.4.6. approve terms of reference and reporting arrangements of committees
- 1.4.7. approve delegation of powers from Board committees to sub- committees

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- 1.5.1. Appoint the Chief Executive
- 1.5.2. Appoint the Executive Directors

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests

1.7. Agree and oversee the approach to disciplining directors who are in breach of

statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.
1.9. Approve arrangements for dealing with and responding to complaints.
1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on Trust
1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. Determination of strategy and policy

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.
2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans
2.2.2. definition of the strategic aims and objectives of the Trust.
2.2.3. clinical and service development strategy
2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3. Direct operational decisions

3.1. Approve capital investment plans:

3.1.1. the annual capital programme
3.1.2. all variations to approved capital plans over £1 million
3.1.3. to acquire, dispose of, or change of use of land and/or buildings
3.1.4. capital investment over £2.5 million in value, supported by a business case and in line with the approval guidance issued by NHS England & Improvement.
3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k).

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.
3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5 million:

3.3.1. Tenders and quotations over the lifetime of the contract
3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement
3.3.3. Orders processed through approved supply arrangements
3.3.4. Orders processed through non-approved supply arrangements
3.3.5. Receipt of loans and trials equipment and materials
3.3.6. Prepayment agreements for services received

3.4. Decide the need to subject services to market testing

4. *Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.
4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:
4.2.1. The Care Quality Commission
4.2.2. NHS Improvement
4.3. Consider and approve of the Trust's Annual Report including the annual accounts.
4.4. Approve the Annual report(s) and accounts for funds held on trust.
4.5. Approve the Quality Account

5. *Audit arrangements*

5.1. Approve audit arrangements recommended by the Audit & Risk Committee (including arrangements for the separate audit of funds held on trust).
5.2. Receive reports of the Audit & Risk Committee meetings and take appropriate action.
5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.
5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit & Risk Committee, where appropriate.
5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

ENDS

Appendix 2 – Standing Financial Instructions

1. Introduction

1.1 General

1.1.1 The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs). There will be a training and communication programme administered by the Chief Financial Officer to affect these SFIs.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters Reserved to the Board and Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer .

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 **FAILURE TO COMPLY WITH SFIs and SOs IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 **Overriding Standing Financial Instructions**
If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non- compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Trust's Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions; and

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

b) '**Board**' means the Board of the Trust;

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

d) '**Budget Holder'** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

e) '**Chief Executive**' means the chief officer of the Trust;

f) '**Chief Financial Officer**' means the chief financial officer of the Trust;

g) '**Executive Director**' means a member of the Trust who is an officer;

h) '**Funds held on trust**' shall mean those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the National Health Service Act 2006 and the Health and Social Care Act 2012. Such funds may or may not be charitable;

i) '**Legal Adviser**' means the properly qualified person appointed by the Trust to provide legal advice;

j) '**Officer**' means employee of the Trust or any other person holding a paid appointment or office with the Trust;

k) '**Non-Executive Director**' means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of the Membership and Procedure Regulations;

l) '**Trust**' means the East Sussex Healthcare NHS Trust;

m) Any reference to an act should be taken to include any subsequent legislation.

1.2.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term 'employee' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Any employee of the Trust who solicits or accepts any gift or consideration of any kind from contractors or their agents or from any organisation, firms or individual, as an inducement or reward for doing or refraining from doing anything in his official capacity, or for showing favour or disfavour to any person in his official capacity shall be liable to dismissal and to prosecution. All dealings shall be in accordance with "Standards of Business Conduct for NHS Staff."

1.2.5 Powers not defined by Standing Orders or these SFIs shall be exercised on behalf of the Trust by such officers as the Chief Executive designates, within such limits and subject to such conditions as the Chief Executive shall prescribe.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) formulating the financial strategy;
b) requiring the submission and approval of budgets within overall income;
c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of Matters Reserved to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as Accountable Officer to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board and employees and all new appointees are notified of and understand their responsibilities within these instructions.

1.3.7 The Chief Financial Officer is responsible for:

a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

d) the provision of financial advice to other members of the Board and the wider organisation;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding unplanned financial losses;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer .

2. Audit

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Trust's Board shall establish an Audit Committee which will provide an independent and objective view of internal control by:

(a) concluding upon the adequacy and effective operation of the organisation's overall internal control system. In particular it is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust;

(b) reviewing the establishment and maintenance of effective systems of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives;

(c) ensuring that there is an effective internal audit function, including the Counter Fraud function, establishment by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;

(d) reviewing the work and findings of the external auditor and consider the implications of management's responses to their work.

(e) receive a report on tenders and waivers and framework direct awards that exceed £250k (cumulative if a supplier is awarded more than one contract for the same project);

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care. (via the Chief Financial Officer in the first instance.)

2.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.2 Chief Financial Officer

2.2.1 The Chief Financial Officer is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities not involving fraud or corruption (for cases involving suspected fraud or corruption see paragraph 15.2.3);

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

i. a clear opinion on the effectiveness of internal control;
ii. major internal (financial) control weaknesses discovered; progress on the implementation of internal audit recommendations;
iii. progress against plan over the previous year;
iv. strategic audit plan covering the coming three years;
v. a detailed plan for the coming year.

2.2.2 The Chief Financial Officer and designated auditors are entitled without necessarily giving prior notice to require and receive;

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case they shall have a duty to safeguard that confidentiality);

b) access at all reasonable times to any land, premises, members of the Board or employees of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of the Board and employee's control; and

d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. fraud and other offences,
ii. waste, extravagance, inefficient administration,
iii. poor value for money or other causes.

e) Internal Audit shall also independently verify the Assurance Framework in accordance with guidance from the Department of Health.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning; cash, stores, other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

2.3.3 The Audit Manager/Director of Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Audit Manager/Director of Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years.

2.3.5 The Audit Manager shall report direct to the Chief Financial Officer who shall refer audit reports, under agreed reporting arrangements, to the appropriate designated officers. Recipients of an audit report shall send a written response within two weeks stating the action to be taken in response to the audit recommendations. Failure to take any necessary action within a reasonable period shall be reported to the relevant Executive Director.

2.4 External Audit

2.4.1 The external auditor is appointed and paid for by the Trust. The Audit Committee must ensure that the Trust receives a cost efficient service. Should there be a problem which cannot be resolved by the Audit Committee, then this should be discussed with the external auditor and if appropriate referred to the Board for resolution. In exceptional circumstances the issue may be referred to NHSI if it cannot be resolved.

2.5 Fraud and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the Secretary of State's Directions on fraud and bribery.

2.5.2 In line with their responsibilities, the Board shall monitor and ensure compliance with the provisions of the Bribery Act 2010. Senior officers (including non-board level managers) can be individually held criminally liable for the Trust's bribery offences.

2.5.3 All suspicions of bribery should be reported to the Trust's Local Counter Fraud Specialist. Detailed guidance can be found in the Trust's Counter Fraud & Bribery Policy.

2.5.4 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.5 The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work with staff in the Directorate of Counter Fraud

Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.5.6 The Local Counter Fraud Specialist will provide a written report, at least annually to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. Business planning, budgets, budgetary control and monitoring

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources and is in accordance with the guidance issued by NHSI.

The annual plan content and the number of submissions are defined by NHSI. The plans usually contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

c) detailed financial templates, accompanying finance narrative and operational/strategic narrative.

3.1.2 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and the delivery of a balanced budget.

3.1.3 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the annual business plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared as far as is reasonably practicable within the limits of available funds; and

e) identify potential risks and the means of mitigating such risks.

3.1.4 The Chief Financial Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Board. As a consequence the Chief Financial Officer shall have the right of access to all budget holders on budgetary related matters.

3.1.5 All budget holders must provide information as required by the Chief Financial Officer to enable budgets and annual plans to be compiled.

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

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

3.2 Budgetary Delegation

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

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement;

e) achievement of planned levels of service; and

f) the provision of regular reports.

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

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

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

3.3 Budgetary Control and Reporting

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

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

(i) income and expenditure to date showing trends and forecast year end position (Income Statement);
(ii) movements in working capital (Statement of Financial Position);
(iii) movements in cash and capital;
(iv) capital project spend and projected outturn against plan;
(v) explanations of any material variances from plan;
(vi) Cost Improvement Programme Report;
(vii) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, activity and workforce budgets;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer ;

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 Contract Income

3.4.1 The Chief Financial Officer of the Trust will:

a) periodically review the bases and assumptions used for compiling budgets and ensure that these are reasonable and realistic;

b) periodically review contract income and all other sources of income to ensure the Trust is obtaining all the funds due;

c) prior to the start of each financial year submit to the Trust's Board of Directors for approval a report showing the total expected contract income received and the proposed allocation including any sums to be held in reserve; and

d) regularly update the Trust's Board of Directors on significant changes to contract income and the uses of such funds.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 13)

3.6 Monitoring Returns

3.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSI within agreed timescales.

3.7 Business cases and service changes

3.7.1 For any service change which requires an increase to the cost base of the Trust even if there is offsetting income, it is the responsibility of the Executive lead for the respective area to ensure the following process is followed:

a) A service change proposal should be developed and submitted to the relevant Integrated Performance Review (IPR) for approval;

b) For cases over £50,000 per annum increase in costs a business case should be submitted to Business Development Group (BDG) for recommendation to Executive Directors which is required to approve the case

c) For cases over £500,000 per annum approval is also required from Finance and Productivity Committee.

d) For cases over £2,500,000 per annum approval is also required from the Board

3.7.2 A case may require approval from a more senior committee than the financial values alone may dictate due to the nature of the change being proposed, this is beyond the scope of this document but the relevant committee will advise on an ad hoc basis and accountability for seeking appropriate approval will sit with the Executive Director lead.

4. Annual Accounts and Reports

4.1 The Chief Financial Officer, on behalf of the Trust, will:

a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

b) prepare and submit annual financial reports to the Secretary of State certified in accordance with current guidelines; and

c) submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care (DHSC).

4.2 The Trust's annual accounts must be audited by the appointed auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting, (see 1.3.2). The document will comply with the DHSC group accounting manual (GAM) .

5. Bank and Office of Paymaster general accounts

5.1 General

5.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account DHSC guidance/directions. In line with 'Cash Management in the NHS', Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and Government Banking Service (GBS) Accounts

5.2.1 The Chief Financial Officer is responsible for:

a) GBS and bank accounts;

b) establishing separate bank accounts for the Trust's non exchequer funds;

c) ensuring payments made from GBS or bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken); and

e) monitoring compliance with DHSC guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of GBS and bank accounts which must include:

a) the conditions under which each GBS and other bank account is to be operated;

b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No bank account may be opened for official monies without the approval of the Chief Financial Officer.

5.4 Tendering and Review

5.4.1 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. Income, fees and charges and security of cash, cheques and other negotiable instruments

6.1 Income Systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The Chief Financial Officer is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow NHSI's and the Department of Health's guidance in setting prices for NHS contracts e.g. "National Tariff Payments System."

6.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the DHSC Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures (See Section 15).

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Chief Financial Officer is responsible for:

a) approving the form of all receipting books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such records;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Cash income may be exchanged for Payable Orders for Petty Cash and Patients Money. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. Tendering and contracting procedure

7.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No 3.12 Suspension of Standing Orders is applied).

7.2 The Public Contracts Regulations 2015 Legislation Governing Public Procurement

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

7.3 Reverse eAuctions

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

7.4 Other Department of Health Guidance

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

7.5 Formal Competitive Tendering

7.5.1 General Applicability

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

The Trust shall ensure that competitive tenders are invited for:

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

7.5.2 Health Care Services

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

7.5.3 Exceptions and Instances where Formal Tendering need not be applied

Formal tendering procedures need not be applied where:

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

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

c) regarding disposals as set out in SFI 15;

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

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

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

g) for construction works under the provision of the DoH ProCure21+/P22/P23 framework;

h) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members where the Head of Procurement and Chief Financial Officer is satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

i) where a statutory payment can only be made to a specific statutory body (eg rates), authorisation of the bodies considered in this category will be determined by the Chief Financial Officer and Head of Procurement.

j) where payment is to another NHS body and the Head of Procurement and Chief Financial Officer is satisfied that the procurement arrangements conform to current statute and deliver value for money;

k) where payment is less than the current 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
From £500,000 to £2,500,000 excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Executive Directors • Chief Financial Officer and Chief Executive
Value of £2,500,000 or above excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Executive Directors • 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
From £500,000 to £2,500,000 excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Executive Directors; and • Finance & Productivity Committee
Value of £2,500,000 or above excluding VAT	• Business Development Group (Revenue) and/or Capital Resource Group (Capital); • Executive Directors; • Finance & Productivity Committee; and • Trust Board and Common Seal of the Trust

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

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

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

The Executive Team is authorised to respond to short notice national capital bids. For any elements over £5m the CEO will have consulted the Chair of the Board before preparing a bid. For the avoidance of doubt Finance & Productivity Committee and the Board retain control over final authorisation of business cases.

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

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

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

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

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

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

7.11 Compliance Requirements for all Contracts

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

a) The Trust's Standing Orders and Standing Financial Instructions;
b) The Public Contracts Regulations 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 8)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's Charitable funds.

8. NHS Service Agreements for provision of services

8.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services. All contracts should aim to implement the agreed priorities contained within the Trust Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- NHS Standard Contract;
- the provision of reliable information on cost and volume of services;
- the NHS Service and Financial Framework (SaFF);
- the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing partnership arrangements;
- that contracts are based on integrated care pathways; and
- The NHS Constitution which has the force of law.

8.2 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast contractual income. This will be supplemented by reports on profitability of individual services based on the costing activity in line with latest guidance.

9. Terms of service, allowances and payment of members of the Board and employees

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting, (see NHS guidance contained in the Higgs report).

9.1.2 The Committee will:

a) provide assurance to the Board around the process for appointing and dismissing all executive directors of the Board, including the chief executive;

b) agree the remuneration package, including performance related pay and other terms of service of the Chief Executive, including the scheme for performance related pay and any other benefits;

c) with the Chief Executive, agree the remuneration packages, including the scheme for performance related pay and other terms of service (including severance terms of applicable) of the executive directors and very senior managers;

d) review and agree the grading and remuneration package of any Director post that falls vacant, prior to the vacancy being advertised; and

e) monitor the system to evaluate the performance of the Chief Executive, the Executive Directors and other senior employees.

9.1.3 The Committee shall report in writing to the Board on an annual basis.

9.1.4 The Trust will remunerate and pay allowances to the Chairman and Non-Executive Directors in accordance with instructions issued by the Secretary of State for Health.

9.1.5 All employees are required as part of their conditions of service to comply with the Trust's and national guidance notes on 'Standards of Business Conduct for NHS Staff'.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or a nominated officer .

9.3 Staff Appointments

9.3.1 Employees may only be engaged, re-engage, or regraded, whether on a permanent or temporary basis, and agency staff may only be hired and changes in any aspect of remuneration can only be made:

a) within agreed policies and procedures; and

b) within the limit of approved budgets and the funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Processing of Payroll

9.4.1 The Chief Financial Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

9.4.2 The Chief Financial Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee and officers;

h) procedures for payment by cheque, bank credit, or cash to employees and officers;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash;

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust; and

n) premature retirement proposals.

9.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Chief Financial Officer 's instructions and in the form prescribed by the Chief Financial Officer ; and

c) notifying termination of employment in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board shall delegate responsibility to a manager for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

10. Non-pay expenditure

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer .

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

10.2.2 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Chief Financial Officer will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of Board members/employees (including specimens of their signatures) authorised to certify invoices.

ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

c) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account The Public Contracts Regulations 2015 rules where the contract is above a stipulated financial threshold); and

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Financial Officer;

c) state the Trust's terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Financial Officer.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made. All leases must be assessed prior to entry and classified as either operating or finance leases under IFRS. Authority to enter into finance leases requires written approval from the Chief Financial Officer .

b) contracts above specified thresholds are advertised and awarded in accordance with The Public Contracts Regulations 2015;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the DHSC;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii) conventional hospitality, such as lunches in the course of working visits;

   iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable, and also notify the details of all such hospitality offered or received, for entry in a register maintained for that purpose by the Chief Executive.

The national guidance contained in HSG 1993/5 'Standards of Business Conduct for NHS Staff' is shown as to Standing Orders 6.2.

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order except for those specifically excepted by the Chief Financial Officer in financial procedures, and purchases from petty cash or on purchase cards;

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of

emergency or urgent necessity. These must be confirmed by an official order and clearly marked ‘Confirmation Order’;

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Chief Financial Officer and;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer ; and

l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

10.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained with ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

Payments to local authorities and voluntary organisations made under the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

11. External borrowing

11.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the DHSC. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer .

11.3 The Chief Financial Officer must prepare detail procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the DHSC.

11.5 Any applications for short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer . The Board must be made aware of all short term borrowings at the next Board meeting.

11.6 All applications for long-term borrowing must be consistent with the plans outlined in the current Trust business plan and be approved by the Trust Board.

11.7 Investments

11.7.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

11.7.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.7.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. Planning Framework

12.1 The Chief Financial Officer shall ensure that members of the Board are aware of the operational planning and contracting guidance issued by the regulator. The Chief Financial Officer should also ensure that the guidance is followed by the Trust.

13. Capital investment, private financing, fixed asset registers and security of assets

13.1 Capital Investment

13.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation, where applicable of commissioner support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 Capital for the purpose of approval should be differentiated between:

a) **Replacement assets**; this is where an asset has reached the end of its useful economic life and requires a like for like replacement with no change to the delivery of the service (outside of incremental benefits from a new asset) – for example replacing an x-ray machine that is no longer fit for purpose or has ceased working or refurbishing a clinical area under the same footprint and layout. These should also have no material impact on revenue costs

b) **Investment assets**; where the asset is not a like for like replacement or results in a non-trivial impact on a service model or material impact on revenue costs – for example re-modelling and expansion of the day surgery unit. This could include increasing the number of assets (e.g. moving from two to three CT scanners).

Capital Review Group will be responsible for final determination of asset type.

13.1.3 For **replacement assets**, as long as the total expenditure falls within the capital allocated to that category (eg Digital or medical equipment) as part of the capital plan approved by the Board, the Chief executive will ensure:

a) that there is a completed Capital Expenditure Approvals Form (CAPEX) approved by the Capital Resource Group (CRG);

b) Replacement assets with capital expenditure proposal above £1,000,000 excluding recoverable VAT are approved by Executive Directors and should have a business case;

c) Replacement assets with capital expenditure proposal above £2,500,000 excluding recoverable VAT are also approved by Finance and Productivity Committee; and

d) Replacement assets with capital expenditure proposal above £5,000,000 excluding recoverable VAT are also approved the Board.

13.1.4 For every **investment asset** capital expenditure proposal in excess of £250,000 excluding recoverable VAT the Chief Executive shall ensure:

a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the combined Business Development Group (BDG) and Capital Resource Group (CRG). The submission can be to CRG only if there are no material revenue implications other than depreciation and public dividend capital.

b) for investment assets every capital expenditure proposal in excess of £250,000 excluding recoverable VAT the business case is also required to be submitted to the Executive Director's meeting for approval.

c) for all investment asset projects over £500,000 excluding recoverable VAT a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Productivity Committee for approval.

d) for all investment asset projects over £500,000 excluding recoverable VAT the Project Director will be required to co-ordinate and complete a monthly capital monitoring return to Capital Resource Group (CRG) showing performance against budget.

f) for all investment asset projects over £1,000,000 excluding recoverable VAT the business case will be submitted to the Trust Board for approval

13.1.5 The table below summarises the approval requirements for capital cases:

Asset Type	Documentation		Approval			
	Capex	Business case	CRG	Executive Directors	F&P	Board
Replacement	✓	<£1,000k	All	<£1,000k	<£2,500k	>£2,500k
Investment	✓	<£250k	All	<£250k	<£1,000k	>£1,000k

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of 'Estatecode'.

The Director of Estates and Facilities shall assess on an annual basis the requirement for the operation of the construction industry scheme in accordance with Her Majesty's Revenue and Customs guidance.

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

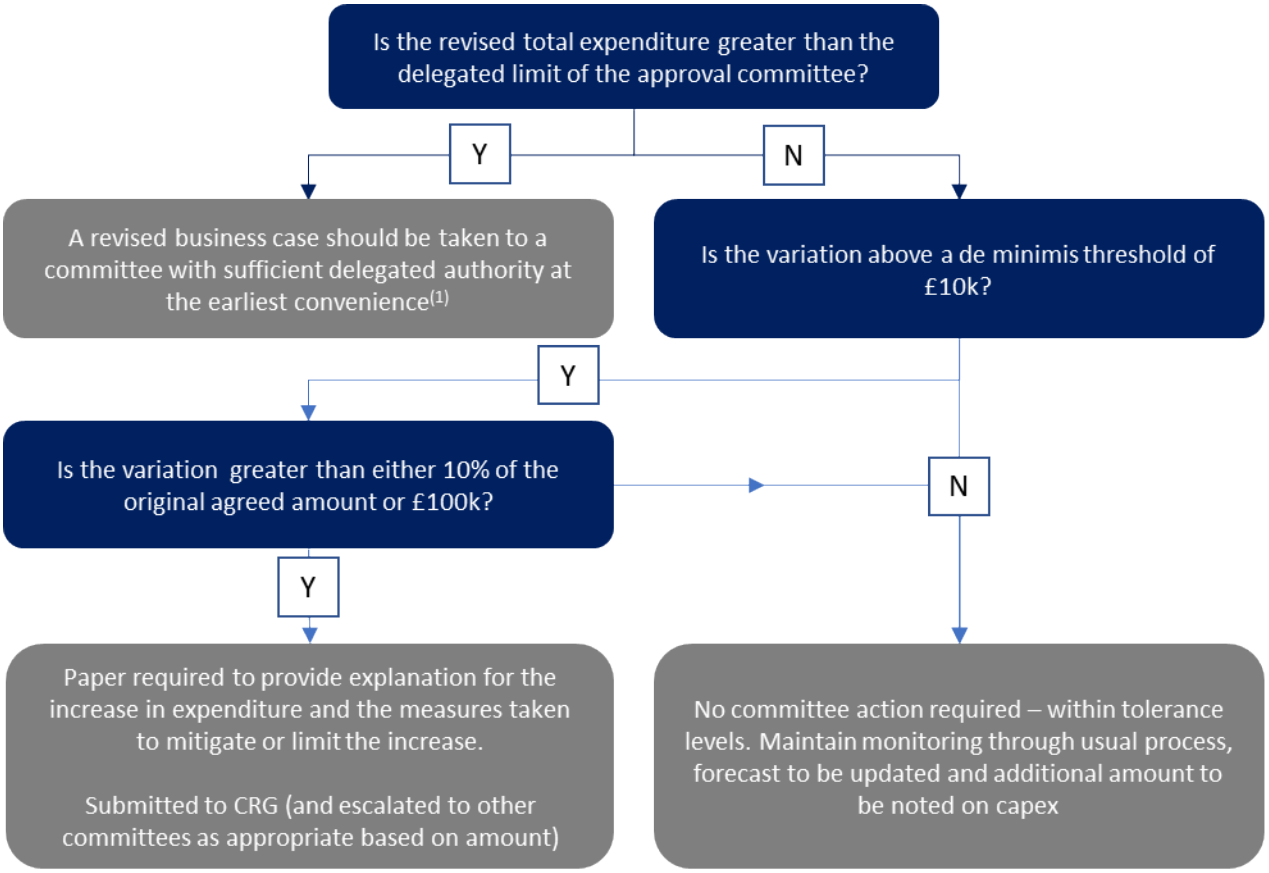
a) specific authority to commit expenditure;
b) authority to proceed to tender;
c) approval to accept a successful tender.

The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with 'Estatecode' guidance and the Trust Standing Orders.

13.1.8 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Regulator.

13.1.9 Capital schemes will be monitored through local and Committee review processes. Variances to capital schemes should be discussed and approved at the CRG and the Finance & Productivity Committee as appropriate at the earliest opportunity following awareness that it is likely that a scheme will overspend.

The flowchart below sets out the process that should be followed for any expected overspend of capital schemes:



(1) At this point this triggers the project should be considered unapproved and where possible expenditure should not be committed until approval is received. If the project is live or timing is critical and delay until a meeting cycle is not possible this should be brought to the attention of the Deputy Director of Finance and the Head of Financial Services immediately and an appropriate action plan will be developed (for example chair's action or extraordinary meeting of appropriate committee).

13.2 Private Finance

13.2.1 When the Trust proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) The proposal must be specifically agreed by the Board.

c) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DHSC body and/or treated as per current guidelines.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 The Trust shall maintain an asset register recording fixed assets. The

minimum data set to be held within these registers shall be as specified in the Capital Regime, Investment and Property Business Case Approval Guidance as issued by the DHSC.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of land and buildings will be at "fair value" on the balance sheet date. Under the requirements of IFRS, the Modern Equivalent Asset valuation method will be adopted.

13.3.7 The value of each asset shall be depreciated according to the useful economic life of the asset. The Trust will use commonly available and appropriate indices for the revaluation of assets or take advice from independent experts. The Chief Financial Officer will ensure that a review of all asset lives will be undertaken annually.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets

recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

13.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

13.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

13.4.6 Where practical, assets should be clearly and securely marked as Trust property.

13.4.7 Trust assets and facilities are to be used for official Trust purposes only, unless approval for private use has been given by the Chief Executive.

14. Stores

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stocktake; and

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to the Head of Procurement by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of estates stock, fuel oil and coal of a designated Estates Manager.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Director of Estates and Facilities. Wherever practicable, stocks should be marked as health service property.

14.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Procurement shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 15 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt of the goods against the delivery note.

15. Disposals and condemnations, losses and special payments

15.1 Disposals and Condemnations

15.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations (Disposal of Surplus Goods/Equipment Procedure) and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer ;

b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.1.5 Land and buildings formally planned for closure and/or disposal shall be valued and referred to the Chief Financial Officer prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The Chief Financial Officer shall prepare a report at least annually to the Audit Committee detailing all losses reported by number and amount with detail for those over £1,000

15.2.3 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive.

Where a criminal offence is suspected, the Executive Directors must

immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Directors must inform the DHSC Counter Fraud Services in accordance with the Secretary of State's directions and the Local Counter Fraud Service.

15.2.4 The Chief Financial Officer must notify the External Auditor of all frauds and suspected frauds.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, at an estimated value in excess of £10,000, the Chief Financial Officer must immediately notify:

a) the Board, and

b) the External Auditor.

15.2.6 The Audit Committee shall approve the writing-off of losses.

15.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

15.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16. Information technology

16.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to Data Protection and Computer Mis-use legislation.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

16.2 The Chief Financial Officer shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.3 The Chief of Staff shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.4 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.5 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during

processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.6 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

16.7 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy himself/herself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) authorised staff have access to such data; and

d) such computer audit reviews are being carried out as are considered necessary.

16.8 The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17. Patients' property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Nurse is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets, (notices are subject to sensitivity guidance),
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where DHSC instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. Charitable funds

18.1 The Chief Financial Officer and Chief of Staff shall ensure that each charitable fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirement.

18.2 Accountability to Secretary of State for Health and other bodies

1) The trustee responsibilities must be accountable to the Secretary of State for all charitable funds.

2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to funds held on trust

1) In so far as it is possible to do so, most of the sections of the Standing Financial Instructions will apply to the management of charitable funds. (see also SFI paragraph 7.15.6)

2) The over-riding principle is that the integrity of each charitable fund must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19. Acceptance of gifts and hospitality by staff

19.1 The Chief of Staff shall ensure that all staff are made aware of the Trust policy on acceptance of gifts, hospitality and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health and Social Care Standards of Business Conduct for NHS Staff (See Standing Orders 6.2).

20 Retention of records

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DHSC guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with the Health Service Circular (1999) 053 shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of records so destroyed.

21. Risk management and insurance

21.1 The Chief Nurse shall ensure that the Trust has a programme of risk management, in accordance with current DHSC controls assurance requirements, which must be approved and monitored by the Board.

21.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including: internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured;

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current DHSC guidance.

21.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.4 With three exceptions Trusts may not enter into insurance arrangements with commercial insurers. The exceptions are:

i) Trust may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

ii) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

iii) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

21.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complimentary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

21.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

22. ANNEX – Tenders and contracting – Financial limits

22.1 Financial Limits – Competitive Tendering

22.1.1 Competitive Tenders will be invited for:

i) the supply of goods, materials and manufactured articles;
ii) the rendering of services;
iii) building and engineering works (including construction and maintenance of grounds) and;
iv) disposals;

where the estimated income/expenditure is expected to exceed **£70,000 excluding VAT**.

22.2 Invitation to Tender

22.2.1 The number of invitations to tender and tenders required to be received will be as follows:

VALUE	TENDERS
Tenders above **£70,000 excluding VAT** to The Public Procurement Threshold	Minimum of 3 invitations to tender
Tenders above The Public Procurement Threshold	Minimum of 4 invitations to tender

22.2.2 The Audit Committee will be updated on a quarterly basis where three suppliers are invited to tender, but less than three tenders are received.

22.2.3 If the required number of tenders is not received, it will be at the discretion, as to whether to proceed with the contract, of:

- the Chief Executive **or** the Chief Financial Officer above **£70,000 excluding VAT** to The Public Procurement Threshold; and

- the Chief Executive **and** the Chief Financial Officer from The Public Procurement Threshold to £1,000,000.

22.2.3 For the purpose of determining the above limitations of **£70,000 excluding VAT**, The Public Procurement Threshold and **£1,000,000 excluding VAT** in circumstances where tenders are invited at any one time for a number of works, which are to be carried out simultaneously or sequentially by one contractor, the total cost may not exceed the appropriate financial limit.

22.3 Financial Limits – Competitive Quotations

22.3.1 The number of quotations required will be as follows:

VALUE	TENDERS
Up to **£25,000 excluding VAT**	Minimum of 1 written quotation (where this may be impractical, 1 verbal quotation may be obtained and the reasons for this documented)
Above £25,000 to **£70,000 excluding VAT**	Minimum of 2 suppliers invited to submit written quotations

22.4 Waivers to Standing Orders

22.4.1 Standing Orders on Competitive Tendering may be waived under certain circumstances and will require the completion and authorisation of a waiver form.

22.4.2 The waiver authorisation limits are:

i) For tenders **£1 - £70,000 excluding VAT** , the Head of Procurement

ii) For tenders above **£70,000 excluding VAT** to **The Public Procurement Threshold**, the Head of Procurement and the Chief Financial Officer or the Chief Executive.

iii) For tenders from **The Public Procurement Threshold up to £500,000 excluding VAT** Head of Procurement, 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 the IPR of the lead division which can approve or reject if funding has been identified then present to Business Development Group (BDG) for logging, noting and socialising with other divisions.

Additional process for between £50k to £500k (please follow steps 1-4 above, then):

5. Business case to be produced with sign off from relevant corporate areas
6. Present Business Case to BDG (revenue) or Capital Resource Group (CRG) (capital) who can recommend a direction of travel. If the business case has both revenue and capital implications it will need to be presented to both groups.
7. Present Business Case to Executive Directors' Meeting for approval

Additional process for between £500k to £15m:

8. Present Business Case to Finance and Productivity Committee for approval if between £500k - £1m
9. Present Business Case to Trust Board for approval if over £1m
10. Submit to NHSE/I for approval if over £5m, or over £15m for capital property investments

Waiver of Standing Orders

East Sussex Healthcare NHS Trust

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.**

ENDS

Appendix 3 – Scheme of Delegation

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
N/A	The Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 (Emergency Powers). 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6 17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
N/A	The Board	**Appointments/Dismissal** 1. Ratify proposals of the Remuneration Committee regarding the appointment and remuneration of the Chief Executive and with the latter the remuneration of executive directors and very senior managers.
	The Board	**Strategy Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Final Business Cases for Capital Investment over £1,000,000 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3-year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer for losses and special payments. 12. Approve proposals for action on litigation on behalf of the Trust. 13. Review use of NHS risk pooling schemes (CNST/RPST).

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
	The Board	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	The Board	**Audit:** 1. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report of the Audit Committee.
	The Board	**Annual Reports and Accounts:** 1. Receipt and approval the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for charitable funds.
	The Board	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary to the Board. 3. Receive reports from Chief Financial Officer on financial performance against budget and business plan and other Directors on activity, workforce, quality and safety. 4. Receive reports from the Chief Financial Officer on actual and forecast income from SLA's 5. Receive assurance on compliance with the appropriate regulations within the Health and Social Care Act 2008 and the related Care Quality Commission outcomes

DECISIONS/DUTIES DELEGATED BY THE BOARD TO THE CHAIRMAN, CHIEF EXECUTIVE AND COMMITTEES

Section 1

Reference		**Decision/Duties Reserved to the Chairman and Chief Executive**
	Chairman	1. Appoint the Vice Chairman 2. Appoint the Senior Independent Director 3. Appointment and dismiss committees (and individual members) that are directly accountable to the Board. 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
	Chief Executive	1. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2)

Reference	**Committee**	**Decision/Duties Delegated by the Board to Committees**
	Audit Committee	The current terms of reference, including powers delegated by the Board, are available from the Chief of Staff.
	Remuneration and Appointments Committee	The current terms of reference, including powers delegated by the Board, are available from the Chief of Staff.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

Section 1

Reference from Accountable Officer Memorandum	Delegated To	Accountable Officer Memorandum – Duties Delegated
7	Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources.
9	Chief Executive and Chief Financial Officer	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	Chief Executive	Ensure effective management systems that safeguard public funds and the Chairman to implement requirements of corporate governance including ensuring managers: • 'have a clear view of their objectives and the means to assess achievements in relation to those objectives; • be assigned well defined responsibilities for making best use of resources; • have the information, training and access to the expert advice they need to exercise their responsibilities effectively'.
12	Chairman	Implement requirements of corporate governance.
13	Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
15	Chief Financial Officer	Operational responsibility for effective and sound financial management and information.
15	Chief Executive	Primary duty to see that Chief Financial Officer discharges this function.
16	Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

Section 1

Reference	Delegated To	Accountable Officer Memorandum – Duties Delegated
17	Chief Executive	Promote the observance of all staff of the Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by the Secretary of State.
18	Chief Executive and Chief Financial Officer Chief Medical Officer Chief Nurse and Chief of Staff	Chief Executive, supported by Chief Financial Officer, Chief Medical Officer, Chief Nurse and Chief of Staff to ensure appropriate advice is given to the Board and Executive Committee on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.1.7	Audit Committee	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of the Code of Conduct and Accountability, and other ethical concerns.
1.3.1.9 & 1.3.2.2	All Board members	Subscribe to the Code of Conduct and Accountability.
1.3.2.4	Board	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	Chairman and Non-Executive Directors	Chairman and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	Board	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.4	Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the board and draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions to reflect these; 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality targets that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main board.
1.3.2.5	Chairman	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner; 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee and any other sub-Committees of the main Board; and 7. advise the Secretary of State on the performance of Non-Executive Board members.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.5	Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	Non-Executive Directors	Non-Executive Directors are appointed by NHS England to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	Chairman	All members of the Board are required to make annual declarations of conflict of interests and fit and proper persons.
1.3.2.9	Board	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Ref	Delegated To	Standing Orders – Authorities/Duties Delegated
1.1	Chairman	Final authority in interpretation of Standing Orders.
2.4	Chairman	Appointment of Vice Chairman and Senior Independent Director.
3.1	Chairman	Call Board meetings.
3.7	Chairman	Chair all Board meetings and associated responsibilities.
3.9	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings.
3.11	Chairman	Having a second or casting vote.
3.12	Board	Suspension of Standing Orders.
3.12	Audit Committee	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
3.13	Board	Variation or amendment of Standing Orders.
4.1	Board	Formal delegation of powers to sub-committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub-committees may be approved by the Chief Executive).
5.2	Chairman & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chairman and Chief Executive after having consulted at least two Non-Executive Directors.
5.3	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	All	Disclosure of non compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	The Board	Declare relevant and material interests.

SCHEME OF DELEGATION FROM STANDING ORDERS

Section 1

Standing Order Reference	Delegated To	Standing Orders – Authorities/Duties Delegated
7.2	Chief of Staff	Maintain Register(s) of Interests.
7.4	All staff	Comply with national guidance contained in NHS England's 'Standards of Business Conduct Policy' for NHS staff
7.4	All	Disclose relationship between self and candidate for staff appointment.
8.1/8.3	Chief of Staff	Keep seal in safe place and maintain a register of sealing.
8.4	Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
1.1.1	Chief Financial Officer	Training and communication programme for staff on SFIs.
1.1.3	Chief Financial Officer	Approval of all financial procedures.
1.1.4	Chief Financial Officer	Advice on interpretation or application of SFIs.
1.1.6	All Members of the Board and all Staff	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible
1.3.4	Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the system of internal control.

SCHEME OF DELEGATION FROM STANDING FINANCIAL 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 FINANCIAL 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	Chief of Staff	Preparation of annual report
5.1.1	Chief Financial Officer	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements).
6	Chief Financial Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
6.2.3	All employees	Duty to inform Chief Financial Officer of money due from transactions which they initiate/deal with.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.5.3	Chief Financial Officer	Report waivers of tendering procedures to the Audit Committee.
7.6.2	Chief Financial Officer	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.4	Chief Executive & Chief Financial Officer	Where one tender is received will assess for value for money and fair price.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
7.6.6	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.
7.7.4	Chief Executive & Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Chief Financial Officer .
7.15	Chief Financial Officer	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
8.1	Chief Financial Officer	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
8.3	Chief Financial Officer	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
9.1.1	Board	Establish a Remuneration Committee.
9.1.2	Remuneration Committee	Take decisions under delegated authority on the remuneration and terms of service of the Chief Executive, other officer members and very senior managers to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements. Monitor and evaluate the performance of individual very senior managers. Oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
9.1.3	Remuneration Committee	Produce an annual report for the Board.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
9.2.2	Chief Executive	Approval of variation to funded establishment of any department.
9.4.1 & 9.4.2	Chief Financial Officer	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 9.4.2).
10.1.1	The Board	Approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. This authority may be delegated to the Chief Financial Officer
10.1.2	Chief Financial Officer	Set out the list of managers who are authorised to place requisitions for the supply of goods and services; and the maximum level of each requisition and the system for authorisation above that level.
10.2.3	Chief Financial Officer	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and regularly reviewed; a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds; b) Be responsible for the prompt payment of all properly authorised accounts and claims; c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; d) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; e) Instructions to employees regarding the handling and payment of accounts within the Finance Department; f) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.2.4	Appropriate Executive Director	Make a written case to support the need for a prepayment.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
10.2.4	Chief Financial Officer	Approve proposed prepayment arrangements.
10.2.4	Budget holder	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Financial Officer if problems are encountered).
10.2.5	Chief Financial Officer	Authorise who may use and be issued with official orders.
10.2.6	Managers and Officers	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer .
10.2.7	Chief Executive Chief Financial Officer	Ensure that Standing Financial Instructions are compatible with Department of Health requirements re building and engineering contracts. Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
11.1	Chief Financial Officer	The Chief Financial Officer will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning any PDC debt and all loans and overdrafts.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
11.2	Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Financial Officer).
11.3	Chief Financial Officer	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	Chief Executive or Chief Financial Officer	Be on an authorising panel comprising one other member for applications for short term borrowing.
11.7.2	Chief Financial Officer	Will advise the Board on investments and report, periodically, on performance of same.
11.7.3	Chief Financial Officer	Prepare detailed procedural instructions on the operation of investments.
12.1	Chief Financial Officer	Ensure that Board members are aware of the Financial Framework and ensure compliance.
13.1.1 & 13.1.2	Chief Financial Officer	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans; b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.1.2	Chief Financial Officer	For every replacement asset capital, as long as the total expenditure falls within the capital allocated to that category (eg Digital or medical equipment) as part of the capital plan approved by the Board, the Chief Executive will ensure: a) that there is a completed Capital Expenditure Approvals Form (CAPEX) approved by the Capital Resource Group (CRG); b) Replacement assets with capital expenditure proposal above £1,000,000 excluding recoverable VAT are approved by Executive Directors and should have a business case; c) Replacement assets with capital expenditure proposal above £2,500,000 excluding recoverable VAT are also approved by Finance and Productivity Committee; and d) Replacement assets with capital expenditure proposal above £5,000,000 excluding recoverable VAT are also approved the Board. For every investment asset capital expenditure proposal over £100,000 a) that the scheme Project Director produces a business case and this is submitted, along with a completed Capital Expenditure Approvals Form (CAPEX), to the Capital Review Group (CRG). b) for every capital expenditure proposal in excess of £250,000 the business case is also required to be submitted to the Executive Directors' Meeting for approval. c) for all projects over £500,000 a risk assessment must be completed to assess the project financial risk. This assessment is to be carried out by the Head of Financial and TW Services (or Deputy Head of Financial Services) in conjunction with the Project Director. The Business case will be submitted to the Finance and Productivity Committee for approval. d) for all projects over £500,000 the Project Director will be required to co- ordinate and complete a monthly capital monitoring return to CRG showing performance against budget.

		e) for every capital expenditure proposal in excess of £500,000 the business case is also required to be submitted to the Combined Business Development Group (BDG) and Capital Review Group (CRG) for approval before any further expenditure is committed. f) for all projects over £1,000,000 the business case will be submitted to the Trust Board for approval g) where any scheme is forecast to overspend by more than the following amounts the Project Director will be required to report reasons to the CAG for approval before any further expenditure is committed: i. where the scheme value is £250k or less – 10% of the approved scheme value ii. for other schemes up to £1m – the higher of 5% or £25k
13.1.3	Director of Estates and Facilities	Assess the requirement for the operation of the Construction Industry Scheme.
13.1.4	Chief Financial Officer	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.5	Chief Financial Officer	Issue procedures governing financial management, including variation to contracts, of capital investment projects and valuation for accounting purposes.
13.2.1	Chief Financial Officer	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	Board	Proposal to use Private Finance Initiative (PFI) schemes must be specifically agreed by the Board.
13.3.1	Chief Financial Officer	Maintenance of asset registers.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
13.3.5	Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.7	Chief Financial Officer	Ensure that a review of asset lives is undertaken annually.
13.4.1	Chief Financial Officer	Overall responsibility for fixed assets.
13.4.2	Chief Financial Officer	Approval of fixed asset control procedures.
13.4.4	All senior staff	Responsibility for security of Trust assets including notifying discrepancies to Chief Financial Officer, and reporting losses in accordance with Trust procedure.
14.2	Chief Financial Officer	Delegate overall responsibility for control of stores. Further delegation for day to day responsibility subject to such delegation being recorded.
14.2	Head of Procurement	Responsible for systems of control over stores and receipt of goods.
14.2	Designated Pharmaceutical officer	Responsible for controls of pharmaceutical stocks.
14.2	Designated Estates Officer	Responsible for control of stocks of fuel.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
14.3	Director of Estates and Facilities	Security arrangements and custody of keys
14.4	Chief Financial Officer	Set out procedures and systems to regulate the stores.
14.5	Chief Financial Officer	Agree stocktaking arrangements.
14.6	Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified.
14.7	Head of Procurement/Pharmaceutical Officer	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.7	Head of Procurement/Pharmaceutical Officer	Operate system for slow moving and obsolete stock, and report to Chief Financial Officer evidence of significant overstocking.
14.8	Chief Financial Officer	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	Chief Financial Officer	Prepare procedures for recording and accounting for losses and special payments and informing police in cases of suspected arson or theft.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
15.2.3	Executive Directors	Where a criminal offence is suspected Executive Directors must inform the police if theft or arson is involved. In cases of fraud and corruption Executive Directors must inform the relevant Anti-Crime Service and Counter Fraud Operational Service (CFOS) in line with Secretary of State's directions.
15.2.4	Chief Financial Officer	Notify CFOS and External Audit of all frauds.
15.2.5	Chief Financial Officer	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.6	Audit Committee	Approve write off of losses.
15.2.8	Chief Financial Officer	Consider whether any insurance claim can be made.
15.2.9	Chief Financial Officer	Maintain losses and special payments register.
16.1	Chief Financial Officer	Responsible for accuracy and security of computerised financial data.
16.2	Chief Financial Officer	Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
16.3	Chief of Staff	Shall publish and maintain a Freedom of Information Publication Scheme
16.4	Relevant officers	Send proposals for general computer systems to Chief Financial Officer .

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
16. 5	Chief Financial Officer	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. The contract should also ensure rights of access for audit purposes.
16.7	Chief Financial Officer	Where computer systems have an impact on corporate financial systems satisfy himself/herself that: a) systems acquisition, development and maintenance are in line with corporate policies and IM&T Strategy; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) relevant staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
16.8	Chief Financial Officer	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
17.2	Chief Nurse	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
17.6	Departmental managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1.	Chief Financial Officer and Chief of Staff	Ensure each charitable fund is managed appropriately with regard to its purpose and to its requirement.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Section 1

Standing Financial Instructions Reference	Delegated To	Standing Financial Instructions – Authorities/Duties Delegated
18.3	Trustees and Authorised Signatories	Relevant sections of SFIs are applicable to charitable funds.
18.3	Chief of Staff	The Chief of Staff will arrange for the creation of a new charitable fund where this is required.
19.1	Chief of Staff	Ensure all staff are made aware of Trust policy on the acceptance of gifts and other benefits in kind by staff.
20	Chief Executive	Retention of document procedures in accordance with Department of Health guidance.
21.1	Chief Nurse	Ensure the Trust has a risk management programme.
21.1	Board	Approve and monitor risk management programme.
21.3	Board	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks (where discretion is allowed).
21.5	Chief Financial Officer	Where the Board decides to use risk pooling schemes or commercial insurers the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.
21.6	Chief Financial Officer	Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures to cover these arrangements.
21.7	Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible.

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
1. To keeping of Declaration of Board Members, Consultants and Senior Staff Interests Register	Chief of Staff	Associate Director of Corporate Governance
2. Receiving Hospitality, Gifts and Sponsorship other than isolated gifts of a trivial nature or conventional hospitality Applies to both individual and collective hospitality receipt items	Declaration required in Trust's Hospitality Register – all Trust Directors and Employees	N/A
3. The keeping of the Interests, Hospitality, Gifts and Sponsorship Register	Chief of Staff	Associate Director of Corporate Governance
4. Quotation, Tendering and Contract Procedures Subject to the requisitioner's responsibility always to obtain best value for money for the Trust, the <u>minimum</u> requirements for goods/services are: **For spend within current budget:**		Authorised Budget Signatory and Purchasing and Supplies Buyer
a) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	
b) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
c) **£70,001** excluding VAT to **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 **£2,500,000**	Finance and Productivity Committee	Finance and Productivity Committee
l) **Over £2,500,000**	Trust Board	Trust Board and Common Seal of the Trust

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
The waiver authorisation limits are:		
a) For quotations	Chief Executive.	Head of Procurement
b) For tenders **£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 **£2,500,000**	Audit Committee	N/A
e) For tenders above **£2,500,000**	Trust Board	N/A
5. Opening electronic Tenders and Quotations	Procurement Department	N/A
6. Attestation of Sealings in accordance with Standing Orders	Chairman/Chief Executive	Executives
7. The keeping of a register of Sealings	Chief of Staff	Board Secretary
8. Implementation of Internal and External Audit Recommendations	Chief Financial Officer	Manager responsible for service.
9. Management of Budgets - Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.	Budget Manager
b) At service level	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
c) For the totality of services covered by a Divisional Triumvirates or Corporate Leaders	Chief Executive	Director for appropriate budget or Divisional Triumvirates or Corporate Leads.
10. Capital Schemes		
a) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Director for appropriate budget.	N/A
b) Financial monitoring and reporting on all capital scheme expenditure	Chief Financial Officer	Deputy Chief Financial Officer
c) Granting and termination of leases	Director for appropriate budget.	N/A
11. Authority to open Bank Accounts	Chief Financial Officer	N/A
12. Management of the Investment of Charitable Funds within the approved investment strategy	Chief Financial Officer	Monitored by the Charity Committee
13. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Financial Officer	Manager responsible for the budget together with the Chief Financial Officer
b) Price of NHS Contracts – charges for all NHS Contracts, be they block, cost per case, cost and volume, or spare capacity	Chief Financial Officer	Head of Contract Income
14. Authorisation of Sponsorship deals	Chief of Staff	Director for appropriate budget or Associate Director of Operations
15. Personnel and Pay		
a) Authority to fill funded post on the establishment with permanent staff	Director for appropriate budget or General Manager	Manager responsible for budget

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b)	Authority to appoint staff to post not on the formal establishment	Chief Executive (approval at Executive Directors' meeting)	N/A
c)	The granting of additional increments to staff within budgets	Chief Executive	Manager responsible for budget with the Chief People Officer
d)	All requests for upgrading/re-grading shall be dealt with in accordance with Trust Procedure	Chief Executive	Payroll Manager
e)	Establishments		
	i) Additional staff to the agreed establishment with specifically allocated finance	Director for appropriate budget or General Manager	Manager responsible for budget
	ii) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	N/A
f)	Pay		
	i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Director for appropriate budget or General Manager	Authorised Budget Signatory
	ii) Authority to complete and authorise positive reporting forms	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iii) Authority to authorise overtime	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iv) Authority to authorise travel and subsistence expenses	Director for appropriate budget or General Manager	Authorised Budget Signatory
	v) The approval of merit awards and discretionary points to Consultant and Associate Specialist staff	Remuneration Committee of the Board	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) Leave – all arrangements should be made in accordance with Trust policy		
i) Approval of annual leave	Manager responsible for the budget	N/A
ii) Annual leave – approval of carry forward (up to maximum of 5 days or in the case of Ancillary and Maintenance staff as defined in their initial conditions of service)	Manager responsible for the budget	N/A
iii) Annual leave – approval of carry over in excess of 5 days	Director for appropriate budget or Associate Director of Operations	N/A
iv) Special leave arrangements		
▪ adoption leave ▪ bereavement leave ▪ paternity leave ▪ urgent domestic distress/crisis ▪ carers leave	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget
v) Leave without pay	Director for appropriate budget or Associate Director of Operations Chief Medical Officer or Chief Executive	Manager responsible for the budget
vi) Medical Staff Leave of Absence – paid and unpaid – including study leave		
▪ Consultants and Career Grades	Chief Medical Officer or Clinical Unit Lead	Clinical Unit Lead
▪ Other Medical Staff	Clinical Tutor together with Clinical Unit Lead	Clinical Unit Lead
vii) Time off in lieu	Director for appropriate budget or Associate Director of Operations	Manager responsible for the budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Director for appropriate budget or General Manager together with Chief People Officer	N/A
ii) Return to work part-time on full pay to assist recovery	Director for appropriate budget or General Manager together with Chief People Officer	Manager responsible for the budget
iii) Extension of sick leave on full pay	Chief People Officer together with Chief Executive	N/A
i) Study Leave (Medical staff included in para 14.g.vi) above		
i) Any Study leave outside the UK	Chief Executive	Chief Medical Officer or Chief Nurse
ii) All other study leave (UK)	Chief People Officer, Director for appropriate budget or General Manager	Training Officer or Manager responsible for the budget
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) within Trust policy limits – currently £10,000.	Chief People Officer or Chief Financial Officer	Payroll Manager or Head of Financial Services
k) Grievance Procedure		
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure	Chief People Officer	Manager responsible for the budget

Section 2

Delegated Matter			Authority Delegated To	Lowest Level to Which Authority May be Delegated
	l)	Renewal of Fixed Term Contract	Manager responsible for the budget	N/A
	m)	Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief People Officer	N/A
	n)	Redundancy	Chief People Officer together with Chief Financial Officer . Approval is required from the Remuneration Committee.	N/A
	o)	Ill Health Retirement Decision to pursue retirement on grounds of ill health	Manager responsible for the budget together with Chief People Officer	Manager responsible for the budget together with Personnel Manager
	p)	Dismissal	Director for appropriate budget with Chief People Officer	N/A
16.	Engagement of Agency Staff			
	a)	Booking of Bank, Agency or Locum Staff – limited to total delegated staffing budgets	Director for appropriate budget or General Manager	Manager responsible for the budget
	b)	Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget
	c)	Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure)	Chief Executive	Director for appropriate budget
17.	Engagement of Professional Consultancy Services			
	a)	Where aggregate commitment in any one year (or total commitment) is less that **£35,000 excluding VAT**	Director for appropriate budget or General Manager	Manager responsible for the budget

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b) Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure and approval for any consultancy spend must be cleared with region by the Chief Financial Officer)	Chief Executive	Director for appropriate budget
18. Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods and Services		
a) Non-Pay Expenditure for which a specific budget has been set up and which is subject to funding under delegated powers of virement.		
i) Value to the Public Procurement Threshold	Chief Executive	Manager responsible for the budget
ii) From the Public Procurement Threshold to £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

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

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
21. Sale and Disposal of Assets (Excluding land and/or buildings) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
a) with current/estimated purchase price < £50,000	Chief Executive	Manager responsible for the budget
b) with current purchase new price > £50,000 (Note: Tender Procedure SFI 7.)	Chief Executive	Manager responsible for the budget together with Head of Procurement
22. Losses, Write-off and Compensation		
a) Losses and cash and cash equivalents due to theft, fraud overpayment and others	Chief Executive and Chief Financial Officer	N/A
b) Fruitless Payments (including abandoned Capital Schemes)		
i) Up to £100,000	Chief Executive and Chief Financial Officer	N/A
ii) Over £100,001	Audit Committee	N/A
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors and Other	Chief Executive and Chief Financial Officer	N/A
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Chief Executive and Chief Financial Officer	N/A
Special Payments		
e) made under legal obligation	Chief Executive and Chief Financial Officer	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
f) Extra Contractual payments to contractors	Chief Executive and Chief Financial Officer	N/A
g) Ex-Gratia Payments		
i) Patients' dentures repaired or replaced through the Community Dental service	Chief Financial Officer	Trust Solicitor
ii) Dentures and spectacles repaired or replaced < £500	Chief Financial Officer	Trust Solicitor
iii) Dentures and spectacles repaired or replaced > £500	Chief Financial Officer	Trust Solicitor
iv) Other ex gratia claims < £500	Chief Financial Officer	Trust Solicitor
v) Other ex gratia claims > £500	Chief Financial Officer	Director responsible for the budget
h) Payments under the Risk Pooling Scheme for Trusts up to the Policy Excess:		
i) Liabilities to Third Parties Scheme for Public and Employees Liability	Chief Financial Officer	Trust Solicitor
ii) Property Expenses Scheme	Chief Financial Officer	Trust Solicitor
i) Settlements on termination of employment – to a limit of £50,000	Chief Executive and Chief Financial Officer and Chief People Officer. Approval is required from the Remuneration Committee.	N/A
j) Other, except cases of maladministration	Chief Executive and Chief Financial Officer	N/A

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
23. Expenditure on Charitable Funds		
a) All expenditure of between £1,000 and £4,999 per request but excluding training and hospitality requests	Director and authorised signatory	Review by Executives, approval from Charity Manager and Authorised Signatory
b) All expenditure over £5,000 per request but excluding training and hospitality requests	Director and authorised signatory	Review by Executives, approval from Charity Committee and Authorised Signatory
c) All other expenditure	Director and authorised signatory	Charity Manager and Authorised Signatory
24. Management and Control of Computer Systems		
a) Financial Data	Chief Financial Officer	Senior Finance Manager Capital Systems Manager
b) Other Data	Chief Medical Officer as Caldicott Guardian	Relevant Service Manager
25. Review of Trust's compliance with Data Protection Act 1998	Chief Medical Officer as Caldicott Guardian	Chief Financial Officer
26. Review the Trust's compliance with the Access to Health Records Act	Chief Medical Officer as Caldicott Guardian	Chief Financial Officer
27. Retention of Records	Chief of Staff	Trust Solicitor
28. Insurance Policies	Chief Executive and Chief Financial Officer	Chief Financial Officer
29. Risk Management	Chief Nurse	Risk & Patient Safety Manager
30. Monitor proposals for contractual arrangements between the Trust and NHS commissioners of healthcare	Chief Financial Officer	Head of Contract Income
31. Maintenance and Update on Trust Financial Procedures	Chief Financial Officer	Technical Accountant

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
32. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Chief Operating Officer	Accommodation Manager
b) Extensions to existing agreements/licences c) Letting of premises to outside organisations 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	Chief Financial Officer	Trust Solicitor
35. Relationships with Press		
a) General Enquiries	Chief of Staff	Communications Team
b) Emergency	On-call Director	On-call Manager

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
36. Facilities for staff not employed by the Trust to gain practical experience		
Professional Recognition, Honorary Contracts, and Insurance of Medical Staff	Chief People Officer	Clinical Tutor, Post-Graduate Medical Education and HR Manager
Work experience students	Chief People Officer	Manager responsible for the budget
37. Review of fire precautions	Director of Estates and Facilities	Nominated Fire Manager
38. Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Chief Nurse	Health and Safety Manager
39. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Estates and Facilities	Estates Manager and Waste Manager

In addition to the delegated matters detailed above the executive team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility and in those key functions, supported by consistent evidence.

Collectively, the team is responsible for providing the systems, processes and evidence of governance and ensuring that these are reviewed, maintained and any gaps closed and that this is reflected in their regular updating of the assurance framework, coordinated by the director of corporate services.

The team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the assurance framework.

The team are responsible for monitoring the risk register at corporate level.

The responsibilities of individual posts are set out in the post holders' job descriptions.

Delegated Authority for the Expenditure of Charitable Funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory + Charity Manager
£1,000 to £5,000	One fund signatory + Charity Manager + Review by Executives
Over £5,000	One fund signatory + Charity Committee + Review by Executives

Spending plans for major projects or investment will require the approval of the Corporate Trustee and the Charity Committee.

East Sussex Healthcare NHS Trust

Use of Trust Seal

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

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable

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

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

Executive Summary	The Trust Seal was used to seal the following document between 7th December 2022 and 31st January 2023: **Sealing 88 – Hughes and Salvidge Ltd, 3rd January 2023** For the demolition/removal of the Polegate building at Eastbourne District General Hospital

Next steps	Not applicable