East and North Hertfordshire NHS Trust
Public Trust Board

Hertford County Hospital, Hertford County Rooms 3&4, North Road , Hertford, Hertfordshire, SG14 1LP
4 May 2022 10:00 - 4 May 2022 12:30

AGENDA

#	Description	Owner	Time
1	STANDING ITEMS		
2	Chair's Opening Remarks	Chair	10:30
3	Apologies for Absence		
4	Declaration of Interests	All	
5	Minutes of Previous Meeting For approval 5. Draft Public Board Minutes 2 March 22.docx 7	Chair	
6	Actions Log For information 6. Public Trust Board Actions Log.docx 19	Trust Secretary	
7	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, stuart.dalton3@nhs.net, by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
8	Staff Story For discussion	Chief People Officer	10.35

#	Description	Owner	Time
9	Chief Executive's Report For discussion 9. CEO Report.docx 21	Chief Executive	10:50
10	Board Assurance Framework For discussion 10. BAF.pdf 23	Trust Secretary	10:55
11	Integrated Performance Report - Finance Update For discussion 11. IPR - M12 2021-22_20220429.pdf 57	All Exec Directors	11:00
11.1	Ambulance Handovers for discussion		
12	STRATEGY & CULTURE		
13	System Collaboration Update For discussion 13. System Collaboration update.pdf 101	Deputy CEO & Director of Finance	11.25
14	Trust Strategy For discussion 14. Trust Strategy.pdf 107	Deputy CEO & Director of Finance	11.30
15	Staff Survey For discussion 15. Staff Survey review.pdf 127	Chief People Officer	11.40
16	Elective Recovery For discussion 16. Elective Recovery update.pdf 143	Planned Care Managing Director	11.45
17	ASSURANCE AND GOVERNANCE SECTION		

#	Description	Owner	Time
18	Annual Report and Accounts, Annual Governance Statement and External Auditor's Report - Approval Process For approval 18. ARA delegated authority.docx 157	Deputy CEO & Director of Finance	12:00
19	New Committee Structure For discussion 19. Committee Structure SO and ToR.pdf 159	Trust Secretary	12:05
20	Ockenden Update For discussion 20. Ockenden Report Final.pdf 243	Chief Nurse	12:10
21	Learning from Deaths For discussion 21. Learning from Deaths Report.docx 251	Medical Director	12:20
22	Sub-Committee Reports		12:25
22.1	Finance, Performance and People Committee Report to Board30th March 202227th April 2022 For noting 22.1a FPPC Board Report 30 March 22 (sent to Ell... 259 22.1b FPPC Board Report 270422 approved by Ch... 263	Chair of FPPC	
22.2	Quality and Safety Committee Report to Board29 March 202229 April 2022 For noting 22.2a QSC Board Report 29 March 22 Chair Appro... 267 22.2b QSC Board Report 260422 Approved by Cha... 271	Chair of QSC	
22.3	Audit Committee Report to Board7 April 2022 For noting 22.3 Draft Audit Committee Board Report 070422.d... 275	Chair of Audit	

#	Description	Owner	Time
22.4	Charity Trustee Committee Report to Board For noting [P] 22.4 CTC Board Report 7 March 22 Chair Approve... 279	Chair of Charity Trustee Committee	
22.5	Equality & Inclusion Committee Report to Board For noting [P] 22.5 EIC Board Report 15 March 2022 - to May 202... 283	Chair of Equality & Inclusion Committee	
23	Annual Cycle For discussion [P] 23. Draft Board Annual Cycle 2022-23 Final.docx 287	Trust Secretary	
24	Any Other Business		
25	Data Pack For noting		
26	Date of next meeting 8 June 2022 - Board Seminar 6 July 2022 - Trust Board		

East and North Hertfordshire NHS Trust

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 2 March 2022 at 10.30am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Non-Executive Director
	Dr Peter Carter	Non-Executive Director (via MS Teams)
	Ms Val Moore	Non-Executive Director (via MS Teams)
	Mr Jonathan Silver	Non-Executive Director (via MS Teams)
	Dr David Buckle	Non-Executive Director (via MS Teams)
	Mr Biraj Parmar	Non-Executive Director (via MS Teams)
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Michael Chilvers	Medical Director (via MS Teams)
	Mrs Rachael Corser	Chief Nurse (via MS Teams)
	Mrs Julie Smith	Chief Operating Officer (via MS Teams)
From the Trust:	Mr Thomas Pounds	Chief People Officer (via MS Teams)
	Ms Jude Archer	Associate Director of Governance (via MS Teams)
	Mr Mark Stanton	Chief Information Officer (via MS Teams)
	Mr Kevin Howell	Director of Estates & Facilities (via MS Teams)
	Mr Kevin O'Hart	Director of Improvement (Via MS Teams)
Also in attendance:	Mr Stuart Dalton	Trust Secretary
	Ms Eilidh Murray	Head of Communications (ENHT) (via MS Teams)
	Ms Cecile Gascon	Ward Leader 9B (MS Teams) (Item 22/034)
	Ms Ruth Bradford	Admiral Nurse (MS Teams) (Item 22/034)
	Ms Katie Chilton	Head of Midwifery
	Helen Bates	For Patient Story (MS Teams) (Item 22/034)
	Julia Smith	Assistant Trust Secretary (MS Teams) (Minutes)

No	Sub-No	Item	Action
22/028		**CHAIR'S OPENING REMARKS**	
	22/028.1	The Chair informed the Board that this would be the last Board meeting the Chief Operating Officer attended before she left the Trust. The Chair thanked the Chief Operating Officer for her hard work, dedication and commitment to the Trust and wished her every success in her new Chief Executive role.	
22/029		**APOLOGIES FOR ABSENCE**	
	22/029.1	No apologies were noted.	
22/030		**DECLARATIONS OF INTEREST**	

22/030.1 There were no declarations of interest.

22/031 MINUTES OF PREVIOUS MEETING

22/031.1 The minutes of the previous meeting held on 12 January 2022 were **APPROVED** as an accurate record of the meeting.

22/032 ACTION LOG

22/032.1 There were no outstanding actions on the Action Log.

22/033 QUESTIONS FROM THE PUBLIC

22/033.1 There were no questions submitted from the Public.

22/034 PATIENT STORY

22/034.1 The Chief Nurse introduced Joyce's daughter Helen and daughter-in-law Anne to the Trust Board meeting and thanked them for agreeing to share Joyce's story with the Board.

22/034.2 The Chief Nurse explained that Ward 9B was an acute elderly ward and in October 2021 were awarded a silver accreditation, it was noted the significant value of the staff, volunteers and leadership. One area of focus had been a recommendation for improved communication and how families were communicated with, which the ward staff had since spent a lot of time developing.

22/034.3 Joyce was a 79 year old female patient with mild Alzheimer's. Joyce lived alone and was mobile and able to care for herself except for cooking. Joyce was brought in by ambulance on 21st December 2021, the crew were aware of her Alzheimer's diagnosis. She was admitted to the ward on 22nd December 2021 for severe back and hip pain. The Doctors called Joyce's family to discuss Joyce's wishes and whether if the situation arose she would want to be resuscitated.

22/034.4 Joyce was put on medication to manage her pain but she remained scared and confused. Because of the Covid pandemic, visiting had been restricted to one hour per day, this was where her family continued to reassure her she was in the right place. The pain medication made it difficult for Joyce to function and she slept a lot of the time.

22/034.5 Joyce's family asked to speak to a doctor but one was never available when the family were able to visit. The family felt there was a skeleton staff on the ward and wanted to understand what was being done to support Joyce. The ward staff were aware of Joyce's family's desire to speak to someone and some of the staff stayed beyond their shift to discuss Joyce with them. Joyce's daughter Helen had then received a call to say Joyce would be discharged but when this was clarified with the ward staff they were unsure and the family felt there was mixed communication.

22/034.6 Joyce's mobility had significantly deteriorated and her family didn't

think she was getting the nutrition she needed. Joyce was catheterised and was then fully dependent on others. Following an Xray the Doctor didn't believe Joyce would walk again.

22/034.7 On January 9th 2022 the ward made a referral to the Admiral nurse who Joyce's family described as a life saver. The Admiral nurse was the liaison between the ward and the family and provided the reassurance the family needed. Joyce was discharged and the Admiral nurse ensured her pain relief was moved with her to ensure Joyce was managed with dignity and independence at home.

22/034.8 The Chief Nurse highlighted the learnings that had been made due to Joyce's experience which included: ward staff confirming with families on day 1 when it is best to communicate with them; the sharing of the dementia strategy to raise the profile of the Admiral nurse; ward staff accepted they could have done better and would in future spend more time with families; accurate and timely communication was important for patients, families and staff.

22/034.9 Mrs Schroder thanked Joyce's family for attending the meeting and allowing the Chief Nurse to share their story. She apologised for their experience and commented to the Board that there was excellence elsewhere in the hospital and needed to ensure it was standard across the hospital.

22/034.10 Mrs Schroder commented that the presence of the Admiral nurse had been so important and that it would be helpful to introduce her earlier in a patients care. Mrs Schroder reiterated that the Trust tried to learn from all situations and accepted that there could always be improvement.

22/034.11 The Medical Director commented that through Covid the Trust had learnt that different models of communication were required and more scheduled communication between ward staff, doctors and families. He thanked Joyce's family.

22/034.12 The Chief Executive commented that Joyce's story demonstrated how broad the concept of care was and how challenging it could be caring for patients and their families. He thanked Joyce's family for their input and the opportunity for the Trust to learn. He thanked the ward team for being open to learning.

22/034.13 The Admiral nurse commented that she had seen some good caring practices on ward 9B. She explained to the Board that she was the only Admiral nurse and wanted to support families as well as role model good dementia care and deliver formal training for staff as well as providing the best care for dementia patients.

22/034.14 Mrs Schroder thanked the team and Joyce's family and passed on the best wishes of the Trust for Joyce's recovery and improved mobility.

22/035 CHIEF EXECUTIVE'S REPORT

22/035.1 The Chief Executive explained to the Board that he had spent some time with the Clinical Technologist team at Mount Vernon Cancer Care (MVCC). He said it was fascinating how technology was driving clinical practice and used the robotic surgery in Urology as a good example.

22/035.2 The Chief Executive explained to the Board that the number of Covid patients in critical care remained low however over 50 Covid positive patients remained in the hospital. He said managing these patients in isolation added complexity and thanked the site team who managed them daily.

22/035.3 The Chief Executive informed the Board that the Trust had treated a significant number of Covid patients with anti-virals who were at high risk of complications. He said the Nightingale as part of the national response to managing the pandemic would be taken down and the Plaza restored. He thanked the Executive Directors and the operational and clinical staff for their involvement and the speed of their response.

22/035.4 The Chief Executive congratulated the Gastroenterology team for being awarded Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation for endoscopy services. To achieve the accreditation, the team had demonstrated they met best-practice quality standards.

22/035.5 Mrs Schroder asked that the Board congratulations were shared with all of the teams mentioned.

22/035.6 Mrs Schroder commented that the Trust's robotic surgery had undertaken the Country's first robotic Thyroidectomy.

22/035.7 The Board **RECEIVED** and **NOTED** the CEO's report.

22/036 BOARD ASSURANCE FRAMEWORK

22/036.1 The Associate Director of Governance informed the Board that all risks continued to be reviewed and scrutinised through the Board sub-committees and there had been no specific recommendations.

22/036.2 The Associate Director of Governance highlighted the Operational risks around performance to the Board and explained the risk was rated at 20 but it would be reviewed to ensure there were sufficient assurances to reduce the risk to a score of 16.

22/036.3 The Associate Director of Governance informed the Board that the Quality and Safety Committee had a robust conversation about the Quality risk. It had been recognised that although the overall risk hadn't moved, the profile of the risk continued to change. She said it was due to the new and emerging risks that the overall risk had maintained its level.

22/036.4 The Associate Director of Governance informed the Board that the Internal Audit of the Board Assurance Framework and Corporate

Risk Register had given reasonable assurance.

22/036.5 Mrs Schroder commented that there would be work undertaken on the Trust's governance structures and the governance risk would need to be reviewed.

22/036.6 Mrs Schroder explained to the Board that the Operational risk had an impact of 10, she said this had been updated two years ago and the risk may need to be reconsidered and a single risk centred on recovery be developed. The Associated Director of Governance informed the Board that the Covid detail would go into the recovery risk.

22/036.7 The Board **RECEIVED** and **NOTED** the Board Assurance Framework.

22/039 INTEGRATED PERFORMANCE REPORT

22/039.1 The Director of Finance introduced the Month 10 Integrated Performance Report and noted that the areas of focus would be Responsive, People, Safe and Caring and Effective.

22/039.2 **Responsive Services**

The Chief Operating Officer highlighted the following:

22/039.3 A paper on elective recovery would be presented at a future Board meeting which would drive improvement.

22/039.4 Cancer

- 62 days Cancer wait metric positioned the Trust third nationally with a performance of 87.3% against a target of 85% for December.
- Tumour sites for Breast and Lung Cancer remained challenging alongside upper and lower GI and Haematology.
- There was an upward trend for diagnostic tests and the capacity modelling and pathway delays would be reviewed to drive improvement.

22/039.5 ED

- Performance for the ED waiting time for January was 69.78% against a target of 95%. Action plans for improvement were in place and the ED team continued to push for improved performance.
- There had been ambulance handover delays and the Trust were participating in a rapid release programme for category 2 patients waiting for an ambulance. It was anticipated this would deliver improvement to the ambulance delays.
- There would be a review of the strategy for the ED space with separate areas for Covid and non-Covid patients. The additional space funded by the successful Capital bid would promote more

efficient urgent and emergency care pathways.

22/039.6 Stroke

- The Sentinel Stroke National Audit Programme (SSNAP) performance had been subject to significant scrutiny including a deep dive of performance, mortality and patient experience. Work continued and although there had been no visible benefits of the actions in place to date, in-month had seen an improvement in the number of patients receiving Thrombolysis.
- An action plan was in place to recover performance which included working with the Integrated Stroke Delivery Network (ISDN), learning best practice from other Acute Trusts who had maintained their Stroke front door performance and the recruitment of additional Therapists.

22/039.7 **People**

The Chief People Officer highlighted the following:

22/039.8 January had been a challenging month for the People team as the transmissibility of the Omicron variant had posed a risk to the number of staff being deployed. There had been enough staff placed to provide care during the period.

22/039.9 There remained a focus on vacancies as the overall vacancy rate had increased. This had been in part due to a change in Establishment rather than an increase in vacancy rates.

22/039.10 Temporary and Bank staff were highlighted for the valuable contribution they made to the Trust.

22/039.11 Turnover had increased at 13.8%. Reflections indicated that this would be due to Pandemic delayed retirements and staff having the time to reassess. There would be a focus on staff experience and creating a thriving environment.

22/039.12 Sickness absence saw an expected increase to 6.3% which had been largely Covid related.

22/039.13 **Safe and Caring**

The Chief Nurse highlighted the following:

22/039.14 As a reflection of Covid and Omicron reported figures of below 80% had been reported for ward fill-rates.

22/039.15 There had been an increase in the number of cases of hospital onset of Covid which had a significant impact on the hospital. All cases would be investigated and the learning widely shared. Across the region the Trust benchmarked against other Trusts favourably and the numbers remained below trajectory.

22/039.16 Complaints and patient experience remained a focus as the services continued to recover and respond to patient needs. The number of complaints acknowledged within three days was positive however

the number of open and overdue was high. Plans to address the backlog had been developed and would be monitored through Division.

22/039.17 **Effective**

The Medical Director highlighted the following:

22/039.18 A reduction in the rolling 12 months crude mortality was reported from 14 to 12.49 deaths per 1000 admissions which was lower than the national rate of 14.4 deaths per 1000 admissions (Jan 21 – Dec 21).

22/039.19 CHKS rebased their Hospital Standardised Mortality Ratios (HSMR) data and as a result the Trust moved into the second quartile. There would be a meeting with CHKS to understand the data in more detail.

22/039.20 The in-month HSMR had improved from 93.36 in October to 88.02 in November with a further decline expected in the coming month.

22/039.21 The Summary Hospital-level Mortality Indicator (SHMI) was unaffected by the rebase and remained in Band 3 category which was lower than expected.

22/039.22 The Covid mortality was average against the national figures.

22/039.23 **Sustainability**

The Director of Finance highlighted:

22/039.24 The Trust continued to perform well within the Covid funding framework and it was expected a full delivery against the statutory targets would be achieved for the current financial year.

22/039.25 The consistency for the financial environment provided the Finance team time to plan for the 2022/23 financial year which would be a more challenging financial environment.

22/039.26 Mrs Schroder asked if there were more flexible ways of working that could be offered to improve staff retention, turnover and sickness. The Chief People Officer explained to the Board that flexibility for staff at stages of their lives was being developed with leaders understanding staff as individuals with specific motivations and how the best solution could be achieved. He said flexible options were being considered such as home and hybrid working.

22/039.27 The Chief Executive commented that urgent and emergency care was an area where system working was successful. He said understanding success would be influenced by the performance of others where mutual aid was happening. He asked that moving forward the comparator graph to highlight partner performance.

22/039.28 The Board **RECEIVED** and **NOTED** the Month 10 Integrated Performance Report

STRATEGY REPORTS

22/040 **SYSTEM COLLABORATION UPDATE**

22/040.1 The Director of Finance presented the paper and highlighted to the Board that provider collaboration would be an important area of the system and framework moving forward. He said there had been discussion to explore this at an ICS level and there would be workshops ahead of a formal arrangement which would be reported to the Board.

22/040.2 The Director of Finance informed the Board that Pathology was a long running project which had gone out to "best and final offer" with system partners and as a project would move to the Finance, Performance and People committee for evaluation before being presented to Board in June/July.

22/040.3 Mrs Schroder commented that the ICS was building a structure for Executive and non-Executive staff alongside a large recruitment programme. She said Place based partnerships would need to be stronger and ICS would devolve decision making to Place based partnerships. Mrs Schroder said the Trust would retain Sovereign obligations to fulfil patient and financial responsibilities. She asked that the Board members remained informed on the ICS structure.

22/040.4 The Board **RECEIVED** and **NOTED** the System Collaboration update.

22/041 **DIGITAL STRATEGY UPDATE**

22/041.1 The Chief Information Officer informed the Board that the previously named Digital Aspirants programme had been updated to the Frontline Digitisation programme which was aimed at levelling up NHS Trusts. He said the Secretary of State had announced that 90% of Trusts would need to be at level 5 by December 2023. The Chief Information Officer explained to the Board that additional information would be required to determine if the timeline was realistic and a business case would be presented at a later Board meeting.

22/041.2 The Chief Information Officer explained to the Board that the previous integration conversations with NHSX had moved on to Convergence conversations with NHSE/I which would continue to evolve. He said Convergence had defined a single system across the ICS recommending a new EPR.

22/041.3 The Chief Information Officer explained to the Board that the ePMA system had gone live and other than minor teething issues, the launch had been successful.

22/041.4 Mrs Schroder asked if a new EPR would be NerveCentre, Lorenzo, a combination of both systems or the procurement of a new system. The Chief information explained to the Board that it would likely be a new procurement but there wasn't a single product in the market that

could deliver. He said if one of the Trusts existing platforms was chosen then it would be built around.

22/041.5 Ms Moore congratulated the Digital team on the strategy and commented that the Patient and Carer Committee had discussed the use of QR codes to better navigate services and to provide disease advice and asked if this was in the Digital vision. The Chief Information Officer explained to the Board that the roadmap would support compliance and patient flow and individual departments, the next level would support specific department Apps and other initiatives.

22/041.6 The Chief Nurse thanked the Digital team for supporting the ambition to keep patients safe. She said the one-click smart cards had saved nurses a lot of time and made a big difference on the wards.

22/041.7 The Board **RECEIVED** and **NOTED** the Digital Strategy update.

ASSURANCE AND GOVERNANCE REPORTS

22/042 OCKENDEN ONE YEAR ON – PROGRESS UPDATE

22/042.1 The Chief Nurse informed the Board that the Trust had reported compliance with the action plan and the team had implemented an improvement plan to address the gaps within the urgent and essential actions. She said good progress had been made which continued to be monitored via internal scrutiny and external colleagues both at the CCG and nationally.

22/042.2 The Chief Nurse explained to the Board that the Morecambe Bay actions continued to be embedded within the service and were demonstrated within the maternity workforce plan to reflect the investment in the expansion of the workforce.

22/042.3 Mrs Schroder congratulated the team for having evidenced 112 of 122 actions. She said the consultant led ward rounds was a major commitment and two additional whole time equivalent consultants would be expensive as well as a potential challenge to recruit. The Chief Nurse explained to the Board that the additional consultants would address the inconsistency of the seven day cover as well as other work in the hospital. She said the team would scrutinise the requirement further and look at skill mix to achieve the leadership support within the team.

22/042.4 The Board **RECEIVED** and **NOTED** the Ockenden one year on progress update.

22/043 ELECTIVE RECOVERY

22/043.1 The Chief Operating Officer presented the report and explained to the Board that the guidance was driving a return to pre-pandemic levels of performance as soon as was possible. She said there would be a 30% increase in activity by 2024/25 with a 10% increase

over the following three years.

22/043.2 The Chief Operating Officer explained to the Board that the Trust had a strong record locally. She said understanding the size of the gap to deliver increased activity by delegating authority to the speciality teams to look at the range of opportunities which would include reducing Covid inefficiencies and maximising productivity, GIRFT, best practice, additional lists and additional substantive workforce would support the activity.

22.043.3 The Chief Operating Officer informed the Board that the main risks were workforce, front door, the late presentation of patients and managing conflicting priorities. She said there would be an opportunity for collaboration with provider colleagues and to share best practice and learning to put the patient at the heart of the service development as well as opening the services to address health inequalities.

22/043.4 Dr Buckle asked whether the 30% increased activity with a shortfall in the workforce was achievable. He also asked how the Trust was ensuring patients remained safe on the long wait lists. The Chief Operating Officer recognised the challenging targets and explained to the Board that the Trust had seen challenging targets in the past and risen to those challenges. She said there was an incentive for clinical staff to work again and if they were positioned at the heart of recovery alongside the patient voice the chances of achieving the targets would be improved. In relation to patient safety the Chief Operating Officer informed the Board that with CCG and primary care colleagues patients were being risk stratified as well as alternative ways to keep patients safe being identified.

22/043.5 The Chief Executive noted that the RTT had disappeared, he said through Covid and with the move to clinical priority, the average patient was waiting longer. The Chief Executive commented that the new target eliminated long waits and the Trust would need to ensure that the internal reporting mechanisms were aligned to the new national mandate. He asked for assurance that clinical leads were taking responsibility and being held accountable. The Chief Operating Officer explained to the Board that there had been an upsurge in digital solutions to help to keep patients safe as well as more accessible secondary care conversations. She said confirming the engagement from the consultant body would be beneficial.

22/043.6 Ms Moore commented that health inequalities would be the first step in understanding patient characteristics which would involve disclosure by patients for recording by staff and asked how this would be undertaken. The Chief Operating Officer informed the Board that characteristics would shape the services and dictate what reasonable adjustments would be required. She said these issues were discussed at the monthly divisional accountability reviews where there was an aspiration for high levels of compliance.

22/043.7 Mrs Schroder commented that there were ambitious targets and the Trust would need to distinguish between understanding where progress had been made and where it was required.

22/043.8 The Board **RECEIVED** and **NOTED** the Elective recovery report.

SUB-COMMITTEE REPORTS:

22/044 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

22/044.1 The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and People Committee meetings held on 26 January 2022 and 23 February 2022.

22/045 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

22/045.1 The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 25 January 2022 and 22 February 2022.

22/046 STRATEGY COMMITTEE REPORT TO BOARD

22/046.1 The Board **RECEIVED** and **NOTED** the summary report from the Strategy Committee meeting held on 16 February 2022.

22/047 AUDIT COMMITTEE REPORT TO BOARD

22/047.1 The Board **RECEIVED** and **NOTED** the summary report of the Audit Committee meeting held on 18 January 2022.

22/048 ANNUAL CYCLE

22/048.1 The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

22/049 DATA PACK

22/049.1 The Board **RECEIVED** and **NOTED** the Data Pack.

22/050 ANY OTHER BUSINESS

22/050.1 No other business was raised.

22/051 DATE OF NEXT MEETING

22/051.1 The next Board Development meeting will be held on 6 April 2022.

The next meeting of the Trust Board will be on 4 May 2022.

Ellen Schroder
Trust Chair
March 2022

	Action has slipped
	Action is not yet complete but on track
	Action completed
*	Moved with agreement

Agenda item: 6

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 4 MAY 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

May 2022

Corporate Update

Lucy Davies has joined the Trust as our Chief Operating Officer. Lucy has extensive experience in the public sector most recently, at the Royal National Orthopaedic Hospital NHS Trust, as the Chief Operating Officer. Lucy has a wealth of experience in a number of senior operational and transformation roles, including as head of performance and head of modernisation at Royal Brompton and Harefield NHS Foundation Trust.

This news follows Julie Smith's recent departure where she will be taking up the role of Chief Executive at Ashford and St Peter's Hospitals NHS Foundation Trust.

This month also saw a political visit at the New QEII Hospital, as the Prime Minister Boris Johnson, Chancellor Rishi Sunak, and Secretary of State for Health and Care Sajid Javid spoke to staff and patients in between filming with the broadcast media.

They were primarily there to hear about progress on our community diagnostic hub at the New QEII – including evening appointments and plans for 7 days a week sessions. Focused on technology, they were keen to know about our new equipment and also our robotic surgery at Lister.

Hospital Pressures

We continue to see high numbers within our emergency department and our dedicated staff continue to work extremely hard in managing this on an ongoing basis. This is the picture across the region and the Trust is working collaboratively with the system to look at ways in which this can be best managed.

We are also experiencing increased Ambulance handover times due to demand and patient flow out of the department. We continue to work with East of England Ambulance Service (EEAST) on the Rapid Release pilot. This has a focus on ensuring release of ambulances from Lister to respond to Category 2 calls with the initial feedback being positive.

The new and expanded ED waiting and triage area at Lister opened on 25 April. The reception and triage area will be the 'front door' to our emergency department and where patients' needs can be identified before entering the department.

On 25 April the Trust had 89 Covid positive inpatients - these numbers have remained fairly steady over the last month and the proportion of staff absent with Covid is now falling.

The NHS Incident Response remains at level 4, the highest level of emergency preparedness. In April 2022 a new 'National infection prevention and control manual for England' was published. These documents set out guidance for hospitals on visiting rules, staff and patient testing for Covid and social distancing. Taking this into account, visiting is

now open to all but, will continue to be reviewed in areas where an infection outbreak has been declared, moving to essential visiting only as required.

Centre of Excellence

The Trust made a big step forward as our third robot was delivered to Lister's Treatment Centre. CMR Surgical's Versius robotic system will ensure we have greater versatility and increased productivity when carrying out robotic operations and means we can expand our robotics programme further. The Trust has just upgraded one of its existing robots, too, meaning we now have two da Vinci Xi surgical systems to complement the Versius.

Taking delivery of our third robot is another important step, as we aim to make robotic procedures available to all patients who would benefit from them and ensure the Trust becomes a centre of excellence in our integrated care system and beyond.

National Portering Award

Finally, congratulations to our porters who have been awarded the team of the year in a recent national awards ceremony. The judges said the award was in recognition of teams that have shown extraordinary resilience, teamwork and contribution to their NHS trust, acknowledging the challenges of the pandemic and demonstrating how teams have adapted to overcome huge difficulties.

The award, one of six given out on the night after more than 100 nominations were received from across the country, also shines a light in recognition of teams that have gone above and beyond to embody the meaning of teamwork.

Adam Sewell-Jones
Chief Executive

Meeting	Trust Board		**Agenda Item**	10
Report title	**Board Assurance Framework Risks**		**Meeting Date**	04.05.22
Presenter	Stuart Dalton, Trust Secretary			
Author	Stuart Dalton, Trust Secretary			
Responsible Director	Each of the risks have been reviewed by the lead Director		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

The following key points are highlighted:

- Risk 1 (Operational Delivery): At the March and April meetings, Finance, Performance and People Committee (FPPC) debated reducing the risk score to 16 but concluded it needed to remain at 20. FPPC recognised the impact score might reduce given the COVID impact affects all Trusts and therefore agreed to revisit the risk scoring once 22-23 data becomes available to assess how the Trust compares nationally.
- Risk 3 (NHS Financial Framework): April FPPC increased the risk score for the Finance risk from 12 to 16 to reflect the significant increase in efficiency requirements as we enter 2022/23 and the legacy of COVID initiatives still in place in the context of COVID funding reducing by ~58% in 2022/23.
- Risk 5 (Digital): April FPPC discussed risk 5 and asked for Part 2 Board discussion due to the commercially sensitive nature of the risk.
- Risk 12 (Pandemic): April Quality & Safety Committee (QSC) recommended that the pandemic impact risk 12 be altered for the 2022-23 BAF to reflect the focus of the risk needs to change to the enduring impact of COVID on recovery.

Following the strategy refresh discussions at the 6 April Board Seminar, work is taking place with Directors to develop the 2022/23 BAF. Following this initial work, the intention is for a workshop on the BAF at the 8 June Board Development/Seminar session. Whilst the full BAF is presented to Board, going forward the intention is to present the BAF summary at Committees along with purely the detailed BAF risks that that Committee owns, to help each Committee is best-placed to focus on the specific risks it is responsible for. FPPC and QSC supported these proposals.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Management of the BAF and strategic risks is fundamental to good risk management and supporting the delivery of the Trust's organisational strategy. Internal Audit annual review of the BAF and Corporate Risk Register concluded 'reasonable assurance.' The recommendations are already part of the work plan and include Board training session on risk for 2022/23 and align the 2022/23 BAF to the new Organisational strategy.

Risk: *Please specify any links to the BAF or Risk Register*

As documented under each risk

Report previously considered by & date(s):

Considered at each Board and Board Committee.
For the 2021/22 BAF, the risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas, using the revised template approved by the Audit Committee. The Trust's strategic risks for the Board Assurance Framework 2021/22 on one page. Appendix a. The Trust's strategic priorities are mapped to the Trust objectives for 2021/22 providing assurance on the coverage. Appendix b. The areas of high risk are covered in the Board Committee agenda items and papers.

The BAF risks continue to be reviewed by each of the lead directors, appendix c, and updates to the

text, controls and assurances from the previous month are highlighted in red text for ease.	
Recommendation	The Board is asked to consider the BAF and any further assurances required.

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Risk Scoring Guide

Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

Level	Description	Safe	Effective	Well-led/Reputation	Financial
1	**Negligible**	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Rumours	Less than £10,000
2	**Minor**	Minor injury or illness requiring minor intervention <3 days off work, if staff	Short disruption to services affecting patient care or intermittent breach of key target	Local media coverage	Loss of between £10,000 and £100,000
3	**Moderate**	Moderate injury requiring professional intervention RIDDOR reportable incident	Sustained period of disruption to services / sustained breach key target	Local media coverage with reduction of public confidence	Loss of between £101,000 and £500,000
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant underperformance of a range of key targets	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
5	**Extreme**	Incident leading to death Serious incident involving a large number of patients	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m

Trust risk scoring matrix and grading

Likelihood / Impact	1 Rare (Annual)	2 Unlikely (Quarterly)	3 Possible (Monthly)	4 Likely (Weekly)	5 Certain (Daily)
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

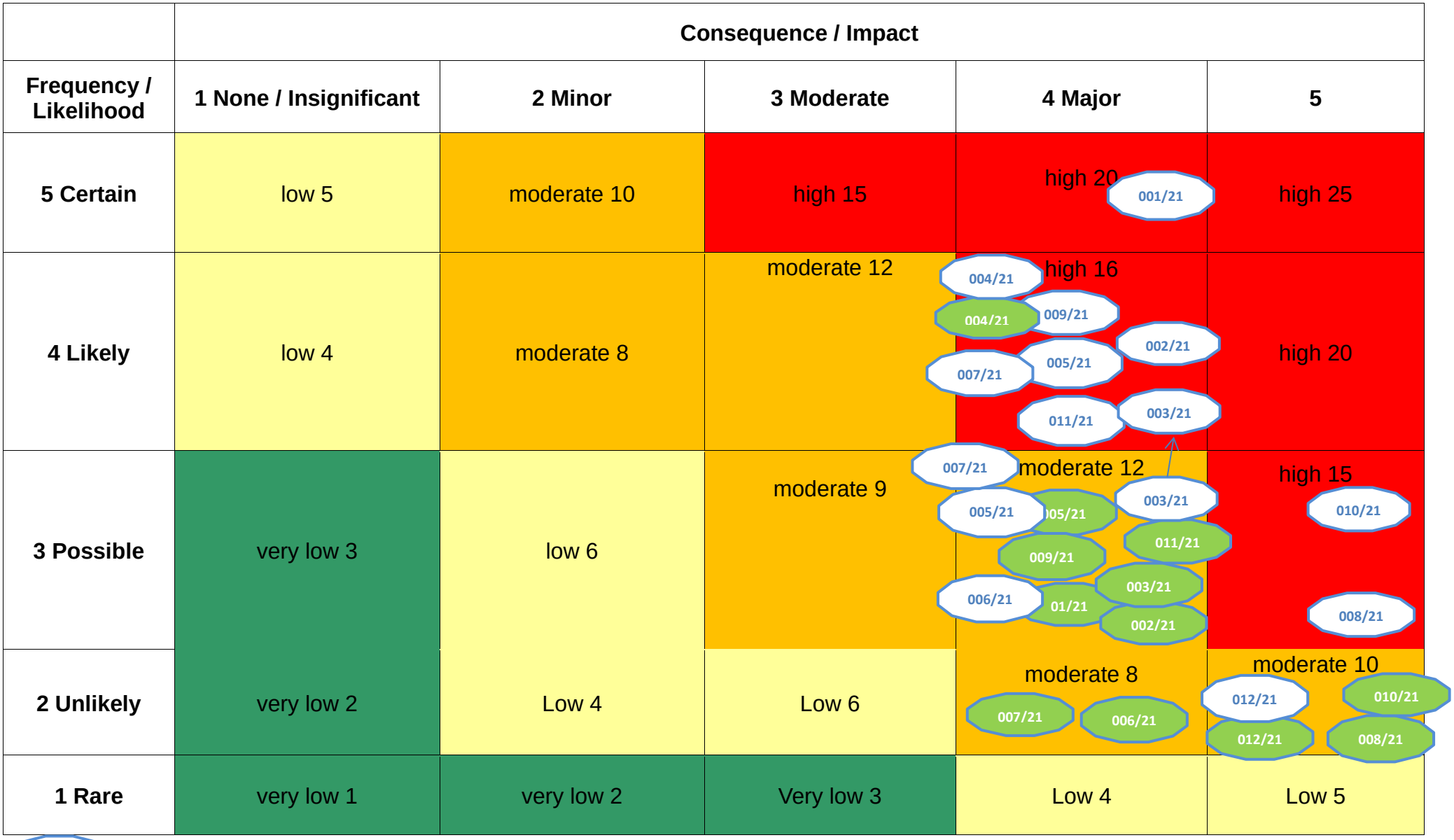
Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2021/22	Lead Executive	Committee	Current Risk March	Last Month Mar	3 months ago	6 months ago	Target Score	Date added (Target dates for risk score/ changes)
001/21	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**20**	**20**	16	16	**12**	01.03.18 (June 21)
002/21	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	**FPPC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (April 21)
003/21	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**16** ↑	**12**	16	16	**12**	01.04.19 (TBC)
004/21	There is a long term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments (Updated May 2021)	Director of Finance	**FPPC**	**16**	**16**	**16**	**20**	**15**	01.03.18 (TBC)
005/21	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	**Strategy**	**12**	**12**	**12**	**12**	**12**	01.04.17 (At target)
006/21	There is a risk ICP / ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Finance	**Strategy**	**12**	12	12	12	8	01.04.20 (April 22)
007/2	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	**Board**	**12**	**12**	16	16	**12**	01.03.18 (21/22)
008/21	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	01.03.18 (TBC)
009/2	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	**QSC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (March 21)
010/2	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements	Director of Estates	**QSC**	**15**	**15**	**15**	**20**	**10**	22.01.19 (TBC)
011/21	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC	Director of Finance	**Strategy**	16	16	16	12	12	01.04.20 (TBC)
012/21	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	**10**	10	10	10	10 (Met June 21)	04.03.20 (April 21)

**Changes to the risk scores discussed at the October Board Committees and approved by Board in November.*

Board Assurance Framework Heat Map – February 2021



REVIEW OF CURRENT STRATEGIC RISKS– MAPPED TO TRUST STRATEGIC PRIORITIES AND DRAFT OBJECTIVES 2021/2022

East and North Hertfordshire NHS Trust

Our Vision

Proud to deliver high-quality, compassionate care to our community

Our Priorities

1. Quality:
R2 Workforce
R4 Capital
R5 Digital
R7 Governance
R8 Quality
R10 Estates
R11 MVCC
R12 Pandemic

2. People:
R2 Workforce R8 Quality
R9 Culture
R12 Pandemic

3. Pathways:
R1 Op Delivery
R5 Digital
R6 ICP
R8 Quality
R11 Pathways
R12 Pandemic

4. Ease of Use:
R1 Op Delivery
R5 Digital
R6 ICP

5. Sustainability:
R1 Op Delivery
R3 Finance
R4 Capital
R6 ICP
R7 Governance
R10 Estates
R11 – MVCC
R12 Pandemic

Our Objectives 2021/22 *Board approved*

a) Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 (R1 Op Delivery, R2 Workforce, R3 Finance , R4 Capital ,R5 Digital, R6 ICS/ICP, R8 Quality, R10 Estates,)

b) Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic (R1 Op Delivery, R3 Finance , R4 Capital ,R5 Digital, R10 Estates, R12 Pandemic)

c) Embed and develop the new divisional structure and leadership model to further improve service quality (R1 Op delivery, R7 Governance, R8 Quality, R9 Culture)

d) Create a health and well-being offer that is amongst the best in the health service (R2 Workforce, R9 Culture)

e) Progress and develop our equality performance to build an inclusive culture in the workplace (R2 Workforce, R7 Governance, R9 Culture)

f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency (R3 Finance, R5 Digital, R6 ICS/ICP, R8 Quality)

g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients (R1 Op Delivery, R2 Workforce , R3 Finance , R5 Digital, R7 Governance, R8 Quality, R12 Pandemic)

h) Harness innovation, technology and digital opportunities to support new models of care (R1 Op Delivery , R4 Capital, R5 Digital , R8 Quality, R7 Governance, R9 Culture)

i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider (R1 Op Delivery, R3 Finance, R5 Digital, R11 MVCC)

Our values

We put our PATIENTS first; we strive for excellence and continuous IMPROVEMENT; we VALUE everybody; we are OPEN and honest; we work as a TEAM

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic c) Embed and develop the new divisional structure and leadership model to further improve service quality g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider**	**Source of Risk:**	Strategic Objective IPR National Directives	**BAF REF No:** 001/21
Principal Risk Decription: What could prevent the objective from being achieved? Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	**Risk Open Date:**	01/07/2020	**Executive Lead/ Risk Owner** **Chief Operating Officer**
	Risk Review Date:	Mar-22	**Lead Committee:** **FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team. vi) Increased risk to delivery of the ERF targets. viii) Impact of winter could impact on overall capacity within the hospital Targets set out in the NHSE/I guidance 'delivery plan for tackling the Covid-19 backlog of elective care' Introduction of new Emergency Care Dataset for Urgent and Emergency Care from April 2022.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence vi) Financial Impact if the Trust does not meet the ERF targets - ERF monies will not be paid. vii) Reputational risk if performance standards are not achieved viii) Risk of winter demand/ illnesses on overall capacity within the hospital	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk stratification of patients is ongoing, overseen by the Clinical Advisory Group. The group is chaired by a consultant. The Trust continues to have oversight of performance through three Delivery & Oversight Groups which meet monthly and focus on (1) Quality and Safety, (2) Performance and Transformation and (3) Finance and Workforce. In addition, a range of groups meet regularly to focus on specific aspects of performance and recovery. These groups take a targeted approached to review performance, identify risks and determine corrective action. These groups include a system-wide Cancer Board chaired by Trust's Chief Operating Officer, a weekly Gastroenterology group and the weekly Executive Committee. A weekly access meeting takes place. Recovery plans are in place for all specialities and progress is reviewed on a weekly basis. A series of deep dives - on monthly basis rotating through speciality Winter initiatives have been agreed to enable the Trust to respond to the pressures of the winter period; The Ward refurbishment work will result in some reduction in bad capacity for a short period; commences April 2022	We have a set of 'flat pack' Covid escalation plans ready for use if required and we have developed Covid policies and procedures. We have developed a recovery dashboard which is divisional and specialty based. FPPC receives and reviews our IPR, performance reports and deep dives at its meetings. It also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have divisional delivery operational groups, divisional Board meetings and a fortnightly clinical transformation group. Performance Deep Dives - Stroke, July 2021, Sept 21, Feb 22 Performance relating to ambulance handovers monitored through usual governance processes including the IPR. Theatre and Outpatients deep dives to FPPC, December 21. Major Trauma and Discharge Improvement Deep Dive Feb 22	Recovery of our performance continues to be good and we are exceeding our plans. Performance against RTT and diagnostics is improving. -RTT and DMO1 deep dive to FPPC June 21. The number of patients waiting over 18 weeks is decreasing.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**			
C1 Complexity of operation recovery in the context of COVID C2 National changes to guidance and policy requiring local response at short notice C3 Phase 3 capacity modeling to deliver national targets within financial model	A1 Define metrics to support monitoring of recovery A2 Capacity to support increased demand post COVID - endoscopy and other specialities - delivery against plans A3 Effectiveness of winter planning initiatives/ transformation with community A4 Optimisation and effective discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available			
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient			

			Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps (Action plan under review with Lead Direcotr and Managing Directors's)

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Deliver Operation Recovery Programme inline with national guidance and with risk stratification	C1, C2, C3	COO, MD's (Planned and Unplanned Care)		Monitored weekly and monthly. Access Manager now in post.	
ii) Continue to engage with our ICS and ICPs. Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	C1, C2, C3, A1, A3, A2	COO, MD's (Planned and Unplanned Care)		Workstreams in place. Winter planning paper to FPPC in October 21 . Winter initiaitves approved - task and finish groups to monitor implementation - implemented	
iii) Delivery of the ED reconfiguation programme and SDEC	A1, A3	Unplannned Care Managing Director		ED capital plan and action plan report to FPPC , Sept 21. ED Programe board in place - monitoring progress	in progress
iv) Delivery of discharge improvement programme	A4	COO		Discharge improvement update on October agenda for FPPC. Processes regulary reviewed.	in progress
v) Delivery of bed reconfiguration programme	A2., A3	COO/ Director of Estates		March 22: monitored through meetings.	
iv) Review delivery performance metrics in line with standards	A1,	COO		Review of new national ED standards. Measures running in shadow form; paper to FPPC in Feb 21. Exploring the use of predictive analyitics (FPPC in June 2021) . March 22: monitored through task and finish groups.	
iv) Delivery of elimination of ambulance handover waits	A1,	COO		Action in place including earlier escalation to surge plans	
Summary Narrative:					

July 2021: New guidance has been issued requiring performance to be at 95% against 19/20 activity levels. This will be challenging to achieve, particularly with increasing Covid numbers and a predicted 4th Covid wave. If the system as a whole does not achieve the targets ERF monies will not be paid. Sept 21: Although challenging the Trust has so far performed well against these new standards. As we approach winter, competing pressures and an increase in Covid numbers and a potential decrease in available workforce could make this position harder to sustain'.
October 2021: Risk level reviewed at QSC and FPPC and recommended increasing the risk from 16 to 20; recognising the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC recieved a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support mitigation of the risk. Noting next months deep dive will focus on RTT recovery.
November 2021: The Board considered the requirement to eliminate ambulance handovers and approved the proposed actions. Monitoring will take place through the usual governance processes including the IPR.
December 2021: Impact of the level 4 incident on performance and operational delivery is under close review.Response developed in line with the national guidance.
February 2022: We are closely monitoring the performance of all specialities. We are developing plans to recover elective performance and deliver the targets set out in the February 2022 ‘delivery plan for tackling the Covid-19 backlog of elective care’. NHSE/I published a ‘delivery plan for tackling the Covid-19 backlog of elective care’. The guidance sets out plans for the NHS to return to pre-pandemic performance as soon as possible. The intention is that around 30% more elective activity is delivered in 2024/25 than before the pandemic. Risk rating under review to consider if it can be reduced.
March 2022: Monitoring across all areas in place. Corrective action in relation to activiity and performance being taken as required. Elective recovery summits taking place with planned and unplanned care divisions in March 2022.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, PeopleWe provide a portfolio of services that is financially and clinically sustainable in the long term . We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **d) Create a health and well-being offer that is amongst the best in the health service** **e) Progress and develop our equality performance to build an inclusive culture in the workplace g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients**	**Source of Risk:**	strategic objectives	**BAF REF No:** 002/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner** **Chief People Officer**
	Risk Review Date:	Jan-22	**Lead Committee:** **FPPC and QSC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Failure to develop effective workforce plan/workforce model for each service that takes account of new/different ways of working. ii) Failure to maximise staffing options through the use of flexible working initiatives. iii)Failure to work collaboratively across the Integrated Care System. iv)Failure to develop staff to be able to work more flexibly in terms of role design. v) Impact of the pandemic and self isolation guidance on the availability of staff	i) Current staffing models may not be cost-effective. ii) There may be an adverse impact on service quality and safety. Iii) Recruitment costs may be higher than necessary. iv) Staff may not have the required skill set to support innovative role design and ways of working.	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	⟺
		Target Risk: (TBC)	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) A process by which articulation of clinical strategy is linked to organisational redesign and workforce modelling. ii)Workforce transformation approach to service development. iii)Demand and Capacity Modelling. iv) People Strategy action planning v) Finance and People Divisional Board / Divisional Oversight Group. Established Workforce triggers and redeployment processes	i) Care Quality Commission service inspections / TRA's ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC Nursing establishment review, Dec 21 Workforce Assurance Framework for winter, Dec 21(N&M)	Erostering Internal Audit - 'reasonable' assurance 2020.		yes

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
C1. Inadequate links between service planning and workforce planning. C2. Lack of horizon scanning to allow early recognition of potential skills gaps. C3. National shortages of clinical professionals and failure to engage clinicians in the	A1 the variation between current staffing arrangements and optimum workforce model is not yet quantified	Green	Effective control is in place and Board satisfied that appropriate assurances are available

C3. National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. C4. COVID/ Post covid challenge to existing workforce model - ability to maximise using staff flexibly	workforce model is not yet quantified. A2 ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action: **(Actions under review with CPO)**	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	C1, A1	Chief People Officer		Staff experience Group in place to consider exit interview data / undertaking workforce planning with services via the integrated business planning process will identify new ways of working and roles to support development / education board considers other development and training mechanisms to support R&R. Jan 22: The Staff engagement group has not met in Dec/Jan due to Covid pressures and staff absences and work will reconvene in February	In progress
ii) Enhance areas of staff supply	C2	Chief People Officer		Continue to work with NHS Professionals on bank recruitment to support staffing shortfalls, plans have been agreed for 21-22 with clear targets in place throughout all staff-groups. / International recruitment continues to identify and recuit additional staff as needed	In Progress
iii) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability	C1, C2, A1	Chief People Officer		Workforce Planning gap identified in current establishment, has been addressed in the revised people team structure. Some work has been undertaken with the planning team around demand and capacity modelling but in it's infancy.	In progress
iv) Improve the offer to staff around flexible working.	C4, A2	Chief People Officer		flexible working review being undertake in conjunction with establishment review to assess winter and summer plans and options appraisals. Jan 22: Research working group completed and scope report due end January, pilot of flexible working to be identified and run with view to scale up later in 2022 in other areas	In progress
v) delivery of a Education and a capability strategy for the organisation	C1, C2, C3, C4	Chief People Officer		The People Stategy launched in 2019, bringing education, training and Leadership under capability. A number of senior personnel changes and covid has led to a slow and steady implementation of this plan. In June 2021 the Capability strategy was launched, this has been presented to QSC. To deliver against the strategy structural changes remain to be implemented, which are planned for Q4. Currently the service is reliant on a high number of seconded staff to meet demands and there are a small number of staff absent due to long term sickness causing a significant impact on service delivery, particularly in Medical Education. These are hard to fill with bank and senior leaders are having to directly support services. A deep dive into the LDA and education finances is required to ensure in future that activity and payment are met, ensuring quality and value for money Jan 22:New AD commenced in post Jan and this work is now underway	In Progress

Summary Narrative:					
December 2021: Impact of the pandemic and self isolation guidance on the availability of staff. Staff Risk assessments in place in line with national guidance. Workforce triggers and redeployment processes reviewed and ready to stand up when required.					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider**	**Source of Risk:**	Operating Plan- Use of Resources - Financial Framework 2021/22	**BAF REF No:** 003/21
Principal Risk Decription: What could prevent the objective from being achieved? Risk of financial delivery due to the radical change of the NHS Financial Framework associated with the current COVID pandemic	**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	Apr-22	**Lead Committee:** FPPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
• Change in the national funding framework during COVID • Mid Year change in funding framework• Good financial management and governance not maintained • Allocation of resources via system mechanisms rather than based on activity volumes• Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience) • Dilution of financial understanding and knowledge within divisional teams• New operational structures weakening traditional arrangements for strong financial control • Significant increase in efficiency requirement as we enter 2022/23 • Legacy of COVID initiatives still in place but COVID funding reducing by ~58% in 2022/23	• Significant increase in costs above funding levels • Financial balance not maintained • Failure to track expenditure causation • Unable to invest in service development • Challenge in tracking spend for regulatory and audit purposes • System funds allocated on differential basis• Spend committed recurrently in response to non recurrent circumstances• Breakdown of regular financial / business performance meetings• Weakening of traditional balance between - Finance / Performance & Quality	**Inherent Risk** (Without controls):	4	5	**20**	↑
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• Regular Monthly financial reporting arrangements in place• COVID expenditure tracking and approval processes in place• Recruitment approval mechanisms in place• Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2022/23 & including ICS developments to FPPC in January 22.	Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • COVID financial planning updates to monthly FPPC and Exec Committee• Monthly Accountability Framework ARMs including Finance (L1) • Bi- Monthly Financial Assurance Meetings & PRM with NHSE (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly D&C activity tracking meetings • Forecast activity and bed model in place • Internal Audit review programme			I&E delivery against financial plan Cash balances maintained within prescribed limits • Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance:Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1 nconsistent delivery of routine budget management meetings across divisions C2 Impact from the system funding distribution under the new finance framework C3 Variable capture and escalation of winter and in year cost pressures C4. Weak temporary staffing control environment in respect of medical and nursing staffing C5 Ongoing COVID ineffiencies	A1. Impact future funding frameworks on Trust financial sustainability strategy A2. Embedding of core financial and business competencies within divisional teams A3 Clarity in respect of NHS contract and business arrangements for 21/22 A4 Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings A5 Assurance in respect of the delivery of the 21/22 summer and winter bed plans within agreed parameters, with the associated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps (Actions under review by Lead Director)					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Launch and development of Finance Academy for all Budget holders	C1, A2	Director of Finance		Launched in May 2021	In progress
ii) Development of Finance Sustainablity Strategy in line with the NHS Financial Framework and monitoring delivery	C2, C5, A1, A3,	Director of Finance		H2 planning guidance and budgets , FPPC Sept / October 21	
iii) Continue to develop BI and support divisions / directorates using effectively	C1, C4	Director of Finance			
iv) Engagement with Divisions/ Directrates on delivery on financial savings from month 6	C5, A4, A5	Director of Finance / Direcotr of Improvement / MD's (Planned ad Unplanned)		H2 CIP Delivery plan to Sept / October 21 FPPC	
Summary Narrative:					
October 2021: Risk level reviewed at FPPC and recommended reducing from 16 to 12, taking in to account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery. December / January/ February: No changes					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites. Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic h) Harness innovation, technology and digital opportunities to support new models of care**	**Source of Risk:**	Business Plan, Clinical Stra	**BAF REF No:** 004/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments.	**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	Apr-22	**Lead Committee:** FPPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
Lack of available capital resources to enable investment • Weakness in internal prioritisation processes • Weak in year delivery mechanisms to ensure commitment of resources • Weak assessment of the long term capital resources to meet strategic objectives • Requirement to repay capital loan debts • Volume of leased equipment not generating capital funding resources • COVID capital funding arrangements impact BAU capital requirements • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills • Capital envelopes issued to systems who have authority over how the envelope is distributed to Trusts	• Aged equipments and assets - at or beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and services developments • Limited innovation and associated limitations on ability to deliver efficiencies • Negative Impact on the potential to deliver the overarching Trust strategy • Annualised and sub optimal process of competitive short term bidding • Difficulty in expressing a coherent capital profile to external stakeholders eg. ICS / Region / DH	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• Six Facet survey undertaken in 17/18 • Capital Review Group meets monthly to review and manage programme spend • CRG Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Asset Register Maintained by the Finance Department • Mandatory training• Equipment Maintenance contracts • Monitoring of risks and incidents • ICS capital monitoring processes across the system • Directors of Finance and E&F meet weekly with teams to track and facilitate capital spend • Equipment review process to support covid 19 pandemic requirements • Implementation of the new Capital and Cash Framework • Detailed Qlikview Capital Monitoring Application in place • Bi weekly MVCC Critical Infrastructure group with stakeholders	• Annual AE report on Fire Safety to H&S Committee (L2) - Monthly Fire Safety Committee • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Steering Groups in place to oversee strategic programme delivery eg. Vascular, Renal, Ward Reconfiguration & ED • Capital programme report, FPPC May 21. - Risk Register reports to CRG	• External Audit process reviews the appropriate accounting and treatment of capital assets. • DH / NHSE review and approval of strategic business case schemes requiring funding		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1. Not fully compliant with all Fire regulations and design C2. No effective arrangements presently in place to monitor and control space utilisation across the Trust C3. No formalised equipment replacement plan or long term capital requirement linked through to LTFM and Trust Strategy C4. Weaknesses in Estates and facilities monitoring structures and reporting C5. Absence of Overarching site Development Control Plan	A1. Availability of capital through either internal or national funding sources A2. Implementation of the new capital and Cash Framework A3.Transparent mechanisms to access Section 106 funding A4. Long Term Capital Investment Plan to regulate investment	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Estates strategy to support the trust clinical strategy	C1, C5, A4	Director of Estates and Facilities	TBC	Development to be reported Strategy Committee	Not yet started
ii) Develop capital equipment replacement plan	C3, A4	Deputy Director of Finance	Ongoing	Capital Planning for 2021/22 paper to FPPC in March 21, based on new planning guidance.	In progress
iii) Develop programme for Charity to support with fundraising	A1	Deputy Director of Finance / Head of Charities	Ongoing		In progress
iv) Agree capital investment for 2021/22 and monitor delivery	C4, A2	Executive	May-22	Report to May FPPC. For 6 monthly review. Report on ED capital plan to FPPC in Sep 21. Up date on ED project and Captial spend against plan to FPPC in November 2021	In progress
v) Review other sources of funding / opportunities for investment	A1, A3	Director of Finance / Project leads	Ongoing		In progress
vI) Undertake detailed space utilisation survey, implement revised strategy and then monitor	C2	Director of Estates and Facilities / Improvement Director	TBC		In progress
Summary Narrative:					

June 2021 ,following review, including structures and monitoring in place, further actions and oversight of the risks, and the FPP Committee discussions in May 21, the rating has reduced to 16. October 2021: FPPC discussed the risk rating and confirmed it remains a 16; taking into account the longer term position of access to capital . December / January: No changes February: Overall risk assessment considered and agreed remains a 16 due to the level of risks that remain on the corporate risk register related to equipment and estate.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Trust Strategic Aims:
services,consistently across all our sites **Quality: To deliver high-quality,compassionate**
Pathways: To develop pathways across care boundaries, where this delivers best patient care
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **Trust Objective:** **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strategy	**BAF REF No:** 005/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	**Risk Open Date:**	Jun-20	**Executive Lead/ Risk Owner** Chief Information Officer (CIO)
	Risk Review Date:	Feb-21	**Lead Committee:** Strategy Committee

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Staff Engagement / Adoption Lack of Clinical/Nursing/Operational engagement in system design - reduces likelihood of system adoption Lack of Clinical/Nursing/Operational adoption of digital healthcare creates innefective process which can introduce clinical risk ii) Financial / Resource AvailabilityFailure to resource its delivery within timescalesTrusts may not be in a position to finance the investment (including Lorenzo renewal 2022) iii) Business RiskIT resources may get diverted onto other competing Divsional projects iv) Knowledge & ExperienceDelivery team does	i) Unable to deliver the Clinical strategy ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Staff Engagement Risk:Digital steering group(Consultant led design focus) and IT steering Group (Project Led delivery led) are in place for project Governance, prioritisation and to support clinical engagementBusiness Risk:CIO is member of the executive team and CIO/CCIO have an agenda item on at the Private board to ensure board members are apprised of progress and risks.Financial / Resource Availability Risk:Finance and PMO to be involved throughout the Business case processFinancial / Resource Availability Risk:Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriateKnowledge & Experience Risk:Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained.New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee,Strategy Committee and Board (L2)• Weekly Executive monitoring(Where appropraite) aligned with clinical strategy- staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG - Strategy for "Evolving our technology" , including including road map to 2022 presented to Strategy Committee, Feb 2021.	Disaster recovery - IA - Limited (action plan in place) Cyber Maturity - IA - green except - network security and secure configuration		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Poor attendance from stakeholders at the Digital steering group C2. Availability of capital to deliver priorities C3. No long term digital plan beyond 2022 (Contractual end date for Lorenzo) C4 Integration into Divisional planning for resource management delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X expection that we implement with little time and enable of - systems / timeface to enable local scruitinty	A1. Delivery of the roadmap and measures of progress A2. DSO and IGM capacity to support the DPIA processes for increase pathway changes (action to be confirmed with CIO) A3 Clinical engagement and leadership to support developing and embedding the changes	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i)Engagement and delivery of the digital roadmap against plan	C1, A1	CIO		Sept 21 update - Delivery in progress. Roadmap has been updated on all workstreams and was presented to the Trust in July 2021. October : KOPS (Keeping our patients safe) launched in October 2021. November 2021: Update on digital strategy presented to Strategy Comm.	In progress
ii) Seek investment through ICS where available	C2	CIO		Sept 21 update - Creation of a business Case to support Digital Aspirant/Unified Technology Digital funding is underway. ICS and regional stakeholders engaged. Other funding oppertunities being actively pursued as they become available.	In progress
iii) Long term Lorenzo strategy/commercials to be finalised	C3	CIO		Sept 21 update- Lorenzo strategy under consideration within the scope of above business case.	In progress
iv) Implementation of a Business partner process (Post Silver)	C4	CIO		Sept 21 update - No update but in progress	In progress
v) Relaunch of EMPA roll out	A1	Deputy Medical Director, Chief Pharmacist and CIO		Sept 21 update - Rollout planning has now commenced. EPMA full rollout delayed.	In progress
vi) recruitment into Chief Nurse Information Officer Role	A3	Chief Nurse	Jan-22	Recruitment commenced August 21 interviews scheduled for end September. October 21: Appointed and due to commence in January 2021.	In progress
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 f)** **Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency**	**Source of Risk:**	National directives	**BAF REF No:** Risk 006/21
Principal Risk Decription: What could prevent the objective from being achieved? ICP/ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	**Risk Open Date:**	01-Apr-20	**Executive Lead/ Risk Owner** Director of Finance (From August 21)
	Risk Review Date:	Mar-22	**Lead Committee:** Strategy

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of effective collaborative system leadership ii) Executive, clinical and operational leadership and capacity iii) Ability of the ICP to effectively engage primary care iv) Lack of synergies between organisational, ICS and ICP strategic development and priorities v) Lack of risk and benefit sharing across the ICP vi) Complex ICP governance arrangements	i) Failure to progress. Lack of strategic direction and modelling of collaborative leadership ii) Slow pace of ICP development and transformation of pathways. Perpetuautes inefficient pathways. iii) Primary care is not effectvely engaged in the development of the ICP impacting the scope and benefits of integration iv) Unwillingness or inability of organisations to adopt new pathways / services because of contractual, financial or other risks v) Impedes the pace and benefits of transformation	**Inherent Risk** (Without controls):	4	4	**16**	⇔
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Joint projects such as Vascular Hub project with West Herts and PAH; ICS pathology procurement; Imaging Networks • ENH improvement methodology - 'here to improve' • Integrated discharge team • OD support for ICP development • ICP Development Director based at ENHT one day/week to support developing relationships - ENH ICP Directors' Group	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board Reports to ICP CPex and TDG Collaboration Report to Strategy Committee and Board Pathology Procurement report, Vascular Services report and monitoring via Stategy Committee and Board Population health data presented to FPPC in May 21			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1. Partnership Board Scope for accelerated development of ICP and governance arrangements that support collaborative transformation at pace C2 Need to identify and release clinical leadership capacity to drive greater pan system understanding of population health and priorities for ICP improvement work C3. Need to influence and understand future Trust and ICP representation with ICS from Apr 22 - Identification of dedicated capacity to support provider collaboration C4 Maximising the implementation of an improvement model to build capability and capacity	A1. Availability of population health data to inform shared priorities for transformation and improvement A2. ICS PHM learning set commenced March 21 Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign. A3. Assurance that ENHT voice fully represented by ICS in key discussions e.g. satellite radiotherapy. To be discussed at CEO level	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps (action plan under reivew with Lead Director)

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Continue to review and evolve the ICP and ISC governance structures in line with national guidance	C1, A3	Chief Executive (with Associate Director of Governance & Trust Secretary)		MoU recommended for approval by statutory Boards. New ICS design guidance published June 2021 - ICP governance under development by Impact Group.	in progress

ii) Agree and deliver approach ICP priorities through collaboration - developing risk and benefit sharing	C3, A2	COO/ Director of Finance		ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Bi-lateral work undertaken with HCT on potential models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission at Lister.	in progress
iii) To consider with the ICS/ICP a joint improvement model to collaborate on to facilitate cross organisational working and building capability and capacity. E.g 'here to improve'	C4	Director of Improvement		The ICP Virtual Transformation Model has now been established and sucessfully working since January 2021. Agreement was reached this month for all Providers toa dopt the same PM3 project software solution. Discussions regarding our CI model are ongoing as there is not yet a shared vision.	
iv) continue to identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	C2, C4	Medical Director/Director of Nursing			
v) To share the ENHT population health data with the wider ICS and ICP to facilitate discussion and agreement of priorities	C3, A2, A1	Director of Finance		Population health data under development. ICP commenced a health inequalities sub-group to enhance and advice CPEx on health inequalities.	in progress
vi) To review the Trust representation at the revised ICS workstreams for 2021/22	A3	Director of Improvement with COO/ Director of Finance		On hold pending ICS confirmation of 21/22 transformation programmes. Director of Strategy attends ICS Design & Delivery Group to maintain connection with ICS programmes pending confirmation.	Not yet started
Summary Narrative:					

Mar 22 - ongoing work with ICS re elective hub development
Feb 22 - Bid submitted to ICS re development of elective hub at Lister Hospital, incorporating capacity for PAH and WHHT. ICS presenting elective hub concept to Region with exact location to be decided. Ongoing work with system partners to support patient flow into and out of hospital.
Jan 22 - work ongoing re future governance structure of ENH HCP; strategy refresh in final stages; population health steering group helping to provide focus on future service development. CDH work progressing.
Sep 21 - DDoS contributing to development of ICP Strategy; ongoing work on Strategy Refresh, including areas identified for PHM projects; transformation team part of shared project resource on key collaborative ICP projects
Aug 21 - confirmation received of funding for year 1 of CDH; business case for year 2 approved in principle by Execs; work on IBP continues
July 21 - ICP bid submitted for Community Diagnostic Hub at QEII, with pilot in community; helping to build joint working with system partners
June 21 - MoU recommended for approval by statutory Boards. ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Work underway to test alternatve models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **new divisional structure and leadership model to further improve service quality** **an inclusive culture in the workplace** **c) Embed and develop the** **e) Progress and develop our equality performance to build** **g) Working with system partners, progress development and delivery of integrated and**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:** 007/21
Principal Risk Decription: What could prevent the objective from being achieved? Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner** **Chief Executive**
	Risk Review Date:	Feb-22	**Lead Committee:** **Board**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) In effective governance structures and systems - ward to board ii) Ineffective performance management iii) ineffective staff engagement iv) Impact of covid 19 pandemic outbreak	i) risk to delivery of performance, finance and quailty standards ii) risk of non compliance against regulations iii) risk to patient safety and experience and outcomes iv) reputational risk	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division • Commissioned external reviewsReview of external benchmarks including model hospital , CQC Insight–reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Board committees with Annual Cycles included scheduled deep dives. - Incident gold/silver command structure in place from mid March 2020 and reviewed/ flexed to ensure meets organisaitonal needs Delivery oversight framework in place. Partnership Board and ICP Board and groups established and link to divisional structures Board development programme	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2)• Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Internal Audit Reports - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting - Jan 22: Reducing the burden review to Board and Executive	Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Financial audits CQC - Positive TRA's - Medicine, Surgery, MVCC Medicine, IPC , ED and medicinces management and well led in 2020/21 NHSI/E - positive vists to ED and Assessment and ICP visit (September / October) Internal Audit - BAF and riskreview - reasonable assurance		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Effectiveness of governance structures at ward to Divisional level C2 Implementation of Internal Audit Recommendations C3 HSE Improvement notices received on V&A, MSD and sharps in October 2019 (awaiting formal closure with HSE) C4 The Trusts existing clinical strategy is no longer appropriate to manage emerging risks and system changes C5 Changes to Board members/ organisational leadership	A1 Embedded risk management and risk appetite - CRR and BAF A2 Embedding effective use of the Integrated performance report / BAF in discussions A3 Evidence of timely implementation of audit actions A4 Consistency in the effectiveness of the governance structure's at all levels A5 Capacity to ensure proactive approach to compliance and assurance A6 Ensuring compliance with other external reviews and follow up	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Implementation against plan of the revised Compliance and Risk Framework	C2, C3, A1, A3, A6 , A5	Associate Director of Governance	on going	Compliance and Risk framework combined and priorities drafted. Discussed divisional oversight group in May 21. Sept: Progress report to QSC and reivew of priorites scheduled for October 2021 inline with the new regulation regimes . Internal Audit - reasonable assurance. Summary of work to QSC in March and 2022/23 plan in development	In progress
ii) Review of the Board and Divisional Governance structure to ensure effective and reduce duplication (including links to ICS/ICP)	C1, A2, A4	Associate Director of Governance	Q2, ongoing	Board and Board committee review in progress. Review of the new divisional structure against the orginal objectives is in progress for completion at the end of Dec/ jan . Review of governance strucutres as an ICS/ICP commenced.	In progress
iii) Recruitment of new CEO	C5	CPO/Chair	Dec-21	completed - commenced in January 2022. Induction scheduled	completed
iv) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	C4	Deputy CEO/ Director of Finance		Implementation of the Strategic Planning Framework and Integrated Business Plan Structure presented to Strategy Committee in February 2021; recommended to Board for approval. Strategy Sessions commenced. Monitored by IBP steering group and Strategy Committee. September 21: Progress reviewed by Strategy Committee and discussion on system collaboration refered for full Board	In progress
v) review of external regulatory actions - CQC and HSE to support closure at next review.	C1, C3, A6	Associate Director of Governance		CQC inspectiion action plan - scheduled for closure in June 2021; testing compliance. Testing HSE actions; training elements recommenced. . Sept 21: CQC action plans reviewed and closed with divsional boards. On going review of the fundimental standards in place and programme of testing. On going testing in place	In progress
vi) Scope / consider independant well led review in line with the national guiidance	C1	Associate Director of Governance / Deputy CEO		To review with new CEO, and Head of Corporate Services in January - scoping being considered . Internal self assessment commenced.	In progress
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality,compassionate services,consistently across all our sites People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Pathways: To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **c) Embed and develop the new divisional structure and leadership model to further improve service quality** **f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency** **g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients** **h) Harness innovation, technology and digital opportunities to support new models of care**			**Source of Risk:**	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:** 008/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience			**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner** **Chief Nurse/ Medical Director**
			Risk Review Date:	Jan-22	**Lead Committee:** **QSC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of consistent approach to quality improvement. ii) Need to embed culture of improvement and learning iii) Inconsistent ward to board governance structures and systems iv) Workforce skill mix, capability and capacity v) increase in activity on some specialities (ED, Assessment, Maternity, Paeds, CCU, Mental Health) post covid vi) Increase in complaints and SIs related to post covid activity and delays in pathways. vii) Fatigued workforce	1) Limited learning opportunites from current and future continuous quality activities 2) Poorer patient and staff experience 3)Limited leadership development of all staff 4) impact on reputation 5 increased regulatory scrutiny	**Inherent Risk** (Without controls):	5	4	**20**	⇕
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
Quality and Safety Governace Structure - reporting into Patient Safety Forum, Patient and Carer Experience, Clinical Audit and Effectiveness, ICP, Safeguarding, Health and Safety Reports to QSC as per annual cycle including deep dives. Pathways to excellence framework and programme 'Here to improve' programme Training and development programmes including Leadership pathway and QI Harm free care and deteriorating patient collaborative Patient and Carer Experience Programme Patient safety specialists / leads Mental Health Srategy Group Complex discharge Improvement group Quailty and Safety Dash boards Oversight of 'hot spots' with clear leads and committee structure, May 21 (QSC and Q&C DOG) Learning events - IPC, safety huddles Clincal Harm Review process and panel Divisional quailty structures GIRFT Board Health Inequalities Committee	ToR, Minutes and papers for the Quailty and Safety Committee Structures Report and deep dives to QSC Internal Audit Programme CQC TRAs and gap analysis Quailty and Safety visits and audit programme Action plans from Mental Health Strategy Group / Discharge Group Maternity surge plan and fortnightly Maternity focus with commissioners, regulators and region LMS - mins and actions (meeting de-escalated)	Positive CQC TRA reviews for Medicine (lister and MVCC) and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE) and well led. EoI, OPD Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Routine Deep dive review at Audit Committee October 2021. Ockenden response October 2021. Pathways to excellence - ward accreditations Quailty Assurance visits (CCG and Trust) NHSI IPC visit 22.10.21 Stroke, Sepsis and VTE deep dive Feb 22		

Gaps in Controls	Gaps in Assurance:Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
•C1 National guidance and GIRFT Gap analysis identifies areas for improvement C2 Consistency with engagement with clinicians C3 Patient safety team and complaints team capacity (impact of COVID) C4 Complex discharge pathway (core action and oversight listed in Risk 1) C5 3 Never events were reported in 20/21 C6 Increased number of Mental Health Patients presenting at the Trust - Adults and CYP	A1 Consistency in following care bundles A2 Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance A3 Embedding of learniing from SIs/Learning from Deaths/ never events A4 Delivery against CQC improvement plan A5 Delivery of harm review process following COVID impact on 52wk waits , follow	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

C7 VTE compliance C8: Environmental Agency review C9: HTA Notice of Direction February 22	up and survieliance A6 Effectivness of Pathway for safe discharging of complex patients - complaints and referals A7 Assurance on Ockenden Report recommendations and PFD (Maternity) A8 Implementation of End of Life Strategy A9 Ward to Board visibility of key Q& S metrics A10 Consistancy of meeting the food hygiene standards and routine assurance A11: Evidence of delivery against HTA standards	Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) i) Delivery of the Quality Strategy Priotrities	C1-7, A1-9	Chief Nurse / Medical Director	ongoing	2021/22 priorities under review . Chief Nurse and Medical Director strategy session scheduled. Priorities under review including strenghtening the divisional governance structures - sessions scheduled for February / March	In progress
ii) Delivery and monitoring of CQC improvement plans and preparedness for future inspections	A4, C2,	Associate Director of Governance		Quailty visit programme recommenced. Compliance and risk framework reviewed. Monthly review of fundimental standards recommenced. Review of divisional action place in progress and governance, compliance, cqc communcation plan in place with supporting materials . January _ QAV visits focusing on safety and wellbeing	in progress
iii) Implemention of patient safety strategy priorities	A2, A3, A5, A7	Patient Safety Specialists		Quailty and safety digital update to QSC Sept 21. Annual cycle of deep dives to the committee reviewed.	in progress
iv) Implementaiton of End of Life strategy and priorities	A8	Medical Director		Review against new guidance in progress for consideration by EoL strategy group.	In progress
v) Develop and implement Mental Health Stategy for Acute Care and work in collboration with the system to support patients required to stay longer in acute care whilst awaitng speciaist beds	C6	Chief Nurse		Mental health strategy in development. System working to develop local solutions to support acute patients awaiting inpatient beds. Remains an area of focus- interanlly and externally	In progress
vi) Implementaion of pathways to excellence	A3, A5	Chief Nurse		Programme recommenced.	In progress
vii) Review harm review, hospital onset COVID reviews and mortality review processes due to increased demand following COVID	C3, C2	Medical Director and Chief Nurse		Progress under currently review to support the increased volum due to Covid.	In progress
iv) Review complaints process and oversight in line with PHSO guidance and increases following COVID	C3	Chief Nurse		Responding to complaints remains a focus. Interium addiitional resources in place to support recovery plan. Recruitment of new Head of Patient Experience in progress; interviews Sept.	In progress
vii) Complete Gap analysis on GIRFT reports and develop and monitor action plans	C1	Medical Director		Report to QC sept 21	in progress
viii) Review the quailty and safety metrix ward to board with BI	A9	Associate Chief Nurse		work in progress and compliance team also reviewing compliance and assurance data sets . Exploring different systems to support greater visibilty of ward to board reporting - Implementation of Inphase to commence in April 2022	In progress
ix) Implementation of Datix Icloud	A9	Associate Director of Governance	Q2/Q3	Project plan and workstreams in place. Awaiting IT to complete the required technical solution due in July 2021. Will then progress to commence inplementaion across Q2/Q3 . Sept 21: Technical solution completed at end August to enable Datix to complete confirguations. User testing to commence in Oct. Review of programm timetime commenced and to be agreed in October. October 2021: claims module went live in October. Anticipate programme to deliver the rest of the modules in Q4.	In progress
x) Implementation of new cleaning contract and active monitoring of the standards	C7, A10	Director of Estates		Supporting implementation of the new cleaning contract and cleaning standards. Contract monitoing, training, early escalation in plan. Further challenged by the increased levels of activity. October 21: Internal IPC / environmental supportive audits in place.	In progress

xi) Delivery of HTA compliance against standards	C8, A11	COO		Action plan in place, supported by project manager, steering group and workstreams. Full refurbishment of the Mortuary scheduled to commence 7 March 2022 - works commenced	In progress
Summary Narrative:					
October 21: Routine deep dive review at Audit Committee October 2021, Discussion on the impact of the backlog of activity , current activity pressures and changes to pathways in the context of quailty and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively and streamlining meeting structure where possible.					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, People **We provide a portfolio of services that is financially and clinically sustainable in the long term. We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**

Strategic Objective: **divisional structure and leadership model to further improve service quality** **best in the health service** **workplace** **c) Embed and develop the new** **d) Create a health and well-being offer that is amongst the** **e) Progress and develop our equality performance to build an inclusive culture in the**	**Source of Risk:**	strategic objectives/ Staff Survey	**BAF REF No:** 009/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner** **Chief People Officer**
	Risk Review Date:	Dec-21	**Lead Committee:** **QSC, FPPC, Inclusion**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	5	**20**	⟺
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i)Trust People Strategy designed to offer mitigations to this risk. ii) All staff are expected to embody PIVOT values. iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff. New role of Head of Culture to commence in June 2021 Equality and Inclusion Committee from May 21	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. failure to review and update some staffing policies C2. Need to develop education approach to supporting staff in under-represented groups C3. Need senior leadership development programmes to support the service improvement and transformation agenda. C4. Maximising the support networks abilty to influence service and culture change C5. Maximining staff access to wellbeing offers	A1. Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk. A2. Capacity of F2SUG and static reporting	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	C1,	**Chief People Officer**	Jul-21	leadership rhythms and compassionate leadership conversations being rolled out across the orgnaisation. 150 targetted to attend ICS sessions 145 confirmed. Additional programmes being identified as part of culture strategy for FPPC consideration in July 2021	in progress

ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Capability strategy developed to support all staff groups across the organisation. Now developing further the delivery of the roadmap	in progress
iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	C4	Chief People Officer	Aug-21	Head of culture in post from 4.6.2021 identifying new ways of working to relaunch culture strategy / staff network chairs backpay agreed via Exec in June 2021 / EIC to include feedback from staff networks / reciprocal mentoring planned for September 2021 / listening events planned in August to hear what is working and what improvements could be made. Head of People Culture in post from 1.6.2021 working on a culture plan aligned to the Trust People Strategy. Allocation of time agreed by the Board for Staff Network Chairs, job purpose and descriptions being finalised for existing chairs. A Staff Network Chair's Away Day was held on 12.7.2021 where the group worked on objectives and outcomes over the next 12 months.	in progress
Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	C5	Chief People Officer	Oct-21	wellbeing pyramid in place for all staff / regular communication of how to access and feedback given on effectiveness / review of interventions to be iundertaken in Autumn 2021	in progress
Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	A1	Chief People Officer	Sep-21	Staff voice and staff experience group ongoing with regular reports to SEG and FPPC. Next report in September 2021	in progress
Roll out talent management approach and support career conversations across whole Trust.	A1, C2, C3	Chief People Officer	Oct-21	Grow together launch on ENH academy taken place in May 2021, managers and staff to discuss long term plans plus CPD. Review in Autumn 2021	in progress
Review of Freedom to Speak Up approach and implement development plan	A2	Chief People Officer/ Chief Nurse	Oct-21	FTSU guardian identified and project plan being developed. Detailed plan to be delivered to FPPC Autumn 2021. Business case approved by Executive committee to support new structure October 21: Fulltime FTSUG appointed and should commence in the new year. Our Trust has been chosen to take part in a pilot project on Inclusive Freedom to Speak up; workshops in place for October/November.	in progress
Summary Narrative:					

July 21: All interventions in place are highlighting particular areas of concern across the organisation, and interventions are being streamlined around these areas to maximise impact. A multi-disciplinary task and finish group is being set up including senior staff from the departments affected to implement the work.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 1. Quality: 5. Sustainability:

Strategic Objective: **direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic** **a)Develop a new strategic b)Safely restore capacity, and operational and**		**Source of Risk:**	Strategic Objectives/ AE reports	**BAF REF No:**	010/21
Principal Risk Decription: What could prevent the objective from being achieved?		**Risk Open Date:**	21.01.19	**Executive Lead/ Risk Owner**	**Director of Estates and Facilities**
		Risk Review Date:	Apr-22	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	**25**	
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Revised leadership and governance structure within Estates & Facilities, Premises assurance framework/data base Specialist Authorised engineers in place as per statutory requirements, annual reports to H&S Health and Safety Group reports into QSC. Meets 6 weekly. Health and Safety Strategy 2020 Fire Policy and Procedures Capital funding prioritiesed Other statutiry groups and supportive workstreams Audit programme including - Weekly environmental audits Water safety group and action plan Ventilation group Links to corporate meeting includign COVID speciatist advisory group.	Assurance reports under statutory requriements - June QSC 21. E&F risk register reviewed and updated. - Risk clinics / workshops held in 2021 Authorised engineer reports Fire safety annual report Internal Audit - PAM (limited assurance) - report to QSC and Audit committees			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Ineffective estates and facilities governance structures C2. Estate strategy due for renewal C3. Lack of capital funding to bring the Lister and other sites to compliance C4. Implementation of actions from the AE reports C5 Limited visibility on the compliance status for the Trusts satellites locations. C6 Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme. C7. Optimal Space utilisation and decision making process for changes	A1. Limited assurance from other sites trust operates from A2. Actions to adress limited assuranceassessment for H&S, Medical Gases, Ventilation and decontamination A.3 PAM GAP analysis and action plan to inform decision making	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Substantive recuitment into leadership structure and other vacancies	C1, A1	Director of Estates and Facilities	Aug-21	Recruitment of E&F Compliance and Deputy Director of E&F underway	COMPLETED
ii) Development of Estates Strategy in line with the Organisational strategy	C3, C2	Director of Estates and Facilities	TBC	Progress report to Strategy Committee in September 21. Estates Strategy completed December 2021	COMPLETED
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	Dec-21	Systems for the management of space being investigated and compared. Investment required to implement Space Utilisation Group (SUG) is now established with standard agenda, terms of reference (clear process), and risk-log. Group meets once a month, is chaired by Director of Estates & Facilities, membership /attendance is good.	COMPLETED
iv) Ensure actions plans and monitoring in place to raise the areas of 'limited assurance' to 'reasonable assurance' - for H&S, Medical Gases, Ventilation and decontamination . Including HSE notices.	C3, C2	Director of Estates and Facilities		Head of Compliance now in post, developing / implementing guideline for governance, control requirements and responsibiliies for all critical systems and functions. Feeding into the Premises Assureance Model (PAM). Estates Compliance monthly meeting in process of being established. Estates Compliance Meeting established, meetings are now scheduled 2nd Wednesday of each month, standard agenda, terms of reference, with the Head of Compliance as Chair. Agenda includes update on all critical functions, including monitoring of actions plans against AE Audits. A Compliance Report is updated on a monthly basis and tabled at the Estates & Facilities Board Meeting. Monitoring of action plans in place, monitoring via monthly Estates Compliance Group and quarterly critical area safety groups. Majority of compliance areas due for annual audit, when assurance levels will be assessed and revised by Authorised Engineer's. Poor trust engagement flagged with Ventilation / Decontamination Group Meetings at Health & Safety, Fire and Security Meeting. Decontamination - gap analysis has now been completed with AE (Decon), AP (Decon) and Head of Compliance. Briefing paper has been produced to highlight gaps and risks of Trust Decontamination management. Paper gone to TIPCOG, on to TIPC week commencing 21st March. Ventilation - gap anaylysis also to be undertaken. Medical Gas Safety Group (MGSG) is progressing well against AE Audit Action Plan, good robust effective monitoring of plan by well attended Trust MGSG. Trust Decontamination Group new chair - Richard Hammond (Deputy COO planned care). Meetings to move to quarterly, handover meeting scheduled between estates (AP / Compliance Lead) mid May.	In progress
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities	Dec-21	Compliance manager recruited and will prioritise this audit. PAM gap analysis is underway, supported by TIAA external PAM Audit. TIAA PAM process assurance audit is now completed. Compliance Manager has updated audit with management response/action - briefing paper has been tabled at Decembers H&S, F,S Group and Q&S Committee. Gap analysis is completed, updating action plan in progress. Note - this is significant exercise requiring trust-wide engagement to provide supporting evidence of process. On-going updating of PAM Action Plan - also acts as PAM Library - directory collating file-pathways for all documents / evidence. Actual PAM submission due end of July. Team aiming for end of May submission date.	In progress COMPLETED
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities		Estates Compliance monthly meeting in process of being established. Estates Compliance monthly meeting now established. To inlcude over-sight of all E&N Herts sites. Agenda includes all E&Nherts sites. Included in ToR's.	COMPLETED / on-going monitoring
vi)					
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term; Quality: To deliver high quality, compassionate services, consistently across all our sites; Pathways: To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	**Source of Risk:**	Specialist Commissioning Review	**BAF REF No:** 011/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC.	**Risk Open Date:**	Apr-20	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	Mar-22	**Lead Committee:** Strategy

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii) Inability of NHSE to reach agreement with providers, including investment required, and execute the transaction iv) Failure of service sustainability in the pre transition phase due to failure to address critical infrastructure priorities	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retention, morale and research. ii) Potential detrimental impact on care pathways at Trust sites. Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and increased financial pressures on the Trust iv) Potential impact on quality, safety and ability to sustain safe service	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
- Programme Board governance in place for Strategic Review of MVCC - Weekly ENHT, UCLH and NHSE Director level call in place and monthly Tripartite meeting in place to monitor delivery of the Strategic Review against plan - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT, HHT) - UCLH Transition Team in place at MVCC - ENHT MVCC Transfer Programme leadership (Programme Director) and governance (Steering Committee and Task & Finish) in place - Escalation reporting to Strategy Committee and Board - Clinical policies - Monthly ENHT, UCLH, NHSE Critical Infrastructure Review in place underpinned by action plans & risk register - MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG, HHT and UCLH) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee - July 21 - Audit Committee Deep Dive	- Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 - Positive Risk Review with Specialist Commissioners, December 2019 - Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to due diligence outcome. - NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. - Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. - May 2021 Submission of Due Diligence reports from UCLH to NHSE. - June 2021 - East of England Clinical Senate review of proposals; informal feedback from review team has been positive - Sept 2021 - UCLH Expression of Interest submitted to DHSC, with support from ENH Trust Board, seeking route to capital as part of new hospitals programme		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
	A1) Confirmation by NHSE of route to access capital for reprovision by UCH, and outcome of public consultation as required by UCH Board A2) Mitigation of financial impact of transfer on our Trust A3) Confirmation of UCH operational and corporate capacity to conclude DD to outcome and implement transition A4) Confirmation of ENHT operational and corporate capacity to implement transition	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
ii) Provide input and support as relevant to NHSE activities to access capital	A1	Deputy CEO/Director of Finance	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues - Input and support provided for UCLH Expression of Interest in capital as part of DHSC new hospitals programme	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	CEO	Ongoing	- Briefing of Regional Director NHSE/I East of England	In progress
iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	SRO (Deputy CEO/Director of Finance)	TBC	- Planning to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Deputy CEO/Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis completed. To be refreshed as required over time	Complete
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Deputy CEO/Director of Finance	Jul-21	- Review of stranded costs agreed with NHSE mid June 2021	Complete
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Director of Finance	01/03/2022 Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- Meetings held in May at which Corporate Directors shared their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Programme Director – MVCC Transfer	May-21 Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- Assurance sought from UCH re resourcing and commitment to delivery Due Diligence activities to revised plan - Initital discussions underway between ENHT and UCLH to discuss transition planning principles, approach and governance	Complete In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Programme Director – MVCC Transfer	Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					

June 21 - Strategic Review Programme Board in May presented a 'Plan A' timeline with Transfer date of April 22 and 'Plan B' timeline which would move the transfer date to July 22. Both dates are at risk due to critical dependency on route to capital, which remains unclear. UCLH Due Diligence reports with revenue and capital requests were submitted at end May 21 to NHSE for assurance process.

June 21 - Strategy Board - discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. Due to the level risk of a delay to the programme increasing the Committee increase the current risk score from 12 to 16. Work being undertaken to mitigate the risk was noted.

July 21 - Strategic Review Programme Board: Confirmation that due to continued uncertainty regarding route to capital, earliest feasible transfer date is now October 2022. In light of the delays, an MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG and HHT) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility. ENHT refresh of scenario analysis in light of the delays, for discussion at July Audit Committee. Government announcement w/c 12th July regarding DHSE competition to fund 8 new hospitals, with Expressions of Interest due early September.

Sept 21 - Expression of Interest in capital for re-provision of MVCC Services was submitted by UCLH to DHSC on 08/09. ENH Trust Board supported the submission (discussed at 01/09 Private Board).
The first MVCC Service Sustainability Group meeting took place 06/09, comprising NHSE, ENHT, UCLH, THH and ENH CCG, to review the sustainability dashboard which will be produced monthly. The Group will next meet in November unless there is an urgent requirement to meet sooner.

Jan 22 - Awaiting feedback following UCLH Expression of Interest in DHSC new hospitals programme for re-provision of MVCC Services. Indications are that short-list of projects to be funded will be published in late spring/early summer. In the meantime UCLH continue to progress their reprovision Business Case and have flagged an expected increase in costs. The second quarterly meeting of the MVCC Service Sustainability Group took place 22/11, to review the Sustainability Dashboard, with no areas requiring escalation.

Mar 22 - Strategic Review Programme Board: Continue to await feedback from the DHSC National Hospital Programme for the re-provision of MVCC Services. The third quarterly meeting of the MVCC Service Sustainability Group took place 01/02 to review the Sustainability Dashboard, with no areas requiring escalation. Hilary Finegan joined the trust 01/03 as MVCC Transfer Programme Director, following the departure of Joanna Osbourne.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim:
compassionate services, consistently across all our sites **Quality: To deliver high quality,**
best patient care **Pathways: To develop pathways across care boundaries, where this delivers**
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term **People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**

Strategic Objective: **b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic progress development and delivery of integrated and collaborative services, making them easier to use for patients** **g) Working with system partners,**	**Source of Risk:**	External/ Civil Contingencies Act	**BAF REF No:** 012/21
Principal Risk Decription: What could prevent the objective from being achieved?**Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**	**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner** Chief Operating Officer/ Chief Nurse
	Risk Review Date:	Mar-22	**Lead Committee:** QSC/ Board

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Covid 19 outbreak/pandemic - impact of varients nationally and world wide -Lifting of the nataional restrictions with no longer a legal requirement to self-isolate -decreased testing with free testing stopping 31st March and no guidance released for the NHS on what is expected from 1st April, self isolation, school closures, sickness. ii) Potential increased need of respiratory and critical care beds iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment , side room capacity and readiroom capacity vi) Likelihood of future surges / increase in covid numbers resulting in an increase in Covid numbers and hospitalisations, ventilated patients and a decrease in available workforce. vii)Future Covid surges combined with a decrease in available workforce could have a negative impact on staff resilience viii) Impact of winter could impact on overall capacity within the hospital	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive.Risk assessments due to the changes in isolation rules to ensure vulnerable patients are not at risk. ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements v) Risk of financial impact if regulatory requirements are not achieved vi) Risk of winter demand/ illnesses on overall capacity within the hospital vii, Increasing Urgent and Emergency Care pressures impacting on overall capacity within the hospital	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	3	10	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident Plan and Business continuity plans in place. Major Incident Command structure - Strategic, Tactical and Operational (Gold , silver, bronze) Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked into and represented at Local and National resilience fourms/ communications/ conference calls Emergency Preparedness, Resilience and Response Committee - Chaired by Managing Director for Unplanned Care COVID Specialist Advisory Group with task and finish group structure reporting to it On call rotas - various Staff training programme - MI, loggist, Fit testing, skills refresh. Mortuary Capacity Plans IPC Policies and BAF Staff well being programme and deployment / reassignment processes - flexible (workforce triggers in place) Monitoring, review and recording of all national guidance and directives received re pandemic People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making Flat packed pathways e.g. Ability to step up capacity esp in respiratory and critcal care pathways LFT testing and fast tracked Point of Care Tests are available for all staff who are critical for a service to continue following a rsik assessment and Executive Director sign off or available to all via the national portal. Staff vaccine hub and vaccination programme currently the covid vaccination hub 'mothballed' Visitors Policies - including agreed triggers if changes required.	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Action Log/ Minutes from Strategic (GOLD), Tactical (Silver) and COVID SAG Trust Communications Visitors Roadmap task and finish group convened to meet the national recommendations for visiting in a safe enviroment.	Compliant with Emergency Planning Core standards 2021/22.	Report to QSC, June 2021 and December 20	
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		

C1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing C2. Possibility of staff being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. C3. Possibility of visitors being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. C5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take C6. There is a risk people in the community with symptoms are directed to ED,lifting of national requirement to isolate if positive and reduced testing availability C7. Business continuity plans may need to include WN-CoV. C8. Updates to national advice daily as the position changes C9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surges on capacity and staffing C10 – Overall hospital capacity limited by winter pressures. Winter initiatives agreed to provide additional capacity.	A1 BCP's for high risk areas / small specialitist services/ On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) A2 Continuity of supplies as position changes - responding to national guidance and alerts A3 Adequacy of Ventilation in clinical areas A4 Implementaion of winter initiatves Ready rooms to prevent further infection and bed closures	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

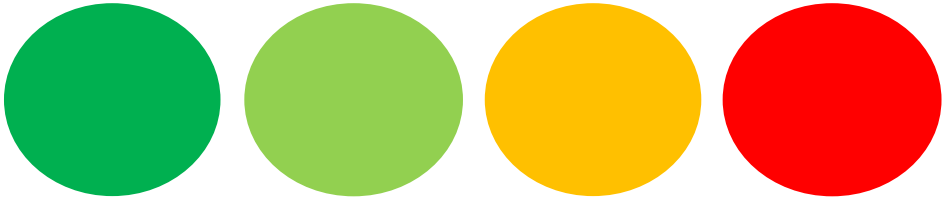
Jan-22	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	A2, C1, C2, C3, C4, C5,	Chief Nurse, Medical Director	Ongoing	Currently meets fortnightly. IPC Summer BAF inder review. Ongoing audit programme. 21 July 2021: meeting weekly meetings reestablished- reporting to SILVER and GOLD. New treatment pathway under development. Test and trace self isolation risk assessment and guidance for staff undeway. Continues to meet weekly / fortnightly dependant on need.	Ongoing
ii) Review of ventilation in clinical areas and develop proposal for improvement	A3	Director of Estates and Facilities/ Ventilation AE	Q1-Q2	Engaged with external company to review the adequacy of the ventilation in the clinical areas and developing a proposal for improvement. This is being monitored through Covid SAG and Health and Safety Committee.	In progress
iii) Prepare for any future National COVID Vaccination Programme in line with National Guidance	C2, C5,	DoF/ CPO / Emergency Planning		July 2021: Awaiting national guidance Sept 21: Covid boosterand flu vaccination programme in place ready to commence in October 21. Vaccination Programmes commenced. November 21: review of mandatory vaccination programme	In progress
iv) Monitoring of triggers to enable responsivness and 'unflat packing' of COVID response if/when required.	C9	COO / Emergency Planning	On going	July 2021: Command and Control structures reviewed - GOLDnow meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. Specialty working groups include - Critical care surge (adults/children), Paeds, Respiratory, Renal, Maternity. October 21: review of the triggers commenced to ensure they remain fit for purpose. Command structure ready to increase freqency if/when required. December 2021: Surge plans and triggers under review	In progress
iv) Implementaion of lessons learnt from previous COVID surges (internal and system)	C7, A1	COO / Emergency Planning	on going	July 2021: Command and Control structures reviewed -Workstreams, task and finish groups and surge plans - reviewed and stood up. Reviewing and preparing taskteam / deployment in readiness to respond.	In progress
v) Annual review programme and testing of the emergency planning standards	A1, C7	COO / Emergency Planning	on going	2020/21 assessment - compliant with the EPRR standards - Report to QSC June 2021. Assessment for the 2021 standards completed and compliant.	completed
vi) Monitoring implemention of winter initiatives (links to risk 1, operational delivery)	C10, A4	COO		see risk 1 performance . Mini nightigale (Additional surge capacity) programme work in line with national guidance	
Summary Narrative:					

June 2021, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. Noted triggers and action in place to 'unflat pack' surge plans and plan in place/underdevelopment for potential increase in children young people attendances/ admissions. July 2021: Command and C|ontrol structures reviewed - GOLD now meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. October 2021: Review of operational triggers and strucutre to support escalation commenced (taking into account the winter pressures) . December 2021 : Frequency of Gold/ Silver incident meetings reviewed and increased in frequency. Review of task and finish groups to support level 4 incident response locally and in line with national requirements. Risk assessment process introduce to support staff return to work in line with National Guidance. February 2022: Successful project to ensure the mini nightingale surge unit for general and acute beds was ready to mobilise at the beginning of February if required. This was fortunately not required and has been stood down. March 22: Although the rates of covid have increased in the hospital and locally, this has not led to increased numbers in CCU, RSU or deaths. Our organisational response to the pandemic remains strong.

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 12 | 2021-22

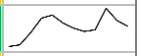
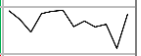
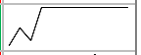
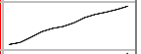
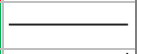
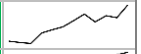
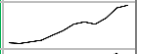
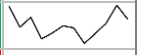


Data correct as at 21/04/2022

NHS Oversight Framework

East and North Hertfordshire NHS Trust

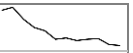
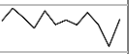
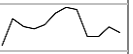
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Monthly	Mar-22	Local	1.9	1.7	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Oct-21 - Mar-22	National	0	2	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Apr-22	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Mar-22	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Mar-22	Local	95.0%	97.3%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Mar-22	Local	90.0%	80.7%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Mar-22	Local	93.0%	0.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Mar-22	Local	93.0%	97.0%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Mar-22	Local	93.0%	91.4%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Mar-22	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Dec-21	Local	15%	16.5%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Apr-21 - Mar-22	NHSI	52	65	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Mar-21 - Feb-22	National	28.85	44.28	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Mar-21 - Feb-22	National	1.10	0.00	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias infection rate	Monthly (12-month rolling)	Mar-21 - Feb-22	National	17.51	12.94	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	Monthly (12-month rolling)	Mar-21 - Feb-22	National	40.79	34.74	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Feb-21 - Jan-22	National	100	90.4	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Dec-21 - Nov-22	National	100	87.2	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Aug-21 - Jan-22	National	4.98%	3.85%	

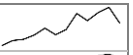
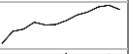
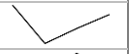
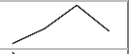
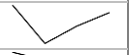
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Feb-22	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	Feb-22	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Feb-22	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	Feb-22	National	1	n/a	
Financial controls	Agency spend	Monthly	Feb-22	National	1	n/a	

Operational performance

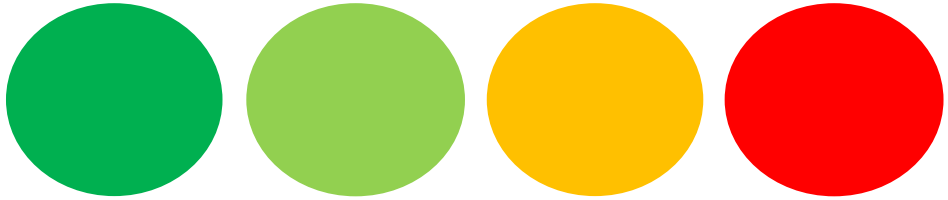
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Mar-22	National	95%	66.64%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Mar-22	National	92%	0.00%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Feb-22	National	85%	87.61%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Feb-22	National	90%	72.73%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Mar-22	National	1%	45.14%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

Leadership and workforce

Organisational health	Staff sickness	Monthly	Feb-22	Local	3.8%	5.27%	
Organisational health	Staff turnover	Monthly	Feb-22	Local	12.0%	13.5%	
Organisational health	Proportion of temporary staff	Monthly	Feb-22	Local	-	12.9%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality & Safety

Month 12 | 2021-22



East and North Hertfordshire NHS Trust

Summary

Key Issues and Executive Response

Incidents and Serious Incidents (SIs)

- 1,093 patient safety incidents were reported in March, with 97% of all incidents reported were low or no harm.
- Outstanding DOC applications reduced from 116. The Divisional breakdown is as follows:
  Unplanned Care – 47 / Planned Care – 52 / Operations – 9
- The recovery plan for overdue serious incidents publications and DOC compliance is priority
- 41 incidents were presented to SIRP in March.
- MDT rounds tables continue to support learning post serious incidents.
- ED and maternity remain a focus due to recognised increased clinical risks.

Deteriorating Patient and Sepsis

- Reliability of documented timely observations within NEWS prescribed timeframe remains a priority.
- Sepsis compliance continue to improve, and no serious incidents related to sepsis were reported in March.
- Reliability of documented observations shall be key focus through the digital transformation programme.
- Support will be given to improve device management at ward level, combined with a relaunch of 'Observation Competency' and NEWS 2.0 competency are planned for April/May 2022.

Patient Experience and Complaints

- An increasing number of formal complaints remained open in March at 204, an improved. number of complaints were closed (74).
- The number of overdue complaints has reduced.
- The Friends and Family Test results sadly also reflect the challenging operational risks currently seen within ED.
- It has been recognised that recovery support is required across quality governance structures to ensure timely response to both complaints and serious incidents.

Infection Prevention and Control

- COVID-19 prevalence has increased nationally in the month of March
- In March, 6 COVID-19 outbreaks were closed and 5 COVID-19 outbreaks are ongoing. COVID-19 outbreaks closed:
  - Planned Care wards: (7B South)
  - Unplanned Care wards: (10A North, SSU, 9B, St Albans and Ashwell)
- Hand Hygiene compliance has been identified as an improvement priority.
- The IPC team was recognised with a Silver award in the annual British Journal of Nursing awards (BJN) on 25 March 2022. The award, which is supported by the Infection Prevention Society, recognises the vital contribution nurses and teams make to infection prevention in healthcare through innovation, evidence-based practice, and vigilance in the workplace. The team would like to thank all staff across the Trust for their dedication to good IPC practices.
- The Trust has been nominated by UKHSA to participate in a Carbapenemase-Producing Enterobacterales/Organisms (CPE/O) point prevalence survey for Intensive Care in our adult and neonatal services, which begins in April 2022 more information to follow next month.
- The Deputy Director and Deputy Lead Nurse of IPC supported the ongoing review and implementation of the Trust visiting guidance.
- Due to the success of the roll out of the Redirooms, and the increase in numbers of COVID-19 positive patients seen in all four categories of hospital onset COVID-19 infections, it was agreed that 40 canopies could be acquired to support the Trust, as there has been a significant burden on Trust operations.
- C.Diff rates are above the target for the financial year. These cases are regularly reviewed and 6 already successfully appealed 6 cases with CCG colleagues and a further 13 that shall also go through appeal processes, which will reduce an internal reduction in year cases.

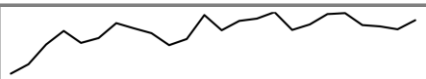
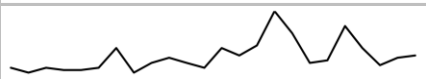
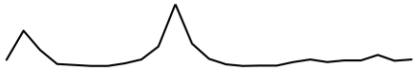
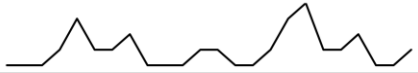
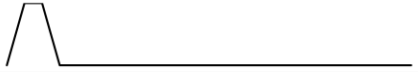
Venous Thrombo-embolism and Hospital-Acquired Thrombosis (HAT)

- No serious incidents related to HAT has been reported in March
- EPMA introduction has seen, as predicted, a reduction in compliance. This remains under close observation.

East and North Hertfordshire NHS Trust

Summary

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

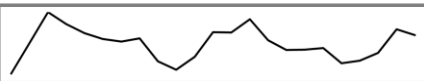
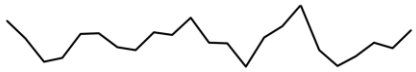
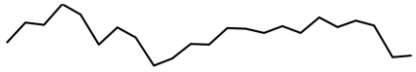
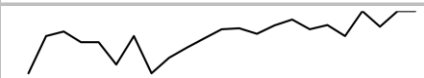
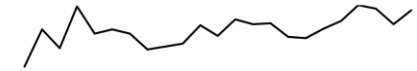
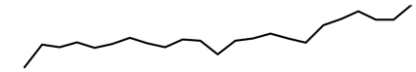
Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Incidents	Total incidents reported	Mar-22	n/a	1,178	◀▶		System change in March 2021
	Serious incidents	Mar-22	5	9	◀▶		Normal variation
COVID	Number of deaths from COVID-19	Mar-22	n/a	16	n/a		
	Number of deaths from hospital-acquired COVID-19	Mar-22	n/a	8	n/a		
Infection Prevention and Control	Hospital-acquired MRSA	Mar-22	0	0	◀▶		Zero hospital-acquired MRSA since Jan-20
	Hospital-acquired c.difficile	Mar-22	n/a	5	◀▶		Normal variation
	Hospital-acquired e.coli	Mar-22	n/a	3	◀▶		Normal variation
	Hospital-acquired MSSA	Mar-22	n/a	3	◀▶		Normal variation
	Hospital-acquired klebsiella	Mar-22	n/a	0	◀▶		Normal variation
	Hospital-acquired *pseudomonas aeruginosa*	Mar-22	n/a	1	◀▶		Normal variation
	Hospital-acquired Carbapenemase Producing Organisms (CPOs)	Mar-22	n/a	0	▼		Zero hospital-acquired CPOs since Jun-20
	Hand hygiene audit score	Mar-22	80%	88.8%	◀▶		Normal variation

Safe Services

East and North Hertfordshire NHS Trust

Summary

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Safer Staffing	Overall fill rate	Mar-22	n/a	78.5%	◀▶		Normal variation
	Staff shortage incidents	Mar-22	n/a	31	◀▶		Normal variation
Cardiac Arrests	Number of Cardiac Arrest calls per 1,000 admissions	Mar-22	n/a	0.73	◀▶		Normal variation
	Number of Deteriorting Patient calls per 1,000 admissions	Mar-22	n/a	1.17	◀▶		Normal variation
Deteriorating Patients	Reliability of observations (4-hour)	Mar-22	n/a	70.3%	▼		Special cause variation (7 consecutive points below mean)
	Reliability of observations (1-hour)	Mar-22	n/a	38.3%	◀▶		Normal variation
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Mar-22	95%	100.0%	◀▶		System change in March 2021
	Inpatients Sepsis Six bundle compliance	Mar-22	95%	53.3%	◀▶		Normal variation
	ED attendances receiving IVABs within 1-hour of red flag	Mar-22	95%	89.3%	◀▶		Normal variation
	ED attendance Sepsis Six bundle compliance	Mar-22	95%	80.0%	▲		Special cause variation (one point above upper control limit)

East and North Hertfordshire NHS Trust

Summary

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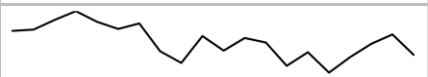
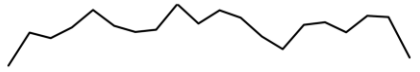
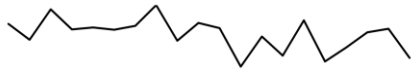
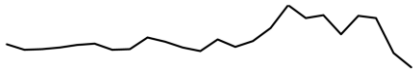
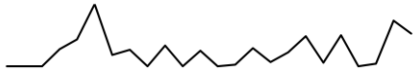
Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
VTE	VTE risk assessment stage 1 completed	Mar-22	95%	70.9%	◀▶		Normal variation
	VTE risk assessment for stage 2, 3 and / or 4	Mar-22	95%	50.6%	◀▶		Normal variation
	Correct low molecular weight heparin prescribed and documented administration	Mar-22	95%	90.0%	◀▶		Normal variation
	TED stockings correctly prescribed and documentation of fitted	Mar-22	95%	57.1%	◀▶		Normal variation
HATs	Number of HAT RCAs in progress (rolling 24 mths)	Mar-22	n/a	-15	▼		Special cause variation (one point below lower control limit)
	Number of HAT RCAs completed	Mar-22	n/a	38	◀▶		Normal variation
	HATs confirmed potentially preventable	Mar-22	n/a	2	◀▶		Normal variation
PU	Pressure ulcers All category ≥2	Mar-22	n/a	21	◀▶		Normal variation
Patient Falls	Rate of patient falls per 1,000 overnight stays	Mar-22	n/a	3.1	◀▶		Normal variation
	Proportion of patient falls resulting in serious harm	Mar-22	n/a	0.0%	◀▶		Normal variation

East and North Hertfordshire NHS Trust

Summary

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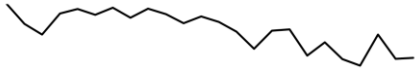
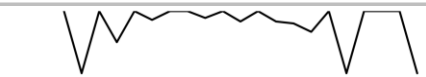
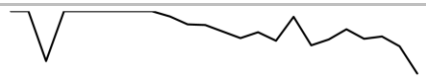
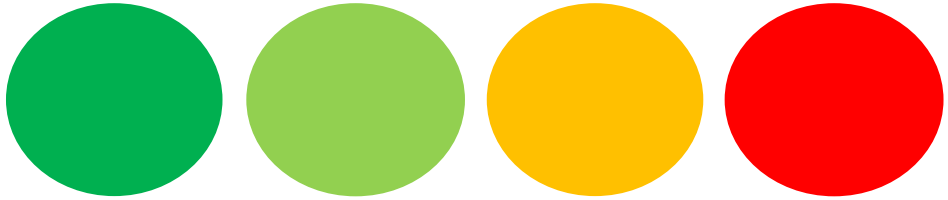
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Friends and Family Test	Inpatient FFT Positive recommendations	Mar-22	93%	97.3%	◀▶		Normal variation
	A&E FFT Positive recommendations	Mar-22	93%	80.7%	▼		Special cause variation (7 consecutive points below mean)
	Maternity FFT - Antenatal Positive recommendations	Mar-22	93%	0.0%	▼		Special cause variation (one point below lower control limit)
	Maternity FFT - Birth Positive recommendations	Mar-22	93%	97.0%	◀▶		Normal variation
	Maternity FFT - Postnatal Positive recommendations	Mar-22	93%	91.4%	◀▶		Normal variation
	Maternity FFT - Community Positive recommendations	Mar-22	93%	100.0%	▲		Special cause variation (9 consecutive points above mean)
	Outpatients FFT Positive recommendations	Mar-22	95%	95.4%	▼		Special cause variation (7 consecutive points below mean)
PALS	Number of PALS referrals	Mar-22	n/a	259	◀▶		Normal variation
Complaints	Number of written complaints received in month	Mar-22	n/a	67	◀▶		Normal variation
	Proportion of complaints acknowledged within 3 working days	Mar-22	75%	78%	▼		Special cause variation (one point below lower control limit)
	Proportion of complaints responded to within agreed timeframe	Mar-22	80%	45%	◀▶		Normal variation

Effective Services

Month 12 | 2021-22



Key Issues

Crude Mortality
- The in-month crude mortality rate decreased to 10.94 deaths per 1,000 admissions in March, compared to 11.85 in February.

- The rolling 12-months crude mortality rate improved to 11.75 deaths per 1,000 admissions in the 12 months to March and is lower than the most recently available national rate of 13.29 deaths per 1,000 admissions (Feb-21 to Jan-22).

Hospital-Standardised Mortality Ratio

- **HSMR has not refreshed since the last IPR, and remains as follows:**
- The in-month HSMR improved from 91.03 in December to 87.89 in January.
- The rolling 12-months HSMR improved from 92.70 to 90.38 in the 12 months to January.
- The Trust is currently in the first quartile of Trusts for HSMR.
- HSMR is usually available 1-2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to November has decreased to 87.19, from 87.99 in October.
- This Trust remains in the 'lower than expected', Band 3 category.

Re-admissions
- The re-admission rate for 12 months to January remained broadly steady at 7.08%, compared to 7.18% in December.
- The Trust's re-admission rate has generally been consistent with national performance. Recent months have seen performance improve, with the Trust tracking below the national average.

COVID-19
- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to the national peer group with mortality tracking in line with the national trend.
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.

Learning from Deaths
- Reforms are underway regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE/I's 'Better Tomorrow' platform. Reforms will include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.

Executive Response

Crude Mortality
- Crude mortality is the factor with the most significant impact on HSMR.
- The general improvements in mortality have resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work, together with a continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with rolling 12 month crude consistently tracking below national.

Hospital Standardised Mortality Ratio (HSMR)
- Following the rebase of their HSMR metric in January2022, CHKS identified a number of issues with their methodology. These errors have now been corrected and the next refresh is awaited to see the final outcome of adjustments made. There has not been a refresh since last month's IPR, with HSMR remaining at 90.38, positioned in the first quartile of trusts nationally.
- Following the National Hip Fracture Databased 3SD outlier alert for #NOF mortality (for the period Jan-Dec 2020) work has continued on the remedial action. The Service reports that a key remaining impediment to improvement is timely access to theatre which is being escalated to the Quality & Safety Committee.

Summary Hospital-level Mortality Indicator (SHMI)
- SHMI remains stable in the 'lower than expected' range.

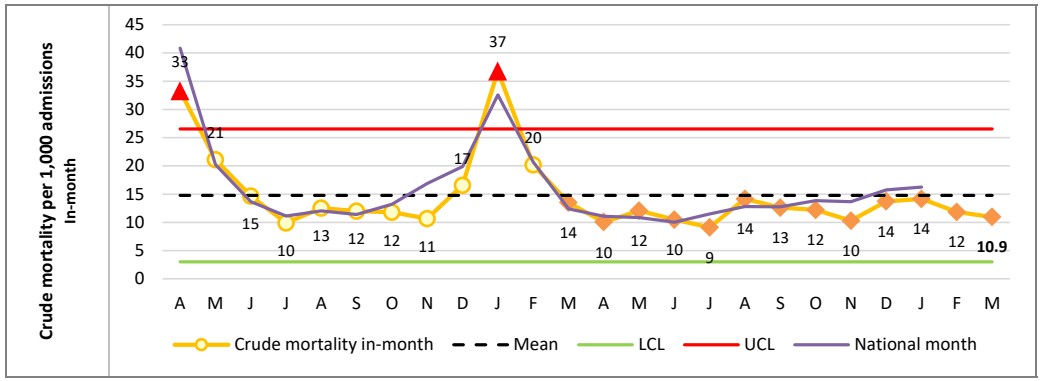
Learning from Deaths
- The SJR Plus review format, soon to be adopted by the Trust, is very different to our existing review tool. Its adoption provides an opportunity to revisit our boarder learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety. Further news will follow over the coming months.

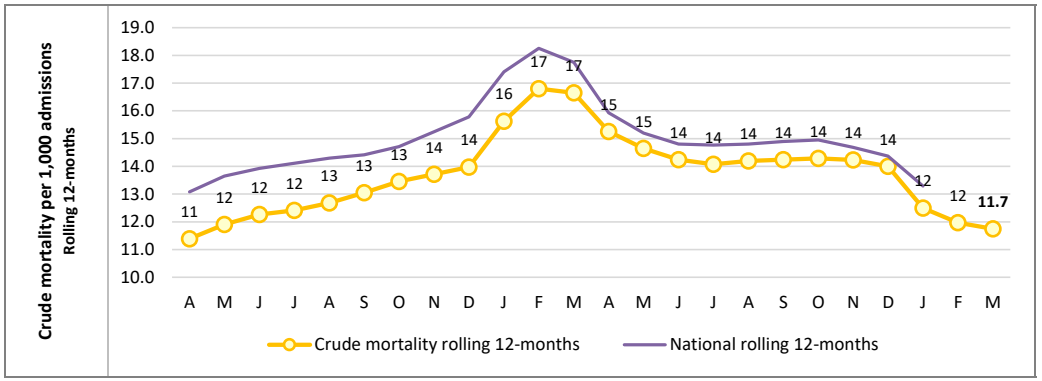
Mount Vernon
- The secession of MVCC as part of the Trust, will affect both our HSMR and SHMI. In preparation for the split, we will shortly begin to report these metrics showing the anticipated effect of the loss of MVCC.

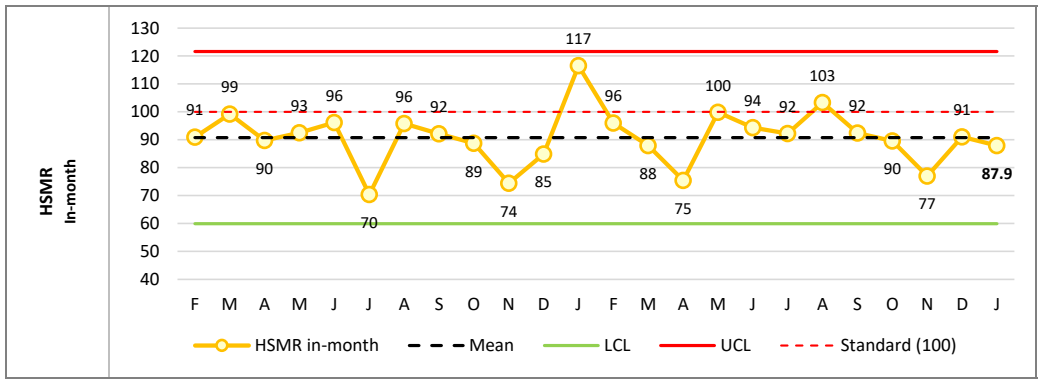
Specialist Palliative Care
- The data provided shows that the portion of patients with whom their preferred place of death has been discussed, has recently risen and stands at 88.4%. The incidence of individualised care pathways remains stable above the mean.

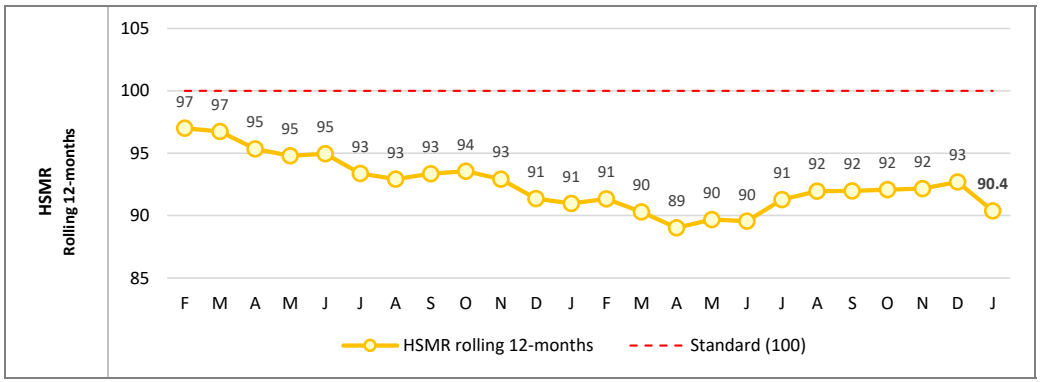
Effective Services

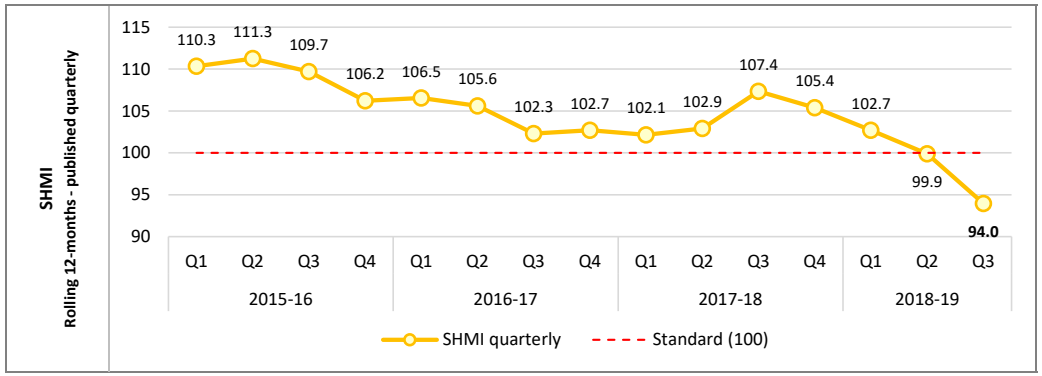
East and North Hertfordshire NHS Trust

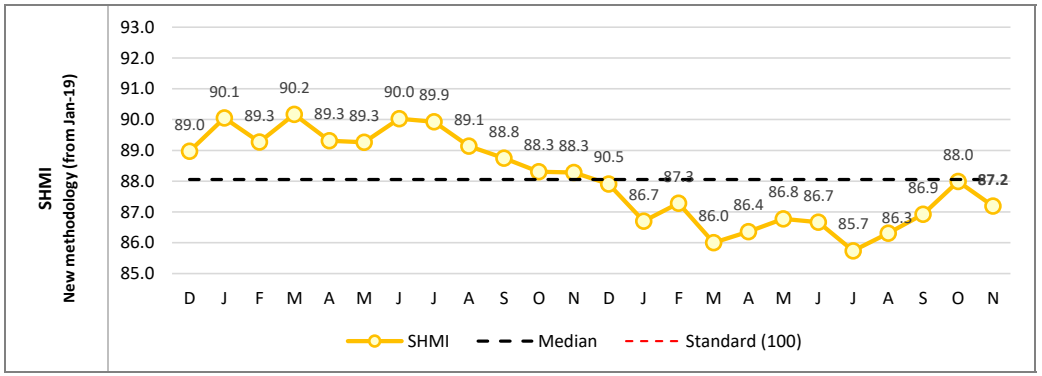






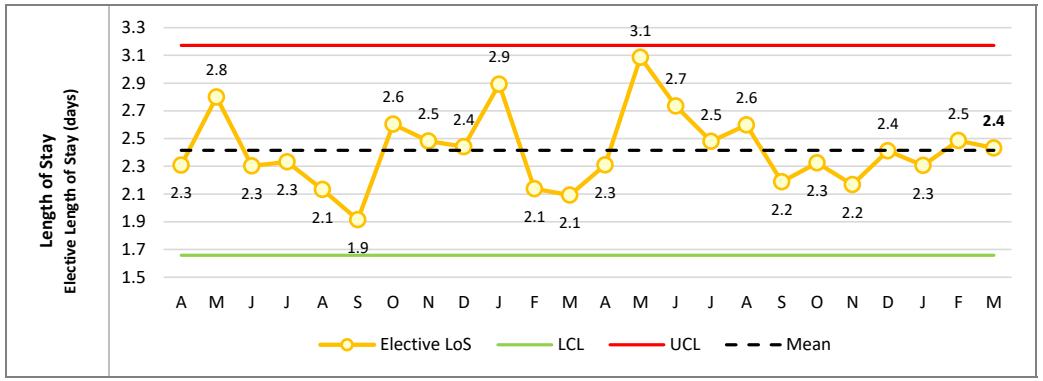


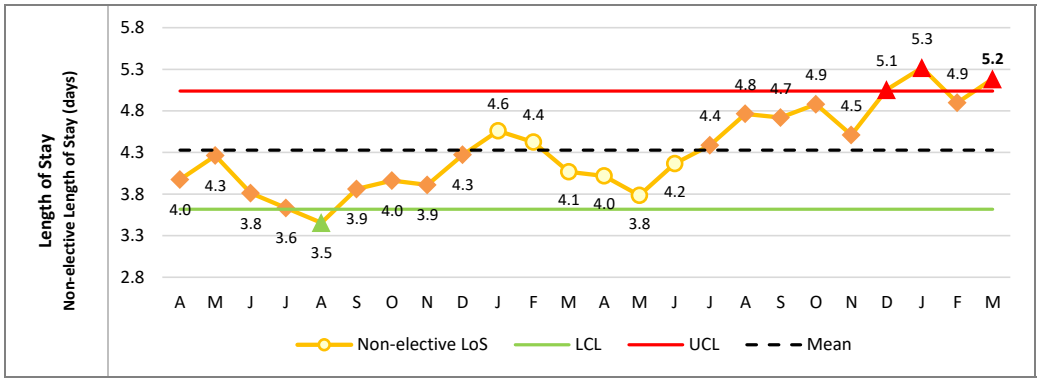


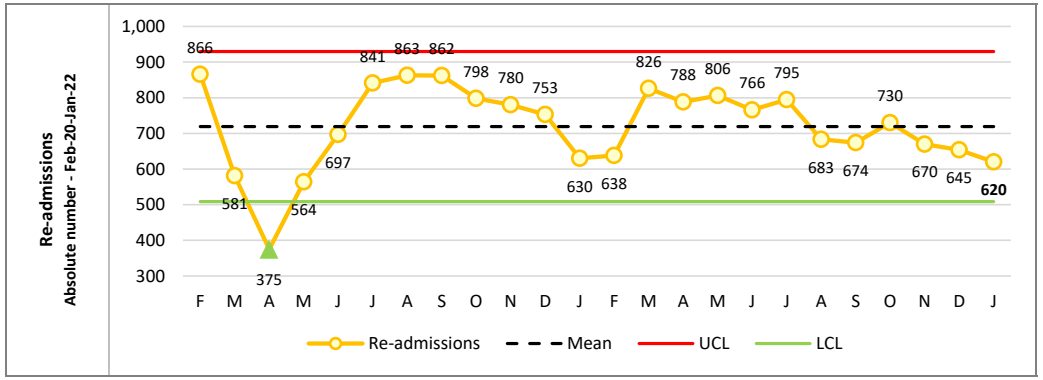


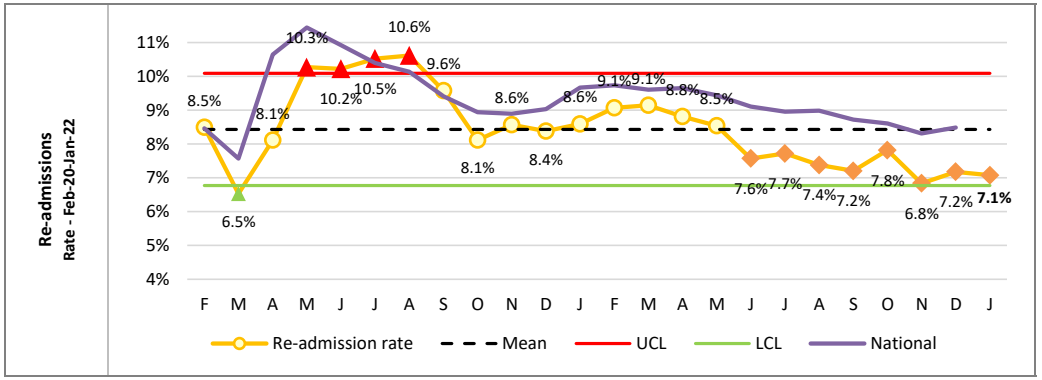
Effective Services

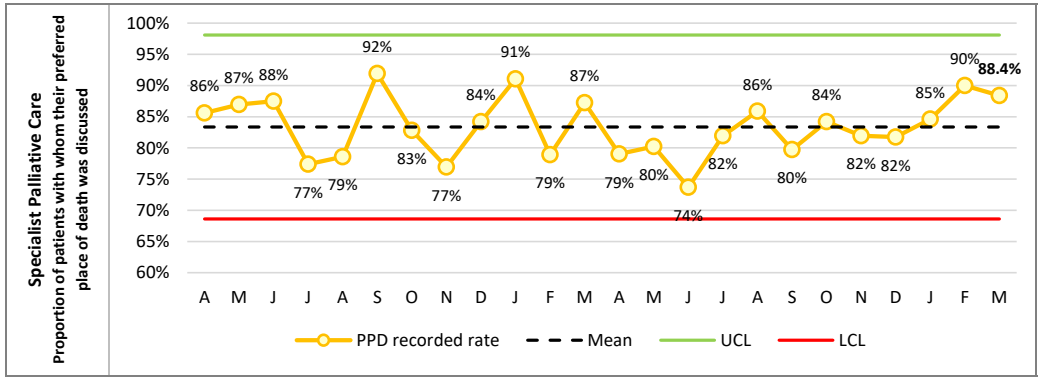
East and North Hertfordshire NHS Trust

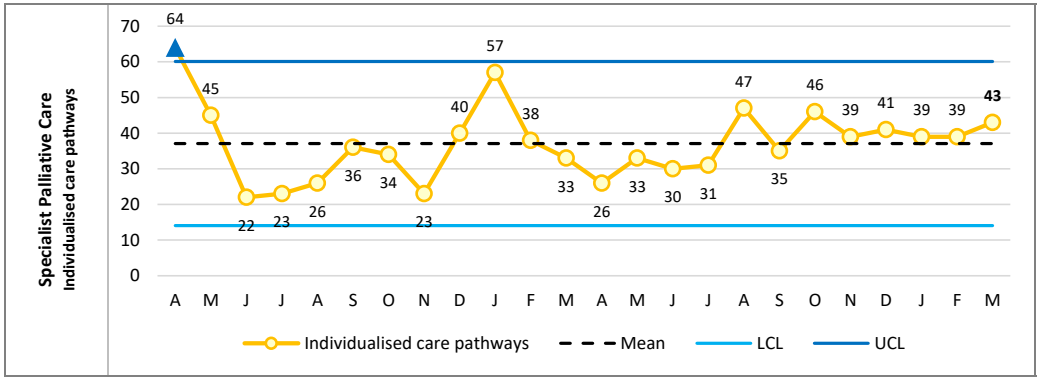






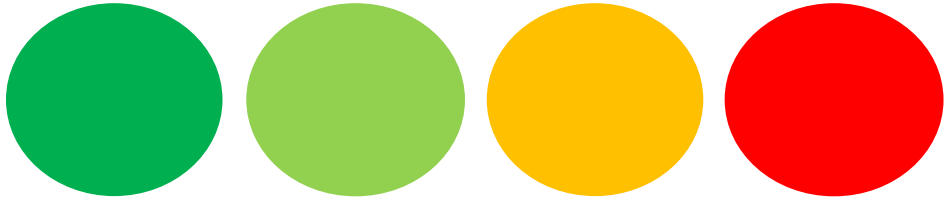






Responsive Services

Month 12 | 2021-22



Key Issues and Executive Response

A&E

- There were 42 12-hour trolley waits reported in March, compared to 19 in Feb. 62% occurred during a significant 4-day period of increased pressure during 13-16th.
- We continued the rapid release pilot throughout March and extended the hours to 24/7. This brought the clinical issue of handover delays to the forefront, resulting in clear actions.
- The trust continues to work with system partners to increase flow associated with complex discharges as well as increasing flow into the virtual ward.

Cancer Waiting Times

- Continued strong performance: achieved 6 of the 8 national targets in February.
- Robust weekly cancer PTL management in place. Good progress on specialty cancer action plans
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.

RTT

- Steady performance. The Trust saw 47.5K outpatients in March, an increase of 17% vs the Apr-19 to Feb-20 monthly average, plus an increase of 1,553 (21%) OP procedures.
- The Trust treated 283 (5%) more day cases, but 56 (10%) fewer inpatients. Increase in Admitted (11%) and Non-Admitted (7%) Clock Stops.
- Patient Tracking list: overall PTL size has increased by 2,079 (4%) vs Feb; 52-week waiters increased by 129 (4%).
- The number of 104 week + waiters has decreased by 15%, to 123 from 144. Detailed plan in place to achieve national requirement of 0 by end June.

Diagnostics

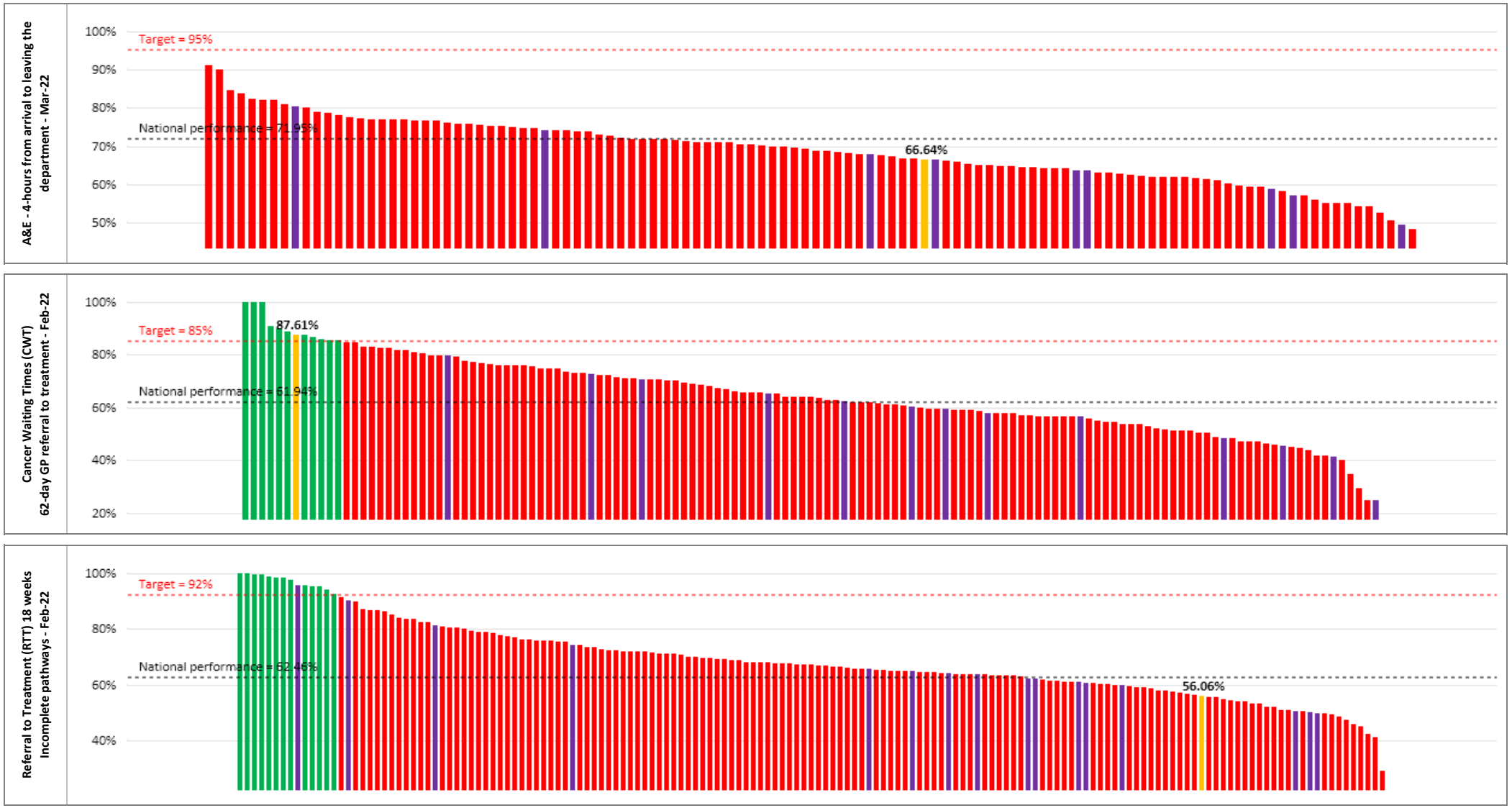
- Deteriorating performance.
- PTL increased by 1897 – 11%.
- 20% (427) increase in patients waiting over 13 weeks vs Feb. Significant increases in cancer referrals.

Stroke

- SSNAP rating performance improvement for last quarter
- ISDN and ENHT first meeting has taken place as part of the New National Stroke Service Model; key themes discussed re SSNAP performance from the MDT groups, providing suggestions and support prior to the regional programme starting in May for next steps within South Region Trusts.

Responsive Services

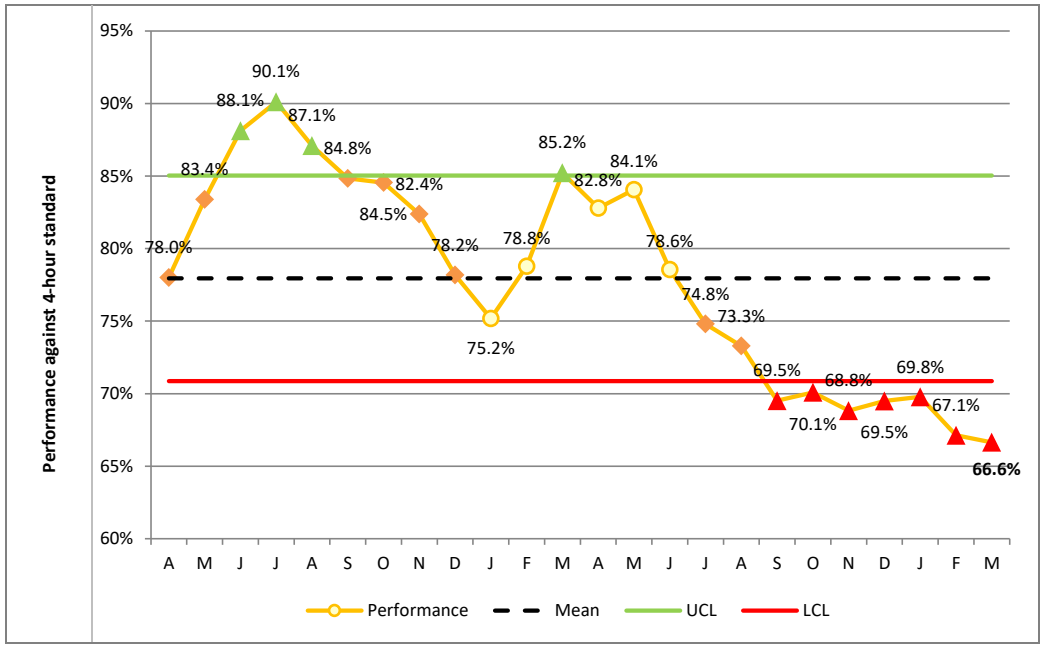
Trust performance against all Trusts nationally



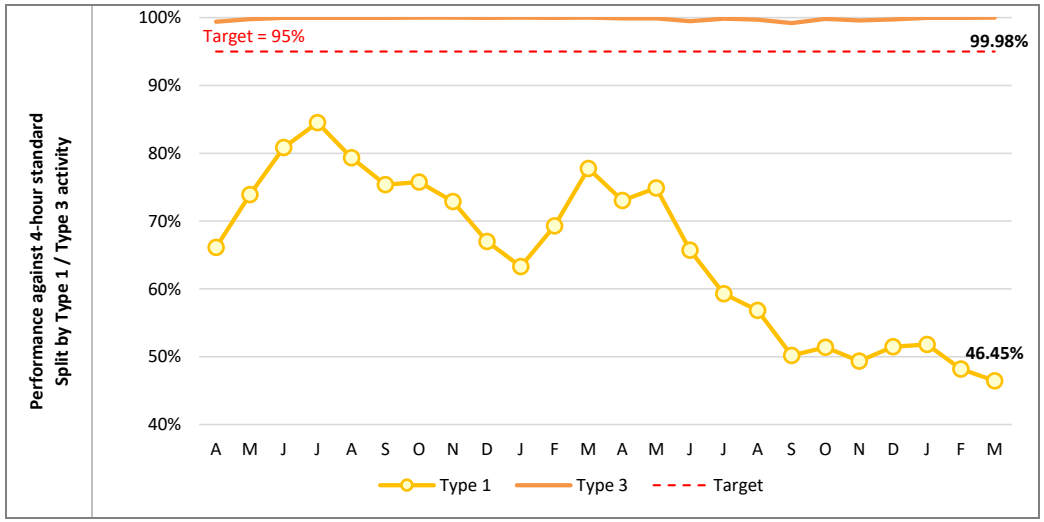
Responsive Services

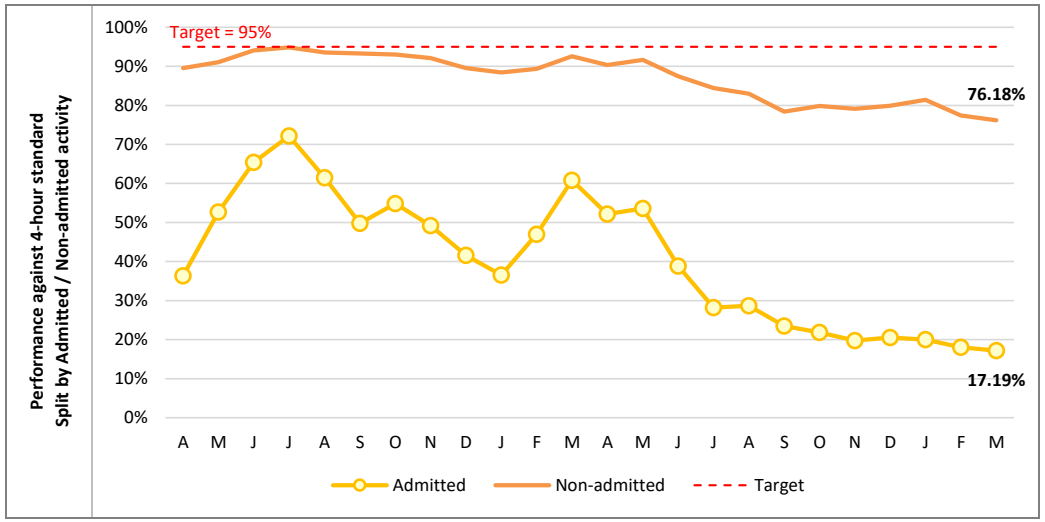
Emergency Department Performance

East and North Hertfordshire NHS Trust

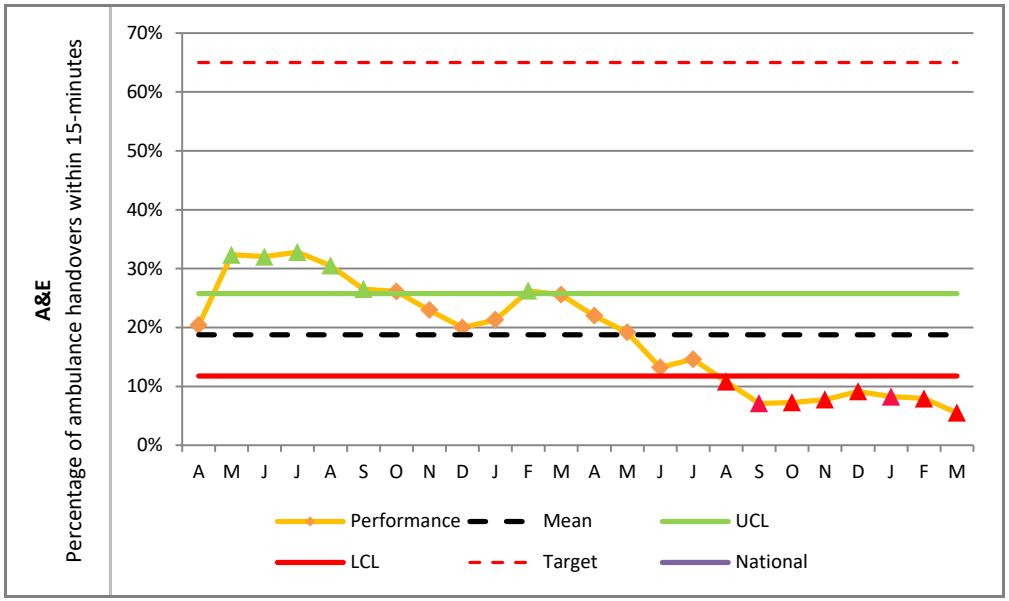


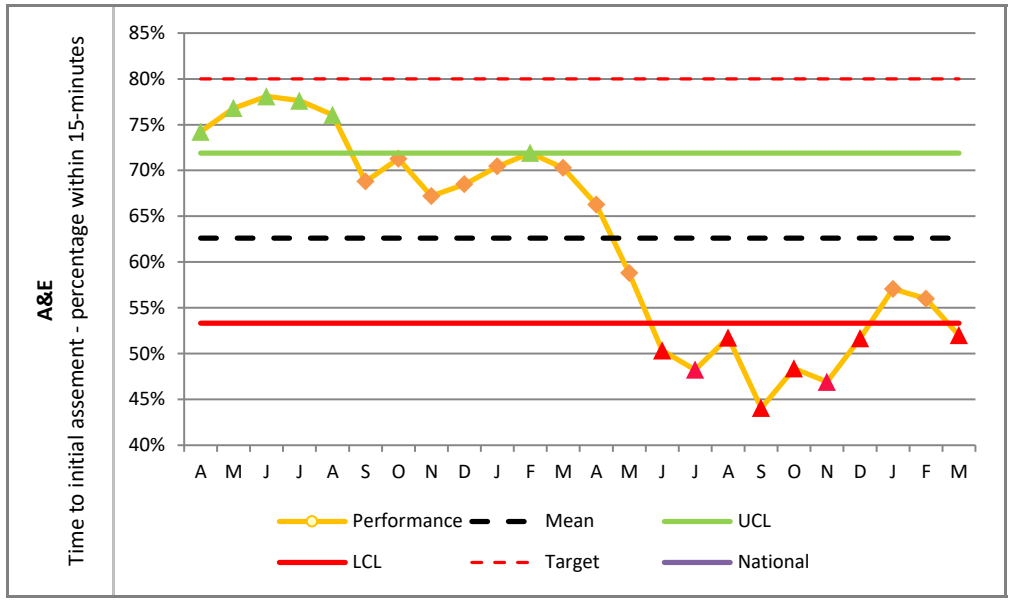
Domain	Metric	Target	Feb-22	Mar-22	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	7.9%	5.5%	▼	
	Ambulance handover breaches 30 minutes	334	787	965	▲	
	Ambulance handover breaches 60-minutes	73	282	388	▲	
	Attendance to admission conversion rate	-	17.5%	16.7%	▼	
	Time to initial assessment Percentage within 15 minutes	-	56.0%	52.0%	▲	
	Average (mean) time in department Non-admitted patients	-	189	196	▼	
	Average (mean) time in department Admitted patients	-	617	634	▲	
	Left department before being seen for treatment	5%	2.26%	2.77%	▲	
	Unplanned re-attendance rate	5%	5.68%	5.41%	▼	

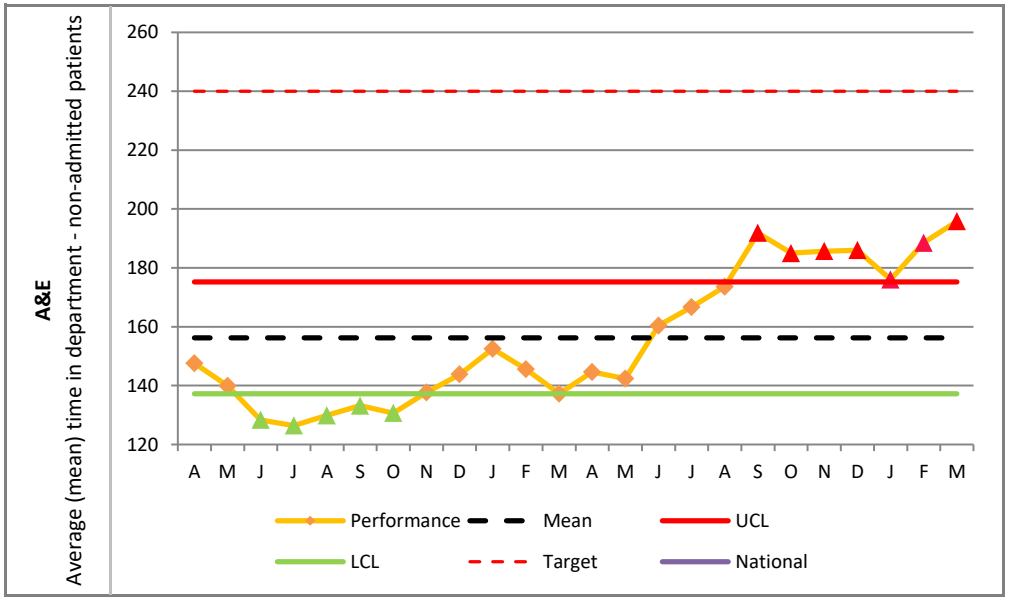


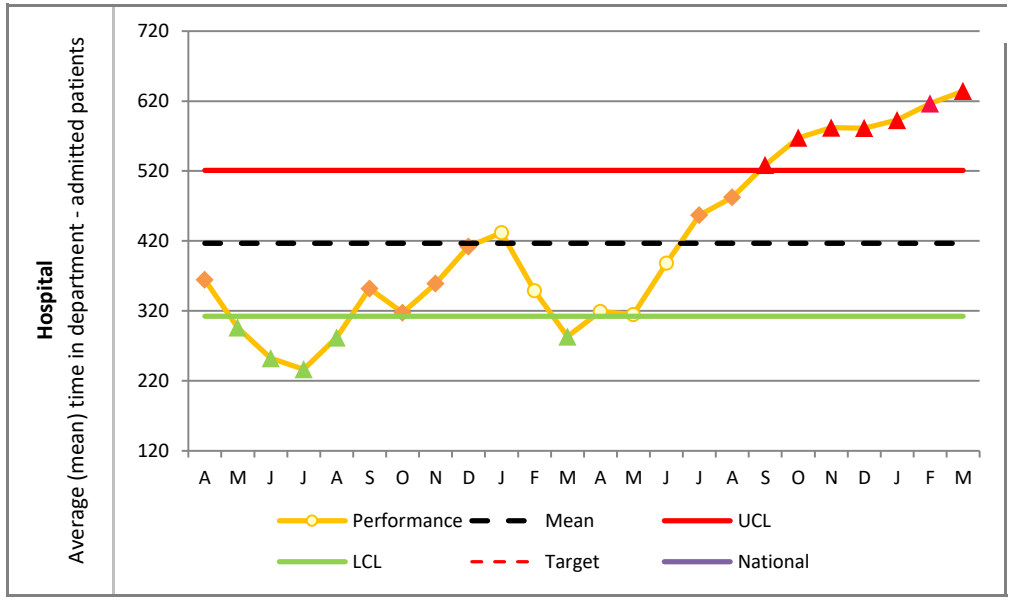


New Emergency Department Standards

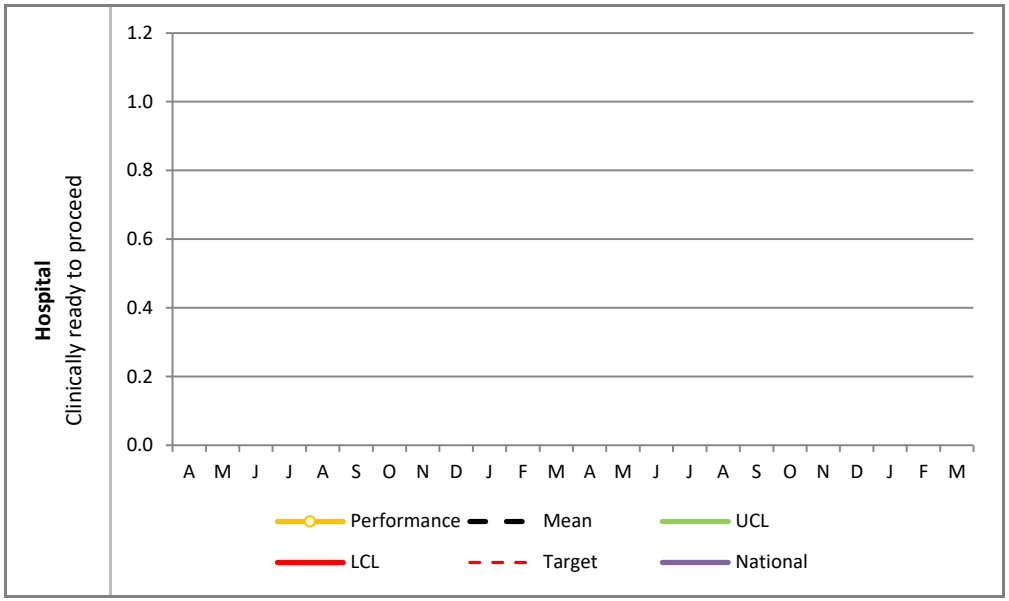


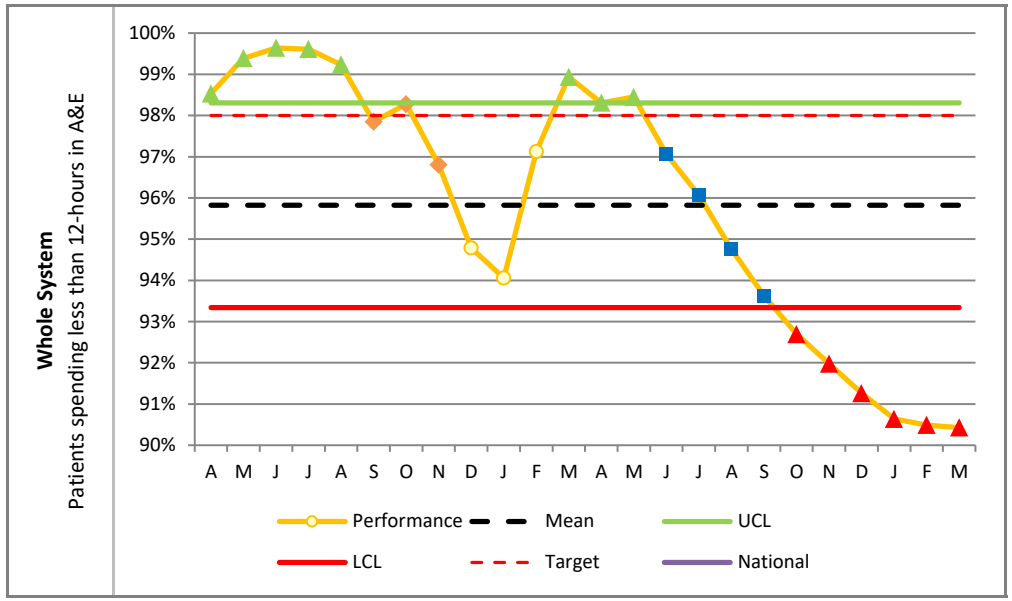


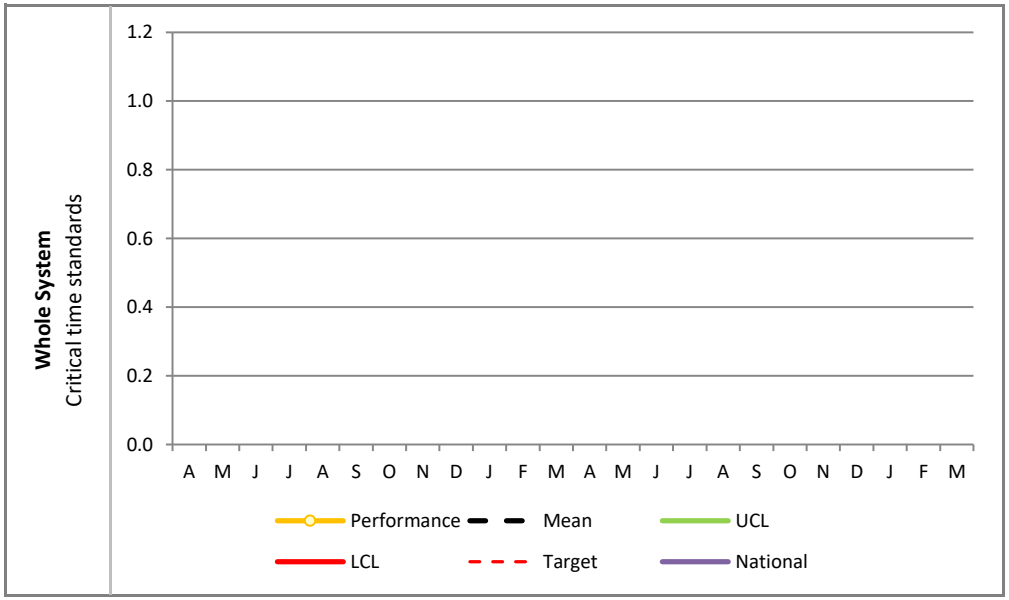




New Emergency Department Standards







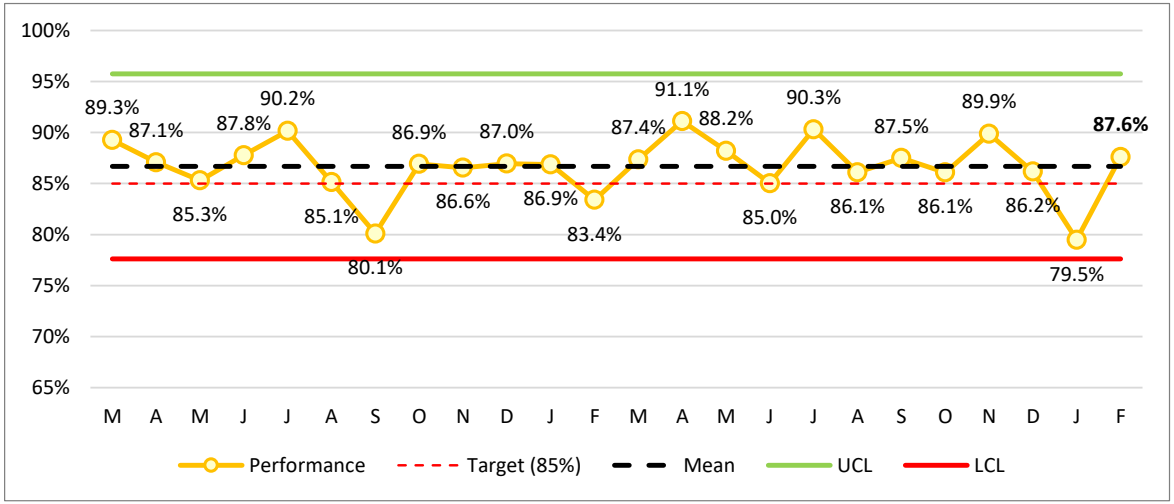
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2020-21		2021-22											
			Mar-21	YTD	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	YTD
	Two week waits Suspected cancer	93%	99.13%	97.26%	96.84%	97.86%	98.60%	97.62%	97.21%	97.49%	97.21%	97.74%	96.96%	94.62%	96.37%	97.17%
	Two week waits Breast symptomatic	93%	100.00%	97.08%	95.10%	95.24%	96.36%	100.00%	97.83%	100.00%	100.00%	97.60%	96.51%	90.11%	97.65%	97.03%
	31-day First definitive treatment	96%	96.97%	98.11%	99.51%	99.51%	96.69%	97.12%	96.93%	96.94%	94.35%	97.54%	98.37%	92.62%	99.55%	97.13%
	31-day subsequent treatment Anti-cancer drugs	98%	100.00%	99.86%	100.00%	100.00%	99.10%	99.48%	99.48%	100.00%	100.00%	100.00%	100.00%	98.94%	100.00%	99.71%
	31-day subsequent treatment Radiotherapy	94%	99.35%	98.87%	99.29%	98.63%	98.50%	98.94%	98.72%	99.37%	99.65%	99.42%	99.07%	100.00%	99.66%	99.20%
	31-day subsequent treatment Surgery	94%	87.76%	92.68%	84.44%	92.50%	88.89%	97.14%	86.67%	78.43%	96.77%	85.00%	87.50%	90.91%	80.77%	87.80%
	62-day GP referral to treatment	85%	87.36%	86.13%	91.12%	88.21%	85.04%	90.32%	86.10%	87.50%	86.09%	89.87%	86.18%	79.50%	87.61%	86.99%
	62-day Specialist screening service	90%	64.29%	69.34%	81.48%	76.47%	75.00%	77.78%	85.00%	88.89%	87.50%	70.00%	70.00%	76.19%	72.73%	77.82%

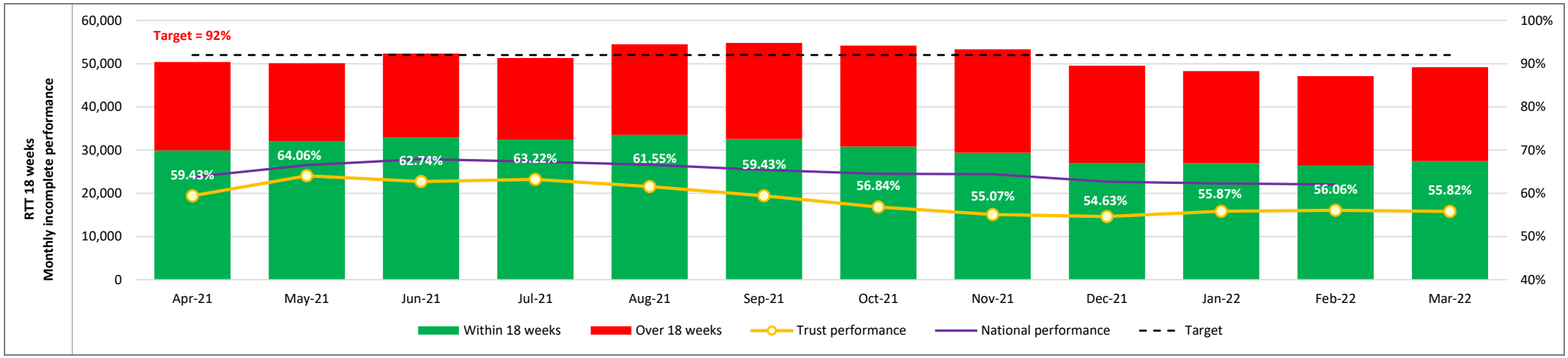
62-day GP referral to treatment Feb-22	Tumour Site	OK	Breach	Total	Perf.	104+ day waits
	Breast	20.5	3.0	23.5	87.23%	1.0
	Gynaecology	3.0	2.0	5.0	60.00%	0.0
	Haematology	2.5	0.0	2.5	100.00%	0.0
	Head and Neck	3.5	1.0	4.5	77.78%	0.0
	Lower GI	9.0	1.5	10.5	85.71%	0.0
	Lung	2.0	0.5	2.5	80.00%	0.5
	Other	1.0	0.0	1.0	100.00%	0.0
	Skin	9.0	3.0	12.0	75.00%	1.0
	Testicular	2.0	0.0	2.0	100.00%	0.0
	Upper GI	8.5	0.0	8.5	100.00%	0.0
	Urology	38.0	3.0	41.0	92.68%	0.0
	Total	**99.0**	**14.0**	**113.0**	87.61%	2.5



Responsive Services

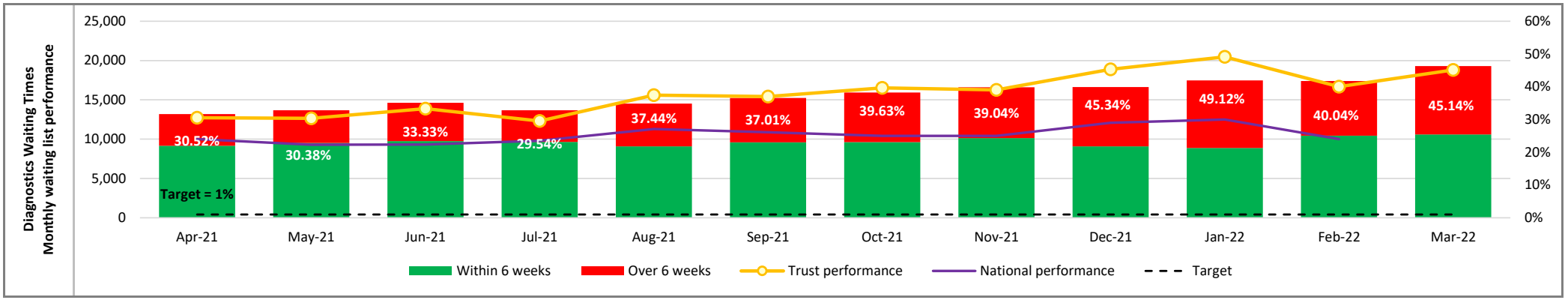
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - Mar-22

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 52 weeks	Over 104 weeks	
General Surgery	263	49.43%	**37**	572	41.08%	13	1,379	808	2,187	**63.05%**	**76**	**1**	644
Urology	202	57.92%	**41**	638	41.85%	5	1,086	799	1,885	**57.61%**	**128**	**2**	493
Trauma & Orthopaedics	90	12.22%	**60**	556	22.30%	51	1,176	2,475	3,651	**32.21%**	**804**	**93**	359
Ear, Nose & Throat (ENT)	118	54.24%	**22**	1,230	24.55%	18	2,278	1,179	3,457	**65.90%**	**121**	**1**	835
Ophthalmology	121	14.05%	**23**	1,876	29.10%	70	2,895	3,034	5,929	**48.83%**	**197**	**0**	950
Oral Surgery	55	10.91%	**34**	854	17.21%	75	587	1,364	1,951	**30.09%**	**309**	**8**	415
Plastic Surgery	257	77.43%	**6**	290	46.90%	0	1,154	391	1,545	**74.69%**	**11**	**1**	613
Cardiothoracic Surgery	0	-	**0**	14	42.86%	0	16	1	17	**94.12%**	**0**	**0**	12
General Medicine	0	-	**0**	0	-	0	17	0	17	**100.00%**	**0**	**0**	14
Gastroenterology	217	76.04%	**24**	664	29.37%	72	2,038	2,535	4,573	**44.57%**	**720**	**3**	894
Cardiology	31	67.74%	**1**	1,404	40.53%	4	1,959	402	2,361	**82.97%**	**4**	**0**	920
Dermatology	1	0.00%	**0**	906	20.42%	1	783	1,010	1,793	**43.67%**	**4**	**1**	357
Thoracic Medicine	24	87.50%	**0**	488	28.69%	2	768	291	1,059	**72.52%**	**2**	**1**	346
Neurology	0	-	**0**	468	45.94%	0	438	37	475	**92.21%**	**1**	**0**	235
Rheumatology	2	100.00%	**0**	268	19.03%	4	457	421	878	**52.05%**	**4**	**0**	170
Geriatric Medicine	0	-	**0**	72	30.56%	0	152	59	211	**72.04%**	**0**	**0**	62
Gynaecology	87	45.98%	**28**	782	21.61%	9	1,895	1,329	3,224	**58.78%**	**68**	**0**	725
Other	171	52.63%	**41**	2,292	80.72%	137	8,376	5,593	13,969	**59.96%**	**864**	**12**	3,845
Total	**1,639**	**53.87%**	**317**	**7,833**	**65.86%**	**461**	**27,454**	**21,728**	**49,182**	**55.82%**	**3,313**	**123**	**11,889**



Diagnostics Waiting Times
In-month performance by Modality - Mar-22

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	1,513	2,610	4,123	63.30%	1,270	1,318	0	286	**1,604**
	Computed Tomography	1,635	1,591	3,226	49.32%	493	1,902	0	2,243	**4,145**
	Non-obstetric ultrasound	4,983	2,250	7,233	31.11%	23	4,932	0	560	**5,492**
	DEXA Scan	522	1,244	1,766	70.44%	672	149	0	0	**149**
Physiological Measurement	Audiology - audiology assessments	38	3	41	7.32%	1	43	0	0	**43**
	Cardiology - echocardiography	991	784	1,775	44.17%	32	1,078	0	0	**1,078**
	Neurophysiology - peripheral neurophysiology	68	0	68	0.00%	0	62	0	0	**62**
	Respiratory physiology - sleep studies	123	0	123	0.00%	0	70	0	0	**70**
	Urodynamics - pressures & flows	53	88	141	62.41%	38	26	0	0	**26**
Endoscopy	Colonoscopy	304	73	377	19.36%	7	318	0	0	**318**
	Flexi sigmoidoscopy	99	25	124	20.16%	1	82	0	0	**82**
	Cystoscopy	25	0	25	0.00%	0	47	0	0	**47**
	Gastroscopy	234	45	279	16.13%	4	291	0	0	**291**
Total		**10,588**	**8,713**	**19,301**	**45.14%**	**2,541**	**10,318**	**0**	**3,089**	**13,407**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

Domain	Metric	2021-22 Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Stroke	Trust SSNAP grade	A	C	C	C	D	D	D	C	C	C	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	88.9%	87.5%	66.7%	100.0%	85.7%	100.0%	91.7%	100.0%	100.0%	100.0%	77.8%	78.6%	
	4-hours direct to Stroke unit from ED Actual	63%	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	23.3%	19.7%	25.0%	25.7%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	66.7%	45.0%	65.5%	47.5%	34.8%	29.5%	34.0%	17.3%	24.3%	19.0%	25.4%	21.9%	
	Number of confirmed Strokes in-month on SSNAP	-	63	62	59	85	72	65	57	78	74	70	71	70	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	80.0%	80.3%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	55.6%	58.1%	49.2%	45.9%	56.9%	49.2%	50.9%	50.0%	48.6%	38.9%	54.9%	58.3%	
	Scanned within 12-hours - all Strokes	100%	98.2%	91.9%	96.6%	94.1%	97.2%	93.8%	96.5%	98.7%	97.3%	97.2%	98.6%	95.8%	
	% of all stroke patients who receive thrombolysis	11%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	12.5%	7.7%	4.1%	11.4%	12.9%	11.4%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	33.3%	50.0%	
	Discharged with JCP	80%	75.8%	91.9%	87.0%	52.6%	72.3%	81.6%	86.8%	90.7%	86.3%	72.7%	64.4%	67.3%	
	Discharged with ESD	40%	56.8%	73.0%	73.9%	60.7%	70.2%	71.7%	65.8%	60.4%	62.7%	62.2%	55.3%	50.0%	

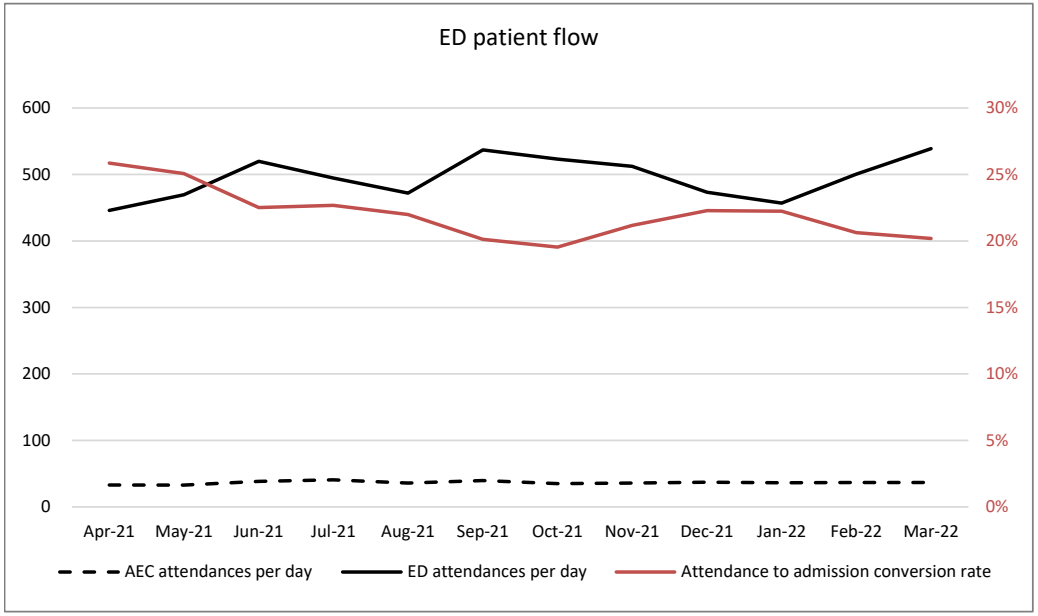
Breaches Mar-22	Breach reasons			Breach reasons: In-hours: 22 Out-of-hours: 31
		• Challenging Diagnosis/Complex Patients = 13 • Late referral = 5 • Share Care Transfers = 3 • Pathway (ED delays) = 7	• Bed Capacity = 12 • Inpatient Stroke = 0 • Patient Related = 0 • COVID POC = 13 • Other = 0	

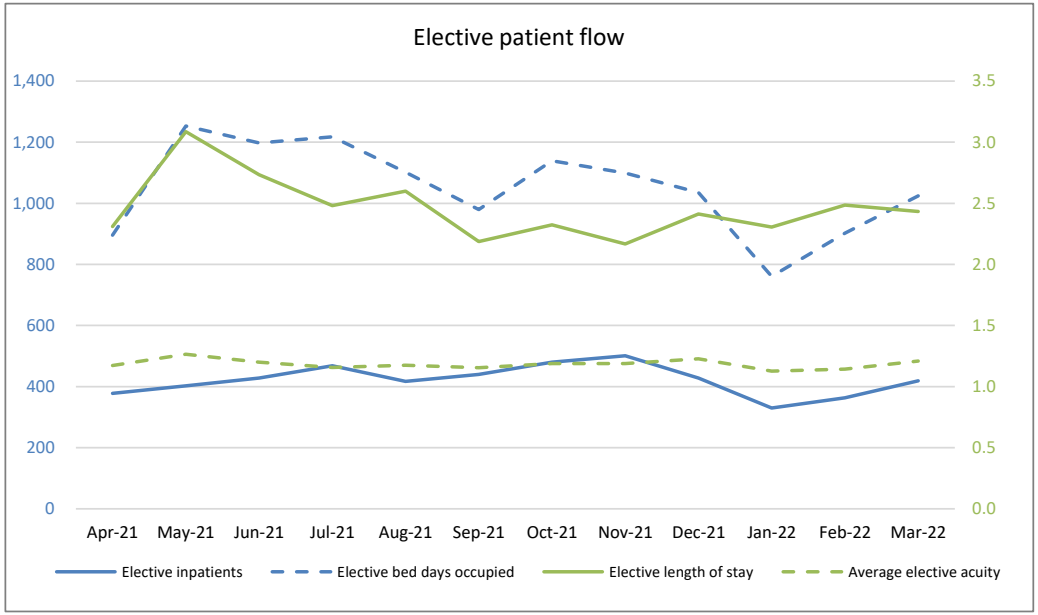
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	13,470	14,720	15,859	15,633	14,928	16,384	16,591	15,617	14,675	14,165	14,015	16,705	
	Attendance to admission conversion rate	25.9%	25.1%	22.5%	22.7%	22.0%	20.1%	19.5%	21.2%	22.3%	22.2%	20.6%	20.2%	
	ED attendances per day	446	470	520	495	472	537	523	512	473	457	501	539	
	AEC attendances per day	33	33	39	41	36	40	35	36	37	36	37	37	
	4-hour target performance %	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	70.1%	68.8%	69.5%	69.8%	67.1%	66.6%	
	Time to initial assessment Percentage within 15 minutes	22.0%	19.1%	13.2%	14.6%	10.8%	7.1%	7.3%	7.7%	9.1%	8.3%	7.9%	5.5%	
	Ambulance handover breaches 30-minutes	380	341	586	548	812	783	932	797	672	869	787	965	

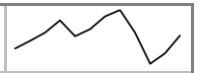
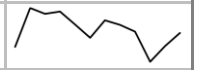
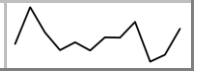
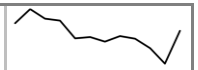
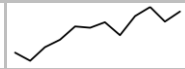
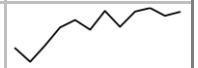
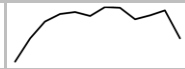
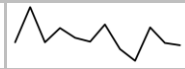
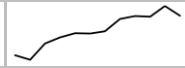
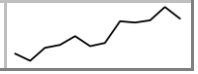




Responsive Services

Patient Flow

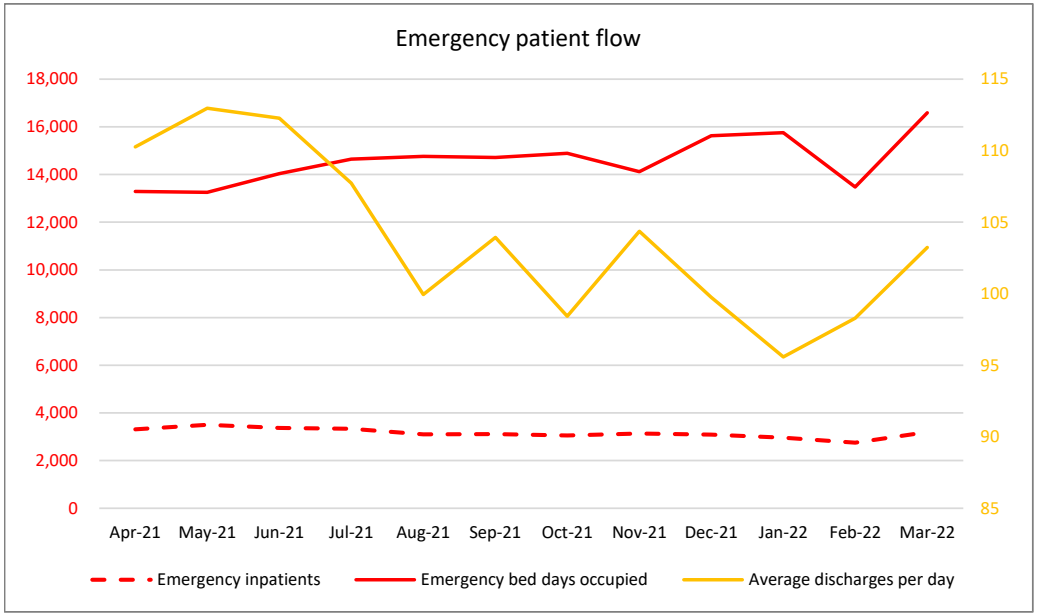
East and North Hertfordshire NHS Trust

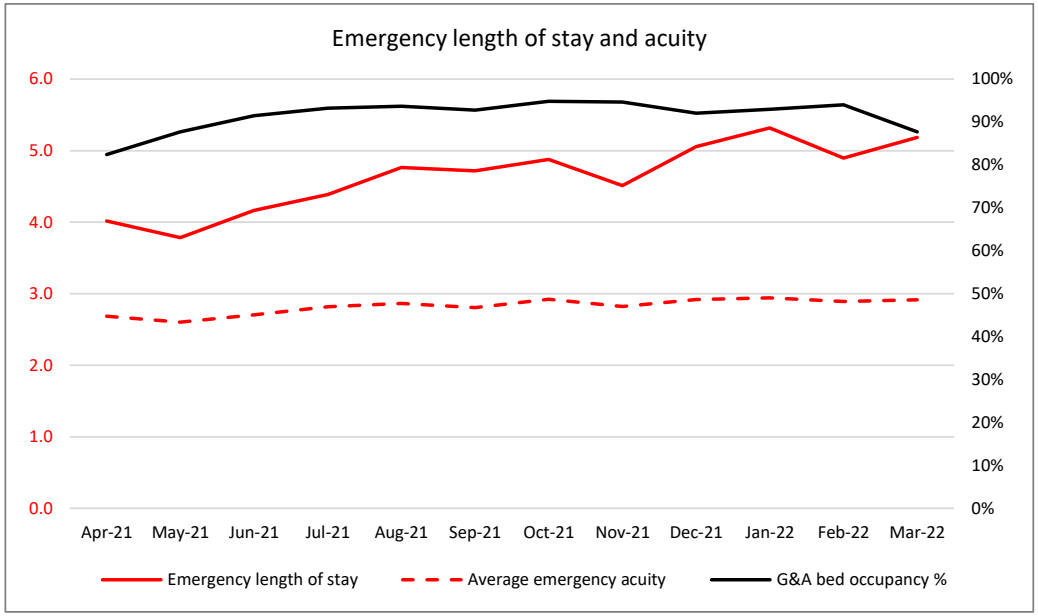
Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Elective Inpatient Flow Indicators	Elective inpatients	378	403	428	468	417	440	480	501	428	330	363	419	
	Elective bed days occupied	896	1,253	1,198	1,218	1,102	980	1,139	1,099	1,035	761	902	1,024	
	Elective length of stay	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.2	2.4	2.3	2.5	2.4	
	Daycase rate %	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.6%	87.7%	90.4%	90.4%	89.9%	
	Average elective acuity	1.17	1.26	1.20	1.16	1.18	1.15	1.19	1.19	1.23	1.13	1.14	1.21	
Emergency Flow Indicators	Emergency inpatients	3,308	3,502	3,368	3,340	3,098	3,118	3,052	3,131	3,092	2,963	2,752	3,200	
	Average discharges per day	110	113	112	108	100	104	98	104	100	96	98	103	
	Emergency bed days occupied	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,122	15,631	15,758	13,480	16,589	
	Emergency length of stay	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.5	5.1	5.3	4.9	5.2	
	Average emergency acuity	2.7	2.6	2.7	2.8	2.9	2.8	2.9	2.8	2.9	2.9	2.9	2.9	
	G&A bed occupancy %	82%	88%	92%	93%	94%	93%	95%	95%	92%	93%	94%	88%	
	Patients discharged via Discharge Lounge	436	477	534	534	538	626	646	659	679	640	644	640	
	Discharges before midday	14.7%	14.6%	14.2%	13.3%	14.0%	15.7%	14.2%	14.7%	14.2%	13.7%	13.6%	14.2%	
	Weekend discharges	14.6%	19.0%	14.5%	16.3%	15.1%	14.6%	16.8%	13.7%	12.2%	16.4%	14.5%	14.2%	
	Proportion of beds occupied by patients with length of stay over 14 days	16.6%	15.9%	18.5%	19.5%	20.1%	20.1%	20.5%	22.4%	22.9%	22.8%	24.5%	22.9%	
	Proportion of beds occupied by patients with length of stay over 21 days	8.9%	8.1%	9.6%	9.9%	11.0%	9.8%	10.2%	12.7%	12.5%	12.8%	14.4%	13.0%	

Responsive Services

East and North Hertfordshire NHS Trust

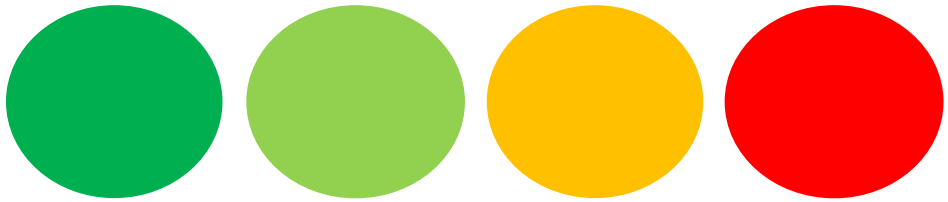
Patient Flow





People Report

Month 12 | 2021-22



Executive Summary

Work

- Vacancy rate overall has decreased slightly from 6.7% to 6.6% (414 vacancies).
- Plans to continue collaboration with the ICS for international nurse recruitment for 22/23 is underway. Additionally, international recruitment is taking place for therapists, midwives and radiographers. 15 international radiographers commenced in 21/22.
- A tailored approach to nursing hotspots such as theatres and paediatrics is underway, with UK based campaigns proving successful, and supported by international recruitment plans.
- Candidate experience rating remains high at 4.7 out of and time to hire is at 11 weeks (against a target of 10 weeks).

Thrive

- Team talks on staff survey are launched with actions to be agreed and collated to enable measure against local actions agreed throughout 2022.
- Staff turnover continues to show a gradual increase, we know from exit data that from Nov-21 to-date of 237 leavers 59 left due to end of contract/retirement reasons and 124 due to voluntary resignation, i.e. lack of development, promotion, Work Life Balance.
- The average length of suspension is beginning to decline as was skewed due to cases both of long-term nature and one outside of our internal controls.
- The increase in time to resolve disciplinaries is in part due to availability of investigation officers time and resource capacity in the system.
- The time to resolve grievances continues to improve as a direct result of the ERAS team continuing to follow up and encourage early resolution.

Grow

- A full launch programme for the new April to August cycle has commenced in March 2022, with a series of Trust briefing messages. Virtual training sessions and drop in events are planned in March and April and during the appraisal cycle.
- The work on early access to the ENH academy for new joiners as part of the on-boarding process is on-going and expected to be completed by the end of March 22. Following this the next phase will include developing the automatic transfer of training records via the inter authority transfer process, which will support improving mandatory training compliance.
- To improve mandatory training compliance weekly notifications are being sent in March via In-brief (newsletter) to prompt managers to check staff compliance and ensure they are up to date prior to the grow together review cycle commencing.
- 264 staff are undertaking apprenticeships across the Trust, with approximately 120 staff on the clinical support L2 apprentice programme. Recent apprenticeships include a QI apprentice which the Trust is currently exploring.

Care

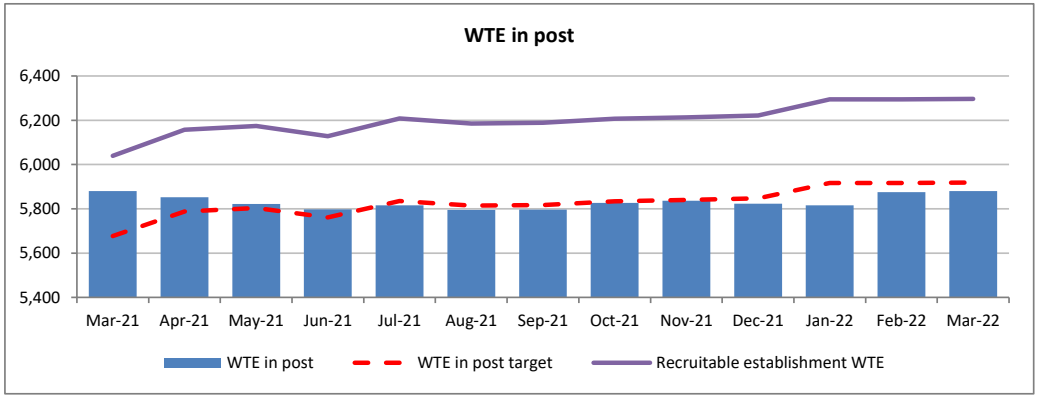
- The People Pulse Survey is live in this month and closes on
- Sickness absence rates have decreased in February by 0.99%, however caution is advised due to rising numbers of positive Covid amongst staff currently occurring.
- Focus on induction and onboarding underway to support improvement of creating a caring work environment.
- We have submitted our SEQOHS application for Health@Work services.
- There continues to be a reduction in FTE days lost to mental health related absence compared to the previous month.
- A Jubilee staff thank you with afternoon tea at Luton Hoo is being launched by the charity with staff nominating in 5 categories and staff with most thank yous will attend, 25 places are available.
- Winter wellbeing is being delivered with decorating and furniture in place at various sites and locations as part of delivery on make a wish scheme promises.

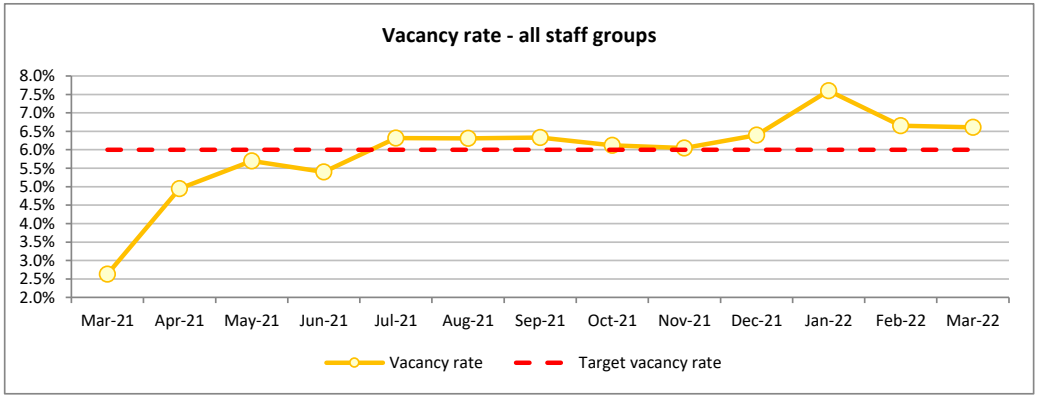
People Report

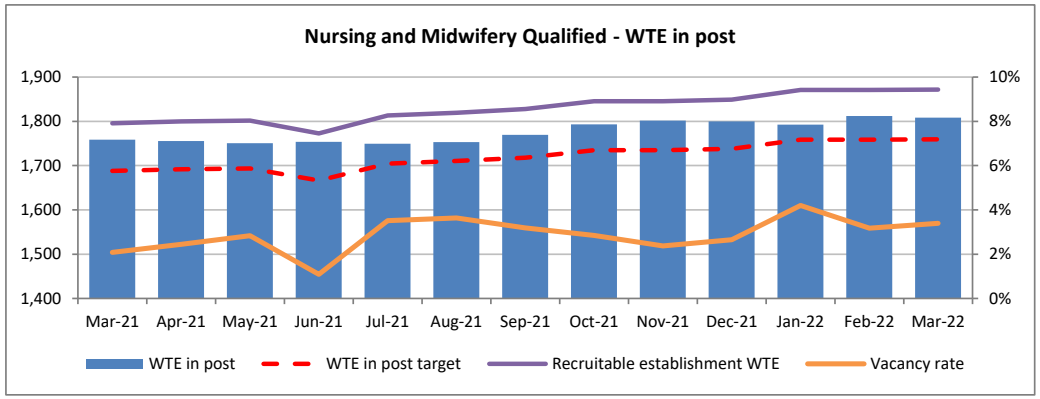
Work Together

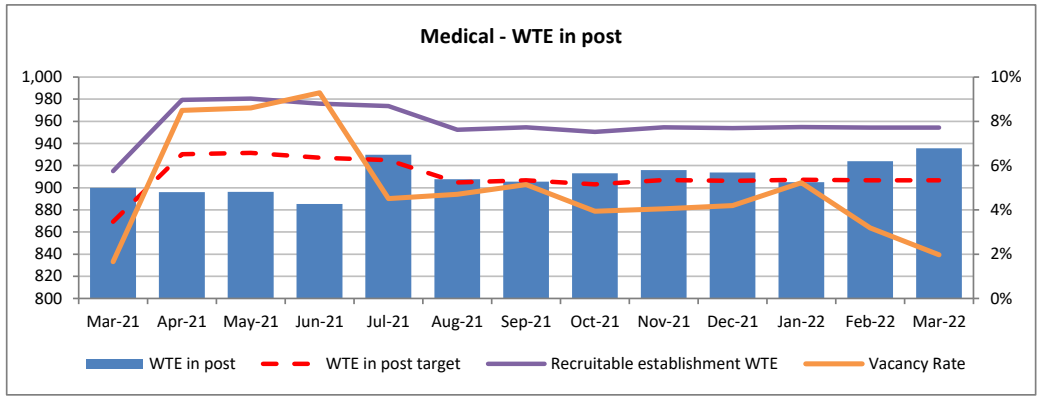
East and North Hertfordshire NHS Trust

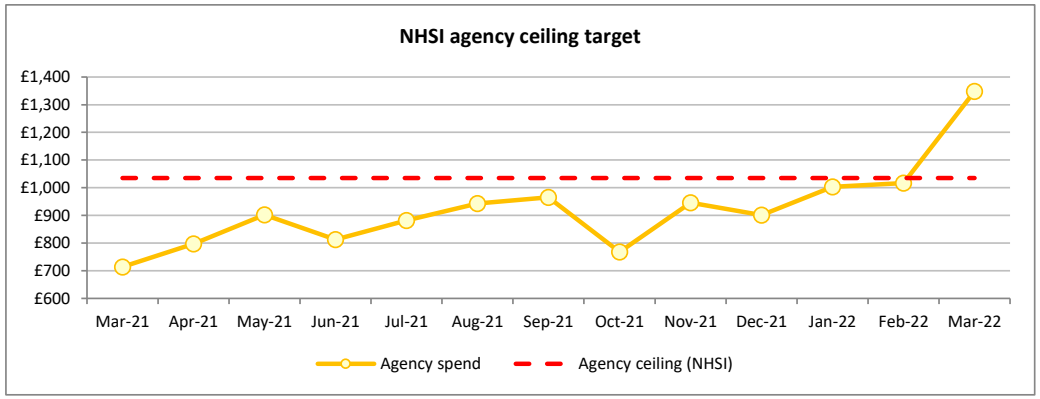
Domain	Metric	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Work	Vacancy Rate	6%	2.6%	5.0%	5.7%	5.4%	6.3%	6.3%	6.3%	6.1%	6.1%	6.4%	7.6%	6.7%	6.6%	
	Time to hire (weeks)	10	10	11	11	10	9	9	9	10	10	10	11	11	11	
	Recruitment experience	4	4.4	4.7	4.7	4.7	4.7	4.7	4.6	4.5	4.5	4.5	4.7	4.7	4.7	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	2.00	2.00			1.43			1.53			1.58			
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	0.70	1.20			1.62			3.10			1.23			
	Agency Spend (% of WTE)	4%	3.3%	3.5%	2.9%	3.3%	3.3%	3.6%	3.1%	3.0%	3.4%	3.1%	3.5%	3.6%	5.3%	
	Bank Spend (% of WTE)	10%	8.6%	10.4%	8.4%	8.1%	7.9%	9.2%	8.5%	9.0%	8.7%	10.7%	11.5%	8.7%	9.8%	
	% of Clinical Workforce (AFC) on eRoster	> 90%	81%	81%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	
	% of Medical & Dental on eRoster	> 60%						83.0%	83.0%	84.0%	83.0%	84.0%	84.0%	84.0%	84.0%	
	% of Rosters Approved more than 6 weeks in advance (NHS E/I recommended)	> 80%						62.0%	43.5%	63.5%	58.9%	61.2%	68.5%	68.2%	47.7%	
	% Staff on Annual Leave	13% - 17%	17.1%	19.1%	12.0%	12.0%	13.4%	16.7%	15.0%	11.3%	12.7%	12.4%	15.6%	13.8%	17.1%	
	Pulse survey Flexibility	55%	60.0%	64.3%			56.6%			tbc			tbc			

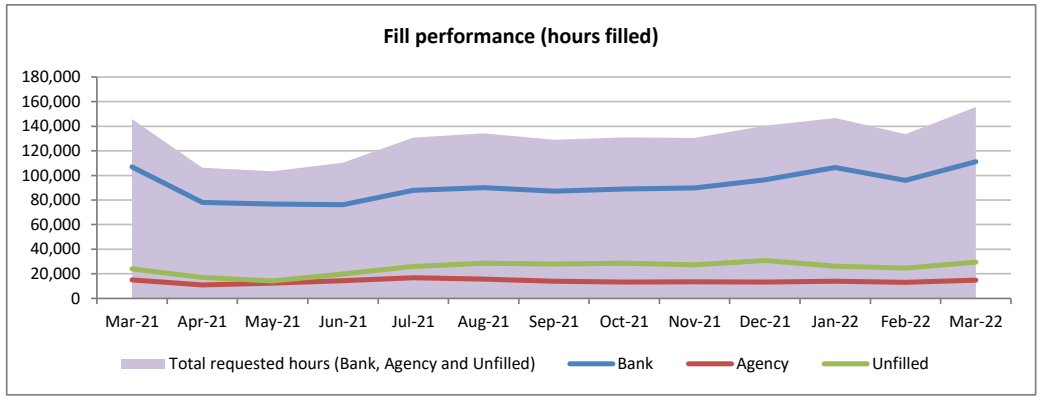


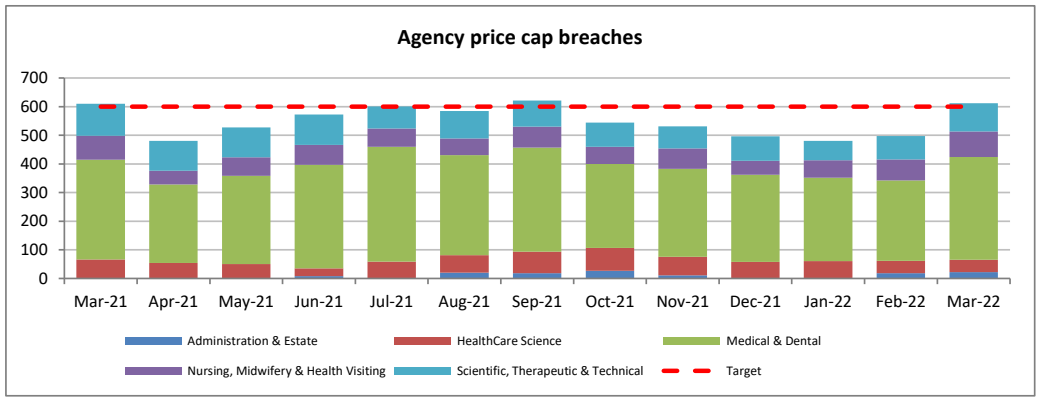


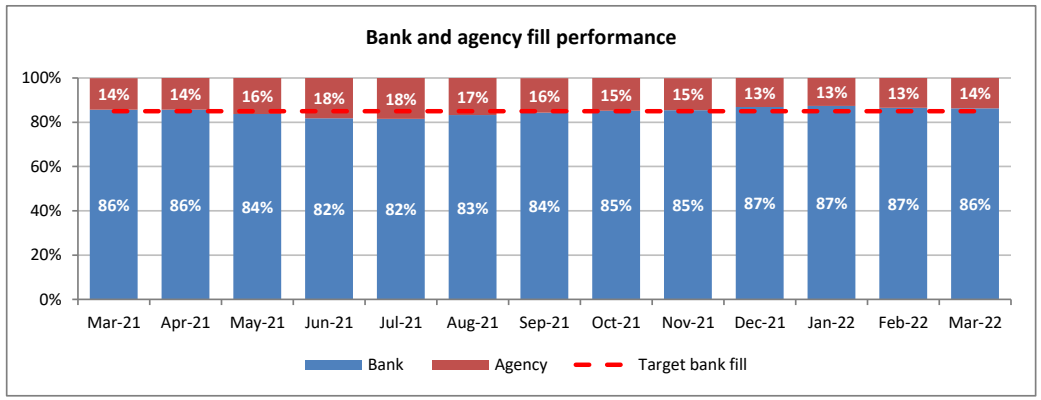

Nursing and Midwifery Qualified - WTE in post
1,900
1,800
1,700
1,600
1,500
1,400
10%
8%
6%
4%
2%
0%
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy rate


Medical - WTE in post
1,000
980
960
940
920
900
880
860
840
820
800
10%
8%
6%
4%
2%
0%
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy Rate


NHSI agency ceiling target
£1,400
£1,300
£1,200
£1,100
£1,000
£900
£800
£700
£600
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
Agency spend
Agency ceiling (NHSI)


Fill performance (hours filled)
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
Total requested hours (Bank, Agency and Unfilled)
Bank
Agency
Unfilled


Agency price cap breaches
700
600
500
400
300
200
100
0
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
Administration & Estate
HealthCare Science
Medical & Dental
Nursing, Midwifery & Health Visiting
Scientific, Therapeutic & Technical
Target

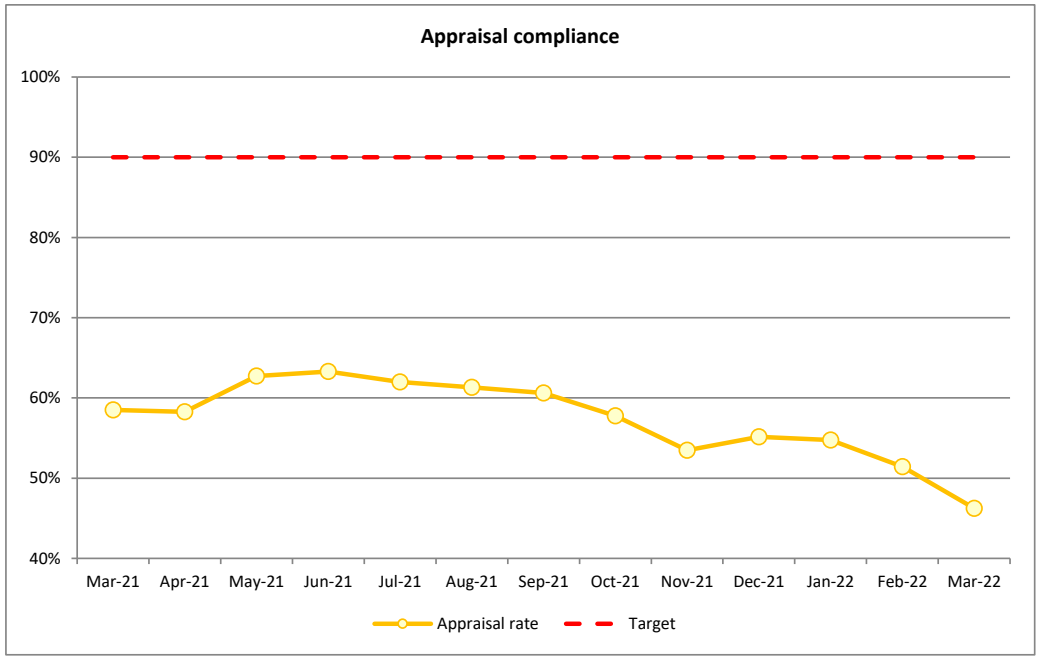

Bank and agency fill performance
100%
80%
60%
40%
20%
0%
14% 14% 16% 18% 18% 17% 16% 15% 15% 13% 13% 13% 14%
86% 86% 84% 82% 82% 83% 84% 85% 85% 87% 87% 87% 86%
Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
Bank
Agency
Target bank fill

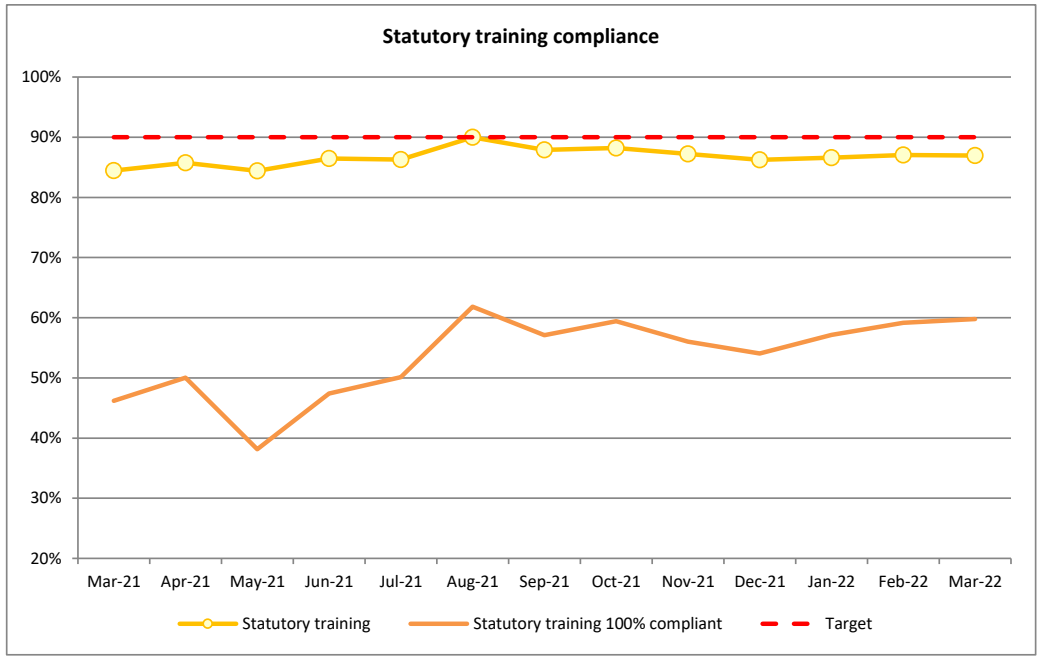
People Report

Grow Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Grow	Statutory & mandatory training compliance rate	90%	84.4%	85.8%	84.4%	86.5%	86.3%	90.0%	87.9%	88.2%	87.2%	86.2%	86.6%	87.0%	86.9%	
	Appraisal rate	90%	58.5%	58.3%	62.7%	63.3%	62.0%	61.3%	60.6%	57.8%	53.5%	55.2%	54.8%	51.4%	46.3%	
	Pulse survey Training and development opportunities	55%	52.1%	55.4%			55.1%			tbc			tbc			
	Pulse survey Talent management	55%	51.3%	61.8%			55.4%			tbc			tbc			
	Likelihood of training and development opportunities (BAME)	1	tbc	tbc			tbc			tbc			tbc			
	Likelihood of training and development opportunities (Disability)	1	tbc	tbc			tbc			tbc			tbc			



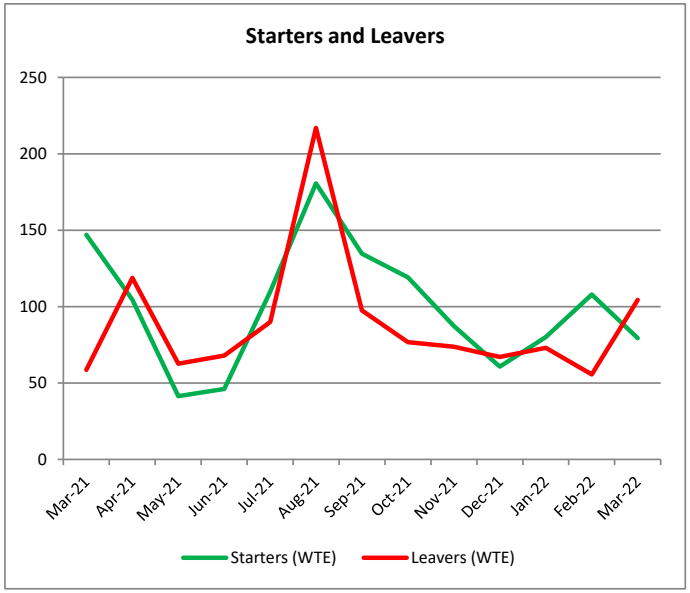


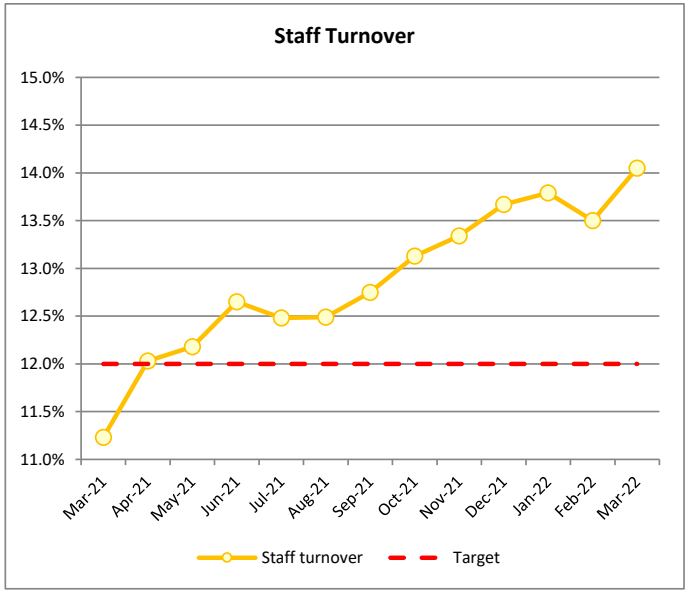
People Report

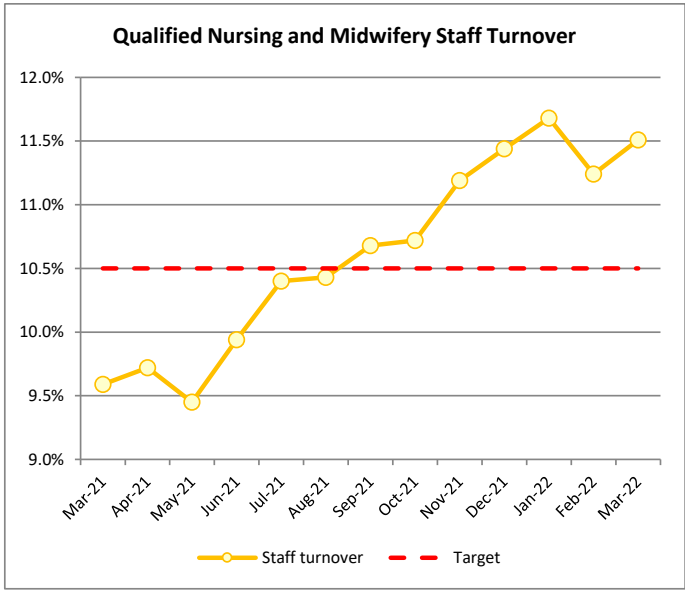
Thrive Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Thrive	Pulse survey My leader	75%	79.8%	85.5%			79.8%			tbc			tbc			
	Pulse survey Harnessing individuality	60%	57.7%	61.8%			52.8%			tbc			tbc			
	Pulse Survey Not experiencing discrimination	95%	68.4%	75.9%			70.8%			tbc			tbc			
	Turnover Rate	12.2%	11.2%	12.0%	12.2%	12.7%	12.5%	12.5%	12.8%	13.1%	13.3%	13.7%	13.8%	13.5%	14.1%	
	Model employer targets (% achieved)	100%	67%	50%			67%			83%			50%			
	Average length of suspension (days)	20	37.0	59.0	57.2	76.6	105.0	96.0	142.5	140.0	177.5	86.0	226.5	201.0	137.2	
	Average length of Disciplinary (excluding suspensions) (days)	60	148.0	168.0	63.0	47.7	86.0	74.0	71.6	51.0	54.9	43.5	72.5	112.4	86.3	
	Average length of Grievance (including dignity at work) (days)	60	91.0	82.0	80.0	86.0	74.0	37.9	23.3	37.0	46.9	45.9	57.7	64.8	94.2	





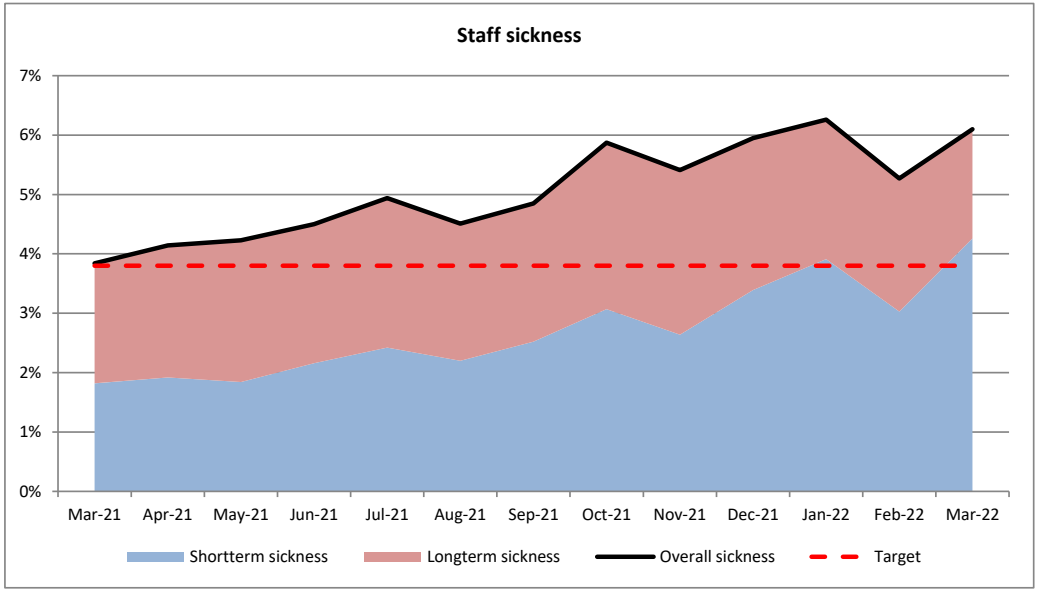


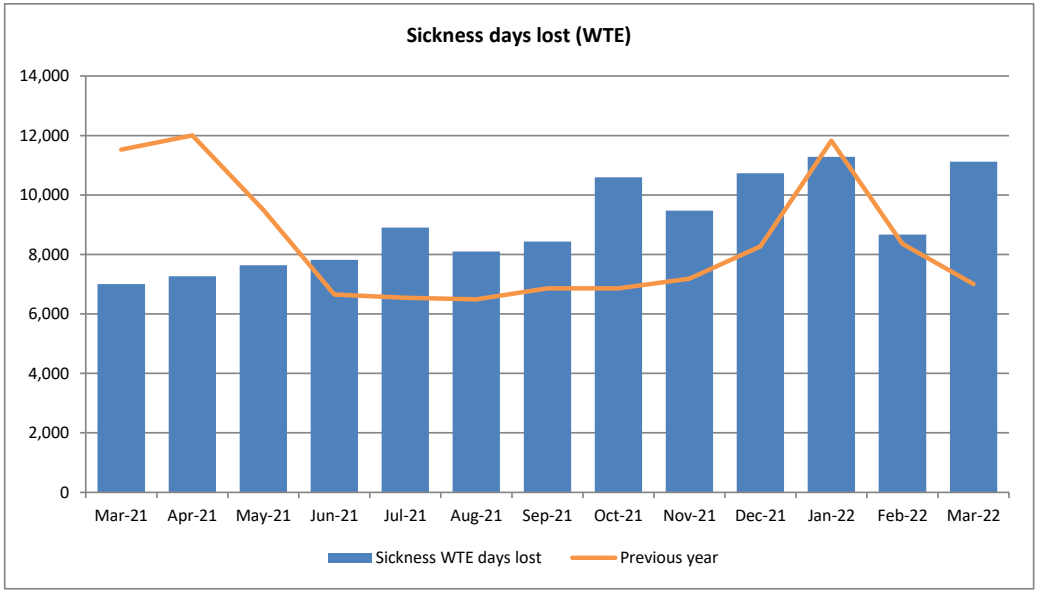
People Report

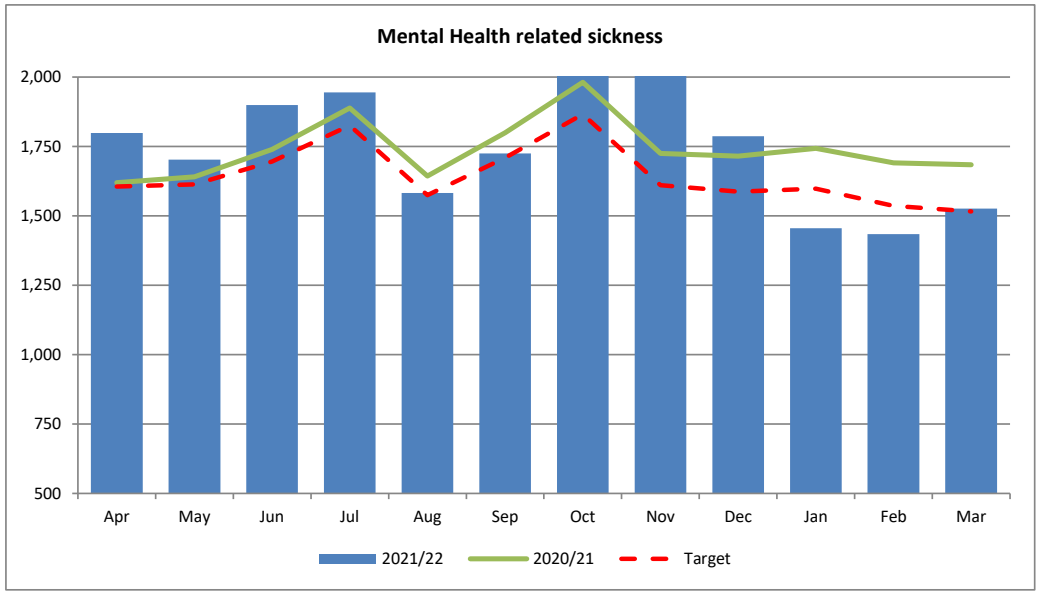
Care Together

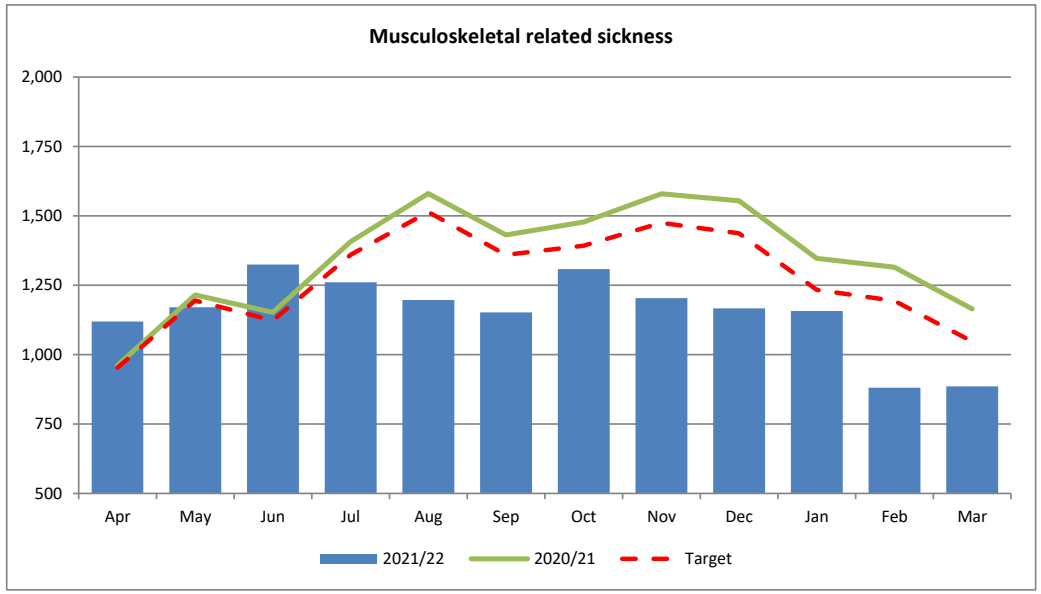
East and North Hertfordshire NHS Trust

Domain	Metric	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Care	Pulse survey Well-being	70%	68.6%	78.9%			71.5%			tbc			tbc			
	Pulse survey Reasonable adjustments	50%	60.4%	88.7%			91.4%			tbc			tbc			
	Staff FFT Recommend as a place to work	60%	47.8%	56.6%			41.7%			tbc			tbc			
	Staff FFT Recommend as a place of care	70%	70.3%	72.7%			65.9%			tbc			tbc			
	Sickness Rate	3.8%	3.84%	4.14%	4.23%	4.50%	4.94%	4.51%	4.85%	5.87%	5.41%	5.93%	6.26%	5.27%	6.10%	
	Sickness FTE Days Lost	6,777	7,005	7,265	7,633	7,818	8,905	8,102	8,437	10,599	9,474	10,735	11,278	8,672	11,124	
	Mental health related absence (days lost)	1,650	1,684	1,798	1,702	1,899	1,945	1,583	1,725	2,223	2,021	1,787	1,455	1,434	1,526	
	MSK related absence (days lost)	1,285	1,165	1,120	1,170	1,325	1,260	1,196	1,152	1,308	1,204	1,166	1,157	881	886	



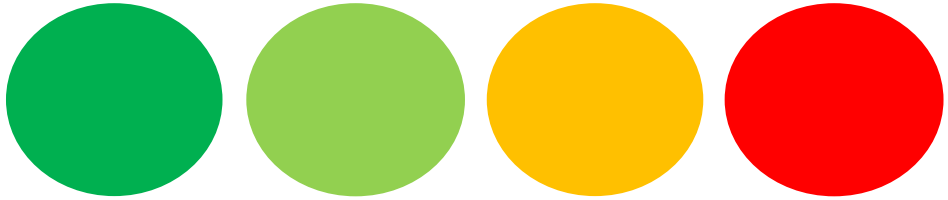



Mental Health related sickness
2,000
1,750
1,500
1,250
1,000
750
500
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22
2020/21
Target


Musculoskeletal related sickness
2,000
1,750
1,500
1,250
1,000
750
500
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22
2020/21
Target

Sustainable Services

Month 12 | 2021-22



Sustainable Services

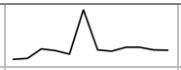
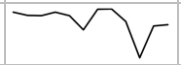
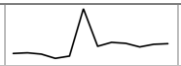
East and North Hertfordshire NHS Trust

Key Issues	Executive Response
• The Trust is reporting a year end surplus of £357k. In addition, the Trust has achieved all of its statutory financial duties for the year. The Trust has submitted its year end accounts to both the Department of Health and also its external auditors. The audit process will commence in early May. • Elective inpatient and day-case activity delivered in year remained some 6% below pre-pandemic levels, with significantly reduced theatres cases per list reflecting the impact of IPC guidelines. Steps to boost elective capacity, productivity and efficiency are a key component of the 22/23 financial plan. • Whilst the Trust waiting lists have lengthened during the pandemic as capacity has dramatically reduced, actual monthly referral levels for elective services currently remain below pre-pandemic levels. • Despite significant reductions in the activity levels delivered by the Trust across 21/22 compared with the pre-pandemic period, the workforce deployed to deliver this activity has increased significantly (7%). A significant productivity challenge and improvement will need to be addressed in 22/23. • The outturn position reflects the receipt of funding to progress backlog maintenance costs at MVCC, a provision for the cost of schemes agreed to mitigate cost of living pressures for staff and also the provision for dilapidation works at sites the Trust currently leases. • The scale of the Trust capital spend is significant by recent historic standards. Significant expenditure was carried out in the last two months of the year, especially in respect of recently awarded NHSE infrastructure schemes and ED refurbishment. The Trust spent £37.4m on capital projects during the year.	• TThe Trust maintains robust mechanisms and systems for monitoring financial performance and maintaining good governance. In addition to its formal Committee structure, the Director of Finance also chairs monthly finance boards which each of the Divisions. Attendance and participation at each of these sessions has been high and they have proved effective in identifying and managing plan delivery and the agreement of remedial action where appropriate. • The Trust acknowledged H2 planning guidance that identified the need for all providers to deliver a stepped change in efficiency levels in the second half of the year. In response the Trust set out a CIP planning framework to deliver savings plans across divisions and corporate services to the value of £5.7m. • In order to monitor and drive the delivery of improved elective activity the Trust has set up a weekly Demand and Capacity review session. This is chaired by the Managing Director of Planned Services supported by senior corporate officers. The session reviews progress at a service line level, discussing opportunities for improvement or how obstacles to achievement can be addressed. • As a component part of the new 'ENHT Academy' learning management system the Finance and Information team have refreshed and significantly expanded the range of business skills training materials that are available to budget holders and managers to assist in the discharge of their responsibilities. • The Trust continues to work with place-based partners to explore new models of service collaboration moving forward. A number of specific areas of project work have been agreed to test the effectiveness of these models.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

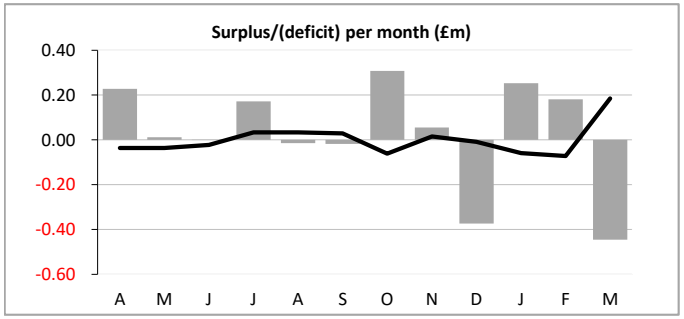
Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.4	36.5	37.3	37.2	36.8	40.6	37.2	37.1	37.4	37.4	37.2	37.2		440.7	448.2	7.5
	Other Income Earned	2.6	7.3	5.3	6.0	4.0	5.3	3.8	3.6	1.5	3.1	12.9	5.2		49.6	60.6	11.0
	Pay Costs	26.5	26.8	26.6	26.9	27.0	31.6	27.5	28.0	28.5	28.2	28.1	29.1		333.4	334.9	1.5
	Non Pay Costs inc Financing	16.6	21.2	20.3	20.4	18.1	19.2	17.4	16.6	15.0	18.7	26.8	18.0		208.7	228.4	19.6
	Underlying Surplus / (Deficit)	-4.1	-4.3	-4.3	-4.1	-4.3	-5.0	-3.9	-3.9	-4.6	-6.5	-4.8	-4.7		-51.8	-54.4	-2.7
	Top up payments	4.3	4.3	4.3	4.3	4.3	5.0	4.2	4.0	4.2	6.7	5.0	4.3		51.8	54.8	3.0
	Retained Surplus / Deficit	0.2	0.0	-0.0	0.2	-0.0	-0.0	0.3	0.1	-0.4	0.3	0.2	-0.4		-0.00	0.36	0.4
Paybill Metrics	Substantive Pay Costs	23.4	23.5	23.4	23.0	23.2	26.8	24.0	24.3	24.2	23.9	24.1	24.2		311.6	288.0	-23.6
	Premium Pay Costs Overtime & WLI	0.2	0.2	0.3	0.3	0.4	0.3	0.3	0.4	0.4	0.3	0.3	0.4		4.0	3.7	-0.3
	Premium Pay Costs Bank Costs	2.2	2.2	2.1	2.5	2.5	3.5	2.5	2.4	2.9	3.0	2.6	3.2		13.4	31.8	18.4
	Premium Pay Costs Agency Costs	0.8	0.9	0.8	1.0	1.0	1.0	0.8	0.9	0.9	1.0	1.0	1.3		4.4	11.4	7.0
	Premium Pay Costs As % of Paybill	11.7%	12.4%	12.1%	14.2%	14.1%	15.2%	13.0%	13.4%	14.9%	15.3%	14.1%	17.1%		6.5%	14.0%	7.5%

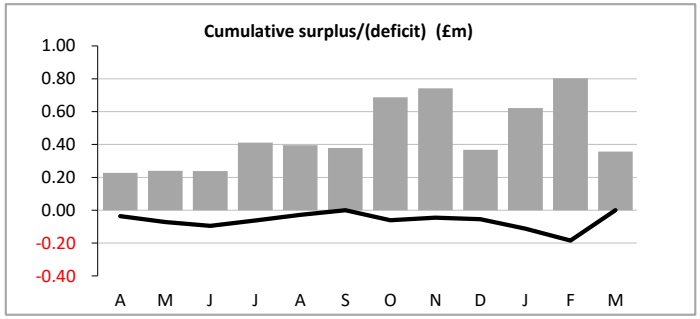
Sustainable Services

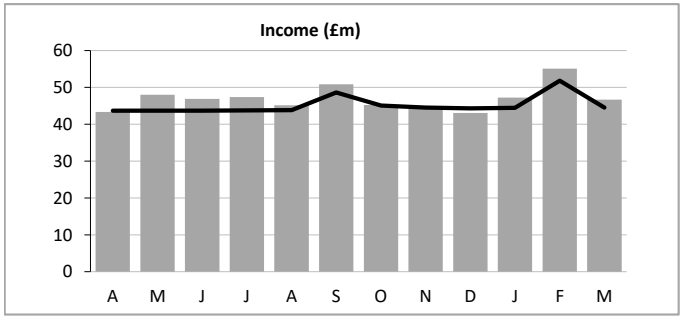
Finance Plan Performance

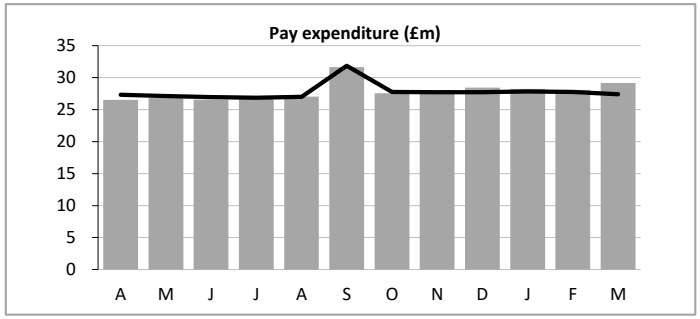
East and North Hertfordshire NHS Trust

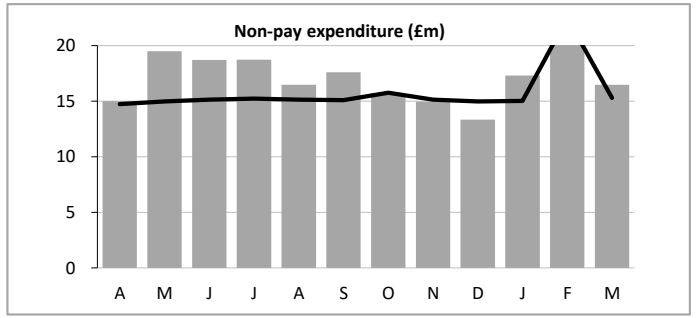
Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Liquid Ratio (Days)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	I&E Margin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Distance from Plan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Agency Spend vs. Ceiling	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Overall Finance Metric	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

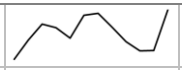
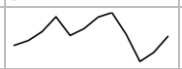
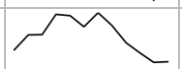
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,372	2,839	468	28,459	31,185	2,726
	Daycases	3,121	3,617	496	37,451	35,999	-1,452
	Inpatient Elective	1,942	1,419	-523	23,307	18,758	-4,549
	Inpatient Non Elective	9,813	9,153	-660	117,759	104,291	-13,468
	Maternity	2,582	2,540	-42	30,985	30,900	-85
	Other	3,182	4,888	1,706	40,203	53,592	13,389
	Outpatient First	2,188	2,387	199	26,250	24,986	-1,264
	Outpatient Follow Ups	2,541	3,111	570	30,492	36,144	5,652
	Outpatient Procedures	1,165	1,321	155	13,982	15,668	1,685
	NHSE Block Impact	0	-1,492	-1,492	0	10,381	10,381
	Other SLAs	65	65	0	779	779	0
	Block	847	847	0	10,163	10,163	0
	Drugs & Devices	3,950	5,068	1,118	47,403	52,751	5,348
	Chemotherapy Delivery	611	716	105	7,328	8,055	727
	Radiotherapy	1,138	1,208	70	13,652	13,578	-74
	Renal Dialysis	1,194	1,282	88	14,329	14,395	66
	Total	**36,710**	**38,970**	**2,260**	**442,544**	**461,626**	**19,082**

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	0	1,492	1,492	0	13,632	13,632
	Specialist Commissioning	192	-1	-193	2,300	-1	-2,301
	Bedfordshire CCG	-126	261	386	-755	-1,261	-506
	Herts Valleys CCG	224	223	-0	2,693	2,693	-0
	Cancer Drugs Fund	21,996	21,978	-18	264,723	264,704	-18
	Luton CCG	0	0	0	0	0	0
	PH - Screening	-0	-13	-13	-0	-30	-30
	Other	14,425	15,030	605	173,584	181,889	8,306
	Total	**36,710**	**38,970**	**2,260**	**442,544**	**461,626**	**19,082**
By Division	Cancer Services	6,332	7,185	853	75,981	82,283	6,301
	Unplanned Care	19,077	20,916	1,839	228,924	225,151	-3,773
	Planned Care	11,431	10,740	-691	137,171	128,809	-8,362
	Other	-130	129	258	467	25,383	24,915
	Total	**36,710**	**38,970**	**2,260**	**442,544**	**461,626**	**19,082**

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	12,793	13,966	14,961	14,727	14,093	15,487	15,619	14,781	13,870	13,322	13,342	15,846		160,649	172,807	12,158
	Chemotherapy Atts	2,457	2,452	2,789	2,677	2,543	2,612	2,506	2,720	2,719	2,492	2,550	2,615		27,233	31,132	3,899
	Critical Care (Adult) - OBD's	574	608	650	702	635	714	666	657	831	787	579	699		7,402	8,102	700
	Critical Care (Paeds) - OBD's	466	709	484	451	518	433	435	452	514	529	361	515		6,659	5,867	-792
	Daycases	2,827	3,282	3,856	4,003	3,328	3,386	3,370	3,593	3,047	3,116	3,426	3,738		47,483	40,972	-6,511
	Elective Inpatients	388	406	438	491	424	448	490	507	429	330	363	421		6,740	5,135	-1,605
	Emergency Inpatients	4,298	4,521	4,526	4,604	4,207	4,350	4,137	4,203	4,238	4,091	3,783	4,339		51,369	51,297	-72
	Home Dialysis	154	176	156	177	202	155	196	151	154	191	171	190		1,984	2,073	89
	Hospital Dialysis	6,260	6,309	6,317	6,677	6,517	6,531	6,616	6,637	6,928	6,731	6,207	6,945		77,319	78,675	1,356
	Maternity Births	415	440	441	475	473	454	478	456	427	410	394	395		5,302	5,258	-44
	Maternity Bookings	520	517	534	475	422	491	459	499	489	457	513	573		6,006	5,949	-57
	Outpatient First	7,950	7,944	8,573	7,990	7,436	8,631	8,709	9,672	7,803	8,739	8,610	9,684		109,284	101,741	-7,543
	Outpatient Follow Up	20,725	18,500	20,197	18,855	17,548	19,466	18,440	20,109	16,162	17,210	17,383	17,210		231,982	221,805	-10,177
	Outpatient procedures	6,727	6,731	7,761	8,084	7,237	7,912	7,506	8,317	6,854	7,299	7,355	8,321		88,985	90,104	1,119
	Radiotherapy Fractions	3,771	4,071	4,704	4,184	4,037	4,195	4,016	4,746	4,805	4,118	4,218	4,670		51,675	51,535	-140

Sustainable Services

Activity and Productivity

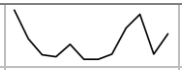
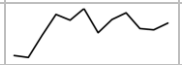
East and North Hertfordshire NHS Trust

Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	161	194	195	204	179	174	184	186	166	172	189	181		214	182	-32
	Emergency Spells per Day	106	109	108	103	95	100	95	100	95	92	94	100		140	140	-0
	ED Attendances per Day	426	451	499	475	455	516	504	493	447	430	477	511		439	472	33
	Outpatient Atts per Working Day	1,007	1,147	1,136	1,137	1,135	1,193	1,217	1,276	1,077	1,201	1,249	1,181		1,701	1,635	-66
	Elective Bed Days Used	896	1,253	1,198	1,218	1,102	980	1,139	1,099	1,035	761	902	1,024		5,059	12,607	7,548
	Emergency Bed Days Used	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,122	15,631	15,758	13,480	16,589		64,145	175,170	111,025
Efficiency	Admission Rate from A&E	26%	25%	23%	23%	22%	20%	20%	21%	22%	22%	21%	20%		23.3%	22.0%	-1.3%
	Emergency - Length of Stay	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.5	5.1	5.3	4.9	5.2		3.8	4.6	0.9
	Emergency - Casemix Value	2,687	2,602	2,704	2,819	2,864	2,805	2,922	2,821	2,917	2,942	2,892	2,916		2,321	2,824	504
	Elective - Length of Stay	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.2	2.4	2.3	2.5	2.4		2.5	2.5	-0.1
	Elective - Casemix Value	1,172	1,265	1,201	1,156	1,176	1,155	1,188	1,188	1,227	1,127	1,144	1,209		2,321	1,184	-1,137
	Elective Surgical DC Rate %	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.6%	87.7%	90.4%	90.4%	89.9%		85%	89%	3.8%
	Outpatient DNA Rate % - 1st	12.7%	11.3%	10.9%	12.2%	12.4%	11.8%	11.0%	11.9%	12.8%	11.5%	12.4%	12.4%		6.4%	7.5%	1.1%
	Outpatient DNA Rate % - FUP	0.0%	6.0%	4.9%	5.2%	5.6%	6.4%	5.8%	6.1%	7.3%	6.7%	6.4%	6.2%		7.1%	5.7%	-1.4%
	Outpatient Cancel Rate % - Patient	5.1%	6.1%	7.0%	7.8%	8.0%	7.9%	7.9%	7.7%	8.4%	7.7%	7.6%	7.6%		5.6%	7.4%	1.8%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	8.7%	8.2%	7.9%	7.8%	8.1%	7.8%	7.8%	7.9%	8.4%	8.7%	7.9%	8.3%		11.1%	8.1%	-3.0%
	Outpatients - 1st to FUP Ratio	2.6	2.3	2.4	2.4	2.4	2.3	2.1	2.1	2.1	2.0	2.0	1.8		2.1	2.2	0.1
	Theatres - Ave Cases Per Hour	2.4	2.5	2.4	2.5	2.6	2.4	2.4	2.4	2.4	2.4	2.5	2.4		2.9	2.4	-0.4
	Theatres - Utilisation of Sessions	84%	84%	83%	85%	82%	80%	81%	83%	79%	81%	81%	77%		85%	82%	-3%
	Theatres - Ave Late Start (mins)	20	20	24	27	26	28	24	27	28	25	25	26		27	25	-1.7
	Theatres - Ave Early Finishes (mins)	34	36	33	33	31	32	37	34	44	41	38	46		39	37	-2.8

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2020-21 YTD	2021-22 YTD	Change
Emergency Department Attendances	124,017	172,807	48,790
Emergency Department Ave Daily Atts	340	473	134
Admission Rate from ED %	29.0%	22.0%	-7%
Non Elective Inpatient Spells	37,176	37,924	748
Ave Daily Non Elective Spells	102	104	2
Daycase Spells	26,787	40,972	14,185
Elective Inpatient Spells	3,807	5,135	1,328
Ave Daily Planned Spells	84	126	43
Day Case Rate	88%	89%	1%
Adult & Paeds Critical Care Bed Days	14,229	13,969	-260
Outpatient First Attendances	93,034	101,741	8,707
Outpatient Follow Up Attendances	215,053	223,754	8,701
Outpatient First to Follow Up Ratio	2.3	2.2	-0.1
Outpatient Procedures	57,804	89,071	31,267
Ave Daily Outpatient Attendances	1,002	1,136	133

Workforce Measures	2020-21 YTD	2021-22 YTD	Change
Average Monthly WTE's Utilised	6,149	6,316	166
Average YTD Pay Cost per WTE	52,078	53,027	1.8%
Staff Turnover	12.4%	11.8%	-0.5%
Vacancy WTE's	629	795	166
Vacancy Rate	9.9%	12.1%	2.2%
Sickness Days Lost	97,553	110,042	12,489
Sickness Rate	4.7%	5.2%	0.4%
Agency Spend- £m's	10.5	11.4	0.9
Temp Spend as % of Pay Costs	3.3%	3.4%	0.1%
Ave Monthlty Consultant WTE's Worked	350.6	346.3	-4.3
Consultant : Junior Training Doctor Ratio	1 : 1.5	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,558.7	2,683.4	124.7
Qual ; Unqualified Staff Ratio	25 : 10	29 : 10	0.2
Ave Monthly A&C and Senior Managers WTE's	1,347	1,360	14
A&C and Senior Managers % of Total WTE's	21.9%	21.6%	-0.3%

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2020-21 YTD	2021-22 YTD	Change
Non Elective LoS	4.0	4.6	0.6
Elective LoS	2.4	2.5	0.1
Occupied Bed Days	69,204	187,777	118,573
Adult Critical Care Bed Days	8,800	8,102	-698
Paediatric Critical Care Bed Days	5,429	5,867	438
Outpatient DNA Rate	7%	8%	0.4%
Outpatient Utilisation Rate	37%	44%	7.2%
Total Cancellations	105,873	122,959	17,086
Theatres - Ave Cases per Hour	1.9	2.4	0.6
Theatres - Ave Session Utilisation	79%	82%	2.6%
Theatres - Ave Late Start (mins)	22	25	3
Theatres - Ave Early Finishes (mins)	35.7	36.6	1
Radiology Examinations	186,079	231,734	45,655
Drug Expenditure (excl HCD & ENH Pharma) - £000s	9,163	10,383	1,220
High Cost Drug Expenditure - £000s	47,916	51,909	3,994

Finance & Quality Measures	2020-21 YTD	2021-22 YTD	Change
Profitability - £000s	3,353	-613	-3,965.8
Monthly SLA Income £000s	36,385	37,350	965
Monthly Clinical Income per Consultant WTE	£103,785	£107,862	£4,077
High Cost Drug Spend per Consultant WTE	£136,675	£149,906	£13,231
Average Income per Elective Spell	£2,533	£1,184	-£1,349
Average Income per Non Elective Spell	£2,533	£2,824	£291
Average Income per ED attendance	£177	£181	£3
Average Income per Outpatient Attendance	£131	£143	£11
Ave NEL Coding Depth per Spell	7.4	7.5	0.1
Procedures Not Carried Out	2,347	2,184	-163
Best Practice HRGs (% of all Spells)	4.1%	3.2%	-0.9%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jun-21	9,368	9,120	-248
Non-elective re-admissions within 30 days % Rolling 12-months to Jun-21	8.67%	8.41%	-0.26%
SLA Contract Fines - £000's	0	0	0

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	13
Report title	System Collaboration Update			**Meeting Date**	04-05-22
Presenter	Martin Armstrong – Deputy CEO				
Author	Martin Armstrong – Deputy CEO				
Responsible Director	Martin Armstrong – Deputy CEO			**Approval Date**	26-04-22
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The report provides an overview of recent system and place based collaborative activity that the Trust has engaged in with partner organisations

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Specific emphasis is placed on activities support the Trust's ability to deliver achieve strategic objectives through joint working with partner organisations.

Risk: *Please specify any links to the BAF or Risk Register*

The report links through to specific BAF risks associated with collaborative working – 006/21

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to discuss the activities contained within the report.

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

East & North Herts NHS Trust

System Collaboration Activity Report

This report provides updates to Committee members in respect of key strands of significant collaborative system activity that the Trust is actively participating in.

Elective Surge Hub

In January 2022 NHS providers were encouraged to develop bids for the development of additional elective surge capacity to support the reduction of elective waiting lists and the improvement of waiting times in line with NHS planning guidance targets. It was expected that successful capital proposals would focus upon facilities that could operate in isolation from emergency pressures, could deliver high volumes of low acuity activity and would be accessible to providers and requirements across an entire system.

The initial preferred option developed for HWE ICS was based around an expansion of the Lister Treatment Centre. However, the position was subsequently complicated by the emergence of a potential option to purchase the One Hatfield private hospital. A full option appraisal of the two schemes was requested to reach a final determination of the preferred way forward by the system. However, in the meantime national timetables required a regional response to access available funding, and as a result a notional allocation has been identified to progress any finally determined prefence. This fixed allocation methodology may subsequently prove a significant risk.

Due Diligence and commercial negotiations in respect of One Hatfield remain ongoing to determine the feasibility of this purchase option, whilst in the meantime work also progresses to develop the Lister Treatment option within the funding envelope agreed

HCP Engagement Event

On the 26th of April the HCP held its second senior leaders' engagement event. All HCP stakeholders were represented. The session focused upon overcoming barriers to effective place-based working and consideration of the development of financial and business frameworks that could support the achievement of transformation priorities. Future similar events will continue to be scheduled.

Provider Collaboration

NHSE expects that provider collaboratives will be key components of system working going forward, being mechanisms through which providers will work together at scale to plan, deliver and transform services. As a result, all Trusts are expected to be part of our or more provider collaborative by July 2022.

In addition to the E&N place-based partnership that the Trust is presently participating in, acute providers across the ICS have also met in January and February to evaluate options to formally collaborate in respect of acute service delivery and transformation. Executive

Directors from ENHT, WHHT and PAH participated in a workshop session that explored a range of collaborative considerations.

- The benefits of acute collaborative activity
- The Case for Change
- Criteria and Scope for collaborative working
- Opportunities for Transformation
- Potential Governance & Resourcing Arrangements

Broad agreement was reached across all participants in respect of the advantages and common benefits that would be derived through the formalisation of an acute collaborative across the ICS footprint. A work programme of further activities and workshops to develop and agree the collaborative arrangements was agreed. A further meeting has been scheduled for the 16th of May for executive and clinical leaders across the three providers to continue to develop the collaboration proposal.

Hospital at Home Expansion

One of the key priorities for 22/23 as outlined in national planning guidance is the necessity of systems and organisations developing plans to further rollout the capacity of virtual ward arrangements that can act as credible alternatives to inpatient admission. Significant additional funding will be made available to support this objective. This has been confirmed and specified with system SDF allocations for 22/23

Whilst the current virtual ward arrangements that are in place across the E&N place represent an encouraging but modest start to this service model during 21/22, it is clear to the Trust that the true potential of this method of care remains relatively untapped.

The Trust and place-based partners have come together to agree an effective model to implement expanded hospital at home arrangements. This process is presently co-ordinated by the HCP Development Director with support from stakeholders. It is expected that this will culminate in the development of business case that will set out both the clinical / operational model and also associated funding and financial aspects.

Enhanced Services Steering Group & NHT / HCT partnership working projects

Over the last twelve months these two separate streams of transformational activity have been progressed by the Trust will a number of place partners.

Enhanced Services

During the course of the COVID pandemic a number of new approaches were developed or extended to help prevent unnecessary admissions into an acute setting or expedite prompt discharge, these include Prevention of Admissions (POA) schemes and Discharge to Assess (D2A) During the course of 21/22 it became apparent that there wasn't a jointly designed and aligned framework to determine the impact of these schemes in respect of activity, flow, finance and workforce. It was acknowledged that this presented an impediment to future planning, design and

mobilisation arrangements unless addressed. ENHT took a lead role in setting up the 'Enhanced Services Steering Group'. This group led by the ENHT Director of Improvement and compromised of Executive Directors across the place ecosystem meets on a bi-weekly basis to progress joint evaluation, design and implementation arrangements.

ENHT / HCT partnership working projects

In April 2021 the two providers-initiated project working arrangements to explore options to maximise service effectiveness and delivery across areas where the organisations currently deliver different aspects of one overarching pathway.

The two areas that were identified for accelerated development are Stroke / Neuro services and Community Paediatrics. To date work has concentrated upon creating revised lead provider arrangements as a mechanism to provide greater integration and thereby promoting enhanced quality and delivery outputs. It is anticipated that the work across these services areas can subsequently act as a model for lead provider delivery arrangements to a further pipeline of activity.

In April 2022 partners have agreed that these transformation workstreams / forums will be closed down and assimilated into alternative forums, yet to be agreed or designed.

East of England Imaging Network

The EoE region has established 2 imaging networks. These are designed to enable clinical images from care settings close to the patient to be rapidly transferred to specialist clinicians across diverse geographical settings. ENHT is acting as the governance and leadership hub for one of these networks. During 2021/22 the networks were successful in developing bids and securing funds that support the expansion of home reporting, iRefer CDS and Imaging sharing capability and infrastructure for providers across the region.

The development of infrastructure bids for 22/23 are currently in development. The Trust CIO is leading this process for the Network.

Community Diagnostic Centres

The expansion of diagnostic services placed within more varied and diverse community settings is a core feature of the government's strategy to improve access to services and address the post pandemic waiting list challenge. The place-based community has responded to this challenge by designing a model for expansion and deployment. This has been achieved through diverse stakeholder design events including acute, community and commissioning colleagues.

The Trust was successful with a Year 1 bid during 21/22 and mobilisation of services associated with the bid are progressing. Revenue funding to support the expansion will be partly released depending on the achievement of activity targets, as such it is important to acknowledge this operational and financial risk. System activity to agree Yr. 2 funding distribution remains ongoing.

Pathology Tendering Process
The Trust remains an active partner in the process to tender ICS pathology services. The timeline for the project has slipped as a product of a number of issues and presently the earliest award of any contract is expected during Q3 of the new financial year. A full business case will be produced by the project team for consideration and approval by participant organisations prior to any contract award. The FPPC will act as the key body to review and scrutinise the business case with onward recommendation to the Trust Board given the duration and financial value of the contract that will be proposed

Martin Armstrong
Deputy Chief Executive
April 2022

Meeting	Trust Board		**Agenda Item**	14
Report title	Trust Strategy		**Meeting Date**	04-05-22
Presenter	Martin Armstrong – Deputy CEO			
Author	Laura Moore – Associate Director of Planning			
Responsible Director	Martin Armstrong – Deputy CEO		**Approval Date**	26-04-22
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

The report sets out the proposed objectives for the Trust for 22-23 within the context of the strategic priorities that the Trust Board has agreed as part of its recent strategy refresh activity.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Specific emphasis is placed upon the cascade through mission, strategic, themes, 22/23 objectives and the linkage to the Trust's Vision

Risk: *Please specify any links to the BAF or Risk Register*

The reports proposal of strategic objectives for 22/23 provides the foundation for a reset of the BAF framework moving into the new financial year.

Report previously considered by & date(s):

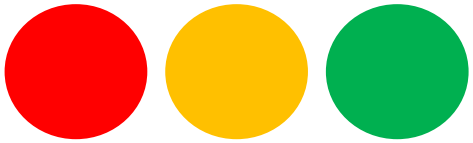
N/A

Recommendation	The Board/Committee is asked to discuss and approve the proposed strategic objectives for 22/23

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

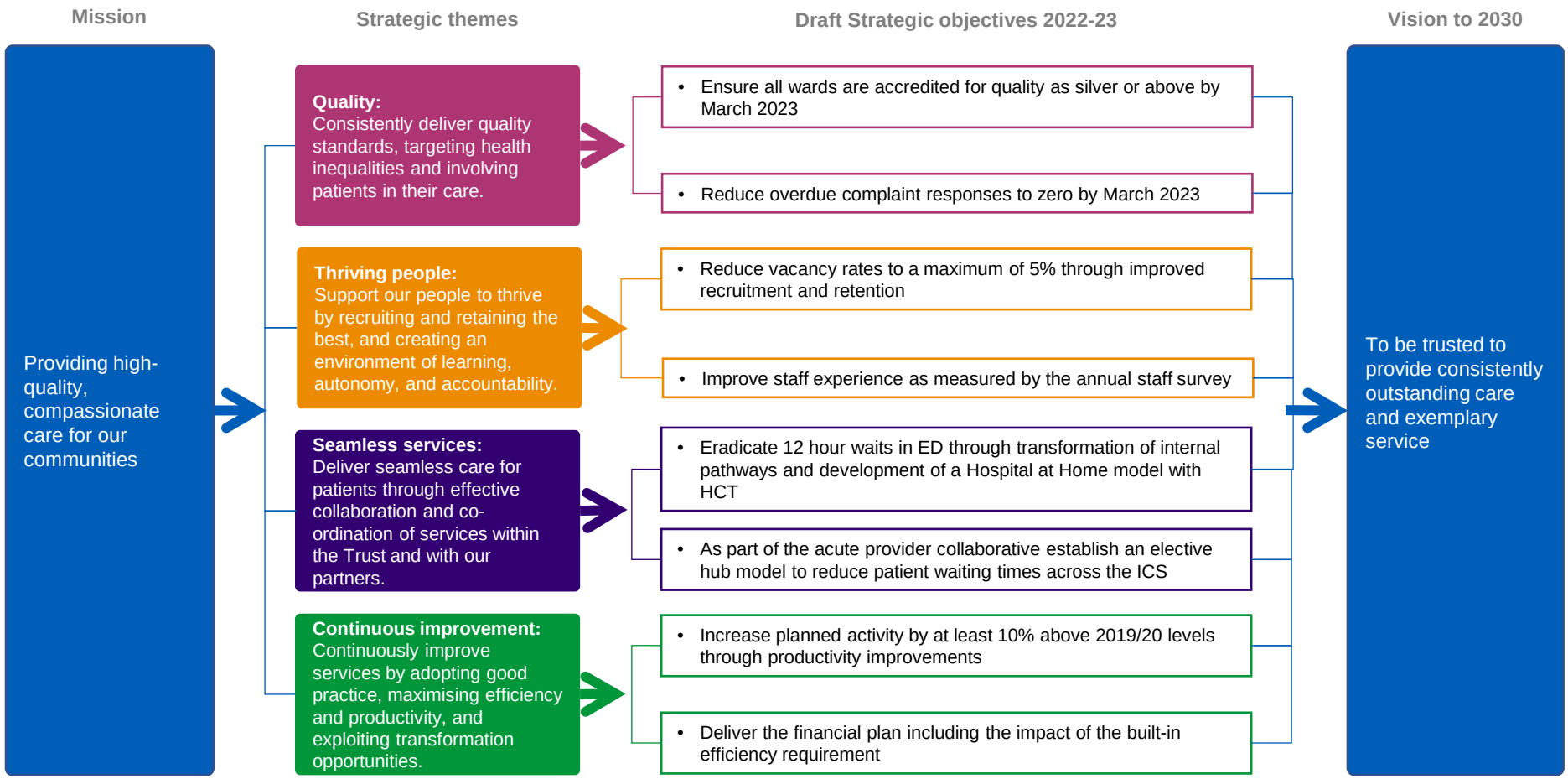
Strategic Refresh: Vision, Mission and Objectives



Trust Board

4th May 2022

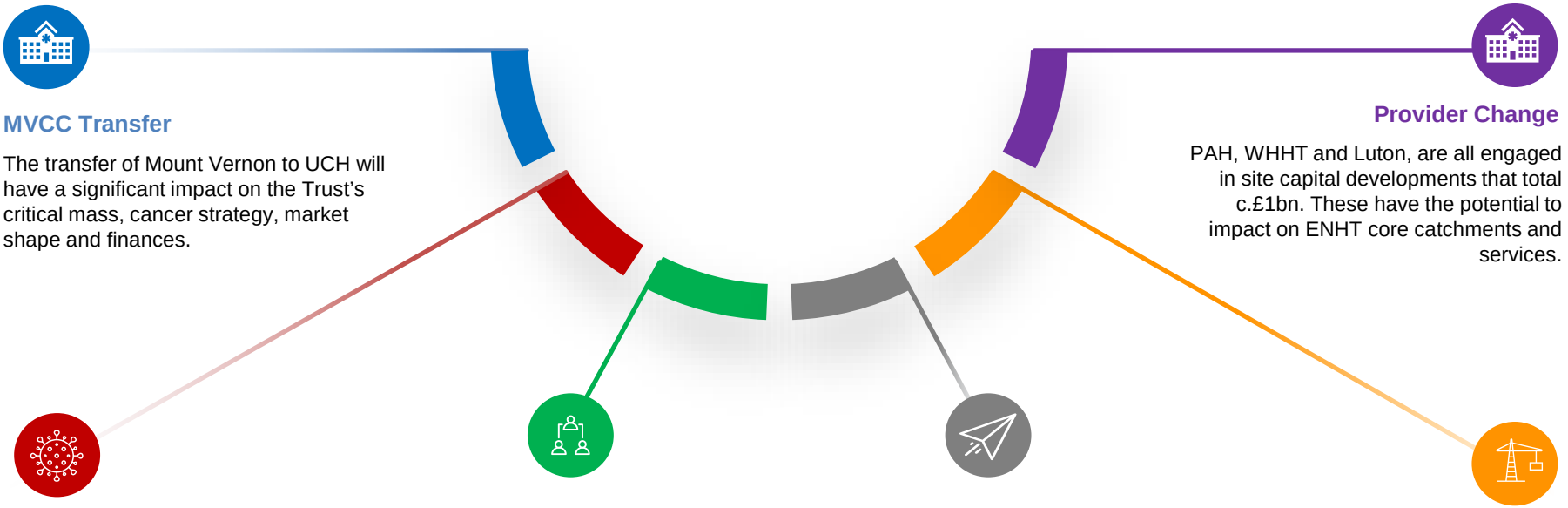
Strategic Proposal



Appendix A:

Supporting Information

Strategic Context and Drivers of Change



MVCC Transfer

The transfer of Mount Vernon to UCH will have a significant impact on the Trust's critical mass, cancer strategy, market shape and finances.

Provider Change

PAH, WHHT and Luton, are all engaged in site capital developments that total c.£1bn. These have the potential to impact on ENHT core catchments and services.

COVID

The pandemic has initiated and accelerated significant change and the movement of some services away from the acute environment. This will not be reversible. Impacts of the pandemic upon both workforce and patient populations have also been profound. We are not yet in a position to know what the long-term impact of COVID will be on health need in the coming years.

System Change

Government policy is driving significant change in the way care is planned, delivered, regulated and paid for. There is a marked shift away from competition, towards a duty to collaborate.

Internal Momentum

Efforts to promote devolved clinical leadership is stimulating a number of individual service developments requiring a Trust response.

Infrastructure

The quality of Trust estate and equipment is mixed. A coherent replacement plan linked through to a development strategy is also required.

Understanding Our Population

451,000
the population in our core catchment area (2019)

276,823
patients seen by us (2019-20)

10,641
patients seen at Mount Vernon (2019-20)

Our Activity (2019-20)

112,830
Emergency Department attendances

62,080
Inpatient stays

477,847
Outpatient attendances

84,281
Theatre and day cases

5,241
Births

859
Dialysis patients

Demographics

4.2%
Population Growth to 2030

16,907
New houses by 2030

Life Expectancy

Female: 84.2 years

Male: 80.7 years

% of people aged 0-14 years will decrease by **5%** 2030

% of people aged 65+ years will increase by **25%** 2030

519,300
the population in our core catchment area by 2030

Our Changing Population

1.4 in 5
people have a long term condition

Disease prevalence is expected to grow, particularly for diabetes and CKD

	2019/20	2029/30
Diabetes	6.1%	10%
CKD	1.2%	6.0%

Health

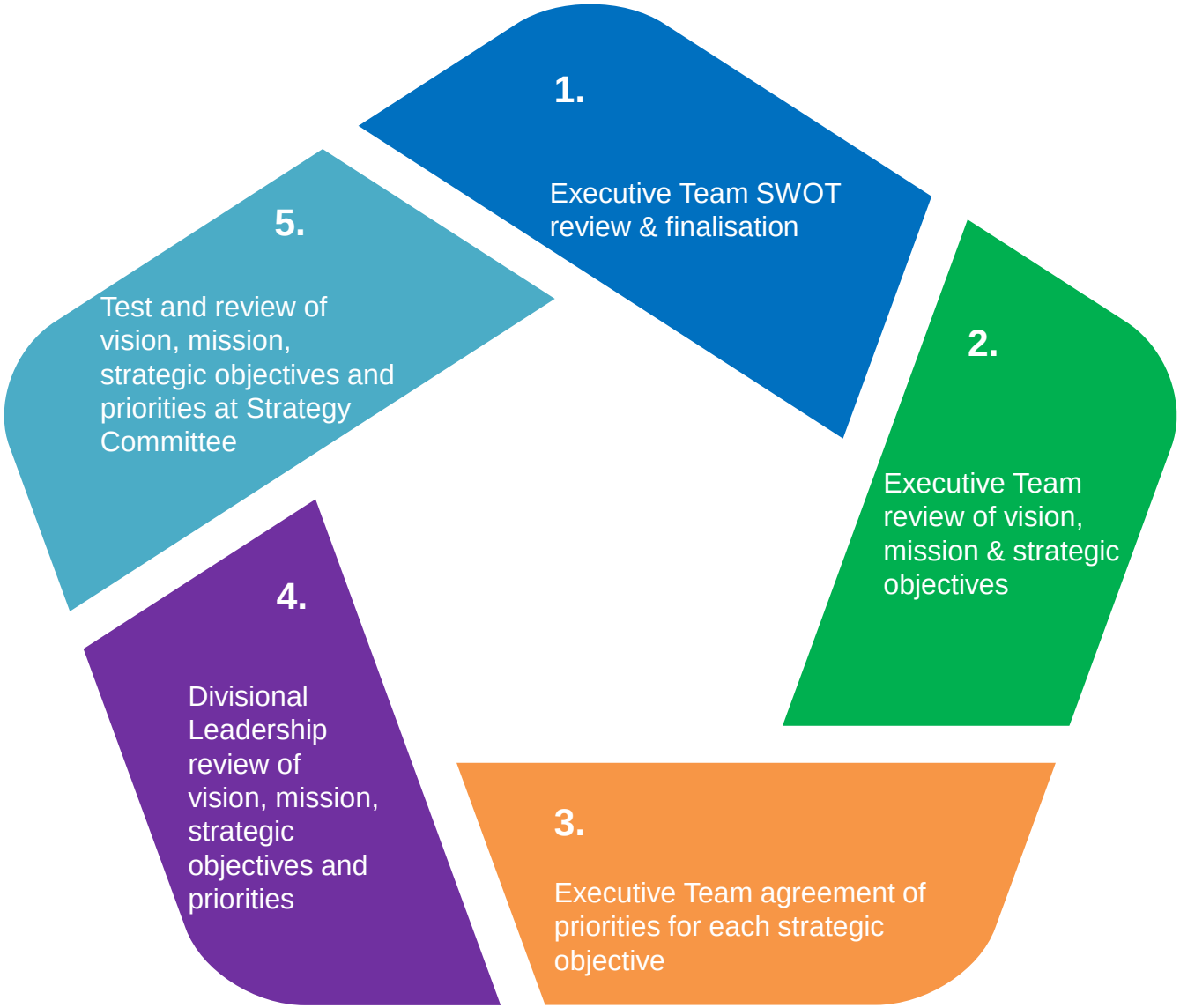
9.7%
of people with a long term condition have 5+ comorbidities

This is expected to increase to **15.2%** by 2030

11%
of people aged 18+ were smokers (19-20)

59.8%
of people aged 18+ were overweight or obese (19-20)

Process to Review Strategic Framework



Proposed Vision to 2030

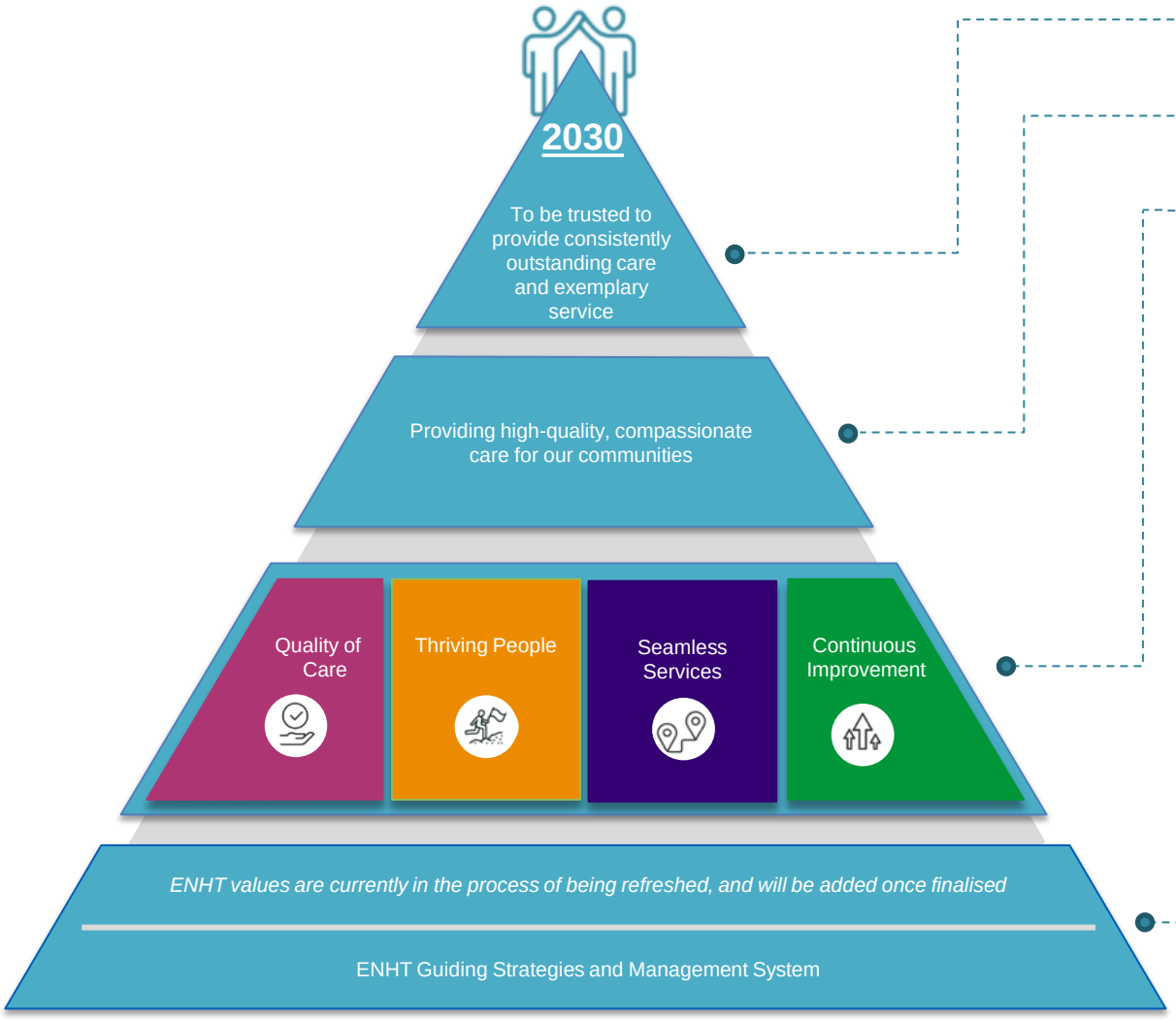
Our proposed vision to 2030 is:

> "To be trusted to provide consistently outstanding care and exemplary service".

We will deliver this vision through a focus on:

- our **patients** and delivery of high quality, safe, compassionate and accessible care;
- our **wider community** through a focus on population health and actions to reduce health inequalities;
- our **partners** and the delivery of holistic and co-ordinated care through maximising how we deliver services collaboratively and in an integrated manner; and
- our **people**, recognising that it will only be through a sustainable workforce and ensuring that ENHT is a great place to work where people can start and develop their careers, that our vision can be realised.

Strategic Proposal



Our Vision

Our Mission

Our Strategic Objectives

Quality of Care: Consistently deliver quality standards, targeting health inequalities and involving patients in their care.

Thriving People: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.

Seamless Services: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners.

Continuous Improvement: Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities.

Our Core Foundations

The core foundations and values reflect the way that we work and the way in which we will deliver our objectives and vision for the future.

Do Nothing Scenario Modelling

2019-20 as the baseline year

+

Population growth projections applied at specialty level

+

Housing development projections

Other Key Factors

Applies 19/20 LOS & assumes 95% bed occupancy rate

Assumes 2 session days, 5 days per week as standard for Theatres and Day Cases

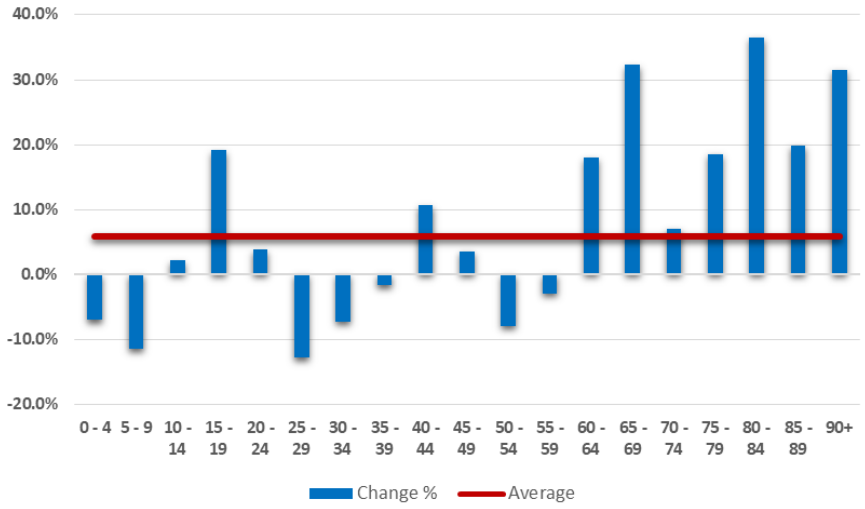
Assumes outpatient clinics run 42 weeks of the year 5 days per week, with 20 mins for a new & 15 mins for a f/up

Does not currently include virtual appointment ambition

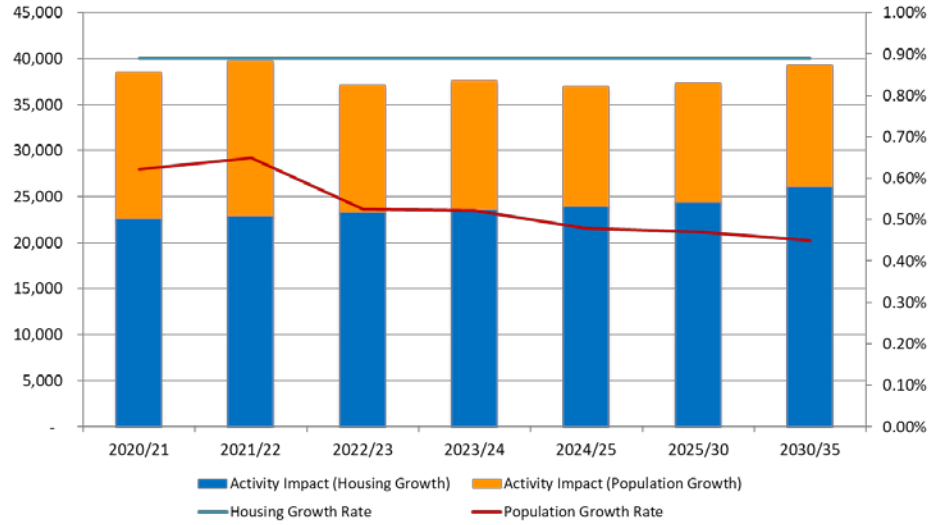
Does not reflect the impact of the MVCC transfer

Demographic and Housing Projections

Demographic Change for Core Catchment Area, 2019-2030
ONS Population Projections



All Activity Impact of Annual Growth in Do Nothing Scenario
Note: 2025/30 and 2030/45 are annual averages



Note: 2025/30 and 2030/45 are annual averages

If we carry on as we are, we will require

	2019/20		2024/25		2029/30		2034/35
ED Activity	**112,830** Lister Attendances	**8.0%**	**121,884** Lister Attendances	**16.7%**	**131,679** Lister Attendances	**26.3%**	**142,542** Lister Attendances
G&A beds	**609** 570 NEL 39 EL	**14.6%**	**698** 642 NEL 56 EL	**25.0%**	**761** 700 NEL 61 EL	**36.0%**	**828** 763 NEL 65 EL
Outpatients	**477,847** Outpatient Appointments	**-0.3%**	**476,376** Outpatient Appointments	**7.8%**	**515,308** Outpatient Appointments	**16.3%**	**555,959** Outpatient Appointments
Theatres	**18,336** Cases (17 theatres)	**39.1%**	**25,509** Cases (7 additional theatres)	**50.4%**	**27,578** Cases (9 additional theatres)	**62.0%**	**29,700** Cases (11 additional theatres)
Day Cases	**186** Spaces	**39.8%**	**260** Spaces	**52.2%**	**283** Spaces	**65.6%**	**308** Spaces

Notes:

i) Percentage increases are compared to 2019/20 figures

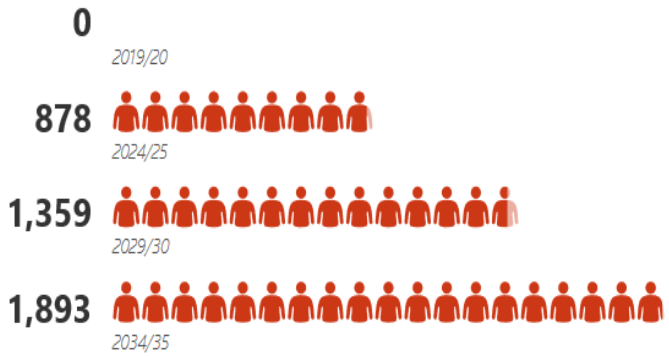
ii) Includes the impact of the 22/23 planning guidance on elective beds, elective surgery/day case, outpatients

iii) ED excludes QEII and Urgent Eye

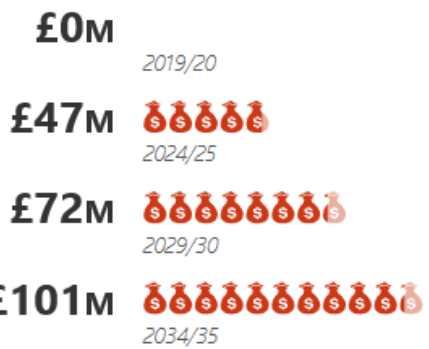
iv) G&A Beds are for Lister only

If we carry on as we are – additional front line staffing requirements
(crude calculations)

Crude projection of front line staff increase

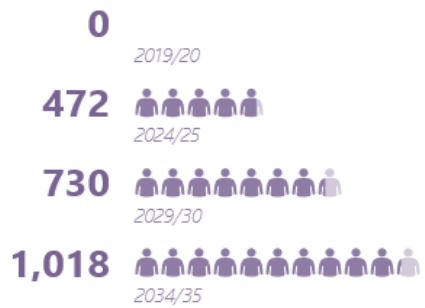


Crude projection of front line pay bill increase

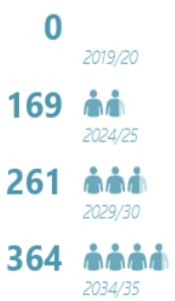


Crude projection of increases for key staff groups

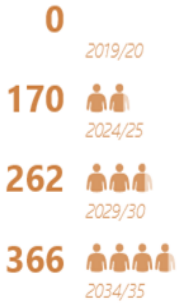
Nursing Staff



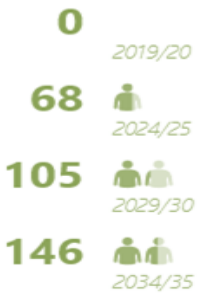
Medical Staff



Science & Technical Staff

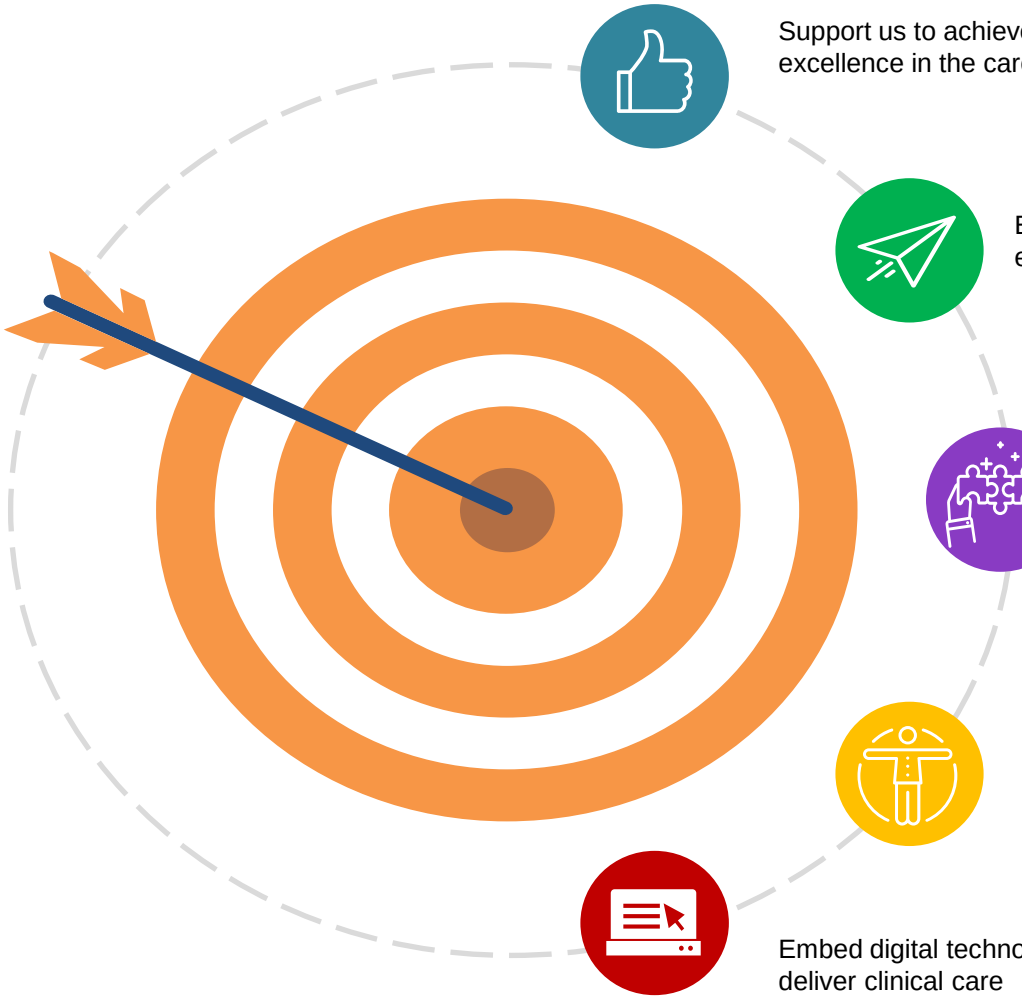


Ancillary & Other Staff



Notes:
i) Baseline is based on 2019-20 worked wte (and so includes bank and agency use)
ii) Predicted increase in resource based on predicted increase in beds as a proxy for change
iii) Assumes no increase in admin & clerical or senior manager workforce
iv) Based on a straight pro-rata increase

Delivery of our Clinical Priorities will…



Support us to achieve a CQC rating of “good” or “outstanding” and to embed excellence in the care we deliver, ensuring care is high quality and safe

Ensure sustainable delivery now and in the future – clinical, environmental, workforce and financial sustainability

Look beyond our hospital walls, maximising our influence as a significant local organisation and employer to positively contribute to our wider community and economy, with an emphasis on collaboration and integration

Utilise a diverse workforce, building on the expertise we already have and developing new skills and roles to meet the challenges of the future

Embed digital technology as an integral way in which we deliver clinical care

Clinical Strategy Phases

1 Identify

The clinical strategy looks to the future to innovate and build new services, but also identifies what needs to be addressed and transformed in the more immediate term, to create the capacity and resources to do something differently in the future.

2 Improve

Continuous improvement will be the key vehicle through which we can ensure sustainable (clinically, environmentally, workforce resilience, financial best use of resources) delivery over the coming years. We need to secure the resilience and stable delivery of our core services through improving our productivity and efficiency and addressing unwarranted variation.

Digital solutions and approaches need to be embedded as a core part of how we deliver clinical services now and in the future.

3 Align

Our services need to be aligned to the growing and changing needs of our population.

We need to ensure that our pathways, our workforce and skill mix, our use of technology and our physical infrastructure are able to respond and align to these needs.

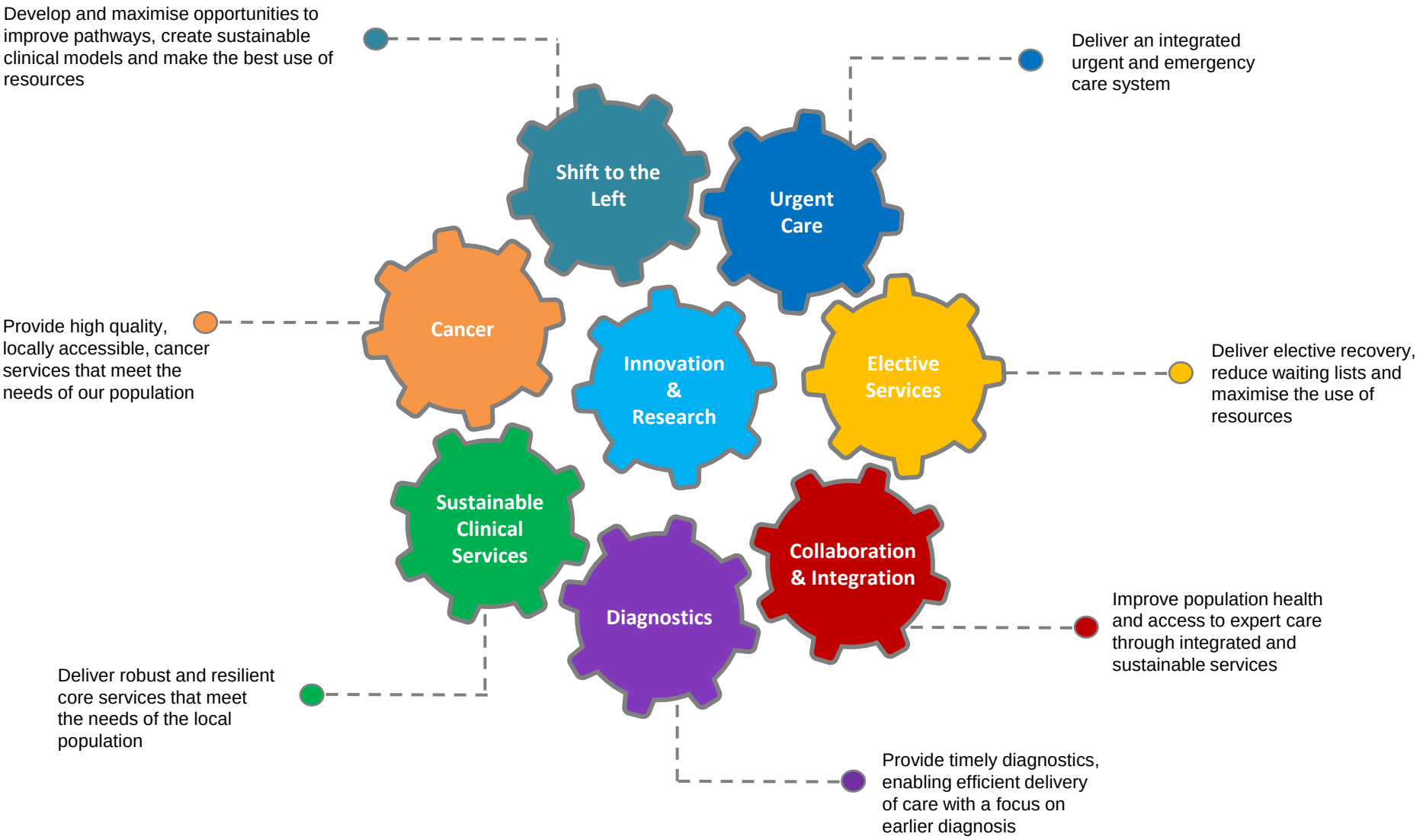
2030

4 Build

The future model of care will require significant transformation to develop and implement new service models to meet our future ambitions.

We will continue to provide acute and planned care services to local people but will increasingly do this in partnership with local providers across, primary, community, mental health and social care to provide more integrated services. This requires a focus on partnership development, collaboration and integration.

Clinical Strategy: Key Programmes of Work



Case Study: ENHT Virtual Chronic Kidney Disease (vCKD) Clinic and Community Nephrology Service

Objective — Create a proactive approach to managing patients with CKD through a virtual clinic

Challenge

- The service was experiencing an overwhelming demand of CKD meaning long waiting times in general nephrology and inappropriate frail elderly referrals, which should be managed in community;
- Data suggested that approximately 50% of referrals were inappropriate;
- Across the ICS it was estimated that there were 64,000 uncoded CKD patients falling through the net resulting in increased mortality, unplanned admission rates and in-hospital Acute Kidney Injury.

Addressing the issue

- An automated pathway between Primary care and Nephrology via Primary care patient EPR (SystmOne) was created;

- The system searches a set of parameters within patient records to identify undiagnosed/uncoded CKD patients or diagnosed patients with poor outcomes;

- An alert is then made to the GP practice within the system flagging that the patient needs to be reviewed;

- The practice can ask for the patient to be reviewed in a virtual community clinic by a Consultant Nephrologist;

- Once the patient has been reviewed in the virtual clinic next steps and advice is provided to the GP practice to support the patient to be managed in the community.

Outcomes to date - highlights

- 240 reviews taken place to date with <15% being converted to a formal nephrology referral;

- Reduction in inappropriate referrals and reduced waiting times for patients who are referred;

- 100 de-prescribing interventions and 57 prescribing interventions, which were all related to long term disease modifying drugs with cardiovascular benefits e.g. statins, SGLT2RI's;

- 5 patients with potential dialysis requirements were picked up early and intervened on to avoid dialysis – huge cost saving both to Trust and wider health economy.

Summary

This program has enabled coding of previously unregistered CKD patients, with 187 patients receiving a new or updated accurate CKD code. This enables surveillance and improves unplanned admission rates, risk of AKI in hospital and mortality.

Patients are receiving proactive care without having to attend an appointment at the Trust and are being better managed in the community by their GP.

Feedback

"This project has been successful and well received by primary care. To realise transformational benefits to secondary care of reduced clinic demand and waiting times, unplanned starts on dialysis and AKI admissions this needs to be supported by both providers and commissioners. I have been very grateful for the Trust support and my partners across the ICS, it has been a compelling experience of collaborative working. Both primary and secondary care have mutually benefitted by placing the patients at the centre of what we do over traditional boundaries."

– Andrew Findlay Consultant Nephrologist

Case Study: Patient Initiated Follow Up (PIFU)

Objective — Enable patients to take an active role in managing their health

Challenge

Routine appointment-based outpatient models can not always accommodate patients with specific conditions getting the advice and treatment when they need it in order to take a proactive approach to managing their condition.

The IBD service at East Surrey Hospital (ESH) looks after approximately 4,000 patients. The service had long waiting times for conventional outpatient care and adverse outcomes for IBD patients unable to access services when required e.g. following a flare up.

Addressing the issue

As part of a service redesign, PIFU was introduced (via the web-based portal Patient Knows Best) to help IBD patients to self-manage their condition.

The platform allows patients to record their symptoms and communicate with the IBD team remotely. This accelerates access to timely advice, clinical review for flare-ups, and escalation to disease-modifying therapy where appropriate. It also offers reassurance to those who are stable without the need for a face-to-face review.

The clinical team are able to monitor patients' care and provide timely access to treatment before symptoms progress, resulting in reduced ED attendances.

Summary

This model of care breaks down the traditional boundaries between the patient and provider, promoting collaborative working with patients with long-term conditions. The service is providing care to more patients requiring close monitoring than would have been possible without a virtual service, without compromising on safety.

Outcomes to date – highlights cont.

- A sample of patients surveyed in 2018 showed that the majority felt that the service had a positive impact on their IBD and improved their quality of life;
- Patient access to specialist care at the time of a flare-up has reduced from 6 weeks to 1 week.

Per annum, the service avoids:

136 emergency department attendances

80 hospital admissions

440 outpatient appointments

Feedback

Patient at ESH: "It has been a great comfort and reassurance. It helps me understand my illness and allows me to take control."

Lead Consultant at ESH: "Our outpatient clinics will always be at capacity, but this is an opportunity to free up space for patients that need to be seen immediately, and provide an alternative for those with less severe symptoms not needing face-to-face appointments."

Implementation in ENHT

Rollout of PIFU has started in ENHT and feedback/impact is starting to be collated.

Feedback from James Quinn (ENT consultant): "PIFU offers a valuable outpatient outcome option. There are some conditions which recur or relapse and often the timing of this is unpredictable. In these cases the PIFU outcome option means that we do not waste unnecessary outpatient appointments but we have the security of knowing that a patient can return if and when they have a problem."

Case Study: Robotic Surgery in Gynaecology at ENHT

Objective — Develop and embed robotic surgery as the operation of choice for suitable patients

Challenge

Pre-existing conditions or complex patient needs means that traditional surgical options are not always a possibility.

For example, elderly patients with endometrial cancer may not be able to tolerate a steep Trendelenburg position and the high pressure needed for abdominal insufflation due to their co-morbidities.

Addressing the issue

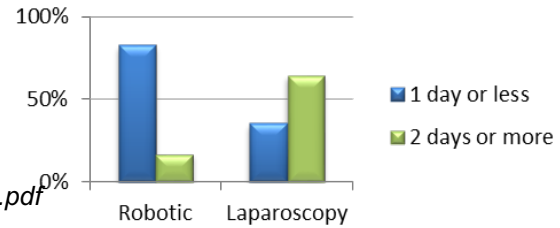
The introduction of robotics into surgery means that there is better visualisation of anatomy and dissection in high BMI patients and patients with pelvic adhesions from endometriosis or previous surgery.

Between December 2020 and December 2021, 99 cases of robotic surgery were performed:

- 62 hysterectomies,
  - BMI range for this group = 35-57
  - Age range = 42-80yrs.
- 35 endometriosis
- 2 other

Outcomes to date - highlights

- Reduction in length of stay in comparison to laparoscopy



Outcomes to date – highlights cont.

- Ability to perform more complex procedures with reduced recovery time
- Reduction in post op pain (10 in 11 patients report a pain score of 0);
- Reduced length of stay creates capacity for more patients to be treated, reducing waiting times.

Summary

The use of robotics offers surgery as an option to more patients as able to offer this option to patients with more co-morbidities than open or laparoscopic surgery. The growing number of co-morbidities and increase of obesity in our population are two of the biggest challenges facing the NHS. The use of robotics enables us to provide quality and safe care to more of our patients.

There is improved experience for patients through reduced length of stay and a reduction in post operative pain.

ENHT is 1 of only 3 UK centres using robotics for Endometriosis.

Feedback

Feedback from Ghadah Ahson (Consultant Gynaecologist): I am now taking on more complex procedures . I performed robotic hysterectomy for patients with 16- and 18-week fibroid uterus who were listed for a laparotomy. One patient went home day 1 and the other on day 2 with minimal pain. The ability of the robotic endoscopic instruments to mimic the dexterity of the human hand to provide a greater range of motion enables me to perform dissection with precision in areas that were not easily accessible with laparoscopy.

The most significant factor for me is that I am able to perform complex procedures without any residual fatigue and don't feel exhausted at the end of my list. To perform complex surgical procedures laparoscopically is rather taxing as it's performed in a standing position and often in poor ergonomic positions for a protracted period of time.

East and North Hertfordshire NHS Trust

Meeting	Trust board		**Agenda Item**	15
Report title	**Staff Survey review**		**Meeting Date**	04/05/2022
Presenter	Thomas Pounds, Chief People Officer			
Author	Laura Mitchell, Staff Engagement and Experience Project Coordinator			
Responsible Director	Thomas Pounds, Chief People Officer		**Approval Date**	NA
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

This report has been created with the purpose of presenting your topline results for the 2021 National Staff Survey. All the People Promise scores for the 2021 NHS Staff Survey for East and North Hertfordshire NHS Trust are broadly in line with the sector scores for similar organisations. Just one sub-theme is significantly worse - 'Diversity and equality'. The rest of the sub-theme scores are in line with the sector scores.

The themes of Morale and Staff Engagement remain key performance indicators for organisations. Both of East and North Hertfordshire NHS Trust's scores are in line with the sector scores, although there has been a slight decline since 2020. The sub-scores of 'Motivation' and 'Thinking about leaving' have both significantly declined.

At question level, most scores are in the intermediate-60% range of similar organisations. However, there are 11 scores which are in the bottom-20% range, and 7 which are in the top-20% range. Some of the question scores around 'Raising concerns' are significantly below the sector but many within 'Team working' are significantly higher. Where comparable to 2020, 20 questions have declined significantly, and 3 have shown a significant improvement.

Impact:

Risk: *Please specify any links to the BAF or Risk Register*

009/2 – There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their efforts to deliver high quality and compassionate care to the community

Report previously considered by & date(s):

NA

Recommendation	

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

East and North Hertfordshire NHS Trust

People

ENHT 2021 National Staff Survey Results: Key Findings

Author: Laura Mitchell

Staff Engagement and Experience Project Coordinator

4th May 2022

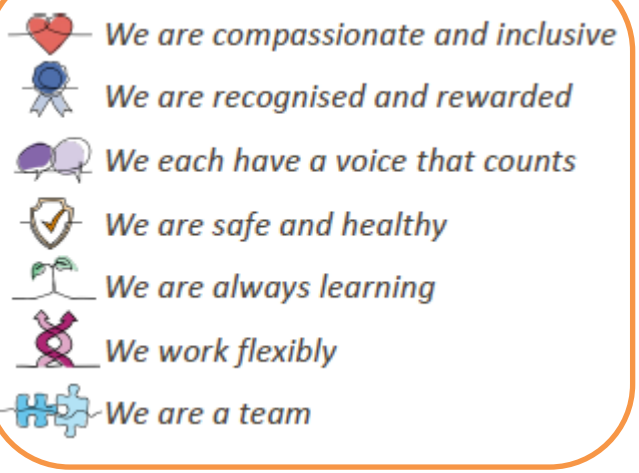
Quality | People | Pathways | Ease of use

2021 National NHS Staff Survey

East and North Hertfordshire NHS Trust

People

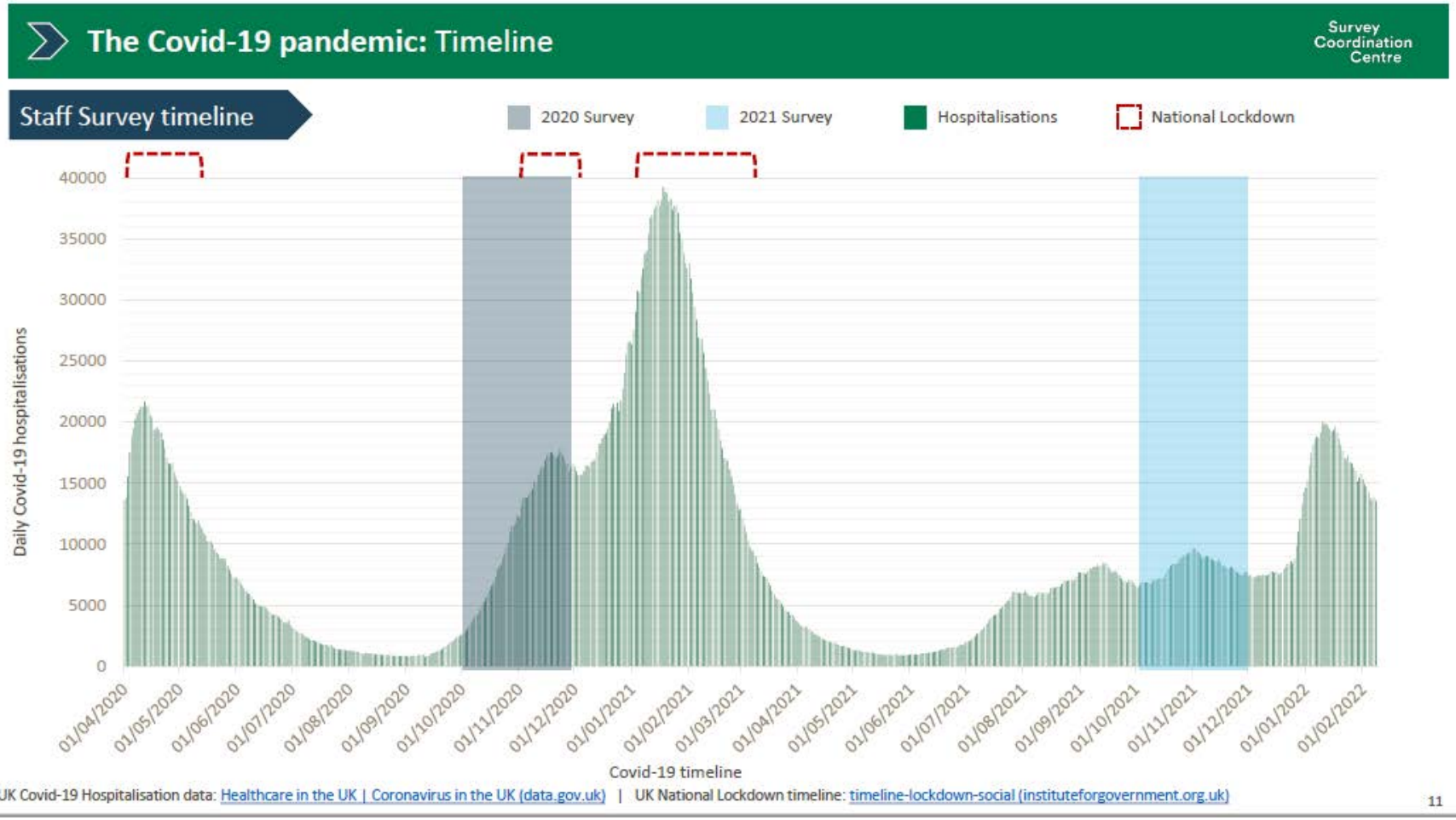
- Used by the NHS and CQC to judge and assess Trust performance
- Links have been shown between staff engagement, patient experience and patient outcomes
- The 2021 survey has been refreshed to align with the 7 People Promise elements. Two previous themes, Staff Engagement and Morale, remain
- ENHT fieldwork period started 20th September 2021 and closed 26th November 2021
- The National results were released on Wednesday 30th March 2022



2021 National NHS Staff Survey

East and North Hertfordshire NHS Trust

People

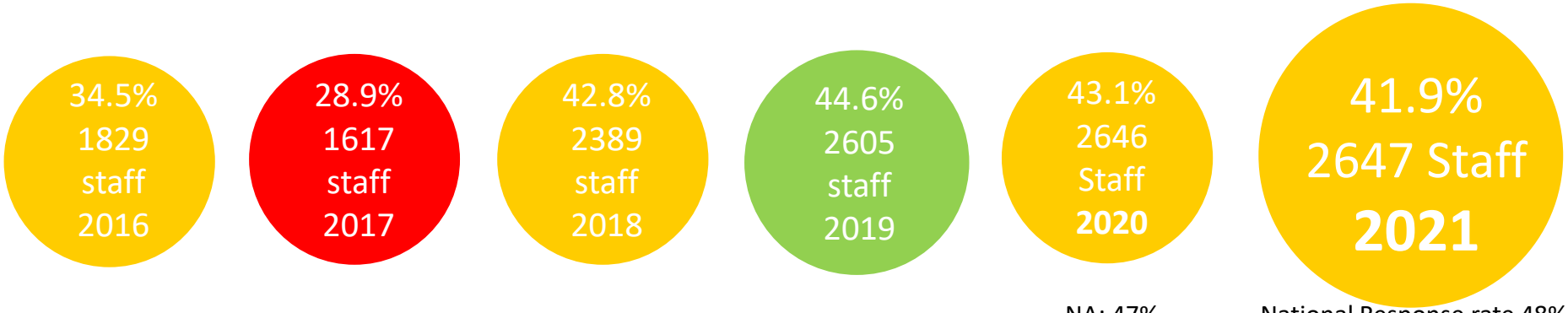


Quality | People | Pathways | Ease of use

Participation & Approach

- Trust Response Rate 2021: 42% (2,647 out of 6,310)
- National Response Rate 2021: 48%
- Acute and Acute & Community 2021: 46.4% (benchmark group median)

- External Provider: Quality Health
- Mixed Mode Approach: Paper and Email
- All Staff Census



NA: 47%

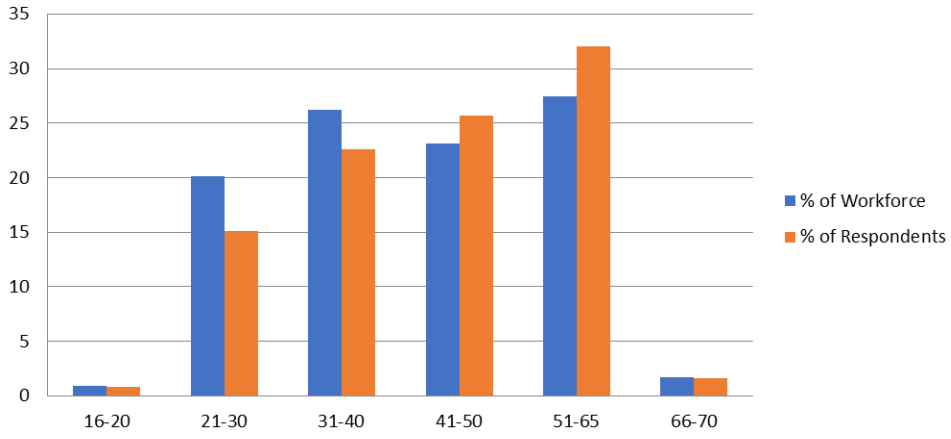
National Response rate 48%

Quality | People | Pathways | Ease of use

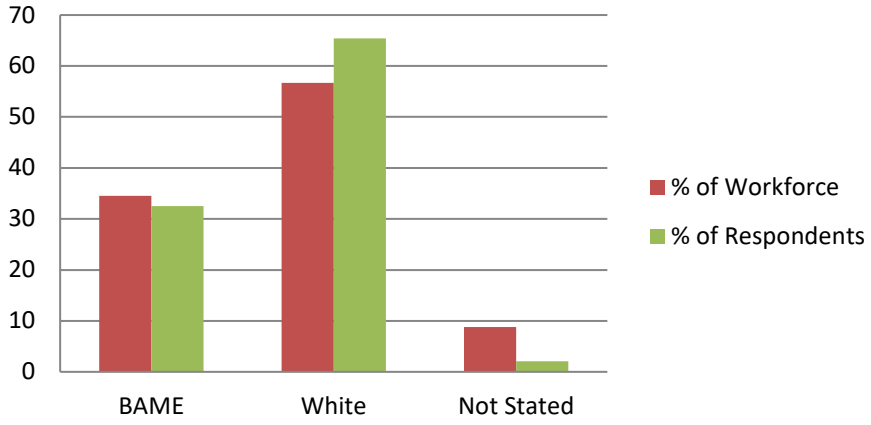
Participation & Approach

- 76% were female – representative of workforce
- 87% No physical or mental illness or condition
- 39% have parental caring duties, 30% said they had other caring responsibilities

Age of Respondents against Workforce Demographic



Ethnic Group of Respondents against Workforce Demographic

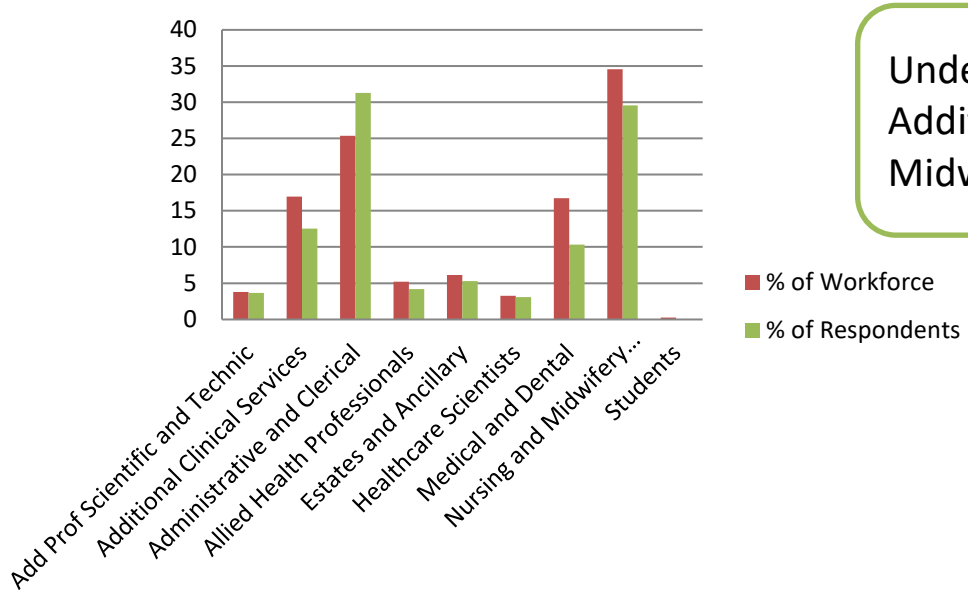


Participation & Approach

East and North Hertfordshire NHS Trust

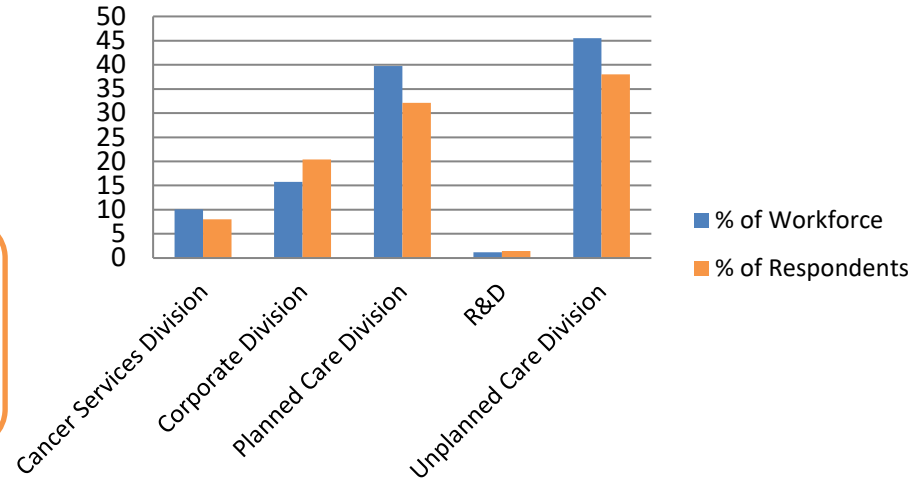
People

% of Workforce vs % of Respondents by Staff Group



Under-representation from our Medical and Dental, Additional Clinical Services and Nursing and Midwifery staff groups

% of Workforce vs % of Respondents by Division



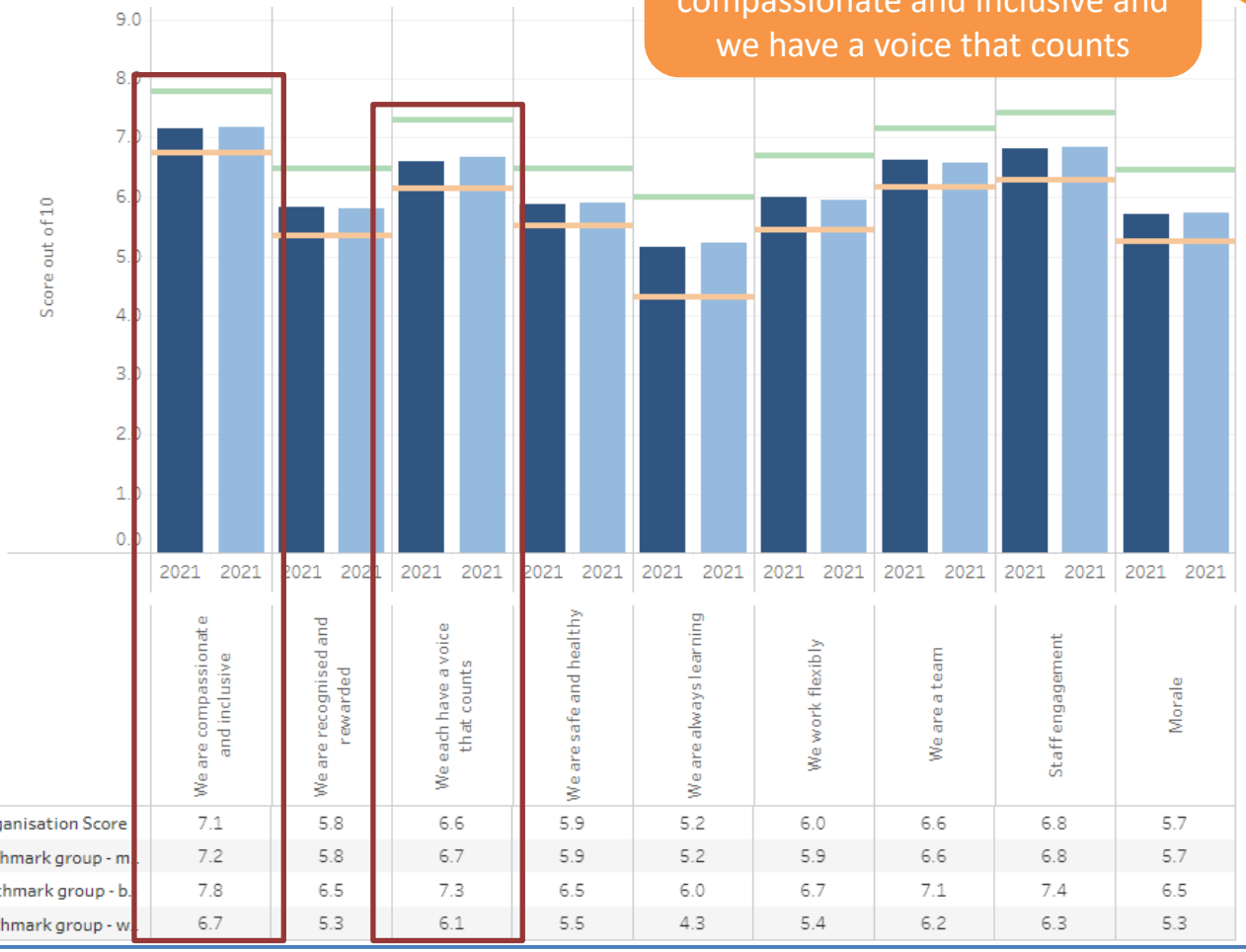
Slightly under-represented by the following divisions: Cancer Services, Planned Care and Unplanned Care

Overall Themes

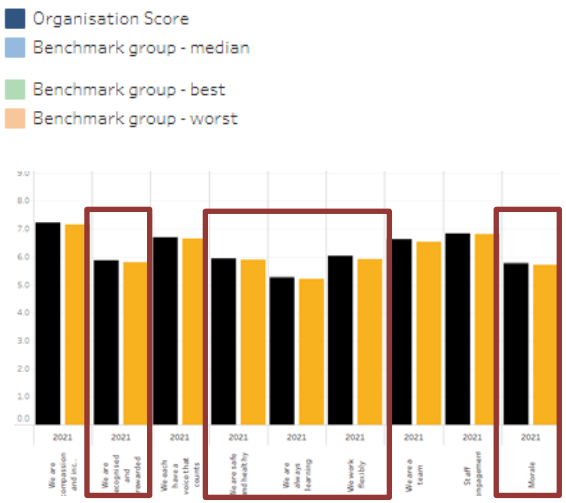
East and North Hertfordshire NHS Trust

Themes that score below average include we are compassionate and inclusive and we have a voice that counts

People



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Organisation Score	7.1	5.8	6.6	5.9	5.2	6.0	6.6	6.8	5.7
Benchmark group - m	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Benchmark group - b	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Benchmark group - w	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3



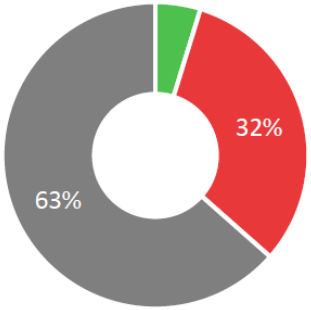
Lowest scoring themes are 'Recognised and Rewarded', 'Safe and Healthy', 'Always Learning' and 'Work Flexibly' as well as 'Morale'. These mirror the National picture (black) and Acute and Acute & Community Benchmark (orange).

Quality | People | Pathways | Ease of use

Year on year comparison

East and North Hertfordshire NHS Trust

People



- 3 (5%) question(s) have shown significant improvements since 2020
- 20 (32%) question(s) have shown significant declines since 2020
- 40 (63%) question(s) have shown no significant movements since 2020

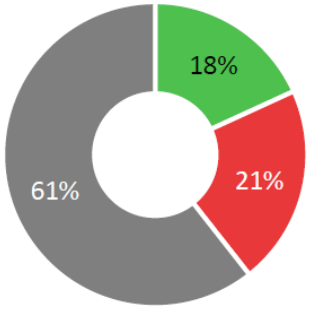
Question		2020	2021	Difference
7a	The team I work in has a set of shared objectives.	70%	74%	+3.71%
14d	The last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it.	42%	47%	+4.62%
17a	I would feel secure raising concerns about unsafe clinical practice.	67%	72%	+4.66%

Question		2020	2021	Difference
2a	I look forward to going to work.	61%	54%	-6.78%
2b	I am enthusiastic about my job.	74%	69%	-5.06%
3i	There are enough staff at this organisation for me to do my job properly.	35%	29%	-6.48%
11d	In the last three months I have come to work despite not feeling well enough to perform my duties.	49%	56%	+7.64%
21c	I would recommend my organisation as a place to work.	62%	57%	-4.99%

Performance against benchmark

East and North Hertfordshire NHS Trust

People



18 (18%) question(s) scored significantly better than the sector

21 (21%) question(s) scored significantly worse than the sector

60 (61%) question(s) showed no significant difference in relation to the sector average or comparisons could not be drawn

Question		Your Org.	Sector	Difference
2a	I look forward to going to work.	54%	51%	+3.00%
3g	I am able to meet all the conflicting demands on my time at work.	48%	43%	+4.91%
12a	I often/always find my work emotionally exhausting.	35%	38%	-3.25%
16c 02	Experienced discrimination on grounds of gender.	16%	21%	-5.18%
16c 06	Experienced discrimination on grounds of age.	14%	18%	-4.00%
19b	The appraisal/review helped me to improve how I do my job.	25%	20%	+4.67%

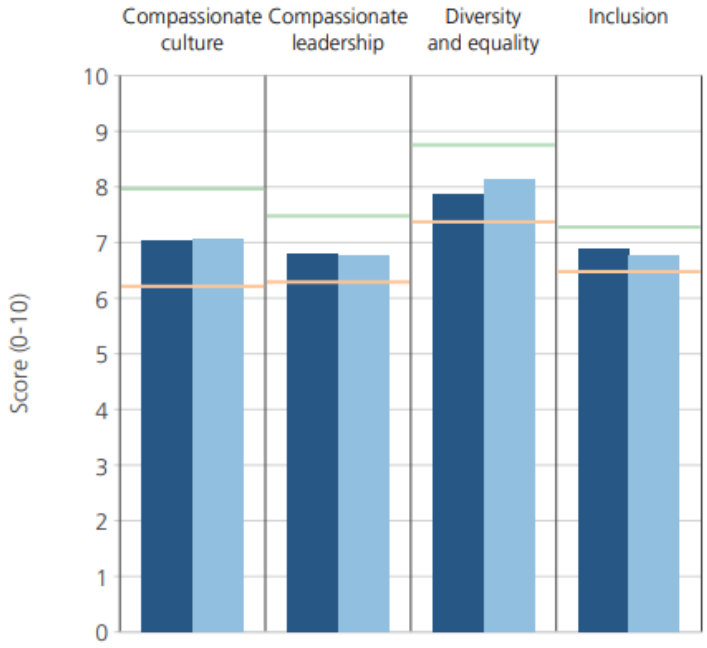
Question		Your Org.	Sector	Difference
3h	I have adequate materials, supplies and equipment to do my work.	48%	55%	-6.85%
11e	I have felt pressure from my manager to come to work.	30%	25%	+4.29%
14a	In the last 12 months I have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public.	32%	29%	+3.38%
16c 01	Experienced discrimination on grounds of ethnic background.	58%	48%	+10.29%
17b	I am confident that my organisation would address my concern.	54%	58%	-3.33%
19a	In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	77%	83%	-5.75%

Theme analysis

East and North Hertfordshire NHS Trust

People

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.0	6.8	7.9	6.9
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	2,624	2,638	2,630	2,629

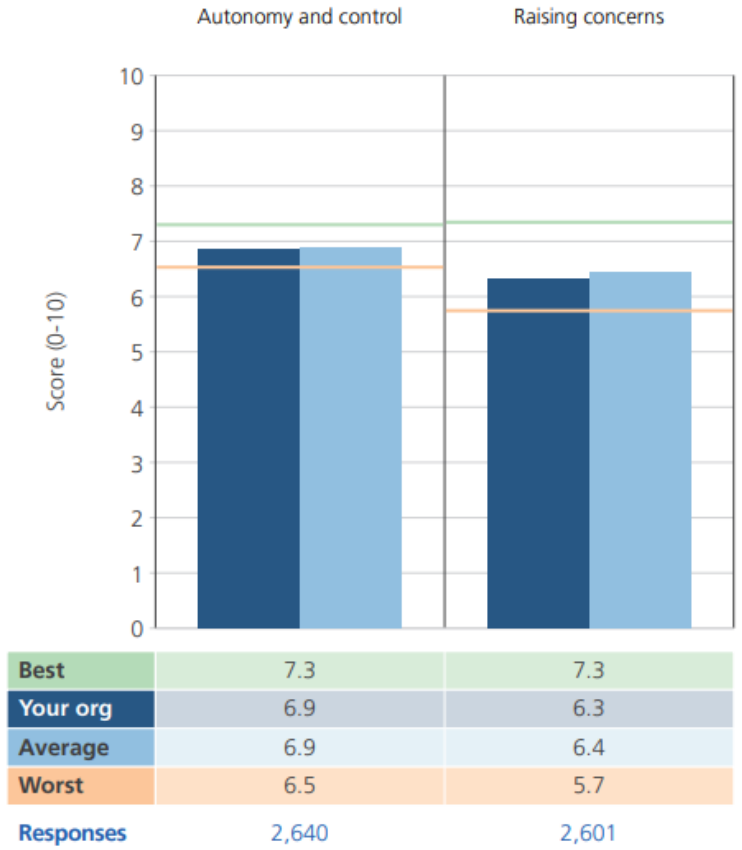
	People Promise/Theme/Question	2020 Score	Significance	2021 Score
	People Promise 1, Subscore 3 - Diversity and equality	-	N/A	7.88
15.	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	52%	Not Significant	53%
16a.	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	9%	**Significantly Declined**	11%
16b.	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	11%	Not Significant	11%
18.	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	-	N/A	64%

Theme analysis

East and North Hertfordshire NHS Trust

People

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Best	7.3	7.3
Your org	6.9	6.3
Average	6.9	6.4
Worst	6.5	5.7
Responses	2,640	2,601

People Promise/Theme/Question		2020 Score	Significance	2021 Score
People Promise 3, Subscore 2 - Raising concerns		-	N/A	6.34
17a.	I would feel secure raising concerns about unsafe clinical practice.	67%	Significantly Improved	72%
17b.	I am confident that my organisation would address my concern.	53%	Not Significant	54%
21e.	I feel safe to speak up about anything that concerns me in this organisation.	61%	Significantly Declined	58%
21f.	If I spoke up about something that concerned me I am confident my organisation would address my concern.	-	N/A	45%

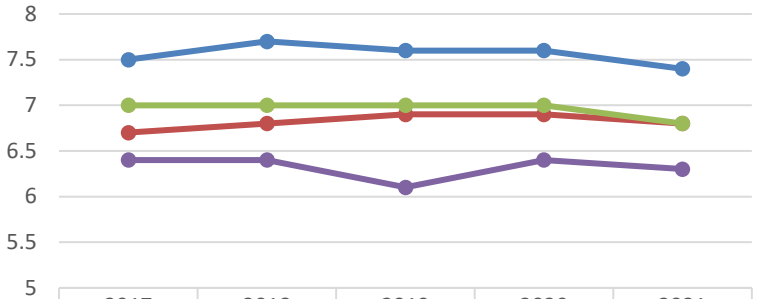
Engagement and Morale

East and North Hertfordshire NHS Trust

People

These themes have been carried over from previous years and therefore we can continuously compare staff satisfaction.

Staff Engagement

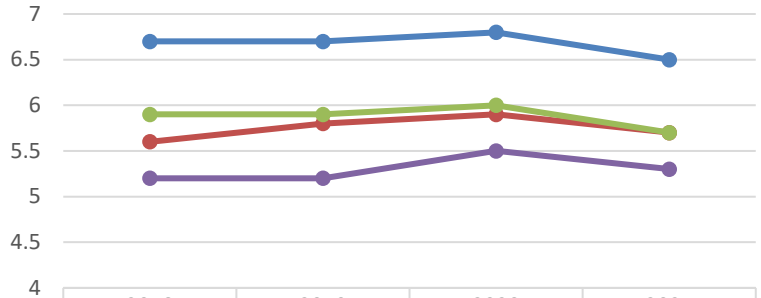


	2017	2018	2019	2020	2021
Best	7.5	7.7	7.6	7.6	7.4
Your org	6.7	6.8	6.9	6.9	6.8
Average	7	7	7	7	6.8
Worst	6.4	6.4	6.1	6.4	6.3

Staff Engagement is measured across three sub-scores:

- Motivation – Staff motivation at work
- Involvement – Staff ability to contribute towards improvement work
- Advocacy – Staff recommendation of the organisation as a place to work or receive treatment

Morale



	2018	2019	2020	2021
Best	6.7	6.7	6.8	6.5
Your org	5.6	5.8	5.9	5.7
Average	5.9	5.9	6	5.7
Worst	5.2	5.2	5.5	5.3

Morale is measured across three sub-scores:

- Thinking about leaving
- Work pressure – Staff having resources to do their work
- Stressors (HSE index) – indicators of stress

Conclusions and next steps

East and North Hertfordshire NHS Trust

People

- Results reflective of the challenges at the time largely influenced by Covid meaning around a third of questions have worsened since the 2020 survey which is consistent with the national picture.

- The majority of Themes and People Promises are in line with similar organisations.

- There have been significant improvements in:
  - Staff feeling secure raising concerns about unsafe clinical practice
  - Staff experiencing HBA* going on to report it
  - Teams having a set of shared objectives

- … and We work flexibly score is better than the sector average

Conclusions and next steps

East and North Hertfordshire NHS Trust

People

- Two People Promises score lower than comparable organisations' average:

  - We are compassionate and inclusive (in particular Diversity & Equality)
    - Strong focus on behaviours and embedding our organisation values and well as developing cultural intelligence capabilities throughout the organisation.
  - We each have a voice that counts (in particular Raising Concerns)
    - Ensure that staff are aware of the organisation's policy and process for raising concerns at work, and are provided with reassurance about how these would be handled to encourage and reassure staff that their concerns will be treated seriously and with transparency. Embed these procedures into all of the organisation's communications and staff management processes.

- Rates of HBA are high and have increased (from patients and the public):
  - Continued effort and focused support to address violence and aggression at work.

Engagement

East and North Hertfordshire NHS Trust

People

- People Strategy continues to drive overall strategy for improving staff survey results
- Team Talk - model for having meaningful and engaging conversations about the staff survey results has been developed
- Team Talk & Manager Packs have been distributed to teams to drive engagement and actions at local level
- All staff team talk taking place
- Communication and engagement plan in place for the year with a focus on driving up response rates
- Work with senior leaders and services to commission the right elements of our development programme which includes the following strands:
  - Building Health Teams (Leadership and team development)
  - Civility Matters (Values, inclusion and differences)
  - Wellbeing (Care support pyramid)

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	16
Report title	Elective Recovery			**Meeting Date**	4th May 2022
Presenter	Richard Hammond - Managing Director				
Author	Richard Hammond - Managing Director				
Responsible Director	Lucy Davies – Chief Operating Officer			**Approval Date**	28th April 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The attached Elective Recovery Slides provide an update on the delivery of key recovery targets during 2021/22 and the plan for delivery for in 2022/23.

- Activity delivery during 2021/22, against 90% of 2019/20 activity
- Plan for 2022/23, against 110% of 2019/20 activity and reduction of follow up activity by 25%
- Performance for:
    a. Advice and Guidance target
    b. Patient Initiated Follow Up (PIFU)

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Benefits:

1. Reduction in the number of patients on a tracking list
2. Financial benefit if activity levels are delivered
3. Reduction in patient harm due to reduced waiting times

Disbenefits:

4. Financial Cost of delivery

Risk: *Please specify any links to the BAF or Risk Register*

BAF - Risk to operational delivery of the core standards
Risk of Harm to patients due to waiting times
Financial Risk – non delivery of Elective Recovery Targets

Report previously considered by & date(s):

Recommendation	The Board/Committee is asked to note the progress in 2021/22 and the recovery plan with risks for 2022/23.

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Elective Recovery Board Update
April 2022

Trust Board

4th May 2022

Recovery 2021/22 – How did we do?

Day cases

Month	2019-20	Actual + Capacity	Target	Gap
	64,998	63,285	58,492	4,793
Apr	5,347	4,686	3,743	943
May	5,543	4,977	4,157	820
Jun	5,403	5,765	4,322	1,443
Jul	5,881	5,864	5,587	277
Aug	5,272	5,100	5,008	92
Sep	5,398	5,210	5,128	82
Oct	6,000	5,163	5,700	-537
Nov	5,677	5,502	5,393	109
Dec	5,038	4,987	4,786	201
Jan	5,906	4,891	5,611	-720
Feb	5,279	5,224	5,015	209
Mar	4,254	5,916	4,041	1,875

Elective

Month	2019-20	Actual + Capacity	Target	Gap
	6,766	6,053	6,077	-24
Apr	551	424	386	38
May	616	427	462	-35
Jun	598	454	478	-24
Jul	658	530	625	-95
Aug	598	448	568	-120
Sep	559	542	531	11
Oct	620	610	589	21
Nov	558	624	530	94
Dec	511	540	485	55
Jan	567	453	539	-86
Feb	531	443	504	-61
Mar	399	558	379	179

First / Follow-up Outpatient Attendances

Month	2019-20	Actual + Capacity	Target	Gap
	477,199	540,253	429,363	159,343
Apr	38,787	43,644	27,151	20,566
May	41,558	43,656	31,169	16,082
Jun	39,786	48,754	31,829	21,016
Jul	44,302	45,664	42,087	7,722
Aug	36,983	42,295	35,134	11,147
Sep	38,887	46,710	36,943	14,142
Oct	44,132	45,104	41,925	7,314
Nov	42,370	49,136	40,252	13,395
Dec	36,307	40,386	34,492	9,870
Jan	43,254	43,761	41,091	6,636
Feb	38,485	42,478	36,561	9,710
Mar	32,348	48,665	30,731	21,743

Outpatient Procedures

Month	2019-20	Actual + Capacity	Target	Gap
	87,143	99,680	78,087	23,381
Apr	8,152	7,581	5,706	1,969
May	7,806	7,821	5,855	2,101
Jun	7,331	8,819	5,865	3,082
Jul	7,914	8,982	7,518	1,631
Aug	7,120	8,199	6,764	1,741
Sep	7,212	8,919	6,851	2,169
Oct	8,176	8,497	7,767	871
Nov	6,808	9,213	6,468	2,857
Dec	6,418	7,597	6,097	1,687
Jan	7,994	8,207	7,594	782
Feb	7,161	7,911	6,803	1,251
Mar	5,051	7,934	4,798	3,241

29th March 2022:

Inpatients:

- Day Case – 97% of 2019/20
- Elective – 89% of 2019/20

Outpatients:

- New and Follow up – 113% of 2019/20
- Outpatient procedures – 114% 2019/20

Activity performance likely to be higher once March is fully counted and coded

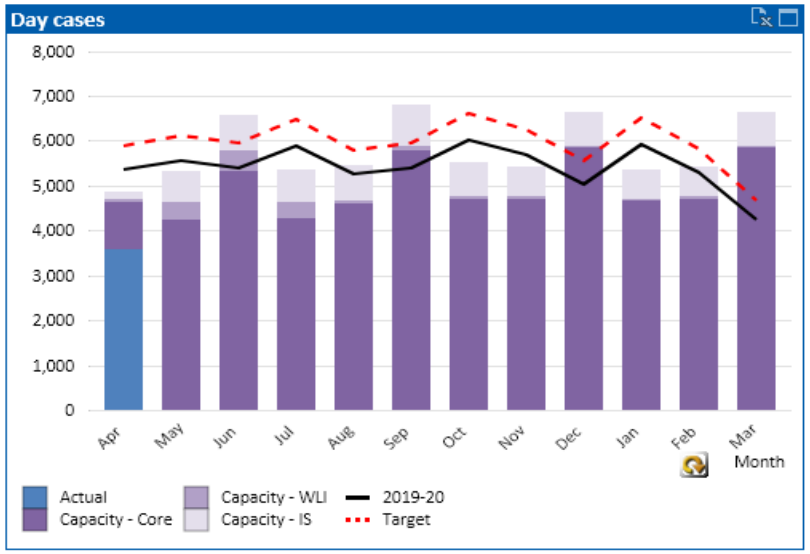
Delivered despite COVID surge, Winter pressures and staffing issue which resulted in theatre closures

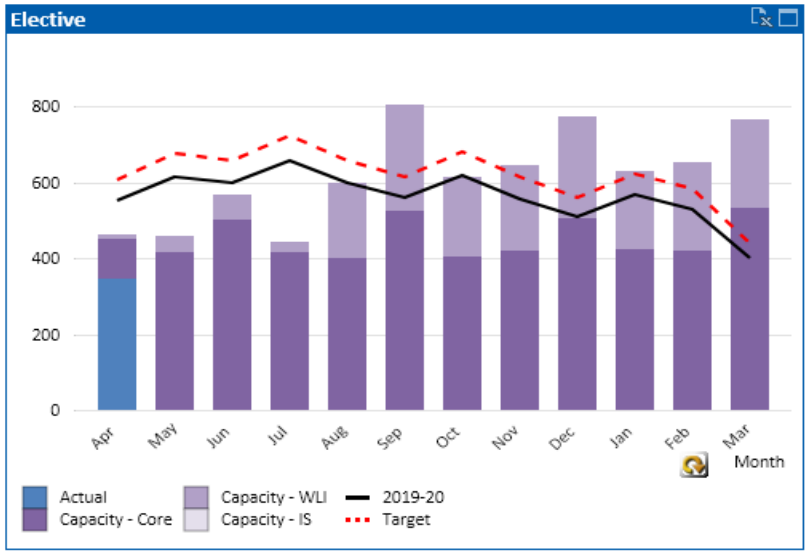
Recovery 2022/23 – The plan

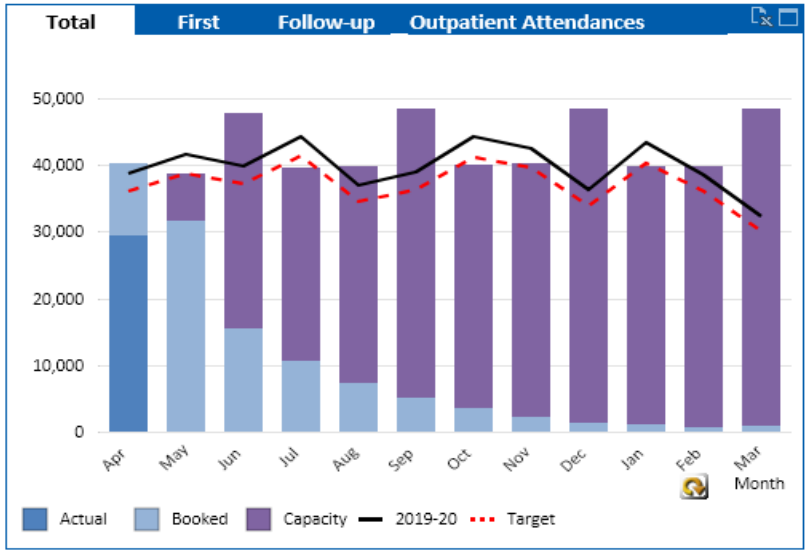
National Operational Planning Requirements

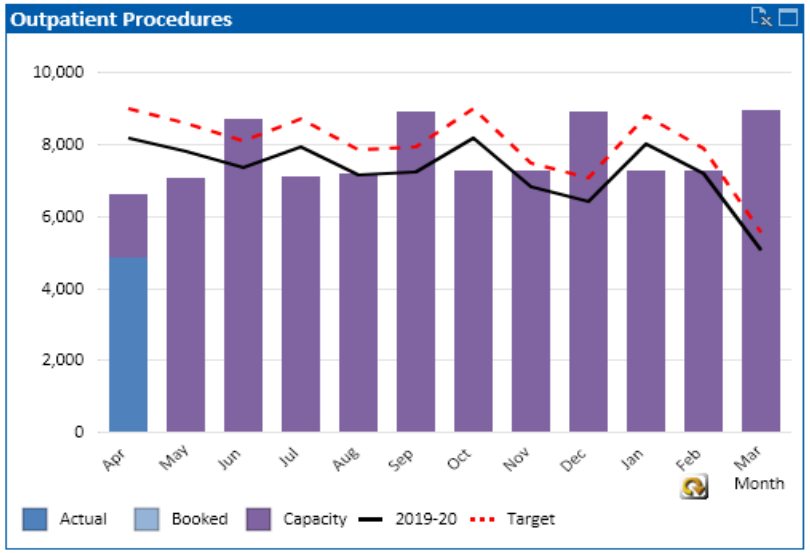
East and North Hertfordshire NHS Trust

	Activity Expectations	Performance Expectations
 ELECTIVE	• Elective activity to be 110% of 2019-20 levels; • Diagnostic activity to be 120% of 2019-20 levels.	• No waits over 104 weeks by end of June 22; • No waits over 78 weeks by March 23.
 OUTPATIENTS	• Outpatient firsts & procedures to be 110% of 2019-20 levels; • Outpatient follow up to be 85% of 2019-20 levels by March 2023.	• At least 25% of outpatient appointments to be delivered virtually; • 5% of patients to be discharged on a PIFU pathway; • Advice & Guidance to constitute 16% of all outpatient first appointments.
 CANCER	• Assumed to follow same requirements as Elective activity.	• Patients >62 days to be equal to the levels seen in Feb 20; • Patient stratified pathways to be in place for breast, prostate, colorectal and one other (by July 22) and for endometrial and one other (by March 23).









East and North Hertfordshire NHS Trust

Trust Elective Recovery Plan for 2022/23

(Achieve 110% of 2019/20 Activity)

Quality People Pathways Ease of use

Recovery Plan – 2022/23 - Inpatient

East and North Hertfordshire NHS Trust

Inpatients Total

Month	Target %	Actual + Capacity vs. 2019 20	2019 20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	110%	92%	5,898	6,488	4,028	1,162	96	165	1,423	5,451	-1,298	-1,202	-1,037
May	110%	94%	6,159	6,775	0	4,665	422	684	5,771	5,771	-2,110	-1,688	-1,004
Jun	110%	119%	6,001	6,601	0	5,823	535	777	7,135	7,135	-778	-243	534
Jul	110%	89%	6,539	7,193	0	4,701	382	728	5,811	5,811	-2,492	-2,110	-1,382
Aug	110%	103%	5,870	6,457	0	5,009	262	774	6,046	6,046	-1,448	-1,186	-411
Sep	110%	128%	5,957	6,553	0	6,306	385	906	7,597	7,597	-247	138	1,044
Oct	110%	93%	6,620	7,282	0	5,093	282	750	6,126	6,126	-2,189	-1,907	-1,156
Nov	110%	97%	6,235	6,859	0	5,116	286	654	6,057	6,057	-1,742	-1,456	-802
Dec	110%	134%	5,549	6,104	0	6,362	303	750	7,415	7,415	258	561	1,311
Jan	110%	93%	6,473	7,120	0	5,115	222	654	5,992	5,992	-2,005	-1,783	-1,129
Feb	110%	104%	5,810	6,391	0	5,113	302	654	6,070	6,070	-1,278	-976	-321
Mar	110%	159%	4,653	5,118	0	6,391	249	766	7,406	7,406	1,272	1,521	2,287
Total	110%	107%	71,764	78,940	4,028	60,856	3,726	8,265	72,846	76,874	-14,057	-10,331	-2,066

Day cases

Month	Target %	Actual + Capacity vs. 2019 20	2019 20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	110%	93%	5,347	5,882	3,681	1,059	84	165	1,308	4,989	-1,141	-1,057	-892
May	110%	96%	5,543	6,097	0	4,250	378	684	5,312	5,312	-1,847	-1,469	-785
Jun	110%	122%	5,403	5,943	0	5,319	469	777	6,565	6,565	-624	-155	622
Jul	110%	91%	5,881	6,469	0	4,285	354	728	5,367	5,367	-2,184	-1,830	-1,102
Aug	110%	103%	5,272	5,799	0	4,608	62	774	5,445	5,445	-1,191	-1,129	-354
Sep	110%	126%	5,398	5,938	0	5,778	108	906	6,792	6,792	-159	-51	855
Oct	110%	92%	6,000	6,600	0	4,687	74	750	5,512	5,512	-1,913	-1,839	-1,088
Nov	110%	95%	5,677	6,245	0	4,694	62	654	5,411	5,411	-1,550	-1,488	-834
Dec	110%	132%	5,038	5,542	0	5,854	36	750	6,640	6,640	312	348	1,098
Jan	110%	91%	5,906	6,497	0	4,691	14	654	5,360	5,360	-1,805	-1,791	-1,137
Feb	110%	103%	5,279	5,807	0	4,694	66	654	5,415	5,415	-1,112	-1,046	-392
Mar	110%	156%	4,254	4,679	0	5,859	13	766	6,638	6,638	1,180	1,193	1,959
Total	110%	107%	64,998	71,498	3,681	55,783	1,720	8,265	65,767	69,448	-12,034	-10,314	-2,049

Elective

Month	Target %	Actual + Capacity vs. 2019 20	2019 20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	110%	84%	551	606	347	103	12	0	115	462	-156	-144	-144
May	110%	74%	616	678	0	415	44	0	459	459	-263	-219	-219
Jun	110%	95%	598	658	0	504	66	0	570	570	-154	-88	-88
Jul	110%	67%	658	724	0	416	28	0	444	444	-308	-280	-280
Aug	110%	100%	598	658	0	401	200	0	601	601	-257	-57	-57
Sep	110%	144%	559	615	0	527	277	0	804	804	-88	189	189
Oct	110%	99%	620	682	0	406	208	0	614	614	-276	-68	-68
Nov	110%	116%	558	614	0	422	224	0	646	646	-192	32	32
Dec	110%	152%	511	562	0	508	267	0	775	775	-54	213	213
Jan	110%	111%	567	624	0	424	208	0	632	632	-200	8	8
Feb	110%	123%	531	584	0	419	236	0	655	655	-165	71	71
Mar	110%	192%	399	439	0	531	236	0	767	767	92	328	328
Total	110%	110%	6,766	7,443	347	5,073	2,006	0	7,079	7,426	-2,023	-17	-17

Headlines:

- Inpatients – 107% of 2019/20 activity
- Day case – 107% of 2019/20 activity
- Elective – 110% of 2019/20 activity
- Top specialties:
  - Plastics – 176% of 2019/20.
  - Pain Management – 155% of 2019/20.
  - Cardiology – 114% 0f 2019/20.
- Excludes orthopedics which requires further work and negotiation to support additional sessions.

Risks:

- Staffing: recruitment, retention and sickness
- Quality of Theatre Estate – possible failure of ventilation. Ventilation upgrade planned 2022/23.
- Future Covid surge: reduction in staff availability
- Urgent Care pathway pressures resulting in poor access to IP beds.
- In sufficient job planned Orthopedic sessions to fully support recovery; mitigations: appoint additional surgeons, insourcing, outsourcing, system mutual aid.

Quality | People | Pathways | Ease of use

Recovery Plan 2022/23 - Outpatients

East and North Hertfordshire NHS Trust

Outpatient First Attendances

Month	Target %	Actual + Capacity vs. 2019-20	2019-20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	110%	97%	12,198	13,418	8,427	2,904	282	207	3,393	11,820	-2,087	-1,805	-1,598
May	110%	105%	13,428	14,771	0	12,006	1,422	686	14,115	14,115	-2,765	-1,342	-656
Jun	110%	132%	13,172	14,489	0	14,604	1,765	1,046	17,415	17,415	115	1,880	2,926
Jul	110%	102%	14,371	15,808	0	12,104	1,350	1,176	14,631	14,631	-3,704	-2,353	-1,178
Aug	110%	119%	12,180	13,398	0	12,104	1,346	1,001	14,452	14,452	-1,294	53	1,054
Sep	110%	138%	12,792	14,071	0	14,577	1,644	1,408	17,629	17,629	506	2,150	3,558
Oct	110%	100%	14,649	16,114	0	12,140	1,319	1,135	14,595	14,595	-3,974	-2,654	-1,519
Nov	110%	105%	13,993	15,392	0	12,140	1,470	1,135	14,746	14,746	-3,252	-1,782	-647
Dec	110%	145%	12,014	13,215	0	14,581	1,460	1,368	17,409	17,409	1,366	2,826	4,194
Jan	110%	102%	14,145	15,560	0	12,100	1,214	1,135	14,450	14,450	-3,459	-2,245	-1,110
Feb	110%	111%	13,041	14,345	0	12,140	1,250	1,135	14,526	14,526	-2,205	-954	180
Mar	110%	169%	10,365	11,402	0	14,677	1,393	1,440	17,510	17,510	3,276	4,669	6,108
Total	**110%**	**117%**	**156,348**	**171,983**	**8,427**	**146,080**	**15,918**	**12,870**	**174,868**	**183,295**	**-17,476**	**-1,558**	**11,312**

Outpatient Follow-up Attendances

Month	Target %	Actual + Capacity vs. 2019-20	2019-20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	85%	102%	26,589	22,601	20,968	5,508	399	253	6,160	27,128	3,875	4,274	4,527
May	85%	88%	28,130	23,911	0	22,589	1,620	429	24,638	24,638	-1,322	298	728
Jun	85%	114%	26,614	22,622	0	27,643	1,999	645	30,287	30,287	5,021	7,020	7,665
Jul	85%	83%	29,931	25,441	0	22,681	1,623	584	24,889	24,889	-2,760	-1,137	-553
Aug	85%	102%	24,803	21,083	0	22,871	1,671	757	25,300	25,300	1,788	3,460	4,217
Sep	85%	118%	26,095	22,181	0	27,817	2,059	967	30,843	30,843	5,636	7,695	8,662
Oct	85%	86%	29,483	25,061	0	22,877	1,671	807	25,356	25,356	-2,184	-512	295
Nov	85%	90%	28,377	24,120	0	22,973	1,767	807	25,548	25,548	-1,147	620	1,427
Dec	85%	128%	24,293	20,649	0	27,824	2,179	999	31,002	31,002	7,175	9,354	10,353
Jan	85%	87%	29,109	24,743	0	22,719	1,767	807	25,294	25,294	-2,024	-256	551
Feb	85%	99%	25,444	21,627	0	22,881	1,623	807	25,312	25,312	1,254	2,877	3,684
Mar	85%	141%	21,983	18,686	0	27,924	1,999	999	30,922	30,922	9,238	11,237	12,237
	85%	**102%**	**320,851**	**272,723**	**20,968**	**276,305**	**20,380**	**8,865**	**305,550**	**326,518**	**24,550**	**44,930**	**53,795**

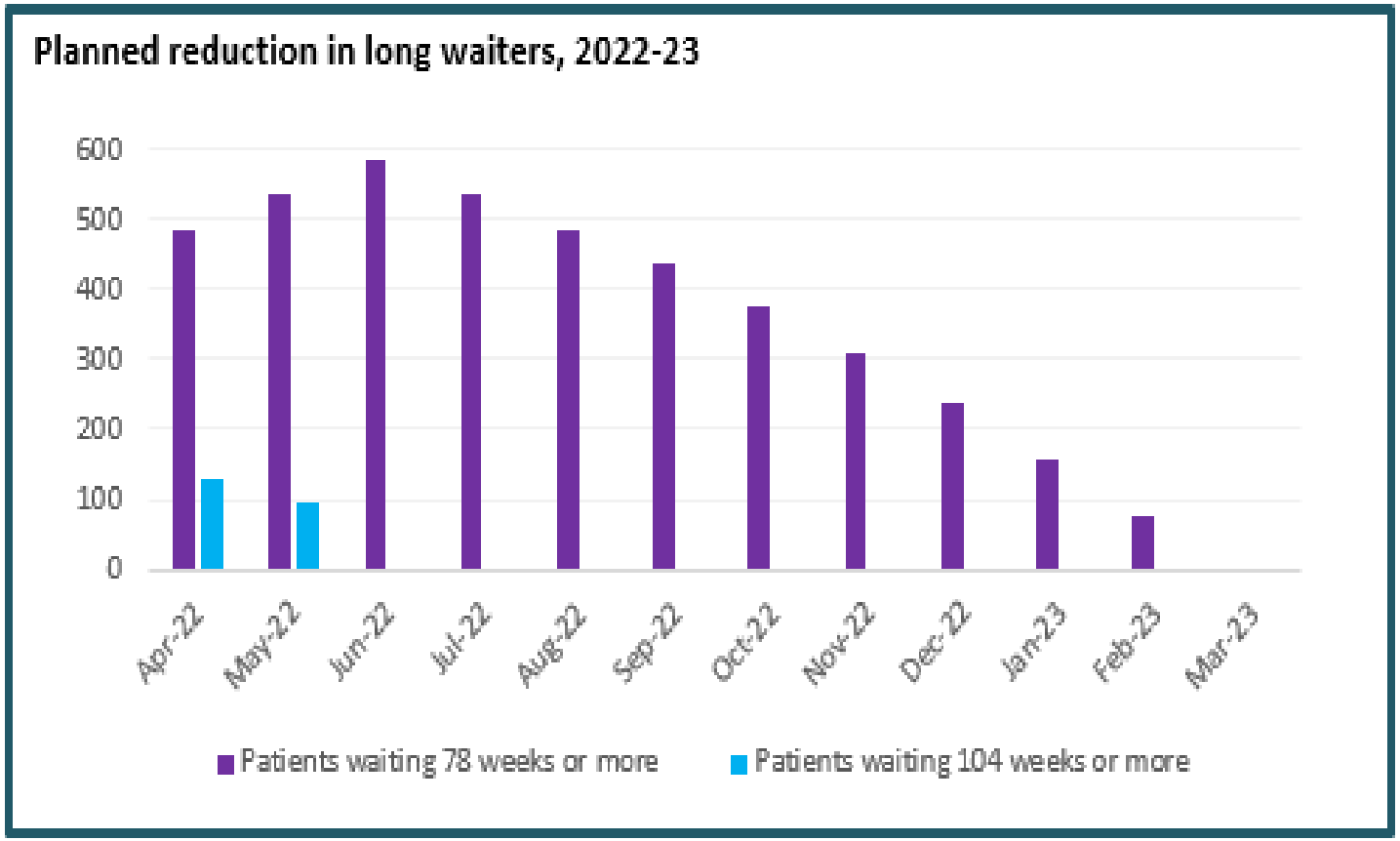
Outpatient Procedures

Month	Target %	Actual + Capacity vs. 2019-20	2019-20	Target	Actual	Core Capacity	WLI Capacity	IS Capacity	Total Capacity	Actual + Capacity	Variance Core	Variance Core & WLI	Variance Core, WLI & IS
Apr	110%	81%	8,152	8,967	4,845	1,571	130	56	1,756	6,601	-2,552	-2,422	-2,366
May	110%	90%	7,806	8,587	0	6,352	515	184	7,050	7,050	-2,235	-1,720	-1,536
Jun	110%	119%	7,331	8,064	0	7,759	664	290	8,714	8,714	-305	360	650
Jul	110%	90%	7,914	8,705	0	6,353	507	240	7,099	7,099	-2,353	-1,846	-1,606
Aug	110%	101%	7,120	7,832	0	6,353	521	300	7,173	7,173	-1,479	-959	-659
Sep	110%	124%	7,212	7,933	0	7,789	644	490	8,924	8,924	-144	501	991
Oct	110%	89%	8,176	8,994	0	6,353	521	384	7,257	7,257	-2,641	-2,120	-1,736
Nov	110%	107%	6,808	7,489	0	6,353	521	384	7,257	7,257	-1,136	-615	-231
Dec	110%	139%	6,418	7,060	0	7,759	664	470	8,894	8,894	700	1,364	1,834
Jan	110%	91%	7,994	8,793	0	6,353	507	384	7,243	7,243	-2,441	-1,934	-1,550
Feb	110%	101%	7,161	7,877	0	6,343	521	384	7,247	7,247	-1,534	-1,014	-630
Mar	110%	177%	5,051	5,556	0	7,792	644	490	8,927	8,927	2,236	2,881	3,371
Total	**110%**	**106%**	**87,143**	**95,857**	**4,845**	**77,129**	**6,359**	**4,056**	**87,544**	**92,389**	**-13,883**	**-7,524**	**-3,468**

Headlines:

- First outpatient– 117% of 2019/20
- Follow up outpatient – 102% of 2019/20
- Outpatient procedures – 106% of 2019/20 (25% reduction required).
- Requirement to reduce follow up activity to 85% of 2019/20 activity levels. This will release time for clinicians to see new patients reducing the unmet demand. This is requiring clinical pathway redesign which is underway at specialty level.
- Top specialties (New Appointments):
  - Gastroenterology – 176% of 2019/20
  - Breast – 120% of 2019/20
  - Cardiology – 119% of 2019/20
- Risks to delivery:
  - Staffing sickness, recruitment and retention
  - Covid surge – reduce capacity
  - Trust will not be paid for follow up activity over 85% and will represent a financial risk.

Performance Expectations – Long Waiters
Zero 104 week waits by end June 2022



- Reduction in 104 week to 0 waiting patients by 30 June 2022. Trajectory planned to end May 2022 to allow for slippage.
- Plan is based on mapping of patients from 78 weeks and above.

Headlines:

Total – 97 patients

- T&O – 72 patients
- Oral – 6 patients
- Pain – 8
- Others – 11 patients

Admitted – 76

Non admitted - 21

Next steps:

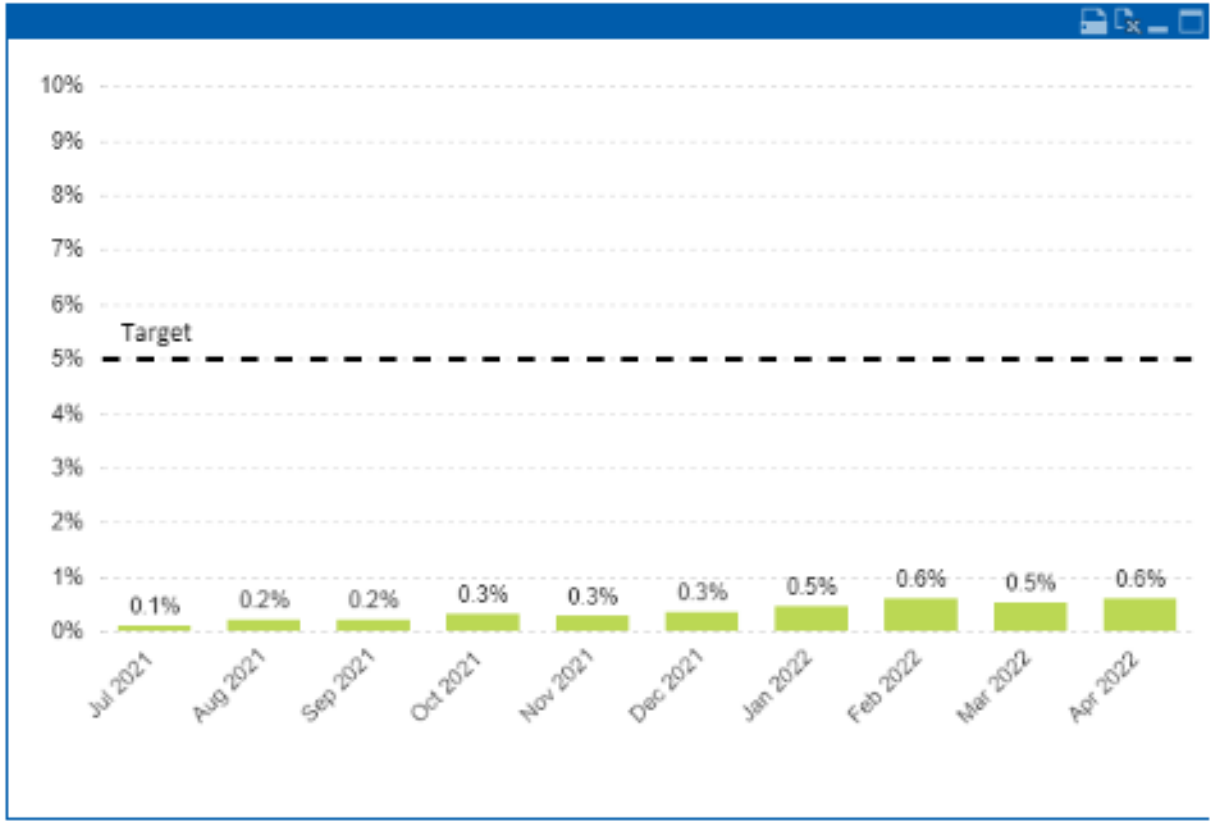
- 30 Procedures booked
- 15 Outpatient appointments
- 5 future dates to be brought forward

Risks

- Orthopaedics, due to large volumes of long waiting. Mitigation: Individual support for Orthopaedics to plan patients to the end of June.

Patient Performance Expectations – PIFU
(5% of patients discharged to a PIFU pathway)

East and North Hertfordshire NHS Trust



- Current number of patient discharges to a PIFU pathway – 0.6% against a target of 5%
- The trust has 7 services actively using a PIFU pathway
- Transformation team working with individual services to develop their own PIFU pathways, ensuring there is a safety net for patients and quality is maintained.
- Current workplan includes Ophthalmology, Plastics PIFU plus for Gastroenterology, and for cancer Patient Stratified Follow up.

- Risks
  - The PIFU pathway is not used as an open pathway, mitigated by planning and safe implementation.
  - Service buy in to PIFU – Transformation team working with services to support identification of suitable patient cohorts and implementation of new pathways – mitigation by support form Transformation team, the system outpatient project and regional national workshops.

Service Specialty	Jan 2022	Feb 2022	Mar 2022	April 2022
SURGERY	3	5	6	2
UROLOGY	44	57	58	45
SURGERY_BREAST	12	10	10	7
SURGERY_VASCULAR	9	10	12	11
ORTHOPAEDICS	14	16	17	6
EAR_NOSE_THROAT	23	28	42	24
OPHTHALMOLOGY	6	7	7	5
ORAL_AND_MAXILLOFACIAL_SURGERY	1	5	4	4
SURGERY_PLASTIC	4	6	4	2
PAIN_MANAGEMENT	2	5	4	4
GI_AND_LIVER_MEDICINE_AND_SURGERY	90	87	139	84
ENDOCRINOLOGY_AND_METABOLIC_MEDICINE	76	84	98	52
HAEMATOLOGY	96	98	114	76
DIABETIC_MEDICINE	3	6	3	1
CARDIOLOGY	91	108	141	85
RESPIRATORY_MEDICINE	29	30	29	20
SLEEP_MEDICINE	7	1	2	2
NEPHROLOGY	48	41	39	32
NEUROLOGY	64	62	81	56
RHEUMATOLOGY	44	43	51	42
CHILDRENS_ADOLESCENT_SERVICES	112	115	138	66
GERIATRIC_MEDICINE	4	3	2	1
GYNAECOLOGY	61	95	102	64
Total Requests	843	922	1103	691
Total 1st Outpatient	13230	13306	15985	10009
Percentage of 1st Outpatient	6%	7%	7%	7%

East and North Hertfordshire NHS Trust

Performance Expectation: Advice and Guidance 16% of First Outpatient Attendances

- Advice and Guidance allows support to try to prevent an outpatient appt and allow the patient to be treated safely within the community
- The Trust has all its services published to allow GPs to request advice prior to a referral
- Reliance is on the GP to use service, so promotional work is being undertaken by CCGs and the ICS
- Consultant Connect is a service that gives Advice and Guidance, using Trust, System, Region and National speciality consultants. The ICS has commissioned a 12 month trial with Consultant Connect to improve access and uptake. Data on this slide does not include Consultant Connect data which enhance our data.

Risks:

- GP uptake. Mitigation CCG's promoting the use of A&G and encouraging GP's to use where appropriate.

Key delivery work streams

The key transformation workstreams to support elective recovery are:

- **Referral Management** – to support and manage the referrals into the organisation through Advice & Guidance, Electronic Referral System, Referral Assessment Services.
- **Outpatients** – transformational improvement to the way we deliver outpatient service through efficiency, better use of space, improved pathways and further roll out of digital solutions such as Virtual Consultations.
- **Diagnostics** – Transformational improvements to pathway, increasing capacity through the Community Diagnostics roll out.
- **Elective** - transformational improvement to the way we deliver theatre service through improve efficiency, better use of our theatres, increases in capacity through the use of procedure rooms.
- **Patient Treatment List & Validation** – ensure of patient lists are clinically stratified and as accurate as possible.
- **Patient Support** - My planned care and Waiting well, to support patients whilst they waiting to keep well, give access to support and information.
- **Weekly Demand and Capacity** – Weekly review of the delivery plan to support the division services when changes occur and the recovery

These Key work streams supported buy QlikView data and project reports will be reviewed at the Elective recovery Group and then the Trusts Transformation Board.

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	18
Report title	Annual Report and Accounts, Annual Governance Statement and External Auditor's Report - Approval Process		**Meeting Date**	4 May 2022
Presenter	Martin Armstrong, Director of Finance and Deputy CEO			
Author	Stuart Dalton, Trust Secretary			
Responsible Director	Deputy Chief Executive and Director of Finance		**Approval Date**	26 April 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

The Trust is required to comply with the guidance in the Group Accounting Manual 2021-22, and submit a set of audited annual accounts by the national deadline of 22 June 2022.

Given the Board will not meet before the submission deadline and in line with practice in previous years, the Board is asked to delegate approval authority to the Audit Committee.

Audit Committee is scheduled for 9am-11.30am 20 June and Board members will have access to the Audit Committee papers and are welcome to attend Audit Committee.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

With annual report and accounts approval reserved to the Board under the Scheme of Reservation, it requires formal Board delegation to the Audit Committee.

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to approve the request to delegate authority to the Audit Committee to sign-off the Trust's annual report and accounts for 2021-22

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

East and North Hertfordshire NHS Trust

Meeting	Public Board		**Agenda Item**	19
Report title	Committee structure and related revised Standing Orders and Terms of Reference		**Meeting Date**	4 May 2022
Presenter	Stuart Dalton, Trust Secretary			
Author	Stuart Dalton, Trust Secretary			
Responsible Director	Martin Armstrong, Deputy CEO		**Approval Date**	26 Apr 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

This paper presents the proposed revised committee structure for approval that reflects the desire expressed by Board/Committee Chairs and Executive Directors to revise the committee structure. The Standing Orders, Scheme of Reservation/Delegation and relevant Committees' Terms of Reference need to be amended and approved to enact the proposed changes.

The changes are intended to achieve two key outcomes:

1) Effective strategy implementation, following completion of the strategy refresh.

With the strategy refresh complete, the need for a standalone Strategy Committee has diminished. With the focus moving to ensuring delivery of the strategy, the intention is for the Strategy Committee to disband and Board to oversee long-term strategic matters with Finance, Performance and Planning Committee providing committee-level scrutiny and support for delivery of the strategy.

2) Increasing the focus and support for our staff by providing dedicated time and space to fully understand people matters and ensure delivery of our People Strategy and improvements in Staff Survey results.

There was significant feedback for the desire for a People Committee, including it being viewed a key vehicle that should help drive people improvements. It is proposed for the new People Committee to combine with the existing Equality & Inclusion Committee to ensure an integrated approach with equality and inclusion activities.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

These improvements are intended to enhance the effective delivery of all our strategic priorities as well as contribute to improved CQC and staff survey results.

There are no financial costs and no disbenefits have been identified. However, the impact of the committee restructure will be kept under review for any unintended disbenefits.

Risk: *Please specify any links to the BAF or Risk Register*

A People Committee should particularly assist with mitigating the two People BAF risks (002 workforce model and 009 staff engagement).
Committee ownership of BAF risks will be amended to ensure risks are allocated to the most appropriate committee.

Report previously considered by & date(s):

An informal Committee Chairs meeting on 16 February supported the proposals.
Executive Committee reviewed the proposals by email on 19 April and supported the

proposals.	
Recommendation	The Board is asked to approve: • The new committee structure; • The changes to the Standing Orders and Scheme of Reservation & Delegation; and • The Terms of Reference for the following committees: People; FPPC; QSC and Remuneration.

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Committee restructure paper to 4 May 2022 Board

Introduction

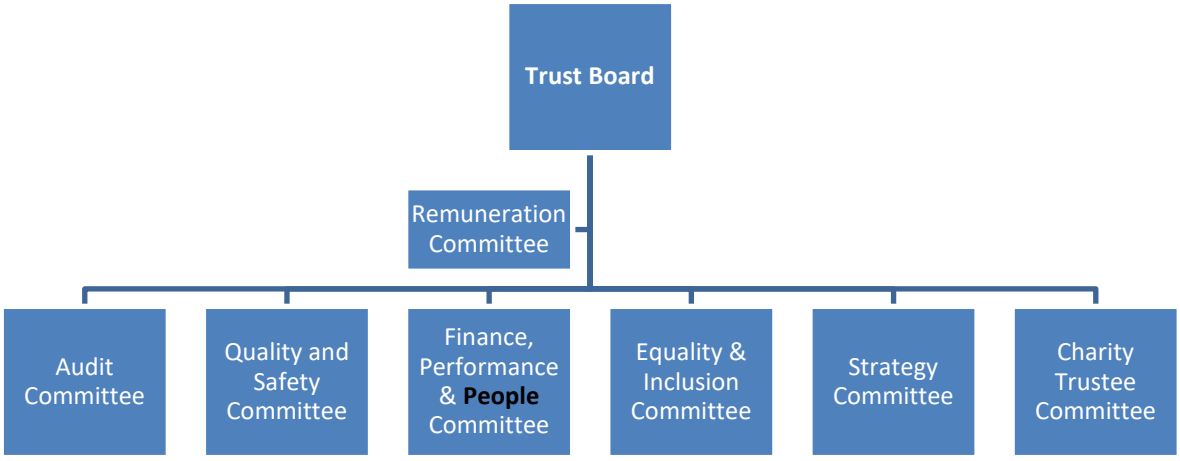
This paper sets out:

A. The proposed committee structure changes and rationale
B. Changes to the Standing Orders, Scheme of Reservation & Delegation and committee Terms of Reference, which require Board approval, to enact the committee restructure

A Proposed committee structure changes

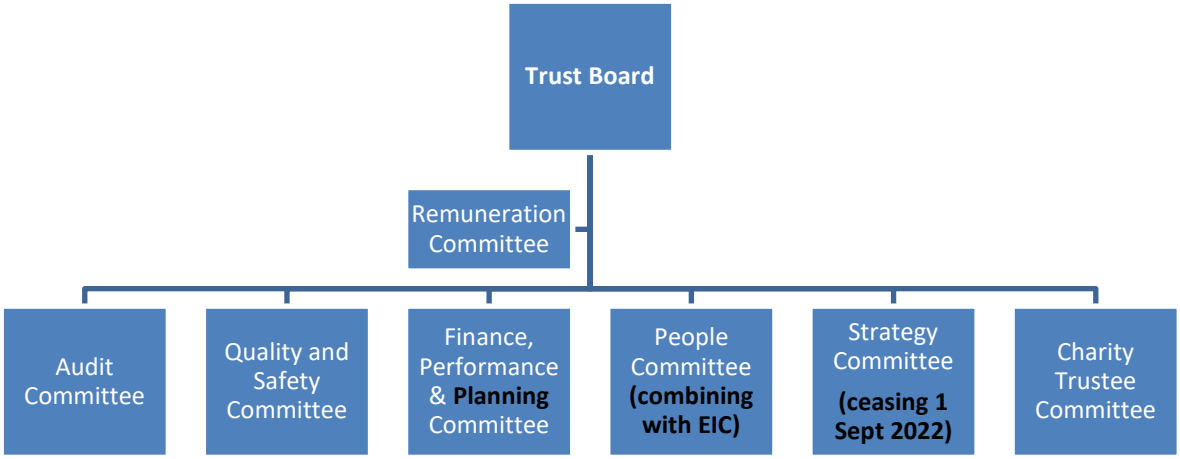
The proposed committee structure set out below, with the current structure for reference, is presented for approval and reflects the feedback provided by Board and Committee Chairs and Executive Directors and discussions on the best way forward.

Current structure



* Please note that Executive Committee, whilst mentioned in the Scheme of Delegation, is not a committee of the Board under the Standing Orders and therefore is not included.

Proposed structure



The rationales for the changes are:

- The desire to bolster focus on our staff through creating a People Committee.
- There was feedback on the importance of ensuring the increased People focus was integrated with the staff equality work of the Equality and Inclusion Committee. Therefore, it is proposed that the People Committee combine with the Equality and Inclusion Committee.
- Population health inequalities, which fell under the Equality and Inclusion Committee, needs specific focus and is proposed to move to the Quality and Safety Committee.
- With the strategy refresh complete, the need for a standalone Strategy Committee has diminished. With the focus moving to delivery of the strategy, the intention is for a Finance, Performance and Planning Committee, to pick up oversight of delivery of the strategy at a committee level, with the Strategy Committee disbanding. Feedback included the need to learn the lessons from the challenges of previous strategy implementation. In addition, an executive Programme Board is also being established to oversee strategy delivery at an operational level. It is also intended to increase the strategic focus at Board with increased strategic items considered at Board (which can be seen in the proposed Board annual cycle of business for 2022-23 – agenda item 26).

Recommendation: The Board is asked to consider and approve the proposed committee structure.

B Standing Orders, Scheme of Reservation & Delegation and Terms of Reference changes

The constitutional documents that govern the committee structures need to be amended to reflect and enact the proposed committee restructure.

B1 Standing Orders and Scheme of Reservation and Delegation summary of changes

The changes to the Standing Order and Scheme of Delegation are highlighted via tracked changes for ease of reference in appendix 1. *(Note: contents page/page numbers will be updated following final wording approval).*

In addition, the opportunity has been taken to clarify some broader points in the Standing Orders and Scheme of Delegation, most importantly in anticipation of the Integrated Care System (ICS) which is due to assume a statutory basis from July 2022.

The review has identified the following substantive amendments:

- Clarifying that Board and Committee meetings can be remote/online and not in person (SO 2.8.3 in conjunction with SO 3.11(iv)) – remote meetings are not excluded currently but neither are they explicit where a member of the public might expect or wish to challenge that a public Board should be in person;
- Adding the ability for joint committees (SO 4.2) or fully delegating functions (SO 5.1.2) to broader health bodies and local authorities in anticipation of the ICS and HCP (SO 4.2);
- Adding a protection as we develop the ICS governance infrastructure, “The Board reserves the ability to, at any time, withdraw a function, duty or power it has delegated and then to exercise the function, duty or power itself or to delegate it.” (SO 5.1.4)
- Adding the flexibility for the Board to approve terms of reference that allow committees to operate differently from the Board for how meetings are conducted

(SO 4.2 and 4.3). Currently the Standing Orders require committees and sub-committees to operate strictly according to Standing Orders without any ability to amend committee ways of working. For example, currently the quoracy and voting Standing Order rules cannot be changed meaning deputies are not allowed for quoracy/voting and a range of other requirements that cannot be varied that may not make for optimal committee working;

- Adding the ability for committees to be able to approve the terms of reference of their sub-committees (SOs 4.3(ii) and 4.4(ii)). Currently sub-committee terms of reference must be approved by the Board. SO 4.5 will still provide the following protection: "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."
- The Remuneration and Appointments Committee is given delegated authority to decide remuneration rather than needing to refer recommendations to the Board to make decisions (SO 4.8.2), in the context all NEDs already sit on the Committee;
- Finance, Performance and People Committee changing to Finance, Performance and Planning Committee (SO 4.8.4 (i)) to reflect the creation of a People Committee and FPPC taking on strategic planning/delivery oversight;
- Strategy Committee to cease from 1 September 2022 (SO 4.8.4 (iii));
- People Committee established and merging with the Equality & Inclusion Committee (SO 4.8.4 (iv));
- Quality & Safety Committee taking over responsibility for health inequalities (SO 4.8.4); and
- Removing Executive Committee from the Scheme of Delegation because it is not one of the committees of the Board under SO 4.8 and therefore has no constitutional standing (SO 5.4.1 only allows CEO delegations to officers and not non-constituted committees) and there is not the desire to make Executive Committee a Committee of the Board. This will mean the CEO has the right to set the terms of reference of any Executive meeting or amend or disband it as he sees fit, as long as delegations are via officers.

There are also some minor clarifications and non-substantive changes which are marked as tracked changes.

The Scheme of Reservation and Delegation has been updated to reflect these above changes.

B2 Committees' Terms of Reference changes

The Terms of Reference of the below committees have been amended to reflect the proposed changes set out above (see appendices 2-5):

- People Committee
- Finance, Performance and Planning Committee
- Quality & Safety Committee
- Remuneration & Appointments Committee

Recommendation: The Board is requested approve the proposed revisions to the Standing Orders, Scheme of Reservation & Delegation and committee terms of reference changes.

Appendices
Appendix 1: Standing Orders & Scheme of Delegation
Appendix 2: Terms of Reference (ToR) for People Committee
Appendix 3: Finance, Performance & Planning Committee ToR
Appendix 4: Quality & Safety Committee ToR
Appendix 5: Remuneration & Appointments Committee ToR

East and North Hertfordshire NHS Trust

APPENDIX 1

TRUST-WIDE POLICY

for

STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS

A document recommended for use

In: Trust-wide

By: All staff

For: NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.
High standards of corporate and personal conduct are essential in the NHS. These "extended" Standing Orders, incorporating the Standing Financial Instructions (SFIs), Schedule of Reservations of Powers (SRP) and Scheme of Delegated Authorities (SoDA) identify who in the Trust is authorised to do what.

Key Words: Policy, Standard Financial Instructions, Standing Financial Orders, Finance, Governance, Delegated Authorities

Written by: Trust Secretary
Financial Controller
Director of Procurement
Local Counter Fraud Specialist / Anti-Crime Specialist

Approved by:
Audit committee

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair),

Policy issued:
To be reviewed before:
To be reviewed by: Trust Secretary / Financial Controller
Doc Registration No. CG05 **Version No.**

Version	Date	Comment
1	2010	
2	2012	
3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care

		Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	October 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.
7	October 2017	Scheduled review. Updated in line with Organisational changes.
8	October 2018	Scheduled review. Updated in line with Organisational changes.
9	October 2019	Scheduled review. Updated in line with Organisational changes.
10	October 2020	Scheduled review. Updated in line with Organisational changes.
11	October 2021	Scheduled review. Updated in line with Organisational changes.
12	May 2022	To enable a committee restructure

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
Managing Conflicts of Interest Policy
Anti-Fraud and Bribery Policy
Trust Values & behaviours

Review
This document will be reviewed annually, or sooner in light of new legislation or new guidance issues by the department of Health.

Key messages

1. The consolidated document provides a single source of the key rules under which the Trust is managed and governed.
2. The regulations which determine the way that the Trust Board operates and the Trust is governed are spelt out in the Standing Orders.
3. Financial responsibilities and authorities are described in the SFIs and SoDA
4. All employees of the Trust need to be aware of their responsibilities and authorities described in this document. Failure to comply with this document is a disciplinary matter, which will be handled in accordance with the Trust's Disciplinary Policy. Where a breach constitutes a criminal offence, the matter may be subject to criminal investigation and will be handled in accordance with the Trust's Anti-Fraud and Bribery Policy and relevant legislation.

EAST AND NORTH HERTFORDSHIRE NHS TRUST

STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS

~~October 2021~~ May 2022

Page

CONTENTS

Commented [DS(ANHNT1]: SFIs removed from paper to the Board to save space as there are no changes to the SFIs

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive or Trust Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **Trust** means the East and North Hertfordshire NHS Trust

1.2.3 **Board** means the Chair, officer and non-officer members of the Trust collectively as a body.

1.2.4 **Bribery -** Giving or receiving a financial or other advantage in connection with the 'improper performance' of a position of trust, or a function that is expected to be performed impartially or in good faith. Where the Trust is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person intending to obtain or retain business or an advantage in the conduct of business for the Trust and it cannot demonstrate that it has adequate procedures in place to prevent such. The adequate procedures that the Trust is required to have in place to prevent bribery being committed on their behalf are performed by six principles – proportionate procedures, top-level commitment, risk assessment, communication (including training), monitoring and review. The Trust does not tolerate any bribery on its behalf, even if this might result in a loss of business for it. Criminal liability must be prevented at all times. Please see the Trust's Anti Fraud and Bribery Policy for a summary of the Bribery Act 2010.

1.254 **Budget** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.6 **Budget holder** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.7 **Chair 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 Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.8 **Chief Executive** means the chief officer of the Trust.

1.2.9 **Clinical Governance Committee** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the East and North Hertfordshire NHS Trust has responsibility.

1.2.10 **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.11 **Committee** means a committee or sub-committee created and appointed by the Trust.

1.2.12 **Committee members** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.13 **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.14 **Director of Finance** means the Chief Financial Officer of the Trust.

1.2.15 **Funds held on trust** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.2.16 **Fraud** any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Please see the Trust's Anti Fraud and Bribery Policy for a summary of the Fraud Act 2006.

1.2.17 **Member** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chair.

1.2.18 **Associate Member** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.19 **Membership, Procedure and Administration Arrangements Regulations** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

1.2.20 **Nominated officer** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.21 **Non-officer member** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

1.2.22 **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.23 **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 Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

1.2.24 **Secretary** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

1.2.27 **Vice-Chair** means the non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The East and North Hertfordshire NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2000 under The East and North Hertfordshire NHS Trust (Establishment) Order 2000 No 535, (the Establishment Order).

(1) The principal place of business of the Trust is Lister Hospital, Coreys Mill Lane, Stevenage, Hertfordshire, SG1 4AB.

(2) NHS Trusts are governed by statute mainly the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

(3) The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and schedule4) and in the Establishment Order.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

(5) 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. Furthermore the Trust has delegated powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation..

(6) The Code of Accountability for NHS Boards (DH, revised April 2013) 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.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

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

(2) The Code of Accountability for NHS Boards (DH, revised April 2013) requires that, 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 makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS as revised by the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.

1.3 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 (Reservation of Powers to the Board and Delegation of Powers). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – '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. The Standing Orders and Standing Financial Instructions will be reviewed annually

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance and other best practice guidance including the Healthy Board will continue to be incorporated in the Quality and Risk Management Strategies. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

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 Chair of the Trust (Appointed by NHS Improvement);

(2) Up to 5 non-officer members (appointed by NHS Improvement);

(3) Up to 5 officer members (but not exceeding the number of non-officer members) including:

- the Chief Executive;
- the Director of Finance

The Trust shall have not more than 11 and not less than 8 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 Trust's Chair and Members of the Trust

(1) Appointment of the Chair and Members of the Trust - National Health Service Act 2006 as amended by the Health and Social Care Act provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Trust's Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chair and Members

(1) The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

2.4 Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an officer member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Patient and Public Involvement

The Trust works with the local involvement network 'Healthwatch'. Healthwatch England was set up to make sure the views and experiences of consumers across the country are heard clearly by those who plan and run health and social care services and they are supported by legislation and a partner of the Care Quality Commission. Each local Healthwatch is part of its local community and works in partnership with other local organisations.

2.7 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.

(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) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(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.

(5) **Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the NHS Improvement - Appointments 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 Chair 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.

2.8 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(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 No. 3. A meeting in public or in private does not require the meeting to be in person. At the Chair's discretion, the meeting may be held remotely, with the public able to view the meeting online.

Commented [SD2]: Added to cover where meetings need to be remote

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.9 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.

2.10 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places (including remotely and not in person) as the Board may determine.

(2) The Chair of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chair 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.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written 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 members at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

(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.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair and Trust Secretary 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 Chair and Trust Secretary.

(5) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, will be made publicly available at least three clear days before the meeting, in accordance with the requirements of section 1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960~~shall be displayed at the Trust's principal offices at least three clear days before the meeting, in accordance with the requirements of (required by~~ the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

Commented [SD3]: To bring it into line with modern practice and the ability to provide the notice online following a COVID amendment to the Act. Wording taken from NHSE's SOs.

3.3 Agenda and Supporting Papers

The Agenda will be sent to members 5 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.4 Petitions

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

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 5 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chair, 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 Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

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

ii) **Contents of motions**

The Chair 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.

iii) **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.

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

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

vi) **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 Chair 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

(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.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of meeting

(1) At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Board has appointed one), if present, shall preside.

(2) If the Chair and Vice-Chair are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

3.10 Chair's ruling

The decision of the Chair 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.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present.

(ii) An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

(iii) If the Chair 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 No.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.

(iv) The Board may agree that its Members can participate in its meetings by telephone, teleconference and video or computer link. Participation in a meeting in this manner will be deemed to constitute a presence in person at the meeting.

3.12 Voting

(i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - 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 (ie: the Chair of the meeting) shall have a second, and casting vote.

(ii) At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

(v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vi) 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 Member.

(vii) A manager attending the Trust Board meeting 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.

(viii) For the voting rules relating to joint members see Standing Order 2.5.

3.13 Suspension of Standing Orders

(i) 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 3.11), 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.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.17 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board 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 l960

- Guidance should be sought from the NHS Trust's Designated Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with 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 Trust Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) **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.

(iv) **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. For the avoidance of doubt, the Trust may choose to hold the meeting remotely online and transmit the meeting electronically.

3.18 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 as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

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

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

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other health or local authority bodies ~~, NHSI, CCG,~~ or other Trusts consisting, wholly or partly of the Chair and members of the Trust or other health service or local authority bodies, or wholly of persons who are not members of the Trust or other health or local authority bodies in question.

(ii) 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 or local authorities 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 or local authorities in question) or wholly of persons who are not members of the Trust, ~~or~~ health bodies or local authorities in question or the committee of the Trust, ~~or~~ health or local authority bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

(i) 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, except where SO 4.3(ii) and 4.4(ii) applyies. ~~.~~ In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

(ii) These Standing Orders and Standing Financial Instructions apply to the meetings of each joint committee, Board meetings in common, Committees or Sub-Committees in Common; in as far as alternative governance arrangements, including terms of reference, have not been established and agreed by the Board or by a Committee for any of its sub-committees.

4.4 Terms of Reference

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

(ii) Where Committees are authorised to establish Sub-Committees, the Committee will also have the authority to determine the terms of reference of each Sub-committee it establishes, taking account of any conditions (including as to reporting to the Board) as the Board decide, legislation or direction issued by the Secretary of State for Health and Social Care.

4.5 Delegation of powers by Committees to Sub-Committees

Commented [SD4]: Future proofs by not naming the health bodies, whilst adding local authorities

Commented [SD5]: Provides the freedom to divert from the Standing Orders where the Board may wish to the committee to operate differently from the Board e.g. the quorum

Commented [DS(ANHNT6]: Wording taken from NHSE's Standing Orders.

Commented [DS(ANHNT7]: Wording taken from NHSE Standing Orders.

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 Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board 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 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, and more recently the Higgs report, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. Assurances with regards to the ongoing management of risk are within the duties of the relevant sub-committee.

The Higgs report recommends a minimum of three non-executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 **Remuneration and Appointments Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration and Appointments Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

The purpose of the Committee will be to make ~~recommendations to the Board~~decisions on the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments.

The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust.

4.8.3 **Charitable Trustee Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board will establish a Trust and Charitable Trust Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

These currently include:

i) Finance, Performance and ~~People~~ Planning Committee - .
The purpose of the Finance, Performance and ~~People~~ Planning Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial and~~,~~ operational and workforce planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- monitoring workforce planning and establishment reviews~~monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls~~;
- overseeing risk management for the duties of the Committee.
- To monitor and review the Trust's strategic plans for IT/Digital and the Green Plan.

~~The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.~~

ii) Quality and Safety Committee -
The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, health inequalities, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such as education and talent management, or where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy.

Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its

statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors.

iii) Strategy Committee [this committee will cease from 1 September 2022]
The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.

iv) ~~Equality and Inclusion Committee~~People Committee
~~The purpose of the Equality and Inclusion Committee (EIC) is to provide assurance to the Board that appropriate arrangements are in place to improve equity and inclusion for our patients and people. Through this work the Committee will play a key role in ensuring the Trust delivers sustainable improvements.~~
The purpose of the People Committee is to provide assurance to the Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported and oversee the development and delivery of the Trust's inclusion, equality and diversity strategy.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 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, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (amended) the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, NHS England and Improvement (NHSE/I), ~~or~~ Clinical Commissioning Group (CCGs), other health bodies or local authorities;

(iii) by arrangement with the appropriate Trust(s), local authority(ies), health body(ies) or CCG(s), by a joint committee or joint sub-committee of the Trust and one or more other health service bodies or local authority(ies);

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI, NHS Trusts, ~~or~~ CCG, health body or local authority.

5.1.3 Where a function is delegated by these Regulations to another Trust, health body or local authority then that ~~Trust or health service~~ body exercises the function in its own right; the receiving ~~Trust~~ body has responsibility to ensure that the proper

delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.1.4 The Board reserves the ability to, at any time, withdraw a function, duty or power it has delegated and then to exercise the function, duty or power itself or to delegate it.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself or delegated 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 Chair after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification or in private session under the qualifying conditions of Section 1 (2), Public Bodies (Admission to Meetings) Act l960 (see SO 3.17).

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance 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

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

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

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

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

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 and North Hertfordshire 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 Policy statements

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:

- the Standards of Business Conduct and Managing Conflicts of Interest Policy for East and North Hertfordshire NHS Trust staff;

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 2010;
- Human Rights Act 1998;
- Freedom of Information Act 2000

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

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

ii) In addition to Board Members Declarations of Interest also applies to all Directors, both Executive and Non-Executive, Senior Managers (Divisional Directors, Divisional Chairs, agenda for change band 8d and above and the

Trust Secretary), Consultants and other Decision Making Staff – (all budget holders, administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions, who have the power to enter into contracts on behalf of Trust). As set out in the Managing Conflicts of Interest Policy.

7.1.2 **Interests which are relevant and material**

(i) Interests which should be regarded as "relevant and material" are:

- Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
- A position of authority in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services
- Research funding/grants that may be received by an individual or their department;
- Interests in pooled funds that are under separate management; and,
- Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with East and North Hertfordshire NHS Trust, including but not limited to lenders or banks.

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

7.1.3 **Advice on Interests**

If Board members or any member of staff (7.1.1 ii) have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships, including general practitioners, should also be considered.

Knowingly providing false information, or knowingly failing to disclose information, may constitute offences under the Fraud Act 2006, which could result in disciplinary action and/or criminal or civil action being taken. Any suspicions of fraud, bribery or corruption must be reported to the Trust's Local Counter Fraud Specialist (LCFS)/Anti-Crime Specialist (ACS).

7.1.4 **Recording of Interests in Trust Board minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board or Board Committee meeting, if a conflict of interest is established, the Board member concerned or any other attendee should declare their interest and should withdraw from the relevant part of the meeting and play no part in the relevant discussion or decision or only participate with the full knowledge and agreement of the Committee members. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

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

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chair and Members in proceedings on account of pecuniary interest

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

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

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

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

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 **Exclusion in proceedings of the Trust Board**

(i) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair 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 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chair" is –

(a) at a meeting of the Trust, the Chair of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chair of that Committee, the Chair of the Trust;

(ii) in the case of any other member, the Chair 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 East and North Hertfordshire NHS Trust ("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 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation; or

(b) services in connection with a pilot scheme under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation;

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 Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair 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

7.4.1 **Trust Policy and National Guidance**

All Trust staff and members of must comply with the Trust's Values and Standards of Business Conduct and Managing Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.2 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) 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 Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

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) Members of the Trust 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 an 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 liable to instant dismissal.

ii) The Chair 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 report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive 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.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

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

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as

amended by the Health and Social Care Act 2012 and any secondary legislation. 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 the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	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.
NA	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 Chair and Chief Executive in public session in accordance with SO 5.2 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 that 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. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	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 Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the Trust Secretary
	THE BOARD	**Audit** 1 Receipt of 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 from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receipt of 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 DoF on financial performance. 4. Receive reports from the Chie Executive on performance matters by exception.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	ALL COMMITTEES	1. Approving terms of reference for sub-committees reporting to that Committee (excluding delegating decision-making, which is reserved to the Board to approve any executive decision-making delegations to a sub-committee).
SFI 11.1.1	AUDIT COMMITTEE	The Committee will act in accordance with the Audit Committee Handbook, and: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. 4. Review the work and findings of the external auditors and consider the implications and management's responses to their work. 5. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 6 Monitor compliance with Standing Orders and Standing Financial Instructions; 7 Review schedules of losses and compensations and making recommendations to the Board. 8 Review the annual financial statements prior to submission to the Board. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
SFI 20.1.2	REMUNERATION AND APPOINTMENTS COMMITTEE (REMUNERATION	The Committee will ~~make recommendations to the Board on~~ approve the remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	COMMITTEE)	payments. The Committee will also review and approve the Remunerations Framework for subsidiary companies of the Trust. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
	QUALITY AND SAFETY COMMITTEE	The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, health inequalities, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such education and talent management, or where there is a clear and direct link to quality and safety issues.. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy. Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE, PERFORMANCE AND ~~PEOPLE~~ PLANNING COMMITTEE	The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		The Committee's work will include: • maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy; • providing scrutiny of operational performance; • monitoring workforce planning and establishment reviews~~monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls;~~ • overseeing risk management for the duties of the Committee; • To monitor and review the Trust's strategic plans for IT/Digital and the Green Plan. ~~The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.~~ ~~A full list of responsibilities can be viewed in the Terms of reference for the committee~~
	~~EXECUTIVE COMMITTEE~~	~~The Executive Committee is the executive decision making body of the Trust and is a forum for handling complex, major organisational issues. Its purpose is:~~ ~~• to oversee the effective operational management of the Trust, including achievement of the Trust strategy, statutory duties, NHS priorities, local targets and requirements.~~ ~~• to support the delivery of safe and high quality patient centred care~~ ~~• to direct and influence the Trust service strategies and other key service improvement strategies which impact on these, in accordance with the Trust overall vision, values and business strategy.~~ ~~• to manage and monitor clinical quality, finance performance and activity.~~ ~~It will ensure executive decision-making and sign-up to delivery through group and personal accountability.~~ ~~The EC will act in the context of corporate governance and the Trust Board can be assured that relevant issues will be aired, whether or not decisions are taken by the EC and reported to the Board or recommendations are formulated by the EC and made by the Board.~~ ~~A full list of responsibilities can be viewed in the Terms of reference for the committee~~

Commented [SD8]: Deleted. The Executive Committee is not a Committee of the Board under the Standing Orders. SO 5.4.1 – only allows CEO delegations to officers

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	CHARITY TRUSTEE COMMITTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives • To champion the charity and its development, providing leadership both within the Trust and externally • To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, East & North Herts Hospitals (registered charity no 1053338). A full list of responsibilities can be viewed in the Terms of reference for the committee
	STRATEGY COMMITTEE [UNTIL 1 SEPTEMBER 2022]	The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee. A full list of responsibilities can viewed in the Terms of Reference for the Committee.
	~~EQUALITY AND INCLUSION COMMITTEE~~PEOPLE COMMITTEE	The purpose of the People Committee is to provide assurance to the Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported and oversee the development and delivery of the Trust's inclusion, equality and diversity strategy. ~~Equality and Inclusion Committee (EIC) is to provide assurance to the Board that appropriate arrangements are in place to improve equity and inclusion for our patients and people. Through this work the Committee will play a key role in ensuring the Trust delivers sustainable improvements.~~ ~~A full list of responsibilities can viewed in the Terms of Reference for the Committee.~~
	AUDITOR PANEL	In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Auditor Panel will be reinstated when the contract requires review. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		Non-Executive Directors. A full list of responsibilities can be viewed in the Terms of reference for the committee.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
1 & 5	**CHIEF EXECUTIVE & TRUST SECRETARY**	**Review scheme of delegation**
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. 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 assist the Trust Chair 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

REF	DELEGATED TO	DUTIES DELEGATED
		• have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	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 NHSI and the National Audit Office (NAO).
15	DOF	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that DoF discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	If CE considers the Board or Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and the Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSI and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct, Trust Values and coaching culture.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS 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.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.24	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 measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair 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 NHSI – Appointments to bring independent judgement 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	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in 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

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	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	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that 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.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating 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 staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	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 Standing Orders, Financial Instructions and financial procedures.
10.2.7	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 are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	DIRECTOR OF FINANCE	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist/Anti-Crime Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board a delivery plan which takes into account financial targets and forecast limits of available resources. The 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.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.4	BUDGET HOLDERS	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	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.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing 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.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Authorised signatory list is maintained by the finance Department and available on request
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	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.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
21.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.1	BOARD	Will approve the Trust's plans for applications for short-term or longer-term borrowings and loans
22.1.2	BOARD	Approve a list of employees authorised to make applications and sign loan documentation on behalf of the Trust. (This must include the CE and DoF.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising at least one other member for loan and borrowing application and documentation submission..
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on 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.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS/ACS, and NHS Counter Fraud Authority NHS requirements underpinned by the Government Counter Fraud Functional Standards.
26.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	Approve write off of losses (within limits delegated by DH).
26.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
26.2.7	DIRECTOR OF FINANCE	Maintain losses and special payments register.
27.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.1	DIRECTOR OF FINANCE	Satisfy himself 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.
27.1.3	TRUST SECRETARY	Shall ensure that a Freedom of Information Scheme is published and maintained.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
30	TRUST SECRETARY	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document

APPENDIX 2

East and North Hertfordshire NHS Trust

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Authority

1.1 The People Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The People Committee is directly accountable to the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2 Purpose

2.1 The People Committee will provide assurance to the Trust Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported.

2.2 The People Committee will ensure the Trust's strategic ambitions in relation to the workforce are delivered in an affordable manner and any corporate risks identified and managed.

2.3 To provide assurance to the Trust Board on all aspects of workforce, capability and OD supporting the provision of safe, high quality, patient-centred care;

3 Membership

3.1 The members of the People Committee shall be appointed by the Trust Board and comprise:

Members

- Three Non-Executive Directors
- Chief People Officer (named as the lead Executive Director)
- Chief Nurse
- Medical Director
- Director of Estates and Facilities
- Deputy Chief People Officer
- Director of Finance
- Chief Operating Officer
- Assistant Director – Communications and Engagement

Attendees

- Equality, Diversity and inclusion Lead
- Managing Director – Unplanned Care
- Managing Director – Planned Care

- Executive Network sponsors
- Staff Network Chairs
- Trades Unions
- FTSU lead role
- Associate Directors of People Function as required
- Divisional Directors as required

3.2 One Non-Executive Director will be appointed as the Chair of the People Committee by the Trust Board. In the absence of the Committee Chair a deputy will be appointed to Chair.

3.3 Only members of the People Committee have the right to attend Committee meetings. However, other post-holders and external advisors may be invited to attend all or part of any meeting, as and when required.

3.4 Each member of the People Committee shall disclose to the Committee:
- Any conflict of interest
- Any personal financial interest in any matter to be decided by the Committee

Any such member shall refrain from discussions concerning such matter and, if requested by the Committee Chair, will leave the meeting for the duration of the discussion.

4. Quorum

4.1 A quorum shall be three members comprising two Non-Executive Directors and one Executive Director.

5. Attendance

5.1 Members should make every effort to attend all meetings of the People Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year. If a member fails to attend more than three meetings in a financial year, the Chair of the Committee will consider with the Chair of the Trust the appropriate action to be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.2 Other Executive Directors and other Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Committee.

6. Frequency of Meetings

6.1 Meetings will be held at least five times a year

6.2 The Chair of the People Committee may convene additional meetings if required to consider specific business that requires urgent attention.

7. Duties

STRATEGY

7.1 Shape and drive the Trust's People and Organisational Development Strategy and its implementation to ensure appropriate impact;

CULTURE & ORGANISATIONAL DEVELOPMENT

7.2 Shape, approve and drive improvements arising from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and

other sources of intelligence; to continually develop and shape the workforce to deliver service needs

7.3 Oversee the development of an inclusive culture where people feel safe and able to raise concerns and that concerns raised are suitably and consistently addressed;

7.4 Monitor the Trust's activities designed to enable colleagues to feel supported in their work, and consistently experience civil and respectful behaviours;

7.5 Oversee the Trust's approach to enhancing the health and wellbeing of staff and integrating health and well-being consideration into organisational decision-making.

EQUALITY, DIVERSITY & INCLUSION

7.5 Oversee the development and delivery of the Trust's inclusion, equality and diversity strategy for our people, particularly ensuring a representative and supported workforce with inclusive leadership;

7.6 Oversee the development of effective data collection and KPIs to enable effective scrutiny of delivery against the equality, diversity and inclusion priorities;

7.7 Receive a regular report on inclusion, equality and diversity in the Trust and specifically review the inclusion, equality and diversity strategy;

WORKFORCE PLANNING & REPORTING

7.9 Review the development and delivery of the Trust's workforce planning with a focus on:

- Strategic workforce information and planning
- Recruitment and retention
- Education, learning and organisation and leadership development
- Inclusion, equality and diversity
- Staff experience and engagement, reward, recognition, health and wellbeing
- Staff benefits, recognition and rewards

7.10 Receive a report at each meeting from the Executive lead for the People Committee covering issues escalated from relevant executive groups and compliance with statutory and regulatory workforce standards, workforce performance indicators and provide assurance that any necessary corrective plans and actions are in place. Provide assurance that legal and regulatory requirements relating to the workforce are met;

7.11 Advise the Board on remuneration proposals changes for Trust employees (excluding senior staff covered by the Remuneration Committee);

7.12 Consider any proposed significant changes in the terms of employment of Trust employees, including national directives requirements;

7.13 Receive annual workforce planning briefs of proposed and major workforce changes taking place in the following year

STAFF ENGAGEMENT

7.13 Oversee the development of the Trust's staff engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

7.14 Ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements;

AUDIT & RISK

7.15 Receive and review at each meeting those entries on the Board Assurance Framework (BAF) which are to be overseen by the People Committee and ensure they are appropriately reflected on the Committee's work programme to enable the Committee to gain assurance on the effective controls in place and address gaps in controls and assurance.

7.16 Review the proposed Internal Audit Plan and make recommendations to the Audit Committee on the internal Audit work programme as relevant to the remit of the People Committee.

7.17 Review on behalf of the Audit Committee the findings of Internal and External Audit reports covering matters within the remit of the People Committee, seeking assurance that appropriate actions are identified and implements in response to recommendations and that learning is shared across the organisation.

7.18 Receive and review reports of significant concern or adverse findings highlighted by Regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the People Committee. Seek assurance that appropriate action is being taken to address these.

7.19 Review any People issues referred to the committee by the Trust Board.

COMMITTEE EFFECTIVENESS

7.20 Develop an annual work programme agreed by the People Committee to discharge duties as set out above.

7.21 Undertake an annual review of the effectiveness of the Committee to inform the Committee's annual report to the Trust Board and the following year's work programme.

8. Reporting Arrangements

8.1 The People Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board and Executive Team to take appropriate action.

8.2 The People Committee will work closely with other Trust Board sub-committees as required.

9. Committee Review

9.1 The People Committee will monitor and review its performance and compliance through the following:

- The Committee's report to Trust board
- An annual evaluation of the People committee
- An annual review of the People Committee Terms of Reference

10. Support

10.1 Administrative support will be provided by the Trust Secretariat alongside advice to the People Committee on pertinent areas.

APPENDIX 3

Finance, Performance and Planning Committee Terms of Reference

FINANCE, PERFORMANCE AND PLANNING COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance, Performance and Planning Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and other short term~~workforce~~ planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- ~~workforce planning and establishment reviews~~
- providing scrutiny of the implementation of the business plans to deliver the Trust's long-term strategy;
- overseeing risk management for the duties of the Committee.

The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.

2. Status & Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

- Chief Executive
- Director of Finance
- Chief Operating Officer
- Chief People Officer

- Director of Nursing
- Medical Director
- Chief Information Officer

Attendees:

- ~~Chief Information Officer~~
- Director of Improvement and Transformation
- Deputy Director of Finance Financial Management
- Deputy Director of Finance Financial Planning
- Deputy Director of Workforce and OD

All other Non-Executive Directors/Directors are welcome to attend.

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either:

- Director of Finance or in their absence
- Chief Executive and a designated Finance representative

5. Frequency of meetings

The Committee will meet every month (with the exception of August) and prior to Trust Board meetings. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities:

To approve:

- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To approve and recommend to the Board:

- ~~The Trust's Marketing strategy and review and monitor progress against this;~~
- The Trust's Business Plan, including the approved financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy including the Long Term Financial Model;
- Proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities;
- Adoption of the annual plan and budgets for revenue and capital;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- The Cost Improvement Programme. Any potential concerns on quality are to be referred to the Quality and Safety Committee (QSC).

To monitor and review:

- Financial impacts relating to enabling strategies (specifically the digital, estates and capital strategies);
- The capital programme and work of the Capital Review Group;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in-year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- Financial implications relating to the system collaboration framework;
- The development of financial forecasts and measures taken to promote financial sustainability.

~~**6.2 Investments**~~

~~To recommend to the Board:~~

- ~~A Treasury Management Policy including delegated arrangements and recommend its adoption by the Board.~~

~~To monitor and review:~~

- ~~Reports as appropriate from the Director of Finance on transactions undertaken on behalf of the Trust.~~

6.3 Financial Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHS Performance Management Framework (NHS Trust). This review should include:

~~To determine or approve:~~

- ~~In conjunction with the Audit Committee agree the timetable for the Annual Accounts and receive the External Auditors report and review and monitor the associated action plan.~~

~~To recommend to the Board:~~

- ~~The application of contingency funding where appropriate;~~

To monitor and review:

- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects;
- To monitor the benefits realisation of major projects.

6.4 Operational Performance

To monitor and review the Trust's operational performance, including consideration of issues such as winter preparedness and bed planning, significant operational service developments and compliance with national performance standards.

The Committee will receive regular updates regarding the national performance standards, currently:

- A&E,
- Cancer waiting times,
- Referral to treatment,
- Diagnostics,
- Stroke.

To work closely with the QSC to understand any quality and safety implications associated with operational performance.

To be kept appraised of operational performance matters relating to system collaboration.

To receive an agreed programme of deep dives relating to significant operational issues.

6.5 Workforce

To monitor and review risk areas that relate to Trust's workforce metrics impacting on our operational performance and financial planning including but not limited to: temporary staffing, recruitment and~~,~~ establishments.~~.~~:

~~o workforce planning and deployment,~~

~~o workforce transformation/organisation design,~~

~~o establishment reviews~~

6.6 Planning

To act as the lead assurance committee for the implementation of short-term business plans to deliver the Trust's long-term strategy.

To gain assurance on the design and delivery of transformation in support of the Trust's strategy.

To monitor and review at a strategic level:

- annual business plans to deliver the Trust's strategy, providing assurance and exception reporting to the Board on strategy delivery progress;
- delivery of the major strategic programmes within the business plans;
- oversee development of the integrated performance report measures for delivery of the strategy.
- financial planning to deliver the Trust's strategy and where relevant develop proposals for discussion/agreement by Trust Board;
- the Trust's strategic plans for IT/Digital and the Green Plan.

6.7 Other duties

To monitor and review:

- Procurement activities, progress against savings targets, tender waivers and key strategic tenders.
- Major change projects which may impact on the core areas of the Committee's work.
- Review elements of the Trust's workforce metrics impacting on our operational performance including but not limited to: temporary staffing, recruitment, establishments.

6.8 Risk Reporting

The Committee will regularly receive risk register reports for the areas relevant to its duties for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Executive Committee and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- FPPC annual evaluation and review of its terms of reference.

9. Support

The Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

APPENDIX 4

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, health inequalities, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and workforce issues relating to the 'Grow Together' pillar of the People Strategy, or where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy and Quality Strategy.

Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.

2. Status and Authority

The Committee is constituted as a formal committee of the Trust Board.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee challenges and provides assurance on all areas of risk to the Audit Committee and the Trust Board. Please note: the Audit Committee provides an independent and objective review of the appropriateness and fitness for purpose of the Trust's systems of internal control to the Trust Board.

3. Membership

Three Non-Executive Directors, one of whom will chair the committee.

Core Attendees

Chief Executive
Chief Nurse
Medical Director
Chief Operating Officer
Chief People Officer
Associate Director of Governance

Other attendees:
Chief Pharmacist
Patient Safety Leads
Trust Secretary
Head of Midwifery
Director of Estates and Facilities
Director of Improvement

In addition to the above list of attendees the committee will co-opt attendance as required from the Chief Information Officer, Divisions, Infection Control, Health and Safety, Patient Safety, Clinical Governance, Information Team etc.

If a conflict of interests is established, the above member/ attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

The Committee will be quorate if two non-executive members are present, and two core attendees; one of which must be the Medical Director or Director of Nursing or their nominated representative.

5. Frequency of Meetings

The Committee will normally meet monthly with the exception of August (unless a meeting is required). The format of the meetings will be agreed with the Committee Chair and some meetings may include a focus on deep dive presentations if deemed appropriate and effective. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

All attendees are expected to attend each meeting or to send a nominated deputy when they are unable to do so.

6. Duties

Managing Quality and Safety Risks

- To provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- To endorse and monitor the Trust's key governance strategies relating to quality and safety, such as the Quality Strategy.
- To review and monitor the Board Assurance Framework and the Corporate Risk Register risks assigned to the Committee, ensuring appropriate action is taken to mitigate risks where possible and advise the Board where acceptance of risk may need to be considered
- To monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS resolution, Health & Safety Executive (HSE), NHS Improvement (NHSI) and ensure action is taken for compliance.
- To improve and develop the effectiveness of the assurance systems across the Trust by monitoring activity across the Trust through regular reports specified by the Committee in the Committee's Annual Cycle, and by exception
- To receive reports and monitor the progress in mitigating quality and safety risks arising from the Trust's major service developments
-

- To review the quality risk assessment of the CIP programme
- To work with the Audit Committee when appropriate, and specifically in agreeing the Annual Internal Audit plan and providing a review of effectiveness on the clinical audit.

Ensuring Compliance

- To monitor and advise the Board on progress against national and local quality and safety governance standards and compliance framework.
- To receive and review regular progress reports for achieving compliance against all aspects of the Quality of Services through the monitoring of the Fundamental Standards and CQC regulations.
- To monitor and advise the Board on compliance with the Hygiene Code and CQC Registration and Regulation
- To receive reports on the changes to Healthcare Regulation and assurance as to how the Trust will manage this process
- To review and approve the annual reports as stated in the annual cycle, with the exception of Health and Safety and Safeguarding which will be scrutinised prior to final approval by Trust Board
- To approve the annual declaration of the Data Security and Protection toolkit
- Working with the Audit Committee to approve the Quality Account

Improving Quality

- To endorse and monitor the implementation of the Trust's key quality strategies.
- To receive regular reports from the Trust and Divisions on Patient Safety and Clinical Quality and Outcomes ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Patient Experience Indicators ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Nurse/Patient Indicators and safer staffing ensuring appropriate action is taken.
- To review the biannual nursing establishment review prior to consideration and decision by the Trust Board.
- To support the implementation of quality improvement programmes.
- To be advised of the progress of any major quality initiatives in the Trust.
- Deliver better health outcomes for our whole community, and actions to reduce health inequalities.
- Improve access and experience for our patients.
- Improve data collection, use and reporting in relation to equalities and inclusion.
- Devise and monitor appropriate KPIs for equalities and inclusion to enable effective scrutiny of delivery against the equalities and inclusion priorities.
- To receive regular reports on the 'Grow Together' pillar of the People Strategy, including regarding learning and education, statutory and mandatory training, talent management, clinical staffing establishment requirements and the report of the Guardian of Safe Working Hours.
- To consider reports regarding any other workforce issues where there is a clear and direct link to quality and safety issues, such as regarding the work of the Freedom to Speak Up Guardian.
- To monitor the quality and safety performance metrics.
- To monitor the delivery of the annual plan and receive the annual report from the Joint Management Group in relation to the Trust's partnership with the University of Hertfordshire.

7. Reporting arrangements

The Committee will provide a report of each meeting to the Trust Board. It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

The Committee will provide reports to the Audit Committee as requested.

The core attendees and attendees will provide reports to the committee in relation to all areas of their portfolio and in line with the Annual Cycle and Action Log.

8. Process for review of the Committee's work including compliance with terms of reference

The committee will monitor and review its compliance through the following:

- The Committee report to Trust Board
- QSC annual evaluation and review of its terms of reference

9. Support

The Trust Secretariat will ensure the committee is supported administratively and advising the Committee on pertinent areas.

APPENDIX 5

East and North Hertfordshire NHS Trust

REMUNERATION AND APPOINTMENTS COMMITTEE (EXECUTIVE)

TERMS OF REFERENCE

1. Purpose

To approve, on behalf of the Board, the appropriate~~make recommendations to the Board on the~~ remuneration and terms of service for the Chief Executive and other Executive Directors and those staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions; to monitor and evaluate the performance of Executive Directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments.

2. Status and Authority

The Committee is constituted as a standing committee of the Trust Board and derives its powers from the Board of Directors (the Board) and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised:

a) To seek any information it requires from any employee of the trust in order to perform its duties;
b) To obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference; and
c) To call any employee to be questioned at a meeting of the Committee as and when required.

The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors and senior staff whilst remaining cost effective.

3. Membership

The Committee shall be made up of the Chair of the Trust and all non executive directors.

Only members of the Committee have the right to attend Committee meetings.

Other individuals such as the Chief Executive, Chief People Officer, Trust Secretary, the Chair or Managing Director of the subsidiary and external advisers may be invited to attend for all or part of any meeting, as appropriate.

The Board of Directors (the Trust Board) shall appoint the Committee chair. The Committee chair shall be an independent Non-Executive Director who ideally is a member with relevant experience of remuneration matters.

In the absence of the Committee chair and / or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting who would qualify under these Terms of Reference to be appointed to that position by the Board.

4. Quorum

The quorum necessary for the transaction of business shall be 3 independent non executive directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

The Committee shall meet at least twice a year and otherwise as required. Ordinarily the Committee will plan to meet four times throughout the year, however if remuneration decisions are required for new appointments or there are other urgent matters for the Committee to consider then additional meetings may be held.

In exceptional circumstances when an urgent decision is required and it is not possible to schedule an additional meeting of the Committee, with the agreement of the Chair, decisions may be made by virtual correspondence.

Notice of meetings
Meetings of the Committee shall be summoned by the secretary of the Committee at the request of the Committee Chair or any of its members. Meetings for the year should be scheduled at the start of the financial year.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers will be sent to Committee members and ~~to~~ to other attendees, as appropriate, at the same time.

Minutes of meetings
The secretary shall minute the proceeding and resolutions of all Committee meetings, including the names of those present and in attendance.

6. Duties

The Committee shall:

a) Determine and agree the framework or broad policy for remuneration and terms of service of the Trust's Executive Directors and other staff that are not covered by Agenda for Change or Medical and Dental Terms and Conditions;
b) In determining such policy, take into account all factors which it deems necessary. The objective of such policy shall be to ensure that Executive Directors of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the long term success of the trust;
c) Design remuneration policies and practices to support strategy and promote long term sustainable success, with executive remuneration aligned to the Trust's purpose and values, clearly linked to the successful delivery of the Trust's strategy;
d) Review the ongoing appropriateness and relevance of the remuneration policy, taking into account its relationship and relativity with remuneration policies and terms and conditions in place for other staff groups;

e) Ensure that any contractual terms on termination (termination of Executive Directors is reserved to the Board), and any payments made, are fair to the individual and the Trust, aligned with the interest of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised;
f) Within the terms of the agreed policy and instructions issued by NHS England/Improvement (NHSE/I), and in consultation with the chair and/or chief executive, as appropriate, determine the total individual remuneration package of each Executive Director including but not limited to bonuses, incentives and other payments such as relocation expenses;
g) Oversee succession planning within the Trust and review the succession planning and talent map annually;
h) Receive assurance regarding the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the Committee, and to obtain reliable, up-to-date information about remuneration in other Trusts.
i) Receive assurance regarding the process for the appointment / removal of the Chief Executive and Executive Directors.
j) Authorise the use of an Appointment Panel, as required, for Executive appointments.

Regarding the a subsidiary:

k) Agree the framework or broad policy for remuneration for Directors of the subsidiary
l) Approve Director appointments to the subsidiary Board;
m) Within the terms of the agreed policy, determine the total individual remuneration package of each subsidiary Director including but not limited to bonuses, incentive payments and other awards such as pension.

.

Other matters

The Committee shall:

a) Have access to sufficient resources in order to carry out its duties, including access to the trust secretariat for advice and assistance as required;
b) Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
c) Give due consideration to all relevant laws and regulations, NHSE/I guidance and the provisions of the Code of Governance;
d) Ensure that no director or senior manager shall be involved in any decisions as to their own remuneration outcome,
e) Work and liaise as necessary with other board committees, ensuring the interaction between committees and with the board is reviewed regularly.

7. Reporting arrangements

The Committee chair shall report formally to the Board, following each Committee meeting held and on a quarterly at least bi-annuallybasis, on its proceedings on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

An annual statement of the Trust's remuneration policy and practices which will form part of the Trust's Annual Report and register of attendance.

8. Process for review of Committee's work including compliance with terms of reference

The committee shall:

a) Ensure that a periodic evaluation of the committee's own performance is carried out.

b) At least annually, review its terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

9. Support

The Trust Secretary or their nominee shall act as secretary of the Committee.

Reviewed ~~January~~ May 202~~1~~2

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	20
Report title	Ockenden Report-Final			**Meeting Date**	4 May 2022
Presenter	Chief Nurse Director of Midwifery Clinical Director				
Author	Director of Midwifery Clinical Director				
Responsible Director	Chief Nurse			**Approval Date**	17 April 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

In December 2020 Donna Ockenden's independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust was published, referred to as the Interim Ockenden Report. The review identified seven Immediate and Essential Actions (IEAs) to be addressed by all maternity units using the Assurance Assessment Tool. Using the published national Assurance Assessment Tool, a review of the recommendations, and a further review of the Morecambe Bay investigation by Bill Kirkup in 2015, the Trust confirmed compliance with 112 of the 122 individual requirements (92%).

An improvement plan was developed to address the gaps in compliance, and this has been monitored through the maternity services divisional governance structures, the Quality and Safety Committee and the Local Maternity and Neonatal Services (LMNS) governance structures. One year on, maternity services were asked to discuss progress against all recommendations, and this was presented at the public Board meeting on the 22 March 2022. The workforce plan to respond to the national requirements was presented to the March 2022 Quality and Safety Committee.

The final report of the Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust, referred to as the Ockenden Report-Final, was published on the 30 March 2022. Following the publication, a letter was sent to all trusts, ICS Leads, LMNS and the CCG outlining the Board's duty to prevent the failings found at Shrewsbury and Telford Hospital NHS Trust happening at your organisation and within your local system. Trusts are asked to take the Ockenden Report-Final to the next public Board meeting and share with all relevant staff – with a strong recommendation that everyone reads it, regardless of their role.

Following review of the Ockenden Report-Final, trusts are asked to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:
1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

This report briefly outlines the findings of the Ockenden Report-Final and next steps for noting.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability

CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources
Implementing the Local Actions for Learning and the Immediate and Essential Actions is both a National and Trust priority; compliance will be reported to the LMS, ICS and NHS England.
Risk: *Please specify any links to the BAF or Risk Register*
This paper relates to two risks on the Board Assurance Framework: 002/21 and 008021 and the following risks: Risk ID 7050 - The risk to women, their babies and staff in relation to staffing levels that fall below establishment Risk ID 7161– The risk to women and babies when using midwives to staff and manage maternity theatres Risk ID 7313- The risk to the service and safety of women and their babies if unable to comply with 7 day service requirements Risk ID 2627 - Risk of inadequate nurse staffing levels in Neonatal Services Risk ID 7154 - The risk to the safety of women and their babies when unable to transfer for ongoing IOL in an appropriate time frame Risk ID 7140 - The risk to the safety of women accessing Maternity Triage Risk ID 6605 - The risk to the safety and quality of care for women and the wellbeing of staff during the Covid-19 pandemic Risk ID 6077 - Risk that the safety of women and babies will be compromised as staff may not be released for mandatory training
Report previously considered by & date(s):
Quality and Safety Committee – 26 April 2022

Recommendation	The Quality and Safety Committee is asked to note the content and next steps

Proud to deliver high-quality, compassionate care to our community

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Ockenden Report-Final

The Ockenden Report-Final follows on from the Interim Ockenden Report which was published in December 2020. The Interim Ockenden Report outlined the Local Actions for Learning, and seven Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England.

The Ockenden Report-Final builds upon the interim report and IEAs within that interim report remain important and must be progressed. For this final report, a number of new themes were identified and must be shared across all maternity services in England as a matter of urgency to bring about positive and essential change in a timely manner. Additionally, there are 68 Local Actions for Learning that must be implemented by Shrewsbury and Telford Hospital NHS Trust. The ENHT Maternity services are committed to mapping the service against these Local Actions for Learning, in addition to the 15 IEAs in the Ockenden Report-Final.

The 15 IEAs are under the following themes:

1. Workforce planning and sustainability
2. Safe Staffing
3. Escalation and Accountability
4. Clinical Governance-Leadership
5. Clinical Governance-Incident Investigations and Complaints
6. Clinical Governance-Learning from Maternal Deaths
7. Multidisciplinary Training
8. Complex Antenatal Care
9. Preterm Birth
10. Labour and Birth
11. Obstetric Anaesthesia
12. Postnatal Care
13. Bereavement Care
14. Neonatal Care
15. Supporting Families

The recommendations include the importance of creating a culture where all staff feel safe and supported to speak up, with the expectation that every trust board has robust Freedom to Speak Up training for all managers and leaders, as well as a regular series of listening events. A dedicated maternity listening event should take place in the coming months.

The Ockenden Report-Final highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

In addition there is specific action on Midwifery Continuity of Carer, supported by IEA2 Safe Staffing;
'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.'

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. They must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make a decision for their maternity service on continuation on MCoC.

Since the publication of the interim report, significant funding has been provided by the NHS, although there is recognition that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs in the interim report.

The commitment to system-wide improvement in maternity services has seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Conclusion and next steps

- A progress report against the seven IEAs in the Interim Ockenden report was presented at ENHT's public Board meeting in March 2022
- The Trust's position was reported and discussed at our LMS and ICS and reported to regional teams on the 11th April 2022. A detailed breakdown of these returns and compliance by trust with the Interim Ockenden IEAs, will be published at the NHSE/I public Board in May 2022.
- The gap against the 15 IEAs and the 68 Local Actions for Learning (from the Ockenden Report-Final) will be presented to divisional Board in May 2022, Quality and Safety Committee in June 2022, and the Trust Board in July 2022 and subsequently the LMNS program board and the ICS.
- We are required to continue to provide reliable data to the regular provider workforce return, with executive level oversight.
- Further recommendations for maternity and neonatal services are expected to be published later this year given other reviews underway.

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

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

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director

East and North Hertfordshire NHS Trust

Meeting	**TRUST BOARD - PUBLIC SESSION**		**Agenda Item**	21
Report title	**Learning from Deaths Report**		**Meeting Date**	4 May 2022
Presenter	Medical Director			
Author	Mortality Improvement Lead			
Responsible Director	Medical Director		**Approval Date**	09 March 2022
Purpose *(tick one box only)*	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

1. **Trust Strategic Objectives:**
   a. **Quality:** To deliver high quality, compassionate services, consistently across all our sites,
   b. **Pathways:** To develop pathways across care boundaries, where this delivers best patient care
2. **Compliance with Learning from Deaths NQB Guidance**
3. **Potential impact in all five CQC domains**

Risk: *Please specify any links to the BAF or Risk Register*

Please refer to page 5 of the report

Report previously considered by & date(s):

Quality and Safety Committee – 29 March 2022
Mortality Surveillance Committee – 09 March 2022

Recommendation	The Committee is invited to note the contents of this Report.

Proud to deliver high-quality, compassionate care to our community

The below summary report together with Appendix 1, formed Part 1 of a detailed Learning from Deaths report considered by the Quality & Safety Committee in March 2022. That report provided additional information regarding key metrics, developments and current risks. This summary is provided to the Public Board meeting in line with NQB Learning from Deaths national reporting requirements.

1. Key mortality metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Table 1: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 1.25% for the 12-month period to January 2022 compared to 1.28% for the latest 3 years.
HSMR: (data period Dec20 – Nov21)	HSMR for the 12-month period is **97.17, 'Mid-range'.** CHKS rebased HSMR on 28 Jan 2022 and so please note HSMR figures in this report are not comparable to previous reports.
SHMI: (data period Oct20 – Sep21)	Headline SHMI for the 12-month period is **86.93 'lower than expected' band 3.**
HSMR – Peer comparison	ENHT ranked 4th (of 8) within the Model Hospital list* of peers.

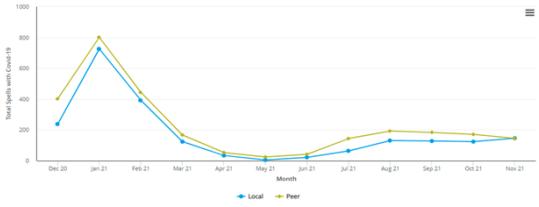
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2021), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2. COVID-19

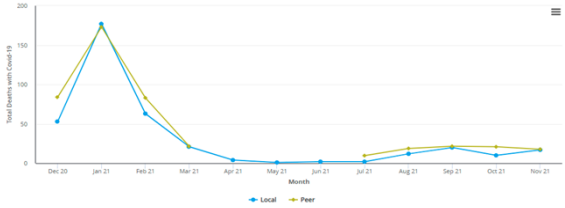
The following charts provided by CHKS show the Trust's alignment with national peers for both spells and deaths reported with COVID-19.

Fig 1: Covid-19 Peer Comparison: Oct-20 to Nov-21

Spells with COVID-19 (Peer: National)



Deaths with COVID-19 (Peer: National)



3. Mortality alerts

3.1 CUSUM alerts

The latest release from CHKS showed one HSMR CUSUM red alert for the rolling year to November 2021 and no SHMI outliers. An initial review has been requested to check the accuracy of coding prior to considering what further review/monitoring is appropriate.

Table 2: HSMR CUSUM Alerts December 2020 to November 2021

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
101 - Coronary atherosclerosis and other heart disease	311.69	7	2	5

Source: CHKS (CUSUM alerts coloured)

3.2 External alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

The National Hip Fracture Database is currently only showing 30-day mortality to December 2020. The lack of more up-to-date data has been attributed to a delay in their contract renewal with NHS Digital. In December 2020 30-day mortality stood at 12.0%, significantly above the national average. More recent local crude mortality provides some indication that 30-day mortality has reduced. As remedial work continues, delays to theatre access remain a key barrier to improvement.

4. Focus areas for improvement

Table 3: Focus Areas for Improvement

Diagnosis group	Summary update
Acute Myocardial Infarct	Six-month joint Cardiology-Coding initiative to review all MI deaths continues.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets including compliance with the Sepsis 6 care bundle.
Stroke	SSNAP rating has fallen to D. Stroke HSMR and SHMI remain above the national peer average, but not to a statistically significant extent. HSMR has improved for 6 consecutive months. The most recently reported SSNAP risk adjusted mortality, considered a better mortality indicator, has improved. We are no longer close to being an outlier. Work is required to improve the Stroke service's performance against SSNAP KPIs.
Emergency Laparotomy	The recent Seventh NELA report saw the Trust's risk adjusted mortality remaining stable at 10.5, following the previous year's significant improvement. Focussed improvement work remains on-going.

5. Learning from deaths data

5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q3 2021-22.

Table 4: Q3 2021-22: Learning from deaths data

	Oct-21	Nov-21	Dec-21
Total in-patient deaths	114	101	126
Mortality reviews completed	76	106	45
Total new ACONs raised	10	5	7
Concluded ACONs (2021-22 deaths): probably ≥50% due to problem in care	0	0	0
Learning disability deaths	2	2	0
Mental illness deaths	0	1	2
Stillbirths	2	0	1
Child deaths (including neonats/CED)*	2	0	0
Maternity deaths	1	0	0
SIs declared regarding deceased patient	2	17	8
SIs approved regarding deceased patient	0	0	0
Complaints regarding deceased patient	1	1	2
Requests for a Report to the Coroner	5	6	11
Regulation 28 (Prevention of Future Deaths)	0	0	0

**Provisional data under review*

5.2 Learning from deaths dashboard and outcomes summary

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1.

It should be noted that for cases where Areas of Concern (ACONs) are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2021-22 deaths which can appear to skew the data. Therefore, for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded. The table below provides a year-to-date summary.

Table 5: 2021-22 concluded ACONs ratings

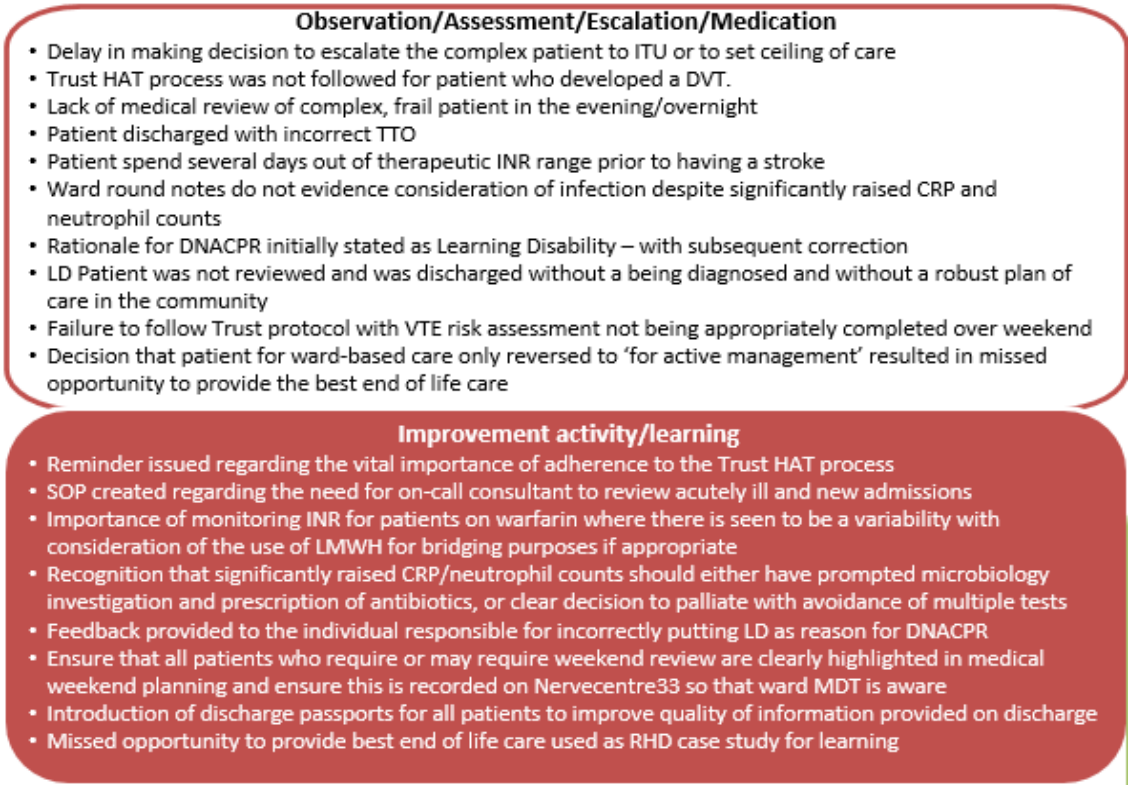
Apr-Dec 2021-22: Concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**-**
2	**Strong evidence of avoidability**	**-**
3	**Probably avoidable, more than 50-50**	**-**
4	Possibly avoidable, but not very likely, less than 50-50	4
5	Slight evidence of avoidablity	10
6	Definitely not avoidable	19

Quality of Care Rating	Definition	SI/RCA detail
A	Excellent	1
B	Good	4
C	Adequate	6
D	**Poor**	**16**
E	Very poor	6

Note: the above data relates to ACONs concluded during 2021-22, irrespective of when the death occurred.

6. Learning and themes from concluded mortality reviews highlighted for concerns and learning opportunities (ACONs)

Figure 2: October to December 2021 ACON Themes



Communication/training

- Complex patient with non-gastro primary problem transferred to Gastro, when arguably should have gone to Cardiology
- Lack of ownership and effective shared care of complex patient between Gastro and Cardiology
- Decision for invasive ventilation later overruled by on-call team without discussion with senior consultant
- Patient was inappropriately taken off oxygen in order to give a nebuliser
- Handover day shift/night shift – opportunity missed for early family discussion/TEP which delayed the decision regarding active treatment
- Frequent change of juniors/lack of continuity of care has a negative impact on quality of care
- Consultants cross covering wards due to AL can lead to over-stretch and negative impact on communication and documentation

Improvement activity/learning

- Gastro registrar must discuss complex patients with non-gastro problem with the on-call consultant before accepting them onto the ward. Discussion held with Gastro registrars
- Medical Director Office to lead an improvement initiative regarding shared care across the Trust
- Any 'overrule made by on-call team in absence of new clinical circumstance should be with agreement with day team. Recommendation for development of appropriate Trust guidance
- Clinical practice teams requested to ensure that all staff outside acute medicine and respiratory (where it is well known) are aware that oxygen should not be removed in order to administer a nebuliser

Process/Policies/Management

- Multiple ward moves for extremely sick, complex patient
- Patient chose to self-discharge and sadly died the following day

Improvement activity/learning

- Recognition of the need for appropriate support structures for those patients who make difficult decisions and choose to self-discharge, in particular regarding follow up and arranging for palliative care at home

Documentation

- Failure to record important information in the medical records including detail of abnormalities of ABG result; no entry of CCOT review; no documentation of the handover of care to the evening team
- Unclear treatment plan in post take ward round compounded by poor hand-written notes
- Slight discrepancy of documentation of neuro-observations for an LD patient
- Concerns raised by the Medical Examiner regarding prior discharge/readmission. It was found that there was poor communication and documentation regarding discussions with family regarding end of life care and advanced care planning. Some discussions were not communicated
- Patient developed DVT as an in-patient. LMWH was withheld due to low platelets. However, this was not documented on the notes

Improvement activity/learning

- Reminder of importance of full and timely documentation at Specialty meeting
- Ongoing training to improve documentation of neuro-observations, and doctors' neurological examination documentation
- Recognition that there is currently no benchmark regarding how quickly GPs should pick up/initiate GSF for discharged patients approaching end of life – an agreed standard would be helpful, in the absence of this importance of follow up with GP to ensure the GSF is being initiated in order to prevent further inappropriate admissions
- Vital importance of documenting the rationale for clinical decisions – such as withholding of LMWH in a patient with DVT

7. Current risks

Table 6 below summarises key risks identified:

Table 6: Current risks

Risks	Red/amber rating
COVID-19	
Fractured Neck of Femur mortality	
Medical Examiner Integration & Community expansion	
Mortality review reform: Process, review format & IT platform	

8. Options/recommendations

The Committee is invited to note the contents of this report.

Appendix 1: ENHT Learning from deaths dashboard December 2021

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: December 2021

Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
131	112	46	105	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
358	354	225	178	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1035	1634	560	774	0	2

Time Series: Start date 2017-18 Q1 — End date 2021-22 Q3

Total Deaths Reviewed by RCP Methodology Score

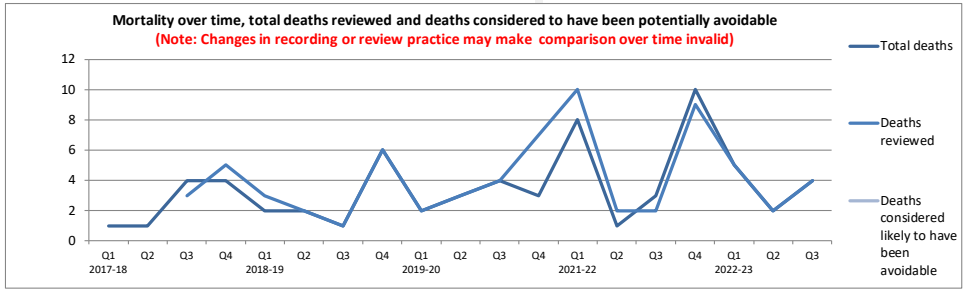
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	2.1%	This Month	0	0.0%	This Month	46	97.9%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.4%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	229	99.6%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	4	0.7%	This Year (YTD)	4	0.7%	This Year (YTD)	557	98.6%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	2	4	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	22	11	23	0	0

Time Series: Start date 2017-18 Q1 — End date 2021-22 Q3



East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public Session		Agenda Item	22.1
Report title	Finance Performance and People Committee		Meeting Date	4 May 2022
Presenter	Finance Performance and People Committee Chair			
Author	Corporate Governance Officer			
Responsible Director	FPPC Chair		Approval Date	
Purpose *(tick one box only)* [See note 8]	To Note	☒	Approval	☐
	Discussion	☐	Decision	☐

Report Summary:
To present the report from the FPPC meeting on 30 March 2022.
Impact: where significant implication(s) need highlighting *Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal* *Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*
Risk: *Please specify any links to the BAF or Risk Register*
The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Report previously considered by & date(s):
N/A

Recommendation	The Board/Committee is asked to note.

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
30 MARCH 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 MAY 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair) and Biraj Parmar.

The following core attendees were present:
Thomas Pounds, Martin Armstrong and Julie Smith.

Finance Report Month 11
The Committee considered the key points in relation to financial performance for month 11.

The Trust continues to report a small year to date surplus of £800k with a £200k surplus in the month. The Trust will continue to meet financial targets to the end of the financial year.

The Committee were advised the elective recovery fund performed well, receiving £12m in revenue throughout the year with the majority earned in the first quarter.

The FPPC were assured the Trust would achieve its statutory duties in month 12, finishing the year with a break even position.

The Committee noted that GP referrals had been low and the risks relating to the pattern of referrals would be discussed at the Committee meeting in April.

Month 11 Capital Update
The FPPC received an update on the Trust's capital position at the end of month 11 and the required actions for month 12. £10m had been spent on capital with ongoing work to the end of March to ensure the capital is spent.

The Committee were advised of increased volume and value of vesting certificates. The Trust has 22 vesting certificates, which equates to 22 items of capital expenditure purchased but will not take delivery until the next financial year. This has a value of approximately £2m. This remains a focus for the finance team.

An agreed capital plan will be provided to the Committee in April.

2022/23 Financial Plan
The FPPC were presented with the draft 2022/23 financial plan for consideration and approval. This sets out assumptions used and outputs from the financial planning budget setting process for one overall plan.

The Committee were advised of the requirement to submit a balanced financial plan and acknowledged the risk that the Trust may be asked to achieve higher CIPs.

The Committee were advised that the final submission will be due on 20 April 2022.

Operating Plan and Workforce Plan

The FPPC considered three areas of focus are impact of elective recovery, local cost pressures and transition into Covid legacy costs, with the risk to the organisation being the unidentified elements of the CIP programme.

The Managing Directors for Planned and Unplanned Care will be involved in the CIP planning within the divisions.

The Committee were advised that Covid costs represent a risk to the organisation. Opportunities for elective recovery, investment and a reduced CIP challenge are areas of focus.

The Committee acknowledged inflation being of concern and that this will be monitored.

The Committee discussed the reintroduction of car parking charges and this will be discussed further by the executive team.

The FPPC were advised the preferred option for the vascular network would be a hybrid theatre on stilts. This would involve a cost pressure of £600k. It was confirmed that the FPPC would not be required to approve this plan and that it could be approved at a local level. The Committee supported this plan.

The Committee were advised that additional waiting list capacity will be provided with additional sessions for clinicians and making use of the independent sector. It is anticipated this will reduce the waiting lists.

Workforce Report Month 11

The FPPC received a workforce update highlighting key points in relation to the Trust's performance against Workforce targets.

The vacancy rate reduced from 7.6% to 6.7% with nursing vacancies reducing by just over 3%. Planning is underway for a care support development worker programme through NHS Professionals, supported by substantive staff.

The Committee noted a reduction in sickness absence levels in February, however this is expected to increase in March due to Covid related reasons. Muscular skeletal and mental health absence continues to improve, partly due to wellbeing initiatives.

Grow Together has been an area of focus with a team in place to redevelop the programme to support on-boarding in the early stages of a new role up to twelve months.

The Committee were advised the staff survey results have been launched and key highlights will be presented at the Trust Board meeting on 4 May.

Performance Report Month 11

The FPPC received an update of the key aspects relating to performance for month 11. ED four hour performance was 67.1% against the national position of 71.40%. This was impacted by Opel 4 days in the month where there were also some 12 hour trolley breaches. There were an average of 501 attendances per day in ED for the month of February.

A pilot scheme to release ambulances within 15 minutes to support category 2 patients has resulted in improvements.

Elective recovery remains a focus, resulting in a slight improvement with increased activities in outpatients, outpatient procedures and day cases. There were only 60 fewer patients in theatres compared to pre-pandemic levels and it is anticipated this will improve further.

The majority of long waiting patients were in trauma and orthopaedics and increased activity in April will address this.

Stroke performance has improved to a SNAAP C rating.

Board Assurance Framework

The Committee received the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee. Discussion was held during the meeting against all areas over which the Committee had oversight.

The Committee deliberated the option of reducing the operational risk from 20 to 16, recognising improvements that have been made. Following this discussion, the Committee agreed to the risk remaining at 20.

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Karen McConnell
Finance, Performance and People Committee Chair
April 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public Session		Agenda Item	22.1
Report title	Finance Performance and People Committee		Meeting Date	4 May 2022
Presenter	Finance Performance and People Committee Chair			
Author	Corporate Governance Officer			
Responsible Director	FPPC Chair		Approval Date	28 April 2022
Purpose *(tick one box only)* [See note 8]	To Note	☒	Approval	☐
	Discussion	☐	Decision	☐

Report Summary:
To present the report from the FPPC meeting on 27 April 2022.
Impact: where significant implication(s) need highlighting *Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal* *Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*
Risk: *Please specify any links to the BAF or Risk Register*
The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Report previously considered by & date(s):
N/A

Recommendation	The Board/Committee is asked to note.

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
27 APRIL 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 MAY 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair) and Biraj Parmar.

The following core attendees were present:
Martin Armstrong, Lucy Davies, Thomas Pounds and Michael Chilvers

DMO1 Deep Dive
The Committee received and noted the information in the DMO1 deep dive presentation.

The Committee received an update on DMO1 the diagnostic performance core standard where no more than 1% of patients should wait more than six weeks for a diagnostic test and the Trust performance against it. They were informed of the current performance against the standard and discussed next steps.

There had been an overall increase in the PTL with demand across all modalities increasing by 3,671 events compared to February. Some improvements in performance were noted for areas including neurophysiology which was now compliant. Much of the increased demand related to imaging. and the Trust was now carrying out a greater number of complicated scans.

The Committee were informed that a full action plan to improve performance was in place including standardising and simplifying MRI protocols. The recovery trajectory would be available following the completion of the demand and capacity work which was now underway.

East of England Imaging Network 2 Deep Dive
The Committee received and noted the EoE Imaging Network 2 presentation.

The Committee received an update on the EoE Imaging Network 2 and were informed that robust governance structures had been implemented and there was good engagement across the network. The Network had agreed to focus on digital, assets and equipment and clinical and workforce workgroups had been established.

The Committee were informed that £4.8m had been awarded to the Network to focus on an image sharing platform, clinical decision support and homeworking equipment. A further £20m had been bid for over the coming five years to support digital transformation.

Emergency Department Deep Dive
The Committee received and noted the ED Deep Dive presentation.

The Committee received an update on the position of the Emergency Department and were informed that adult emergency activity had returned to and exceeded pre-pandemic levels with the added pressure of significant lengths of stay. Average length of stay in the department for admitted patients has increased due to the current bed pressures including a

high number of patients who do not meet the criteria to reside. Mental health is also a significant contributory factor. Factors contributing to non-compliance with the 4 hour emergency standard included access to other services, complex pathways surrounding Covid, increased activity and acuity, exit blocks, the impact of the capital build, staff absences and reduced bank shift fill.
The Committee were informed that the department had aligned to the new Emergency Professional Standards of which ambulance handovers were a key part The new standards have been disseminated and BI are working on the dashboards.

The Committee discussed the series of actions being implemented to improve performance and the trajectory for recovery based on the implementation of the actions.

Bed Capacity Deep Dive
The Committee received and noted the Bed Capacity Deep Dive presentation.

The Committee received an update on the Trust's bed capacity and were informed that assumptions had been made for the 2022/23 bed planning in relation to Exit rate, Length of Stay and elective speciality levels.

The Committee were informed that modelling work was underway to understand current demand and use, investigate opportunities for change and understand unmet demand.

Workforce Report Month 12
The Committee received and noted the Workforce Report month 12.

The FPPC received a workforce update highlighting key points in relation to the Trust's performance against Workforce targets. The Committee noted that:

- The vacancy rate had decreased slightly from 6.7% to 6.6%.
- Staff turnover continued to show a gradual increase
- Over 260 staff were currently undertaking apprenticeships across the Trust.
- Sickness absence had decreased by 0.99%.

Finance Report Month 12
The Committee received and noted the month 12 Finance report.

The Committee were informed that at the end of March 2022 the Trust had delivered its statutory financial responsibilities, had a surplus of £0.4m and earned £13.61m from the Elective Recovery Fund. The Committee noted that the results were pre-audit.

The Committee heard that the Capital expenditure was £37,363k against a plan of £37,540k which was a huge achievement for all teams involved in Capital spend.

Financial Plan Update
The Committee received a verbal update in relation to the Divisional Cost Improvement Plans. They were informed that overall, the target remained at a little under £19m. The remaining gap had been identified and there was a willingness to identify a contingency.

The Committee reviewed and approved the 2022/23 Capital Plan The Committee noted the financial risks to the 22/23 revenue budget.

Digital Strategy Update

The Committee received and noted the Digital Strategy update.

Board Assurance Framework

The Committee received and noted the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee.

The Committee discussed the merits of receiving only the Committee owned risks at the FPPC and agreed this for the May meeting onwards.

The Committee deliberated the option of increasing the Finance risk (risk 3) from 12 to 16 recognising the Covid legacies and cost of living increase. The Committee agreed to increase the risk from 12 to 16.

The Committee discussed the operational risk scoring of 20 and following discussion agreed it should remain at 20.

_____

Karen McConnell
Finance, Performance and People Committee Chair
April 2022

Meeting	Trust Board			**Agenda Item**	22.2
Report title	Quality and Safety Committee Report to Board			**Meeting Date**	4 May 2022
Presenter	Chair of Quality and Safety Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Quality and Safety Committee			**Approval Date**	8 April 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 29th March 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

[

Recommendation	The Board/Committee is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 29 MARCH 2022
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 4 MAY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, David Buckle, Val Moore

The following core attendees were present:

Michael Chilvers, Rachael Corser

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). It was recommended to and supported by the Committee that Risk 1 – Operational Performance was reduced to 16 from 20. The Committee was informed that the Board had supported that the Risk 8 – Quality score remained unchanged.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. The Committee discussed risk oversight across the organisation and agreed for a task and finish group meet to address the issue.

Quarterly Compliance Report

The Committee received and noted the Quarterly Compliance report. The Committee was informed that the Children's and Young People's services CQC Direct Monitoring Approach (DMA) call would be on 28 April 2022. They heard that local intelligence indicted that the CQC would place patient experience as their highest risk factor as they decide when and where to inspect. This will form part of the Trusts Fundamental Standards of Care test and challenge in May 2022.

Estates and Facilities Health and Safety Report

The Committee received and noted the Estates and Facilities Health and Safety Report. The Committee was informed that the Environmental Health Officer (EHO) had revisited the site and noted a marked improvement overall. The Committee heard that the Internal Audit actions had been completed and a governance and reporting structure had been implemented. It was highlighted to the Committee that the fire safety meetings had been cancelled due to poor attendance and the fire inspection was scheduled for 25th April 2022. This is a matter serious concern that must be addressed immediately.

CQC Briefing Deep Dive

The Committee received and noted the CQC Deep Dive report. The Committee was informed of the Trusts rolling programme of review of performance against core services to determine areas of priority. The Committee heard that the CQC had not defined their process for 2022/23 and insight indicated that the earliest would be July due to their recruitment of local inspectors. The Committee was informed that the CQC domains would not change however the descriptions had been streamlined. The Committee heard that the Trust had not received any actions from the Direct Monitoring Approach calls and feedback to date had been positive.

Quality and Safety Report - Month 11

The Committee received and noted the month 11 edition of the Quality and Safety Report.

Key points discussed included:

- A key priority for the Divisions had been to reduce the outstanding Duty of Candour applications.
- There had been a cluster of Serious incidents within Maternity services, investigations will be carried in partnership with the Health Safety Investigations Branch (HSIB).
- 92% of complaints had been acknowledged within three days which was above the Trust target however 47% had final responses which was below the Trust target. The committee recognised the importance of responding to complaints on time. An improvement aim to reduce all overdue complaints to zero by March 2022 had been set.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews process update. They were informed that each Division had a plan and trajectory for completing the backlog. The data cleansing was almost complete and the improving data had improved the position. The Committee was informed that there had been two moderate harms identified which would be presented to the SI review panel.

Learning from Deaths Report

The Committee received and noted the Learning from Deaths report. The Committee were informed that following the HSMR rebase a data error had been identified and since the data had been corrected the Trust had returned to the first quartile. The Committee heard that due to delays of Fractured Neck of Femur patients getting to Theatre, the Divisions would investigate to determine specific inefficiencies.

Mortuary Update

The Committee received and noted the Mortuary update. They were informed that the Mortuary refurbishment was underway and there were no delays in any of the key workstreams.

Maternity Dashboard Exceptions and Maternity Safety Concerns and Neonatal Dashboard

The Committee received and noted the update Maternity reports. The Committee were informed that there had been an increase in poor outcomes which had affected five babies. Investigations with the CCG and regional colleagues were underway.

Maternity Workforce Recruitment and Retention Plan

The Committee received and noted the Maternity Workforce Recruitment and Retention plan. The were informed that the plan formed a part of the Trust's response to Ockenden and that there was a 6% vacancy rate which equated to 20 midwives.

The Committee noted the following reports:

- Integrated Performance Report for Month 10
- Gastroenterology Surveillance SI Update

- Quality and Safety Committee Internal Audit Plan

Dr Peter Carter
Quality and Safety Committee Chair
March 2022

Meeting	Trust Board			**Agenda Item**	22.2b
Report title	Quality and Safety Committee Report to Board			**Meeting Date**	4 May 2022
Presenter	Chair of Quality and Safety Committee				
Author	Assistant Trust Secretary				
Responsible Director	Chair of Quality and Safety Committee			**Approval Date**	28 April 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 26th April 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 29 MARCH 2022
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 4 MAY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, Val Moore

The following core attendees were present:

Michael Chilvers, Rachael Corser, Lucy Davies

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). The Committee approved the recommendation to receive those risks managed by the Committee at future meetings. The Committee were informed about a new risk added that detailed the ongoing impact of the pandemic, it was agreed the team would consider rearticulate the risk to ensure it was reflected in full.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. The Committee discussed the impact of staff morale particularly in relation within the Urgent and Emergency Care service and the immense pressure that the department continued to manage.

Harm Free Care Deep Dive

The Committee received and noted the Harm Free Care Deep Dive report. The Committee heard the detail of the six safety workstreams including the Keeping Our Patients Safe (KOPS) programme. The Committee was informed that the workstreams aligned to the quality strategy as well as the national patient safety strategy. Twenty ideas were being tested and service users were engaged and based in part on their feedback processes were updated and implemented. The Committee were informed that the next steps were to develop a robust "Safety II approach", focus on VTE improvement and continue to engage service users.

Quality and Safety Report - Month 12

The Committee received and noted the month 12 edition of the Quality and Safety Report.

Key points discussed included:

- Key priorities were to close the overdue and open SI's as well as the Duty of Candour applications.
- Sepsis compliance continued to improve, and support would be provided to improve device management at Ward level.
- A continued increase in patient complaints was to be expected with the ongoing pressures within the service and the workforce.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews process update. The Committee was informed there had been two moderate harms identified, one of which would be reported to

the SI panel. The Committee heard there was little capacity within the team to undertake harm reviews and therefore WLI's may be utilised.

Incidents & Inquests Report

The Committee received and noted the Incidents & Inquests report. The Committee were informed that the Hertfordshire Coroner had issued the Trust with one Prevention of Future Deaths report in Q4 which had been investigated, responded to and learning shared. The Committee heard that one Never Event had been reported since the last report and the closure of overdue SI's remained a priority.

Complaints, PALS & Patient Experience Report

The Committee received and noted the Complaints, PALS and Patient Experience Report. They were informed that there had been an increase in the number of patient experience surveys completed as well as an increase in patient satisfaction. The In-Patient survey highlighted areas for improvement included hospital food and being involved in decision making. The Committee heard that the number of complaints had increased slightly whereas the number of PALS enquiries had decreased.

Freedom to Speak Up Report

The Committee received and noted the Freedom to Speak Up (FTSU) report. The Committee were informed that there was a new FTSU Guardian who would provide more robust reporting through the newly formed People Committee rather than the Audit Committee. The Committee heard that themes over the last twelve months were bullying, harassment & abuse and patient safety issues. They were informed that a meaningful network of FTSU Champions were being recruited and working across the Trust to educate staff about speaking up in a safe and protected environment. The Committee was informed that a new strategy would reset and relaunch the FTSU service.

Maternity Dashboard Exceptions and Maternity Safety Concerns and Neonatal Dashboard

The Committee received and noted the update Maternity reports. The Committee were informed that the Workforce issues were beginning to be visible with in dashboard. They heard that releasing staff for training remained an issue. A new risk to the Trust's reputation regarding the National Bereavement Care Pathway had been added to the register. The Committee were informed that the new Matron being in post was positive and would provide greater assurance.

Ockenden Report - Final

The Committee received and noted the Ockenden Report - Final. The Committee were informed that the Ockenden visit had been successful and complimentary about the senior-team and staff knowledge. The visit had provided assurance, the essential actions were reviewed and there had been no red flags or outliers. The Committee heard that a women's experience lead Midwife would be employed.

The Committee noted the following reports:

- Integrated Performance Report for Month 12
- Mortuary Update

East and North Hertfordshire NHS Trust

Dr Peter Carter
Quality and Safety Committee Chair
April 2022

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	22.3
Report title	Audit Committee Board Report		**Meeting Date**	4 May 2022
Presenter	Chair of Audit Committee			
Author	Assistant Trust Secretary			
Responsible Director	Chair of Audit committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To present the report from the Audit Committee meeting held on 7 April 2022 to the Board.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

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AUDIT COMMITTEE MEETING – 7 APRIL 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 MAY 2022

The following Non-Executive Directors were present:
Jonathan Silver (Chair)

Internal Audit Reports:

Internal Audit Progress Report and Action Log
The Audit Committee received an update from the Internal Auditors. Four internal audit reports had been finalised since the previous meeting, as follows:

- Payroll – Substantial Assurance
- Harm Free Care – Substantial Assurance
- Mandatory Training and Appraisals – Reasonable Assurance
- BAF & Risk Management – Reasonable Assurance

The Committee also received the latest internal audit actions tracker and of the 16 outstanding actions, 8 were overdue.

Draft Annual Report and Head of Internal Audit Opinion
The Audit Committee received the draft annual report and it was noted the Head of internal Opinion provided Reasonable assurance. There were no items that were likely to change the outcome.

Audit Strategy 2022-2025 and Annual Plan 2022-23
The Audit Committee received and noted the Audit Strategy and Annual Plan. It was noted the number of days included the carried forward contingency days from the previous year that had remained unused. It was noted that the plans had been reviewed by the Executive Directors.

Counter Fraud Progress Report
The Committee received and noted the Counter Fraud Progress Report which detailed the activity carried out against the Counter Fraud work plan 2021/22 since the Audit Committee on 18 January 2022. It was noted that the current Counter Fraud Champion would be leaving the Trust and agreement would be required for the next nominated Fraud champion.

The Committee received and noted the Counter Fraud Work Plan for 2022/23.

External Audit Reports:

External Audit Plan
The Committee received and noted the External Audit Plan. The Committee was informed that new IFRS 16 disclosures would be required and would be reported on separately due to the complexity.

Other Reports:

Data Quality and Clinical Coding Report
The Committee received and noted the data quality and clinical coding report. The Committee noted that the data quality audit was ongoing and had facilitated the development of a Qlikview app that would provide the opportunity to interrogate the data with an initial focus on ED errors and issues.

Cyber Security Report
The Committee received and noted the latest update regarding the Trust's cyber security position. The Committee were informed that although there had been an increase in cyber threats due to the Russian/Ukraine conflict, none had been activated in the UK. The team continued to work with NHSD to strengthen the security of all products.

Board Assurance Framework and Risk Update
The Committee received the BAT and noted that only one risk, the Operational Performance risk had closed the financial year with a score of 20. It was noted that there had been a recommendation for no changes to the format of the BAF due to the proposed move to the Inphase module.

Corporate Risk Register
The Committee received the review of the risks scoring 20 and noted two had reduced since the Quality and Safety committee. The Committee heard there had been a review of Paediatrics/Children's service and the team were being supported by Head of Compliance and Risk.

Clinical Audit Assurances
The Committee received and noted the Clinical Audit Assurances report. The Committee was informed that the number of national audits had increased by 42% as well as an increase in NICE guidance. The Clinical Audit team had met with seven of the specialities and planned to meet the remainder over the coming months. It was highlighted that the Clinical Audit internal audit had receive d a substantial assurance rating.

Quality Account Timeline
The Committee received the Quality Account update and noted the deadline of a June approval by the Quality and Safety Committee with publication on 30 June 2022.

Jonathan Silver
Audit Committee Chair
April 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	22.4
Report title	Charity Trustee Committee Report to Board		**Meeting Date**	4 May 2022
Presenter	Chair of Charity Trustee Committee			
Author	Assistant Trust Secretary			
Responsible Director	Chair of Charity Trustee Committee		**Approval Date**	18 March 2022
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To appraise the Board of the funding approvals made and the significant items discussed at the Charity Trustee Committee held on 7th March 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

None

Recommendation	The Board/Committee is asked to Note the report.

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CHARITY TRUSTEE COMMITTEE MEETING HELD 7 MARCH 2022

SUMMARY REPORT TO BOARD

The following members were present: Dr David Buckle (CTC Chair), Thomas Pounds (Chief People Officer, Odunayo Basorun (Financial Controller)

Key decisions made under delegated authority:
The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
Maternity: LifeStart Resuscitator trolley to improve outcomes for delayed core clamping as well as an improved experience for couples.	£19,000	Approved
Cancer: 3D printer to print treatment bolus for radiotherapy patients aiding patient comfort and experience.	£7,000	Approved
Palliative Care: Training video's for Butterfly volunteers to enhance respect and understanding of death within different religions and cultures.	£5,394	Approved.
Corporate: Breakfast/snack box refreshments at other sites to Lister to support staff health and wellbeing.	£30,000	Approved subject to a revised plan to support all staff across all sites. CTC requested that the money was used to promote healthy eating .
Corporate: Staff awards resource.	£8,500	Approved.
Cancer: Complimentary Therapy Service to reintroduce group sessions and extend online support.	£125,708	Approved
Cancer: MVCC Wellbeing Map for staff, patients and the local community to provide a range of MVCC and community detail	£10,000	Approved subject to a sustainable solution that would be easy to update.
Cancer: MVCC Outdoor Space Project and Nature Recovery Ranger role extension for an additional 18 months.	£77,035	Approved with the understanding there would be no employment risk to the Trust.

Other outcomes:

Charity Strategy Update

The Charity Trustee Committee received and noted the updated strategy which they heard had created an air of excitement for future possibilities. The Committee agreed to defer the approval until all members had provided feedback.

Approvals of Budget / Forecast

The Committee received the report with the reforecast and heard that 70% of income raised in the current financial year had been for Lister, QEII and Hertford County. The Committee were informed that there was no expectation to have to draw down any cash before the end of the financial year because the balance sheet was robust. The Committee approved the updated plan.

Charity Finance Report

The Committee received and noted the report. It was noted that charitable spending remained focused on patient and staff benefit. The Committee heard the 35% of income was being used to run and manage the Charity and to fundraise.

Investment Portfolio Update

The Charity Trustee Committee received and noted the report on the Charity's investment portfolio .Rathbones (via Teams) outlined the factors that had adversely affected investment performance. The Committee were informed that the markets were being driven by world politics and were difficult to read. The Committee was informed that after one year the portfolio had increased by 10% which was in line with the benchmark.

Charity Highlight Report

The Charity Trustee Committee received and noted the Charity Highlight Report. The Committee was informed that a claim for £12,000 had been submitted for backdated Gift Aid to June 2021. They heard that it was expected Gift Aid would be collected monthly moving forward and the position would be amber in the following month.

Major Projects Update

The Charity Trustee Committee received and noted the Major Projects update. The Committee was informed that a communication plan would be developed to promote the Sunshine appeal. It was expected that the building work would commence in 2023 following a fundraising push.

Charity Trustee Committee Annual Review

The Charity Trustee Committee received and noted the annual review. The Committee discussed the ongoing management of large bids and it was recommended that progress reports were built into the application process.

The Committee received and approved the recommended changes to the Terms of Reference of which the most notable change was the Chief People Officer as the lead executive director for the Committee.

Any Other Business

The Committee noted that former authorised signatories Mr Nick Carver and Mr John Sloane had been substantively replaced and there were no implications for the Trust.

Dr David Buckle
Chair of the Charity Trustee Committee
March 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public Session		**Agenda Item**	22.5
Report title	Equality & Inclusion Committee		**Meeting Date**	4 May 2022
Presenter	Chair of Equality & Inclusion Committee			
Author	Corporate Governance Officer			
Responsible Director	Chair of Equality & Inclusion Committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To present the report from the Equality and Inclusion Committee meeting on 15 March 2022 to the Board.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

The discussions at the meeting reflect the BAF risks assigned to the Equality and Inclusion Committee.

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

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EQUALITY AND INCLUSION COMMITTEE MEETING – 15 MARCH 2022
SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 MAY 2022

The following Non-Executive Directors were present:
Val Moore (Chair) and Ellen Schroder (Trust Chair).

EDI Dashboard
The Equality and Inclusion Committee reviewed the EDI Dashboard noting a change in the report which now shows non-disabled and white colleagues as well as BAME colleagues.

The Committee noted an increase of individuals declaring a disability, and also noted a reduction of BAME staff experiencing discrimination at work. However there was an increase in staff experiencing bullying and harassment and this was being reviewed to understand the reasons why.

Ramadam Update
The committee learned that Ramadam will start the beginning of April and were assured that colleagues will be supported to ensure they are able to take their breaks when needed.

Gender Pay Gap
The Equality and Inclusion Committee noted recommendations to carry out a deep dive to understand any gender related pay gaps. A comparison was made of male and female colleagues from 2020 and 2021. The Committee were assured that the data will be fully reviewed before an action plan is put into place to reduce the pay gap.

Recommendations made will be presented to Trust Board for approval, at a later date.

Flexible Working
The Committee noted a working group had been set up to understand flexible working and agile working and how these could be applied across the organization.

The Committee discussed how flexible working practices, when applied successfully, could improve retention and help to attract people to the organization. However, the Committee agreed that there needs to be a cultural change within the organization to ensure flexible working practices are happening across all areas.

International Recruitment
The Equality and Inclusion Committee were presented with key highlights relating to international recruitment which outlined plans to improve the induction and onboarding process. A working group is in place to ensure the improvements happen.

Equitable and Inclusive Working Practices during Holiday Season
The Committee wanted to understand why more BAME staff were on shift during the Christmas and New Year holiday period.

The Committee welcomed a Trauma and Orthopaedic nurse from an Asian staff group to talk about why he and other colleagues preferred to work during the Christmas and New Year holiday season.

After investigation, it was discovered that some staff prefer to use block leave to travel home to their families in other countries at other times of the year due to high travel costs at Christmas time, but also to do with the seasons in other countries. Many also wanted to take advantage of enhanced pay during this period of time.

The Committee were assured that staff were able to choose whether to work during certain periods throughout the year and recognized the need for the Trust to understand workforce preferences.

Facilities Recruitment Project
The Equality and Inclusion Committee were advised that housekeeping, catering and linen functions had been combined into a generic Band 2 Facilities Assistant role with individuals joining the organization having an individualized profile that will outline their working hours, additional needs and preferred work area and career aspirations.

Trust Values Refresh
The Committee were presented with an overview of the Trust's Values Refresh, noting how things could be done differently and improved. The Committee were advised that the current values were 17 years old and although they have served a purpose, it was now time to review and refresh them to make them more relevant.

Any Other Business
The Committee recognized there may be individuals from Ukranian and Russian backgrounds who may require support at this time and learned that this support was being coordinated nationally. The Committee welcomed the idea that refugees could find work at the Trust.

Val Moore
Equality & Inclusion Committee Acting Chair
April 2022

Draft Board Annual Cycle 2022-23

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Elective Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee final meeting July 2022 before moving to Board Development		X		X								
EIC moving to People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		

Draft Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						
Annual budget/financial plan		*(X) from 2023*										
Long-term strategic infrastructure						X						X
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update				X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X

Draft Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								
Staff Survey Results		X										X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report						X						
QSC TOR and Annual Review								X				
Strategy Committee – move to Board Development in September												
Digital Strategy Update				X								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										

Draft Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								