East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 26th August 2025

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, EDGH

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:35	Yes
3.	Electronic Patient Records	Duncan Robinson	Information		No
4.	Declarations of Interest	Chair	Information		No
5.	Minutes of Trust Board Meeting in public 24.06.25	Chair	Approval	09:50	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Chief Executive's Report	CEO	Information	10:00	Yes
8.	Board Committees Chairs' Reports	Committee Chairs	Assurance	10:10	Yes
Quality, Safety and Performance					
9.	Integrated Performance Report, Month 3 (June) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO DCNO/CMO DCEO COO ICFO	Assurance	10:15	Yes
10.	Response to Fuller Enquiry Part 2 Report	CMO	Assurance	11:00	Yes
11.	Avoidability of Inpatient Deaths Q3	CMO	Assurance	11:10	Yes

Break – 10 minutes

Strategy					
12.	Key policy updates	CoS	Discussion	11:20	Yes

Governance and Assurance					
13.	Winter Planning	COO	Assurance	11:30	Yes
14.	Trust Response to Jim Mackey's National Maternity Investigation	DCNO / DOM	Assurance	11:40	No

15.	Medical Revalidation Annual Report	CMO	Approval	12:00	Yes
16.	Q1 Board Assurance Framework	COS	Assurance	12:05	Yes
17.	Annual Review of Trust Governing Documents	CFO	Approval	12:10	Yes
For Information					
18.	Use of Trust Seal	Chair	Information	12:15	Yes
19.	Questions from members of the public	Chair		12:15	No
20.	Date of Next Meeting: AGM: 23rd September 2025 Trust Board: 14th October 2025	Chair	Information		
21.	Close	Chair			

Steve Phoenix
Chairman

Key:	
Chair	Trust Chair
CEO	Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
ICFO	Interim Chief Finance Officer
COS	Chief of Staff
CMO	Chief Medical Officer
DCEO	Deputy Chief Executive
DCNO	Deputy Chief Nurse
DEF	Director of Estates and Facilities
DOM	Director of Midwifery

Board Meetings in public: Etiquette

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

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

Board Meetings in public 2025:

Month	Location	Timing	Any other information
14th October 2025	Relais Cooden Beach Hotel	0930-1245	
16th December 2025	Lecture Theatre, Conquest Hospital	0930-1245	

Agenda Item: 2

Report To/Meeting	Public Trust Board	**Date of Meeting**	26th August 2025
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter(s):**	Steve Phoenix, Chair
Outcome/Action requested:	The Board is asked to receive this report for information and for assurance about the formal recognition of our people over the last two months		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	5	**Appendixes**	No
Governance and Engagement pathway to date:	None		
What happens next?	Delivery of the colleague recognition programme		
Publication	Yes		

1. Changes to long service recognition

We know how much colleagues value recognition of their contribution to the NHS. From 1 April we have increased opportunities for colleagues to be recognised for their continuous long service. A key change to policy is to recognise NHS continuous long service, rather than limiting recognition to service only within the Trust.

However, we are aware that in some cases service information from previous NHS employers on some systems does not automatically transfer across to the Trust. We are investigating the cause of this issue and are working towards a reliable process for verifying NHS continuous service. In the meantime, we continue to recognise continuous service at our Trust only.

2. Trust Awards

The Trust Awards are an opportunity to recognise and celebrate the great work carried out by colleagues and teams across the Trust.

We are returning to the De La Warr Pavilion in Bexhill on Sea for the 2025 Trust Awards, with the ceremony taking place on the 14 October.

Following feedback from the Partnership Forum, the format of the event has been updated for a more inclusive approach and will enable more colleagues to get involved and support this uplifting and inspiring event.

This year we have 10 awards, plus the Chairman's Award and the People's Choice Award which is voted for by patients and members of the public. Details about how nominations can be made for the People's Choice Award can be found here: https://www.esht.nhs.uk/your-care/patient-experience/send-a-thank-you/peoples-choice-award/.

The award nominations went live on the extranet in July and the closing date for nominations is the 22 August.

Anyone can nominate a colleague, team, ward or service and the names of all those making nominations are entered into a prize draw to win a token voucher.

3. Celebrating our people

3.1 Hero of the Month

Colleagues can nominate an individual or team who has gone above and beyond their job role to help a patient, family member or colleague, demonstrating the Trust values of kindness, integrity and inclusivity. At the end of each month nominations are scored against the three trust values. Each division will have a winner and the individual or team with the highest overall score will be announced as the Trust's Hero of the Month.

May 2025 – Maddie Bloomfield, Ellie Hume, Baphiwe Pindela and the wider Occupational Therapy Team – Conquest Hospital, CHIC Division

'I would like to nominate Maddie Bloomfield, Ellie Hume, Baphiwe Pindela, and the wider Occupational Therapy (OT) Team at Conquest Hospital for their exceptional kindness, calmness, and effective management during a highly stressful clinical situation.

A patient contacted the OT department in distress, reporting he felt he was about to experience a seizure. During the call, it became apparent the patient did indeed have a seizure. The team acted swiftly and appropriately by calling an ambulance to support him at his property. The patient regained consciousness, but it was clear he had fallen during the seizure, injuring his shoulder and becoming trapped.

The OT team promptly explored all options to expedite help. They contacted the patient's care agency, who assured arrival within five minutes. The team also informed the patient's next of kin and investigated whether the Urgent Community Response Service could attend while waiting for the ambulance and carers. When the patient experienced a further seizure, became unresponsive, and was heard choking on the phone, the Occupational Therapist maintained a calm, compassionate, and reassuring presence. They stayed on the call, offering updates and reassurance until carers and the ambulance arrived.

Thanks to their swift and coordinated actions, the patient was promptly attended to and safely brought to the Conquest emergency department for further assessment and treatment.

This team's professionalism, compassion, and teamwork in managing this critical emergency undoubtedly contributed to the patient's safety and wellbeing. I wholeheartedly commend Maddie, Ellie, Baphiwe, and the entire Occupational Therapy Team for their outstanding dedication and actions under pressure.'

June 2025 – Theresa Street, Clinical Nurse Specialist, and Dr Eleni Ladikou – Haematology, EDGH – Medicine Division

'Theresa Street and Dr Eleni Ladikou went above and beyond to help a patient experiencing a mental health crisis.

Both stayed hours after their shift had finished to ensure the safety of the patient, and to comfort and reassure the patient. They both showed amazing compassion and kindness to support this patient through this difficult time. Neither are experienced in mental health crises, so to show such amazing support and competence in this situation was really going above and beyond their role.'

3.2 Long Service Awards issued: June - July 2025

Month	5 years	10 years	15 years	20 years	25 years	30 years	35 years	40 years	45 years	50 years	Extras	Total
June 25	27	17	12	23	20	2	4	3	1	0	10	119
July 25	18	12	21	16	11	6	1	1	0	0	0	86

4. Celebrating our retiring colleagues

We recognise colleagues who are retiring after 20 years' service in the NHS. Colleagues are invited, along with a family member and/or work colleague, to a retirement celebration hosted by the Chairman and executive colleagues. Events are held at alternate sites on a monthly basis.

The event is an opportunity to thank colleagues for their contribution on behalf of the Trust board and to present them with a framed retirement certificate. Feedback to date has been extremely positive with people saying how much it means to them to have their service acknowledged formally.

Below are some of our colleagues receiving their Retirement celebration certificates from Steve Phoenix, Chairman, in June.

Janet Mulvey, Joanne Thomas, Julia Duffy and Jacqueline Gurr with Steve Phoenix

5. Celebrating Long Service

Iwona Gottschalk – 5 years

Nadia Ilieva – 10 years

Shelley Baumber – 10 years

Wesley Irving – 10 years

Hannah Walke – 10 years

Emma Calvin-Thomas – 10 years

Claire Evans – 15 years

Carol Pearce – 20 years

Elaine Andrews – 25 years

East Sussex Healthcare NHS Trust Board Minutes

Date: 24th June 2025

Time: 09:30 – 12:45

Venue: Lecture Theatre, Education Centre, Conquest Hospital

		Actions
	Attendance: Steve Phoenix, Chair and Non Executive Director Jayne Black, Chief Executive (CEO) Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Amanda Fadero, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Frank Sims, Non-Executive Director Andrew Strevens, Chief Finance Officer (CFO) <u>Non-Voting Directors</u> Ama Agbeze, Associate Non-Executive Director Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) <u>In Attendance</u> Charlotte Bright, Named Lead for Safeguarding Adults (NLSA) Jacquie Fuller, Assistant Director HR – People Engagement Team (ADHR) Brenda Lynes, Director of Maternity Services (DOM) Pete Palmer, Board Secretary (BS) (minutes) <u>Observing</u> Kaia Vitler, Divisional Director of Operations (Women & Children's Division) Seven members of the public were in attendance at the meeting.	
	Apologies: Paresh Patel, Vice Chair and Senior Independent Director Nicki Webber, Non-Executive Director Carys Williams, Non-Executive Director	
44/25	**Chair's Opening Remarks** Steve, Chair welcomed everybody to the meeting. It was confirmed that the notice of the meeting had been duly issued to the members of the Board entitled to receive notice and attend Board meetings. The meeting was quorate according to the Constitution of the Trust. He welcomed Andrew Strevens as the Trust's new Chief Finance Officer and thanked Ian O'Connor for his hard work during his time at the Trust.	
45/25	**Colleague Recognition** Steve, Chair reported that the Housekeeping Team at Bexhill Irvine Unit won the Hero of the month award in February. They had won for their work in helping to maintain infection control standards during an incredibly challenging winter period.	

	Leah Falla & Kayleigh Clark, from the Conquest Maternity Team had won the award in March, for their work in identifying a dangerous boiler during a routine smoking cessation community visit and alerting the appropriate authorities. Garry East, Deputy Chief Operating Officer, had received the award for April after he intervened when an agitated patient was confronting reception staff, putting himself in danger to protect colleagues when the situation escalated. The Trust had recently changed the way that it celebrated the retirement of colleagues by introducing retirement events. These had been very successful with staff invited to bring a relative or colleague with them.	
46/25	**Trauma Informed Care in ESHT** Charlotte, NLSA delivered a presentation to the Board on the development and implementation of Trauma Informed Care (TIC) within the Trust. She outlined the relevance of TIC across all areas of public service, noting that between 50% and 70% of the population had experienced at least one traumatic event in their lifetime. Unaddressed trauma is frequently a hidden cause of many preventable illnesses and there is substantial evidence demonstrating the effectiveness of trauma-informed systems in improving outcomes for both staff and service users. The NLSA explained that TIC was a framework designed to recognise the impact of trauma and to provide more effective and accessible care. The model adopted by ESHT was based on the approach being taken in Scotland, where all public services were structured around trauma-informed principles. The aims of TIC were aligned with the Trust's strategic objectives and with broader local strategies across Sussex. The NHS Long Term Plan also interfaced with TIC and the principles of compassionate leadership were closely aligned with trauma-informed approaches. Work had commenced to embed TIC within the organisation, with initial efforts focused within the Violence and Aggression (V&A) Reduction Group with a significant amount of work already underway across the Trust in support of this initiative. The organisation was now viewing its operations through a TIC lens, considering both service users and staff. The programme's effectiveness would be monitored and measured using the ten implementation domains outlined in the NHS Scotland toolkit. It was anticipated that TIC would improve individual outcomes, enhance sustainability and reduce the frequency of attendances to A&E. Over time, it should also contribute to reductions in length of stay and hospital admissions. Additional benefits included improved staff retention and reduced sickness absence. Awareness training had been introduced in the Trust on a small scale with plans to expand this. A recent visit to A&E departments by an Expert by Experience had led to suggestions for trauma-reducing changes such as adjustments to colour schemes, signage, and lighting. Jacqui, ADHR noted that TIC was being adopted across Sussex in a system-wide approach supported by partner organisations. She highlighted evidence that TIC could reduce incidents of V&A against staff and commended the estates teams for their commitment and support in implementing TIC-related changes. Amanda, NED, thanked the NLSA for the presentation and asked what the Trust's ambition for TIC was and how the Board could support its implementation. The NLSA explained that training was imperative as TIC could be challenging to embed. She advised that the initiative was currently led by a partner funded by the Local Authority and that efforts were underway to develop a Sussex-wide network for TIC. She added that ESHT had participated in this network and that there were plans to create an online library of accessible training packages to ensure a consistent approach across Sussex, involving primary care, mental health services, and social services. Amber, Associate NED asked about the changes to language around zero tolerance and whether the Board should be more mindful of its own language in this context. The	

	ADHR explained that while the initiative was being driven within Sussex, it was also a national objective with new benchmarking introduced in December 2024. ESHT was ahead of other organisations in adopting trauma-informed language and posters had been displayed conveying more supportive messaging, such as "we are here to help." She emphasised the importance of embedding this language in written materials and in interactions with service users to ensure a consistent approach. The CN noted that there was a distinction between tolerance and inclusion and that the language used within the organisation needed to reflect this. She cautioned against referring to individuals as "mental health patients," as this could be labelling and judgemental, even if unintentionally so. She stressed that this represented a significant cultural change and that staff would be encouraged to reflect on their language and approach. There being no further questions, the Chair thanked Ms Bright for her informative presentation and noted the Board's support for the continued development and implementation of TIC across the Trust.	
47/25	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	
48/25	**Minutes** The minutes of the Trust Board meeting held on 29th April 2025 were reviewed. No amendments were noted and they were otherwise as a correct and accurate record of the meeting.	
49/25	**Matters Arising** There we three matters arising, two of which were not yet due. • *18/25 – Patient Parking* It was confirmed that while the annual review of parking had not yet concluded, a grace period for patient parking would be reintroduced.	
50/25	**Chief Executive's Report** The CEO presented her report to the Board. She explained that she had recently attended the NHS Confederation Conference, where the Secretary of State for Health and other senior leaders had spoken about the evolving direction of travel for the NHS, with a particular emphasis on a shift towards prevention. She welcomed this approach, noting that it presented a real opportunity for the Trust to develop its services for patients. She particularly endorsed the focus on integrated neighbourhood teams, highlighting that the Trust had already commenced work in this area. The organisation had begun to review its strategy in light of changes to the national landscape. She noted that the New Hospital Programme (NHP) had been put on hold until 2037 and as a result it was now necessary for the Trust to set a clear strategic direction for the next three to five years. The Trust would be engaging with staff across the organisation to gather their views, followed by consultation with patients. The intention was to revise the existing strategy to reflect a new tone and direction of travel. She described the Trust's new approach to engagement using Gemba methodology, which involved visiting clinical and operational areas to speak directly with staff and patients. This approach had been built into the weekly timetable for the CEO and Executive Team and would provide a structured means of gathering feedback and offering support. Findings from these visits would be reported back to the Board, along with explanations of the actions taken in response.	

	The CEO provided an update on robotic surgery at the Conquest Hospital, noting that the programme had now been in place for one year. During that time, 165 operations had been carried out, primarily in colorectal and gynaecological surgery. She described this as a forward-looking development and commended the team for their impressive work. She further reported that colleagues in cardiology and stroke had recently presented at the British Cardiovascular Society, led by Dr Rick Veasey. The presentation had been included as one of the top ten international trials. She also praised Jackie Hunt as an emerging leader within the organisation. Frank, NED, noted that he had undertaken a Gemba walk the previous day and had found it to be a valuable experience. He had visited the diabetes and endocrinology team, who had shared a number of constructive ideas for service improvement. He emphasised the importance of these visits and confirmed that he would provide further feedback separately. The Chair noted that the Gemba approach represented a more formalised and systematic method of undertaking visits than had previously been the case. He highlighted the need for structured feedback loops to ensure that insights from these visits were captured and acted upon. The CEO reported that a QR code system was being trialled to enable the recording of comments and feedback during visits. She stressed the importance of being able to report back to colleagues on the outcomes of these visits and reiterated the need to approach them with purpose and with respect for colleagues' time. Amanda, Non-Executive Director, expressed her support for the Gemba approach but noted that she had not been aware of the QR code system. The CEO confirmed that the system was currently being trialled and would provide further information in due course. ***The Board noted the CEO's report.***	
51/25	**Board Committees Chairs' Upwards Reports** <u>Audit Committee</u> The CFO reported that the Audit Committee had met on 20th June 2025 to approve the Trust's Annual Report and Accounts. The accounts had been produced within the required timeline and he expressed thanks to the finance and wider teams for their considerable efforts in achieving this. He reported that Non-Executive Directors had requested a short extension to allow additional time to provide feedback on the Annual Report and that, following receipt of any feedback, the report would be finalised and signed off accordingly. <u>Finance and Productivity Committee</u> Steve, Chair presented the Finance and Productivity (F&P) Committee's report. ***The Board approved the updated Terms of Reference for the Committee.*** <u>People and Organisational Development Committee</u> Frank, NED presented the report of the People and Organisational Development (POD) Committee. He explained that the Committee had undertaken deep dives into key areas during May and June, with a particular focus on gaining assurance around the workforce plan. POD had considered how the workforce plan aligned with other organisational plans and strategies, and early indications suggested that the necessary workforce reductions were progressing in line with expectations. The Committee had also received a report from the Freedom to Speak Up Guardians.	

	Quality and Safety Committee Amanda, NED presented the report of the Quality and Safety (Q&S) Committee to the Board. The Committee had received updates on maternity services and recent Never Events; further work remained to be done in these areas to ensure improvements and sustained assurance. The Committee continued to monitor several key areas, including medication safety and the care of dying patients. The Committee had received its first comprehensive quality dashboard, which had been in development for the past two years. The dashboard enabled the Committee to drill down into the data to identify and understand emerging issues. Amanda, NED thanked Sandeep Patel and his team for their work in developing this valuable tool. ***The Board noted the Committees Chairs' upward reports.***	
52/25	**Delivery Plan 2025/26** The CEO thanked the DCEO, the Executive Team, divisional leaders, and colleagues across the organisation for their work in developing the organisation's delivery plan. The DCEO reported that the planning process had recognised that the traditional approach of incremental cost-cutting was no longer sustainable. As a result, a fundamentally different approach had been adopted for the current year with the plan having been developed from the bottom up, triangulating activity, performance, and finance, underpinned by detailed operational plans to enable daily, weekly, and monthly monitoring of progress. The Trust was required to deliver savings of just under £50 million in 2025/26. This represented a significant challenge and would need to be achieved in a way that aligned with the organisation's strategic goals. The plan had three core pillars: 1. Quality, with standards embedded into the planning process from the outset, driving the actions required to meet them. 2. People, where the plan addressing issues raised in the staff survey and to embed quality improvement processes across the organisation. 3. Sustainability, with plans supporting long-term improvement rather than one-off savings. The planning process had incorporated national benchmarking to identify opportunities for improvement; Quality Impact Assessments (QIAs) had been undertaken for all the proposed changes to ensure there were no unintended consequences. The organisation had come together to review the plans collectively, ensuring alignment and mitigating cross-divisional impacts. The plan required growth in elective activity, which had been factored into delivery assumptions. Non-elective activity was expected to reduce through improved ways of working. The workforce, being a major cost driver, would be reduced slightly in line with activity and efficiency changes. Divisions had identified their own efficiency opportunities as part of the planning process. Delivery of the plan would be supported by five key areas of focus: length of stay, workforce, income, optimisation of business cases, and digitally enabled change. These areas were expected to have a key impact on delivery and would support divisions in achieving their targets. A Programme Support Office had been established to monitor progress on a weekly and monthly basis, ensuring that the detailed activity underpinning the plan remained on track. In terms of Board assurance, the DCEO emphasised the importance of oversight through Board Committees, with assurance flowing from divisional Integrated Performance Reviews (IPRs) to Committees and then to the Board. IPRs were being revised to be shorter and more focused, ensuring that the right issues were being addressed. The challenge of delivering across multiple fronts was acknowledged and key elements of the plan would be used to demonstrate progress and identify corrective actions where necessary. He described the plan as ambitious but well-constructed, with a savings	

target of 6.3%. He noted that the approach that had been taken to developing plans had placed the Trust in a stronger position than in previous years and was aligned with national requirements and standards.

The Chair commended the plan, describing it as the most comprehensive and granular he had seen during his time at the Trust. He noted that the scale of the savings required was two to three times greater than in previous years and that the level of preparation had been significantly improved.

Amber, Associate NED, asked whether the plan would be flexible enough to adapt if performance deviated from expectations. The DCEO confirmed that the plan would be adjusted in real time if necessary, drawing on the Trust's experience in managing emergency department performance in this manner. He assured the Board that deviations would be identified early and addressed promptly.

Frank, NED, asked whether early warning systems were in place to detect any disproportionate impact on staff or the population. The DCEO explained that the plan had been developed with consideration of health inequalities and population needs; any deviations would be corrected through the existing framework rather than requiring a change in course. The COO added that she was not aware of any actions that would have such unintended consequences. The Chair stressed the importance of reviewing actions holistically to avoid adverse impacts. The CEO reiterated that the impact on staff, patients, and Divisions had been carefully considered. She confirmed that Divisions had the support they needed, particularly as demands were expected to increase heading into winter.

Amber, Associate NED, noted that mitigations were in place at Divisional level and that the organisation was taking a proactive rather than reactive approach. The DCEO agreed, highlighting the importance of triangulation in identifying issues early and maintaining clarity on the actions required to remain on track.

Amanda, NED, praised the plan as exceptionally well connected and noted that it was the earliest in the year the Board had ever discussed such a plan in detail. She emphasised the importance of using the Board Assurance Framework (BAF), Committees, and the Corporate Risk Register (CRR) to provide further assurance. She encouraged dynamic conversations at Divisional level to identify unintended consequences early. The Chair agreed, stating that governance processes should act as enablers rather than barriers. The CoS confirmed that work was underway with the corporate risk team to streamline processes and reduce bureaucracy. Divisions were being encouraged to bring relevant risks to monthly IPRs to ensure early identification of emerging issues.

The CEO reported that performance in months one and two had been strong, but that this was typical of early-year trends. She anticipated greater challenges in months three and four, particularly in relation to emergency department performance and other trajectories. She advised that additional mitigations would be required and that financial pressures would increase as the year progressed. She stressed the importance of supporting Divisions in delivering against targets and committed to maintaining transparency about progress. She reiterated that the five key areas of focus would be developed further to support delivery and that a clearer picture would emerge by months five and six.

The CFO added that the finance team had reviewed expected performance for the first half of the year. While financial targets had been met in months one and two a change in run rate would be required to meet financial targets from month three onwards. This would be discussed at the upcoming F&P Committee. He noted that while some Integrated Care Systems had already deviated from their financial plans, Sussex remained on target overall. Weekly tracking of actions was undertaken and the finance team was actively supporting Divisions in balancing business-as-usual activity with

	transformation. Divisions had taken ownership of their plans and the number of Cost Improvement Plans identified exceeded the required savings, providing additional assurance. He commended the collaborative working that had been evident across the organisation. The Chair concluded that while the plan was strong, it carried significant risk, which had been acknowledged and signed off by the Board. He emphasised that this was a collective responsibility and that clinical colleagues needed to feel supported. **The Board noted and approved the Delivery Plan 2025/26**	
53/25	**Integrated Performance Report (IPR) for Month 1 (April)** The IPR was jointly reported by the CN, CMO, DCEO, CFO and COO. <u>Quality and Safety</u> The CN presented the update. Highlights from this section included: • Quality watch metrics for April had remained broadly stable. The introduction of the new quality dashboard had been welcomed, as it enabled teams to examine data in greater detail and identify emerging issues more effectively. • Significant work had been undertaken around length of stay and discharge planning. The operational tempo across the Trust had been fast-paced in recent weeks, with considerable pressure on services. The CN acknowledged the complexity of the patient cohort and commended colleagues for their exceptional efforts during this challenging period. • Ongoing implementation of the Trust's mental health strategy was structured around four key pillars: environment and estates, workforce, education, and commissioning pathways. This work was being progressed in collaboration with system partners. • The Trust was preparing to host its first week-long patient safety event, which would focus on learning and improvement. In addition, deep dives into falls prevention and medicines safety had commenced and would become regular standing items within the quality governance framework. • Length of stay and discharge planning had been confirmed as one of the five organisational priorities. The CN shared that she had recently met with new volunteers supporting work on reconditioning and discharge, describing the experience as inspirational. • The CN had undertaken a recent Gemba visit to the urgent care navigation hub, where she had spent time with colleagues from South East Coast Ambulance Service (SECAMB) and the Urgent Community Response (UCR) teams. Frank, NED, queried whether there was a version of the Multi-Agency Discharge Event (MADE) specifically for patients with mental health needs. The COO responded that mental health organisations in Sussex ran MADE events and that the Trust could explore the possibility of hosting a similar event in East Sussex. She noted that joint work was ongoing with system partners on patient pathways and that, at present, there were 10–11 patients in the Trust who might be better managed in alternative settings. The CN added that system-wide conversations were continuing and that the Trust did not separate patients with severe mental illness from those with physical health needs, meaning that existing MADE events had covered both. She confirmed that discussions had taken place with Sussex Partnership NHS Foundation Trust regarding potential changes to current practice. Frank, NED also raised a query regarding a security incident referenced in the IPR asking whether work was underway to understand the learning from the case. The CoS responded that further detail would be provided in part two of the meeting. He confirmed that discussions were ongoing regarding follow-up with patients, particularly those with no fixed abode or a registered GP, and that the team had considered alternative approaches to communication with these individuals.	

Amber, ANED, noted that nursing fill rates appeared strong but queried why night shift fill rates were recorded at 104%. The CN explained that fill rates were stable overall, but that staffing occasionally exceeded 100% due to specific circumstances such as the need for special nursing.

Amber, ANED, also asked about the two Prevent referrals noted in the report, querying whether such referrals were increasing and whether the Trust had ongoing obligations following referral. The CN responded that Prevent referrals were not common within the Trust and that there was no indication of an upward trend. She confirmed that the Trust worked effectively with partner organisations from a safeguarding perspective and that staff received appropriate training. She assured the Board that this was not a cause for concern locally.

The CMO provided an update on mortality data. He reported that the Trust was ranked at 67th out of 135 trusts nationally, with the Summary Hospital-level Mortality Indicator (SHMI) for the Trust standing at 103, which was comfortably within the normal range. He noted that SHMI was not ideally suited to integrated trusts, as the retention of patients in community beds tended to inflate the figure. Crude mortality for February had been better than the same period in the previous year. The Risk Adjusted Mortality Index (RAMI) was reported at 86, against an expected level of 100, placing ESHT 35th out of 130 acute trusts. He also noted that mortality on admission at weekends was better than during the week.

Our People – Our Staff
The DCEO presented the update. Highlights from this section included:

- There had been an increase in workforce figures in April, primarily due to changes associated with the opening of the surgical centre and endoscopy centre.
- A number of operational changes had taken place during the same period, including the introduction of intermediate care wards. These changes had contributed to improved discharge processes and enhanced patient care. Preparations for ward closures had also commenced in April, with care being transitioned into community settings.
- Workforce metrics were reported to be broadly stable. However, the appraisal rate had shown a slight decline. A new digital appraisal system had been introduced, and feedback from staff was being used to inform improvements to the system.
- Sickness absence had reduced slightly for the third consecutive month. Training compliance remained stable, although some challenges had been noted in relation to face-to-face training delivery. The volume of such training had increased and localised training sessions were being implemented to support this.
- Trust had remained on plan for month one for workforce usage and cost and was £0.6 million below planned expenditure. A similar position was anticipated for month two, although it was acknowledged that financial pressures would increase as the year progressed.

Access and Responsiveness
The COO presented the update. Highlights from this section included:

- Emergency Department (ED) performance in April had reached 77.5% against the 78% standard, with further improvement seen in May, where performance exceeded 79%. The focus remained on identifying and implementing measures to improve sustainability in performance.
- MADE Events held during April and May had had a positive impact, contributing to reductions in length of stay. The introduction of integrated care wards, supported by general practitioners for patients not requiring acute care, had also supported improved discharge processes.

- In planned care, the number of long-waiting patients had reduced significantly. By the end of May, only four patients remained waiting over 65 weeks, with the expectation that this number would reduce to zero by the end of June. Referral to Treatment (RTT) performance was reported at 58.6% in May and 61.98% in June.
- Cancer performance remained strong, with the Trust delivering against the 77-day and 62-day standards. Plans were in place to achieve the 75% Faster Diagnosis Standard by the end of the year. Challenges remained in relation to the Diagnostic Waiting Times (DM01) standard, but recovery plans had been developed.
- Virtual ward occupancy was reported to be good. Ambulance handover delays remained an area of focus, with a target of completing handovers within 45 minutes. Plans were in place to improve performance in this area.
- In community services, waiting times for community paediatrics continued to reduce, supported by ongoing outsourcing arrangements.

Steve, Chair, queried whether the new 45-minute ambulance handover target was proving challenging for the Trust and others. The COO confirmed that it was, but expressed confidence that the Trust would meet the target. She noted that the Trust had experienced its highest-ever level of ED attendances the previous day, with 599 attendances across emergency departments designed for 150 patients. This elevated level of attendance had been sustained throughout June. No specific factors had yet been identified to explain the increase, but a review would be undertaken to explore this further.

Amanda, NED, raised concern about the deterioration in DM01 performance and asked for the underlying causes. The COO explained that the recent inclusion of audiology and echocardiography surveillance patients, along with an increase in the MRI waiting list, had contributed to the decline. Work was ongoing to understand and address these issues.

Amanda, NED, asked when community paediatric waiting times were expected to return to business-as-usual levels. The COO explained that the Trust was currently reviewing the appropriate model of care and that continued outsourcing might remain the most effective approach. The Trust commissioned the service directly and was in discussions with commissioners about potential changes.

Frank, NED, expressed concern about the high ED attendance figures and requested that a review of this be brought back through a sub-committee. The COO agreed and confirmed that this would be taken through the Finance and Performance Committee. **COO**

Amber, ANED, asked whether the Trust was able to see primary care access data and whether there was a link between this and ED attendances. The COO confirmed that the Trust was working with GP federations to examine appointment data and assess any correlation. She noted that GPs were also experiencing high levels of demand. Steve, Chair, added that there had been a general rise in both primary care activity and ED attendances in recent years, although the reasons for this remained unclear.

<u>Financial Control and Capital Development</u>
The CFO presented the update. Highlights from this section included:

- Efficiency savings were ahead of plan, driven primarily by workforce-related measures. This positive trend had continued into month two.
- Capital programme expenditure had slipped against expectations. A “hockey stick” effect was anticipated, with spending expected to ramp up significantly towards the end of the financial year. The capital programme would be closely monitored going forward, with particular attention given to estates and medical equipment investments.

The Board noted the Integrated Performance report.

54/25 **Maternity Update Q4**

The DOM presented the Q4 maternity update to the Board. She noted the complexity of maternity services and the importance of multidisciplinary team working in delivering positive outcomes and experiences for women and families. The update was framed around the targets set out in the three-year maternity delivery plan, with the majority of deliverables for 2023/24 now achieved. Over the past 18 months, the focus had been on continuous improvement, underpinned by compassionate listening to women and families. Key achievements had included the implementation of personalised care support plans for all women by the end of 2023/24, and improvements in neonatal cot capacity.

The Trust had met its workforce establishment requirements using the Birthrate Plus methodology. A new review had recently been completed, and the team was working through the findings. Local retention and improvement plans had been implemented, and a comprehensive training plan was in place to meet national standards. All of these elements had been discussed and reported through the Q&S Committee. NHS England and the ICB were working with the Trust on the perinatal surveillance programme, which was also in place. The Trust had implemented the Saving Babies' Lives Care Bundle and was now 99% compliant. Digital systems had been introduced, including BadgerNet for electronic patient records, MEWS and NEWS monitoring, and compliance with digital maternity standards. All of these areas were being actively monitored.

NHS England had conducted an insight visit on 23rd April to assess progress against delivery standards. The visit had been broadly positive, with no surprises. Two minor actions had been identified—one relating to privacy and the other to pathway development—both of which were being addressed in collaboration with system partners. The Trust was also supporting staff following the national review of maternity services.

In terms of local risks, the DOM reported that the Trust continued to respond to findings from previous reviews. A no-harm event had occurred in June 2024, followed by a further event in March 2025. A robust plan had been implemented to prevent recurrence. Although there had been an increase in stillbirths, the Trust's average remained below the national average, and appropriate plans were in place to address this.

Staffing levels were reported to be good, although the service could feel busy due to the complexity of cases. A robust escalation plan was in place to support staff. Neonatal and medical workforce levels were in line with national recommendations. Amanda, Non-Executive Director, was confirmed as the Board's maternity safety champion and met monthly with the perinatal leadership team and the Chief Nursing Officer to raise and address issues.

The DOM reflected on the significant progress made over the past year and noted that the team was taking time to celebrate achievements. A new obstetric lead had been appointed to lead on pre-term birth initiatives.

Amber, ANED, referred to recent national media coverage and the announcement of another national maternity review, asking about the impact of this on staff. The Chair noted that a review of maternity services at University Hospitals Sussex (UHSx), was due to take place soon; he acknowledged that the frequency of reviews could be unsettling for staff and that this was reflected in the reporting to the Board. The Trust was not formally part of the national rapid review of maternity services, but would continue to work to ensure that its services were safe and effective.

The CN noted that the Trust might see an increase in women choosing to access its services as a result of developments elsewhere. She emphasised the importance of using this as an opportunity to self-assess and benchmark services, and confirmed that the matter would be discussed at ICB level. She acknowledged the burden of

	information requests associated with national reviews but expressed confidence in the robustness of the Trust's data and the quality of its services. Amber, ANED, expressed her appreciation for the work being done and her empathy for staff working under such scrutiny. Amanda, NED, commended the team for the significant amount of work involved in compiling and presenting the report. She welcomed the celebrations of good practice, which she felt would help support staff morale. She acknowledged the intense scrutiny faced by maternity teams and stressed the importance of maintaining vigilance. She thanked the DOM and her team for their continued focus and commitment to improvement. ***The Board noted the Q4 Maternity Update***	
55/25	**Freedom to Speak Up Guardian's Update** The DCEO presented the Freedom to Speak Up Guardian (FTSUG) report, which was brought to the Board twice a year. He noted that a more detailed discussion would take took place in the private session of the Board, where the FTSUG presented directly. He reported that the number of staff approaching the FTSUG had remained stable over time. However, there had been a shift in the themes raised, partly due to the introduction of additional reporting categories. Incivility remained one of the most common themes, with the use of language in high-pressure environments continuing to be a concern. This linked back to the earlier discussion on Trauma Informed Care (TIC). There had been a slight increase in patient safety concerns during Q4. These had been discussed at the POD Committee, where assurance was provided that all concerns were being escalated appropriately and without delay. The DCEO confirmed that concerns raised through the FTSUG were consistently redirected into the appropriate formal channels. The staff survey indicated that while staff felt able to speak up, there was a gap in closing the communication loop and providing feedback which was an area of focus. A deep dive had been undertaken into some of the delays referenced in the report. It was found that in several cases, delays were due to external investigations that needed to conclude before the Trust could initiate internal processes. The DCEO assured the Board that where there was any risk to individuals, immediate action was taken. Amber, ANED, referred to the staff survey findings and asked whether the Trust could do more to demonstrate how raising concerns had led to change. She suggested that sharing examples across the organisation could help reinforce a culture of openness. The DCEO confirmed that the FTSUGs already undertook "You Said, We Did" communications and that a broader organisational initiative was also underway. This included reviewing Datix reports and providing feedback based on the issues raised. The CEO added that it was essential to demonstrate that the organisation was listening and acting on concerns. Ama, ANED, asked about the resolution process, noting that some colleagues had expressed dissatisfaction with the outcomes of resolution meetings and asked for further clarification. The DCEO explained that the Trust had moved away from formal grievance procedures in favour of resolution-based approaches, unless there was a clear reason not to do so. He acknowledged that while this was often the most appropriate route, some individuals were uncomfortable with the process; he was, however, confident about the approach being taken. Ama, ANED, suggested that the rationale for this approach could be better explained in the report. The DCEO agreed and noted that it was inevitable that some individuals would be dissatisfied if the outcome did not align with their expectations.	

	Ama, ANED, asked whether there was a process in place for maintaining contact with staff on long-term sick leave. The DCEO confirmed that such a process existed and was included in Trust policy. In the case referenced in the report, the issue had been a failure to follow the policy rather than a gap in the process itself. Amanda, NED, expressed concern about the increase in patient safety concerns and asked how these had been resolved. She suggested that if the trend continued, a thematic review would be helpful to ensure that the Board maintained oversight. The DCEO agreed and confirmed that any patient safety issues raised through the FTSUG were escalated immediately. ***The Board noted the Speak Up Guardian's Update***	
56/25	**Delegation of Approval of Quality Account** The CN requested the Board's approval to delegate authority the sign off of the 2024/25 Quality Account to the Q&S Committee. ***The Board delegated authority to approve the 2024/25 Quality Account to the Quality and Safety Committee.***	
57/25	**Use of Trust Seal** Four uses of the Trust Seal since the last Board meeting were noted.	
58/25	**Questions from members of the public** Liz Walke raised a question regarding the potential return of maternity services to Eastbourne. The Chair responded that there were several reasons why this was not feasible, including the inability to provide safe services across two sites and the absence of capital funding to support such a move. He added that this was not likely to change in the near future, particularly given the continuing decline in birth rates across East Sussex. Ms Walke asked about the possibility of establishing a walk-in centre for urgent care. The Chair stated that, if capital funding were available, it would be prioritised to increase capacity within existing departments. He noted that walk-in centres had not historically delivered strong outcomes for the NHS. The COO added that the Trust was working with GP federations to improve access to GP appointments but confirmed that there were no plans to relocate services off-site. Colin Campbell asked about the pace of progress in developing integrated community teams. The CEO acknowledged that progress had not been as rapid as desired but emphasised that the Trust was actively engaging with local organisations to accelerate development. She described this as a national priority and a significant opportunity for the Trust. She confirmed that the Trust would not wait for a prescribed model but would instead work with local councils, GPs, and other partners to design and implement a locally appropriate solution. The Chair added that forthcoming changes within the Integrated Care Board (ICB) presented an opportunity for the Trust to take greater ownership of this work. Mr Campbell suggested extending Gemba walks to include end-to-end reviews of patient pathways. The CEO agreed that Gemba could be used in a variety of ways, including service and pathway reviews. She noted that the Trust already undertook deep dives and pathway reviews and that Gemba provided a structured method for engaging with staff and testing processes. Mr Campbell highlighted the importance of placing the patient at the centre of pathway reviews and shared examples from his volunteering experience where relatives struggled to understand the steps required to continue care. Helen Burt shared her personal experience of trauma following a hospital admission, noting that it had taken her a year to be able to drive past the hospital and two years for	

	her nightmares to cease. She emphasised the long-term impact that traumatic experiences within NHS settings could have on individuals and urged the Trust to explore this further. Ms Burt raised a concern about the complication rate associated with robotic surgery, suggesting that it was higher than other forms of surgery. She also questioned the use of QR codes, noting that they could be spoofed and were not inclusive for individuals without smartphones. Ms Burt asked what percentage of additional funding Sussex had received in recent years, referencing page 44 of the Board papers. The Chair responded that he could not provide an exact figure but explained that NHS resource allocation models had changed over time, with even small adjustments to the formula having significant impacts on individual organisations. He noted that previous changes had shifted weighting from age-based demographics to deprivation, which had altered funding allocations. He acknowledged that while the required savings figure for the Trust was large, it represented a relatively small proportion of overall spend and should be achievable over time. The CFO added that such savings could not be delivered rapidly and would require transformation. He emphasised the importance of managing the pace of change to avoid unintended consequences. Ms Burt expressed concern that negative repercussions were not always reported, with a tendency to focus on positive outcomes. The Chair confirmed that the Trust would be transparent about what could and could not be achieved, and the consequences of any decisions taken. He reiterated that the NHS was a national service operating within the resources allocated by government. Bruce Hardwick welcomed the reintroduction of the car parking grace period. He also raised concerns about the acoustics in the meeting room and asked whether equipment could be introduced to improve sound quality. The Chair, agreed that the acoustics were poor and undertook to explore options for improvement. Mr Campbell asked whether the Trust was receiving data from Sussex to explain the increased volume of attendances at A&E. The COO responded that there was no clear indication of the cause, although increases had been observed in both GP and A&E attendances. Mr Campbell noted that significant data was being fed into the Sussex Integrated Dataset and suggested that this could be used to inform understanding of the trend.	
59/25	**Agenda Forward Plan** The Board's forward plan was noted.	
60/25	**Date of Next Trust Board Public Meeting** Tuesday 26th August 2025	

Matters Arising from Public Board meetings

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
OPEN ACTIONS					
None					
NOT YET DUE					
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	November 2025	29.04.25 As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is **expected to be in place from November**
08.10.24	72/24	Executives were asked to reflect on how reporting to the Board could be improved moving forward.	Execs	November 2025	29.04.25 As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is **expected to be in place from November**
ACTIONS COMPLETED					
24.06.25	53/25	Review of underlying reasons for record ED attendances to be presented to Finance and Performance Committee	Charlotte O'Brien	August 2025	Review on the agenda for the Finance and Performance Committee meeting on 28.08.25

Agenda Item: 7

Report To/Meeting	Trust Board	**Date of Meeting**	26th August 2025
Report Title:	Chief Executive's Report		
Key question	What key news from the Trust does the Chief Executive want to highlight to the Board?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Jayne Black, Chief Executive	**Presenter(s):**	Jayne Black, Chief Executive
Outcome/Action requested:	The Board is asked to note the Chief Executive's report.		

Executive Summary

Chief Executive's report

Over the last few weeks we have been engaging with our colleagues at NHS England and our local commissioners on the upcoming new oversight regime that will come into effect next month.

The regime will, ultimately, create a national 'league table' of trusts, with each organisation being given an overall score based on metrics relating to accessibility and quality of services, patient safety, staff sickness and engagement as well as finance and productivity. Each trust will be allocated to one of four segments, segment one being the most high-performing with segment four needing more significant oversight and support.

While we have yet to formally receive our score, our quality metrics are broadly robust and one of our most significant ongoing challenges – delivering our financial plan – is on a similar scale to many other trusts across the country and we are performing well on delivering this to date.

What is clear, however, is that the centre of the NHS views a successful trust as one that can fulfil all of its obligations to its patients and the wider health and care system. We will need to continue all aspects of our improvement work to ensure that we meet those expectations.

Sussex Surgical Centre handed over

Thanks to the hard work of our estates and DAS colleagues, the significant majority of the building system works for the Sussex Surgical Centre have now been completed and we have formally taken back the building from our construction partners IHP.

Over the next few weeks our estates team will undertake a thorough clean of the building, while our DAS team bring across the necessary equipment to make it clinically ready.

This has been one of the most significant capital projects that the trust has delivered for a considerable time, and we will be opening our doors to our first patients early in September.

Repurposing of Tressell Ward

As the Sussex Surgical Centre is brought into use at EDGH, at Conquest we are making changes to expand our services in another way, with the repurposing of Tressell Ward into an Intermediate Care ward.

The ongoing challenges within Sussex to support speedy discharge has meant we have continued to have high levels of NCTR patients in our hospitals. Although on our Conquest hospital site, the newly-repurposed Tressell ward will be managed by our CHIC division as a transitional facility – pulling NCTR patients from our acute wards and creating capacity on these while providing the care that the patients need while a full hospital discharge is facilitated.

Cardiology changes

The trust is continuing to work towards the implementation of the new cardiology model in East Sussex, delivering the newly configured status to the blueprint that was agreed in 2022 after public consultation. This includes the consolidation of specialist cardiology inpatient care at EDGH.

As with any significant service move, our communities in and around Hastings have expressed their anxieties that the changes will disadvantage them and reduce the quality of cardiology care that they can access.

While this is not the case – and the changes will actually improve clinical outcomes for all patients across our catchment in both the short and long term – we are sympathetic to their worries. We are actively engaging with political stakeholders in the area to explain the benefits of the new model and reassure them and their constituents that they will continue to be able to access the high quality cardiology care they and their families need and except.

HSJ Award shortlisting for work on care for Veterans

We have been shortlisted for prestigious HSJ Award for our Veteran Aware and Armed Forces Initiative work in the Military and Civilian Health Partnership Award category.

Our award entry covered the work led by our Deputy Chief Executive Steve Aumayer which has seen the roll-out of Armed Forces awareness training for staff, our work to better identify veterans in our patients pathways, our strengthened links with military charities and our rapid progression to achieving the Defence Employer Recognition Gold Award in under two years.

The final winner in the category will be announced at the Awards in London in November.

Body-worn camera trials in our Emergency Departments

We have recently launched a trial of body-worn cameras in our emergency departments at the trust. While the overwhelming majority of our interactions with patients in our EDs remain positive, in common with much of the NHS we have sadly seen an increase in violence and intimidation of our staff by patients and members of the public in recent years.

	To deter incidents from happening – as well as providing valuable evidence should an incident occur – clinical staff within our EDs will be wearing the cameras while on shift. These will only be activated should a colleague feel threatened and will not compromise patient privacy and dignity, but we hope that they will help our staff be and feel safer in their duties.
Regulatory/legal requirement:	Not applicable.
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	Not applicable.
Risk:	Not applicable.
No of Pages	3 **Appendixes** None.
Governance and Engagement pathway to date:	Not applicable.
What happens next?	Not applicable.
Publication	Report is for publication.

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	8.1
Date of Meeting	**26 August 2025**		

Title of Report:	Audit Committee (AC) – Chair's Report
Status:	For Discussion
Sponsor:	Paresh Patel, Chair of AC
Author:	Paresh Patel, Chair of AC
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 24 July 2025 to provide the Board with an update of the Committee's activities.

Background

The Audit Committee holds delegated responsibility from the Board of Directors as set out in ToRs; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

- The Committee received the Security Annual Report, noting a 19% increase in physical assaults and a rise in hate crime incidents. A pilot of body-worn cameras was launched, and the Trust's three-tier sanction system was reviewed. Concerns were raised about the classification of acute sites as "places of safety" and the challenges in recruiting mental health assistants.
- The Board Assurance Framework (BAF) was presented in a revised format. The Committee welcomed improvements but requested alignment between BAF risks and the Corporate Risk Register.
- The Committee was updated on Cybersecurity, including progress on Active Directory and Windows 11 migration. Staff behaviour was identified as the greatest vulnerability.
- The Committee reviewed the Data Security protection Toolkit (DSPT) Annual Report, noting a 79% compliance rate under the new Cyber Assurance Framework. The Trust submitted its return as "Standards Not Met," in line with national expectations.
- The Committee approved updates to the corporate governance documents (including SFIs) and reviewed Losses and Special Payments, noting a reduction to £53,700.
- Nine Waivers were noted
- The Committee received the External Audit Report confirming finalisation of year-end accounts and the Internal Audit Report
- The Committee conducted its Annual Self-Effectiveness Review, confirming that cybersecurity risk oversight would transfer to the Finance & Performance Committee.

Alert, Advise and Assure

Alert

- Rising incidents of violence and aggression, particularly in community settings.
- Strategic concerns regarding the Trust's legal responsibilities under the Mental Health Act.

Advise/Inform/Update

- None

Assure

- Year-end accounts were signed off by external auditors.
- DSPT submission broadly aligned with regional peers.

Key Risks or Opportunities and their impact on the Trust

- Increased security incidents and mental health-related challenges could impact staff safety and operational resilience.
- Cybersecurity and digital infrastructure improvements presented opportunities for enhanced risk management.

Key Decisions

- Approved governance document revisions.
- Endorsed external audit extension fee.

Exceptions and Challenges

- Recruitment of mental health assistants remained difficult.
- Internal audit actions were sometimes delayed due to resource constraints and cross-team dependencies.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	Agenda Item:	8.2
Date of Meeting	26th August 2025		

Title of Report:	Finance & Productivity (F&P) Committee
Status:	For Discussion
Sponsor:	Steve Phoenix, on behalf of Chair of F&P Committee
Author:	Steve Phoenix, on behalf of Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Productivity Committee on 24th July 2025.

Background

The Finance & Productivity (F&P) Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

Alert, Advise and Assure

The Committee received updates on the following matters:

1. Financial Performance

- A reconciliation exercise was being undertaken to ensure that the Trust's contract schedules were fully aligned.
- Internal audit review would be undertaking a review of the Trust's financial planning and reporting, commencing in August to provide independent assurance.
- Positive elective recovery performance was noted.

2. Board Assurance Framework (BAF)

- The Q1 BAF risks overseen by F&P were reviewed. It was noted that the cybersecurity risk on the BAF had moved from the Audit Committee to F&P in line with best practice.
- Corporate risks had been realigned with BAF risks; this was a work in progress

3. Capital Programme

- A revised capital report presented with improved structure and clarity.
- The delay to the opening of the Sussex Surgical Centre (SSC) was discussed with associated risks highlighted to the Committee.

4. System & Strategic Planning

- The Sussex system was on track to receive Q2 deficit support funding.
- Medium-term (3–5 year) planning was discussed; national guidance was awaited.

5. Operational Performance (IPR)

- Mixed performance across urgent care, cancer, diagnostics, and elective activity.
- Discussions took place about how operational performance could be sustained.
- Improvements to future reports to the Committee were agreed.

6. Transformation Programme

- “Art of the Possible” Phase 1 was delivering strong outcomes in community care as well as financial savings.
- Phase 2 had been approved and had commenced.
- The programme had been recognised regionally as a model for transformation.

Key Risks or Opportunities and their impact on the Trust

Key Decisions

Exceptions and Challenges

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	**Board of Directors**	**Agenda Item:**	8.3
Date of Meeting	**26th August 2025**		

Title of Report:	**People & Organisational Development (POD) Committee**
Status:	For Discussion
Sponsor:	Frank Sims, Chair of POD Committee
Author:	Frank Sims, Chair of POD Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 24 July 2025 to provide the Board with an update of the Committee's activities.

Background

The People & Organisational Development (POD) Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

POD Workforce Insight Report

The Committee expressed concern over rising staff stress, anxiety, and sickness, due to recent changes and pressures. They called for clear actions from divisions on managing these issues. While bank staff usage is not yet a major risk, its impact on training and sickness was noted.

Workforce challenges include delays in efficiency projects and many staff nearing retirement. The Trust is addressing this through flexible contracts, retire-and-return options, and manager support.

POD Workforce Insight Report – aligning plans with the Finance and Performance (F&P) Committee

The F&P Committee had noted some discrepancies in the reporting of workforce costs between HR and Finance. This has been identified as being due to some technical adjustments within the ledger which will be corrected.

Going forward it was noted that F&P Committee would receive only financial workforce date, but POD would continue to receive both financial and WTE data for review so as to ensure that both headcount and costs were in line with plans.

Alert, Advise and Assure

Staff Survey – Estates and Facilities

The Estates & Facilities Staff Survey identified key areas for improvement: community engagement, training, multi-skilling, and communication. Actions are aligned with organisational goals, focusing on culture, career growth, and inclusion.

Despite strong engagement scores, sickness absence remains high. The Chair welcomed progress and HR collaboration.

The HRBP gave a verbal update on proactive efforts to tackle stress and burnout, praising the division's responsiveness and use of new tools. Assurance was noted around continued improvement.

HR Appraisal Rate Deep Dive

A deep dive into HR appraisal compliance revealed data inaccuracies due to missing entries in ESR and user difficulties with the new system. Actions were taken to update records and improve user understanding. Concerns were raised about system complexity and low training uptake within HR. A temporary paper-based option was introduced, and minor system adjustments are underway. Lessons from this rollout should be learnt for future digital implementations.

Appraisal Compliance
The Committee discussed appraisal compliance, with the Chair questioning whether the decline was due to technical issues or a broader drop in completion rates. It was noted that five areas, including Estates & Facilities and Urgent Care, had improved, showing the new tool's positive impact when used effectively. The DCEO/CPO proposed gathering feedback from HRBPs to better understand user experiences, and the Chair supported reviewing the action plan alongside this feedback.

Annual Review of Effectiveness
The Annual Review of Effectiveness confirmed the Committee's compliance with its Terms of Reference and reflected positive feedback from members. The review highlighted strong structure, effective organisation, and high-quality papers, with agenda management and recent deep dives particularly valued. No major changes were identified, though members were invited to raise further suggestions if needed.

Terms of Reference
The Committee reviewed and approved the Terms of Reference. Previous feedback on streamlining membership and allowing nominated deputies was noted, with no further comments raised.

Key Risks or Opportunities and their impact on the Trust

The Committee requested for update on the following risks: N/A

Key Decisions

Board Assurance Framework (BAF)
BAF 1, concerning recruitment and retention, has improved due to a stronger market and lower turnover, though some roles remain hard to fill. The risk rating remains at 9 and will be reviewed again next quarter. Industrial action by resident doctors was considered operational and not a BAF-level concern.

BAF 2, focused on staff welfare and engagement, remains high at 16 due to ongoing NHS-wide challenges. Concerns were raised about declining morale and the potential impact on care standards. It was noted that the Mental Ill Health Strategy was missing from the BAF, and the committee discussed the inappropriate placement of mental health patients and lack of specialist support for staff. This issue will be given more attention in future reviews.

Medical and Nursing Revalidation Annual Reports
The reports were reviewed and approved by the POD Committee. The Nursing & Midwifery report confirmed no revalidation lapses, with two minor registration issues—one due to long-term sickness and another related to a payment delay, both resolved. The Medical Revalidation report showed 100% appraisal compliance. A potential risk for 2024/25 was noted regarding a shortage of medical appraisers, with mitigation plans in place.

Exceptions and Challenges

N/A

Recommendations

The Board is asked to note this report.

Report to:	Board of Directors	Agenda Item:	8.4
Date of Meeting	23rd July 2025		

Title of Report:	Quality & Safety Committee (QSC) – Chair's Report
Status:	For Discussion
Sponsor:	Amanda Fadero, Chair of QSC
Author:	Amanda Fadero, Chair of QSC
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC on 23rd July 2025 to provide the Board with an update of the Committee's activities.

Background

The QSC holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

IGM: The CNO shared a positive overview of the Annual Inpatient Survey, though detailed results remain under embargo. June's Watch Metrics showed stable performance across key areas, and while some reports were delayed due to operational pressures, they will be presented at future meetings.

Deep Dives: Still Birth's: The DoM and HoM presented findings from a stillbirth review of ten cases, highlighting recurring issues such as late booking, missed appointments, and complex social and medical factors. In response, targeted actions have been implemented—including policy changes and digital inclusion initiatives—with a continued commitment to reducing risks, and the team's efforts were formally commended by the NED Chair.

Divisional Report - Medicine: The ADNM highlighted key updates from the Medicine Division, including a reduction in harm from falls and progress on initiatives such as Criteria-Led Discharge and bespoke Basic Life Support training. Areas requiring improvement—such as anticipated deaths and medication incidents—are being actively addressed, and a positive patient story showcased the impact of strong multidisciplinary teamwork.

Maternity Dashboard & Ockenden Perinatal Quality Surveillance Report: The ANDCS presented the Trust's response to Jim Mackey's letter on maternity improvements, including plans for a taskforce, enhanced staff support, and strengthened clinical leadership. Key developments such as data monitoring, external reviews, and an audit of shoulder dystocia are helping to drive quality and safety, with further actions pending the taskforce's Terms of Reference.

Governance Quality Report Including H&S (by exception): The ADCG reported improved compliance with duty of candour and a reduction in overdue PSIR templates, alongside consistent incident reporting levels. Twelve significant maternity incidents were noted, including two Never Events, and while a slight rise in moderate harm cases was observed, all incidents are being reviewed and classified in line with national guidance.

Quality Dashboard: Mortality rates remain comfortably within expected range; the Power BI dashboard provides strong visibility of trends—no escalation required.

Mortality Dashboard: The CMO reported that SHMI remains slightly elevated but within national limits, with no concerns raised by the CQC; contributing factors such as longer hospital stays are being monitored. Deep dives into mortality data—particularly for fractured neck of femur and COPD—are underway, and the impact of recent industrial action will be appropriately contextualised in future reporting.

Patient Safety Week – Learning and Reflections: The DCNQP shared highlights from Patient Safety Week, including well-received Gemba walks and initiatives to improve incident reporting awareness, duty of candour training, and staff engagement. Planning is already underway for the next event, with a focus on building momentum and increasing participation, especially among junior staff.

Patient Experience Report: PEL reported a slight increase in high-risk complaints in June, which are being closely monitored, while early resolution through PALS continues to be effective. The Trust-wide Friends and Family Test score reached 93.95%, with a notable rise in responses, and the team is now analysing feedback themes to guide service improvements aligned with core values.

Board Assurance Framework: The CNO provided an overview of two BAF risks—both rated at 16 and at the limits of tolerance—relating to the delivery of safe, high-quality care and meeting the four-hour clinical standard. Ongoing discussions are addressing these risks, including considerations around patients with significant mental illness, with final positions agreed collaboratively through meetings led by the Board Secretary.

Annual Review of QSC Effectiveness & Terms of Reference: The committee reviewed its annual effectiveness and Terms of Reference, formally approving both for submission to the Trust Board. Flexibility in inviting relevant individuals to attend was discussed and confirmed to be appropriately covered within the existing ToR.

Annual Report – QSC Annual Report to Trust Board: The committee expressed their appreciation to Assistant Company Secretary for compiling the information on behalf of the group. Everyone was satisfied with the content and thanked him for his contribution.

Harm Reviews: DCNQP provided an update on the pilot phase of the harm review process, which now uses a more robust online form to improve data capture and measurement. Initial feedback has raised concerns about time demands, but the pilot—covering 1 to 2 wards per division—will run through August to inform refinements ahead of a full trial later in the year.

Mental Health Strategy Update: The CNO outlined the Trust's Mental Health Strategy, structured around four key pillars aimed at improving care for patients in crisis, including environment, education, workforce, and access to specialist services. She also shared details of the Baton of Hope initiative, with the Trust invited to nominate a representative to carry the baton during its national suicide prevention campaign stop in Hastings this September.

Alert, Advise and Assure

None.

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

None required for this meeting.

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

NHS
East Sussex Healthcare
NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period June 2025 (Month 3)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

1.	About our Integrated Performance Report (IPR)
2.	Chief Executive Summary
3.	Balanced Scorecard and Benchmarking
4.	Quality and Safety
5.	Our People
6.	Access and Responsiveness
7.	Financial Control and Capital Development

About our IPR

East Sussex Healthcare NHS Trust

Our IPR outlines how the Trust is currently working and how the on-going journey of improvement and excellence, as reflected within our 2025/26 Operational Plan, is being delivered.

Throughout our work we remain committed to delivering and improving on:

- Care Quality Commission Standards
  - Are we safe?
  - Are we effective?
  - Are we caring?
  - Are we responsive?
  - Are we well-led?
- Constitutional Standards
- Financial Sustainability in the long-term plan

Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.

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

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

KINDNESS
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Chief Executive Summary

East Sussex Healthcare NHS Trust

ESHT continues to demonstrate stable quality outcomes and performance improvements, despite ongoing workforce pressures and a challenging financial environment.

The Trust is operating within its planned £4.5m year to date (YTD) deficit, aligned with a challenging breakeven plan for 2025–26. The delivery of the £49.6m efficiency plan remains on target with M03 YTD £349k above plan.

The Trust is making measurable progress in key areas, whilst delivering safe care.

RTT compliance improved for the third consecutive month (63.4%), and cancer standards exceeded trajectory.
In June, 75.8% of patients were seen and discharged or treated and admitted within 4 hours, against a trajectory of 74%. This places the Trust at 48 out of 123 Trusts nationally, second quartile performance. Friends and Family Test (FFT) score in ED has consistently returned above 80% despite a congested environment due to the high level of attendances – improvement plans focusing on 12 hour waits and length of stay are in place to decompress the department. There are persistent challenges in mental health support within ED and in in-patient setting, the associated security costs adding further to the Trust's financial pressures.

Reportable infections remain within expected thresholds, with no MRSA cases and CDI within limits. Patient safety indicators such as falls and medication errors show no significant concerns, with the majority of incidents resulting in no or low harm. However, a never event occurred in June, PSIRF (Patient Safety Incident Response Framework) is in progress to identify learning.

Controls remain in place to ensure staffing continue to meet the needs of our patients. Vacancy rate is historically low (3.2%). The Trust reduced it's reliance on agency nursing. Workforce usage is 129 wte below budget, reflecting organisational transformation and service redesign to meet the Trust efficiency plan.
Sickness rates remain at 5.5%, with identified increase in mental health (anxiety, stress, depression) related sickness.

The focus for next month is to plan for the July industrial action, ensuring minimum impact on elective activity and recover diagnostic delivery for underperforming modalities.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)		952	922	794	Common Cause	Target required
Number of Patient safety events (severity 3)		11	28	6	Concern	Target required
Number of Patient safety events (severity 4 ...		1	10	2	Concern	Target required
Never Events		0	1	0	Common Cause	Target required
Inpatient Falls per 1,000 Bed days		5.42	4.62	5.18	Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0	0	0	Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0	0	0	Common Cause	Target required
Healthcare Associated MRSA Bacteraemia (r...		0	0	0	Improvement	Target required
Healthcare Associated C Diff Infections (rate)...		0.445	0.165	0.181	Common Cause	Target required
Healthcare Associated MSSA Bacteraemia (r...		0.121	0.0825	0.241	Common Cause	Target required
RAMI	100	85.4	85.5		Improvement	Achieving
SHMI (NHS Digital monthly)	100	104	103		Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)		93.5%	95.1%	84.8%	Improvement	Target required
Patient Safety Incident Investigation Events		0	0		Common Cause	Target required
Maternity and Newborn Safety Investigation...		1	1		Common Cause	Target required

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		52	45	19	Common Cause	Target required
Complaints Response Compliance (60 w...	80%	76.9%	81.3%	29.4%	Common Cause	Inconsistent
Reopened Complaints		7	7	2	Common Cause	Target required
A&E FFT Score	85%	86.0%	82.3%		Improvement	Inconsistent
A&E FFT Response Rate		15.3%	14.6%		Improvement	Target required
Inpatient FFT Score	95%	97.1%	98.5%		Common Cause	Achieving
Maternity FFT Score	95%	100%	100%		Common Cause	Inconsistent
Outpatient FFT Score	95%	95.6%	95.8%		Concern	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,275	8,282	7,385	Common Cause	Target required
Agency Rate	1%	0.557%	0.625%	2.91%	Improvement	Inconsistent
Vacancy Rate	5%	2.8%	3.2%	9.86%	Improvement	Inconsistent
Staff Turnover	10.6%	10.1%	9.8%	9.79%	Improvement	Inconsistent
Retention Rate	92%	92.1%	91.5%	92.4%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	18.8	19.9	19.9	17.1	Concern	Not Met
Staff Appraisals	85%	79.3%	78.3%	76.6%	Concern	Not Met
Statutory & Mandatory Training	90%	91.7%	91.9%	86.3%	Improvement	Inconsistent
Annual Sickness - Absence %	5%	5.45%	5.45%	4.7%	Improvement	Not Met
Medical Job Plan Compliance Rate	95%	83.8%	78.1%		Common Cause	Not Met

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	78%	79.3%	75.8%	95.0%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	670	907	25	Common Cause	Not Met
A&E waits over 12 hours from DTA	0	20	31		Common Cause	Inconsistent
Conveyance handover >60 mins	0%	0.483%	1.15%	0.344%	Common Cause	Inconsistent
Non Elective Length of Stay		5.37	4.69	3.26	Common Cause	Target required
Average daily NCTR		198	206		Common Cause	Target required
Cancer 62 Day	75%	71.7%	71.3%	65.1%	Improvement	Inconsistent
Cancer 31 Day Combined	96.6%	89.9%	89.7%	97.7%	Common Cause	Inconsistent
28 Day General FDS	80%	81.7%	82.1%	72.8%	Improvement	Inconsistent
104 day Backlog		58	52	96	Common Cause	Target required
Elective Activity (ELIP,DC,OPFA, OPFUP P...		109%	106%		Common Cause	Target required
RTT under 18 weeks	67%	62.0%	63.4%	68.6%	Improvement	Not Met
RTT 65 week wait	0	4	3	0	Improvement	Not Met
RTT Total Waiting List Size	59441	61672	61657	23064	Concern	Inconsistent
Diagnostic <6 weeks	1%	16.6%	16.5%	32.7%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	84.7%	84.6%		Improvement	Achieving
CHIC wait times < 13 weeks	80%	82.8%	83.1%	36.5%	Improvement	Inconsistent
Intermediate Care Length of Stay	30	46.3	32.8	17.5	Common Cause	Inconsistent
% Discharges delayed 1+ days		22.4%	22.6%		Concern	Target required
Total delay days from monthly Discharges	4937	4861	4258		Common Cause	Inconsistent
Number of Deferred visits/ care plans		8913	8739	1768	Concern	Target required
1+ Non Elective LoS (Acute)	8.8	7.82	6.90	5.33	Common Cause	Inconsistent
RTT proportion waiting over 52 weeks	1%	1.37%	1.41%	0.317%	Improvement	Not Met
4 hour standard with additional mappe...		80.7%	77.3%		Common Cause	Target required

Finance	Target/ Limit	Previous Month	Current Month	1920 Same period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(1,000)	(1,749)	(996)	n/a	n/a	Achieving
Surplus/(deficit) (£'000) - YTD	(4,486)	(3,479)	(4,475)	n/a	n/a	Achieving
ERF (£'000) - in month	13,707	12,003	13,457	n/a	n/a	Achieving
ERF (£'000) - YTD	37,230	23,907	37,364	n/a	n/a	Achieving
Efficiency (£'000) - in month	2,826	2,412	2,908	n/a	n/a	Achieving
Efficiency (£'000) - YTD	7,261	4,699	7,607	n/a	n/a	Achieving
Capital (£'000) - YTD	5,083	1,028	2,434	n/a	n/a	Not met
Capital (£'000) - FOT	40,125	39,925	44,213	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

East Sussex Healthcare NHS Trust

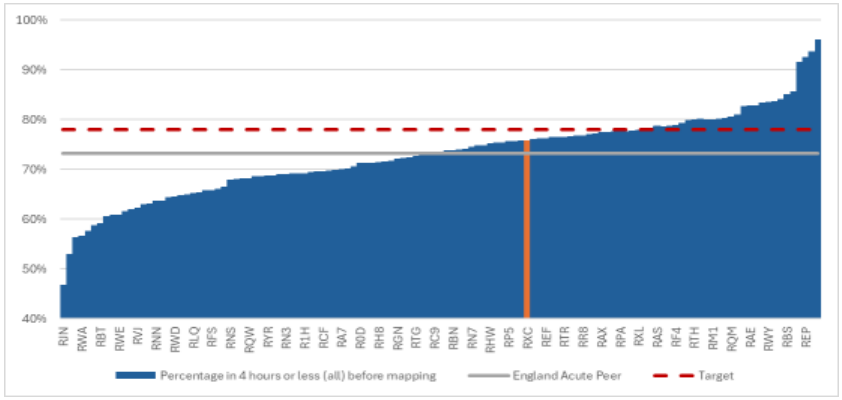
*NHS England has yet to publish all June 2025 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

June 2025 Peer Review

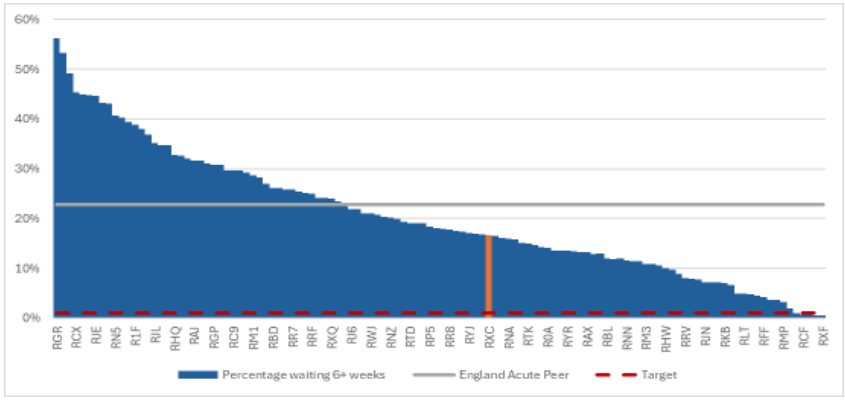
National Average: 73.1% ESHT Rank: 48/123



Planned Care – Diagnostic Waiting Times

May 2025 Peer Review*

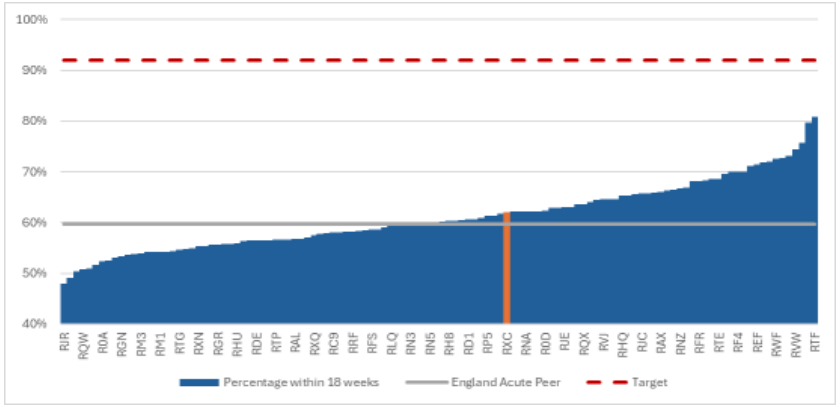
National Average: 22.8% ESHT Rank: 52/118



Planned Care – Referral to Treatment

May 2025 Peer Review*

National Average: 59.7% ESHT Rank: 49/118



Cancer Treatment – 62 Day Combined Standard

May 2025 Peer Review*

National Average: 67.6% ESHT Rank: 56/118

Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

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

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Infection Control

Healthcare Associated Infection limits have now been set by NHSE for 2025/26. ESHT thresholds remain the same as last year for CDI = 67, E. coli= 109 and Pseudomonas = 19. Klebsiella threshold is 44 a 10% reduction on 24/25.

The overall number of reportable infections is stable. No MRSA bacteraemia reported for June. The incidence of CDI was within the limit for the month and Q1 overall. In June we reported two HOHA and 3 COHA CDIs. One patient had a previous reportable CDI in May, has recovered and been discharged. The infection was identified as 002 ribotype on Littlington ward, this is the same as another patient on the ward at the same time. Further subtyping is pending, and the ward is being supported by IPC. The other HOHA infection occurred in an elderly patient treated for respiratory tract infection.

Two MSSA bacteraemia, both community onset, were reported for June. The source remained unknown despite investigation. Both cases assessed as unavoidable.

Safety Events

924 incidents were reported in June 2025, comparable with the average numbers reported for ESHT only incidents. 96% of the total patient events were no / low harm/near miss, which are comparable with the National average (96%), indicative of a good reporting culture at ESHT. The top three categories of incidents reported were;

1. Slips, Trips and Falls – 132 reported incidents, all but 3 Moderate harm, were No / Low harm (Severity 1 / 2). The falls rate for ESHT in June 2025 was 4.62, a common cause variation with no concerns.
2. Medication Errors - 104 reported incidents for ESHT. All, except One Moderate Harm, were 'No / Low Harm'.
3. Diagnosis and Diagnostic Services - 98 reported incidents, all were 'No / Low Harm' incidents.

Harm

Two Fatal Harm (Severity 5) incidents were reported in June 2025. Eight Severe harm incidents were reported: one was highlighted via the complaint process and is being investigated to confirm the level of harm, as well as 5 others which are being reviewed. One severe harm incident has been reviewed and reclassified as Moderate harm.

All three incidents are undergoing further review to determine whether there were any gaps in care delivery that impacted on the patients' outcome in line wit the PSIRF process.

Safeguarding

Compliance for Think Family level 3 remains an ongoing challenge despite additional capacity within the virtual sessions accommodating up to 70, with take-up nearer 50. Compliance has slowly improved but has remained static at 67% for the last two months. The safeguarding week was facilitated the week of 7th July, with bite size training on specific topics and trolley dashes to clinical areas..

There remains ongoing challenges within the Children in Care team , the line manager , Named Lead remains off work and the team supported by the broader safeguarding leads.

Adherence to the required KPI's for review health assessments reduced in June with exception reporting showed 67% due to team capacity. However, for the initial health assessments there was an improvement with 90% completed and distributed within timescales.

Discussions are ongoing with finance regarding the low volume activity (LVA) monies.

Maternity safeguarding continue to see very complex cases with two current cases highlighting the 'think Family' ethos has having risks associated within the broader family network and not solely the expectant mother.

A joint piece of work is ongoing with Safeguarding, Discharge Leads and Named Doctor to scrutinise those patients that have compound needs and are high intensity users. The Head of Nursing for mental health is included in this work stream. A paper is being drafted to summarise the issues.

Author(s)

Vikki Carruth
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Simon Merritt
Chief Medical Officer

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Patient Experience:
We received 45 new complaints, a decrease of 7 vs. June's number. Against our internal targets, 5 complaints were overdue at the end of June (the oldest being 12 working days over).

Of the complaints closed in-month: Against the timeframe of 60 working days, 81% were completed in time (May =77%). The target response rate is 80%.

Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern:

- 5 high risk (May =2), 3 are continuing via the complaints process, 1 is awaiting further discussion at WPSS, and 1 is following the PSIRF process
- 29 moderate risk (May =31) where aspects of clinical care appear suboptimal
- 11 low risk (May =19) where clinical quality does not form part of the complaint

Re-opened complaints/PHSO contacts are taken as proxies for learning: 7 complaints were reopened (May =7), 4 to Urgent Care, 2 to DAS, and 1 to Medicine (4 were meeting requests, 2 where appropriate authorisation was received and 1 was unhappy with the Trust's response). The Trust received 0 contacts from the PHSO in June.

Of the 45 complaints received in June 33% came from 1 category: Patient Care =15 (failure to provide adequate care)

Top complaint location in June was (this does not necessarily relate to care provided in June):Outpatients Department =7 (EDGH =4 and CQ=3), Emergency Department =4 (EDGH =2 and CQ =2) and Cookson Attenborough Short Stay Unit =3.

655 contacts were recorded by PALS in June, which is an increase of 10 when compared to June (=645). Of these contacts, 378 PALS contacts were recorded as "concerns" (June =374). 3% of PALS concerns (=12) were escalated to formal complaints.

Top 3 locations of PALS concerns: Emergency Department (=43) (EDGH =25 and CQ =18),Outpatients Department (=24) (CQ =17 and EDGH =7) and Radiology Department (=6).

The top three primary PALS subjects recorded as a "concern" were as follows:

- Communication =124 (of these 45% related to communication with patients/relatives. There was also a data breach in Gynaecology which accounted for 16% of cases)
- Appointments =64 (of these 65% related to long waiting times and cancelled appointments)
- Clinical Treatment =50 (of these 32% related to delay in treatment and 22% related to diagnosis issues)

The Trust received 13,744 FFT responses; this is a significant increase on May (=10,140) but is primarily due to the late entry of May paper FFT's by our FFT provider. The Trust-wide positive FFT feedback rate was 94.35%, which is in line with the last three-month average of 93.95%.

The comments patients provide as to why they gave their rating generate word-based themes; this month, the top positive theme was Staff Attitude (7,255 positive comments), followed by Implementation of Care (3,767) and Environment (2,151). Conversely, the top negative theme was Staff Attitude (341 negative comments), followed by Environment (263) and Waiting Time (235).

The positive FFT comments (=10,037) accounted for 99% of all plaudits (=10,125) received in the month, with a great many of these reflecting the Trust values.

Workforce
Continued high level of attendances to the Emergency Departments and high occupancy, although we have reduced escalation beds open. The MADE events have helped to focus improvement programmes for discharge and length of stay. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas, requiring specialist Mental Health support/skills, especially at EDGH.
Ward and Community staffing in June remained stretched to cover the additional requirements.
The focus continues on Healthroster efficiency and non-medical job planning, use of temporary nursing workforce, authorisation of additional shifts and supernumerary time. There are significant improvements noted regarding the reduction in use of agency and additional shifts through roster efficiency and fortnightly oversight from the Chief Nursing Officer and Deputy Chief Nurse for Workforce.

Author(s)

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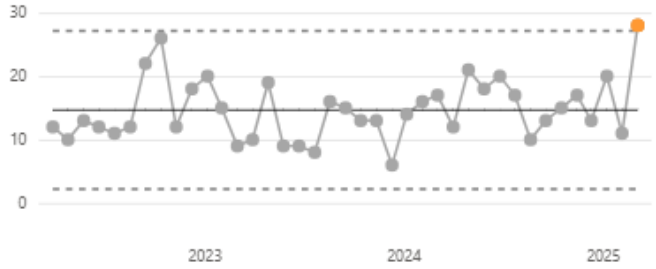
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

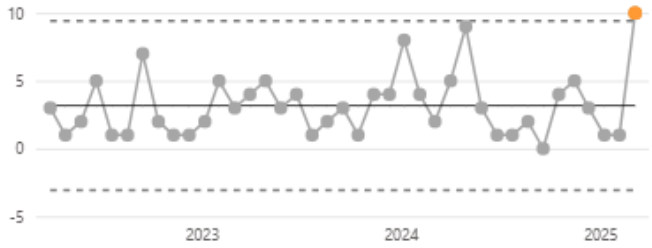
Number of Patient safety events (severity 3): Total, Safety

Target required	Concern	28



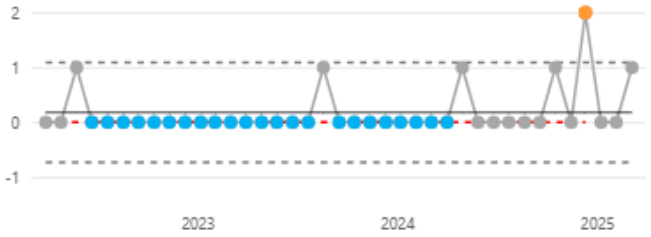
Number of Patient safety events (severity 4 and 5): Total, Sa...

Target required	Concern	10



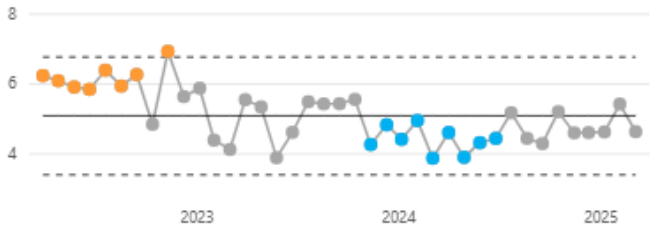
Never Events: Total, Safety

Target required	Common Cause	1



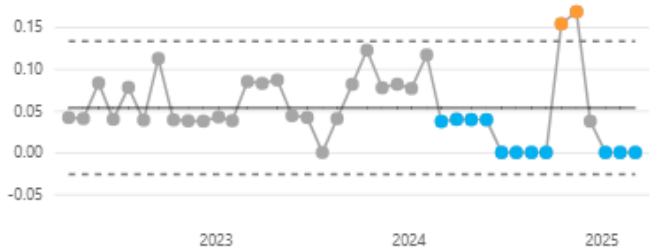
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.62



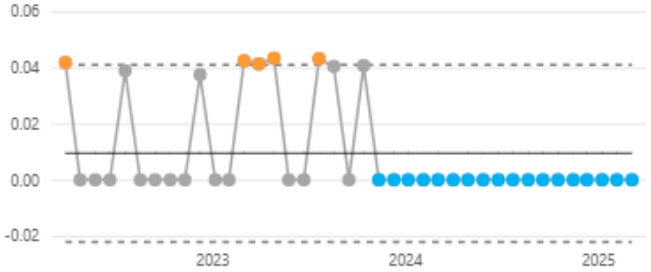
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Target required	Improvement	0



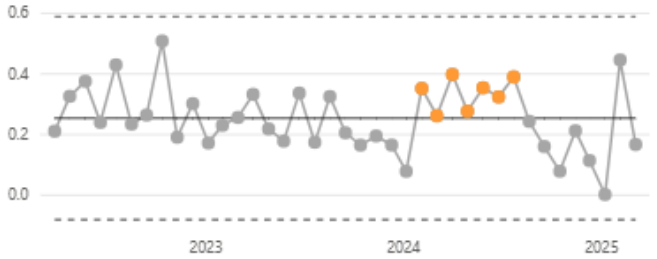
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Target required	Improvement	0



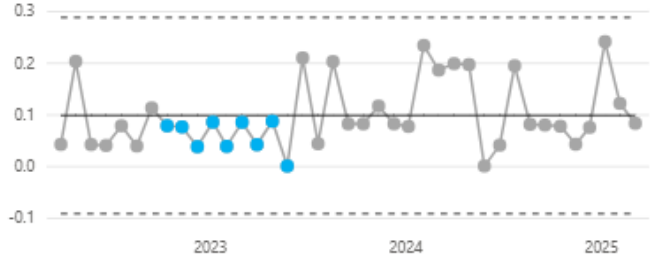
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Target required	Common Cause	0.165



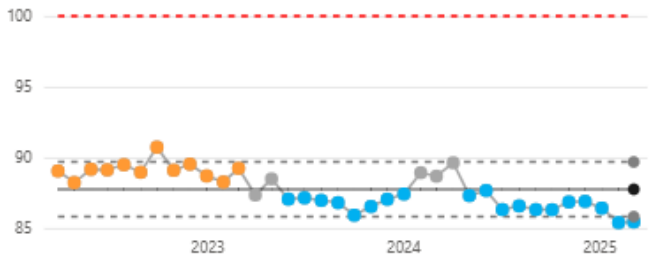
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Target required	Common Cause	0.0825



RAMI: Total, Safety

Achieving	Improvement	85.5

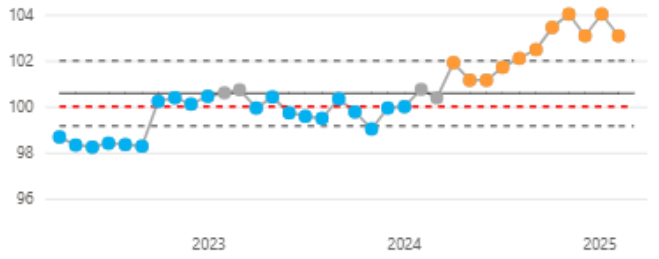


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

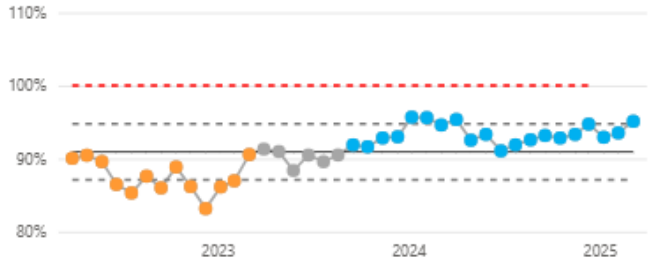
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	103



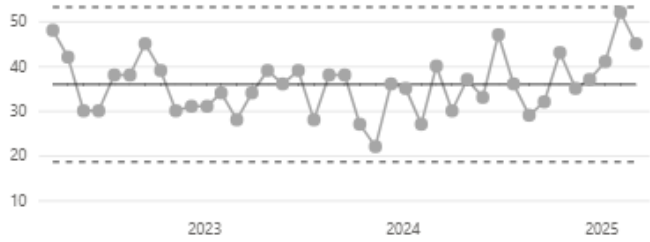
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Target required	Improvement	95.1%



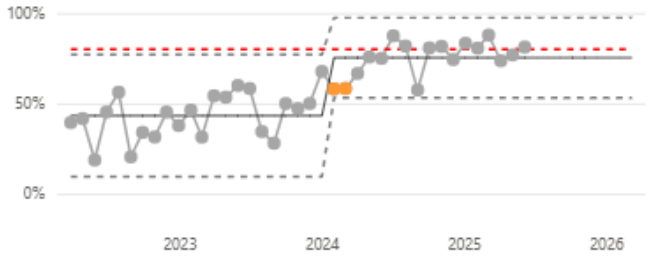
Complaints received: Total, Patient Experience

Target required	Common Cause	45



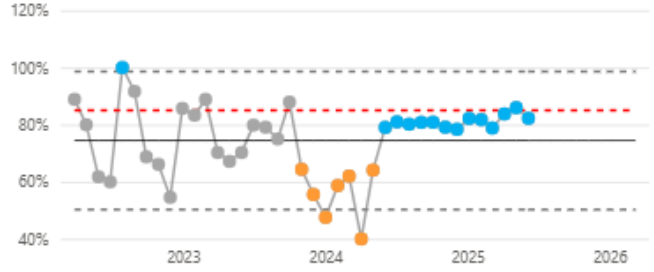
Complaints Response Compliance (60 working days as of 1...

Inconsistent	Common Cause	81.3%



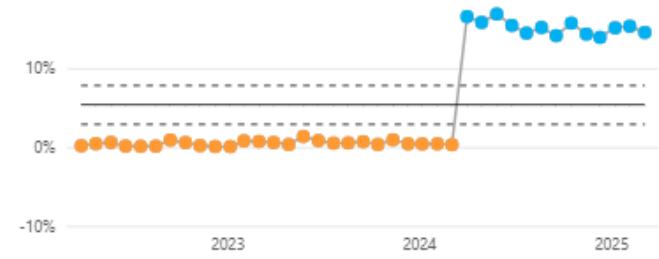
A&E FFT Score: Total, Patient Experience

Inconsistent	Improvement	82.3%



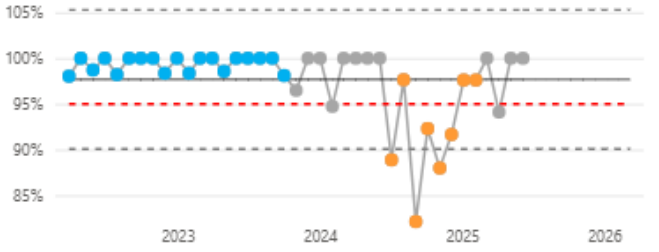
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	14.6%



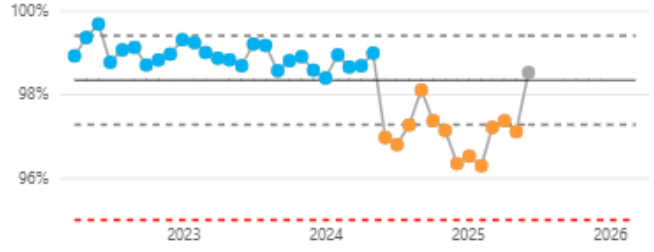
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	100%



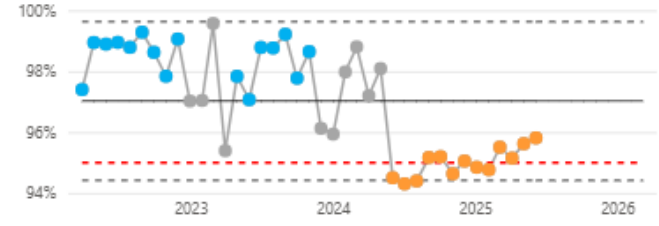
Inpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	98.5%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	95.8%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	During May occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding in corridors and significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients and there is an overall reduction in the reliance on agency nurse staffing. Ward nursing CHPPD overall was 8.6 for May (noting distortion by specialist areas) which is a small improvement most likely due to a reduction in the escalation bed numbers, with the closure of Murray Medical ward. Nursing fill rates for day shifts = RN 93% and HCSW 86%. Nursing fill for night shifts = 96% for RN and 103%.	• A day was dedicated to DoC as part of Patient Safety week held in the week commencing June 30. Further DoC training workshops will be provided to support understanding and knowledge of the process. • The PSIRF Review Group reviews all completed review reports, and learning is shared across services and Divisions, where appropriate. • Work to update the PSIRF Plan and Policy and the PSIRF templates is ongoing; The Chronology template has been fully reviewed. The AAR template is undergoing review. Processes are being reviewed with the aim to move from paper to digital documentation, through collaboration with the Datix team • Uptake of Training for All Staff Level 1 PSIRF training remains positive. The compliance figure for June 2025 was 94.7% for ESHT overall.
Nursing & Midwifery Workforce	During June occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding in corridors and significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients and there is an overall reduction in the reliance on agency nurse staffing. Ward nursing CHPPD overall was 8.5 for June (noting distortion by specialist areas) and we are continuing to reduce our escalation beds. Nursing fill rates for day shifts = RN 93% and HCSW 88%. Nursing fill for night shifts = 98% for RN and 105%. Changes to our inpatient services and bed base means a number of areas are currently under consultation and staff are being supported through our redeployment process.	• The annual Nursing Establishment Review (NER) for 2025, the first data collection for acute and community has been completed and is currently being analysed • A review of non ward nursing posts has commenced with a programme of work to look at non-medical job planning, education and supervision frameworks • Recruitment to the Mental Health Outreach team continues and they are deployed to support our most complex patients. New training opportunities for staff as part of the MH Strategy is also underway. The pilot in our Emergency Department at Eastbourne is to offer enhanced assessment and initial care plans for those patients who present with an acute mental illness crisis commenced in May with a trail of body worn cameras for nursing staff starting soon. • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Deputy Chief Nurse to ensure effective/efficient nursing rosters. The fortnightly roster assurance panel continues, to support working within budget and review of temporary staffing requests. There is evidence of good controls to support enhanced observations and requests for additional staff. The focus is now on reducing reliance on Agency staffing • Analysis of the job specific skills and leadership training needs is on going and we are working with NHS Elect to identify the skills gap and plan an education framework to ensure training meets the needs of our people • We continuing to offer training and support in the clinical areas with the restorative supervision programme and are reviewing the role of practice educators and current resources.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

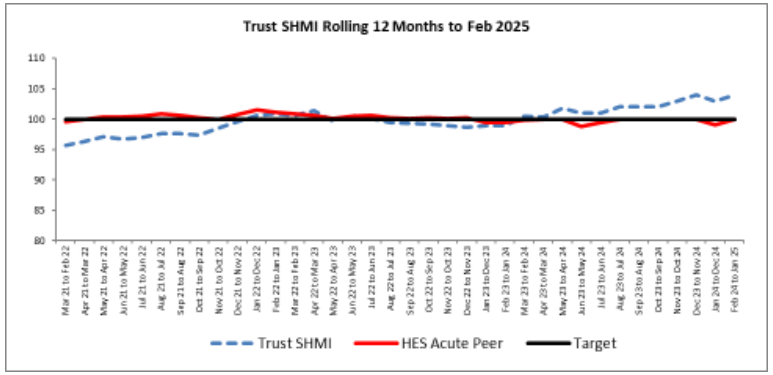
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls - The inpatient falls rate for ESHT per 1000 bed days was 4.62 in June 2025 remaining within the control limits with common cause variation. All incidents reported were No or Low harm except three Moderate harm incidents for which SWARM reviews are being undertaken to determine whether there were any lapses in care delivery in line with the PSIRF policy. The top sub-category continues to be 'patient fall whilst mobilising independently' all reported as No harm except for one Moderate harm. Falls incidents by service are discussed at the Trust Falls group bi-monthly	•SWARM Forms are currently being reviewed. Completed forms continue to be monitored, and peer reviewed by the PSIRF Review Group •Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities •Deep Dive report of Falls incidents has been undertaken with no issues identified.
Patient Experience	Cookson Attenborough (=3) was the third top location for complaints. Radiology Department featured in the top 3 PALS concerns location (=6)	Post treatment complications (=2) and patient care/ nursing (=1) were the themes for the three Cookson Attenborough complaints. Radiology 16 out of 30 concerns were assigned to waiting times and delays with appointments. Both themes have been shared with the relevant division.
Harm reviews	The NCTR Harm Review Process was last presented at Q&S in March, where the limitations of the current process were discussed and an undertaking was made to redesign and refine the process to ensure greater relevance and consistency. This was to be ready to trial by July 2025.	• This redesign is on schedule for trial end of July • The process has been redesigned to narrow the parameters for those who are reviewed to only patients who have NCTR, and who have come to harm since that time • The process is being digitalised to ensure ease of data gathering and completion.
Pressure Damage	No new category 3 or 4 pressure ulcers have been reported amongst inpatients in the last 3 months. Four patients in the community setting (residing in their own home or with other care providers) have pressure damage, originally reported in pervious months, that has deteriorated to category 3 or 4 during June.	• New Pressure Ulcer & Wound Care training produced by the National Wound Care Strategy Programme, approved by the Education Steering Group in 2024 has now been launched for ESHT staff to book on the MYLearn platform. • The PUSG has agreed an annual work plan for 2025-26. This includes the introduction of new audit tool in line with CQUIN 12 which is being piloted in July. • We are working in partnership with NHS Sussex to standardise practice and share learning, a new PU Quality Improvement Network is being established.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

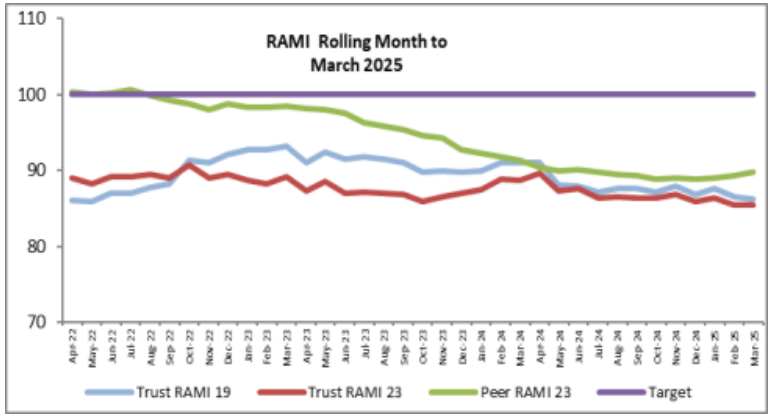
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

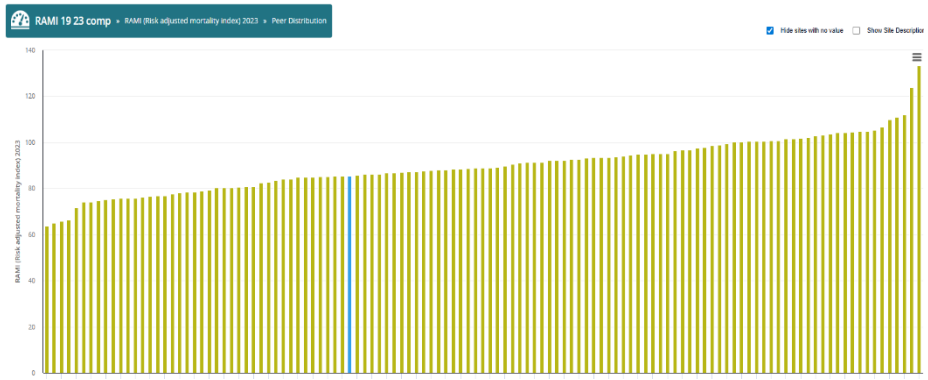
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – March 2024 to February 2025 is showing an index of 103 and is within the expected range. EDGH is showing 100 and Conquest is 108, both also within the expected range.
- SHMI is rebased each time it is published whereas RAMI is not. RAMI has recently been rebased, and the new RAMI 23 is now available.
- RAMI 23 – Apr 2024 to Mar 2025 (rolling 12 months) is 85, and 89 for the same period last year. Peer RAMI was 90 for this period
- The line graph below shows the rolling 12 month figure
- Crude mortality shows Apr 2024 to Mar 2025 at 1.58% compared to 1.62% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 59% for June 2025 deaths compared to 63% for May 2025 deaths.

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





This shows our position nationally against other acute trusts – currently 42/119

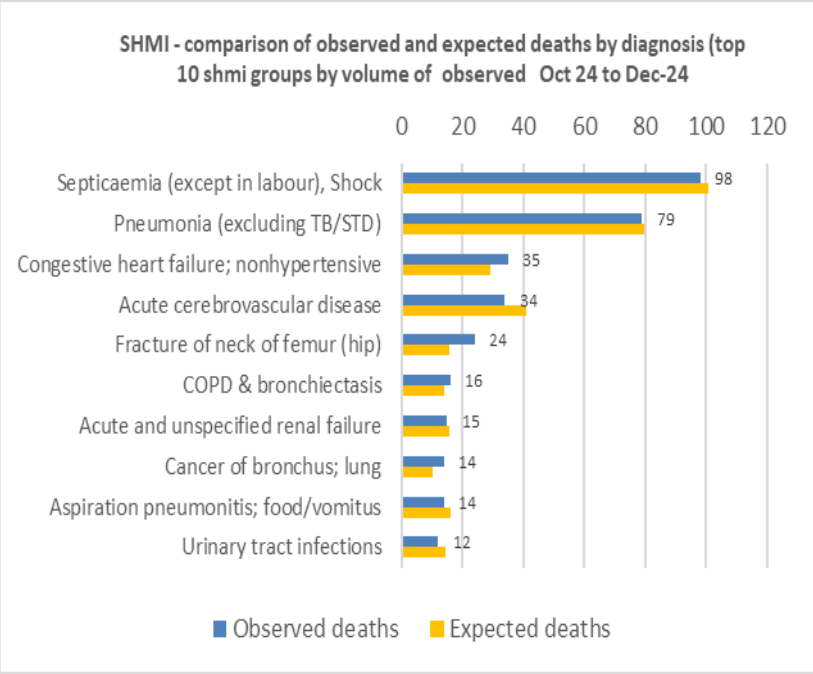
Effective Care - Mortality

East Sussex Healthcare NHS Trust

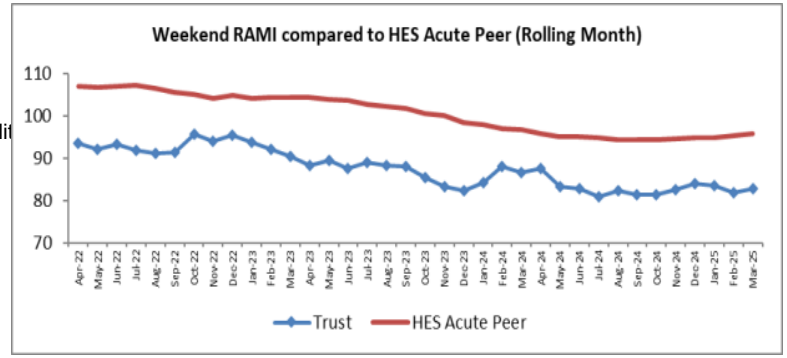
Jun 2025 Main Cause of In-Hospital Death Groups

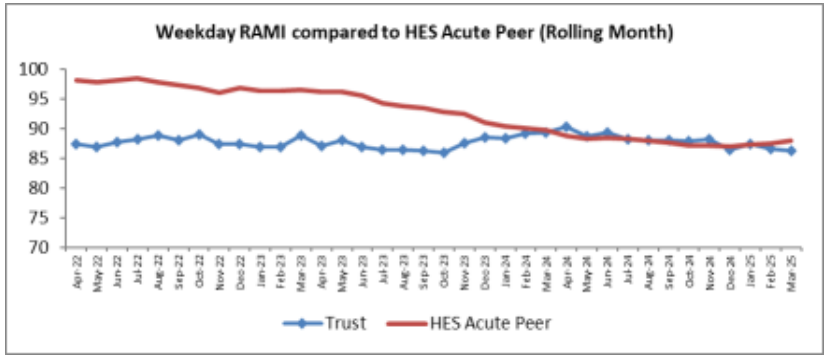
Description	Apr-Jun 25	Jun-25
Cancer	52	16
Sepsis/Septicaemia	40	13
Heart Failure	39	12
Pneumonia	33	10
Frailty of Old Age	28	12
Aspiration Pneumonia	21	5
Hospital-acquired Pneumonia	20	4
Multiple Organ Failure	18	10
Chronic Obstructive Pulmonary Disease (COPD)	16	5
Community-acquired Pneumonia	16	4
Stroke	13	4
Myocardial Infarction (MI)	9	3
Spontaneous Intracerebral Haemorrhage	7	2
Urosepsis	6	3
Congestive Cardiac Failure	5	
Dementia	5	2
Type 2 Respiratory Failure	5	2
Acute Kidney Injury (AKI)	4	2
Bowel Obstruction	4	1
Liver Disease	4	
Atrial Fibrillation (AF)	3	2
Spontaneous Upper Gastrointestinal Haemorrhage	3	1
Bronchopneumonia	2	1
Cerebrovascular Accident	2	1
Intersitial lung/pulmonary disease	2	1
Pulmonary Embolism	2	
Type 1 Respiratory Failure	2	1
Alcoholic liver disease	1	
Cellulitis	1	
Ischaemic Bowel	1	
Pulmonary Oedema	1	1
Other not specified	61	24
[Uncertified]	28	9
Total	454	151

SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)
Weekend and Weekday Mortalit
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

Our People | Executive Summary

East Sussex Healthcare NHS Trust

Responsive	Positives:	Challenges and Risks:	Author
	Turnover reduced by 0.3% to 9.8% and the vacancy rate increased to 3.2% - both KPIs are within targets. Mandatory Training increased by 0.2% and is above target at 91.9%.	Monthly sickness rate increased by 0.3% to 5.3%. Annual sickness rate remains at 5.5% - above 5% target Appraisal rate continues to fall, for the sixth successive month, by another 1.0% to 78.3% and is below target.	

Overview:

Workforce usage was 129 whole time equivalent (wte) below budget with a reduction was in substantive usage (-13 wte). Temporary workforce has seen increases in bank & locum usage (9 wte) and agency usage (6 wte). The increase in bank & locum usage is amongst Additional Clinical Services staff whilst more expensive locum usage has reduced. Pay expenditure has therefore fallen this month. Workforce usage is 174 wte lower than June last year.

The turnover rate has been the lowest since Apr 2021 at 9.8% with 719.2 wte leavers over the past 12 months. Turnover rates have reduced for all staff groups with the exception of Medical & Dental staff (excluding Resident Doctor rotation), which increased by 0.4% to 9.8% (39.9 wte leavers in year). Registered Nursing & Midwifery turnover reduced by 0.1% to 8.3% (182.1 wte leavers) which is one of the lowest nationally.

The Trust vacancy rate increased by 0.4% to 3.2% (258.6 wte vacancies) which is historically low and well within the Trust target of 5%. This partly reflects recruitment controls, as a component of the Cost Improvement Plans. Vacancy rates are highest for Additional Clinical Services staff at 9.4% (162.5 wtes) which links to the increase in Bank . The Medical & Dental vacancy rate was 7.2% (62.3 wtes) whilst the rate for Registered Nursing & Midwifery staff was 2.2% (50.3 wtes).

Monthly sickness increased by 0.3% to 5.3% however this has not impacted the 12-month annual sickness rate which remains unchanged at 5.5%. The sickness levels in general are largely driven by an increase in absence for Anxiety, Stress & Depression illnesses. These absences increased by 376 wte days lost, in Jun, and are at their highest level in the past six years at 3,465 days lost in month (28.2% of total monthly sickness). In month, this reason accounts for 32% of Additional Clinical Services absence, 29% of AHP absence and 26% of Reg Nursing & Midwifery absence.

The mandatory training rate increased again by 0.2% to 91.9%, which is a new, positive high and 1.9% above target. Basic Life Support compliance is improving, up by 1.7% this month, to 73.1%. All other statutory & mandatory modules are above the 90% target, with the sole other exception of Information Governance at 88.8% (+0.3%)

The appraisal rate has fallen again by another 1% to 78.3% which is the lowest it has been since Feb 23 and 6.7% below target. 1,761 staff overdue for appraisal.

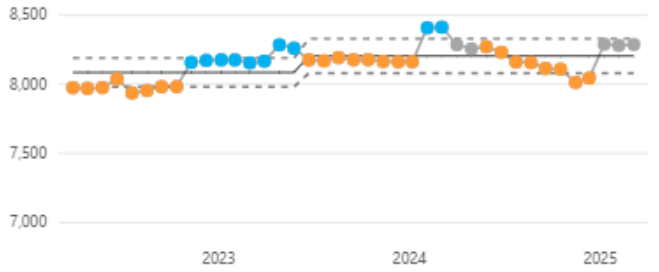
Steve Aumayer
Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

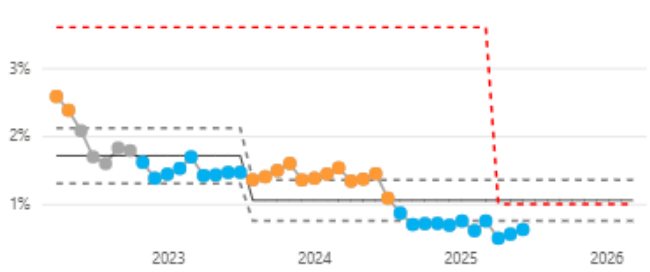
Establishment (WTE) All: Total, Our People

Target required	Common Cause	8,282



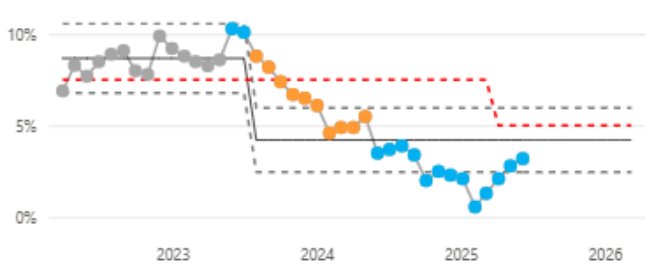
Agency Rate: Total, Our People

Inconsistent	Improvement	0.625%



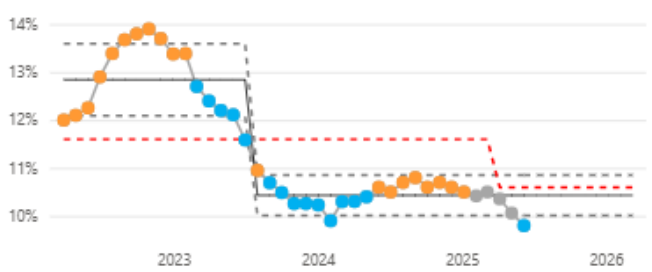
Vacancy Rate: Total, Our People

Inconsistent	Improvement	3.2%



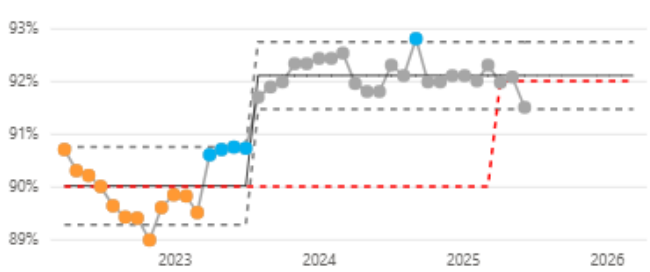
Staff Turnover: Total, Our People

Inconsistent	Improvement	9.8%



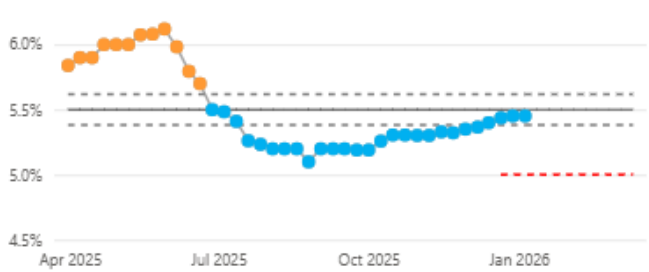
Retention Rate: Total, Our People

Inconsistent	Common Cause	91.5%



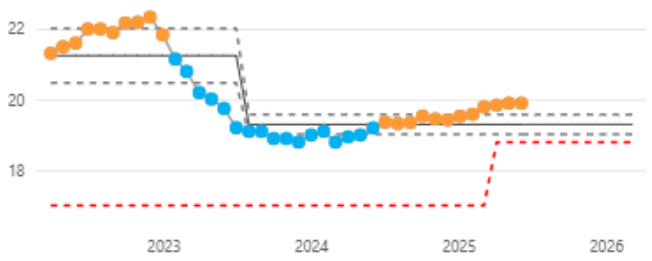
Annual Sickness - Absence %: Total, Our People

Not Met	Improvement	5.45%



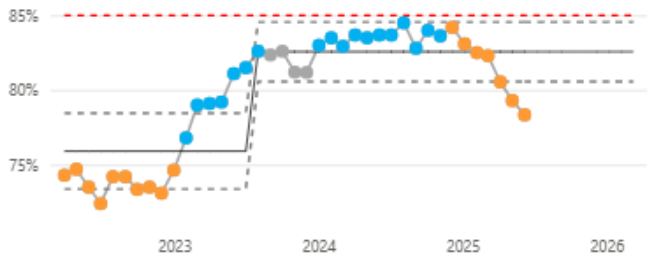
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.9



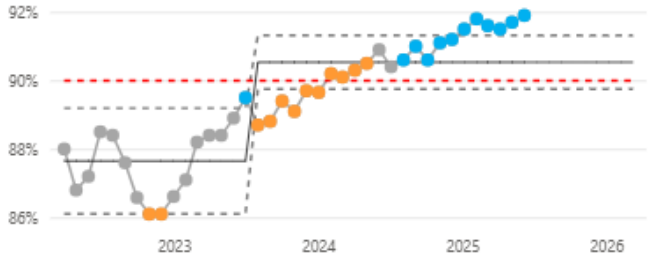
Staff Appraisals: Total, Our People

Not Met	Concern	78.3%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	91.9%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate reduced by another 0.3% to 9.8%. The stability rate reduced by 0.6% to 91.5%.	Undertaking a service review of TRiM to explore different delivery models that will sustain and further embed this essential provision for our people. Team in Need (TIN) Referrals. This approach is proving beneficial and efficient in allocating resources and interventions to both teams and individuals facing work challenges. The People Engagement Leads review referrals weekly and are working with key stakeholders to evaluate and continually improve this process. Legacy Mentoring pilot programme closed this month and will now be evaluated and reviewed with the prospect of exploring how this can be combined with other mentoring and coaching provision being offered within the Trust. Reviewed the Action Learning Set approach and developing into a Peer Coaching model to better align with existing coaching provision within the Trust to utilise resources more effectively and reduce duplication. Application submitted on 6th June to NHS Charities for Workforce Wellbeing grant for funding to support the following programmes aligned to the Trust staff survey priorities: • Phase 3 & 4 of the Restorative Supervision programme • TRiM train the trainer opportunity and exploring a regional model • Developing a cohort of in-house mediators by extending the remit of the Early Resolution Facilitators, (ReFs) • Individual funding for each staff network to enhance wellbeing and be utilised in agreement with network members Feedback will be given in August as to whether this has been successful.
Vacancy Rate	Vacancy rate increased by 0.4% to 3.2% (258.6 wte vacancies).	• Ongoing support with temporary workforce agencies to increase candidate pipelines for both Community and Escalation areas • Activity to support recruitment for ‘Art of the Possible’ posts within Community areas • All posts now being advertised for two weeks internal only. • Continued support with redeployment activity and placing colleagues affected by this process. Support provided for both colleagues and hiring managers. • Ongoing governance activity to ensure TWS and Agency spend on target (weekly Temp Approval Panels-TAP); Chairing of South East Temporary Staffing group to ensure governance and consistency across ICB. • Focussed recruitment activity to address hard to recruit posts with recruitment activity around Medics and Allied Health Professionals. Headhunters engaged for Microbiology and Stroke Consultants. • Activity for Doctors intake/onboarding

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased by 0.3% to 5.3% whilst annual sickness was unchanged at 5.5% Average sick days per WTE unchanged at 19.9. Above target	The focus continues on reducing long term sickness. Unfortunately, some colleagues are undergoing long term treatments, and then occupational support and intervention is offered. Anecdotally, colleagues have reported feeling well supported by the revised Health and Wellbeing conversations introduced as part of the management for long term sickness. It is recognised that any period of absence, but particularly long term, can impact significantly on the remaining teams and their own health and wellbeing. The Trust Sickness Focus Group continues to meet regularly to look at preventative strategies, as well as ensuring there is ongoing consideration of the most appropriate support. Those areas which are repeatedly showing higher levels of short-term sickness are being identified and examined to better understand whether there is any underlying cause and intervention from our Engagement or Wellbeing teams is required.
Statutory & Mandatory Training	Trust compliance increased by 0.2% to 91.9%, 1.9% above target.	The mandatory training rate increased by 0.2% to 91.9%, All training modules are over 90% compliance, with the exceptions of Information Governance at 88.8% (+0.3% on last month) and Basic Life Support (BLS) at 73.1% (+1.7%). A total of 170 staff did not attend BLS sessions with 80 giving no reason for their absence. As for last month, the majority of the non attenders were staff in nursing roles across all divisional areas. An additional 400 places were made available and sessions delivered by the Resuscitation Team, including bespoke sessions at the request of Divisions. Despite this, attendance remained disappointing. The national review of the Core Skills Training Framework (CSTF) (Statutory and Mandatory) training, remains ongoing. All essential skills and CSTF delivered training is being reviewed. The National Team have also announced that work on the Staff Digital Passport has been cancelled. The Trust Local Oversight Group will meet again at the end of Jul/beginning of Aug. Following the second meeting the Local Oversight Group decision making form for Subject Matter Experts to complete is being refreshed.
Appraisal	Compliance rate reduced by 1.% to 78.3%, 6.7% below target	There has been some feedback by colleagues which will support how the new appraisal process evolves. It was anticipated that there would be some reduction in compliance rates, with the transition to the online system, and it may be judicious to review progress and plan for the launch of a new version of the software in the Autumn (Sept) which will improve functionality and the user experience

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Access and Responsiveness | Executive Summary

East Sussex Healthcare NHS Trust

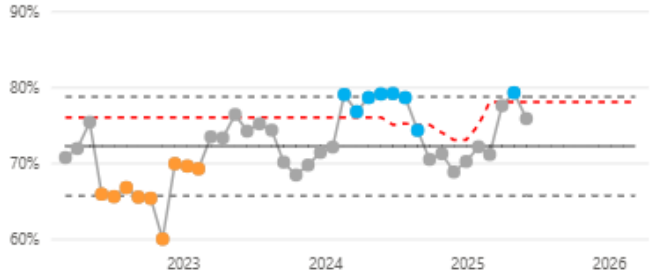
	Positives	Challenges & Risks	Author
Responsive	**4 Hour Emergency Access Clinical Standard** In June, 75.8% of patients were seen and discharged or treated and admitted within 4 hours, against a trajectory of 74%. This places the Trust at 48 out of 123 trusts nationally, second quartile. **Cancer** In May, the Trust delivered 82,1% against a trajectory of 77% for the Faster Diagnosis Standard. Performance against the 62-day standard was 71.3% versus a trajectory of 70%. **Urgent Community Response (UCR)** The UCR standard of 70% has been achieved consistently in the Trust, with 84.6% of patients seen within the 2-hour response window in May. **Elective long waits (RTT)** The Trust expects to report a small number of patients who waited more than 65 weeks in June.	**Cancer** The backlog of patients waiting over 62 days at the end of June was 229 against an internal trajectory of 266. This was a reduction of 55 on end of May position of 284. A plan is in place at tumour site level to reduce the number of patients waiting more than 62 days. This is monitored weekly, alongside action plans and the transfer of tertiary referrals where required. The 31-day pathway achieved 89.7% against a standard of 96%. The tumour sites impacting this standard are Urology and Skin. Recovery plan is in development to reduce wait times to be treated. **Length of Stay (LoS)** Non-elective LoS for June was 4.95 days, compared to 5.37 in May. The Trust is reviewing its LoS programme following an Urgent Emergency Care workshop in June. Four workstreams, comprising of Admission Avoidance, Clinical Care Pathways, Operational Flow and Discharge Planning, will focus on LOS reduction.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Refresh the Length of Stay Improvement plans based on learning from MADE events, NHSE feedback and performance data – to be prioritised and delivered through a Quality Improvement process • Focus on reducing non-admitted breaches and overnight waiting times in ED to support delivery of the 78% Emergency Access Clinical Standard • Continued focus on eliminating >65 and >52 week waits across • Recover diagnostic standard for non-complying modalities.		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

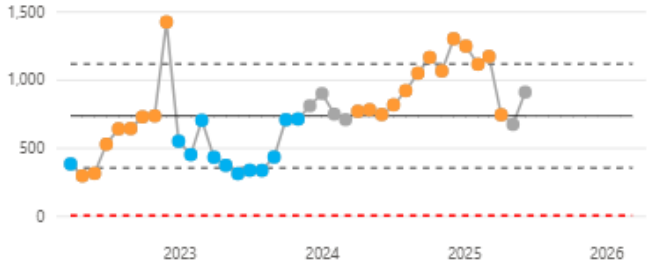
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	75.8%



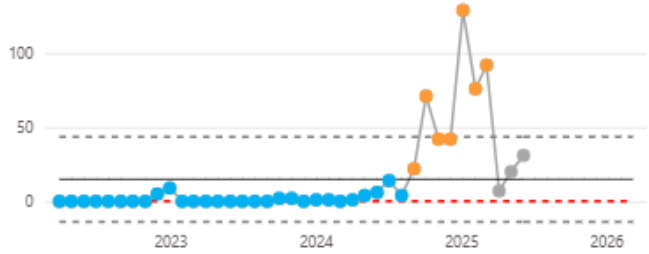
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Common Cause	907



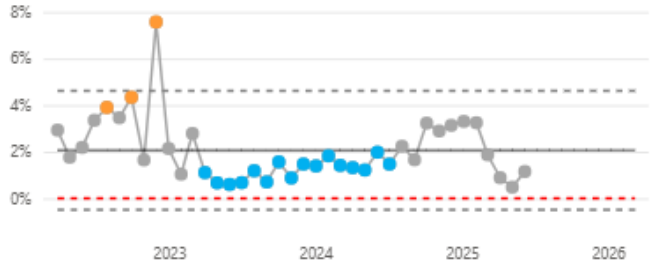
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Common Cause	31



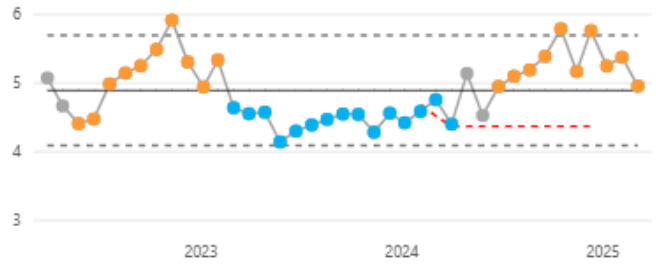
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	1.15%



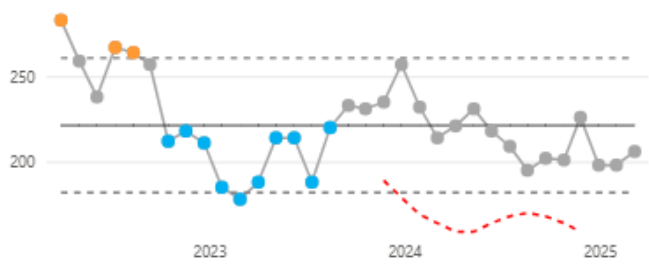
Non Elective Length of Stay: Total, Our Performance

Target required	Concern	4.95



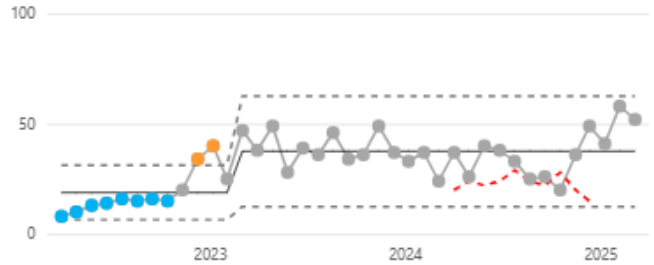
Average daily NCTR: Total, Our Performance

Target required	Common Cause	206



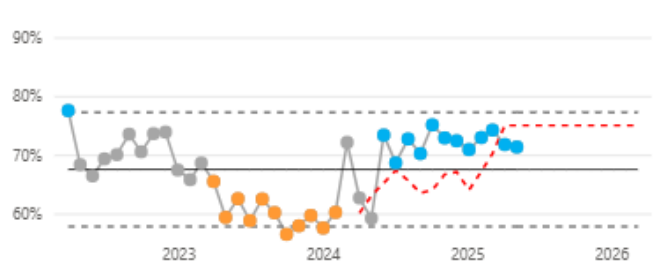
104 day Backlog: Total, Our Performance

Target required	Common Cause	52



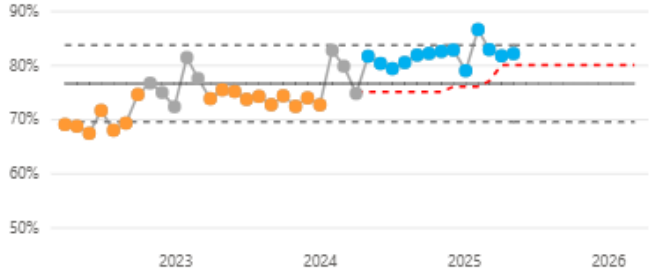
Cancer 62 Day: Total, Our Performance

Inconsistent	Improvement	71.3%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	82.1%

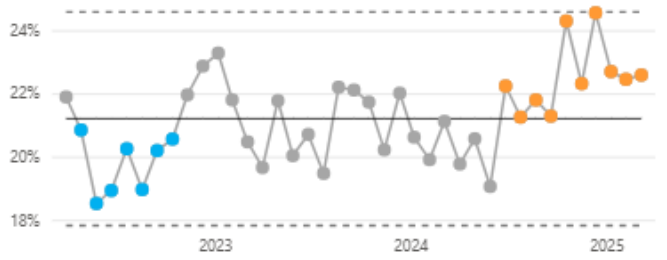


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

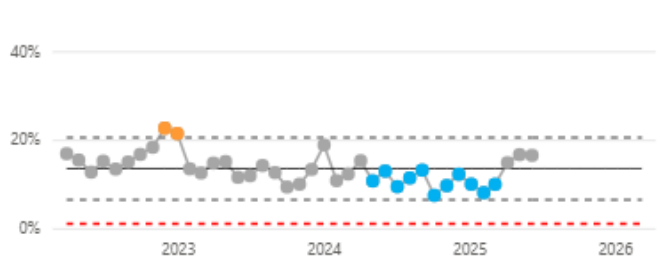
% Discharges delayed 1+ days: Total, Our Performance

Target required	Concern	22.6%



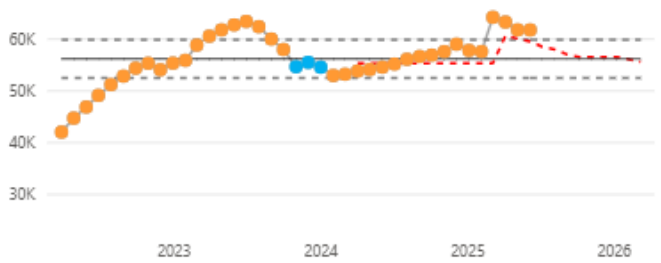
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	16.5%



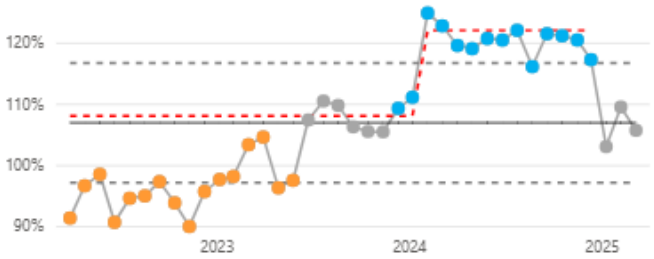
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Concern	61657



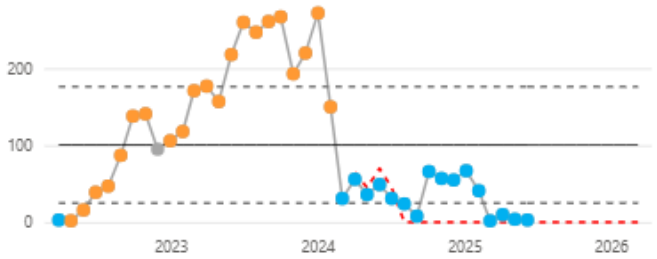
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Target required	Common Cause	106%



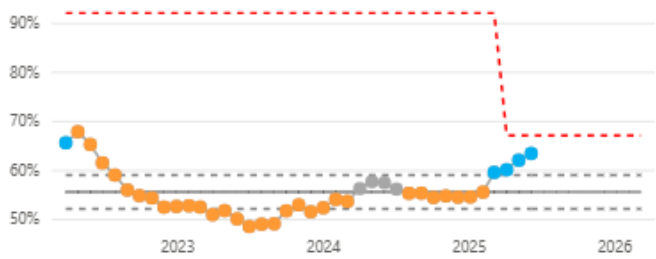
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	3



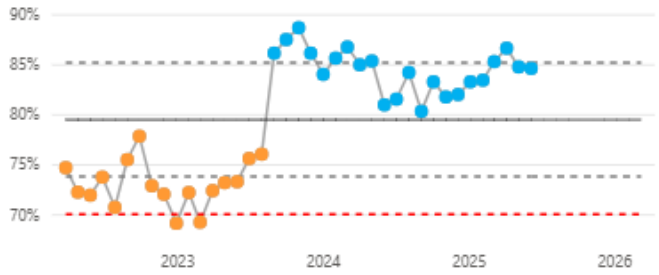
RTT under 18 weeks: Total, Our Performance

Not Met	Improvement	63.4%



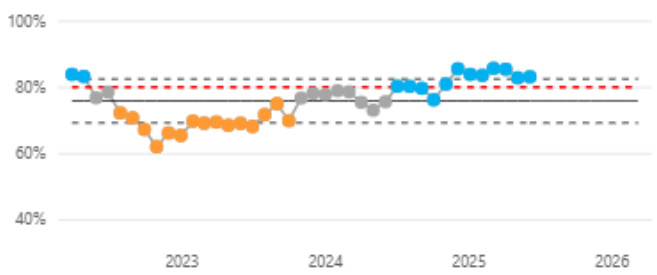
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	84.6%



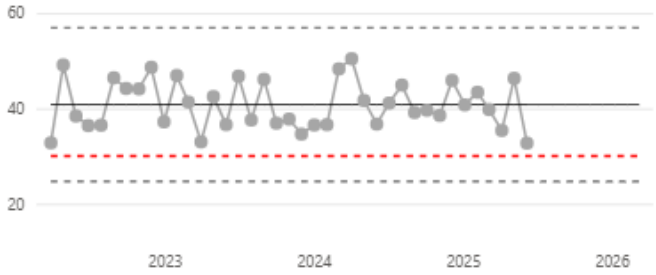
CHIC wait times < 13 weeks: Total, Our Performance

Inconsistent	Improvement	83.1%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	32.8



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In June, 75.8 % of patients were seen and discharged or treated and admitted within 4 hours. This places the Trust at 48 out of 123 Trusts nationally, and in the second quartile for performance against the 4-hour Emergency Clinical Access Standard. To achieve 78%, the Trust would require a reduction of 11 breaches per day.	• Escalation of delays and pathways that are not optimised with support from all division • Trust wide focus to achieve 78% 4-hour clinical standard • Focus on roles and responsibilities to support overnight resilience • Ringfence CDU for Emergency Department • Embedding use of AI tool to support improvements in timely patients' pathways • Focus on re-direction for T3 patients and overnight appointment allocation.
Patients in department over 12 hours from arrival to discharge	The number of patients waiting over 12 hours from arrival to discharge increased to 907 patients (8.6% of T1 attends) , compared to 670 (6.3% of T1 attends) in May. 31 patients waited over 12 hours following a decision to admit. Although this is an increase from the 20 in May, this is significantly lower than levels observed towards the end of 2024/25.	• Timely escalation within the ED department when at full capacity to enable ED and divisional teams to create capacity • Continued focus on reducing LOS and the number of patients not meeting the criteria to reside to enable flow • Focus on timely escalation of patients at risk of >12-hour LOS.
Conveyance Handover >60 mins	The percentage of patients handed over >60 mins was 1.15 % in June. This represents an increase in the number of patients the Trust were not able to offload within 60 minutes compared with May (0.48%).	• Continued focus on ambulance handover times, early escalations and actions to mitigate delays and support decompressing the department • Improve staffing and flow through Rapid Assessment and Triage (RAT) to allow for improved RAT process and model • Continue to work with SeCAMB to ensure crews are not waiting longer than 15 minutes to offload • Improve timeliness of SeCamb electronic recording for off-loading patients • Escalations to site managers and ED operational leadership team for inbound conveyances with no capacity to support offloading.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	Non-elective LoS slightly decreased in June to 4.95 days from 5.37 days in May. Reducing the pressure on hospital bed capacity is a recognised challenge.	• Focus on reducing clinical LOS and embedding SAFER on wards by implementing learning from MADE events • Support for ward areas to plan discharge from point of admission • Optimising the Transfer of Care Hub and trialling the Multiagency Pull Leadership Model for patients on stroke pathway • Increased P1 capacity to support same day / next day discharges, 7 days a week using a Home First approach • Working with system partners to agree key enablers to support a reduction in the number of patients not meeting the criteria to reside • NCTR patients have reduced from a peak in May 24 (n=257) to an average of 200 over last three months. Work in progress to report Intermediate Care Ward as community patients. The impact of this change will reduce the number of NCTR patients reported in the Trust.
Community Waiting Times (Paediatric)	Outsourcing to an independent sector provider has supported improvements in community paediatric waiting times over last 2 years. The insourcing has been temporarily paused to enable a full procurement exercise to take place. This concluded in July and a new provider is being onboarded – likely start date will be September. In the interim, the current award has been extended to improve wait times until the new provider is enabled. The number of children waiting for a first outpatient appointment is 2676. There were zero >104 weeks at the end of June. There were 114 children waiting over 78 weeks (compared to 24 in June 2024) and 816 children waiting over 52 weeks (compared to 233 in June 2024).	• Digital redesign is underway • Working with NHS Sussex to develop new models of care for ASD assessments • Workforce requirements under review • Robust validation of waiting lists underway • Mobilisation of new community paediatric contract following the recent procurement exercise.
Community Waiting Times (Adult)	Urgent Community 2-hour response achieved 84.6% in June (slight reduction on May 84.7%), continues to exceed the national target of 70%. In June, 83.1% of patients were seen within 13 weeks, against a target of 80%. The standard has been achieved for the last eight months despite an increase in demand.	• Clinically prioritising patients, ensuring that the most urgent patients are prioritised to be seen.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Trust delivered 82.1% in May against the 77% Faster Diagnosis trajectory and the 80% waiting time standard by March 2026. The Trust delivered 89.7% against the 96% 31-Day diagnosis to treatment standard. Performance against the 62 Day standard in May was 71.3% against a trajectory of 70% and the 75% waiting time standard by March 2026. There were 229 patients waiting over 62 days at the end of June 2025 against an internal trajectory of 266 and a reduction of 55 in month. The Trust continues to receive high number of GP urgent suspected cancer referrals and in May 2025 received 3006 referrals (11% increase on May 24), the highest number of referrals received in month over the last two years. Significant increases have been noted in Skin, Urology and Gynaecology USC referrals. In addition, the Trust receives Screening and Upgrade referrals.	• Detailed tumour site Cancer Action Plans underpinned by improvement trajectories • Weekly review of in month and future month performance to support delivery of tumour site level trajectories • Enhanced focus on patients early in the pathway and weekly monitoring to improve transfer dates to tertiary providers by day 38 • Focus on long waiting patients to reduce the number of patients waiting over 62 days. This includes working with tertiary centres • Increased focus and challenge in some tumour sites with daily touchpoints • Capacity and demand review in some tumour sites with high increase of referrals and initial discussions/consideration of AI options to support a high-volume tumour site.

Elective Activity	In June, the Trust achieved 105% of baseline activity levels, a slight decrease from 109% in May, however this figure is expected to improve further once June's activity data is fully validated.	• Enhance outpatient clinic utilisation to maximise the delivery of outpatient activity and improve patient access
		• Support outpatient productivity, focusing on:
		  ○ Targeted actions to reduce Did Not Attend (DNA) rates
		  ○ Robust validation of waiting lists
		  ○ Transitioning away from paper-based systems
		  ○ Improving follow-up appointment management
		• Advance the Theatre Productivity Programme, with emphasis on:
		  ○ Increasing utilisation including additional governance measures to minimise cancellations

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT long wait position and waiting list size	The number of patients waiting 65+ weeks reduced in June with the Trust reporting a smaller number of 65ww+ breaches (0 over 78 weeks). The Trust continues to work to ensure there are no patients waiting greater then 65 weeks by the end of July. The Trust continues to be ahead of trajectory in the volume of patients waiting >52weeks. In June 1.4% of patients on the RTT waiting list waited >52weeks, against a trajectory of 2.00%. The Trust is confident, that by March 2026 less than 1% patients on the waiting list will be waiting more than 52 weeks. Phase One of the National Validation Sprint, which began in April and concluded in June, saw the Trust achieve a removal rate of 11.3% above the baseline. The work undertaken as part of the validation sprint has supported a further, albeit smaller, reduction in the total waiting list which stands at 61,657 in June, compared to 61,672 in May. RTT compliance has improved for the third consecutive month, up from 61.9% in May to 63.4% in June. As a result of initiatives to improve both validation and elective capacity, the Trust can demonstrate improvement in RTT performance in over 70% of services (comparing June 25 performance to the November 2024 baseline).	• Proactive oversight of patients with the longest waits to ensure timely movement through their care pathways and minimize delays, with a minimum of twice weekly review of all 65-week risks on the PTL • Ongoing review of the specialty-specific trajectories that are aligned with 2025/26 RTT targets to drive progress towards meeting the national Referral to Treatment (RTT) standards • Ongoing optimisation of clinic templates to increase capacity for first outpatient appointments, helping to reduce waiting times across all specialties • Sustained validation efforts to enhance RTT Performance, with ongoing, targeted validation of patient pathways to support accurate reporting and continuous improvement in RTT performance.
Diagnostic DMO1	In June, the number of patients waiting more than 6 weeks decreased from 1,918 in May to 1,864. The Trust delivered 83.52% performance in June, against national standard of 95%. • The overall size of the DM01 waiting list remained stable at 11,310 patients despite increased demand for MRI, CT and Echocardiology • Echo waiting list decreased from 1,633 in May to 1,406 in June. The number of patients waiting more than 6 weeks decreased from 512 in May to 376 delivering a performance of 73% • Audiology waiting list also decreased slightly in June from 618 in May to 498 in June. Breaches also decreased to just 68 (from 116 in May). • NOUS performance improved to 99% and Endoscopy also improved to 99%. • However, these improvements were offset by MRI increasing waiting list size and breaches to 854 in June from 698 in May.	• Recovery plans and trajectories are being finalised for all modalities that are below the standard • Opportunities to increase CT capacity are being explored through demand and capacity programme • Audiology continue to improve position with additional sessions in place • WLIs in Echo in place to increase capacity • Exploring mutual aid for MRI: for routine and cardiac MRI • Improved process of monthly validation being introduced to provide more consistency and accuracy across modalities • NHSE Improvement Support Team completed working with the Trust in early July to support improvements and a return to delivery of >90% against this standard. Draft report issued which will be used to inform improvements in data, monitoring, governance and application of access policy.

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance | Executive Summary

East Sussex Healthcare NHS Trust

Finance

	Positives	Challenges & Risks	Author
Responsive	• M3 deficit of £1.0m in line with plan. YTD £4.5m deficit in line with plan. • Capital plan for 25-26 £40.1m. Spend in Month 3 £1.4m, ytd £2.4m. • Pay run rate similar to M1 + M2 and underspent by £0.1m in month, £0.8m ytd. M3 extra pay CIP achieved. • Non Pay run rate higher than M3 with some pressures related to activity. Ytd (£0.5m) overspent. • Use of Resources was £0.3m over plan ytd to Month 3. • Work is now commencing on the production of a 3 year plan	The Trust has agreed a challenging breakeven plan for 25-26, which includes an efficiencies target of £49.6m and has involved detailed plans worked up with Divisions over Q4. Some of these schemes have enablers so robust monitoring and reporting alongside proactive recovery planning is essential. The budget is phased over the year according to factors such as CIP's starting up in later months. The budget aligns the Operational Plan with the Financial Plan and enables budget and business planning to be an ongoing piece of work rather than once a year. This should help identify potential issues earlier and mitigating actions to occur. There is a current review of the 25-26 plan in train, in particular reviewing the income envelope agreed alongside internal targets to identify any risks for Q2 and beyond. The results of this review will be reported in M4.	 **Andrew Strevens** Chief Finance Officer

Overview:

I&E: The Trust position is in line with plan, both for the month and YTD.

UoR: M3 ytd delivery of £7.6m against plan of £7.3m, an over-delivery of £0.3m.

Over delivery of technical items (interest income, M1-M3 catch up) delivering improvement over plan.

Risk: Delays in opening of the SSC and elimination of Digestive Diseases as well as some CIPs in H2 being delayed will add pressure to achieving plan.

Capital: Capital expenditure ytd at month 3 was £2.4m, £2.6m below plan.

Cash: Cash position concluded at £18.9m, well above the £2.1m minimum permitted balance and is likely to remain above target throughout Q3 of 2025/26.

Trust Summary

East Sussex Healthcare NHS Trust

Income and Expenditure

At month 3 the Trust has reported a deficit of £0.996m, which is in line with plan. Key areas to highlight are:

- Income month to date (MTD) is positive to plan, driven primarily through increased activity in SPH and Q1 Education funding.
- A positive position on pay driven through permanent vacancies, however offset by use of temporary labour
- Non-Pay variances within CORE (Pathology), Urgent Care & Medicine (contract security)

The **Use of Resources** plan shows over achievement at £346k YTD.

Income delivered above plan, driven predominantly through Divisional Income aligned to SPH (increased OP and self pay activity) and Education funding for Q1. ERF on plan in month and improved alongside phased plan.

Pay Overall pay has seen an improvement on plan by £157k driven through vacancies. However, there are pressures, in month within Medicine, aligned to Nursing costs for enhanced observation shifts, Resident Medical pressures (Exec approved) and early recruitment costs for Sussex Endoscopy Centre (unfunded).

Non Pay Over plan in month. Driven by Security Costs mainly with Urgent Care and Medicine aligned to Mental Health and Violence & Aggression. A Q1 'true up' has occurred and impacted within M3, a refinement of the operational process is in train. Clinical Supplies impacted by high costs within Pathology (Roche managed contract due to budgeting challenge) outsourced Histology and Inpatient Covid Testing due to staffing vacancies.

TEDDS increase within paeds insulin pumps, cardiology ICD's, offset through activity.

A deep dive continues into trends/activity/inflation.

Overall, the position M3 and Q1 is on plan.

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	40,719	40,826	107	122,906	122,236	(670)
Divisional	6,284	6,568	284	19,417	18,942	(474)
ERF	12,876	12,830	(45)	36,566	37,364	798
Total Income	**59,878**	**60,224**	**346**	**178,889**	**178,542**	**(347)**
Operating Expense						
Pay						
Permanent	(37,995)	(36,109)	1,887	(113,427)	(108,455)	4,972
Temporary	(1,727)	(3,457)	(1,730)	(6,412)	(10,572)	(4,160)
Total pay	**(39,722)**	**(39,565)**	**157**	**(119,839)**	**(119,027)**	**812**
Non-Pay						
Drugs	(1,575)	(1,584)	(9)	(4,636)	(4,745)	(109)
TEDD	(3,899)	(4,254)	(355)	(11,697)	(12,073)	(376)
Clinical supplies	(4,658)	(5,191)	(532)	(14,023)	(14,433)	(409)
Purchased services	(2,304)	(2,233)	71	(6,954)	(6,540)	413
Finance costs	(3,030)	(2,737)	293	(9,086)	(8,554)	532
Other	(5,690)	(5,656)	34	(17,139)	(17,645)	(506)
Total Non-Pay	**(21,156)**	**(21,655)**	**(499)**	**(63,536)**	**(63,990)**	**(454)**
Total Expense	**(60,878)**	**(61,220)**	**(342)**	**(183,375)**	**(183,017)**	**358**
Surplus/(Deficit)	**(1,000)**	**(996)**	**4**	**(4,486)**	**(4,475)**	**11**

Finance - Capital

East Sussex Healthcare NHS Trust

Capital Scheme	Funding	Planned End Date	Fcast End Date	In Month			Year to Date			Full Year		
				Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Fcast £'000	Variance £'000
Backlog	Core			46	318	(272)	104	544	(440)	700	700	(0)
Endoscopy	Core	Sep-25	Oct-25	495	(179)	674	1,113	24	1,089	7,500	7,500	0
Fire	Core	Jan-25	Mar-29	82	122	(40)	186	305	(120)	1,250	1,250	-
Sussex Surgical Centre	Core	May-25	Sep-25	82	98	(15)	186	432	(247)	1,250	1,250	0
Cardiology	Strategic	Mar-25	Oct-26	231	72	159	519	106	413	3,500	3,500	-
Conquest Decant Space creation	PDC	Mar-26	Mar-26	148	5	143	363	5	358	2,114	2,114	-
Maternity & SCBU Refurbishment	PDC	Mar-26	Mar-26	70	-	70	172	-	172	1,000	1,000	-
Eastbourne Midwifery Unit	PDC	Mar-26	Mar-26	136	-	136	333	-	333	1,938	1,938	-
Sub 4 Switchgear	PDC	Mar-26	Mar-26	32	-	32	77	-	77	450	450	-
Distribution Boards	PDC	Mar-26	Mar-26	37	-	37	90	-	90	525	525	-
Fire Doors - Cq	PDC	Mar-26	Mar-26	79	-	79	194	-	194	1,131	1,131	-
Fire Doors - Eb	PDC	Mar-26	Mar-26	79	-	79	194	-	194	1,131	1,131	-
Old Macerators	PDC	Mar-26	Mar-26	15	-	15	36	-	36	210	210	-
Sub Station Tripping Batteries	PDC	Mar-26	Mar-26	4	-	4	9	-	9	55	55	-
UEC	PDC	Mar-26	Mar-26	67	-	67	202	-	202	3,000	3,000	-
Diagnostics	PDC	Mar-26	Mar-26	13	-	13	38	-	38	560	560	-
Audiology	PDC	Mar-26	Mar-26	-	-	-	-	-	-	900	900	-
Total Estates				**1,616**	**436**	**1,180**	**3,816**	**1,417**	**2,398**	**27,214**	**27,214**	**0**
Digital	Core	Mar-26	Mar-26	280	182	98	631	802	(171)	4,250	4,250	(0)
Our Care Connected	Strategic	Mar-26	Mar-26	165	625	(460)	371	625	(254)	2,500	2,500	0
EPR	PDC	Mar-26	Mar-26	-	-	-	-	-	-	3,036	3,036	-
LIMS - DDC	PDC	Mar-26	Mar-26	-	(0)	0	-	(73)	73	1,038	1,038	-
OCS - DDC	PDC	Mar-26	Mar-26	-	-	-	-	-	-	297	297	(0)
Total Digital				**445**	**807**	**(362)**	**1,002**	**1,354**	**(352)**	**11,121**	**11,121**	**(0)**
Medical Equipment	Core	Mar-26	Mar-26	330	36	294	742	364	379	5,000	5,000	(0)
Total Medical Equipment				**330**	**36**	**294**	**742**	**364**	**379**	**5,000**	**5,000**	**(0)**
Business Cases	Core	Mar-26	Mar-26	66	-	66	148	-	148	1,000	578	422
Aquablation	Core	Sep-25	Sep-25	-	-	-	-	-	-	-	422	(422)
Other	Core	Mar-26	Mar-26	55	128	(73)	123	(701)	824	831	(122)	953
Total Other				**121**	**128**	**(7)**	**272**	**(701)**	**973**	**1,831**	**878**	**953**
Total Capital				**2,511**	**1,406**	**1,106**	**5,831**	**2,434**	**3,398**	**45,166**	**44,213**	**953**
Slippage	Core			(332)	-	(332)	(748)	-	(748)	(5,041)	-	(5,041)
Total Charge to CRL				**2,179**	**1,406**	**773**	**5,083**	**2,434**	**2,649**	**40,125**	**44,213**	**(4,088)**

	Full Year		
	Plan £'000	Fcast £'000	Variance £'000
Core	16,740	20,828	(4,088)
Strategic	6,000	6,000	0
PDC	17,385	17,385	(0)
	40,125	**44,213**	**(4,088)**

The forecast CRL position matches the ICS allocation and includes £8.6m for Critical Estates Safety Funding, £3.6m Constitutional Standards schemes split between urgent emergency care (£3.0m) and Diagnostics (£0.6m), £2.8m of EPR funding, and Diagnostic Digital Capability schemes of £1.3m (LIMS and OCS).

As at month 3 cumulative capital expenditure totals £2.4m. Most of the cumulative expenditure incurred relates to schemes that began in 2024/25.

The Sussex Surgical Centre and Endoscopy major schemes are forecast to complete in July and October, respectively.

Cumulative expenditure is lower than plan predominantly due to Endoscopy expenditure not yet spending against current year budget, credits of £900k relating to a VAT reclaim on EPR scheme, and the Estates Critical Safety schemes having not yet started.

Use of Resources – YTD positions

East Sussex Healthcare NHS Trust

Division	M3 Plan	M3 Act	M3 Var	M3 YTD Plan	M3 YTD Act	M3 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
CHIC	43	39	(5)	68	60	(8)
Core	292	465	173	852	900	48
DAS	225	309	84	450	595	145
Medicine	393	63	(329)	1,073	677	(396)
Urgent Care	258	259	1	529	511	(19)
WAC	105	93	(12)	293	250	(43)
SPH	10	20	10	20	20	0
E&F	135	175	39	343	357	14
Corporate	234	234	0	705	719	13
Central	1,295	1,428	134	3,432	4,039	606
Investment	(159)	(173)	(14)	(505)	(519)	(14)
Total	**2,831**	**2,912**	**81**	**7,261**	**7,607**	**346**

The tables show the in month and year to date delivery by Division, Priority area, recurrent/non-recurrent split and by category. There is under-delivery in Medicine (£396k) due to delays in medical staffing and income projects, Women's and Children's (£43k) due to delays with job planning, Urgent Care (£19k) due to recruitment delays and CHIC (£8k) delay ordering bariatric equipment.

The over-delivery on central is due to a number of technical items that have been reflected in the position in M1-3, including interest income being higher than expected.

Performance against Trust priorities are being monitored as shown . "Other" relates to non-pay and other improvements that do not fall naturally into the defined groupings. It is expected through the improvement process now being put in place that further upside will be identified to both mitigate pressure and develop plans ahead of the 2026/27 planning round.

Priority Area	M3 Plan	M3 Act	M3 Var	M3 YTD Plan	M3 YTD Act	M3 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Length of Stay	273	296	23	583	569	(14)
Workforce	935	643	(292)	2,120	1,856	(264)
Income	641	978	337	1,878	2,312	434
Business Cases	525	557	32	1,240	1,238	(2)
Digitally Enabled Change	15	1	(14)	54	2	(52)
Other	442	437	(4)	1,385	1,630	245
Total	**2,831**	**2,912**	**81**	**7,261**	**7,607**	**346**

Recurrent/ Non-Recurrent	M3 Plan	M3 Act	M3 Var	M3 YTD Plan	M3 YTD Act	M3 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent	2,128	2,028	(100)	5,733	5,747	14
Non-Recurrent	703	885	181	1,527	1,860	333
Total	**2,831**	**2,912**	**81**	**7,261**	**7,607**	**346**

Category	M3 Plan	M3 Act	M3 Var	M3 YTD Plan	M3 YTD Act	M3 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Pay	1,179	852	(327)	2,727	2,208	(518)
Non-Pay	762	1,010	248	2,185	2,824	638
Income	889	1,050	161	2,349	2,575	226
Total	**2,831**	**2,912**	**81**	**7,261**	**7,607**	**346**

Agenda Item: 10

Report To/Meeting	Trust Board	**Date of Meeting**	26th August 2025

Report Title:	Update on mortuary services actions identified from the phase 1 and 2 reports from the Sir Jonathan Michael independent inquiry into the issues raised by the Fuller case
Key question	What progress has the Trust made in implementing Phase 1 recommendations, and what action will be taken to implement Phase 2 recommendations?
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐

Report Sponsor:	Dr Simon Merritt, CMO & HTA Licence Holder	**Presenter(s):**	Dr Simon Merritt - CMO & HTA Licence Holder
Report Author:	David Garrett, DDO Core Services Division and HTA Designated Individual		

Outcome/Action requested:	The Board is asked to note progress against the Phase 1 actions and to consider recommendations from the Phase 2 independent inquiry report.

Executive Summary	In November 2023 Sir Jonathan Michael, Chair of the Independent Inquiry into the issues raised by the actions of David Fuller, published the Phase 1 Report. This phase of the Inquiry was to establish what happened in the Maidstone and Tunbridge Wells (MTW) NHS Trust mortuary and to understand how the offending remained undetected for so long. The Phase 1 Report made a number of recommendations based on what was found at MTW and these were passed to all trusts with mortuaries to take immediate action. These actions are detailed in the first pages of the attachment and have been either closed or on course for closure. Only 37% of trust boards had discussed the Phase 1 Report, of which ESHT was one. Phase 2 of the Inquiry looked at the broader national picture. ESHT Executives and the Designated Individual (DI) were interviewed by the Inquiry team as were 36 other trust teams. The Inquiry considered whether procedures and practices in hospital and in non-hospital settings where deceased people are kept were in place to safeguard the security and dignity of the deceased; it specifically looking at: • Whether procedures and practices in hospital settings safeguard the security and dignity of the deceased and would prevent a recurrence of the offending seen at MTW. • Procedures and practices in non-hospital settings, including local authority mortuaries, funeral directors, the NHS ambulance service, medical schools, temporary mortuaries, direct funeral companies and hospices.

	• The role of regulators and their use of regulatory measures in assuring that mortuary practices safeguard the security and dignity of the deceased in all settings, and hence the effectiveness of the national regulatory regime. The Phase 2 report was published in July 2025 and lists 21 further recommendations for the acute sector to consider. These are listed in the second part of the attachment.
Regulatory/legal requirement:	Human Tissue Authority (HTA) compliance.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have not yet been taken into consideration but will be in Phase 2 action plan once agreed.
Resource Implication/VFM Statement:	Likely to require additional security measures such as CCTV inside *post mortem* rooms on both sites trained towards inside of doors. Also swipe card devices to record exits as well as entrances to mortuaries. Costs to be confirmed, but could be around £50-£75,000.
Risk:	With the work already completed from the Phase 1 recommendations and the August 2024 HTA inspection, the Trust appears well placed to respond to the Phase 2 recommendations. More discussion is needed around the 21 new recommendations with an agreed action plan to follow monitored through Mortuary Steering Group and then up through the Quality and Safety Committee and Trust Board.

No of Pages	2	**Appendixes**	1
Governance and Engagement pathway to date:	Discussed at ELT and due for discussion at Mortuary Steering Group September 2025.		
What happens next?	1. Confirmation of the governance at ESHT reporting up from the mortuary team to the Mortuary Steering Group, Health & Safety Committee quarterly and Trust Board twice yearly. 2. Ongoing communication of the roles of the Designated Individual, Licence Holder and the Chief Nursing Officer and expectations of Trust Executives and Board including NEDS. 3. Agreement on the 21 new actions at September 2025 Mortuary Steering Group including whether further security measures are required such as additional CCTV in the *post mortem* room and swipe cards at exit doors to enable more thorough audit of staff entering and leaving the premises. 4. CMO to ensure NHS Sussex ICB fully briefed on compliance and further actions.		
Publication	Public Board		

Aug 2025 Update on Actions identified from the phase 1 and 2 reports from the Sir Jonathan Michael independent inquiry into the issues raised by the Fuller case

Phase 1 Report			
Action	**Date for review**	**Latest update**	**RAG status**
Mortuary Access Policy to be updated (combining current out of hours policy with the mortuary security procedure). Ensure that all security procedures are adequately recorded in the new policy.	Sept-25	16/07/25: Advanced draft now completed – to be submitted for ratification by end July. 07/08/25: Draft being reformatted ready for submission	Amber = delayed but recoverable
Ensure that all security procedures are adequately recorded in the new policy.	July-25	See 'Mortuary Access Policy to be updated' above	Blue = Complete
Understand what level of DBS checks non-mortuary staff and non-ESHT staff have including maintenance staff, coroner's crews etc.	Jun-24	03/07/24: Information from Assistant Director of Resourcing: All Porters and maintenance staff receive standard DBS checks.	Blue = Complete
Work towards uplift in role for the Deputy Mortuary Manager to become Mortuary Manager. Backfill to Deputy Manager role	Sept-25	16/07/25: Mortuary business case approved, to be implemented incrementally. Post submitted to TRAC. Interviews to take place shortly. Date revised to Sept-25.	Amber = delayed but recoverable
Complete training of current staff (over the next 4 years)	2028	30/06/25: MF has completed her training. KT has passed her first year exam.	Green = On track
Backfill to Deputy Manager role	April-25	See 'Uplift in role for Deputy Mortuary Manager' above.	Blue = Complete
Need to establish security of porters keys at EDGH and Conquest	Nov-24	13/09/24: There are no longer any porters keys hence this action has essentially been completed but further works are planned relating to this, hence it remains open. 01/11/24: Locks at EDGH are being replaced with security locks by Nov-24	Blue = Complete
Look at the feasibility of the mortuary being a 24/7 staffed service.	Dec-24	15/01/25: following a discussion it was agreed that it was not feasible to have the mortuary staffed 24/7. However, it was agreed that out of hours there was already at least one staff member on call to respond to any incidents. It was agreed to close this objective in light of the unfeasibility of this objective.	Blue = Complete

Aug 2025 Update on Actions identified from the phase 1 and 2 reports from the Sir Jonathan Michael independent inquiry into the issues raised by the Fuller case

Action	Date for review	Latest update	RAG status
Annual audit to be set up to review who has swipe access and whether this is still appropriate	Sep-24	01/11/24: Swipe access review audit now scheduled every 2 months following HTA report.	Blue = Complete
Further support required from the trust security team for reviewing swipe access patterns particularly out of hours.	Dec-24	15/01/25: Trust security have agreed to conduct a walk around every quarter.	Blue = On track
Consider how to enhance CCTV audit.	Feb-25	26/02/25: Adam Oxley has agreed to carry out six monthly spot checks of the CCTV reviews and compare with the Mortuary checks.	Blue = On track
Implement a reciprocal auditing programme with other mortuaries in the region Initially meet monthly and discuss policies/SOPs	Feb 26	06/02/25: agreed at MSG to work towards reciprocal audit of ESHT and UHS facilities but to first harmonise polices and working practices. 30/06/25: no further updates.	Green = On track
ESHT to further consider how security can be treated as a corporate concern.	Mar-24	17/10/24: There is limited capacity within the security team, however there will be representation from the security team at the HTA governance meetings and the Mortuary steering group meetings	Blue = Complete
To include mortuary representation at Trust security forums	Mar-24	25/04/24: DJ is now attending the security forum.	Blue = Complete
Risk assess the possibility of the Trust security team being involved in CCTV audits.	Feb-25	26/02/25: Adam Oxley has agreed to carry out six monthly spot checks of the CCTV reviews and compare with the Mortuary checks.	Blue = Complete
Review current CCTV governance e.g. DPIA	May-25	16/07/25: DPIA form approved	Blue = Complete
Risk assessment of CCTV coverage in the PM room. Need to balance extra security with privacy and dignity of the patient.	TBC	16/07/25: Phase 2 report states that CCTV only needed in PM room if patient storage units are double ended and can open into the PM room. We do not have these type of storage units.	Blue = Complete
Consider the feasibility of installing swipe access to all doors, including fridge doors	TBC	16/07/25: The Phase 2 report has been published, there are some recommendations relating to swipe access, this will be reviewed in our response to the phase 2 report.	Blue = Complete
ESHT require further guidance on the meaning of “appropriately trained” staff for CCTV reviews	TBC	16/07/25: The Phase 2 report has been published, there are some recommendations relating to CCTV, this will be reviewed in our response to the phase 2 report.	Blue = Complete

Aug 2025 Update on Actions identified from the phase 1 and 2 reports from the Sir Jonathan Michael independent inquiry into the issues raised by the Fuller case

Action	Date for review	Latest update	RAG status
Include HTA reports during contract review meetings.	Ongoing	15/01/25: this will be reviewed at the next contract review meeting which is due in September. Already happening with East Sussex CC. Action plans shared with ESCC lead.	Green = On track
Check that retrieval and donation teams have auditing in place.	Sep-24	18/09/24: There is an auditing process for tissue retrieval – reports provided by NHSBT and sent on to the Trust board. Mortuary lead Debbie James sits on the organ donation committee and attends meetings where any issues with the use of mortuary services can be raised. Final HTA inspection reports for ESHT mortuaries will be shared with Clinical lead for tissue retrieval and NHSBT specialist nurse.	Blue = Complete
Include council and coroner's representation at HTA Governance meeting.	Jun-24	25/04/24: as there is now coroner's office representation at the HTA meetings this objective can be closed.	Blue = Complete
During contract renewal ensure that the contract is reviewed to ESCC's as well as ESHT's satisfaction that the safety and dignity of the deceased is included.	Mar-24	26/06/24: Complete	Blue = Complete
Report regarding the response to this enquiry to be submitted to the Trust board in Feb	Mar-24	15/01/24: CHD reported that the report has now been submitted to the board.	Blue = Complete
Agreed for DI at ESHT to report 6 monthly to Board from February 2024 onwards and quarterly to Trust Quality & Safety Committee.	Ongoing	Reported regularly. Need to confirm with Trust Q&SC admin support that this is on the agenda as well as with Trust Board support. Then close.	Green = On track
Review HTA governance membership e.g. consider additional divisional representation	Jun-24	11/03/24: Discussed with DG on 08/11/24, DG to invite Sue Allen initially with a view to understanding who else should be attending	Blue = Complete
Ensure ongoing attendance of all personnel with HTA responsibilities at the HTA governance meeting.	Ongoing	29/05/24: this is now happening and is ongoing.	Blue = Complete
Trust to ensure that the Mortuary team and those with HTA responsibilities are involved in the ongoing review of the End of Life Care Policy, and the Guidance for Staff Responsible for Care after Death in Adults.	Mar-25	05/02/2025: Awaiting review of documents 26/03/25: DJ reported this is now completed.	Blue = Complete

Phase 2 Report			
Recommendation/Action	**Date for review**	**Latest update**	**RAG status**
All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: -the systems in place to identify any unauthorised access to the facility; -the strength and effectiveness of barriers to prevent unauthorised access to the facilities; -the systems in place to identify any access to deceased people for unauthorised purposes; -how CCTV is used, including its monitoring and any audits undertaken.	Sept-25	07/08/25: A Quarterly Trust security review is undertaken by ESHT Head of Security, however a specialist Strategic review has not been considered to date. This will be discussed at the Mortuary steering group meeting in Sept, and Executive Leadership team meeting.	Green = On track
All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.	Sept-25	07/08/25: We already have good CCTV coverage within the mortuary and covering access and exit doors as well as the body store. There is no CCTV in the PM suite, however we do not have double ended fridges. We may need to consider CCTV inside PM looking at inside of doors at both sites. Quotations awaited for blind spots in walk in cold stores at CQ and EDGH and the entry/exit door at CQ (under bridge). This will be discussed at the Mortuary steering group meeting in Sept, and Executive Leadership team meeting.	Green = On track
All NHS trusts should routinely audit the access data of all facilities used to store deceased people.	Oct-25	07/08/25: Access data is regularly audited, this process could be improved e.g. by reviewing abnormal access patterns. This will require additional staffing resource.	Green = On track

Recommendation/Action	Date for review	Latest update	RAG status
The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	N/A	07/08/25: No shared access cards, no further action required.	Blue = Complete
All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Sep-25	07/08/25: ESHT Mortuary has a good reporting culture for incidents and a very low threshold for reporting incidents to the HTA. The Head of Security is often asked to review mortuary related security incidents but not necessarily all, depending on circumstances. This recommendation will be discussed with the Head of Security at the Mortuary Steering Group meeting to see if any further action is required.	Green = On track
The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	N/A	07/08/25: ESHT body stores are part of HTA licensed premises, all standards apply. No further action.	Blue = Complete
All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	Sep-25	07/08/25: Mortuaries do not have "swipe to exit" as standard, but will consider following the Phase 2 report. Two external mortuary doors at Conquest have swipe-to-exit installed. A further 5x doors at Conquest and 6x doors at EDGH may require swipe-to-exit to be installed. Decision to be made at Mortuary Steering Group.	Green = On track
NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	N/A	07/08/25: The DI feels that sufficient time is allocated to this role at present.	Blue = Complete
NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	Oct-25	07/08/25: A document prepared for Execs explaining the HTA regulations and the roles associated with them. This will be presented to the Executive Leadership Team meeting. Document prepared and sent to Exec Team July 2025, will continue to update and re-share.	Green = On track

Recommendation/Action	Date for review	Latest update	RAG status
NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	Sep-25	07/08/25: The DI will confirm which meetings require their attendance and then ensure these are scheduled.	Green = On track
A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.	N/A	07/08/25: This is already in place, as evidenced by the job description. No further action.	Blue = Complete
NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Dec-25	07/08/25: This is dependent on the implementation of the mortuary staffing business case. Recruitment in progress.	Green = On track
All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: -staffing matters; -security incidents; -all serious incidents; -Human Tissue Authority reports (where applicable); and -all security audits, including audits of access and any access breaches.	Nov-25	07/08/25: Need to understand what is required and how this can be delivered to the correct forum. CMO will be the accountable officer.	Green = On track

Aug 2025 Update on Actions identified from the phase 1 and 2 reports from the Sir Jonathan Michael independent inquiry into the issues raised by the Fuller case

Recommendation/Action	Date for review	Latest update	RAG status
Trust boards should assure themselves that the recommendations in this Report have been implemented	N/A	07/08/25: Twice yearly updates are already being sent to the Board and these will continue indefinitely.	Blue = Complete
Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people.	N/A	07/08/25: There are no temporary facilities in place, in the event that temporary facilities are required then they would be subject to the same procedures as the permanent Mortuary facilities	Blue = Complete
Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	Oct-25	07/08/25: A document will be prepared explaining the HTA regulations and the roles associated with them. This will be presented to the Executive Leadership Team meeting. **DONE**	Green = On track
NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Sep-25	07/08/25: Chief Nursing Officer to raise with Chief Executive for discussion at Executive Leadership Team meeting.	Green = On track
The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.	Sep-25	07/08/25: Chief Nursing Officer to raise with Chief Executive for discussion at Executive Leadership Team meeting.	Green = On track

Agenda Item: 11

Report To/Meeting	Trust Board	**Date of Meeting**	26th August 2025

Report Title:	Avoidability of Inpatient Deaths
Key question	To review a selection of deaths to ascertain whether there was any avoidability.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Dr Simon Merritt Chief Medical Officer	**Presenter(s):**	Dr Simon Merritt Chief Medical Officer
Report Author:	Dr Simon Merritt Chief Medical Officer		

Outcome/Action requested:	The Board are requested to note the report.
Executive Summary	The current "Avoidability of Inpatient Deaths" report details the April 2017 – December 2024 deaths, recorded and reviewed on the mortality database. 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 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. There are two reasons as to why we are behind with regard to learning disability deaths; Firstly, we recently discovered that 15 cases dating back over 2 years had not been discussed, we have now discussed 9 of them. Four were found to have a learning difficulty rather than learning disability. The remaining two will be reviewed at our next meeting, but this is dependent on whether the related LeDeR report has been completed., There is a considerable time lag from death to external completion of the LeDeR report, without which we cannot proceed.
Regulatory/legal requirement:	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	N/A		
Risk:	N/A		
No of Pages	3	**Appendixes**	1
Governance and Engagement pathway to date:	N/A		
What happens next?	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 assessed as having an overall care rating of very poor, poor, or adequate, patient safety incidents severity 3 and above, complaints relating to bereavement, unexpected deaths, 'low risk' deaths, fatal hospital acquired thrombosis (HAT), concerns raised by Medical Examiners, Swarms, avoidable cardiac arrests and learning disability deaths are all reviewed for completeness.		
Publication	Published		

Avoidability of Inpatient Deaths Dashboard April 2017-December 2024 (Data as at 25/06/2025)

Department of Health

Organisation	**EAST SUSSEX HEALTHCARE TRUST**
Financial Year	**2024-25**
Month	**December**

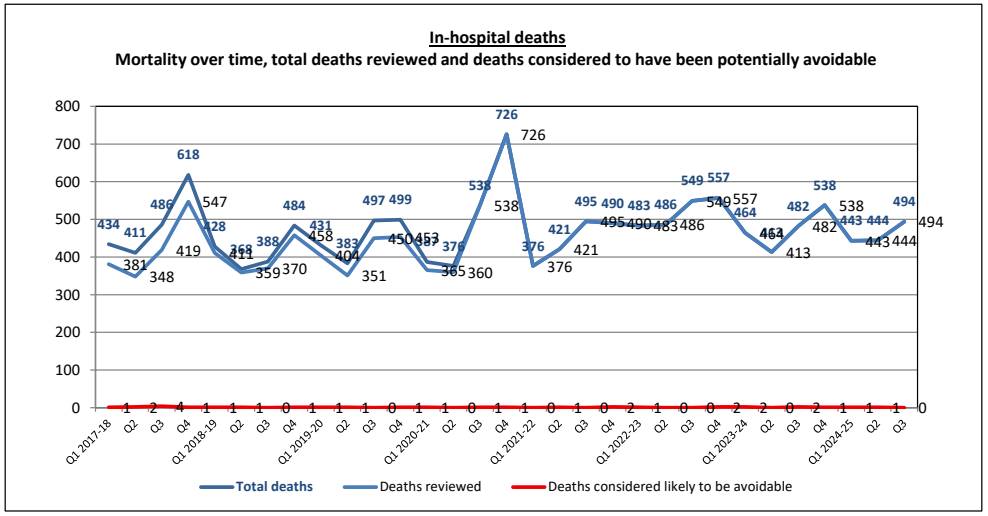
EAST SUSSEX HEALTHCARE TRUST: Avoidability of Inpatient Deaths Dashboard December 2024-25

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 25/06/2025)

Time Series:	Start date	2017-18	Q1	End date	2024-25	Q3

Total number of deaths recorded in the mortality database - excluding Learning Disability		Total deaths reviewed by Medical Examiner		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
164	165	164	165	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
494	444	494	444	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1381	1897	1381	1897	2	5



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

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	5	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	19	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	3.5%	This Year (YTD)	1	1.8%	This Year (YTD)	2	3.5%	This Year (YTD)	52	91.2%

Data above is as at 25/06/2025 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 3 2024/25 deaths, neither were taken forward as complaints.
Complaints - Of the complaints closed during Quarter 3 2024/25 which related to to bereavement in hospital, all had an overall care rating of 'good care' or 'excellent care'.
There was one patient with an overall rating of 1 or 2, poor care. This case is due to be reviewed at the Mortality Audit Review Group.
Patient Safety Incidents - There were no severity 5 patient safety incidents raised in Q3 2024/2025.
As at 25/06/2025 there are no September 2020 - December 2024 deaths outstanding for review on the Mortality database.

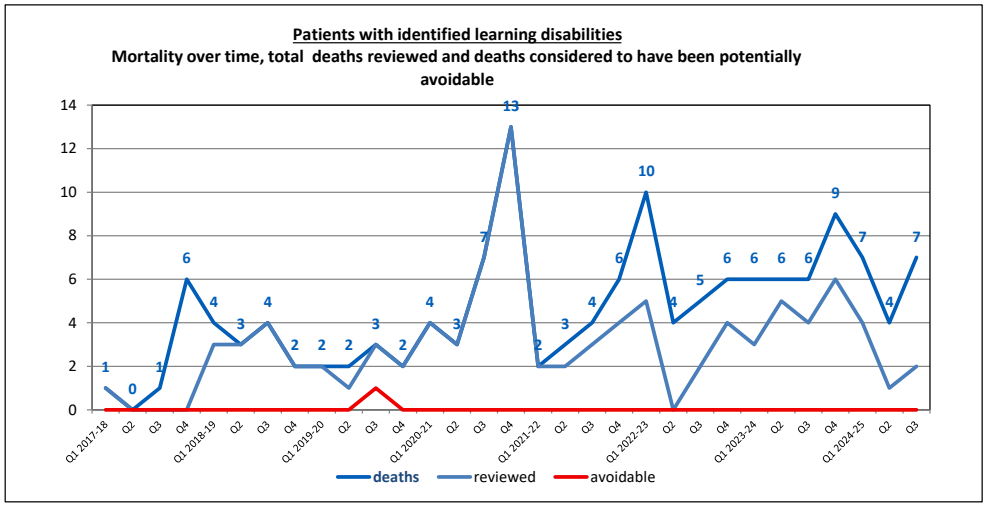
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 25/06/2025)

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	2024-25	Q3

Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	4	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	4	2	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
18	27	7	18	0	0



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

Agenda Item: 12

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	26th August 2025
Report Title:	Key policy updates		
Key question	The Board is asked to: 1. Review the summaries of the key policies/documents 2. Discuss the implications for the Trust		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief Of Staff	**Presenter(s):**	Richard Milner, Chief Of Staff
Report Authors:	Richard Milner, Chief Of Staff		
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		
Executive Summary	Since the June Board, three important documents have been published that, collectively, provide a clear sense of direction for the NHS nationally and also here in Sussex. We have brought these documents together to show the common themes – largely echoing the three priorities as set out by Lord Darzi in his earlier report on the NHS in 2024. The Sussex draft commissioning intentions show the intentions from the commissioning work into FY 2026/7 and how this will change the structure of provider contracts and increase the focus on patient outcomes. Given the breadth of impact these documents will continue to serve as reference points for the Trust as we work through what the changes mean for both services for patients and contracting models, as NHS Sussex seeks to move to a non-institutional model of contracting for services that prioritises patient outcomes		
Regulatory/legal requirement:	The Trust supports the direction of the commissioning intentions and is working with partners toward the implementation of the Alliance model		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration		
Resource Implication/VFM Statement:	None from these papers		
Risk:	Failure to engage with the Sussex commissioning intentions carries relationship and contract-based risk		
No of Pages	5	**Appendixes**	0
Governance and Engagement pathway to date:	The potential impact arising from these papers has already been shared with the Board and executives have reviewed this paper before it was brough to the Board.		

What happens next?	As noted earlier, the implications from these papers, as highlighted in the report, will continue to be reflected across a range of Trust papers to the Board and sub committees – in terms of quality, operational performance and finance.

Publication	This paper is appropriate for publication.

Introduction

1.1 The purpose of this paper is to share with the Board the key points affecting us following the recent activity around national policy and guidance (The 10-year Health Plan, The Dash Review into safety regulation) and further developments at local level now that the NHS Sussex draft commissioning intentions have been published.

1.2 We have already explored the potential implications and strategic impact of the new direction for national policy during the July Board development day, and this paper updates with the Sussex draft commissioning intentions, published in early August.

The 10-year Health Plan: Fit for the Future

2.1 The government has clearly set out this policy as an inflection point for health and care policy making. The Prime Minister's exhortation to "reform or perish" acknowledges the scale and nature of the choices involved and – as the Sussex Commissioning Intentions (SCI) make clear – strengthening care in the county cannot be delivered without "bold redesign".

2.2 We will work closely with NHS Sussex in partnership as we put into place our own versions of this bold redesign and as we play an active role in the both the Acute Collaborative and Neighbourhood Health Collaborative overseeing further changes presaged by the Major Service Review findings.

2.3 The Plan makes a powerful, persuasive case about how much more can be done in the community and we welcome wider discussions about service changes and recognise that some services are better provided in a different way and/or by other providers where we feel the outcomes would be better for users.

2.4 As was widely noted in the media coverage at the time of the announcement, the Plan places the three drivers of future direction as set out in the earlier report by Lord Darzi at the centre of the document:

- Shifting activity from hospital to community
- Moving toward greater preventative care
- Enhancing the digital role in the provision of services

2.5 As the sole integrated Trust within Sussex, we are uniquely positioned to support, shape and move at pace the aspiration to shift activity from an acute setting into neighbourhoods. We considered the main changes to our acute and community services arising from the Plan, and these are summarised over the page.

Figure 1: Summary of key changes to ESHT services arising from the 10-year Health Plan

- **Acute Services**
  - **Shift in role**: Acute trusts will no longer be the default setting for care. They will focus on **complex, specialist, and emergency care**.
  - **Financial pressure**: Acute providers must deliver **financial surpluses by 2030**. Deficit support funding will be phased out.
  - **Incentive reform**: Emergency care funding will be tied to quality metrics and success in shifting care to community settings.
  - **Competition and procurement**: High-performing acute trusts may become **"accountable care organisations"**, managing full population budgets. Others will face **increased competition** from private and VCSE providers

- **Community Services**
  - **Central to delivery**: Community services will be key players in **neighbourhood health centres** and integrated care teams.
  - **Funding boost**: New **year-of-care tariffs** will bundle payments across hospital and community services, rewarding coordination and outcomes.
  - **Expanded scope**: Expected to deliver more diagnostics, chronic disease management, and urgent care outside hospitals.
  - **Digital enablement**: Community providers will need to adopt shared records, AI tools, and remote monitoring to meet expectations.

2.6 In a recent interview with the Lead Non-Executive Director at the Department of Health and Social Care[1], he described the provision of healthcare as an "ecosystem of very different providers" including public and private suppliers (the latter 'at the margins') emphasising that "… we've got to stop viewing the healthcare system in this country as a single institution that we happen to call the NHS…". This has been expressed separately, in the early years of this century, as strategic commissioners needing to be 'agnostic' about who provides healthcare.

2.7 The term 'ecosystem' fits neatly in East Sussex, where partnerships across sectors, including ESHT, ESCC and local hospice providers, to name but a few, have been in development for over a decade. Some examples of this collaborative approach already in place include:

- **A new 'GP front end' within our hospitals** where GPs in-reach and run hospital wards to facilitate appropriate community care and discharges. GPs work as part of a formal MDT, alongside nurses, therapists and social care, to identify patients who can receive care in an alternative setting and expedite a supported discharge, to help tackle high numbers of patients with no criteria to reside (NCTR). Initial reports showed a 12-15% reduction in NCTR numbers and a corresponding average length of stay reduction from 8 days to 7 days
- **Working with South Downs GP Federation** to hold appointments away from hospitals where clinically appropriate for ED 'type 3' patients, in order to release pressure from the ED and into primary care
- **Operating a general virtual ward (VW) model** run by South Down Federation GPs alongside specialty VWs. These are run on a multidisciplinary approach, with GPs and consultants overseeing the care, with 78 virtual beds in total, of which the general VW is just less than half
- **Proactive care for people with/at risk of frailty to prevent unscheduled attendances** and admissions during winter. Over 2400 patients identified using a risk

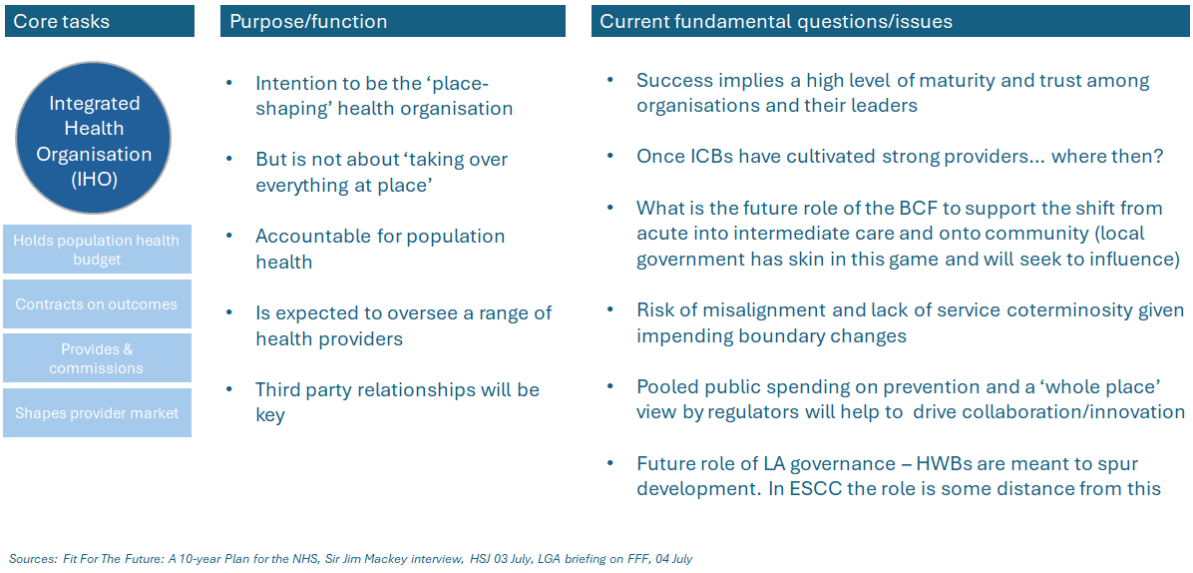
[1] NHS must be seen as just one part of health 'ecosystem', says Milburn | News | Health Service Journal

stratification tool in primary care were referred to community teams, avoiding an acute-led care pathway with care delivered closer to home. Reviews highlighted the information-sharing benefits that drove improved access for patients, and also work needed on communication across organisational boundaries.

- **Multidisciplinary proactive respiratory management pathway** combining primary care, community services and consultants to tackle higher than national average pneumonia admissions. A community risk tool supported referrals to Virtual Wards to jointly stratify risk, with secondary care community remotely monitored the highest-risk group and primary care-led monitoring of low-risk groups. The secondary care community respiratory caseload was also stratified to pilot remote monitoring and community management of escalating needs. Primary care and ESHT also support joint CYP asthma clinic and educational sessions.

2.8 The final aspect within the Plan that we would bring to the Board's attention concerns the opportunities for organisational development, and we have discussed informally with NHS Sussex colleagues that we are keen explore these further. The Plan talks of a new wave of Foundation Trusts (offering greater flexibility and potential to innovate for Trusts) and also re-introduces an approach seen around a decade ago, of Place-based co-ordination of care that is referred to as the Integrated Health Organisation (IHO). This is currently envisaged in places where the FT model is mature and presupposes significant experience of joint working among care partners.

Figure 2: Summary of Integrated Health Organisation and associated issues



Sources: Fit For The Future: A 10-year Plan for the NHS, Sir Jim Mackey interview, HSJ 03 July, LGA briefing on FFF, 04 July

The Dash Review: the quality of safety regulation

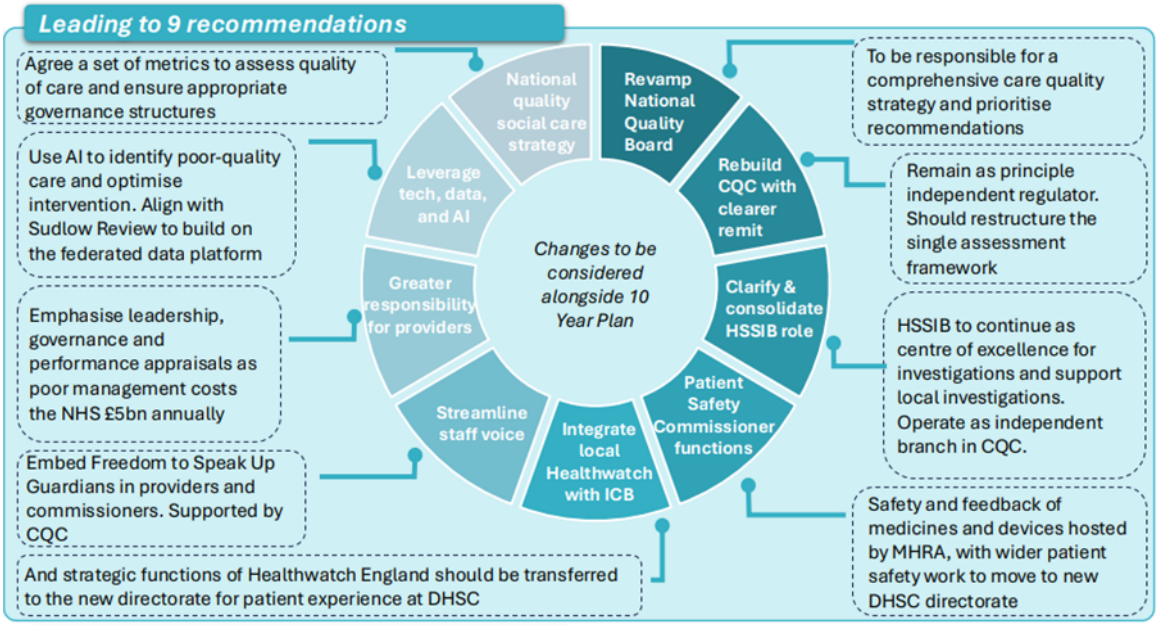
3.1 Following her earlier report in May 2024 - a review of the CQC - Dr Dash has undertaken an independent review of patient safety, with reference to the organisational landscape that oversees quality and focuses on a range of key national organisations.

3.2 The report recognises that regulating safety has become more complex/fragmented/noisy over time. Her recommendations consider whether we could we do this differently – in a more co-ordinated way with fewer arbiters, clearer accountabilities and greater patient/family engagement.

3.3 The report notes resource misallocation (increasing hospital staff numbers not matched by an improvement in outcomes) and data utilisation (across the whole of the NHS) not being optimised to generation insightful analysis. The report also flags the challenge of governing such a patchwork of organisations, with variable effectiveness and sometime opaque accountabilities

3.4 The conclusions in the review point toward fundamental issues with quality despite large investment in safety infrastructure. Dr Dash's prescription takes the shape of 9 recommendations (see below) that includes a co-ordinated national strategy for care quality, tightened up regulatory landscape, with clearer accountabilities for regulators and providers. The report remains confident that care outcomes can improve if the recommendations in the review are implemented.

Figure 3: Summary of Dash Review recommendations



Source: CF, Review of Patient Safety across the Health & Care Landscape

3.5 We understand that the Dash Review has been accepted by government and that, as the Review makes clear, this is designed to support the implementation of the 10-year Plan.

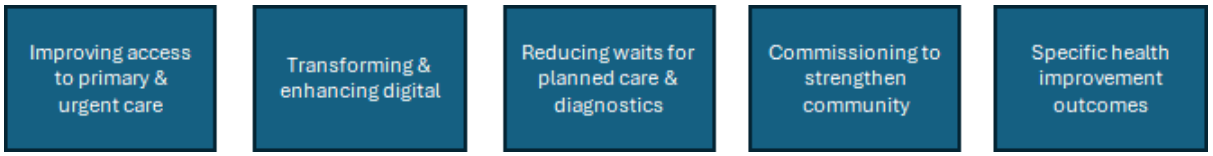
Sussex Draft Commissioning Intentions to 2026/7

4.1 The Sussex draft Commissioning Intentions (SCI) were published in early August and set out the NHS Sussex aim to shift from institution-led, reactive care to community-based, outcome-driven models. This transformation is guided by the Improving Lives Together strategy and is aligned with the Government's 10-Year Health Plan. The SCI will be submitted for approval in

September 2025 at the NHS Sussex Board meeting following feedback from providers and survey responses from members of the public.

4.2 The SCI embrace the three key shifts identified in the earlier Darzi report, which are also driving our thinking about service development as we come to refresh our clinical strategy. We share both the scale of ambition and the aspiration for pace of change that runs through the document.

4.3 The core commissioning intentions cover the segments set out below:



4.4 NHS Sussex will commission through two main Alliances:

- **Sussex Neighbourhood Health Alliance**: coordinates community-based care, working with Integrated Community Teams (ICTs) to deliver services tailored to local population needs
- **Sussex Acute Provider Alliance**: focuses on hospital and specialist care, improving value through collaboration across acute trusts

4.5 From April 2026, the Alliances will be commissioned to deliver specific health outcomes, not just activity and contracts will include shared risk and reward mechanisms to incentivize innovation and improvement. Alliances will be able to sub-contract to organisations with subject matter expertise, including third sector and independent providers.

4.6 Integrated Community Teams (ICTs) will be the primary delivery units for out-of-hospital care, and each will receive: A commissioning specification, an outcomes framework across six domains and authority to coordinate urgent, recovery, and preventative care

4.7 Over time the aim is that planning transitions to place-based, collaborative commissioning with the intention that this will focus on reducing fragmentation, improving equity, and addressing legacy inefficiencies. On this latter point, Alliances are expected to help correct a £200 million funding imbalance by shifting care from hospitals to more cost-effective community models, and associated changes across acute providers.

4.8 We welcome the SCI and that it is explicit about the scale of the financial reality facing all NHS organisations. We look forward to further conversations on the detail and how Alliance-led transformations will support the county returning to a sustainable health care system.

Next steps

5.1 These documents form key planks of the government and NHSE's forward agenda and we will bring updates to the Board as required. Many will be reported as integral parts of other reports given their centrality to the Trust's operational and strategic planning.

Agenda Item: 13

Report To/Meeting	Public Trust Board	**Date of Meeting**	26th August 2025

Report Title:	Winter Planning 25/26 Board Assurance Statement
Key question	The purpose of the Board Assurance Statement (BAS) is to ensure the Trust's Board has assurance that all key considerations have been met. It should be signed off by both the CEO and Chair.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Charlotte O'Brien, Chief Operating Officer	**Presenter(s):**	Garry East, Deputy Chief Operating Officer
Report Author:	Tom Bayston, Head of Operational Transformation		

Outcome/Action requested:	The Board is asked to: • **Note** the work undertaken to date to develop the Winter Plan and the further work required to finalise the plan. • **Note** that the Plan is a live document and will be updated on an ongoing basis to reflect emerging changes throughout the winter. • **Note** that the following area of the Plan is continually being reviewed: ○ Bed model and quantification of admissions avoidance and demand management schemes.
Executive Summary	This Board Assurance Statement (BAS) outlines East Sussex Healthcare NHS Trust's preparedness for the 2025/26 winter period, ensuring robust governance, operational resilience, and system-wide collaboration. **Key Highlights:** • **Governance & Oversight:** The Winter Plan has been developed with input from system partners including Sussex ICB, Local Authority, SPFT, and SECAMB. • **Quality & Equality Impact Assessment (QEIA):** QEIA is pending and will be completed based on the final version of the Winter Plan. • **Testing & Assurance:** A regionally-led winter exercise is scheduled for 8th September 2025, followed by a Trust-level tabletop exercise to incorporate lessons learned. • **Operational Readiness:** The Trust has modelled winter demand scenarios and developed responsive plans for base, moderate, and extreme pressures. Rotas, discharge profiles, and elective/cancer delivery plans have been reviewed to ensure resilience. • **Infection Prevention & Control (IPC):** IPC teams have been actively involved in planning, with fit testing and PPE controls in place. Cohorting plans are ready for activation. • **Leadership & Monitoring:** On-call arrangements are in place and tested. Real-time pressure monitoring is embedded via the OPEL framework and Demand Escalation Plan. • **Mental Health Provision:** Not applicable to ESHT as a non-mental health provider.

Regulatory/legal requirement:	N/A
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	N/A
Risk:	Initial modelling for winter indicates the Trust should be able to manage demand over the winter months within the existing bed base and planned winter escalation beds (including surge and super surge areas) providing the internal transformation schemes deliver. It should be noted the known challenges linked to length of stay and the number of NCTR patients continues to present an ongoing risk to the organisations plans.
No of Pages	2 **Appendixes** 1
Governance and Engagement pathway to date:	Executive Leadership Team meeting on 12th August
What happens next?	**Next Steps:** • Final QEIA to be completed. • Regional and Trust-level winter exercises to be conducted. Final Board approval and submission to NHS England by **30 September 2025**. Plan will be reviewed and updated on an ongoing basis (reflecting emerging changes over the winter months).
Publication	Public Board 26th August 2025

Winter Planning 25/26

Board Assurance Statement (BAS)

East Sussex Healthcare NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	East Sussex Healthcare Trust (ESHT)

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		Initial draft presented at Executive Leadership Team meeting 12/08/25. First draft to be approved by Trust Board 26/08/25 (TBC)
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	No	Will be completed and based around the final plan
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The plan has been developed in partnership with Sussex ICB, Local Authority, SPFT and SECAMB
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	No	This is planned for 8th September when there is a Regional Winter Exercise. This will be followed by a Trust level tabletop exercise in late September- enabling the Trust to incorporate any learning from the regional exercise.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Charlotte O'Brien, Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	The Winter plans supports delivery of the trajectories submitted as part of the planning submission. These were compliant with all national requirements.

Provider:	East Sussex Healthcare Trust (ESHT)

Provider CEO name	Date	Provider Chair name	Date
Jayne Black		Steve Phoenix	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Winter Sickness (including Flu) Plan has been developed and shared with execs. This plan includes the uptake objective among front line staff and links to the Trust Winter Wellness staff Handbook.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	The demand model has been provided by the Trust Business Intelligence team. Trust plans can respond to modelled moderate and extreme demand scenarios.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Nursing rota cover is reviewed on an on-going basis (with an 8-week forward view).
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	The Trust site improvement plan has objectives set against all the various actions that align to discharge profiles across all pathways.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	The Trust will maintain historical policy to protect and ring fence elective capacity during winter. Furthermore, the Trust will enter the winter period ahead of the compliant elective activity plan agreed with commissioners.
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	ESHT IPC team continue to work in partnership with operational and clinical teams on the development of the winter plan. The IPC team are also working with the

			Sussex IPC Cell to ensure plans are aligned.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Mask Fit testing remains in place for the relevant staff and is recorded under 'skills' on Health Roster.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Patients will be cohorted in the most appropriate way to ensure patient flow and support patients receiving their care in the most appropriate ward to meet their needs. The Trust plan incorporates the ability for additional ward based and community capacity.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	On-Call Managers and Director rota is in place up until the end of January 2025. On site presence will be reviewed throughout the winter period. Tested via an on-call training course that takes places monthly and requires all managers to attend on an annual basis.
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is BAU and links to the Trusts Demand Escalation Plan (DEP).
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

Agenda Item: 18

Report To/Meeting	Public Trust Board	**Date of Meeting**	26th August 2025

Report Title:	Medical Revalidation Annual Report 2024/25
Key question	This is the Medical Revalidation Annual Report presented in the template required by NHS England. This report needs to be approved and signed off by the CEO and/or the Chair of the Trust Board before it is submitted by the Revalidation team to the Secretary of State for Health by 30 September 2025. The purpose of this report is to demonstrate the compliance by ESHT with the regulatory requirements for medical revalidation and to record the achievements of the organisation in meeting these requirements.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Dr Simon Merritt	**Presenter(s):**	Dr Simon Merrit
Report Author:	Shelley Christou		

Outcome/Action requested:	The CEO and/or Chair of the Trust Board are asked to approve and sign the Statement of Compliance at the end of this report so that it can be submitted to the Secretary of State for Health. NHS England's Regional Responsible Officer also requests a copy of this report.
Executive Summary	During 2024-25 the Trust's Medical Revalidation compliance remained at 100%. There were 122 positive recommendations made and no non-engagement recommendations. There were 14 deferred recommendations made for reasons mostly relating to insufficient information due to sickness absence, maternity/paternity/adoption leave etc. All revalidation recommendations due have been made on time, whether these were a positive recommendation or a deferral as suggested by NHS England. The key risk faced during 2024/25 for medical revalidation and appraisal is an ongoing shortage of medical appraisers; actions are in place to mitigate against this risk of a lack of sufficient medical appraisers.
Regulatory/legal requirement:	This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	Included in budget
Risk:	Retaining and recruiting medical appraisers

No of Pages	13	Appendixes	None

Governance and Engagement pathway to date:	POD 24.06.2025

What happens next?	Signed statement is sent to NHSE Higher Level Responsible Officer

Publication	Not private

1A – General

The board/executive management team of East Sussex Healthcare Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	To update the Trust policy Recruitment of medical appraisers A review of the Education Strategy is to commence to link this to the Long Term Workforce Plan and the additional governance requirements as set in the NHSE Funding Agreement for 2024-2027. To ensure the agreement for funding continues.
Comments:	Dr Simon Merritt is the Chief Medical Officer and Responsible Officer for ESHT. Dr Gez Gould is Deputy Chief Medical Officer. Shelley Christou is Revalidation Team Manager.
Action for next year:	Recruitment of medical appraisers To ensure the agreement for funding continues.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	The Chief Medical Officer has a revalidation team that supports the work for medical revalidation. Funding has been sought and secured for the use of external appraisers to meet the statutory requirements for medical appraisal and revalidation.
Action for next year:	To ensure the agreement for funding continues.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The revalidation team maintains an accurate record of all licensed medical practitioners with a prescribed connection. This is monitored daily, and the team has full access to the GMC records of those doctors claiming a prescribed connection. Revalidation and appraisal software is used for doctors, appraisers and administrators. The system assists in the management of records for the doctors.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	To review and update the medical appraisal and revalidation policy
Comments:	There is a fully ratified medical revalidation policy
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	The last peer review undertaken at ESHT was in November 2014. A further peer review was requested by ESHT in 2022 but NHS England considered it was unnecessary due to the very high standards of medical revalidation compliance and appraisals in ESHT. A mock peer review was undertaken internally in January 2025 This proved very successful, and we feel confident that should this be required we are very well prepared.
Comments:	The last peer review undertaken at ESHT was in November 2014. A further peer review was requested by ESHT in 2022 but NHS England considered it was unnecessary due to the very high standards of medical revalidation compliance and appraisals in ESHT. A mock peer review was undertaken internally in January 2025 This proved very successful, and we feel confident that should this be required we are very well prepared.
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None
Comments:	ESHT provides support to all doctors with a prescribed connection to the Responsible Officer. The Integrated Education, Governance and Development Team provides additional support for continuing professional development. Doctors without a prescribed connection to ESHT are guided to seek support from their own designated body with appraisal and revalidation. The Responsible Officer an provide governance information via the confidential transfer of information form to support the process for these doctors.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None
Comments:	The Trust can be proud that the compliance with the Medical Revalidation & Appraisal Policy for medical appraisals and doctors with a prescribed connection is once again 100% for the year. All doctors who were expected to have an appraisal (n= 564) had their appraisal. Some doctors were granted an authorised postponed appraisal by the Responsible Officer (n=140) and some were granted an authorised missed appraisal (n=88) Full support is provided to doctors in the form of the provision of complaints and incident reports that include all direct and indirect involvement of doctors in complaints and significant events over the previous year or since their last appraisal, whichever is the longest period of time.
Action for next year:	None

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	None
Comments:	The revalidation team maintains a careful and thorough record of all doctors with a prescribed connection to ESHT including recording any reasons for missing an appraisal and any support or actions provided. Agreements for a date for a future appraisal are recorded.
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	To review and update the medical appraisal and revalidation policy
Comments:	There is a fully ratified medical revalidation policy in place.
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Recruitment
Comments:	ESHT was able to remain compliant with appraisals through requesting our internal appraisers to undertake additional appraisals. The under-capacity of medical appraisers is being addressed by frequent recruitment drives and the engagement of appraisers sourced externally. Appraisers are required to do a minimum of 6 appraisals. A recruitment drive is due to be held in June 2025. In addition, we continue to use external and bank appraisers to ensure the Trust has sufficient medical appraisers in the Trust.
Action for next year:	Ongoing recruitment

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	None
Comments:	The revalidation team organises two update training sessions for medical appraisers each year and these sessions are generally well attended. In 2024-25, sessions took place on 15th May 2024 and 4th December 2024. In addition, appraisers attend software training at times convenient to themselves. The planned sessions have been delivered by the Appraisal Lead and The Revalidation Team Manager, with guest speakers In May 2024: ○ Trust manager for the National Consultant Information Programme (NCIP) ○ In December 2024 ○ The pastoral fellow for the Trust ○ Edgecumbe Doctor 360 – new providers for MSF software Attendance is fully monitored, and the Appraisal Lead and Revalidation Team Manager have additionally provided 1-1 support for appraisers who are unable to attend the sessions or for those requiring 1-1 feedback on the quality of their appraisal outputs.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None
Comments:	• ESHT has a quality assurance tool adapted from the NHS England tool. There is a programme in place to be able to assess systematically all appraisal outputs such as the appraisal summary and personal development plans. • Appraisal Lead and Revalidation Team Manager undertakes quality assurance exercises once a year for each appraiser and provides constructive feedback to them. The first three appraisal outputs of new appraisers are reviewed by the Appraisal Lead and feedback is provided to promote continuous improvement. • The QA activity is recorded annually on a spreadsheet. The Appraisal Lead reports on quality assurance of medical to the Medical Revalidation Advisory Panel twice yearly. • Themes from the QA exercise are used to inform the learning plans for the update sessions.
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	ESHT has 100% compliance and has never missed making a revalidation recommendation on time. This can often be a challenge if a new doctor adds themselves without any notice to the GMC list of prescribed connection to ESHT immediately before their revalidation recommendation is due. As the revalidation team is vigilant in checking the GMC list regularly, it has been able to support all doctors to have their revalidation recommendations made in a timely manner. During 2024-25, there were 122 positive recommendations made and no non-engagement recommendations. There were 14 deferred recommendations made for reasons mostly relating to insufficient information due to sickness absence, maternity/paternity/adoption leave etc.
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The revalidation team ensures that all recommendations to revalidate are confirmed to the doctor at the time the recommendation is made. If the recommendation is to defer, the reasons for the deferral and actions needed are sent to the doctor via email first, requesting an acknowledgement from the doctor. Full support is always offered by the revalidation team to the doctor if there are any actions required.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None
Comments:	ESHT has a formal clinical governance structure and appraisal governance reports are provided to each doctor prior to the appraisal meeting by the Revalidation Team. Appraisal Governance Reports offer each doctor information about any complaints or significant events in which they are directly or indirectly involved over the previous year. These can then be reflected upon and discussed during the appraisal meeting so that learning can be applied and any appropriate actions added to the doctor's personal development plan for the following year. Additionally, CLiP (clinical outcome) reports are provided to the relevant doctors.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None
Comments:	Regular meetings are held between the Chief Medical Officer/ Deputy Chief Medical Officer and Human Resource colleagues to monitor the conduct and performance of doctors in ESHT. Where specific actions are required, the doctor is obliged to include these in their appraisal supporting information and is expected to discuss these with their appraiser during the appraisal meeting. Appropriate actions and learning can then be applied to their personal development plan.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None
Comments:	The Doctors are provided with an incidents report and a complaints report in the second or third week of the month before their appraisal. This is downloaded straight into the software system and the Doctor is notified when it is ready for review.
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None
Comments:	The Trust has a regularly reviewed Remediation: Responding to Concerns Policy and formal well tested processes and procedures in place. Regular meetings are held between the Chief Medical Officer, Chief People Officer and the GMC Employment Liaison Advisor.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None
Comments:	The Chief Medical Officer ensures that he runs regular and formal monthly medical review meetings. These meetings provide assurance that matters and any arising issues involving concerns about doctors are reviewed and actions are progressed. The meetings are formally recorded.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None
Comments:	The revalidation team ensures that all requests from other Responsible Officers are acted upon and provided within ten working days. A Transfer of Information form is requested from a new starter's previous Responsible Officer after the date that the doctor has joined the Trust. Doctors who work in other organisations are required to bring any relevant information from their other employers to their appraisal, for example any involvement in incidents or complaints so that they can be included in the appraisal discussion. Doctors who work elsewhere are expected to be participating fully in the appraisal process of their own organisation and the revalidation team provides confidential information to their organisation's Responsible Officer on request.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	None
Comments:	The monthly medical review meeting, Chaired by the Chief Medical Officer is attended by the Deputy Chief Medical Officer, Chief People Officer and Head of Operational HR to ensure fair and consistent processes are adhered to. All members of the meeting have attended equality and diversity training.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	None
Comments:	Our Medical Appraisers are trained and kept regularly updated with relevant reports and information from the HLRO, GMC. NHSE and other organisations. They incorporate this information when aiding and encouraging annual Personal Development Plans that identify educational needs and set development objectives in line with the Trust governance policies, procedures and culture. **In addition please see the response from Education Dept:** There was an initial review of the Education Strategy in 2024 and this work was ongoing when it was announced by the new Labour Government that NHS England were to be dis-established at the time. As a result, it was agreed to develop annual plans for each of the Services within Integrated Education to manage and monitor both existing priorities and new initiatives for the organisation during this period of uncertainty. This has been completed and is reviewed every month at Integrated Education Senior Managers Meeting and formally through the Trusts Education Steering Group. In addition, with the additional governance requirements that are evident within the NHSE Education funding Agreement , and the national work currently being undertaken by NHSE on the National Statutory and Mandatory Framework there is to be a national focus on measuring more the impact of education. As a result we are refreshing the Governance frameworks for the Education Steering Group as well as look to enhance educational metric dashboards that will collate educational data.
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None
Comments:	The Trust Excellence in Care Standard Operating Procedure is a framework that provides one source of robust data to enable clinical teams to review, analyse and understand their performance against a range of metrics which align with national guidance and local policy. This enable improvement to be identified and the resource to monitor consistency in care delivery with a reduction in unwarranted variation.
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None
Comments:	The ongoing process is that any Trust doctors who are not recruited via an agency have recruitment checks completed through the Trust applicant tracking system 'TRAC' which ensures all pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties. This includes checking the candidate's GMC

	registration. This is countersigned by another member of the recruitment team and filed against the candidate. Interviews take place for the clinicians to ascertain their skills are suitable for the post to which they are applying. Consultants are appointed following an AAC Panel selection process. Where international , DBS would be enacted once in post bridged by the COGS and If OH screening and EPP were required - can only be done in person once arrived in the UK. The above processes are reviewed on a regular basis to ensure compliance, by both the recruitment leads and TIAA auditors.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None
Comments:	The accountability framework supports the delivery of trust strategies and processes, ensuring that it is well led with regular monitoring and assurance. Periodically the Trust is required to undertake national initiatives and programmes. The accountability for these is determined at the outset to ensure their implementation is as successful as possible. Currently one such national programme is GIRFT (Getting it Right First Time).
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None
Comments:	Yes – this is linked into our recruitment process - our trust values- and our policies
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None
Comments:	Both the Values and Freedom to Speak Up are included in the Trust Welcome sessions by both the Wellbeing Team and Exec welcome slot. This is an overview but makes clear from day 1 the expectations of the Values and the importance of Freedom to Speak Up
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None
Comments:	Comments, concerns, and complaints are recorded on Datix, which is ESHT's risk management system. As well as a robust complaints policy the Trust is committed to listening and learning from feedback and has a Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy as well as two Freedom to Speak Up Guardians.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None
Comments:	The Trust holds a number of policies in relation to equality and diversity and actively seek to eliminate unlawful discrimination and foster good relations between those who share a protected characteristic (age, race religion, gender, gender reassignment, sexual orientation, marriage and civil partnership, pregnancy and maternity and disability – including carers). The last published Annual Equality Report includes the result of a survey for ESHT's multicultural colleague experience. The trust proves a Chaplaincy and Pastoral care team Pastoral, Spiritual and Religious Care to patients, staff and relatives. All staff must undertake mandatory Equality and Diversity training. The end goal remains; thriving and culturally competent staff providing inclusive care to promote positive health outcomes and tackle health inequalities.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None
Comments:	The RO, Deputy RO, Appraisal Lead and Revalidation Team Manager attend regular updates organised by: South East High Level Responsible Officers team and The GMC. The Revalidation Team Manager, Appraisal Lead and team members attend regular meetings organised by the National Medical Appraisal and Revalidation Managers Network The Appraisal Lead is due to attend an external training session in April 2024. The Revalidation Manager has an external training webinar on supporting overseas doctors, clinical fellows, and physician associates. The last peer review undertaken at ESHT was in November 2014. A further peer review was requested by ESHT in 2022 but NHS England considered it was unnecessary due to the very high standards of medical revalidation compliance and appraisals in ESHT.
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1st April 2024 to 31st March 2025
All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	ESHT	St Wilfrid's	St Michael's	Joint total
	593	4	4	601

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	556	4	4	564
Total number of appraisals approved missed	88	0	0	88
Total number of unapproved missed	0	0	0	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	135	1	0	136
Total number of late recommendations	0	0	0	0
Total number of positive recommendations	121	1	0	122
Total number of deferrals made	14	0	0	14
Total number of non-engagement referrals	0	0	0	0
Total number of doctors who did not revalidate	0	0	0	0

2D – Governance

Total number of trained case investigators	**11**
Total number of trained case managers	**4**
Total number of new concerns registered	**3**
Total number of concerns processes completed	**3**
Longest duration of concerns process of those open on 31 March	**N/A**
Median duration of concerns processes closed	**14.8 weeks**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**1**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	295
Number of new employment checks completed before commencement of employment	295

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
There were four actions from last year's report. One was to update the Trust Policy for medical revalidation and appraisal. The second is a review of the Education Strategy. The last two are ongoing with regard to recruitment of and funding for medical appraisers.
Actions still outstanding
None
Current issues
The main issue facing medical revalidation currently is that internal medical appraisers are facing challenges in meeting rising clinical demands and conducting medical appraisals and are stepping down. This is causing a shortage of medical appraisers.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Recruitment of medical appraisers To ensure the agreement for funding continues.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Despite its challenges, the medical revalidation and appraisal process is well established in the Trust and appraisals meet 100% compliance with the Trust's Medical Revalidation Policy. Actions are in place to mitigate against the risk of a lack of sufficient internal medical appraisers.

Agenda Item: 16

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	26th August 2025
Report Title:	Q1 2025/26 Board Assurance Framework		
Key question	The Board is asked to: 1. Review and note the position of the BAF risks 2. Note that the draft CRR allocation		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief Of Staff	**Presenter(s):**	Richard Milner, Chief Of Staff
Report Authors:	Richard Milner, Chief Of Staff and Pete Palmer, Board Secretary		
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		

Executive Summary

Several changes have been made to the BAF to make it clearer, more dynamic and more forward looking for this year. Colleagues will see that, in response to Board requests, we have streamlined the formatting to improve readability and have included assessments of risk tolerance and risk appetite.

Alongside this overhaul of the BAF we have also undertaken a significant risk register refresh.

This means that we are in a position to share the draft corporate risk register (CRR) risks that align most closely to either the remit of the sub-committee and/or the BAF risks assigned to the committee. These appear on the final page and we would welcome comments from the sub-committee on this draft.

This report provides an overview of the risks on the BAF; these are overseen by the Finance and Performance Committee, People and Organisational Development Committee and Quality and Safety Committee. The Audit Committee maintains oversight of the entire BAF.

BAF 1 is currently rated at 9, reflecting the buoyant recruitment market for ESHT which is driven in part by pressure in other parts of the health and care sector.

BAF 2 is rated at 16 due to the significant challenges and changes that lie ahead for both the Trust and the wider NHS. It is recognised that the present NHS climate may contribute to a further decline in annual staff survey results for the Trust.

BAF 3 is rated at 15, reflecting that controls and governance are in place which provide assurance about the progress being made, notwithstanding the scale of the ask in 2025/26.

BAF 4 is rated at 16 as even with an additional in-year capital award of £8.5m the criticality of infrastructure and estates risks means that the risk profile is unlikely to change during 2025/26 without significant additional financial support.

	BAF 5 is rated at 16 which is the limit of our risk tolerance. The primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance. In line with best practice BAF 5 has been moved from being overseen by the Audit Committee to being overseen by the Finance and Performance Committee. BAF 6 is also rated at 16, the limit of our risk tolerance. Again, the primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance. BAF 7 is rated at 12 reflecting the positive moves on EPR implementation, increased activity around AI initiatives and the potential benefits that they might bring to the organisation. BAFs 8 and 9 are rated at 16 and are at the limits of their tolerance; delivering improvements to both will require collaboration across the health and wider care sector.
Regulatory/legal requirement:	The Trust Board is required to have a BAF in place as it one of the key sources of evidence to support for the preparation of the Annual Governance Statement.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	Outcomes focus: achieving the best sustainable outcomes for patients and service users by encouraging continuous improvement, clinical excellence and value for money
Risk:	Failure to monitor risks may result in the Trust not monitoring triggers which will prevent
No of Pages	2 **Appendixes** 1
Governance and Engagement pathway to date:	Each BAF risk has been reviewed by the Executive Risk Owner and the Chief of Staff. Collectively the full BAF is reviewed by the Executive Committee and shared quarterly with the Audit Committee before going to the next scheduled Trust Board. Each Board sub-committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter.
What happens next?	Comments from the Board received will be assessed and implemented accordingly. The Q2 BAF is due to be presented to the Trust Board in October.
Publication	This paper is appropriate for publication.

NHS
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NHS Trust

Q1 Board Assurance Framework

- Summary of current & future strategic risk profile
- Risk-by-Risk analysis


Trust Board, August 2025

2025/6 BAF: Overview of changes made and Q1 view on current and future risk profile

Changes made for 25/26 to the BAF

- As per papers to the May Board Development Day and the June Board, we have made several changes to the BAF this year designed to make it clearer, dynamic and more forward-looking
- We agreed a tighter set of BAF risks for this year (from 12 to 9, with three risks moving to the corporate risk register) and we have refocused the committees through which the BAF risks are assessed
- We have streamlined formatting to address readability issues and have included risk tolerance and appetite, replacing the YE 'target' risk. We believe that this will help colleagues to better understand our expectations and approach to each BAF risk
- We have been able to refresh the CRR so as to enable a draft allocation of CRR risks across the three main Board sub-committees and each one is being asked for its views

Summary of Q1 risks and forward look

- The Q1 assessment from executive risk owners reflects the wider sense that 2025/6 will carry significant risk in terms of quality, people and finance over the duration of the year. Most BAF risks are at, or close to the limit of the risk tolerances set for this year – with two notable exceptions at Q1
- There is some confidence going forward as regards BAF 1 (attracting, retaining and developing the right people) due to the buoyant recruitment market for ESHT, driven in part by pressure in other parts of the health and care sector
- BAF 2 reflects that the national mood music of significant changes ahead combined with the invocation of austerity is unlikely to support us as we seek to improve staff survey scores
- The commentary on BAF 3 (finance and delivery) demonstrates both controls and governance are already in place to seek assurance on progress, notwithstanding the scale of the ask this year
- BAF 4 notes that even with the additional in-year capital award of £8.5m, the criticality of the infrastructure and estate risks means that without significant financial support, the future risk profile is unlikely to shift before YE
- BAF 5 and 6 scores reflect the structural challenges we have faced in these areas – with both sitting at their tolerance levels. The primary aim this year in these two areas will be undoubtedly the prevention of exceeding their tolerances, rather than reducing the scores in year
- BAF 7 reflects the positive moves on EPR implementation, the increased activity around AI initiatives and the potential benefits these may together bring
- BAF risks 8 and 9 are similar to 5 and 6 above in the sense that both are at the limits of their tolerance and delivery requires the collaborative and concerted efforts of the health and wider care sector, which are similarly stretched over the coming year

2025/6 BAF risk template: Aide memoire of formatting changes and their purpose

Risk Scoring

Inherent risk *If there were no mitigations*		Current risk level *Assessment based on evidence*				Rationale for current risk level *Evidence that provides assurance of current risk level*	Risk tolerance *Acceptable range/boundaries of risk score*	Risk appetite *Amount/type of risk accepted/taken*
		Q1	Q2	Q3	Q4		Score	*Single word description**
Likelihood	3							
Impact	5							
Risk level	15							

This is set at the beginning of the year and reflects the innate scale of risk. We would expect all of these to be high – because these are BAF risks and so their consequences/impact are de facto existential

This approach to monitoring remains unchanged from last year, and the scores should reflect the confidence/assurance that risk owners can take from the evidence they have seen (or not). In the event that the level is not moving and/or is outside the tolerance level, risk owners need to explain why in the next section (rationale)

This section is where the risk owner explains why the current score is what it is. We would expect reference in here to the evidence and any variation that has been seen in the last quarter

These two sections are new this year and replace the "target/anticipated" YE risk category from previous years. By using the tolerance and appetite approach it will be easier for Board members to understand a) whether the current level is a cause for concern (e.g. if it falls outside our tolerance level and so triggers extraordinary or additional actions) and/or our position toward the risk (e.g. are we prepared to innovate and so accept an open approach, or is this a risk where we will be conservative around the level/scale of risk that we accept

This is also new for this year and will help us share with the Board how we anticipate this risk evolving over the coming quarters – in response to the ask that we discuss the potential direction of the risks and any pre-emptive actions for consideration, rather than assessments being exclusively backward-looking

Forward forecast of risk level *Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available*
fgfg

**As per the GGI categories used in our risk statement (June Board paper)*

2025/6 BAF: Q1 summary position

BAF Ref	Risk Summary	Monitoring Committee	Inherent Risk	2025/26 Quarterly Position				Change	Risk Tolerance	Risk Appetite
				Q1	Q2	Q3	Q4			
1	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD	15	9					No higher than 16	Significant
2	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD	20	16					No higher than 20	Cautious
3	We fail to use our resources as efficiently as possible and do not improve services for patients.	F&P	20	15					No higher than 16	Seek
4	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	20	16					No higher than 16	Seek
5	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.	F&P	20	16					16	Minimal
6	Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions.	F&P	16	16					No higher than 16	Seek
7	Failure to transform digitally and deliver associated improvements to patient care.	F&P	16	16					No higher than 16	Seek
8	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.	Q&S	20	16					No higher than 16	Cautious
9	Failure to meet the four-hour clinical standard.	Q&S	20	16					No higher than 16	Cautious

1. Risk Summary

Reference & title	BAF 1: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.			Fit with Trust corporate priorities					
Description	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	Director of People	Lead Committee	People and Organisational Development	Date last reviewed	27/03/2025				
Corporate Risk(s) aligned	• No current risks on the Corporate Risk Register that align								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	3
Risk level	15

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
3			
3			
9			

Rationale for current risk level
Evidence that provides assurance of current risk level

There are recognised national shortages of roles within some specialities which may require short to medium term temporary workforce whilst international recruitment or retained searches are undertaken. Currently the high impact roles are within stroke consultants, respiratory and ultrasound. The Trust's vacancy level as of May 2025 was 2.8%.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Significant

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

It is anticipated that the risk rating will remain as a 9 due to the buoyant recruitment market and planned apprenticeship pathways. We also have workforce reduction programmes where staff will be redeployed into vacant roles; nationally the NHS recruitment external market is subdued and NHS workforce reduction programmes are being undertaken nationwide.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- None identified

3. Providing assurance *Additional actions that can be undertaken to support mitigations*					
No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Continue with recruitment initiatives and international sourcing of candidates as required	CPO	August 2025	• Expanding agency recruitment initiatives to include retained recruitment, trialling with two specialities. • Initiated internal first recruitment which supports our present workforce to apply for promotion or try a different speciality • Engaged with NHSE international recruitment for sonography	Amber
2	Local outreach initiatives	CPO	Sept 2025	• Campaign to increase volunteer numbers across the Trust. • Targeted campaigns with Eastbourne College to support candidate pipelines • Designing apprenticeship pathways with Eastbourne College to support our workforce pipeline • Designing, in conjunction with Eastbourne College, placement opportunities for non-clinical placements	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy/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 • Review of nursing establishment six monthly as per Developing Workforce Safeguards • Workforce efficiency metrics and monitored • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • Quarterly reviews in place to determine workforce planning requirements.	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board • Temporary workforce costs scrutinised and reviewed weekly at TAP meetings with DDOs • Wellbeing offering enhanced (includes Pastoral Fellows support) and reviewed by POD	• Triangulation of National Staff Friends and Family Test reports, reviewed by POD • ICB Quarterly Workforce meetings • Internal audit review reports on effectiveness of workforce policies and processes • NHS Staff Surveys and Pulse Surveys and benchmarking data

1. Risk Summary

Reference & title	BAF 2: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.				Fit with Trust corporate priorities				
Description	There is a risk that any decline in staff motivation negatively impacts on our ability to deliver the required levels of activity to the standards we require.				LOS	Workforce	Income	Bus Case	Digital
					✓	✓	✓		
Lead executive	Director of People	Lead Committee	People and Organisational Development		Date last reviewed	27/03/2025			
Corporate Risk(s) aligned	• Violence and Aggression in Intermediate Care								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4			
4			
16			

Rationale for current risk level
Evidence that provides assurance of current risk level

Multiple data sources such as staff surveys, Datix and Freedom to Speak Up Guardian feedback indicate a decrease in both engagement and morale within our workforce. This data demonstrates a decline from 2024 results.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 20

Risk appetite
Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level
Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Enhanced initiatives have been implemented to review and resolve key issues raised within the staff survey, such as feedback on Datix. The focus for the next quarter will be on improving engagement scores, but we recognise that within the present NHS climate our results may decline further.

3. Providing assurance
Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- None identified

3. Providing assurance *Additional actions that can be undertaken to support mitigations*					
No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Development of actions from the staff survey	DoP	Sept 2025	• We have established a staff survey steering group to focus on key people promise elements from actions on the People Promise statement from the staff survey. • The Violence and Aggression reduction group have revised the focus to four pillars: education, pathways, workforce and environment.	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • DME monitors and reviews 'trainees in difficulty' register • Workforce efficiency an availability reviews considering registered and unregistered nurses, and AHPs • Ongoing reviews of effectiveness and efficiency of rostering • Development of task and finish focus groups to support key remedial actions in response to staff survey	• Workforce metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments • Oversight and monitoring by Health and Safety Steering Group • Deep dive cultural reviews	• Health and Safety Executive review of violence and aggression • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust

1. Risk Summary

Reference & title	BAF 3: We fail to use our resources as efficiently as possible and do not improve services for patients.			Fit with Trust corporate priorities			
Description	The Trust has agreed a breakeven plan with detailed supporting schemes (both recurrent and non-recurrent) which will help move the organisation to become financially sustainable. NHS England has been clear that organisations need to live within their financial envelopes.			LOS	Workforce	Income	Bus Case	Digital
				✓	✓	✓	✓	✓
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance	Date last reviewed	30/01/2025			
Corporate Risk(s) aligned	• No current risks on the Corporate Risk Register that align							

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	5
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
3			
5			
15			

Rationale for current risk level
Evidence that provides assurance of current risk level

There are detailed plans by division and centrally which support the delivery of a balanced plan. However, the Trust needs to ensure that there is sufficient capacity and capability in order to deliver the plans. Steps have been taken to bring in additional expert transformation resource to enable the plans to succeed.

Progress on schemes is being monitored on a weekly basis. Monthly reports will be going to the Finance and Performance Committee.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level
Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

We will probably remain at 15 until September when significant numbers of the transformation schemes are due to be delivered. The risk level will be formally reassessed at this time.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Lack of clarity about business case approval.
- Lack of divisional influence in capital prioritisation.

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Currently developing new Standard Operating Procedure (SOP) for business cases	CFO	Sept	• This has just commenced	Amber
2	Work being undertaken to increase divisional influence in capital prioritisation	CFO	Sept	• Revised membership of capital resource group • Capital plan to be discussed at Executive Committee	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Weekly report to Executive Leadership Team (ELT) from Project Support Office on progress of schemes • Weekly updates on the five key priorities and their progress into ELT • Vacancy control panel approves internal and external recruitment on a weekly basis.	• Oversight by Use of Resources Programme • Regular reporting to Trust Board and relevant committees • Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive. • Monthly Use of Resources meeting	• Internal audit review reports • ICS oversight • NHSE oversight

1. Risk Summary

Reference & title	BAF 4: 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.				Fit with Trust corporate priorities				
Description	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes				LOS	Workforce	Income	Bus Case	Digital
					✓		✓	✓	
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance		Date last reviewed	30/01/2025			
Corporate Risk(s) aligned	• Fire Safety EDGH and Conquest • Failing clinical environments • Insufficient isolation space • Fascia debris falls	• Lack of capital • Power loss to critical areas • Insufficient decant for deep cleaning • Maintenance Standards	• Inadequate prep for major/critical incident • Poor compliance with S&M requirements						

2. Risk Scoring

Inherent risk
If there were no mitigations

Likelihood	5
Impact	4
Risk level	20

Current risk level
Assessment based on evidence

Q1	Q2	Q3	Q4
4			
4			
16			

Rationale for current risk level
Evidence that provides assurance of current risk level

The Trust's capital budgets are insufficient to support the current EME medical equipment replacement priorities and is also insufficient to address the estates maintenance backlog.

A bid for capital funding for medical equipment and critical infrastructure risk (CIR) has been submitted to the ICS to help address 25/26 and 26/27. A report had been presented to ELT and ExCom to highlight the challenges in the next 5 years. We were awarded £8.55m of Critical Infrastructure Funding from NHSE/ICB which we will use the help in addressing elements of the Fire Compartmentation project, together with a start on some of the planning and design of the electrical infrastructure risks. We continue to work with Friends to support to address the equipment gap.

A report on estates backlog maintenance was submitted to the ELT and F&P Committee in May 2024; an update on medical equipment was presented to ELT in October and December 2024 and was then presented to the Executive Committee in January 2025. The BAF risk score has been increased to 20 for Q4 due to due to the delays in the New Hospital Programme (NHP) in the Trust to 2037.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level
Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

We are compiling a ten-year investment backlog programme, which is due to be completed in Q2 2025/26. In addition, future bids will be made as we understand £5bn has been earmarked nationally for critical infrastructure risks for the next four years. However, there is no certainty as to the levels that may be awarded to the Trust.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed until 2037 and timeframe and scope/extent of work against the funding allocation is not clear at present

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	ICS will undertake a medium-term financial plan	DEF	Q2	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	A
2	Development of ten-year investment backlog programme	DEF	Q2	• Plans are being developed within the Estates team	A
3	External funding opportunities	DEF	Q2	• The Trust will continue to bid for funding through ICS and national programmes as and when opportunities occur	A

	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 and prioritisation by services	• Oversight by Finance and Productivity and Strategy Committees • Estates and Facilities IPR • Clinical procurement group in place • Prioritisation decisions about capital expenditure are made by CRG, BDG and F&P	• Capital business cases reviewed by ICS • External review report of critical infrastructure

1. Risk Summary

Reference & title	BAF 5: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.			Fit with Trust corporate priorities					
				LOS	Workforce	Income	Bus Case	Digital	
Description	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack					✓		✓	
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed	27/03/2025			
Corporate Risk(s) aligned	• Cyber attack • Unattached op systems vulnerability • Limited visibility / control over network		• Server vulnerable to cyber attack • Bereavement system overload with data						

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4			
4			
16			

Rationale for current risk level

Evidence that provides assurance of current risk level

A number of elements of the cyber action plan have been delivered, reducing our cyber exposure. There are a number of robust controls in place, but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda.

A significant amount of work has been done to increase the robustness of the Trust Cyber security posture. The current security risk status has reduced which has been a great achievement. But the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations.

Cyber maturity has improved over the last six months, which has reduced the Trust from a high to a medium risk status. We are no longer looking to deliver Cyber Essentials as this has now been incorporated into a new version of the Data Security Protection Toolkit (DSPT) called Cyber Assurance Framework (CAF).

Risk tolerance

Acceptable range/boundaries of risk score

16

Risk appetite

Amount/type of risk accepted/taken

Minimal

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

The cyber action plan, which is presented to the Audit Committee, has four elements: Internal Audit recommendations, CAF Self Assessment, External Penetration Test recommendations, 10 risks on the trust risk register

Two of the key actions to achieve the anticipated risk level of 12 will be to deliver the active directory migration and a further reduction in unsupported legacy systems along with the Conquest core LAN migration.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Obtain CAF to provide assurance on reliability and security of systems and information
- Continue with patching programme and address points raised by internal audit
- Cyber Action plan developed which sets out all of the actions that would need to be taken to mitigate cyber risks

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Cyber Assurance Framework	DCEO	June 26	• Internal CAF self-assessment completed which identifies gaps in compliance • Gaps have been used to create the cyber action plan • CAF action plan to be agreed with Regional teams • Refreshed cyber five-year strategy and awaiting approval	Amber
2	Medical devices with network connectivity asset list	DCEO	March 26	• Increased visibility across EDGH and risks identified • Further work required to enable greater visibility • Anticipate that full visibility will be delivered at EDGH by end of March 2026 • Conquest delivery anticipated in 2025/26	Amber
3	LAN Refresh EDGH	DCEO	March 26	• Migration of Edge network over the course of 2025/26 • Delayed due to winter pressures and fire compartmentalisation work	Green
4	LAN Refresh Conquest	DCEO	March 26	• Replace the Core Network and Fibre connections to the Edge Switches • Equipment delivered • Fibre network now installed and should be complete by end of March • Planning underway for Core cut over	Amber
5	Active directory migration	DCEO	Dec 26	• Migration of users and devices has started and is 20% complete • Migration of services during 2025	Amber
6	Windows 11 migration	DCEO	Oct 26	• Migration of client devices to latest supported operating system • Testing underway	Amber

	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	• Self-assessment against CAF to support development of actions for protection against threats, reviewed by division • Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex & two internal events with senior leaders • We have run in-house email phishing campaigns	• Regular quarterly security status report to IG Steering Group and every six months to Audit Committee	• RSM internal audits reports • Feedback from NHS Digital on Cyber Exposure score • Advice and guidance provided by third party security operation centre

1. Risk Summary

Reference & title	BAF 6: Failure to develop business intelligence limits insightful and timely analysis to support decisions.			Fit with Trust corporate priorities			
Description	It is likely there will continue to be delayed, inaccurate, or incomplete data analysis due to a failure to attract/recruit/develop business intelligence resource. The impact of this is significant/major, ultimately leading to poor decision-making or missed opportunities not meeting objectives and efficiency goals. Mitigating actions described will reducing the risk likelihood.			LOS	Workforce	Income	Bus Case	Digital
				✓	✓	✓	✓	✓
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed	30/01/2025		
Corporate Risk(s) aligned	• No current risks on the Corporate Risk Register that align							

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	4
Risk level	16

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4			
4			
16			

Rationale for current risk level
Evidence that provides assurance of current risk level

This risk has the potential to severely impact strategic decision-making and operational efficiency, as the failure to develop robust business intelligence capabilities can hinder timely and accurate insights. Such limitations are likely to have a high impact on both financial performance and patient outcomes. The likelihood of this risk materialising is considerable, given the rapid advancements in BI technologies and the growing demand for specialized talent, making it increasingly challenging to attract and retain the necessary expertise.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Over 2025/26, the risk level is expected to reduce from significant (16) to high (9). The target risk score of 9 is dependent on recruitment of BI staff. Recruitment has been challenging, however, a new targeted drive is underway, benefiting from an increased candidate availability in the region due to the national changes in the structure of NHSE and ICS. Internal development is also progressing, with team members taking on expanded roles, enhancing resilience and capability. Key upcoming mitigations:

- Fill vacant BI posts by end of Q4 2025/26 to boost analysis capacity; Implement improved self-service BI reports by end of Q3 2025/26 to reduce routine demands and focus on strategic analytics.
- Strengthen partner and consultancy support in Q2 and Q3 for expertise in key report development, data visualisation and advanced analytics.
- When the team is fully recruited, some team members will still require development - development completion will move the risk target score to moderate (6).
- Improvement on the reporting infrastructure (interdependency on Digital for data warehouse) will move the target risk score to low - this will not be achieved until Q1 2026/27.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Limited Data Integration: Challenges integrating data from disparate clinical systems/sources into a central data warehouse, resulting in incomplete or inaccurate insights.
- Insufficient Data Governance: Weak data governance practices that fail to ensure data quality, consistency, and security across systems.
- Outdated BI Tools: Use of outdated or incompatible BI tools that do not support advanced data analytics or real-time reporting.
- Fragmented Reporting: Ineffective reporting mechanisms that do not provide timely, accurate, or actionable insights to decision-makers.
- Inadequate BI Training Programs: Insufficient or outdated training for staff on BI tools and data management, leading to skill gaps and ineffective use of BI systems.
- 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.

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Enhance BI Structure and Investment	DCEO	Dec 25	Recruitment of BI staff has been challenging, but a new targeted drive is underway, benefiting from a tighter NHS job market and increased candidate availability. Internal promotions achieved, members taking on expanded roles, enhancing resilience and capability	Red

2	Update BI Tools	DCEO	Sept 25	Power BI Online Service implemented and SharePoint front end development complete	Green
3	Enhance BI Training Programs	DCEO	Dec 25	Continued Microsoft/NHS BI training uptake; targeted SQL and Power BI skills programme to complete by deadline	Green
4	Improve Reporting Mechanism, Automation First and Self Service	DCEO	March 26	• New developments are being produced on a web front automated first approach; including elective programme utilisation reporting, A&E , flow, quality and safety and theatre reporting. • Theatre reporting complete, Outpatient reporting in progress. • Scoping and requirements for other areas such as Radiology in progress	Amber
5	Engage External Partners	DCEO	Sept 25	BI consultancy and visualisation partnerships secured to accelerate key developments by deadline	Green
6	Design and Implement a New Data Warehouse	DCEO	March 26	Technology assessment and data migration planning are progressing to support delivery by the deadline. The upcoming implementation of the new PAS system over the next two years will significantly impact data structures and integration requirements. An agreed plan for the data warehouse approach pre-merger is needed to ensure alignment and reduce the risk of continuing data disparity. This will support clarity on interim and longer-term solutions in line with organisational priorities.	Red

	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	• Risk Assessment and Monitoring: Regular assessment and monitoring of BI-related risks, including evaluating the effectiveness of BI systems and controls. • Review of Risk Management Practices: Evaluating the effectiveness of risk management and compliance processes related to BI capabilities.	• Regular status and progress updates reported to ELT • Providing independent reports and recommendations to ELT and Executive Committee for review, regarding the adequacy of BI controls and risk management practices.	• Independent Audit review reports of BI Systems • Internal Audit review reports

1. Risk Summary

Reference & title	BAF 7: Failure to transform digitally and deliver associated improvements to patient care.				Fit with Trust corporate priorities				
Description	Failure to transform digitally and deliver associated improvements to patient care and develop a digital culture				LOS	Workforce	Income	Bus Case	Digital
					✓	✓	✓	✓	✓
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed	27/03/2025			
Corporate Risk(s) aligned	• No current risks on the Corporate Risk Register that align								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	4
Risk level	16

Current risk level *Assessment based on evidence*

Q1	Q2	Q3	Q4
3			
4			
12			

Rationale for current risk level *Evidence that provides assurance of current risk level*

To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources. However, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles.

The long-term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions. The progress on Electronic Patient Record (EPR) procurement has increased the level of engagement across the organisation as well as the need for digital and structured data.

Risk tolerance *Acceptable range/boundaries of risk score*

No higher than 16

Risk appetite *Amount/type of risk accepted/taken*

Seek

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Embedding clinical and operational staff within the digital system delivery is greatly supporting the digital culture across the organisation. Digital awareness across the organisation has greatly improved; divisions are looking to embed digital processes. EPR readiness work is underway to improve digital maturity across the organisation. The implementation of EPR/LIMS/OCS order comms should lead to a reduction of this risk rating.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust
- We need a training plan to increase digital literacy and add digital into all job descriptions

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	EPR implementation	CMO	Phase 1: July 26 Phase 2: July 27	• FBC signed off by national EPRIB Board on the 26th Feb 2025 • Contract negotiations complete and contract signed in March 2025 • A large number of posts being recruited to support implementation • Implementation started, initiation stage signed off • EmPoweR launch events started • End date of implementation will be July 2027	Green
2	Digital transformation roadmap to support digital strategy	DCEO	Aug 25	• New Strategy signed of by ELT waiting on alignment of the Trust priorities • To be presented for approval to Trust Board in August 2025	Green
3	Digital Literacy Assessment	DCEO	March 26	• Digital literacy assessment has started to be rolled out across clinical wards • Development of a plan to increase digital literacy • Developing links with education teams to embed digital literacy into workforce descriptions	Amber
4	Increase digital culture	DCEO	Ongoing	• Communications strategy and engagement • Multidisciplinary team working • Attendance at DMGs • Identifying a new Non-Executive Digital Champion	Green

	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	• Project Prioritisation Matrix used to track and manage priorities for digital • Process Mapping utilised to monitor and facilitate change acceptance and benefits management	• Regular reports to Exec, F&P & Trust Board • Regular presentation to Digital IPR • Reports to Transformation Board (monthly) • Regular reports to OMG • Regular reports to Digital Steering Group	• Capital Business cases reviewed by ICS • Internal audit review reports

1. Risk Summary

Reference & title	BAF 8: Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.			Fit with Trust corporate priorities					
Description	The Trust has large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition, there is a negative impact on patient experience as a result.			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety			Date last reviewed	26/03/2025		
Corporate Risk(s) aligned	• Risk of insufficient acute beds during winter								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4			
4			
16			

Rationale for current risk level

Evidence that provides assurance of current risk level

Evidence on a daily basis of the impact of greater than 200 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff.

Situation continues with large numbers of patients who are discharge ready and significant extra bedded capacity open including "supersurge" capacity.

In addition, it is necessary to pre-emptively place (board) additional patients on wards in corridors until a bed space is available.

Risk tolerance

Acceptable range/boundaries of risk score

No higher than 16

Risk appetite

Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

There are a variety of actions underway which form part of the length of stay programme which all aim to address this risk. If all of those programmes of work progress in a timely manner, we could cautiously expect the risk score to at least reduce to 16.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance
• Lack of suitable physical space for surge capacity and boarding • Lack of space for additional equipment for surge capacity and boarding • Lack of Adult Social Care capacity • Lack of Nursing Home capacity • Accuracy and timeliness of data on NerveCentre • Lack of mental health capacity resulting in stranded patients requiring mental health support and those with Significant Mental Illness (SMI)

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Ensure clinical areas are staffed as safely as possible	COO/ CNO/ CMO	Q4	• Workforce pressures remain • Escalation processes and de-escalation processes in place • MH Outreach HoN now in post and recruitment and onboarding of rest of team underway • Agreement to invest in therapy resource for inpatients with recruitment well underway and all posts recruited to	Amber
2	Ensure that patients are placed as safely and appropriately as conditions permit	COO/ CNO/ CMO	Q4	• All escalation areas remain open with additional supersurge capacity remaining open and boarding placement of patients.	Amber
3	Ensure complex/high risk patients are assessed and flagged appropriately	COO/ CNO/ CMO	Q2	• Meetings to review and escalate patients with LOS in excess of 7,14 and 21 and 100 days under review • As required on a case-by-case basis, divisions escalate particularly complex patients	Amber
4	Need to roll out and embed process for capturing and reporting on the impact of deconditioning (harm reviews)	CNO/ CMO	Q2	• Initial work demonstrated that a review of the process was/is required. This work is almost complete with plans to report in July/August.	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Daily capture and monitoring of escalation and supersurge capacity • System escalation calls to discuss the number of Super Surge patients being cared for at the Trust and the number of patients not meeting the criteria to reside	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P1-P3 patients with system partners • Clear oversight and responsibility for operational delivery, and of quality and safety • Monitoring of patients admitted over establishment and their location in the Trust using NerveCentre • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Quality and Safety Committee and Trust Board • Provider assurance meetings and system clinical quality review meetings

1. Risk Summary

Reference & title	BAF 9: Failure to meet the four-hour clinical standard.			Fit with Trust corporate priorities			
Description	Due to ongoing challenges with patient flow (there remain around 200 patients with No Criteria to Reside), there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.			LOS	Workforce	Income	Bus Case / Digital
				✓	✓	✓	
Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety		Date last reviewed	26/03/2025	
Corporate Risk(s) aligned	• Risk of insufficient acute beds during winter • FUOPA database risks loss to f/up • Unchaperoned ultrasound exams • Limited rad physics service support • Rising delays for paed dietetic appts	• Lack of external capacity spec path • Pharmacy capacity and med safety • Transgender records • Provision of a 24/7 blood sciences service • Nutritional equip supply problems		• NCPOD non-compliance bowel • Delayed f/up risks glaucoma • Audiology – sound treatment rooms • Inappropriate location for CYP			

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*				
	Q1	Q2	Q3	Q4
Likelihood	4			
Impact	4			
Risk level	16			

Rationale for current risk level

Evidence that provides assurance of current risk level

There is robust data/evidence on a daily basis that describes the length of time patients stay in the department and that the standard/ambition is not being met.

The risk rating remains at 20 for Q4 due to ongoing challenges to sustain overall performance. Non-admitted performance has improved, but no sustained improvement has been seen in length of stay, or in the overall number of patients with no criteria to reside.

Risk tolerance

Acceptable range/boundaries of risk score

No higher than 16

Risk appetite

Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

There are a variety of actions underway which form part of the length of stay programme which all aim to address this risk. If all of those programmes of work progress in a timely manner, we could cautiously expect the risk score to at least reduce from 16.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- We do not have a mechanism for immediately decompressing emergency departments.
- We cannot immediately respond to significant surges in activity.
- It is not easy or possible to see ward level length of stay data; this is only available by speciality.
- Unsure that workforce plan matches increase in activity.

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Continue to invest in Home First and community capacity and transformation of the acute footprint, including ongoing rollout of intermediate care wards.	COO	Q4	• Work is underway; we have on ICW already with plans for a second • We are reducing our acute footprint and investing in community services.	Amber
2	Priority actions identified and include work regarding culture, education and roles and responsibilities. (SAFER and Reconditioning work)	CNO	Q2	• Programmes of work clear and work underway on pilot areas re SAFER and Reconditioning • Likely a requirement for programme management – now in place • Part of the length of stay programme of work	Amber
3	Still working on KPIs and dashboard to support work on Length of Stay and internal/external processes e.g. wait times for therapies, Adult Social Care and Mental Health.	COO/ CNO	Q2	• As part of the refresh of the length of stay programme this needs complete review and refresh and will likely include other KPIs	Amber

	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	• Live bed state provides accurate information regarding occupancy and available bedded capacity • Breach compliance assurance across divisions • Long length of stay reviews across divisions • Complex/high risk patient reviews escalated to CMO/CNO/COO	• Bed strategy programme reporting through Use of Resources, with programme of work to reduce LOS in addition to areas described above	• Internal Audit Reports • Healthwatch feedback following visits • Family and Friends Test Feedback from ED patients

We now have an updated BAF and significantly more focussed risk register (June)

	POD – Frank Sims and CPO	F&P – Paresh Patel and CFO	Q&S – Amanda Fadero and CNO/CMO
BAF risks assigned to Board Sub-Ctees	1 Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time. 2 Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	3 We fail to use our resources as efficiently as possible and do not improve services for patients. 4 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. 5 Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack. 6 Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions. 7 Failure to transform digitally and deliver associated improvements to patient care.	8 Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay. 9 Failure to meet the four-hour clinical standard.
Associated CCR risks	**V&A in i/med care** (16) C Spokes	**Failing clinical environments** (15) J Hinkley **Maintenance standards** (15) M Chewter **Fire safety compliance (CQ)** (16) M Chewter **Fascia debris falls** (15) M Chewter **Power loss to critical areas** (16) J Hinkley **Fire safety EDGH compartment'n** (20) M Chewter **Insufficient isolation space** (16) C Hodgson **Insufficient decant when deep cleaning** (16) C Hodgson **Poor compliance with S&M reqmts** (15) M Clements **Cyber attack** (15) S Crouch **Server vulnerable to cyber attack** (16) P Ouston **Unpatched op systs vulnerable** (16) R Kumar **Limited Visibility/ Control over Network** 16) R Kumar **Bereavement system overload with data** (16) N Turner **Inadequate prep major/crit incident** (16) L Blackwell **Lack of capital** (20) A Strevens	**FUOPA database risks loss to fup** (16) D Garrett **Unchaperoned u/sound exams** (16) K Howe-Bush **Limited rad physics service support** (15) N Botros **Lack of external capacity spec path** (20) C H-Dunn **Pharmacy capacity & med safety** (16) S Badcott **Transgender records** (16) C Rodgers **Provision of a 24/7 blood sciences** (16) M Thomas **NCPOD non compliance bowel** (16) N McNeillis **Delayed f-up risks glaucoma** (16) I Woodward **Audiology- sound treatment rooms** (16) V Sharp **Inapprop location for CYP** (16) M Standen **Rising delays for paed dietetic appts** (20) H Perry **Nutritional equip supply problems** (16) H Perry **Insufficient beds in Winter** (16) G East

Agenda Item: 17

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	26th August 2025
Report Title:	Annual Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation		
Key question	What changes are proposed to the Trust's governing documents following their annual review?		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	**Presenter(s):**	Andrew Strevens, Chief Finance Officer
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Trust Board is asked to endorse the proposed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.		

Executive Summary

The Trust Board is required to review the Standing Orders, Standing Financial Instructions and the Scheme of Delegation on an annual basis. The proposed changes were reviewed and endorsed by the Audit Committee on 24th July 2025.

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 undertaken jointly by the Head of Financial Services and Board Secretary, with input from the Chief Finance Officer and Chief of Staff.

All of the documents were subject to a full review, and as a result a number of non-material changes, to improve clarity and consistency, were made throughout the documents to bring them up to date. The documents have been updated throughout to remove gendering (for example his/her) which has been replaced with neutral terminology.

In addition, a number of material changes are proposed to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation and these are detailed below.

	Standing Orders: • P20: Reference to the Trust Board establishing a Strategy and Transformation Committee has been removed. **Standing Financial Instructions:** • P42/43: Updated business case process has been included. • P44: Updated wording around the preparation of annual financial statements included • P69, 11.4: Added wording that any short-term external borrowing must 'be consistent with the overall cash flow position' of the Trust • P70/71: Updated capital expenditure proposal process included. • P88: Business case sign off process added in place of process map. **Scheme of Delegation:** • No material changes proposed. A full version of the documents, including tracked changes, can be found as an appendix to the Board papers.

Regulatory/legal requirement:	NHS organisations are required to have robust and effective governing documents.		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	None identified		
Risk:	None identified		
No of Pages	2	**Appendixes**	1
Governance and Engagement pathway to date:	The proposed changes have been reviewed and approved by the Chief Finance Officer and the Chief of Staff. The proposed changes were reviewed and endorsed by the Audit Committee on 24th July 2025.		
What happens next?	Subject to the Board's endorsement, the updated governing documents will be shared with colleagues and updated on the Trust's extranet.		
Publication	This report can be made public.		

Agenda Item: 19

Report To/Meeting	Trust Board	**Date of Meeting**	26th August 2025
Report Title:	Use of Trust Seal		
Key question	Has the Trust Seal been used since the last Trust Board meeting?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	**Presenter(s):**	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Board is asked to noted the use of the Trust Seal.		
Executive Summary	The Trust Seal has not been used to seal any documents since the last Board meeting in public.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	**Appendixes**	None
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

East Sussex Healthcare NHS Trust

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

Document ID Number	
Version:	~~V1.2~~V1.3
Ratified by:	Trust Board
Date ratified:	~~13th February 2024~~
Name of author and title:	~~Chief Financial Officer~~Chief Finance Officer & Chief of Staff
Date originally written:	January 2024
Date current version was completed	July 2025
Name of responsible committee/individual:	Trust Board / ~~Chief Financial Officer~~Chief Finance Officer & Chief of Staff
Date issued:	
Review date:	August 2026
Target audience:	All Staff
Compliance with CQC Fundamental Standard	N/A.
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	N/A

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1	January 2023	Pete Palmer	New Document	New Document
V1.1	May 2023	Pete Palmer	Internal Consistency	Changes made to values to ensure internal consistency within documents
V1.2	January 2024	Pete Palmer	Annual Review	Minor updates
V1.3	July 2025	Pete Palmer Lydia Crouch	Annual Review	SFIs amended to reflect Business Process, Capital and Revenue Process, and other minor adjustments. Other minor changes made throughout the governing documents.

Consultation Table

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

Name of Individual or group	Title	Date
ESHT Trust Board		13 February 2024
Audit Committee		25 January 2024
Lydia Crouch	Head of Financial Services	July 2025
Andrew Strevens	Chief Finance Officer	July 2025
Richard Milner	Chief of Staff	July 2025

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

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Foreword to Standing Orders

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

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

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

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

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

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

.

1. Introduction

Statutory Framework

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

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

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

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

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

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust takes into account the rights and pledges set out in the NHS Constitution which has the force of law

NHS Framework

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

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

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

Delegation of Powers

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

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

2. Interpretation

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which ~~he/she~~they 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~~They 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 Financ~~e~~ial 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~~who provide~~s~~ advice on corporate governance issues to the Board and the Chairman and monitor~~s~~ 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~~Chief Finance 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 Financeial 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 72 to 49 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/hertheir term as a member of the Trust, as they may specify on appointing him/herthem. 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/hertheir 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~~ their term as a Member of the Board, as they may specify on appointing ~~him~~them. 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)~~6 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~~They ~~is~~ are 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 Financeial Officer**

The Chief Financeial 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~~They 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~~Chief Information Officer etc).

3. Meetings

3.1 Calling Meetings

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

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

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

3.1.4 A member desiring a matter to be included on an agenda shall make ~~his/her~~their 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 on the Trust's website 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~~them at least three clear days before the meeting. The notice shall be signed by the Chairman, or by an officer authorised by the Chairman to sign on their behalf. Want of service of the notice on any member shall not affect the validity of a meeting.

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

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

3.3 Agenda and Supporting Papers

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

3.4 Petitions

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

3.5 Notices of Motion

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

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

3.6 Emergency Motions

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

3.7 Motions: Procedure at and during a meeting

3.7.1 **Who may propose?**

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

3.7.2 **Contents of motions**

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

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

3.7.3 **Amendments to motions**

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

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

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

3.7.4 **Rights of reply to motions**

a) <u>Amendments</u>

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

b) Substantive/original motion

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

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

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

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

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

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

3.8 Motion to Rescind a Resolution

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

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

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

3.10 Quorum

310.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is an officer member and one who is not) ~~is~~ are 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~~they think~~s~~ fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

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

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

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

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

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

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

3.17 Observers at Trust Meetings

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

Part 4 – Appointment of Committees and Sub Committees

4.1 Appointment of Committees

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

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

4.2 Suspension of Standing Orders

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

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

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

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

4.4 Terms of Reference

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

4.5 Delegation of powers by Committees to Sub-Committees

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

4.6 Approval of Appointments to Committees

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

4.7 Appointments for Statutory functions

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

4.8 Committees established by the Trust Board

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

4.8.1 Audit Committee

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

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One member should also be a member of the Quality and Safety Committee and one member a member of the Finance and ~~Investment~~ Performance 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~~Performance ~~-~~ Performance Committee

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

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

4.8.6~~7~~ **Inequalities Committee**
The Trust Board will establish an Inequalities Committee to provide a Board level focus on the Trust's broad approach to equality, both in staffing and service delivery.

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

4.8.7~~8~~ **Executive Committee**
The Trust Board delegates power to the Executive Team to oversee the management of an effective system of governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. They exercise this function in collaboration with senior operational colleagues through the Executive Committee.

4.8.8~~9~~ **Other Committees**
The Board may also establish such other committees as required to discharge the Trust's responsibilities.

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

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

5.1 Delegation of Functions to Committees and Officers
Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, in each

case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

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

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying ~~his/her~~their 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~~Chief Finance OfficerChief Finance 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~~Chief Finance Officer~~–~~ shall be accountable to the Chief Executive for operational matters.

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

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

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

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

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

6.1 Policy Statements General Principals

The Trust Board will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by East Sussex Healthcare NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust

Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Legislation, Policy and Guidance

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

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

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

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

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

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

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

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

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

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

7.2 Register of Interests

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

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

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

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

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

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

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

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

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

a) ~~he/she~~they, or a nominee of ~~his/her~~them, 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~~they ~~is~~ are 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~~they or any person connected with ~~him~~them/~~her~~ has any beneficial interest in the securities of a company of which ~~he/she~~they or such person appears as a member, or

b) any interest that ~~he/she~~they or any person connected with ~~him/her~~them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence ~~him/her~~them 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~~them) 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~~they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to ~~him/her~~them 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~~they ha~~s~~ve 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~~they ~~is~~ are 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~~their 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~~they will perform personally and shall nominate officers to undertake the remaining functions for which ~~he/she~~they 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~~they or any person connected with ~~him/her~~them (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~~Chief of Staff as soon as practicable.

ii. An officer should also declare to the Chief Executive or Chief of Staff any other employment or business or other relationship of ~~his/hers~~thiers, 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~~them 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~~Chief of Staff 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 S~~s~~tanding ~~f~~Financial ~~i~~Instructions.

8.3 Register of Sealing

The ~~Associate Director of Corporate Governance~~Chief of Staff or nominated Manager shall keep a register in which ~~he/she~~they, or another manager of the Authority authorised by ~~him/her~~them, shall enter a record of the sealing of every document.

8.4 Custody of Seal

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director. ~~The Associate Director of Corporate Governance may act as a counter signatory if required.~~

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

Part 9 – Miscellaneous

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

Appendix A – Schedule of decisions reserved to the Trust Board

Introduction

Standing Order 1.5 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, , which may include members participating by video or telephone." These powers and decisions are set out in this Schedule.

1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1. Approve, including variations to:

- 1.1.1. Standing Orders for the regulation of its proceedings and business.
- 1.1.2. this Schedule of matters reserved to the Trust Board.
- 1.1.3. Standing Financial Instructions
- 1.1.4. Scheme of Delegation, including financial limits in delegations, from the Trust Board to officers of the Trust.
- 1.1.5. suspension of Standing Orders

1.2. Determine the frequency and function of Trust Board meetings, including:

- 1.2.1. administration of public and private agendas of Board meetings
- 1.2.2. calling extra-ordinary meetings of the Board

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation ; and:

- 1.4.1. delegate functions from the Board to the committees
- 1.4.2. delegate functions from the Board to a director or officer of the Trust
- 1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies
- 1.4.4. receive reports from Board committees and take appropriate action in response to those reports
- 1.4.5. confirm the recommendations of the committees which do not have executive decision making powers
- 1.4.6. approve terms of reference and reporting arrangements of committees
- 1.4.7. approve delegation of powers from Board committees to sub- committees

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- 1.5.1. Appoint the Chief Executive
- 1.5.2. Appoint the Executive Directors

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests

1.7. Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.

1.9. Approve arrangements for dealing with and responding to complaints.

1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on Trust

1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. *Determination of strategy and policy*

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans
2.2.2. definition of the strategic aims and objectives of the Trust.
2.2.3. clinical and service development strategy
2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3. *Direct operational decisions*

3.1. Approve capital investment plans:

3.1.1. the annual capital programme
3.1.2. all variations to approved capital plans over £1 million
3.1.3. to acquire, dispose of, or change of use of land and/or buildings
3.1.4. capital investment over £2.5 million in value, supported by a business case and in line with the approval guidance issued by NHS England & Improvement.
3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k).

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5 million:

3.3.1. Tenders and quotations over the lifetime of the contract
3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement
3.3.3. Orders processed through approved supply arrangements
3.3.4. Orders processed through non-approved supply arrangements
3.3.5. Receipt of loans and trials equipment and materials
3.3.6. Prepayment agreements for services received

3.4. Decide the need to subject services to market testing

4. *Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

4.2.1. The Care Quality Commission
4.2.2. NHS Improvement

4.3. Consider and approve of the Trust's Annual Report including the annual accounts.

4.4. Approve the Annual report(s) and accounts for funds held on trust.

4.5. Approve the Quality Account

5. Audit arrangements

5.1. Approve audit arrangements recommended by the Audit & Risk Committee (including arrangements for the separate audit of funds held on trust).
5.2. Receive reports of the Audit & Risk Committee meetings and take appropriate action.
5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.
5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit & Risk Committee, where appropriate.
5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

ENDS

Appendix B – Standing Financial Instructions

1. Introduction

1.1 General

1.1.1 The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs). There will be a training and communication program administered by the ~~Chief Financial Officer~~Chief Finance 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 their financial transactions are carried out in accordance with the law and Government policy 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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/~~They 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 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**~~**Chief Finance 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~~Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors 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~~ their official capacity, or for showing favour or disfavour to any person in ~~his~~ their 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 (SOs) 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 and Social Care, 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~~Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is the 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~~Chief Finance 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, 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~~Chief Finance 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 the~~S,~~ 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 people are made aware of this.

1.3.10 For all members of the Board and employees who carry out a financial function, the form in which financial records are kept and the way members of the Board and employees discharge their duties must be to the satisfaction of the ~~Chief Financial Officer~~Chief Finance 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. 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 considering 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~~Chief Finance Officer in the first instance.)

2.1.3 It is the responsibility of the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer

2.2.1 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 and Social Care.

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~~Chief Finance 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~~Chief Finance Officer. The reporting system for internal audits shall be agreed between the ~~Chief Financial Officer~~Chief Finance 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 should be reviewed at least every 3 years.

2.3.5 The Audit Manager shall report directly to the ~~Chief Financial Officer~~Chief Finance Officer who shall refer to 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 NHS England (NHSE) if it cannot be resolved.

2.4.2 The Trust will not purchase any non-audit services from its appointed external auditor unless required to do so by NHSE or the Department of Health and Social Care.

2.5 Fraud and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and ~~Chief Financial Officer~~Chief Finance 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 Anti-Fraud, Bribery, and Corruption 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~~Chief Finance 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 Anti-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 and Social Care 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 and Social Care 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~~Director of Estates ~~(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 considers financial targets and forecast limits of available resources and is in accordance with the guidance issued by ~~NHSI~~ NHSE.

The annual plan content and the number of submissions is defined by ~~NHSI~~NHSE. 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~~Chief Finance 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~~Chief Finance Officer shall monitor financial performance against budget and business plans, periodically review them, and report to the Board. Consequently, the ~~Chief Financial Officer~~Chief Finance Officer shall have the right to access all budget holders on budgetary related matters.

3.1.5 All budget holders must provide information as required by the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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 projects 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~ NHSE 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:~~It is the responsibility of the Executive lead for the respective areas to ensure the Business Case sign-off process is followed. A Business Case Brief (BCB) is required that explains the need for service change, the key reasons driving the change, and any indicative costs, with a full Business Case being necessary if the BCB is approved and the service change is more than £50,000. The Business Case sign off process is as follows:

a) A BCB should be developed and submitted to the relevant Integrated Performance Review (IPR) for approval.

b) IPR supported cases of less than £50,000 can be implemented from existing budget, supported by the Business Planning Team.

c) IPR supported cases of more than £50,000 per annum should proceed to production of a full Business Case led by the author and supported by the Business Planning Team.

d) The completed Business Case must be submitted to the Operational Management Group (OMG) for approval.

e) OMG supported Business Cases of less than £500,000 must be presented to the Executive Committee for approval.

f) For OMG supported cases over £500,000 must be submitted to the Finance and ~~Productivity~~Performance Committee (F&P).

g) For business cases over £2,500,000 approval is also required from the Board.

h) Any business case exceeding £5,000,000 must be presented to NHSE for approval.

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~~Chief Finance 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;~~

a) prepare financial statements that meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which is agreed by HM Treasury. Accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view is selected.

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 in line with the national timetable.

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~~Chief Finance 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 consider 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer.

5.4 Tendering and Review

5.4.1 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~ NHSE and the DHSC guidance in setting prices for NHS contracts e.g. "NHS National Tariff Payment Scheme."

6.2.2 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~ NHSE 'Capital investment and property business case approval guidance' and 'Estatecode' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with relevant ~~Department of Health~~DHSC 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 ~~Department of Health~~DHSC 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~~Chief Finance Officer is satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

i) where statutory payment can only be made to a specific statutory body (e.g. rates), authorisation of the bodies considered in this category will be determined by the ~~Chief Financial Officer~~Chief Finance Officer and Head of Procurement.

j) where payment is to another NHS body and the Head of Procurement and ~~Chief Financial Officer~~Chief Finance Officer ~~-~~is satisfied that the procurement arrangements conform to current statute and deliver value for money;

k) where payment is less than the current Public Procurement Threshold for Goods & Services and is for the renewal of maintenance services under an original supplier contract to provide equipment or IT and the ~~Chief Financial Officer~~Chief Finance Officer and Head of Procurement is satisfied that the

procurement arrangements conform to current statute and deliver value for money;

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

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

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

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

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

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

d) when the task is essential to complete the project, and arises ~~as a consequence~~because 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~~Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the cost~~ing~~ of such work.

g) where allowed and provided for in the Capital ~~Regime~~, i~~I~~nvestment and p~~P~~roperty ~~B~~business ~~C~~case ~~A~~approval ~~G~~guidance.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a

consultant originally appointed through a competitive procedure (except in circumstances outlined in 7.5.3 (d) above)

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

7.5.5 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 7.1, 7.5.3 and 7.5.4 don't apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than **three** firms/individuals (unless demonstrated to be a restricted market), having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.6 Building and Engineering Construction Works

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

7.5.7 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in Standing Financial Instructions for which formal tendering procedures are not used, and which subsequently prove to have a value above such limits, should 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~~DHSC guidance and, in minor respect, 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~~ their 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~~Chief Finance 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/her/them~~their 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 clients' 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 considered 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 is clearly stated.

iii) No tender shall be accepted which will commit expenditure ~~in excess of~~more than 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~~more than the current market rate/price 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 the appropriate manager with a copy of their safety policy and evidence of the safety of plants and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

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

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

7.6.10 Should a tender be stopped due to supplier objection, injunction or other valid reason and then a new tendering process commenced, the reinvolvement of any staff member involved in the original process should be reviewed before any involvement in the new process.

7.7 Quotations: Competitive and Non-Competitive

7.7.1 General Position on Quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income is reasonably expected to exceed £25,000 but not exceed £70,000, excluding VAT.

7.7.2 Competitive Quotes

(i) Where possible requests for Quotations over £25,000 excluding VAT shall be logged using an e-tendering portal.

(ii) Quotations should be ~~invited~~ collected 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/her/~~their 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/her/~~their 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~~if 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~~more than 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~~Chief Finance Officer.

7.8 Authorisation of Tenders and Competitive Quotations

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

(Please note that the UK Public Procurement Threshold (for supplies and services – £139,688 incl VAT)

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

Value of the Public Procurement Threshold	• Individual responsible for the Budget as per scheme of delegation
From The Public Procurement Threshold to £500,000 excl VAT	• Individual responsible for the Budget as per scheme of delegation
From £500,000 to £2,500,000 excl VAT	• Individual responsible for the Budget as per scheme of delegation • ~~Chief Financial Officer~~Chief Finance Officer and Chief Executive
Value of £2,500,000 or above excl VAT	• Operational Management Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget as per scheme of delegation • ~~Chief Financial Officer~~Chief Finance Officer and Chief Executive

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

Value of the Public Procurement Threshold	• Individual responsible for the Budget as per scheme of delegation
From the Public Procurement Threshold to £500,000 excl VAT	• Individual responsible for the Budget as per scheme of delegation • Executive Directors and Director responsible for the Budget
From £500,000 to £2,500,000 excl VAT	• Operational Management Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget

	as per scheme of delegation; and • ~~Chief Financial Officer~~Chief Finance Officer and Chief Executive; and • Finance & ~~Productivity~~Performance Committee
Value of £2,500,000 or above excluding VAT	• Operational Management Group (Revenue) and/or Capital Resource Group (Capital); • Individual responsible for the Budget as per scheme of delegation; and • ~~Chief Financial Officer~~Chief Finance Officer and Chief Executive; and Finance & ~~Productivity~~Performance Committee; and • Trust Board and Common Seal of the Trust

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

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

If there is any doubt about whether proposed expenditure falls outside of the £139,688 incl VAT then please seek advice from the Procurement team.

The Executive Team is authorised to respond to short notice national capital bids. For any elements over £5m the Chief Executive will have consulted the Chair of the Board before preparing a bid.

For the avoidance of doubt the Finance & ~~Productivity~~Performance 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~~Chief Finance 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~~NHSE 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 based on ~~the basis of~~ competitive tendering or quotations.

7.11 Compliance Requirements for all Contracts

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

a) The Trust's Standing Orders and Standing Financial Instructions;

b) The Public Contracts Regulations 2015 and other statutory provisions;

c) Any relevant directions including the Capital Investment ~~Manual~~and Property Business Case Guidance, Estatecode and guidance on the Procurement and Management of Consultants;

d) ~~Such of t~~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 using 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 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 Foundation Trust, being a Public Benefit Contract (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~~their 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 should 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~~Chief Finance 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 work, 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 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~~consider:

- 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~~ between appropriate stakeholders~~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 risks 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 and Appointments Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting, (see NHS guidance contained in the Higgs report).

9.1.2 The Committee will:

a) provide assurance to the Board around the process for appointing and dismissing all executive directors of the Board, including the chief executive;

b) agree the remuneration package, including performance related pay and other terms of service of the Chief Executive, including the scheme for performance related pay and any other benefits;

c) with the Chief Executive, agree the remuneration packages, including the scheme for performance related pay and other terms of service (including severance terms of applicable) of the executive directors and 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-engaged, 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer's instructions and in the form prescribed by the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 seeking 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~~Chief Finance Officer (and/or the Chief Executive) shall be consulted.

10.2.2 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 ~~in order for payment~~arithmetically correct;
- the account is for payment.

iii) A timetable and system for submission to the ~~Chief Financial Officer~~Chief Finance 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 prepayment agreement unable to meet ~~his~~ their commitments;

c) the ~~Chief Financial Officer~~Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (considering The ~~Public Contracts Regulations 2015~~Procurement Act 2023 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~~they 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~~Chief Finance 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 Financ~~eial~~ Officer.

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 finance leases requires written approval from the ~~Chief Financial Officer~~Chief Finance Officer~~.~~.

b) contracts above specified thresholds are advertised and awarded in accordance with The Procurement Act 2023~~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~~while undertaking working visits;

iii) any employee receiving any offer or inducement will notify their line manager as soon as practicable and 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 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~~Chief Finance 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~~Chief Finance Officer in financial procedures, and purchases from petty cash or on purchasing 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~~Chief Finance 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~~Chief Finance Officer ; and

l) petty cash records are maintained in a form as determined by the ~~Chief Financial Officer~~Chief Finance Officer.

10.2.7 The Chief Executive and ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer which shall be in accordance with this Act.

11. External borrowing

11.1 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 to 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~~Chief Finance Officer~~.~~.

11.3 The ~~Chief Financial Officer~~Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period ~~of time~~ possible, be consistent with the overall cash flow positions, 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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. This 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**, if the total expenditure falls within the capital allocated to that category (e.g. 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 Business Case Brief (BCB) approved by the Capital Resource Group (CRG) and confirmed in plan;~~ that there is a completed Business Case Brief (BCB) approved by the Capital Resource Group (CRG) and confirmed in plan;

b) Replacement assets with capital expenditure proposals above £500,000 will also need to be approved by Finance and ~~Productivity~~Performance ~~Performance~~ Performance Committee;

c) Replacement assets with capital expenditure proposal above £2,500,000 are also approved by Board; and

d) Replacement assets with capital expenditure proposals above £5,000,000 are also approved by NHSE.

13.1.4 For every **investment asset** capital expenditure proposal 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~~Performance ~~Committee for approval.~~~~

~~d) for all investment asset projects over £500,000 excluding recoverable VAT the Project Director will be required to co-ordinate and complete a monthly capital monitoring return to Capital Resource Group (CRG) showing performance against budget.~~

~~f) for all investment asset projects over £2,500,000 excluding recoverable VAT the business case will be submitted to the Trust Board for approval~~

a) for investment assets less than £50k the Project Lead must complete a Business Case Brief (BCB), and this is submitted for consideration at the relevant Divisional IPR. If supported, BCB will require CRG approval.

b) for investment assets where proposed capital expenditure is more than £50,000 a full Business Case (BC) must be developed and requires approval at Operational Management Group (OMG), and Executive Directors Committee.

c) the BC for investment asset projects over £500,000 also requires approval at Finance and ~~Productivity~~Performance Committee (F&P) .

d) the BC for investment asset projects over £2,500,000 also requires approval by Board.

e) Any BC for investment asset projects over £5,000,000 requires approval by NHSE.

Project Lead will be required to provide a monthly capital forecast and phasing of planned expenditure throughout the project through to completion. Monthly monitoring is required by Capital Resource Group (CRG) showing performance against budget and risks to financial delivery.

13.1.5 The table below summarises the approval requirements for capital cases:

	Documentation			Approval						
	Capital Plan	Business Case Brief (BCB)	Business Case (BC)	IPR	OMG	Executive Directors	F&P	Board	NHSE	CRG
Replacement	✔	✔	-	All	-	< £500k	< £2,500k	< £5,000k	> £5,000k	All
Investment	✔	✔	> £50k	All	All	All	< £2,500k	< £5,000k	> £5,000k	All

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~~His Majesty's Revenue and Customs guidance.

The ~~Chief Financial Officer~~Chief Finance 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:

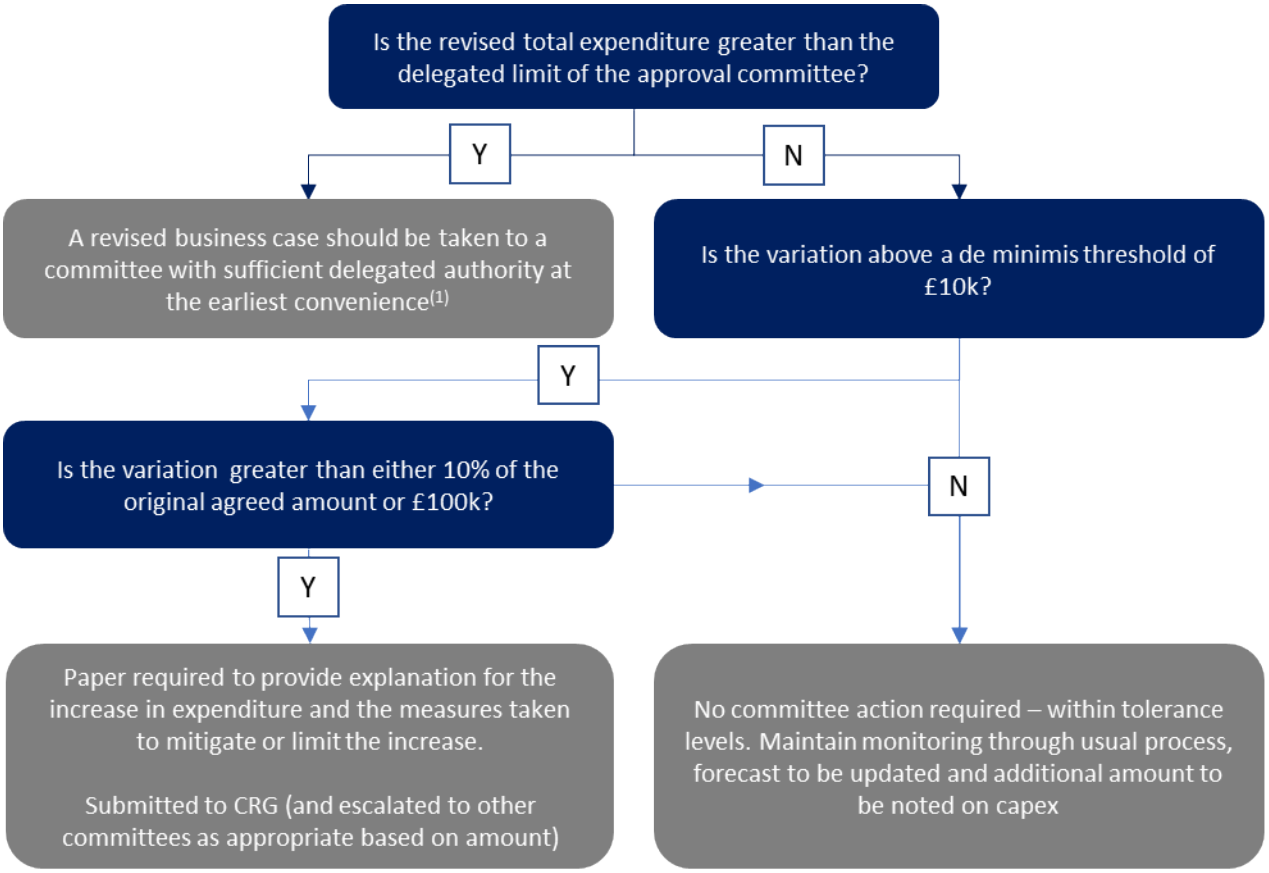
a) specific authority to commit expenditure;
b) authority to proceed to tender;
c) approval to accept a successful tender.

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~~Chief Finance 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~~consider 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~~Performance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer. This procedure shall make provisions 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~~Chief Finance 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 department stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stock take; and

c) valued at the lower of cost and net realisable value.

14.2 Subject to the responsibility of the ~~Chief Financial Officer~~Chief Finance 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/~~them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer.

14.7 The Head of Procurement/Pharmaceutical Officer shall be responsible for a system approved by the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer ;

b) recorded by the Condemning Officer in a form approved by the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer.

15.1.4 The Condemning Officer shall satisfy ~~himself/herself/~~themselves as to whether there is evidence ~~or not~~ of negligence in use and shall report any such evidence to the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer prior to any offer for sale.

15.2 Losses and Special Payments

15.2.1 The ~~Chief Financial Officer~~Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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 more than £10,000, the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interest in bankruptcies and company liquidation~~s~~.

15.2.8 For any loss, the ~~Chief Financial Officer~~Chief Finance Officer should consider whether any insurance claim can be made.

15.2.9 The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~they ~~is~~ are responsible from accidental or intentional disclosure to unauthorised people, 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~~they may consider necessary are being carried out.

16.2 The ~~Chief Financial Officer~~Chief Finance Officer shall satisfy himself/herself/themselves 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 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~~most Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 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~~Chief Finance 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~~Chief Finance Officer shall satisfy ~~him/her/~~themselves 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~~Chief Finance 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~~Chief Finance 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 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~~Chief Finance Officer.

17.5 In all cases where property of a deceased patient is of a total value more than £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~~Chief Finance Officer and Chief of Staff shall ensure that each charitable fund which the Trust is responsible for managing is managed appropriately regarding its purpose and to its requirement.

18.2 Accountability to Secretary of State for Health and other bodies

1) The trustee's 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 acting.

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 being retrieved by authorised people.

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 the risks covered by the risk pooling schemes. If the Trust Board decides not to 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 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 an 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~~Chief Finance Officer shall ensure that the arrangements entered are appropriate and complimentary to the risk management programme. The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured because of this decision. The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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 excl 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~~fewer than three tenders are received.

22.2.3 If the required number of tenders ~~is~~ are not received, whether to proceed with the contract~~, it~~ will be at the discretion of:

- the Chief Executive **or** the ~~Chief Financial Officer~~Chief Finance Officer above **£70,000 excluding VAT** to The Public Procurement Threshold; and
- the Chief Executive **and** the ~~Chief Financial Officer~~Chief Finance 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 excl 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 excl 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~~Chief Finance Officer or the Chief Executive.

iii) For tenders from **The Public Procurement Threshold up to £500,000 excluding VAT** Head of Procurement and the ~~Chief Financial Officer~~Chief Finance Officer and the Chief Executive.

iv) For tenders from **£500,000 to £2,5000,000 excluding VAT** the Audit Committee

v) For tenders above **£2,500,000 excluding VAT** the Trust Board

22.4.3 Any waiver request must be submitted on the requisite form and, after authorisation, must accompany the requisition sent to the Head of Procurement.

22.4.4 The ~~Chief Financial Officer~~Chief Finance Officer will establish and maintain a register of Waivers to Standing Orders.

22.5 Expenditure Authorisation

22.5.1 All requisitions that result in an order for goods and services must be approved in accordance with the scheme of delegation.

22.5.2 In the case of contracts which have a life in excess of one year, the approval value applies to the total value of the contract.

22.6 Capital Expenditure

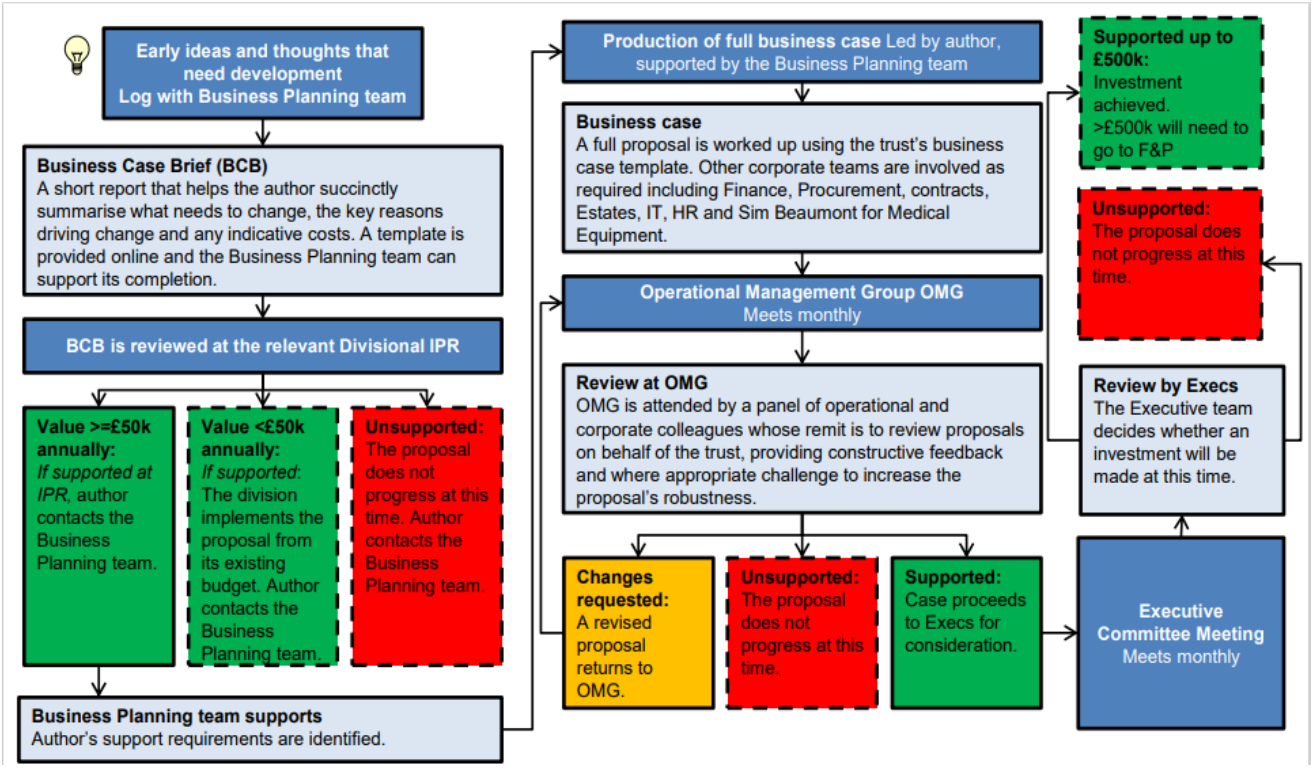
22.6.1 There are specific requirements for every capital expenditure proposal ~~in excess of £100,000~~; see section 13.1.2.

22.7 Monetary Values

22.7.1 All values, thresholds and limits contained within this document must refer to VAT exclusive prices except where specifically mentioned.

22.7.2 The Public Procurement Threshold are available from https://www.legislation.gov.uk/uksi/2021/1221/regulation/3/made

CAPITAL AND REVENUE PROCESS



Business case sign-off process

Where	When	Why	How
IPR Monthly (Week 3)	All	To provide support for the concept as set out in the brief for full development and/or to agree minor changes up to £50k expenditure.	• Submit a Business Case Brief (BCB) to IPR • A number of sign-offs are required on the form
Operational Management Group (OMG) 1st Friday of the month	>£50k or if there is a high-risk, sensitive, political or potentially contentious proposal	To act as a gateway for execs to ensure accuracy, consistency and completeness of a business case as well as providing subject matter expertise on operational, finance, contracts, IT, procurement and estates. OMG "recommends" to EDs.	• Draft a Business Case (BC) document • Obtain all relevant pre-approvals (please ensure Divisional leadership has approved) • Submit to esht.businessplanning@nhs.net • Attend next OMG for questions/comments
Executive Directors Committee (ExCom) 2nd Wednesday of the month	>£50k or if there is a high-risk sensitive, political or potentially contentious proposal	To provide approval for a case from an executive management perspective, to ensure Trust leadership is fully sighted and aligned. Approval up to £500k, otherwise recommend to F&P.	• Submit to ExCom through Executive Sponsor (most likely for Divisions this is the COO) to esht.businessplanning@nhs.net who will arrange for a timeslot on the agenda • Cover sheet is also required • Generally paper deadline is Monday for the Wednesday
Finance & Productivity Committee (F&P) Generally last Thursday of the Month	>£500k	To provide check and challenge to the Executive Decision through a subset of Trust Non-Executive Directors. Approval up to £2,500k, otherwise recommend to Board.	• Notify esht.businessplanning@nhs.net that paper is coming (as early as possible) they will arrange for it to be included on the agenda • Exec Director sponsor to submit paper to F&P admin chriskyprianou@nhs.net. Cover sheet is also required • Deadline is Tuesday in week 3 generally
Trust Board Bi-monthly, second Tuesday	>£2,500k	Case is so material that it requires full Trust Board approval where all Non-Executive Directors are present.	• Notify Corporate Secretariat peterpalmer@nhs.net that paper is coming for Agenda (as early as possible, agenda's can get busy) • Cover sheet is also required • Exec Director sponsor to submit. • Deadline is two weeks in advance for public board and one week for private.

This process is cumulative, a paper should have gone through all previous steps

Reference
1. Section 3.7 of SFIs (Standing Financial Instructions) sets out the limits for Trust approval
2. Further information available on the Business case page (or type business case into the intranet search bar)

Waiver of Standing Orders

Reason for Request to Waive Standing Orders:	Please Tick
1 Competitive tenders/quotations were sought insufficient responses returned	
2 Only provider of goods/services	
3 Genuine reason for continuity or compatibility	
4 Risk where timescales/urgency genuinely exceed time required to competitively tender/obtain quotes	
5 Director/Deputy Director of Finance	
6 Retrospective expenditure - goods/services have already been received	
7 Quotes/tenders not obtained due to clinical/technical preference	
8 Market tested and most economical providers not selected	
9 Agency expenditure exceeding the NHSI allowable price caps	

Full written details and justification must be provided in the "Supporting Information" section on the reverse of this form before this waiver request will be considered for approval.

The current limits set by East Sussex Healthcare NHS Trust under which competitive quotations/tenders are required are defined in the Standing Financial Instructions. These are as follows:

Up to £25,000 (ex VAT)	1 Verbal quotation.
£25,001 to £70,000 (ex VAT)	Minimum of 2 invitations to quote.
£70,001 (ex VAT) to The Public Procurement Threshold	Minimum of 3 invitations to tender.
Above the Public Procurement Threshold	Minimum of 4 invitations to tender with at least 2 received.

The waiver authorisation limits are (ex VAT):

For quotations £25,001 to £70,000	Head of Procurement or ~~Chief Financial Officer~~Chief Finance Officer or Chief Executive.
For tenders £70,001 to Procurement Threshold	~~Chief Financial Officer~~Chief Finance Officer or Chief Executive.
For tenders Procurement Threshold to £500,000	Chief Executive **and** ~~Chief Financial Officer~~Chief Finance Officer.
For tenders £500,001 to £2,500,000	Audit Committee via Chair/~~Chief Financial Officer~~Chief Finance Officer.
For tenders over £2,500,000	Trust Board.

In accordance with East Sussex Healthcare NHS Trust's Standing Order number 9.5, I request a waiver of the requirement to obtain competitive quotations/tenders in respect of Requisition Number: _____

Name of Supplier: _____

Description of goods/services: _____

Total value of goods/services: Exc. VAT _____ Inc. VAT _____

Department for which goods are required: _____

Conflicts of interest/subsequent measures taken: _____

CERTIFICATION BY SENIOR BUSINESS MANAGER		HEAD OF PROCUREMENT VERIFICATION **PRIOR** TO APPROVAL BY A DIRECTOR	
Signature:	Date:	Signature:	Date:
Title:	Department:		

APPROVAL OF WAIVER

I/We hereby approve this waiver

Signatures authorising the waiver of Standing Orders.

Signature:	**Signature:**	**Signature:**
Designation:	**Designation:**	**Designation:**
Chief Executive	**Director of Finance**	**Head of Procurement**
Date:	**Date:**	**Date:**

Procurement & Supplies use only Waiver Register Number:	Waiver Register Entry By:	Date:

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DETAILED SUPPORTING INFORMATION This section **must** be completed in all instances. Insufficient information may result in the waiver being returned unauthorised.		
a) Brief description of goods/services: **b) Justification:**		
Has lowest quotation been accepted?	**Yes / No** (Delete as appropriate)	If "No" – reason for accepting higher quotation:
Will this be the subject of a future, formal procurement competition?	**Yes / No** (Delete as appropriate)	If yes, please state when - if "No", please state reason below:
If previously procured, last price paid (if known):	**£**	If previously procured, please state when (if known):
List alternative providers (if any) and reason for not considering:		
Consequences of non-approval of this waiver:		

Please note:

- **All Trust expenditure is subject to Public Sector Procurement Regulations and transparency rules. The information detailed on this form is subject to audit and challenge.**
- **All breaches to Trust Financial policies will be investigated and reported to the Audit Committee.**

ENDS

Appendix C – Scheme of Delegation

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
N/A	The Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 (Emergency Powers). 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

SCHEME OF DECISIONS RESERVED TO THE BOARD

Section 1

Reference	The Board	Decisions Reserved to the Board
N/A	The Board	15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6 17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
N/A	The Board	**Appointments/Dismissal** 1. Ratify proposals of the Remuneration and Appointments 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Operational responsibility for effective and sound financial management and information.
15	Chief Executive	Primary duty to see that ~~Chief Financial Officer~~Chief Finance 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 Finance Officer Chief Medical Officer Chief Nurse and Chief of Staff	Chief Executive, supported by ~~Chief Financial Officer~~Chief Finance 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 and Appointments Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main board.
1.3.2.5	Chairman	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner; 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration and Appointments Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee and any other sub-Committees of the main Board; and 7. advise the Secretary of State on the performance of Non-Executive Board members.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

Section 1

Reference	Delegated To	The Codes of Conduct and Accountability – Authorities/Duties Delegated
1.3.2.5	Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	Non-Executive Directors	Non-Executive Directors are appointed by 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~~their 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~~Chief Finance Officer	Training and communication programme for staff on SFIs.
1.1.3	~~Chief Financial Officer~~Chief Finance Officer	Approval of all financial procedures.
1.1.4	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Ensure an adequate internal audit service, for which ~~he/she~~they ~~is~~ are 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Preparation of annual accounts
4.3	Chief of Staff	Preparation of annual report
5.1.1	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Report waivers of tendering procedures to the Audit Committee.
7.6.2	~~Chief Financial Officer~~Chief Finance Officer	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.4	Chief Executive & ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer .
7.15	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services
8.3	~~Chief Financial Officer~~Chief Finance Officer	Ensure that regular reports are provided to the Board detailing actual and forecast contractual income
9.1.1	Board	Establish a Remuneration and Appointments Committee.
9.1.2	Remuneration and Appointments Committee	Take decisions under delegated authority on the remuneration and terms of service of the Chief Executive, other officer members and 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 and Appointments 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~~Chief Finance 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~~Chief Finance Officer
10.1.2	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer if problems are encountered).
10.2.5	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer .
10.2.7	Chief Executive ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	The ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer).
11.3	~~Chief Financial Officer~~Chief Finance Officer	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	Chief Executive or ~~Chief Financial Officer~~Chief Finance Officer	Be on an authorising panel comprising one other member for applications for short term borrowing.
11.7.2	~~Chief Financial Officer~~Chief Finance Officer	Will advise the Board on investments and report, periodically, on performance of same.
11.7.3	~~Chief Financial Officer~~Chief Finance Officer	Prepare detailed procedural instructions on the operation of investments.
12.1	~~Chief Financial Officer~~Chief Finance Officer	Ensure that Board members are aware of the Financial Framework and ensure compliance.
13.1.1 & 13.1.2	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Performance 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~~Performance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.7	~~Chief Financial Officer~~Chief Finance Officer	Ensure that a review of asset lives is undertaken annually.
13.4.1	~~Chief Financial Officer~~Chief Finance Officer	Overall responsibility for fixed assets.
13.4.2	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer, and reporting losses in accordance with Trust procedure.
14.2	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Set out procedures and systems to regulate the stores.
14.5	~~Chief Financial Officer~~Chief Finance Officer	Agree stocktaking arrangements.
14.6	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer evidence of significant overstocking.
14.8	~~Chief Financial Officer~~Chief Finance Officer	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	~~Chief Financial Officer~~Chief Finance Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.

15.2.1	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Notify CFOS and External Audit of all frauds.
15.2.5	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Consider whether any insurance claim can be made.
15.2.9	~~Chief Financial Officer~~Chief Finance Officer	Maintain losses and special payments register.
16.1	~~Chief Financial Officer~~Chief Finance Officer	Responsible for accuracy and security of computerised financial data.
16.2	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance 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~~Chief Finance	Ensure each charitable fund is managed appropriately with regard to its purpose and to its requirement.

	Officer and Chief of Staff	

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 the Trust's 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~~Chief Finance Officer	Where the Board decides to use risk pooling schemes or commercial insurers the ~~Chief Financial Officer~~Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ~~Chief Financial Officer~~Chief Finance Officer shall ensure that documented procedures cover these arrangements.
21.6	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer will draw up formal documented procedures to cover these arrangements.
21.7	~~Chief Financial Officer~~Chief Finance 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~~Board Secretary
2.	Receiving Hospitality, Gifts and Sponsorship other than isolated gifts of a trivial nature or conventional hospitality Applies to both individual and collective hospitality receipt items	Declaration required in Trust's Hospitality Register – all Trust Directors and Employees	N/A
3.	The keeping of the Interests, Hospitality, Gifts and Sponsorship Register	Chief of Staff	~~Associate Director of Corporate Governance~~Board Secretary
4.	Quotation, Tendering and Contract Procedures Subject to the requisitioner's responsibility always to obtain best value for money for the Trust, the minimum requirements for goods/services are: **For spend within current budget:**		
	a) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	Authorised Budget Signatory and Purchasing and Supplies Buyer
	b) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
	c) **£70,001** excluding VAT to **te prevailing Public Procurement Threshold**– invite 3 written quotations.	Head of Procurement together with ~~Chief Financial Officer~~Chief Finance Officer	Authorised Budget Signatory and Head of Procurement
	d) **Above the prevailing Public Procurement Threshold** up to **£500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	~~Chief Financial Officer~~Chief Finance Officer or Chief Executive
	e) **£500,001** to **£2,500,000**	Executive Directors' Meeting	~~Chief Financial Officer~~Chief Finance Officer or Chief Executive
	f) **Over £2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Executive Directors' Meeting	

		~~Chief Financial Officer~~Chief Finance Officer and Chief Executive
For new spend		
g) Up to **£25,000** – one written quotation.	Director for appropriate budget or General Manager	Authorised Budget Signatory and Purchasing and Supplies Buyer
h) **£25,001** up to **£70,000** excluding VAT– invite 2 written quotations	Head of Procurement	Authorised Budget Signatory and Head of Procurement
i) **£70,001** excluding VAT to **the prevailing Public Procurement threshold**– invite 3 written quotations.	Head of Procurement together with ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer or Chief Executive
k) **£500,001** to **£2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Finance and ~~Productivity~~Performance Committee	Finance and ~~Productivity~~Performance Committee
l) **Over £2,500,000** – a minimum of 4 Invitations to Tender with at least 3 received (where such number of suppliers exists). See also SFI 22.2.2 and 22.2.3	Trust Board	Trust Board and Common Seal of the Trust

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
The waiver authorisation limits are:		
a) For quotations	Chief Executive.	Head of Procurement
b) For tenders **£70,001 excluding VAT** to the **Public Procurement threshold**	Chief Executive or ~~Chief Financial Officer~~Chief Finance Officer	N/A
c) For tenders from the **Public Procurement threshold** up to **£500,000**	Chief Executive and ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	Deputy ~~Chief Financial Officer~~Chief Finance Officer
c) Granting and termination of leases	Director for appropriate budget.	N/A
11. Authority to open Bank Accounts	~~Chief Financial Officer~~Chief Finance Officer	N/A
12. Management of the Investment of Charitable Funds within the approved investment strategy	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Manager responsible for the budget together with the ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b)	Authority to appoint staff to post not on the formal establishment	Chief Executive (approval at Executive Directors' meeting)	N/A
c)	The granting of additional increments to staff within budgets	Chief Executive	Manager responsible for budget with the Chief People Officer
d)	All requests for upgrading/re-grading shall be dealt with in accordance with Trust Procedure	Chief Executive	Payroll Manager
e)	<u>Establishments</u>		
	i) Additional staff to the agreed establishment with specifically allocated finance	Director for appropriate budget or General Manager	Manager responsible for budget
	ii) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	N/A
f)	<u>Pay</u>		
	i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Director for appropriate budget or General Manager	Authorised Budget Signatory
	ii) Authority to complete and authorise positive reporting forms	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iii) Authority to authorise overtime	Director for appropriate budget or General Manager	Authorised Budget Signatory
	iv) Authority to authorise travel and subsistence expenses	Director for appropriate budget or General Manager	Authorised Budget Signatory

	v) The approval of merit awards and discretionary points to Consultant and Associate Specialist staff	Remuneration and Appointments Committee of the Board	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
g) Leave – 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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Director for appropriate budget or General Manager together with Chief People Officer	N/A
ii) Return to work part-time on full pay to assist recovery	Director for appropriate budget or General Manager together with Chief People Officer	Manager responsible for the budget
iii) Extension of sick leave on full pay	Chief People Officer together with Chief Executive	N/A
i) Study Leave (Medical staff included in para 14.g.vi) above		
i) Any Study leave outside the UK	Chief Executive	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~~Chief Finance 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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
l)	Renewal of Fixed Term Contract	Manager responsible for the budget	N/A
m)	Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief People Officer	N/A
n)	Redundancy	Chief People Officer together with ~~Chief Financial Officer~~Chief Finance Officer . Approval is required from the Remuneration and Appointments 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

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
b) Where aggregate commitment in any one year is more than **£35,000 excluding VAT**. (Note: Tender Procedure and approval for any consultancy spend must be cleared with region by the ~~Chief Financial Officer~~Chief Finance Officer)	Chief Executive	Director for appropriate budget
18. Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods and Services		
a) Non-Pay Expenditure for which a specific budget has been set up and which is subject to funding under delegated powers of virement.		
i) Value to the Public Procurement Threshold	Chief Executive	Manager responsible for the budget
ii) From the Public Procurement Threshold to £2,500,000	Chief Executive and Director for appropriate budget	N/A
iii) Value of £2,500,000 or above	Common Seal of the Trust	N/A
In the case of contracts which have a life in excess of one year, the above limits apply to the total value of the contracts.		
b) Non-Pay Expenditure for which specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive and ~~Chief Financial Officer~~Chief Finance Officer	N/A

	c)	Commitments/orders exceeding 12 month period	~~Chief Financial Officer~~Chief Finance Officer or Chief Executive	Manager responsible for the budget
	d)	Variations to contract for goods and services	Director for appropriate budget or General Manager.	Manager responsible for the budget together with Purchasing and Supplies Department Senior Buyer

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
	e) Approving expenditure > order price up to 10%	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Senior Buyer
	f) Approving expenditure > order price by more than 10%		
	i) AND the variance is <£1,000	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Category Manager
	ii) AND the variance is >£1,000	Director for appropriate budget or General Manager together with Head of Procurement	Manager responsible for the budget together with Deputy Head of Procurement or Head of Procurement
19.	Petty Cash Disbursements		
	a) Expenditure up to £50 per item	Director for appropriate budget or General Manager	Authorised Budget Signatory
	b) Reimbursement of patients monies held up to £100	Hospital Cashier	N/A
	c) Pay advances up to £50	Payroll Manager or Payroll Team Leader	Senior Payroll Clerk
	d) Urgent exceptional payments in excess of the above limits	Head of Financial Services	N/A
20.	Management and Control of Stocks		
	a) Pharmaceutical Stocks	~~Chief Financial Officer~~Chief Finance Officer	Designated Pharmaceutical Manager

b)	Theatres	~~Chief Financial Officer~~Chief Finance Officer	Theatres Manager
c)	Estates	~~Chief Financial Officer~~Chief Finance Officer	Estates Manager
d)	Eastbourne Hospital Services	~~Chief Financial Officer~~Chief Finance Officer	Manager responsible for budget
e)	General	~~Chief Financial Officer~~Chief Finance Officer	Manager responsible for budget

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
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~~Chief Finance Officer	N/A
b) Fruitless Payments (including abandoned Capital Schemes)		
i) Up to £100,000	Chief Executive and ~~Chief Financial Officer~~Chief Finance 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~~Chief Finance 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~~Chief Finance Officer	N/A
Special Payments		
e) made under legal obligation	Chief Executive and ~~Chief Financial Officer~~Chief Finance Officer	N/A

EAST SUSSEX HEALTHCARE NHS TRUST – DETAILED SCHEME OF DELEGATION

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
f) Extra Contractual payments to contractors	Chief Executive and ~~Chief Financial Officer~~Chief Finance Officer	N/A
g) Ex-Gratia Payments		
i) Patients' dentures repaired or replaced through the Community Dental service	~~Chief Financial Officer~~Chief Finance Officer	Trust Solicitor
ii) Dentures and spectacles repaired or replaced < £500	~~Chief Financial Officer~~Chief Finance Officer	Trust Solicitor
iii) Dentures and spectacles repaired or replaced > £500	~~Chief Financial Officer~~Chief Finance Officer	Trust Solicitor
iv) Other ex gratia claims < £500	~~Chief Financial Officer~~Chief Finance Officer	Trust Solicitor
v) Other ex gratia claims > £500	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Trust Solicitor
ii) Property Expenses Scheme	~~Chief Financial Officer~~Chief Finance Officer	Trust Solicitor

i) Settlements on termination of employment – to a limit of £50,000	Chief Executive and ~~Chief Financial Officer~~Chief Finance Officer and Chief People Officer. Approval is required from the Remuneration and Appointments Committee.	N/A
j) Other, except cases of maladministration	Chief Executive and ~~Chief Financial Officer~~Chief Finance 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~~ Board Secretary 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~~ Board Secretary and Authorised Signatory
24. Management and Control of Computer Systems		
a) Financial Data	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer
26. Review the Trust's compliance with the Access to Health Records Act	Chief Medical Officer as Caldicott Guardian	~~Chief Financial Officer~~Chief Finance Officer
27. Retention of Records	Chief of Staff	Trust Solicitor
28. Insurance Policies	Chief Executive and ~~Chief Financial Officer~~Chief Finance Officer	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Head of Contract Income
31. Maintenance and Update on Trust Financial Procedures	~~Chief Financial Officer~~Chief Finance Officer	Technical Accountant

Section 2

Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
32. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Chief Operating Officer	Accommodation Manager
b) Extensions to existing agreements/licences	}	}
c) Letting of premises to outside organisations	} Chief Executive and/or responsible Director	} } N/A }
d) Approval of rent based on professional assessment	}	
33. Reporting of Incidents to the Police or Local Counterfraud service		
a) Where a criminal offence is suspected	Director responsible for the service or department	Each Trust Employee
b) Where a fraud is involved	~~Chief Financial Officer~~Chief Finance 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~~Chief Finance Officer	Trust Solicitor
35. Relationships with Press		
a) General Enquiries	Chief of Staff	Communications Team
b) Emergency	On-call Director	On-call Manager

Section 2

	Delegated Matter	Authority Delegated To	Lowest Level to Which Authority May be Delegated
36.	Facilities for staff not employed by the Trust to gain practical experience		
	Professional Recognition, Honorary Contracts, and Insurance of Medical Staff	Chief People Officer	Clinical Tutor, Post-Graduate Medical Education and HR Manager
	Work experience students	Chief People Officer	Manager responsible for the budget
37.	Review of fire precautions	Director of Estates and Facilities	Nominated Fire Manager
38.	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Chief Nurse	Health and Safety Manager
39.	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Estates and Facilities	Estates Manager and Waste Manager

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Entire document, to ensure that it remains in line with best practice	Richard Milner / ~~Damian Reid~~Andrew Strevens	Annual review by finance, procurement and governance teams	Annual	Trust Board	Audit Committee	Audit Committee

In addition to the delegated matters detailed above the executive team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility and in those key functions, supported by consistent evidence.

Collectively, the team is responsible for providing the systems, processes and evidence of governance and ensuring that these are reviewed, maintained and any gaps closed and that this is reflected in their regular updating of the assurance framework, coordinated by the director of corporate services.

The team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the assurance framework.

The team are responsible for monitoring the risk register at corporate level.

The responsibilities of individual posts are set out in the post holders' job descriptions.

Delegated Authority for the Expenditure of Charitable Funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory + ~~Charity Manager~~Board Secretary
£1,000 to £5,000	One fund signatory + ~~Charity Manager~~ Board Secretary + 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.

1. Equality and Health Inequalities Assessment Statement

Guidance on completing an EHIA and the current template can be found via **Equality and Diversity Extranet page**.

Appendix A: Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and polices do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty

Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

- eliminate discrimination

- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty
The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. “Due regard” means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

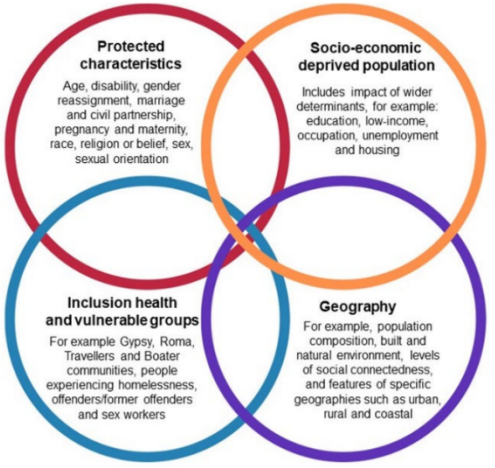
Health Inequalities Duties- Equity for all
In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

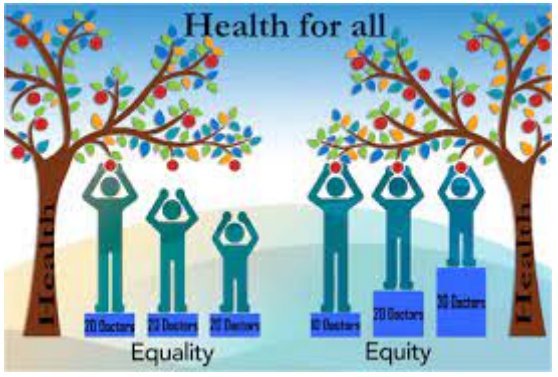
Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same good outcomes for everyone, or whether we might need to make some tweaks or adjustments to enable everyone to benefit equally. The health tree diagram shows that unless we think about the needs of different people, equal services might generate unequal outcomes.

The Health Tree[1]

Factors associated with poorer health outcomes (PHE 2021)[1]



[1] https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914



The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on MyLearn before completing this EHIA.

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. **Function/policy/service name and number:**			
Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):	The Trust's governing documents set the manner in which the Trust Board and Trust operates, the overarching rules for financial governance and the levels to which authority may be delegated within the organisation.		
How will the function/policy/service change be put into practice?	The updated governing documents will be shared with specific teams, such as finance and procurement, and placed on the Extranet so that they are available for all staff.		
Who will be affected/benefit from the policy?	This policy applies to all staff		
State type of policy/service	Policy ☐	Service	
	Business Case	Function	Existing
Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions such as routine procedures	Yes ☐		
	No ☐ (If no state reasons)		
Accountable Director: (Job Title)	Chief Finance Officer		
Assessment Carried out by:	Name: Peter Palmer		
Contact Details:	peterpalmer@nhs.net		
Date Completed:	16.07.25		

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties
For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised
Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

There is no potential impact on protected characteristics from this policy as it is applicable to all members of ESHT staff

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Age: older people; middle years; early years; children and young people.	N/A	This policy applies to all ESHT staff	
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	N/A	This policy applies to all ESHT staff	
Gender Reassignment and/or people who identify as Transgender	N/A	This policy applies to all ESHT staff	
Marriage & Civil Partnership: people married or in a civil partnership.	N/A	This policy applies to all ESHT staff	
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.	N/A	This policy applies to all ESHT staff	
Race:	N/A	This policy applies to all ESHT staff	
Religion and belief: people with different religions/faiths or beliefs, or none.	N/A	This policy applies to all ESHT staff	

Protected characteristic groups	Summary explanation of the *potential* positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Sex:	N/A	This policy applies to all ESHT staff	
Sexual orientation	N/A	This policy applies to all ESHT staff	
Veterans/Armed Forces Communities	N/A	This policy applies to all ESHT staff	

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact**. If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health inequalities[2]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.			

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies your may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally
Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	**No**

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please **add an x** to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?			
Uncertain whether the proposal will support?	x	x	x

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?		
Uncertain if the proposal will support?	x	x

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1		
2		
3		

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	**Peter Palmer**	**Date: 16.07.25**
Line Manager of person completing:	**Richard Milner**	**Date: 16.07.25**

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health inequalities[3]	**Summary explanation of the potential positive or adverse impact of your proposal**	**How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback**	**Action that will be taken to address the potential for negative impact.**
Looked after children and young people			
Carers of patients			

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.			
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.			
People with addictions and/or substance misuse issues			
People or families on a low income			
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).			
People living in deprived areas			
People living in remote, rural and island locations			
Refugees, asylum seekers or those experiencing modern slavery			

Groups who face health inequalities[3]	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
People who have served in the Armed Forces			
Other groups experiencing health inequalities (please describe)			

EHIA Resources
Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data
State of the County 2021 Focus on East Sussex

East Sussex JSNA

Community Insight

Further Reading on Equality and Health Inequalities

Training