East and North Hertfordshire NHS Trust

Trust Board Part I

Rooms 2 & 3, Hertford County Hospital

1 November 2017 14:00 - 1 November 2017 15:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	
2	Declaration of Interests		
3	Questions from the Public Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting 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 Secretary can be contacted by email (jude.archer@nhs.net), by telephone (01438 285454), by fax (01438 781281) or by post to: Company Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to address the meeting for no more than three minutes and 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.		
4	Apologies for Absence		
5	Minutes of Previous Meeting For approval 5 Minutes from 6 September 2017 Part I.pdf 5	Chair	
6	Matters Arising and Actions Log For information 6 Pt I Actions Log to November 2017.pdf 15	Chair	
7	Annual Cycle For information 7 Board Annual Cycle 2017-18.pdf 17	Company Secretary	

#	Description		Owner	Time
8	Chief Executive's Report For discussion 8 CE Report - Nov 2017.pdf 8. Appendix A - Trust Floodlights 2017-18 (M06) Se...	23 27	Chief Executive	
9	Finance and Performance Committee Report For discussion 9 FPC Report to Board.pdf	35	Chair of FPC	14.15
9.1	Finance Report - Month 6 For discussion 9.1 Finance Report Part 1.pdf	39	Director of Finance	
9.2	Performance Report For information 9.2 Month 6 Performance Report.pdf	47	Chief Operating Officer	
9.3	Workforce Report For information. 9.3 Workforce Report.pdf	53	Chief People Officer	
10	Risk and Quality Committee Report For discussion 10. RAQC Report to Board October 2017 FINAL.pd...	79	Chair of RAQC	14:45
10.1	Learning from Deaths Report For discussion 10.1 Learning from Deaths report Oct-17 - FINAL.p...	103	Medical Director	
11	Audit Committee Report to Board For discussion 11. Audit Committee Report to Board.pdf	131	Chair of Audit Committee	

#	Description	Owner	Time
11.1	**Review of Standing Financial Instructions and Standing Financial Orders** For approval 11.1 Standing Financial Instructions and Standing F... 135	Chair of Audit Committee	
12	**Charity Trustee Annual Report and Accounts** For approval 12.a Charity Annual Report and Accounts.pdf 251 12.b Letter of Representation.pdf 301 12.c External Auditor Report - Closing ISA260 2016... 303	Chair of CTC	
13	**Data pack** For information 13. Data Pack.pdf 321	All Directors	
14	**Part II** The Trust Board resolves that under Standing Order 3.17(i) 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 matters to be transacted, publicly which would be prejudicial to the public interest.		15:45-18:00
14.1	**Commercial-in-confidence**		
14.2	**Governance Matters**		
14.3	**Personnel Matters**		
15	**Date of next meeting:** 10 January 2018 - New QEII		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 6 September 2017 at 2.00pm at the Lister Education Centre, Lister Hospital, Stevenage

Present:	Mr Bob Niven	Non-Executive Director (Chair)
	Mr John Gilham	Non-Executive Director
	Mr Nick Carver	Chief Executive
	Mr Martin Armstrong	Director of Finance
	Miss Jane McCue	Medical Director
	Ms Liz Lees	Director of Nursing (Acting)
From the Trust:	Ms Jude Archer	Company Secretary
	Ms Kate Lancaster	Director of Strategy
	Mr Tom Simons	Chief People Officer
	Mrs Jane Chapman	Board Committee Secretary (minutes)
In attendance:	Mr Justin Jewitt	Public (until 2.27pm)
	Mr Martin Gray	Anaesthetist SPR (final year)
	Mr Santhini Jeyarajah	Senior Colorectal Registrar
	Ms Harriet Aldridge	PWC

ACTION

17/154 CHAIR'S OPENING REMARKS

17/154.1 Mr Niven advised that he would be chairing this meeting in the absence of Ms Schroder (Chair) and welcomed everyone present, thanking the members of the public and the PwC representative for attending.

17/155 DECLARATIONS OF INTEREST

17/155.1 There were no declarations of interest.

17/156 QUESTIONS FROM THE PUBLIC

17/156.1 The Chair informed the Board of a question that had been submitted by Mr Jewitt regarding the 62-day Cancer Pathway. His question was as follows:

'"What do the individual non-executive Board members think are the reasons for ENHERTS poor performance on the 62-day Cancer Care pathway versus Princess Alexandra Hospital at Harlow? And how quickly can the performance be improved? "'

17/156.2 Mr Niven thanked Mr Jewitt for his question and stated that the performance is currently lower than the Trust would expect, acknowledging that data identified it is currently achieving 65% of the 85% target. Mr Niven referred to the trajectory and advised Mr Jewitt that this is showing signs of improvement. Mr Niven acknowledged that a comparison with Princess Alexandra Hospital could inform the Trust's improvement plan. He advised that each pathway is under review and that the Trust is achieving target in some areas and the 62-day Patient Pathways continue to be reviewed to drive improvement. He suggested that the tertiary centre at the Mount

Vernon Cancer Centre receives referrals from other organisations, due to the late timing of these it can have a detrimental impact on meeting targets and this issue is being considered. Mr Niven advised Mr Jewitt that the Trust will continue to be transparent and publish results. He invited further questions should progress not be evident.

17/156.3 The Director of Nursing advised that the 62-day Cancer Pathway is complex. She advised that much work is being undertaken to improve services on the Mount Vernon Cancer Centre site. She advised that validated results for July have not been received to date; however, early indications imply improvements are evident. It is anticipated that August will continue on this trajectory. Further results will be available for the November Public Board meeting. The Medical Director advised that the National Cancer Alliance have been jointly commissioned to work with the Trust on these pathways in conjunction with the CCG in order to provide a sustainable solution. Mr Niven also advised that two more Oncologists have been appointed at the Mount Vernon Cancer Centre who are engaging with personnel to develop the services being provided. The Chief Executive stated that the Trust has historically achieved highly in this area and anticipates a return to this status.

17/156.4 Mr Jewitt stressed that his question was not to criticise and praised the achievements within SHMI and mortality. He advised that he is familiar with the non-executive role and was surprised that performance at Princess Alexandra Hospital has not been investigated in order to develop the East and North Herts pathways and he proposed for this to take place. Mr Jewitt advised that he is a lay member for the CCG representing patients. Mr Jewitt advised the CCG are supportive of the Trust and that he also sits on a quality committee where there was an example of joint working supporting improvements to SHMI and mortality practice and could this approach support improvements in the Cancer division.

17/156.5 Mr Niven thanked Mr Jewitt for his openness and suggestions. The Chief Executive requested that Princess Alexandra Hospital pathways be investigated and for the findings to be reflected in the public domain. Mr Jewitt concluded by speaking favourably of the manner in which the Trust has been engaging with the public and raising its profile within the community. Mr Niven acknowledged that the Trust must work with the CCG in order to improve standards. The Chief Executive advised that, although the Trust has not looked at Princess Alexandra Hospital to date, this is not an indication that it is resistant to learning and accepted suggestions. **Interim Chief Operating Officer**

17/157 APOLOGIES FOR ABSENCE

17/157.1 Apologises for absence were received from Ms Ellen Schroder – Non-executive Director (Chair), Ms Val Moore – Non-executive Director, Ms Alison Bexfield - Non-executive Director.

17/158 MINUTES OF THE PREVIOUS MEETING

17/158.1 The Board reviewed and approved the draft minutes of the previous meeting subject to some minor typing amendments and the re-phrasing of 17/133.6 (Medical Director to confirm with Board Committee Secretary).

17/159 MATTERS ARISING AND ACTIONS LOG

17/159.1 The Board reviewed and noted the actions log with the following comments:

The Company Secretary advised that minute reference 17/125.2 Social Care Funding – this action is being presented at a future meeting. Mr Gilham suggested an update in October on the use of funding with an update relating to the use of additional Social Care funding for bed capacity in relation to winter usage.

17/160 ANNUAL CYCLE

17/160.1 The Board noted the annual cycle. The Company Secretary advised that anomalies of subcommittees should be identified in order to align with the new cycle.

17/161 CHIEF EXECUTIVE'S REPORT

17/161.1 The Chief Executive delivered the Chief Executive's Report, highlighting the following items:

- Ms Angela Thompson - Director of Nursing has been appointed Director of Nursing and Deputy Regional Chief Nurse for NHSI London region. Plans are in place to recruit a substitute Director of Nursing in October 2017.
- Mr Nigel Kee - Chief Operating Officer has taken up a new post as Strategic Operations Improvement Director with the University Hospitals Coventry and Warwickshire NHS Trust, where he will be working closely with NHS Improvement. As an interim measure, Ms Bernie Bluhm is returning to work for the Trust from 11 September 2017.
- The Trust has been successful in its bid to be designated to create a specialist vascular surgery hub for Hertfordshire and West Essex. Further updates on funding and progress will be provided to the Board accordingly.
- The roll out of the new patient administration system, Lorenzo, will take place on 8 September 2017. The Trust has invested c£11m in this initiative which has recently been successfully implemented at the Ipswich NHS Trust. A meeting of the Board took place on 30 August 2017 to determine the Trust's readiness ahead of NHS Digital review confirming that all risks have been mitigated as far as possible and the Trust is fit and ready to Go Live on 8 September 2017. The focus remains on training and reporting. Staff core training is currently at 90% complete. The target of 80% for specialist training is close to being achieved. Completion of Patient Transfer Lists is now being finalised. Internal Command and Control Bronze, Silver and Gold are being implemented together with communications across all sites including daily "town hall" meetings during the Go Live period to ensure a smooth transition. The Medical Director advised that Emergency Preparedness and Response will be implemented in the Emergency Department during this transitional period.

17/161.2 Mr Gilham referred to the Vascular Surgery Hub and enquired whether the Trust could give a level of assurance to provide a good standard of service when this is implemented. The Director of Strategy advised that a business case would be developed to ensure a high level of **Director of Strategy**

service and to provide assurance.

17/161.3 Mr Gilham also referred to the report on the Maternity Team audit and highlighted the point that referred to the screening of women that appears to compromise the correct timing for Chorionicity and Amnionicity. He questioned whether this was a risk and if this is being mitigated. The Director of Nursing advised that further assurance would go through the Risk and Quality Committee and would be provided to the Board. **Director of Nursing**

FINANCE AND PERFORMANCE

17/162 Finance Report Month 4

17/162.1 The Director of Finance delivered the Month 4 Finance Report. Key highlights included:

- The Trust reported a Month 4 breakeven position against plan, bringing the year to date position to £10.5m deficit;
- The overall income position for Month 4 recorded a £0.1m favourable variance to plan; however, the year to date position on income remains a shortfall of £5.3m against plan due to the significant impact of the cyber-attack in May, at a cost of £0.7m;
- Pay and non-pay remain at reduced run rates and below budget plan with Agency expenditure reduced materially compared with the 2016/17 run rate. Good recruitment and retention have influenced this;
- Income and activity levels – elective and planned activity together with outpatients have improved utilisation of capacity during the first 4 months of the year. There has been improved focus since July with August and September anticipating further improvements.

17/162.2 Mr Niven enquired whether changes would be evident between the planning and improvement stages. The Director of Finance advised that, due to improved utilisation and planning in outpatients and theatres, there has already been an increase in activity following re-scheduling and delivery during August which is historically a difficult month. He advised that the daily Drumbeat sessions will be continuing for the foreseeable future as this is proving to be a successful method of embedding good practice with staff. The Director of Finance advised that the next 3 months are a crucial period to the recovery plan.

17/162.3 Mr Niven enquired what has been key to the improvements to date. The Director of Finance advised that some areas have exceeded expectations, such as workforce expenditure and this must continue. Planned use of capacity requires continued development but the mechanics and routine of Grip and Control have influenced the changes.

17/162.4 Mr Gilham enquired whether targets were achieved for the July/August period. The Director of Finance advised that July fell short but action was being taken to mitigate this. Although figures have not been finalised for August, early indications appear to show improvement from July. Mr Gilham enquired by how much the Trust failed to meet the July target and whether robust systems and processes were in place to ensure targets are achieved in future. The

Director of Finance advised that the implementation of the new Lorenzo system would provide clearer and more accurate data to work from going forward. Changes in the workforce have been implemented and specialist activity and delivery is now being reviewed in order to match demand and capacity. He advised that there are indications of improvement.

17/162.5 Mr Gilham enquired when the Trust will be proactive rather than reactive. The Director of Finance advised that he is confident that the Trust would be in this position within the year. He advised the Board that complex models had been developed with Four Eyes Insight during the last quarter and these models are now being turned into action with the correct skill sets and it is anticipated that forward planning will begin by early autumn.

17/162.6 Mr Gilham referred to the report that indicates that the second quarter payment for STF funding was not achieved and enquired whether this was predicted to continue or whether it is an anomaly. The Director of Finance advised that it is anticipated that this will not be recovered. He clarified in order to receive funding the Trust was required to meet its financial plan and Emergency Department performance trajectory. The Chief Executive advised that this is the 90% that does not equate to the target and therefore, if the Trust was on trajectory it would still not achieve target.

17/162.7 The Chief Executive advised that the Trust is becoming more fluent with data and utilising it to forward plan and forecast. A significant change in practice has been possible due to a higher quantity of data being available. Mr Gilham asked the executive team to reflect on the changes. The Director of Strategy advised that Drumbeat meetings are bringing greater scrutiny and changing the culture of performance and clinical capacity. Staff are now considering patients' requirements along with finances. There has been improved motivation and within a 6 week period positive changes are impacting on patients. Mr Gilham enquired of the plans for the outpatient improvements. The Director of Strategy advised that there remains much solid groundwork to be undertaken at this stage including a consistent and conservative effort in order to deliver. She advised that, due to many complexities, the outpatient department remains under review in order to improve all areas.

17/163 Performance Report

17/163.1 The Director of Nursing introduced the Month 4 Performance Report (with the exception of Cancer which is Month 3). Key highlights included:

- 31 day pathway – this remains a challenge; however, there is improvement and the Trust is committed to make further improvements by August.
- Emergency target challenge – the Trust did not achieve the 4 hour Emergency Department standard in July but continued to achieve against the STF improvement trajectory, delivering 87.77% against a trajectory of 87.10%. Performance in August has been challenging and final figures are awaited.
- RTT – the Trust failed to meet the 92% standard in July which was due to the increasing number of pathways over 18 weeks. The backlog increased by 949 from the end of June to the end of July. There were increases across all specialities with the

exception of Cardiology. There remains performance work to be carried out including the development of the clinical teams.

- Ambulance hand-over times remain excellent.
- Emergency Department attendance is just above the mean.
- Admissions have not been high due to the low number of conversions.

17/163.2 The Director of Nursing advised that the Emergency Department have had challenges with patient flow and are in the process of rectifying these ahead of the Lorenzo Go Live. With the new interim Chief Operating Officer taking up post next week, it is anticipated that the Emergency Department will show signs of improvement. Mr Niven enquired whether this was influenced by the season. The Director of Nursing advised that August has historically proved a challenge due to annual leave and the holiday period for both patients and staff. Performance trajectories for June and July have significant challenges and patient flow through beds has been a particular challenge this year; however, it is anticipated that performance will change in coming months due to patient flow workstream changes in line with the Model Hospital. This will also be supported by the use of real-time data following the implementation of Lorenzo. The Medical Director advised that Ambulatory Care requires improvements. The Director of Nursing advised that the Discharge and Assess programme is now available and will improve bed numbers. This change will be supported by partners and services in the community.

17/163.3 Mr Gilham enquired what impact the RTT's downward trajectory would have on patients. He highlighted that complaints indicate concerns. He was interested in the actions that are being taken and the time scale in which the trajectory would be met. The Chief Executive advised that, on arrival, the Interim Chief Operating Officer will review procedures for reporting in order to provide a higher level of information to Board. Mr Gilham requested assurance of plans in relation to performance to be delivered to the October Board Development meeting. The company Secretary advised that the Finance and Performance Committee meet prior to the next Trust Board meeting therefore provide scrutiny.

17/163.4 The Non-executive Directors were assured by the Stroke performance indicators despite challenges with the thrombolysis rate which has improved.

17/164 Workforce Report

17/164.1 The Chief People Officer delivered the Month 4 Workforce Report. Key highlights included:

- *Temporary staffing* – the improvement in agency spend continues to remain below the NHSI ceiling at c£1m year to date which improved during July. This will be c10% down for August at c£31.10m to date.
- *Removal of agency use* – the Trust is building a sustainable in-house model in order to control doctors spend which is proving successful.
- *Introduction of shared bank* - West Herts, Herts Community and ENHT shared bank has aided a reduction in bank rates whilst adding different dynamics within the market. c70 - 80% of the workforce are now on the shared bank at the current time.

- *Permanent resourcing targets* – this continues to be a challenge for the Trust. Plans are revised on a regular basis in order to improve this, in particular for securing Band 5 nurses. Five overseas nurses joined the Trust in August. This is being monitored closely and improvements are visible.
- *Efficiencies of financial pathway* – the Trust is developing a work efficiency programme that is in the process of being implemented.
- *Clinical administration* – the Trust is currently developing a programme that will have a significant impact on patients. Staff will be appointed to patients in order to improve patient experience.
- *Reduction of staff by c130* – this has been achieved by natural attrition, contracts that ended and were not replaced and, the implementation of the MARS scheme (a national scheme of voluntary redundancy). This will be launched over the next 3 weeks for administration and corporate areas only.
- *FFT score* –the Trust has a requirement to capture the friends and family survey with regard to the environment for both patient care and staff working conditions. Results for the last quarter indicated a significant downwards trend regarding the Trust as a place to work. A detailed analysis of the results is underway to determine the cause for this. Results will be presented to the November Trust Board. **Chief People Officer**

17/164.2 Mr Niven raised the question of a 1% pay ceiling and enquired how this is being managed. The Chief People Officer advised that he was not aware of this change for the NHS although was aware that there are changes outside of the NHS. He advised that the Trust diverted from recruiting from the EU 12 months ago and is now focusing on international recruitment. Although this has a significantly higher cost, retention numbers are higher.

17/164.3 Mr Niven enquired whether the 'Family & Friends' results were as expected. The Chief People Officer advised that the Trust is gradually implementing a change of culture in order for staff to take accountability which has brought varied responses. This will be monitored to ensure improved results in future. Mr Niven requested that a comparison with other Trusts be made and results be presented to the November Trust Board. The Chief People Officer advised that this would be done in order to benchmark for the national trend. **Chief People Officer**

17/164.4 Mr Niven enquired whether the unions had taken an interest in the reduction of c130 posts. The Chief People Officer advised that significant changes had taken place in order to reduce the number of posts; however, redundancy had not taken place in order to meet this target. However, there had been involvement from the unions in terms of understanding the programme of work.

17/164.5 Mr Niven enquired whether there were any issues with the introduction of MARS. The Chief People Officer advised that individuals who come forward would require vetting to ensure that the correct staff take advantage of the scheme.

17/164.6 Mr Gilham referred to the workforce and capacity element of the report and requested that future reports include a trajectory to indicate that the Trust is delivering. The Chief People Officer advised that timescales and achievements would also be included.

17/164.7 In relation to 'job planning' Mr Gilham enquired whether there is a final date to complete the job plan and for sign off. The Medical Director advised that job plans will have gone through the appeals process by end September (a total of 4 appeals) and will then be signed off.

17/165 Finance and Performance Committee – Annual Report and Terms of Reference

17/165.1 The Company Secretary delivered the Finance and Performance Committee Annual Report and Terms of Reference to the Board. She advised that the report demonstrates that the Committee meets its duties as set out in the Terms of Reference but, recognises the requirement to improve the strengthening of financial risk. This has been addressed within the revised Terms of Reference. The Company Secretary advised that the Committee is appointing a new Chair, as Mr Nicholls' term of office ended in July. With a new Chair, the Committee will inevitably make changes in order to make further improvements. Interviews will be taking place next week.

17/165.2 Mr Gilham referred to Capacity and Demand and enquired whether the Terms of Reference takes into account the monitoring of Capacity and Demand and whether this is included in the plan. The Company Secretary advised that although Capacity and Demand has not been explicitly mentioned, it is implicit in many areas. Amendments will be made to reflect this so that it is in summary with the Terms of Reference at the beginning. The report and amendments were approved with the minor alteration to reflect Capacity and Demand. **Company Secretary**

RISK AND QUALITY

17/166 Risk and Quality Committee Report

17/166.1 The Company Secretary advised that the Committee does not meet in August; however, there are a number of quality reports provided in the data pack.

17/167 Charity Trustee Committee Report

17/167.1 The Board formally reconvened as corporate Trustee of the Charity.

Mr Niven (Chair of the Charity Trustee Committee) delivered the Charity Trustee Committee report. He advised the Board that he was the only Non-executive Director present at the meeting and prior to the meeting held on 4 September 2017 the Committee had not met since 13 March 2017 due to the major incident that took place in May.

17/167.2 The Committee made the following key decisions under delegation at the September meeting:

- The Committee agreed to renew funding of the voluntary services engagement function at Mount Vernon Cancer Centre subject to the funding coming from the Mount Vernon general fund and for a commitment to ensure the continuation of close working between the community engagement department at Mount Vernon with the Trust wide team and, the production of a short report on formalising that process being provided for the next meeting.
- Mount Vernon Cancer Centre received a £700k+ legacy and the Committee approved proposals for the following funds:

1. Clinical research posts – to provide improved clinical trials for Cancer patients.
2. Ambulatory Care Unit – to be set up on the current Marie Curie Ward allowing for some conditions to be treated without the need for an overnight stay. Awaiting final approval from the Business Development Committee.
3. John Bush Research Suite – to refurbish the clinical research area on ward 10 at Mount Vernon.

- A laser system for the new Siemens MRI scanner.

Mr Niven advised that these requests were discussed at length to ensure appropriate allocation of funding.

17/167.3 A number of requests were approved for capital expenditure of over £5k including:

- Hertford X-ray room
- Emergency Department portable ultrasound machine
- Labour Ward portable ultrasound machine
- Pharmacy education and training to support the transformation plan

17/167.4 The Medical Director enquired whether all four items where approved. Mr Niven advised that they had all been approved in principle. The Medical Director advised that this was a significant addition to capital this year. The Director of Strategy advised that the Committee's aim is to promote the work and expenditure of the charity and the patient benefit derived from it.

17/167.5 The Chief Executive referred to the £700k legacy and suggested that due to the size of this, it should be used to help promote the charity. The Director of Strategy advised that the development for priorities for how to spend funds would soon be circulated to staff. She also advised that the Charity is developing ideas for fundraising in order to purchase large equipment requested.

17/167.6 A request for a SPE-CT at the Lister site was presented to the Board for approval due to the significant size of the funding request at £675k. The Board gave approval for this request subject to a business case.

17/167.7 Mr Niven advised that: the Committee had reviewed the investment fund and this was performing higher than the market; a new head of charity had been identified and would be in post at the beginning of November; the Committee had approved the financial plan for the coming year; approved the Committee's Annual Review and Terms of Reference and; that applications for funding of £.5m+ now have amended procedures to go through prior to being presented to Board for approval. The annual report and revised Terms of Reference were approved.

17/167.8 The Company Secretary advised that a clean audit report had been received for the Committee's accounts and once some testing had been finalised, the report will be presented at the next Board meeting, at which time the letter of representation will also be ready for sign off.

17/167.9 The Chief People Officer enquired what assurance was received for funding requests, in particular for significant funds. Mr Niven advised that the Committee seeks regular reports to ensure that bids have

been realised. The Medical Director suggested that Mr Phil Smith be sighted on this to assist with providing assurance with regards to Fellows posts. The Director of Strategy advised that Mr Smith had been very involved in this bid. The Company Secretary advised that a programme has been developed that requires each project to report how funds are being spent.

17/167.10 Mr Niven advised that other requests for funding had not been approved and referred to the Divisional Executive Committee as the Charity was unable to fund these, all of which are urgent requirements.

17/167.11 The Chief People Officer enquired what communications are made with the families of significant legacies and he questioned whether families should be engaged in the decision making of how funds are allocated. The Director of Strategy believed that family expectations had been managed to a high standard. She advised that the Divisional Chair for Cancer had met with the family of the recent £700k donor in order to ascertain how they wished to be involved. The family took part in discussions, voted on initial ideas and were invited to see proposals prior to being presented to the Committee. The family advised that they would like the donor's name associated with the projects and to receive updates. The Chief People Officer enquired whether this case followed standard practice for all legacies. The Director of Strategy advised that this particular legacy was unusual due to the size; however, the charities Strategy and Legacies Policy will be developed further. Mr Niven advised the Board that he has written to the family on this occasion to inform them of the proposal and has invited their response. The Director of Nursing felt that all contributions should be acknowledged regardless of size. Mr Gilham highlighted that benefits of substantial legacies should be recognised in the Committee's Annual Report.

17/167.12 The Board approved the Terms of Reference.

17/168 DATA PACK

17/168.1 The Board noted the data pack.

17/168.2 *There being no further business the Chair closed the meeting at 15:40pm.*

Bob Niven
Non-executive Director

September 2017

	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 PART I TO NOVEMBER 2017

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
26 July 2017	17/125.2	Social Care Funding	Once each quarter provide a briefing to Board on the progress with workstreams regarding the additional H&SC funding as part of the Performance Report.	**November 2017:** Verbal update to be provided at the meeting	Chief Operating Officer	November 2017
26 July 2017	17/132.3	Nursing and Midwifery Establishment Review	NHSI Model Hospital bench-marking data to be included in the next Nursing Establishment Review.	**September 2017:** Being presented at October's Board Development session to provide an update on development of an up to date dashboard for workstreams including smart metrics in one location to track progress.	Director of Nursing	January 2018
26 July 2017	17/134.3	Audit Committee	Amend Audit Committee annual review to reflect the gap in financial controls identified in 2016/17.	**September 2017:** Proposed wording circulated to AC members for consideration. Will append to actions log once confirmed. **06.09.2017:** Presented to September Board. Action completed.	Company Secretary	September 2017
6 Sept 2017	17/156.5	Operational Performance - Cancer	To review PAH cancer pathways to explore if there is learning for the Trust		Chief Operating Officer	December 2017 (FPC)
6 Sept 2017	17/161.2	Vascular Surgery Hub	Develop a business case in order to ensure a high level of service and to provide assurance.		Director of Strategy	January 2018

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
6 Sept 2017	17/161.3	Maternity Team Audit	Provide assurance that the risk of timing for Chorionicity and Amnionicity screening of women has been mitigated.	29.09.2017: Action referred to RAQC	Director of Nursing	November 2017
6 Sept 2017	17/164.1/ 17/164.3	Workforce	Provide analysis of Friends and Family survey together with benchmarking against other Trusts.	**November 2017:** Report provided for Trust Board Part II	Chief People Officer	November 2017
6 Sept 2017	17/165.3	FPC TORs	Amend TORs to reflect Capacity and Demand in summary.	Completed	Company Secretary	November 2017

Board Annual Cycle 2017-18
- **A Formal Board is held on alternate months.**

Note: The annual cycle is currently under review following the agreed changes to the Board and Board Committee meeting dates that took effect from September 2017.

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Standing Items												
CEO Report inc Floodlight Scorecard		x		x		x		x		x		x
Data Pack[i]		x		x		x		x		x		x
Patient Testimony (Part 2)		x		x		x		x		x		x
Suspensions (Part 2)		x		x		x		x		x		x
Committee Reports												
Audit Committee Report		x		x				x			x	
CTC Report *May 2017 meeting not held due to Major Incident		X*				x				x		
FPC Report [ii]	*x	x	*x	x			*x	x	*x	x	*x	x
RAQC Report	*x	x	*x	x			*x	x	*x	x	*x	x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependant on national timeline)*								*x (awaiting national guidance/ timetable)				*x

Board Annual Cycle 2017-18

- **A Formal Board is held on alternate months.**

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Strategic Review & Financial recovery Plan (TBC)			*x (draft recovery plan)	*x (final recovery plan)				*x (final recovery plan) (awaiting confirmation of date / timeline of final submission)				
Sustainability and Transformation Plan (STP) (Part 2 new standing item)				x		x		x		x		x
Other Items												
Audit Committee												
Annual Audit Letter				x								
Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report		x										
Audit Committee TOR and Annual Report				x								
Quality Account and External Auditor's Report			x									
Raising Concerns at Work				x								x
Review of SO and SFI								x				
Charity Trust Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						x						
Finance and Performance Committee												

Board Annual Cycle 2017-18

- **A Formal Board is held on alternate months.**

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Draft Floodlight Indicators and KPIs				x								
Financial Plan inc CIPs and Capital Plan *(subject to change as dependant on national timeline)*							*x		*x			x
FPC TOR and Annual Report			x									
IM&T strategy review										x		
Market Report		x						x				x
Market Strategy Review (TBC)												x
Risk and Quality Committee												
Adult Safeguarding and L.D. Annual Report		x										
Detailed Analysis of Staff Survey Results	x											
Board Assurance Framework and review of delivery of objectives										x		
Equality and Diversity Annual Report and WRES.				x (WRES)				X (Annual report) (due to be considered at RAQC in Dec)		x		
GMC National Training Survey *(subject to change as dependant on national release)*								X (reported in RAQC Report at Oct Board Development)				
Health and Safety Strategy Review				x								
Improving Patient Outcomes Strategy				x								
Mortality (Learning from Deaths)	x			x				x				x

Board Annual Cycle 2017-18

- **A Formal Board is held on alternate months.**

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Nursing and Midwifery Strategy Review								X (due to be considered at RAQC in Nov)		x		
Nursing Establishment Review				x						x		
Patient Experience Strategy Review				X (RAQC/ Data Pack)								
Nursing - PQAF / Education report								x				
RAQC TOR and Annual Review				x								
Research and Development Annual Review			X (RAQC)									
Responsible Officer Annual Review				X (RAQC)								
Safeguarding Children Annual Review				x								
Serious Incidents Report (Part 2)				x				x				x
University Status Annual Report												X (TBC)
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [iii]				x						x		
tPP (Part 2)	x	x	x	x		x		x		x		x

Board Annual Cycle 2017-18
- **A Formal Board is held on alternate months.**

[i] The Data Pack will include the Friends and Family Test, Statutory and Mandatory Training Exception Report, Health and Safety Indicators, Nursing Quality Indicators, Finance Data, Performance Data, CQC Outcomes, Workforce Data, Safer Staffing Data and Infection Prevention and Control Data.
[ii] The FPC Report will include the Committee Report, the Finance Report, Performance Report and Workforce Report for the month.
[iii] To include the Annual Governance Review in July

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However forward agenda planning will aim to minimise this. *Items considered at the prior to the Board Development Session.
The Board Annual Cycle will continue to be reviewed in year in line with best practice and any changes to national scheduling.

N.B. May 2017: There have been some delays in finalising May reporting due to the Major Incident – Cyber-attack 12-19 May 2017.
Reviewed September 2017 – April 2018 to reflect changes to Board dates.

EAST AND NORTH HERTFORDSHIRE NHS TRUST

CHIEF EXECUTIVE'S REPORT

November 2017

1.	**Trust's director of nursing and patient experience** I am pleased to confirm that Rachael Corser will become the Trust's director of nursing and patient experience. Rachael, who will start at the Trust on 2 January 2018, joins from West Hertfordshire Hospitals NHS Trust, where she has been the deputy director of nursing and governance for the last two years, leading its quality improvement programme. Previously Rachael had been the interim director of nursing at Northampton General Hospital and the national director of nursing at Care UK. Over the last eight years, therefore, Rachael has held a number of senior nursing leadership roles across the acute, community, integrated and independent healthcare settings. Her passion for advancing nursing practice – Rachael has a particular interest in developing roles to support new and innovative models of care – has enabled her to support nursing and midwifery staff at all levels within organisations to make real improvements for the patients in their care. Rachael is a Florence Nightingale Foundation scholar and is working with the Foundation currently on developing a framework for accrediting nursing excellence. I am also pleased to confirm that Liz Lees, the Trust's acting director of nursing and patient experience, will continue in this role until Rachael joins the Trust on 2 January 2018. With this in mind, I would like to thank Liz for her considerable contributions to the Trust in this role over the last year.
2.	**Trust Completes Initial Roll-out of New Electronic Patient Record Computer System** The weekend of 8 to 11 September 2017 saw the Trust roll out of Lorenzo, its new electronic patient record computer system. Lorenzo allows the Trust's staff to have improved access to information about their patients in real-time, which in turn supports clinical decisions being made more quickly. Implementing such a major change is always a challenging time and I would like to record my thanks to all of our staff who have worked hard to minimise any disruption for our patients. There are a number of post implementation challenges that we are still working through to restore key performance reports which will be discussed later in the Board meeting. In addition to Lorenzo, the Trust has also launched a new electronic patient observation system called Nervecentre. This allows clinical staff to enter observations about their patients, such as blood pressure and temperature readings on hand held devices. Not only does Nervecentre do away with traditional hand-written charts, it supports the automatic escalation of patients who are at risk of deteriorating and need urgent review. This represents a significant improvement in patient safety.

3.	**Latest CQC A&E Patient Experience Survey Shows Real Improvement** Patients who took part in the Care Quality Commission's national survey of NHS emergency departments reported improvements in 31 out of 35 categories for the Trust's services compared to the last set of survey results for 2014. Several hundred people locally responded to the CQC, who surveyed patients who used the service in October 2016. The survey covered a range of areas, including: arrival at the emergency department; waiting times; doctors and nurses; care and treatment; diagnostic tests; the hospital's environment and facilities; leaving the emergency department; respect and dignity; and overall experience. It should be noted that whilst we continue to focus on improving performance within our emergency department services, including waiting times, it is clear from this latest survey that our patients have seen real improvements in the quality of care provided by our doctors and nurses. These results are in line with feedback that we have been getting for some time from patients directly through a variety of means – including social media and our Friends and Family Test survey scores. This latest CQC survey suggests that we are moving in the right direction.
4.	**Butterfly Volunteer Team Receives Funding to Help Expand Service** The Trust's Butterfly volunteer team, which supports people in the last days of their lives, has been awarded funding worth a total £64,450 over three years from the Dunhill Medical Trust to help continue and expand the service. The Butterfly volunteer project was first piloted in May last year and the team provides one-to-one companionship for dying patients who have few or no visitors. The team also supports families and carers, providing them with valuable respite whilst they care for loved ones. Over the next three years, the Butterfly volunteer team is aiming to make 6,000 visits. The donation will allow Butterfly volunteer co-ordinator Angela Fenn to continue her role with supporting existing colleagues and recruiting more people to join the current team.
5.	**Lister's A&E Well-being Room Refurbished Thanks to Friends of Lister Donation** The Lister hospital's well-being room in its emergency department has been refurbished, thanks to a donation from the Friends of Lister. The room provides a safe and welcoming area for vulnerable patients to be looked after whilst they wait to be been seen by specialist teams, such as those who help patients suffering with issues relating to their mental health. The Friends of Lister donated £5,000 towards the refurbishment of the room and the East and North Hertfordshire CCG and Hertfordshire Partnership NHS Foundation Trust also agreed to contribute the same amount each. Some of the money has been spent on the installation of a flat-screen TV and upgrading the air conditioning system, which has helped reduce background noise that some patients have found stressful. The room has also been re-painted and new flooring has been added.
6.	**Trust marks Baby Loss Awareness Week with newly refurbished bereavement room** The Trust marked Baby Loss Awareness Week (w/c 9 October 2017) with a newly refurbished maternity bereavement room, thanks to donations from Darcie's Wish and Albie's Football Challenge (via Sands). Although the loss of a baby is a very rare event, the room provides mothers and their families

	with a quiet and comforting environment during what is a difficult time for all involved. A double bed and en-suite bathroom have been added, and the room has also been decorated to make it a more homely environment.
7.	**Purple Star Award for Ambulatory Care at the New QE2** Ambulatory Care at the New QEII have been awarded the Purple Star. The Purple Star is an accreditation to recognise the achievement of a service in improving the health outcomes for people with learning disabilities. Our staff have worked extremely hard to get this accreditation and we have had a huge number of staff trained in how to make reasonable adjustments for people with learning disabilities.
8.	**East and North Herts Institute of Diabetes and Endocrinology Annual Report** East and North Herts Institute of Diabetes and Endocrinology (ENHIDE) has focused on improving the care of young type 1 diabetes patients. The paediatric and adults teams have worked closely together for over 20 years and through the CCG commissioned telehealth project. Their work has received national recognition in the 2016 Quality In Care awards, and has been an exemplar of transitional and acute care of those aged 18-30. The work has been overseen by the Trust's Young Adult and Adolescent committee established and chaired by Dr Peter Winocour. They have also worked together to improve the care of patients with diabetes and kidney disease through local regional and national initiatives. One initiative to reduce the risk of acute kidney injury received national recognition in the 2017 Quality In Care awards. The Renal and Diabetes telehealth project was commissioned by the CCG and has to date reviewed over 100 patients under primary care and use Skype to promote specialist GP consultations. Dr Peter Winocour in ENHIDE has led on the national guideline programme for diabetes and kidney disease.
9.	**Floodlight Scorecard** The current Trust floodlight scorecard is attached as ***(Appendix A).*** Explanation of red indicators is provided within the appropriate accountable Director's report and the reports in the data pack. The Board committee executive summary reports reflect the key discussions that have taken place at both the Finance and Performance and the Risk and Quality Committees. Please note that some of the data is unavailable this month and the report is currently being reviewed to develop as an Integrated Performance Report.

Chief Executive
October 2017

East and North Hertfordshire NHS
NHS Trust

TRUST FLOODLIGHT

DASHBOARD AND SCORECARD 2017/18

September 17 - Month 06

The Purpose of this report is to give an overview of Key Performance Indicators (KPI's) which the Trust have agreed to measure and monitor throughout 2017/18.
The indicators compare to monthly and year-to-date performance targets scoped within quarter 1 of this financial year.
The intended audience is the Executive Team, Operations and Governing Bodies to support strategic design making and identify emerging issues across the Trust.

East and North Hertfordshire NHS
NHS Trust

GUIDANCE

Executive Summary	• Overview of the Trusts performance when compared to targets and historical performance
Dashboard	• High-level visualisation of the Key Performance Indicator Themes grouped to give an indication of overall performance
All KPI's by Theme	•Second level of detail of agree Key Performance Indicators showing change in performance when compared to the previous month.
Trust Floodlight Scorecard	•Further detail on KPI's showing both monthly and year to date performance RAG to in-month and year-to-date targets with change when compared to the previous month
Scorecard 2017/18	•Full detail of the Key Performance Indicators showing month-on-month performance
Targets 2017/18	•Target and threshold set by the Trust for ease of reference.
Data Dictionary	•Link to the Trust Floodlight Data Dictionary which gives detail of how the Key Performance Indicator is calculated, any exceptions, where the information is sourced, system and so on.

Executive Summary September 2017

East and North Hertfordshire NHS
NHS Trust

Trust Overall

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
▲	34	▬	11	▼	37

Highlights:

Lowlights:

Key Findings:

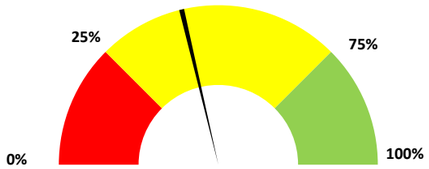
Executive Summary

HSMR figure under review with Medical Director (27/10/17)

Trust Floodlights Dashboard
September 2017 (M06)

1 - Safe

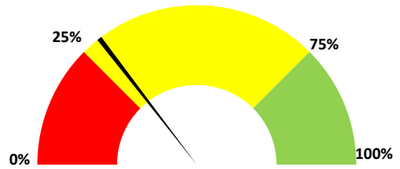
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	9		1		10

2- Effective

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	4		0		3

3 - Responsive - Efficiency

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	2		1		3

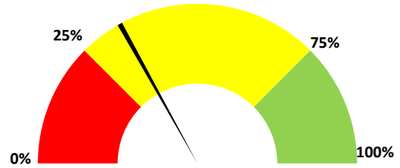
4 - Responsive - Key Targets

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	5		0		10

5 - Caring

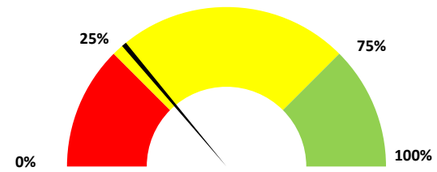
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	1		1		4

6 - Well-Led

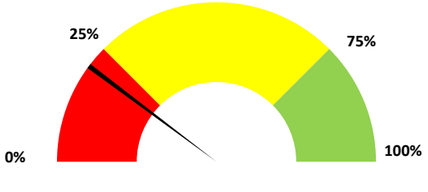
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	6		3		2

7 - Financial Performance

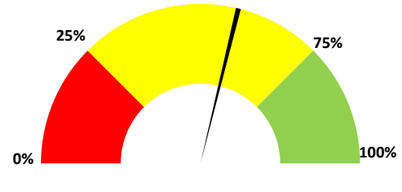
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	3		5		2

8 - Sustainability

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	4		0		3

Trust Floodlights Dashboard
September 2017 (M06)

Monthly Information,
Performance and RAG Rating

SAFE

Patient Safety

ID	Indicator (YTD)	Month Change
1.1	Never Events 2	▼
1.2	Safety Thermometer Patients with Harm 137	▼
1.3	Clostridium Difficile Cases 13	▲
1.4	MRSA Post 48 hours Cases 1	▬
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher 0.14	▼
1.6	Inpatient Falls 3.89	▼
1.7	Ambulance Handovers > 30 mins 223	▲
1.8	Fill Rate RNs (%) 94.7	▼
1.9	Fill Rate RNs Unreg (%) 94.6	▲

Training

ID	Indicator (YTD)	Month Change
1.10	Statutory Mandatory Training 86.41	▼
1.11	Safeguarding Adults Training 87.0	▼
1.12	Safeguarding Children Training 87.2	▼
1.13	Competancy Coverage 63.8	▼

Health & Safety

ID	Indicator (YTD)	Month Change
1.14	RIDDOR Incidents 0.45	▲
1.15	Musculosketal Injuries Reported 0.95	▲
1.16	Physical Assault Incidents 1.31	▲
1.17	Manager Referrals to OH for Stress 0.66	▲
1.18	Staff Slips, Trips & Falls 0.86	▲
1.19	Staff Sharps Injuries 2.08	▲

EFFECTIVE

Mortality

ID	Indicator (YTD)	Month Change
2.1	HSMR - 3 month lag 95.0	▼
2.2	SHMI - 6 month lag 102.69	▼
2.3	SHMI (Palliative Care Adjustment) - 6 month lag 93.8	▼

Admissions

ID	Indicator (YTD)	Month Change
2.4	Medical & Surgical Patient Outliers 85	▲
2.5	Number of Patients with LOS > 14 days 112	▲
2.6	LOS - Non Elective 3.8	▲
2.7	Readmissions 7.6	▲

FINANCIAL PERFORMANCE

Single Oversight Framework - Finance and Use of Resources Metrics

ID	Indicator (YTD)	Month Change
7.1	Capital Servicing Capacity 4	▬
7.2	Liquidity Ratio (days) 3	▬
7.3	I&E Margin 4	▬
7.4	Distance from financial plan 3	▲
7.5	Agency spend variance from ceiling 1	▬
7.6	Overall Finance Metric 3	▬

Other Financial Metrics

7.7	Pay Spend 101.0	▼
7.8	Capital Plan Trajectory 44	▼
7.9	CIP Plan delivered 66	▲
7.10	Cash Plan 253	▲

RESPONSIVE-EFFICIENCY

ID	Indicator (YTD)	Month Change
3.1	New to Follow-Up Ratio 2.21	▼
3.2	Overnight Bed Occupancy Rate 87.3	▬
3.3	Pre OP bed days (elective) 3.3	▼
3.4	Delayed Transfer of Care 32	▼
3.5	Post Acute Transfer Delays	
3.6	Ward Discharges before Midday 14	▲
3.7	Cancelled Ops - on Day 445	▼
3.8	Number of Discharges from Discharge Lounge	

RESPONSIVE-KEY TARGETS

ID	Indicator (YTD)	Month Change
4.1	A&E 4 hour Target 86.7	▲
4.2	RTT Admitted 73.2	▲
4.3	RTT Non Admitted 85.5	▼
4.4	RTT - Open Pathways 85.7	▼
4.5	RTT Patients Waiting > 18 weeks 4834	▼
4.6	Diagnostic Waits < 6 weeks 98.7	▼
4.7	Cancer 2week Ref to Appt 98.2	▲
4.8	Cancer 31day : Diag 91.0	▼
4.9	Cancer 62day : Urgent RTT inc ITP transfers 72.7	▼
4.10	TIA: High Risk treatment within 24 hrs 67.8	▼
4.11	TIA: Low Risk treatment within 7 days from 1st contact 86.2	▲
4.12	4 hrs direct to Stroke Unit 78.6	▼
4.13	90% of time on the Stroke Unit 87.3	▲
4.14	60 minutes to scan 92.7	▼
4.15	Thrombolysed within 3 hrs 6.1	▼

CARING

ID	Indicator (YTD)	Month Change
5.1	Inpatient FFT % of patients would recommend 97.4	▼
5.2	FFT Response Rate % 39.6	▼
5.3	Friends & Family Recommend Place of Care 74.4	
5.4	Complaints - % received telephone call 100.0	▬
5.5	% of Complaints concluded within agreed timeframe 65.0	▲
5.6	GP Enquiries Response Rate - Routine 60.0	
5.7	GP Enquiries Response Rate - Urgent 18.0	

SUSTAINABILITY

ID	Indicator (YTD)	Month Change
8.1	GP referrals Received - 2WW 4908	▲
8.2	GP referrals Received - non 2WW 48036	▼
8.3	A&E Attendances 75048	▲
8.4	Elective Spells (PBR) 23263	▲
8.5	NonElective Spells 22312	▼
8.6	OP Attendances/Procs (Total) 218276	▼
8.7	Outpatient DNA Rate 8.1	▼
8.8	Theatre Utilisation	

WELL-LED

ID	Indicator (YTD)	Month Change
6.1	Continuity of Services Risk Rating	
6.2	Risk register	▬
6.3	CQC Outcomes	▬
6.4	NHSI Governance Risk Rating 3	▬
6.5	Friends & Family Recommend Place of Work 52.4	▲
6.6	Vacancy Rate % 8.9	▼
6.7	Vacancy rate (Baseline) 8.4	▲
6.8	Bank Staff Usage 9.39	▲
6.9	Agency Staff Usage 4.3	▲
6.10	Sickness % 3.39	▲
6.11	Substantive Staff Turnover 12.7	▼
6.12	Appraisal Rate 80.72	▼

Trust Floodlights Dashboard
September 2017 (M06)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
1.1	Never Events	0		2	1		▼	
1.2	Safety Thermometer Patients with Harm	336	168	137	21		▼	
1.3	Clostridium Difficile Cases	11	5	13	2		▲	
1.4	MRSA Post 48 hours Cases	0		1	0		▬	
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.14	0.24		▼	
1.6	Inpatient Falls	3.17		3.89	3.75		▼	
1.7	Ambulance Handovers > 30 mins	2604	868	223	43		▲	
1.8	Fill Rate RNs (%)	90		94.7	92.1		▼	
1.9	Fill Rate RNs Unreg (%)	90		94.6	92.3		▲	
1.10	Statutory Mandatory Training	90		86.4	86.4		▼	
1.11	Safeguarding Adults Training	90		87.0	87.0		▼	
1.12	Safeguarding Children Training	90		87.2	87.2		▼	
1.13	Competancy Coverage	85		63.8	63.8		▼	
1.14	RIDDOR Incidents	0.56		0.45	0.17		▲	
1.15	Musculosketal Injuries Reported	1.09		0.95	0.85		▲	
1.16	Physical Assault Incidents	1.13		1.31	1.53		▲	
1.17	Manager Referrals to OH for Stress	0.57		0.66	0.51		▲	
1.18	Staff Slips, Trips & Falls	1.18		0.86	0.85		▲	
1.19	Staff Sharps Injuries	2.00		2.08	2.21		▲	

2 - EFFECTIVE

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.1	HSMR - 3 month lag	94	95.0			▼	
2.2	SHMI - 6 month lag	100	102.7			▼	
2.3	SHMI (Palliative Care Adjustment) - 6 month lag	95	93.8			▼	
2.4	Medical & Surgical Patient Outliers	50	85			▲	
2.5	Number of Patients with LOS > 14 days	100	112			▲	
2.6	LOS - Non Elective	3.5	3.8	3.3		▲	
2.7	Readmissions	7.75	7.6	6.1		▲	

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	New to Follow-Up Ratio	2	2.21	2.21		▼	
3.2	Overnight Bed Occupancy Rate	85	87.3	88.4		▬	
3.3	Pre OP bed days (elective)	6	3.3	4.5		▼	
3.4	Delayed Transfer of Care	8	32	11		▼	
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed					
3.6	Ward Discharges before Midday	13	14.1	15.3		▲	
3.7	Cancelled Ops - on Day	504	445	74		▲	
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection to be confirmed					

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	A&E 4 hour Target	95		86.7	86.8		▲	
4.2	RTT Admitted	0		73.2	70.9		▲	
4.3	RTT Non Admitted	0		85.5	82.5		▼	
4.4	RTT - Open Pathways	92		85.7	85.7		▼	
4.5	RTT Patients Waiting > 18 weeks	1231		4834	4834		▼	
4.6	Diagnostic Waits < 6 weeks	99		98.7	96.7		▼	
4.7	Cancer 2week Ref to Appt	93		98.2	97.6		▲	
4.8	Cancer 31day : Diag	96		91.0	92.1		▼	
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		72.7	72.2		▼	
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.8	51.6		▼	
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.2	96.6		▲	
4.12	4 hrs direct to Stroke Unit	90		78.6	71.6		▼	
4.13	90% of time on the Stroke Unit	80		87.3	88.9		▲	
4.14	60 minutes to scan	90		92.7	87.8		▼	
4.15	Thrombolysed within 3 hrs	12		6.1	4.8		▼	

5 - CARING

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
5.1	Inpatient FFT % of patients would recommend	95		97.4	97.4		▼	
5.2	FFT Response Rate %	40		39.6	39.6		▼	
5.3	Friends & Family Recommend Place of Care	76		74.4	74.4			
5.4	Complaints - % received telephone call	85		100.0	100.0		▬	
5.5	% of Complaints concluded within agreed timeframe	75		65.0	77.0		▲	
5.6	GP Enquiries Response Rate - Routine	80		60.0	60.0		▼	
5.7	GP Enquiries Response Rate - Urgent	95		18.0	18.0		▼	

6 - WELL-LED

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
6.1	Continuity of Services Risk Rating	0	0	0			
6.2	Risk register	1	3	0		▬	
6.3	CQC Outcomes	1	2	0		▬	
6.4	NHSI Governance Risk Rating	4	3	0		▬	
6.5	Friends & Family Recommend Place of Work	61	52.42	52.42		▲	
6.6	Vacancy Rate %	10	8.9	8.9		▼	
6.7	Vacancy rate (Baseline)	5	8.38	8.38		▲	
6.8	Bank Staff Usage	9	9.39	9.39		▲	
6.9	Agency Staff Usage	7	4.3	4.3		▲	
6.10	Sickness %	3.5	3.39	3.39		▲	
6.11	Substantive Staff Turnover	11	12.71	12.71		▼	
6.12	Appraisal Rate	85	80.72	80.72		▼	

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
7.1	Capital Servicing Capacity	1		4.0	4.0		▬	
7.2	Liquidity Ratio (days)	1		3.0	3.0		▬	
7.3	I&E Margin	1		4.0	4.0		▬	
7.4	Distance from financial plan	1		3.0	3.0		▲	
7.5	Agency spend variance from ceiling	1		1.0	1.0		▬	
7.6	Overall Finance Metric	1		3.0	3.0		▬	
7.7	Pay Spend	100		101.0	101.0		▼	
7.8	Capital Plan Trajectory	90		44.0	44.0		▼	
7.9	CIP Plan delivered	100		66.0	66.0		▲	
7.10	Cash Plan	90		253.0	253.0		▲	

8 - SUSTAINABILITY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
8.1	GP referrals Received - 2WW			4908	1175		▲	
8.2	GP referrals Received - non 2WW			48036	7584		▼	
8.3	A&E Attendances	147144	73759	75048	12384		▲	
8.4	Elective Spells (PBR)	37060	18530	23263	5185		▲	
8.5	NonElective Spells	46703	23006	22312	3543		▼	
8.6	OP Attendances/Procs (Total)	471770	235886	218276	29003		▼	
8.7	Outpatient DNA Rate	8		8.079194	10.23992		▼	
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed						

Key: Monthly Change

▲	Improvement in monthly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly performance

Trust Floodlight Scorecard - The Scorecard shows a summary of performance against each KPI. The KPIs are displayed in the KPI Groups and contain the details of the Target set for 2017/18 and the Target YTD if this is different. The Actual YTD and Actual month performance are detailed separately even if the YTD is the same as the monthly figure. The RAG rating for the month is derived from comparing the monthly reported data against the monthly target. the Month change indicator reflects whether performance has improved, stayed the same or declined when compared to last month. the RAG for YTD is a comparison of the YTD performance for the KPI against the target levels.

Trust Floodlights Dashboard September 2017 (M06)

Monthly Information, Performance and RAG Rating

1 - SAFE																							
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1	Never Events	0		2	1				0	1	0	0	0	1						
1.2	Safety Thermometer Patients with Harm	336	168	137	21				20	24	34	20	18	21						
1.3	Clostridium Difficile Cases	11	5	13	2				2	2	3	4	2							
1.4	MRSA Post 48 hours Cases	0		1	0				0	0	1	0	0							
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.14	0.24				0.000	0.189	0.100	0.000	0.243							
1.6	Inpatient Falls	3.17		3.89	3.75				2.70	2.41	3.10	3.27	3.75							
1.7	Ambulance Handovers > 30 mins	2604	868	223	43				42	94	44	43		One month in arrears						
1.8	Fill Rate RNs (%)	90		95	92				96.1	96.3	95.7	94.1	93.6	92.1						
1.9	Fill Rate RNs Unreg (%)	90		95	92				104.3	94.8	91.5	93.3	91.4	92.3						
1.10	Statutory Mandatory Training	90		86.4	86.4				89.3	87.8	88.3	87.3	87.5	86.4						
1.11	Safeguarding Adults Training	90		87.0	87.0				90.5	89.2	89.5	88.2	87.5	87.0						
1.12	Safeguarding Children Training	90		87.2	87.2				91.1	89.6	90.0	88.8	88.0	87.2						
1.13	Competancy Coverage	85		63.8	63.8				66.4	64.0	64.8	64.1	64.8	63.8						
1.14	RIDDOR Incidents	0.56		0.45	0.17				0.36	0.54	0.90	0.36	0.36	0.17						
1.15	Musculosketal Injuries Reported	1.09		0.95	0.85				0.91	0.54	1.45	0.54	1.44	0.85						
1.16	Physical Assault Incidents	1.13		1.31	1.53				0.73	0.00	1.81	1.61	2.16	1.53						
1.17	Manager Referrals to OH for Stress	0.57		0.66	0.51				1.09	0.36	0.18	0.54	1.26	0.51						
1.18	Staff Slips, Trips & Falls	1.18		0.86	0.85				0.18	0.90	1.27	1.08	0.90	0.85						
1.19	Staff Sharps Injuries	2.00		2.08	2.21				1.99	1.27	2.17	2.15	2.70	2.21						
2 - EFFECTIVE																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.1	HSMR - 3 month lag	94.0		95.0					95.0	95.0	94.4	93.7	92.50	95.0						
2.2	SHMI - 6 month lag	100		102.7					n/a	n/a	102.3	n/a	n/a	102.7						
2.3	SHMI (Palliative Care Adjustment) - 6 month lag	95.0		93.8					n/a	n/a	92.9	n/a	n/a	93.8						
2.4	Medical & Surgical Patient Outliers	50		85					91	91	88	108	85							
2.5	Number of Patients with LOS > 14 days	100		112					172	148	129	116	126	112						
2.6	LOS - Non Elective	3.5		3.8	3.3				3.8	4.0	3.8	3.6	4.1	3.3						
2.7	Readmissions	7.75		7.57	6.1				8.7	8.1	7.7	7.7	7.1	6.1						
3 - RESPONSIVE - EFFICIENCY																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	New to Follow-Up Ratio	2.0		2.21	2.21				2.19	2.18	2.16	2.15	2.14	2.21						
3.2	Overnight Bed Occupancy Rate	85		87.30	88.44				84.8	87.5	88.4	88.4								
3.3	Pre OP bed days (elective)	6		3.30	4.5				4.1	2.1	2.5	4.5		One month in arrears						
3.4	Delayed Transfer of Care	8		32	11				5	0	3	10	3	11						
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed																		
3.6	Ward Discharges before Midday	13.0		14.1	15.3				14.5	14.0	13.2	13.0	14.3	15.3						
3.7	Cancelled Ops - on Day	504	210	445	74				46	71	157	97	74							
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection to be confirmed																		
4 - RESPONSIVE - KEY TARGETS																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	A&E 4 hour Target	95		86.7	86.8				89.23	84.07	87.53	87.77	85.06	86.77						
4.2	RTT Admitted	0		73.2	70.9				74.8	78.8	73.6	67.8	70.9	No Submission						
4.3	RTT Non Admitted	0		85.5	82.5				87.2	86.0	88.6	83.1	82.5	No Submission						
4.4	RTT - Open Pathways	92		85.7	85.7				92.2	90.5	88.9	87.4	85.7	No Submission						
4.5	RTT Patients Waiting > 18 weeks	1231		4834	4834				2022	2436	3191	4140	4834	No Submission						
4.6	Diagnostic Waits < 6 weeks	99		98.7	96.7				99.72	99.00	99.55	96.65	No Submission	One month in arrears						
4.7	Cancer 2week Ref to Appt	93		98.2	97.6				98.6	98.3	98.2	98.7	97.6	97.6						
4.8	Cancer 31day : Diag	96		91.0	92.1				93.0	86.3	90.3	90.7	93.8	92.1						
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		72.7	72.2				73.5	77.9	71.0	66.4	74.9	72.2						
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.8	51.6				91.7	57.9	60.0	73.7	82.4	51.6						
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.2	96.6				88.0	81.3	79.3	86.7	81.0	96.6						
4.12	4 hrs direct to Stroke Unit	90		78.6	71.6				82.5	76.6	77.6	78.6	71.7	71.6						
4.13	90% of time on the Stroke Unit	80		87.3	88.9				88.9	91.4	88.5	88.0	83.9	88.9						
4.14	60 minutes to scan	90		92.7	87.8				95.2	91.7	87.8	96.2	92.9	87.8						
4.15	Thrombolysed within 3 hrs	12		6.1	4.8				10.8	6.6	9.0	14.3	6.3	4.8						
5 - CARING																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	Inpatient FFT % of patients would recommend	95		97.4	97.4				96.6	97.0	97.2	97.5	97.5	97.4						
5.2	FFT Response Rate %	40		39.6	39.6				52.84	51.45	44.06	49.11	44.16	39.61						
5.3	Friends & Family Recommend Place of Care	76.0		74.4	74.4				75.0			74.4								
5.4	Complaints - % received telephone call	85		100.0	100				100	100	100	100	100	100						
5.5	% of Complaints concluded within agreed timeframe	75		65.0	77				68	74	67	53	51	77						
5.6	GP Enquiries Response Rate - Routine	80		60.0	60.0				58	74	86	89	60	One month in arrears						
5.7	GP Enquiries Response Rate - Urgent	95		18.0	18.0				100	80	100	100	18	One month in arrears						
6 - WELL-LED																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
6.1	Continuity of Services Risk Rating								Metric removed in September 2016.											
6.2	Risk register	1		3					3	3	2	3	3	3						
6.3	CQC Outcomes	1		2					2	2	2	2	2	2						
6.4	NHSI Governance Risk Rating	4		3					3	3	3	3	3	3						
6.5	Friends & Family Recommend Place of Work	61		52.4	52.4				46.60			52.42								
6.6	Vacancy Rate %	10		8.9	8.9				12.13	9.66	10.71	8.56	8.92	8.90						
6.7	Vacancy rate (Baseline)	5.0		8.4	8.4				5.48	9.02	9.07	8.09	8.43	8.38						
6.8	Bank Staff Usage	9		9.4	9.4				5.9	8.23	5.9	10.22	8.61	9.39						
6.9	Agency Staff Usage	7		4.3	4.3				5.4	5.7	5.34	5.68	4.93	4.3						
6.10	Sickness %	3.5		3.4	3.4				3.64	3.62	3.58	3.46	3.41	3.39						
6.11	Substantive Staff Turnover	11.0		12.7	12.7				13.2	13.2	13.2	12.8	12.6	12.7						
6.12	Appraisal Rate	85		80.7	80.7				81.9	82.7	83.7	84.2	85.4	80.7						
7 - FINANCIAL PERFORMANCE																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Capital Servicing Capacity	1		4	4				4	4	4	4	4	4						
7.2	Liquidity Ratio (days)	1		3	3				3	3	3	3	3	3						
7.3	I&E Margin	1		4	4				4	4	4	4	4	4						
7.4	Distance from financial plan	1		3	3				2	4	1	2	4	3						
7.5	Agency spend variance from ceiling	1		1	1				1	1	1	1	1	1						
7.6	Overall Finance Metric	1		3	3				3	3	3	3	3	3						
7.7	Pay Spend	100		101	101.0				97.0	98.0	96.0	100.0	100.0	101.0						
7.8	Capital Plan Trajectory	90		44	44.0				13	108.2	149	84	89	44						
7.9	CIP Plan delivered	100		66	66.0				122	107	120	102	61	66						
7.10	Cash Plan	90		253	253.0				146.5	131.0	135.6	124.2	117.7	253.0						
8 - SUSTAINABILITY																				
ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	GP referrals Received - 2WW			4908	1175				532	649	795	870	887	1175						
8.2	GP referrals Received - non 2WW			48036	7584				7671	8537	8432	8036	7776	7584						
8.3	A&E Attendances	147144	73759	75048	12384				12354	12706	12835	12849	11920	12384						
8.4	Elective Spells (PBR)	37060	18530	23263	5185				2947	3285	3347	3553	4946	5185						
8.5	NonElective Spells	46703	23006	22312	3543				3691	3747	3876	3780	3675	3543						
8.6	OP Attendances/Procs (Total)	471770	235886	218276	29003				33886	41380	42996	39670	31341	29003						
8.7	Outpatient DNA Rate	8		8.1	10.24				7.21	8.07	7.52	7.22	8.22	10.24						
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed																		

Agenda Item: 9

TRUST BOARD MEETING – 1 NOVEMBER 2017

FINANCE AND PERFORMANCE COMMITTEE – 25 OCTOBER 2017
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board Development meeting the report from the Finance and Performance Committee (FPC) meeting of 25 October 2017
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	CHAIRMAN OF FPC
PRESENTED BY:	CHAIRMAN OF FPC
AUTHOR:	BOARD COMMITTEE SECRETARY/COMPANY SECRETARY
DATE:	25 October 2017

We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement

FINANCE AND PERFORMANCE COMMITTEE – 25 OCTOBER 2017

EXECUTIVE SUMMARY REPORT TO BOARD – 1 NOVEMBER 2017

The following members were present: Alison Bexfield (acting Chair), Ellen Schroder (Trust Chair), Nick Swift (incoming Chair), Jonathan Silver (designate Non-executive Director)

Other Directors/core attendees in attendance: Nick Carver (Chief Executive), Jude Archer (Company Secretary), Martin Armstrong (Director of Finance).

DECISIONS MADE UNDER DELEGATED AUTHORITY:

The Finance and Performance Committee (FPC) made no decisions on behalf of the Trust under the authority delegated to it within its terms of reference.

OUTCOMES:

Digital Transformation Programme update
The FPC was briefed on the latest position post Lorenzo and Nervecentre implementation. The Trust continues to address a number of material stabilisation challenges. The daily validation process to support accurate daily A&E performance reporting continues to be a major call upon operational resources. Actions to support the availability and maintenance of PTL's is a key priority for the Trust. In addition planning and scheduling of outpatient clinics from Lorenzo remains a key concern. A Daily Recovery Board has been established to track progress with resolving the current challenges with the system to ensure these are addressed with pace. A further date and assurance will be provided to Part 2 Board.

Financial Report Month 6
The FPC received the Month 6 Finance report highlighting that the Trust reported a £1.4m deficit in month, bringing the year to date position to a £16.8m deficit. The SLA income for September activity shows a £1.1m adverse variance, but this is mainly offset by a positive impact of £1.0m from the refresh of August activity. There is now a £7.9m shortfall on SLA income for the year to date. In month CIP delivery was £1.5m. This was £670k adverse to plan, the planned savings required stepped up significantly in Month 6.

Underperformance of non-elective activity relates to both accurate data capture and coding of activity. Actions are in place and income recovery plans are now monitored weekly. Reporting has now been resolved following the Lorenzo implementation. Weekly tracking methods are in place to monitor delivery of plans and flag up any potential risks in order to mitigate them promptly.

Financial Improvement Plan Progress Report
The Committee received and discussed a summary to date of the Financial Improvement Plan report. This included: Recent Financial Results; FOT 2017/18 & Key Assumptions; Key Risks to 2017/18 Position; Key Actions Already Undertaken; Accountability Framework and, Key Next Steps. Activity Recovery Plans continue to be reviewed to ensure that the Trust reduces the deficit. This is monitored on a weekly basis and CIP plans are tracked to ensure that activity and income fall back in line with trajectory.

Clinical Coding and Data Capture Issues update
The FPC discussed the latest position of Clinical Coding and the Data Capture Issues. The Trust outturn forecast mitigation plan has set out a target of legitimately improving the run rate of non-elective activity valuation by £1.5m between November and March through the delivery of the improvement plan. The Trust has previously under coded and the FPC discussed the possibility of recovering this through CCG. External reviews have been commissioned to ensure clinical coding is in line with best practice and inform the action plan to address the issues going forward.

Workforce Report Month 6
The FPC received the Month 6 Workforce report. Key highlights included:

- The monthly agency ceiling target was achieved, year to date the Trust is under the ceiling target by £1,879k;

- A recognition scheme has been set up to identify departments that have removed all agency staffing gaining an 'Agency Free Zone' status;
- The Trust's vacant posts for Band 5 Registered Nurses at the end of September 2017 was 132.9 WTE, this equates to a 15.6% vacancy rate which represents a decrease on August's 17.8% Band 5 Nurse vacancy rate;
- Last month was the first full month of shared bank and the Trust now manages the North and East
- eRosters are now moving forward with middle grade staff. When in place, this will allow for a more stringent appraisal process.

Performance Report Month 6
The FPC received the Month 6 Performance report and discussed targets. Key points included:

- RTT – this has not been reported on since Lorenzo Go Live; however, data validation resources are in place for reporting to resume by the end of November;
- ED Performance – external daily reporting resumed last week following Lorenzo Go Live;
- Ambulance handover time – the 10 minute handover time has been maintained and the Trust remains the best in the region;
- Cancer – 62 day performance reports an improving trajectory. September is tracking at 79.8% which is a significant improvement on the past 16 months. The number of patients waiting over 100 days is down to 18.5, the lowest recorded in recent times;
- Stroke is consistently delivering SNAPP rating of A which the highest to be reported.

The Committee acknowledged the new COO is making changes and improvements are evident.

Data Quality update
The FPC received a report from the new Head of Data Quality. Areas for improvement have promptly been identified and an action plan is in place. A 'Ward Clerk Forum' has been established to provide support to staff ensuring that correct procedures for data inputting are followed. These measures will support the capabilities of the Lorenzo programme going forward.

Securing Pathology Services at ENHT 2018-19 update
The FPC noted the Securing Pathology Services at ENHT 2018-19 update. The current contract with Cambridge will continue until a new the Trust procures a new provider.

OTHER MATTERS:

Floodlight Scorecard Month 6
The FPC noted that the new integrated Floodlight Scorecard is still under review; however, it was agreed that the current format should be presented to the Committee until the new format is finalised.

Finance Risk Register
The FPC received and discussed the format of the Finance Risk Register. This will be updated and return to the Committee on a monthly basis.

Market Report
The FPC noted the Market report and it was agreed that this should be used more widely as a forecasting tool and support operational strategic decisions/responses.

Procurement update
The FPC noted the Procurement update report.

Alison Bexfield
Chairman (acting)

25 October 2017

Agenda Item: 9.1

TRUST BOARD PART 1 – 1 NOVEMBER 2017

FINANCE REPORT MONTH 6

PURPOSE	To set out the Trust's financial position for Month 6.
PREVIOUSLY CONSIDERED BY	FPC
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial risks are described in the main report
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

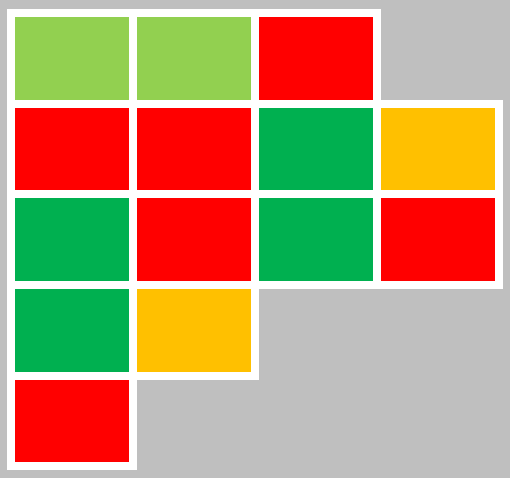
DIRECTOR:	Director of Finance
PRESENTED BY:	Director of Finance
AUTHOR:	Director of Finance
DATE:	October 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

***** tick applicable box

East and North Hertfordshire NHS
NHS Trust

Finance Report



Month 6 - 2017/18

Mth 6 Finance Report - Commentary

KEY BOARD MESSAGES

- Pay and non-pay expenditure levels remains at reduced run rates and below budget plan
- SLA income levels are still significantly below plan
- Poor utilisation of planned capacity remains a significant issue that requires immediate redress, it also results in poor performance against some CIP targets
- The accurate and comprehensive capture and coding of activity remains a high priority

SUMMARY

- The Trust reported a £1.4m deficit in month, bringing the year to date position to a £16.8m deficit, an adverse variance against plan of £2.1m for the year to date.
- There has been a £0.2m adverse variance against in plan in month, after removing the impact of STF funding.
- As a result of the adverse year to date variance, the Trust has assumed that it will not be eligible for STF funding in Qtr 2.
- The SLA income for September activity shows a £1.1m adverse variance, but this is mainly offset by a positive impact of £1.0m from the refresh of August activity. There is now a £7.9m shortfall on SLA income for the year to date.
- The adverse SLA income receipts are being partially offset by pay and non-pay underspends in the year to date position.
- Savings performance during September fell short of plan, with the theatre and outpatient productivity savings not achieving the anticipated levels of activity.

EXCEPTIONAL ITEMS

- The normalised I & E run rate analysis presents exceptional items.
- The month 6 reported position assumes that the Trust will not receive any STF funding for quarter two. The Trust expects to receive quarter one of the funding only (£1.3m).
- The SLA income in month has had a positive benefit from the refresh of Month 5 income, as well as from reaching agreement with the ENH CCG regarding receipt of renal CQUIN income, which had previously been disputed.
- There has been an adverse impact on the outpatient activity in month, as planned in the first two weeks following Lorenzo go live the Trust reduced capacity.
- There is also a tranche of costs for Consultancy expenses that relate to the Financial Recovery Plan.

SLA ACTIVITY & INCOME PERFORMANCE

- The Trust continues to report significant under performance against its SLA plan. This adverse variance now totals £7.8m as at M6. However, the level of underperformance has slowed from M5. The material drivers of the shortfall are detailed below:

Issue	Impact
Reduced Elective Activity - DC & EL	£1.7m
Non-elective - reduced volume & casemix	£2.6m
Outpatient activity below plan	£1.6m
Reduced Maternity Antenatal bookings	£1.0m
Cyber Attack - reduced activity	£0.7m

- The Trust planned for a 20% reduction in OP capacity for the two week period around the cut over to Lorenzo in September. While most specialities did see a return to expected levels of delivery after this, some specialties appear to remain in a low delivery mode. This is being investigated within Divisions to ensure that all activity has been captured in the new system.

Mth 6 Finance Report - Commentary

- Day case activity throughput continued to increase during September, whilst Elective work saw a slight decrease. Elective activity is now some 500 cases or £1.7m behind plan.
- Non Elective inpatient activity saw a marked decrease in September to the lowest levels of activity recorded this year. Non Elective is now just under 700 spells below plan, equating to £2.6m in financial underperformance.
- Work is ongoing to investigate the apparent decline in depth of coding and both the timely and accurate capture of all activity undertaken within the Trust. External reviews of the Trusts coding are currently being undertaken to highlight areas of potential opportunity.
- The volume and income associated with WLI activity has reduced materially compared with prior years. However, separate analysis within the report demonstrates that the impact on the Trust financial bottom line is minimal given the small contribution generated by this activity i.e. reduced income is offset by reduced cost.

DIVISIONAL FINANCIAL PERFORMANCE

- Medicine, Surgery and Women & Children's divisions report significant adverse variances for the year to date against agreed budgets. In each case this is predominantly driven by under performance on SLA income/activity.

YEAR ON YEAR COMPARISON

- Income levels are now showing a £9.5m reduction compared to the same period in 2016/17. However, at this period last year, the Trust was incorrectly assuming significant income values that was later found not to be due and payable (£5.8m). STF receipts were also higher £3.8m higher in 16/17 at M6.
- Elective activity is 8% down on previous year, although this is partially offset by an increase in daycase activity.
- Non elective activity is down 2%, year on year. This is atypical compared with other local providers and the national picture.
- Both Outpatient first and follow up attendances, as well as outpatient procedures, are significantly below volumes delivered last year – 7% reduction.
- Pay expenditure in 17/18 compared to the same period last year, this includes the impact of the current year pay award and the transfer of Pathology staff from CUH.

PAYBILL METRICS

- The Trust reported an over spend of £180k against its pay budget in September. Pay budgets are underspent by £2.5m in the year to date.
- Approximately £114k of backdated pay arrears were incurred in September relating to a locum Consultant and additional locum pathology sessions.
- Agency expenditure is £6.5m year to date, which is significantly lower than the £14.1m incurred in the same period in 2016/17. Agency expenditure is below the NHSI agency ceiling target at M6. The Trust has moved a significant element of medical agency spent into a locum setting.
- Further work is required to reduce medical locum spend as the rates currently paid in many cases continue to significantly exceed national agency caps.
- The Trust continues to target recruitment into its substantive work force but September numbers remained static when compared to the previous month.

Mth 6 Finance Report - Commentary

CIP PERFORMANCE METRICS

- The Trust has delivered £9.7m savings in the year to date, against a plan of £8.2m.
- This assessment includes the impact of below pay budget expenditure that has resulted from better than planned impacts from Grip and Control arrangements.
- In month CIP delivery was £1.5m. This was £670k adverse to plan, the planned savings required stepped up significantly in M6.
- The theatre and outpatient efficiency schemes, in particular, are not delivering to the scale anticipated. There continues to be 'daily drumbeat' meetings, weekly information assurance meeting and CIP meetings, to ensure that savings increase in future months.
- Divisions have produced CIP forecasts, which are being challenged at Executive led sessions regarding year end forecasts.

CASH

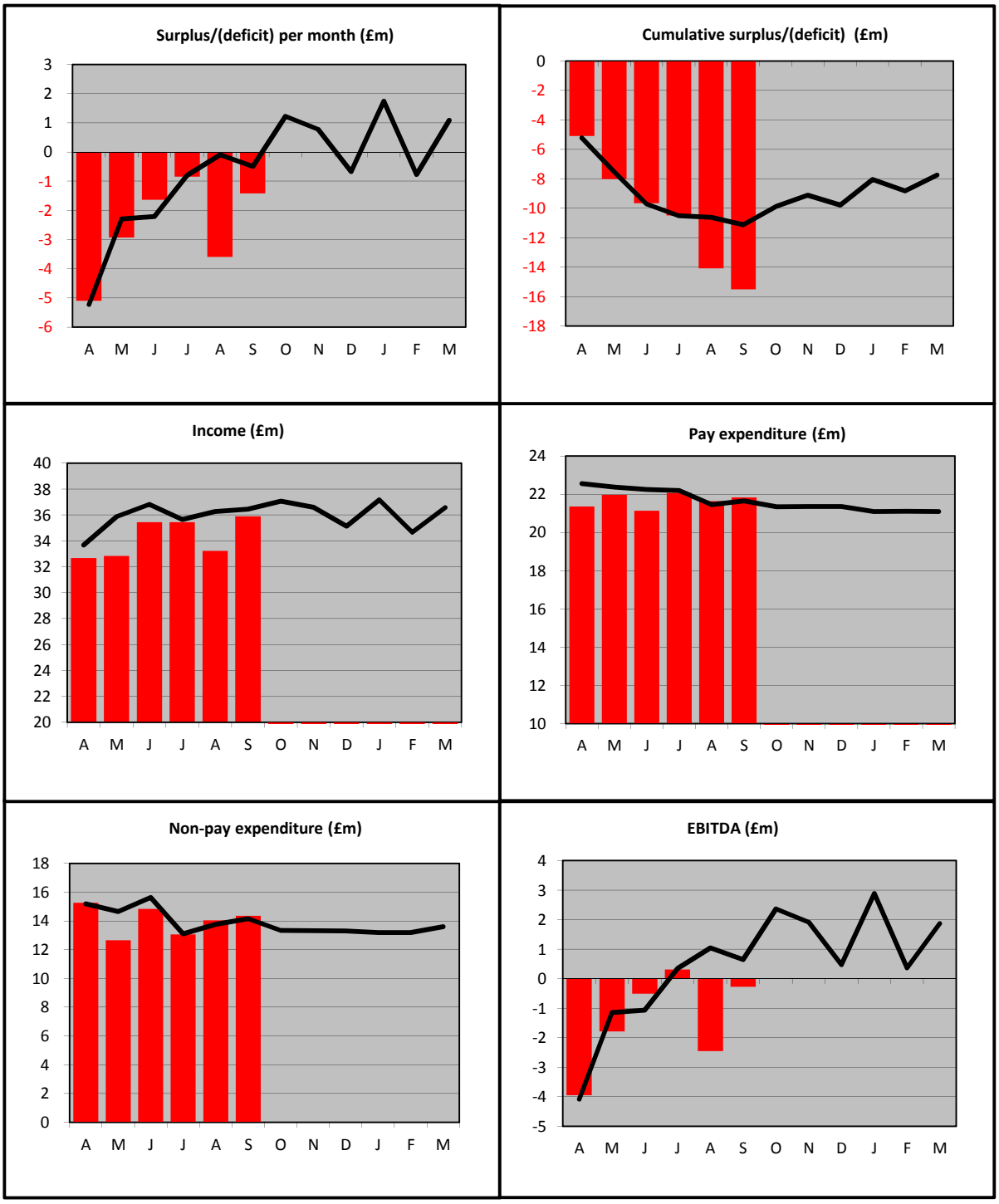
- If the Trust does not achieve its planned levels of income and expenditure, including receipt of Strategic Transformation Fund monies this will result in a cash shortfall that will need to be actively managed. This may include further applications to the Department of Health for additional borrowing facilities. Also, the Trust will need to manage the creditor portfolio with a view to extending creditor payment terms.

CAPITAL AND BALANCE SHEET

- Owing to the Trust's current financial position the internally generated resources for capital expenditure are very restricted which has led to a limited capital programme. This programme has been revised in order to accommodate enabling works for a funded replacement linac and the pressure of an extended Lorenzo launch. However, the Trust is currently still on track to deliver the amended and re-phased plan.

Summary Financial Performance

	Annual Plan £m	Budget Mth £m	Actual Mth £m	Variance mth £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	421.8	35.8	35.9	0.1	211.2	204.2	-6.9
Pay	-259.9	-21.7	-21.8	-0.2	-132.5	-130.0	2.5
Non Pay	-166.5	-14.2	-14.3	-0.2	-86.5	-84.2	2.3
EBITDA	-4.6	-0.0	-0.3	-0.2	-7.8	-10.0	-2.1
Financing Costs	-13.4	-1.1	-1.1	0.0	-6.9	-6.8	0.0
STF Monies	10.2	0.7	-0.0	-0.7	3.6	1.3	-2.3
Retained Deficit	-7.7	-0.5	-1.4	-0.9	-11.1	-15.5	-4.4



Income & Expenditure Account Overview

	Annual Plan £000's	Actual £000's						Monthly Plan £000's	Monthly Actual £000's	Monthly Var £000's	Plan to Date £000's	Actual to Date £000's	Var to Date £000's
		Apr	May	Jun	Jul	Aug	Sep						
Catering Income	1,153	90	93	81	80	32	122	96	122	26	575	499	-76
NHS Non Patient Care Income	1,931	323	144	141	207	130	201	146	201	55	1,053	1,147	94
NHS Patient Care Income	382,655	28,969	29,160	31,494	31,586	30,781	31,896	32,053	31,896	-157	191,641	183,886	-7,756
Other Income Category C	20,471	1,414	1,412	1,477	1,474	312	1,150	1,587	1,150	-438	8,719	7,239	-1,479
Other Patient Care Income	66	4	4	4	4	5	4	5	4	-2	32	25	-7
Private Patients	5,069	308	356	466	348	328	326	425	326	-99	2,516	2,132	-384
R&D Income	5,081	468	399	448	416	395	447	424	447	23	2,539	2,572	33
RTA Income	1,173	-39	144	205	58	91	111	98	111	14	586	571	-15
Training & Education Income	14,357	1,135	1,136	1,135	1,269	1,150	1,642	1,620	1,642	23	7,082	7,468	386
Income Total	**431,956**	**32,672**	**32,849**	**35,452**	**35,444**	**33,224**	**35,899**	**36,454**	**35,899**	**-555**	**214,742**	**205,539**	**-9,203**
Admin Staff	-36,022	-2,919	-3,021	-2,701	-2,990	-2,986	-2,994	-3,148	-2,994	154	-18,152	-17,612	540
Ambulance Service Staff	10	16	-2	-2	-2	-2	-2	1	-2	-3	5	7	2
Ancillary Staff	-7,611	-669	-697	-668	-701	-693	-655	-685	-655	30	-3,859	-4,083	-224
Clinical Support Staff	-15,676	-1,387	-1,349	-1,306	-1,392	-1,424	-1,349	-1,206	-1,349	-142	-7,812	-8,207	-395
Maintenance & Works Staff	-979	-70	-68	-68	-66	-69	-69	-81	-69	12	-492	-410	82
Medical Staff	-82,186	-6,889	-7,013	-6,799	-7,008	-6,941	-7,126	-6,840	-7,126	-286	-41,392	-41,776	-383
Nursing Staff	-81,018	-6,550	-6,672	-6,498	-6,692	-6,568	-6,563	-6,807	-6,563	245	-40,778	-39,543	1,236
Other Staff	43	-17	-6	-1	-20	-13	-6	4	-6	-10	21	-63	-84
Pay Reserves	2,060	-197	-106	-24	-98	109	-82	308	-82	-390	-894	-398	496
Scientific Theraputic & Technical	-33,143	-2,283	-2,659	-2,665	-2,717	-2,650	-2,576	-2,750	-2,576	174	-16,465	-15,550	915
Senior Managers	-5,270	-387	-370	-394	-379	-388	-400	-439	-400	39	-2,635	-2,318	316
Social Care Staff	-84	-10	-9	-10	-11	-10	-10	-6	-10	-3	-45	-59	-14
Pay Total	**-259,876**	**-21,363**	**-21,973**	**-21,135**	**-22,077**	**-21,634**	**-21,830**	**-21,651**	**-21,830**	**-180**	**-132,499**	**-130,012**	**2,487**
Admin Expenses	-26,469	-2,720	-3,048	-2,278	-2,131	-2,105	-2,027	-1,862	-2,027	-166	-14,670	-14,309	360
Catering	-1,805	-169	-154	-166	-155	-189	-174	-150	-174	-24	-912	-1,006	-94
Commissioning Expenditure	-74	-5	-7	1	-10	-5	-44	-7	-44	-37	-38	-71	-33
Drugs, Blood & Lab Consumables	-44,078	-3,773	-3,558	-4,197	-3,215	-3,984	-4,008	-3,860	-4,008	-148	-22,346	-22,734	-388
Energy & Utilities	-2,287	-224	-196	-127	-189	-186	-93	-191	-93	98	-1,166	-1,015	151
IM&T Costs	-2,934	-248	-219	-303	-240	-228	-282	-244	-282	-39	-1,573	-1,520	53
Internal Recharges	-30	-0	0	0	0	-0	0	-2	0	2	-15	0	15
Medical Consumables	-17,774	-1,341	-1,502	-1,448	-1,488	-1,494	-1,482	-1,481	-1,482	-1	-8,904	-8,755	149
Non Pay Reserves	-6,268	-65	888	-293	17	-193	-376	-814	-376	437	-2,786	-20	2,766
P or L - Sale of Fixed Assets	700	0	0	0	0	0	0	0	0	0	0	0	0
Property Costs	-5,139	-429	-421	-418	-472	-415	-499	-431	-499	-68	-2,584	-2,654	-70
Purch & Maint of Equip - Medical	-15,988	-1,307	-1,339	-1,380	-1,364	-1,381	-1,353	-1,392	-1,353	39	-8,213	-8,124	89
Purch & Maint of Equip - Non Medical	-1,676	-147	-125	-298	26	-69	-88	-140	-88	52	-846	-702	144
Purchase of Healthcare - Non NHS	-6,961	-553	-622	-561	-559	-607	-588	-624	-588	36	-3,556	-3,490	66
Recharges In / Out	-1,324	-117	-154	-138	-174	-135	-144	-133	-144	-11	-782	-860	-78
Services from Other NHS bodies	-18,689	-2,769	-840	-1,574	-1,468	-1,422	-1,498	-1,472	-1,498	-26	-9,561	-9,572	-11
Site Support Services	-14,603	-1,342	-1,268	-1,582	-1,566	-1,584	-1,650	-1,269	-1,650	-381	-8,018	-8,992	-974
Suspense Accounts	0	-1	1	0	0	0	0	0	0	0	0	0	0
Training Costs	-1,071	-53	-97	-65	-67	-49	-41	-89	-41	48	-540	-373	167
Non Pay Total	**-166,469**	**-15,260**	**-12,661**	**-14,826**	**-13,058**	**-14,045**	**-14,348**	**-14,160**	**-14,348**	**-187**	**-86,510**	**-84,198**	**2,313**
Depreciation	-7,773	-648	-648	-538	-607	-607	-607	-648	-607	41	-3,886	-3,655	232
Dividend	-1,662	-168	-168	-168	-168	-168	-168	-168	-168	0	-1,006	-1,006	0
Interest Payable	-3,944	-329	-329	-421	-378	-365	-364	-329	-364	-35	-1,972	-2,185	-213
Interest Receivable	25	3	2	2	2	2	2	2	2	-0	13	13	1
Financing Total	**-13,354**	**-1,141**	**-1,142**	**-1,124**	**-1,150**	**-1,138**	**-1,137**	**-1,142**	**-1,137**	**5**	**-6,852**	**-6,832**	**20**
Grand Total	**-7,743**	**-5,093**	**-2,927**	**-1,633**	**-841**	**-3,593**	**-1,415**	**-499**	**-1,415**	**-916**	**-11,120**	**-15,503**	**-4,383**

East and North Hertfordshire NHS
NHS Trust

Agenda Item: 9.2

TRUST BOARD PART I – 1 NOVEMBER 2017
PERFORMANCE REPORT MONTH 6

PURPOSE	To update the Trust Board on: • Progress against Monitor Compliance Framework, DH Operating Standards, Contractual standards and local performance measures. • Exception reports outlining action take and next steps are provided for indicators that are either 'red' in month, or at risk year to date.
PREVIOUSLY CONSIDERED BY	**FPC**
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings, Governance risk Rating, Contractual performance.
Healthcare/ National Policy (includes CQC/Monitor)	Achievement of Monitor, CQC, DH Operating Framework and other national and local performance standards.
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	CHIEF OPERATING OFFICER
PRESENTED BY:	CHIEF OPERATING OFFICER
AUTHOR:	DIRECTOR OF OPERATIONAL PERFORMANCE
DATE:	OCTOBER 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

***** tick applicable box

PERFORMANCE REPORT

1. Key Headlines

The following table shows the trust's summary position against the 3 key KPIs that had been agreed with NHSI for 2017/18. Achievement of the ED standard is linked to the STF funding.

August 18 (STF) KPI Performance

RTT - 2017/18 Trajectory						Comments
Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Following Lorenzo 'go live' the trust is unable to report September's performance
92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	
92.16%	90.49%	88.93%	87.43%	85.68%		

ED - 2017/18 Trajectory						
Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	July performance has been corrected following an over statement as raised last month. Following Lorenzo 'go live' the trust is unable to report September's performance
84.50%	84.60%	85.64%	87.07%	88.62%	90.19%	
89.24%	84.07%	87.53%	85.24%	85.06%		

Cancer - 2017/18 Trajectory						
Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	September' s performance is not finalise until 1st November
70.80%	79.56%	85.04%	84.96%	85.19%	85.00%	
Pre Breach Sharing 75.00%	70.60%	64.50%	71.20%	69.30%		
Post Breach Sharing 77.90%	71.00%	66.40%	74.96%	72.20%		

2. RTT – 18 weeks

Following the migration to Lorenzo the trust is unable to report September's performance against the RTT standard.

2.1 RTT Reporting

The trust has committed towards returning to national reporting in November. Therefore November's RTT performance will be reported before the close date in December.

2.2 RTT PTL Reports

At the time of writing the trust is not in possession of a number of PTL reports, the open pathway PTL has been developed although there are a number of data quality issues that limits the assurance that can be derived from the PTL.

The trust does not have the following key reports:

- Outpatient PTL
- Follow up PTL
- Planned PTL
- Diagnostic PTL

Since ‘go live’ the weekly trust Access Meeting has not been able to assess or provide an overview of waiting list management as the reports are not currently available, therefore at this time we are therefore unable to provide assurance to the board that patients are being tracked appropriately and are being booked in order.

2.3 Validation / Data Quality

Post migration a number of patient pathways require validation in order to ensure that any PTL’s that are produced will be accurate. The validation has been separated into essentially three components:

a) The current contract validators will continue to focus on validating and correcting pathways from the post ‘go live’ activity
b) An additional team of contract validators will focus on 4 cohorts of patients that migrated across, once these have been completed, the trust expects to be able to return to national reporting. Expected timeframe, 4 weeks from the point the team are in post
c) A further cohort represents patient pathways that would have required validation even if Lorenzo had not been implemented. Internal staff have been focused onto this cohort however once the second contractor validation team have completed cohort ‘b’, that team of staff will also be directed onto this cohort. The expected timeframe to complete this cohort is 8-12 weeks.

3. 4 Hour Performance

August’s performance has not been finalised at the time of the last committee and is therefore shown in the table below.

As highlighted last month, July’s reported performance was being reviewed, this has subsequently been amended and is also reflected in the table below. July’s activity numbers had been overstated resulting in an overstated performance, originally reported as 87.77%, this has now been amended to 85.24%. The amendment has also been uploaded to Unify and the CCG have been informed.

Systems within the informatics department have been implemented that should mitigate the likelihood of a similar occurrence..

Month	% Performance	Quarterly Performance
Sep-16	82.98%	Q2 83.20%
Oct-16	88.16%	
Nov-16	89.43%	
Dec-16	85.41%	Q3 87.63%
Jan-17	83.41%	
Feb-17	83.82%	
Mar-17	83.90%	Q4 84.22%
Apr-17	89.24%	
May-17	84.82%	
Jun-17	87.53%	Q1 83.72%
Jul-17	85.24%	
Aug-17	85.06%	

The trust is unable to report September's performance against the 4 hour standard; furthermore it does not expect to be able to retrospectively provide September's performance due to issues with retrospectively validating pathways.

However the trust returned to daily 'sitrep' submissions to NHSI / Unify week commencing 16th October and is expecting to report a month end performance for October.

4. Cancer

Cancer performance is reported retrospectively, August's finalised position is shown below.

Performance August 2017

Target	Goal	Threshold	2016/17	Month	Quarter 2	Year 17/18	Nat Average (Aug)	Nat Average Qtr (Q1)
Target Referrals								
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	97.4%	97.6% ▲	97.6% ▼	98.0% ▲	93.6%	93.7%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	94.1%	93.3% ▼	94.9% ▲	93.9% ▼	93.1%	90.7%
Cancer Treatments								
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	91.7%	92.1% ▼	92.9% ▲	90.8% ▼	97.7%	97.5%
Referral to Treatment from Consultant Upgrade	< 62 Days	90.0%	75.5%	75.0% ▲	75.0% ▲	66.1% ▼	88.1%	88.2%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	87.5%	58.8% ▼	60.5% ▲	59.0% ▼	91.9%	92.3%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	95.1%	96.7% ▲	96.3% ▲	95.4% ▲	99.4%	99.3%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	91.9%	94.7% ▲	92.5% ▲	88.9% ▼	97.4%	96.8%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	85.8%	86.5% ▲	85.5% ▲	85.5% ▼	95.9%	96.0%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	69.3%	69.2% ▼	70.3% ▲	70.0% ▲	82.5%	81.4%
Urgent Referral to Treatment of All Cancers (following breach reallocation)	< 62 Days	85.0%	72.2%	- ◀	- ▲	- ▲	-	-

Performance by tumour site against the 31 and 62 day standards shown below.

By Tumour Group								
Breast Cancer								
Decision to Treat to 1st Definitive Treatment for Breast Cancer	< 31 Days	96.0%	98.8%	96.7% ▼	98.6% ▼	98.8% ▼	98.6%	98.4%
Urgent Referral to Treatment of Breast Cancer	< 62 Days	85.0%	89.6%	81.8% ▼	87.5% ▲	87.3% ▼	94.1%	93.5%
Colorectal Cancer								
Decision to Treat to 1st Definitive Treatment for Colorectal Cancer	< 31 Days	96.0%	96.6%	97.2% ▼	98.4% ▲	90.3% ▼	98.2%	97.5%
Urgent Referral to Treatment of Colorectal Cancer	< 62 Days	85.0%	48.3%	50.0% ▲	45.6% ▼	50.0% ▲	73.2%	70.5%
Gynae Cancer								
Decision to Treat to 1st Definitive Treatment for Gynae Cancer	< 31 Days	96.0%	93.9%	100.0% ◀	100.0% ▲	97.9% ▲	97.4%	97.1%
Urgent Referral to Treatment of Gynae Cancer	< 62 Days	85.0%	61.4%	90.0% ▲	77.8% ▼	81.8% ▲	79.1%	77.7%
Haematology Cancer								
Decision to Treat to 1st Definitive Treatment for Haematology Cancer	< 31 Days	96.0%	98.3%	90.0% ▼	96.8% ▼	98.6% ▲	99.5%	99.5%
Urgent Referral to Treatment of Haematology Cancer	< 62 Days	85.0%	74.5%	80.0% ▲	71.8% ▲	65.8% ▼	78.2%	77.7%
Head and Neck Cancer								
Decision to Treat to 1st Definitive Treatment for Head and Neck Cancer	< 31 Days	96.0%	91.8%	75.0% ▼	79.2% ▼	88.5% ▼	92.6%	94.8%
Urgent Referral to Treatment of Head and Neck Cancer	< 62 Days	85.0%	49.7%	57.9% ▼	63.3% ▲	58.5% ▲	65.3%	66.6%
Lung Cancer								
Decision to Treat to 1st Definitive Treatment for Lung Cancer	< 31 Days	96.0%	96.7%	100.0% ◀	100.0% ▲	96.4% ▼	98.5%	98.3%
Urgent Referral to Treatment of Lung Cancer	< 62 Days	85.0%	56.4%	68.0% ▲	61.7% ▲	56.3% ▼	72.2%	72.5%
Sarcoma, Brain & Other Cancer								
Decision to Treat to 1st Definitive Treatment for Sarcoma, Brain & Other Cancer	< 31 Days	96.0%	96.9%	100.0% ▲	90.0% ▼	95.0% ▼	99.4%	98.6%
Urgent Referral to Treatment of Sarcoma, Brain & Other Cancer	< 62 Days	85.0%	75.0%	40.0% ▲	30.8% ▼	52.2% ▼	74.6%	69.0%
Skin Cancer								
Decision to Treat to 1st Definitive Treatment for Skin Cancer	< 31 Days	96.0%	96.7%	97.7% ▲	96.6% ▼	97.3% ▲	97.9%	97.8%
Urgent Referral to Treatment of Skin Cancer	< 62 Days	85.0%	91.4%	91.7% ▼	96.2% ▲	95.2% ▲	95.2%	96.5%
UpperGI Cancer								
Decision to Treat to 1st Definitive Treatment for UpperGI Cancer	< 31 Days	96.0%	96.5%	100.0% ◀	100.0% ▲	95.0% ▼	99.0%	98.6%
Urgent Referral to Treatment of UpperGI Cancer	< 62 Days	85.0%	73.9%	64.7% ▲	59.4% ▼	65.2% ▼	73.5%	73.2%
Urology Cancer								
Decision to Treat to 1st Definitive Treatment for Urology Cancer	< 31 Days	96.0%	73.4%	71.4% ▼	77.6% ▲	72.5% ▼	95.9%	95.4%
Urgent Referral to Treatment of Urology Cancer	< 62 Days	85.0%	58.0%	56.4% ▼	58.5% ▲	58.1% ▲	78.8%	75.6%

4.1 Recovery

ENHT did not achieve the 62 day performance standard or achieve against the recovery trajectory, delivering 72.2.4%, post breach sharing, against an original trajectory of 85.04%. However during August a number of patients elected to wait longer than the standards for their diagnostic procedure, this is not unusual during this holiday period.

September's performance will not achieve the 85% standard; however it remains a possibility that the trust will achieve 80% (post breach sharing). If the trust achieves 80% this would represent the highest performance since August 2016 and would represent a step change in performance.

At the time of writing performance is tracking at 78.4% (post breach sharing) and 72% pre sharing. Achievement of the standard in September was always predicated on the trust delivering activity levels that resulted in C. 120-130 qualifying treatments being achieved. In August the trust delivered 123 treatments, however at this time the trust has only 91 treatments in September. With the Lorenzo migration a number of unexpected consequences have subsequently developed that have resulted in some treatments not tracking through onto the cancer tracking system, therefore a detailed review of all other systems is currently in progress. An additional 7 treatments would increase our performance to 80% post breach sharing.

Furthermore the number of breaches of the standard post breach sharing is down to 18.5, this is also the lowest recorded breach number in recent times against the 62 day standard. The reduced level of breaches also demonstrates that cancer performance is continuing to improve albeit slower than we ideally would like.

4.2 Cancer PTL

During October the trust has successfully implemented a trust level combined 62 day cancer PTL. Previously the PTL was split between the Mount Vernon and Lister sites, the change is beneficial and aids oversight by providing a trust level overview. However at this time we are currently unable to produce trust level trend graphs, it is anticipated that these will be provided for the next committee report.

5. Stroke

August '17 Stroke performance

Metrics	Aug '16	Sep '16	Oct' 16	Nov'16	Dec '16	Jan' 17	Feb '17	Mar '17	Apr ' 17	May'17	June'17	July '17	Aug '17
Trust SSNAP Grade	B	B	B	B	A	A	A	A	A	A	A	A	
Stroke Discharged with AF on anticoagulants (ASI 1)	83.30%	80%	88.90%	75%	86.70%	72.20%	88.20%	91.70%	54.50%	90%	92.30%	62.50%	100%
Stroke – 4 hours direct to stroke unit from ED	91%	75.40%	80.90%	76.10%	76.60%	71.80%	76.40%	73.40%	82.50%	76.60%	77.60%	78.60%	71.70%
No. Confirmed Strokes in Month (figure excludes inpatient strokes & hospital transfers)	67	57	47	66	77	78	72	79	40	36	67	42	53
Stroke – 80% of patients spent 90% of time on the stroke unit	91%	91.40%	93%	84.30%	85.70%	86.90%	83.30%	92.50%	88.90%	91.40%	88.50%	88%	83.90%
Stroke – 60 min to scan from time of arrival – target 50%	58.80%	56.90%	51.90%	40.90%	47.60%	51.20%	46.20%	51.30%	52.40%	55.10%	57.50%	70%	59.60%
Stroke 60 mins to scan for those patients deemed urgent	89.50%	93.80%	100%	91.30%	86.10%	91.70%	90%	89.20%	95.20%	91.70%	90%	96.20%	92.90%
Stroke – scanned within 24 hrs (all strokes) targed 100%	100%	100%	98%	100%	98.80%	100%	98.70%	100%	100%	98.60%	100%	100%	100%
Total Thrombolysis Rate for confirmed strokes	6.60%	14.90%	8.20%	3.40%	9.90%	17.10%	7.50%	13.60%	16.20%	11.50%	13.40%	14.30%	16.70%
Stroke patients thrombolysed within 3hrs-4.5hrs	3.30%	14.90%	6.10%	3.45%	7.10%	12%	6%	9.10%	10.80%	6.60%	9%	7.10%	6.30%
Stroke – discharged with JCP – target 80%	92.30%	94.40%	94.10%	90.50%	79.20%	95.80%	100%	100%	100%	100%	100%	100%	94.70%
Stroke –discharged with ESD target 40%	31.10%	33.30%	27.50%	39.60%	36.50%	42.10%	42.40%	40%	54.50%	26.50%	48.10%	50%	33.30%
TIA – high risk, not admitted, tx within 24hrs	63.30%	66.70%	75%	70.80%	73.20%	68.40%	66.70%	63.30%	91.70%	57.90%	60%	73.70%	82.40%
TIA – high risk tx within 24hrs	63.30%	66.70%	75%	70.80%	71.40%	68.40%	66.70%	63.30%	91.70%	57.90%	60%	73.70%	82.40%
TIA – low risk, treated within 7 days from first contact	88.90%	100%	81.50%	88.90%	94.40%	90.90%	93.30%	88.90%	88%	81.30%	79.30%	86.70%	81%
TIA – low risk, treated within 7 days from onset	48.10%	100%	40.70%	72.20%	44.40%	72.70%	53.30%	48.10%	60%	56.30%	48.30%	53.30%	61.90%

September's stroke performance has not been finalised at the time of writing.

6. Diagnostic Standard (DM01)

The trust did not report the DM01 in August and is unable to retrospectively make the submission as the data was not 'frozen' at that time and therefore the denominator / numerator for each of the modalities cannot be established. The informatics team have implemented mitigating actions that should reduce the likelihood of this occurring.

The trust is currently unable to report performance against the monthly diagnostic standard (DM01).

The trust aims to have built the diagnostic PTL by the end of the month so that operational teams can test and check its accuracy. On completion the trust will be able to return to national reporting, the most likely timeline at this time is to be able to report November's performance before the submission closure in December.

** End of document **

Agenda Item: 9.3

TRUST BOARD PART I – 1 NOVEMBER 2017

Workforce & OD Board Report – Month 6

PURPOSE	To present an update to the Trust Board on Workforce and OD issues
PREVIOUSLY CONSIDERED BY	Monthly standing item RAQC and FPC
Objective(s) to which issue relates *	[√] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial: increased workforce costs HR: failure to meet agreed standards Legal: failure to meet CQC and other national standards Patient Safety: failure to maintain appropriately trained workforce
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	[√] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[√]	For information	[ ]

DIRECTOR:	Chief People Officer
PRESENTED BY:	Chief People Officer
AUTHOR:	Deputy Director of Workforce and Head of Workforce Planning, Information, and Performance
DATE:	20 October 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

* tick applicable box

Workforce Report

OCTOBER 2017

BASED ON MONTH 6 DATA

Executive Summary

The trends for the Trust workforce report for month 6:

Key Headlines

Temporary Staffing

The monthly agency ceiling target was achieved in month 6 with agency spend under by £455K. Year to date the Trust is under the ceiling target by £1,879k, therefore continuation of this work will ensure that the target is achieved by year end.

Sickness Rate:

Between August and September 2017, there was a reduction in the number of days lost by 33 days in month and an overall reduction in the number of long term sickness cases. The annualised sickness absence rate has improved further and reduced to 3.39%.

Medical Staffing:

Year to date there has been a net increase in medical staff of 19.5, which is 4.5 away from the year end target. Achievement of this target will reduce the vacancy rate to below 5% based on current establishment. In September, 15 new full time medical staff were appointed and in post in month 6 . In the same month, staff in post reduced by 10.5 WTE, leaving a net position of 4.5 WTE.

Resourcing:

The vacancy rate at the end of September 2017 was 8.4%. Compared to the same month last year there has been an additional 198.3 WTE in post (excludes 132.2 WTE for TPP). There are currently 260.8 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust.

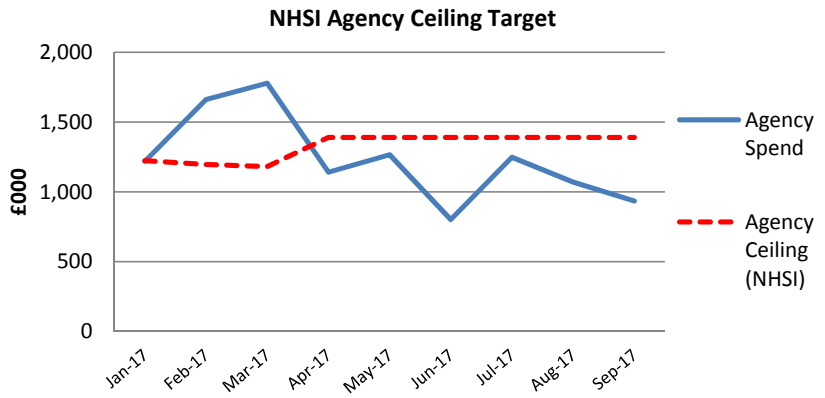
Workforce Board Report

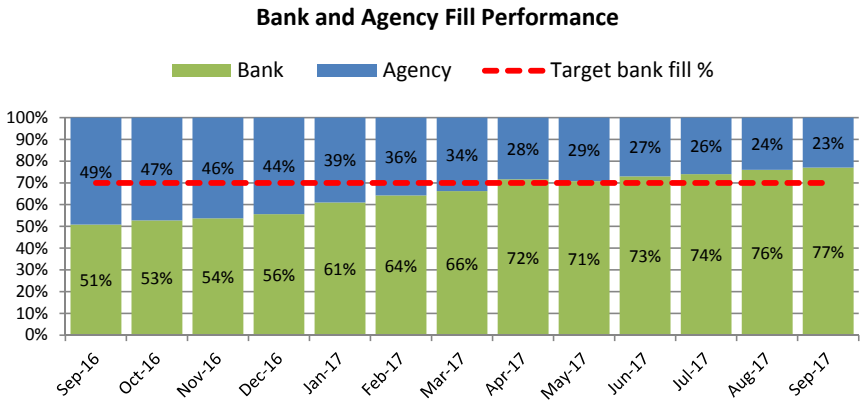
Index

1. Temporary Staffing

Confidence Rating

Strategy: To reduce agency pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To improve the efficiency and performance of the temporary staffing service, ensuring that processes, policies and guidelines are adhered to for optimal service delivery and financial control.





Headlines:

The monthly agency ceiling target was achieved in month 6 with agency spend under by £455K. Year to date the Trust is under the ceiling target by £1,879k, therefore continuation of this work will ensure that the target is achieved by year end.

Spend on bank, in relation to hours booked in month, decreased (9%) however the budget statement reflects a slight increase due to adjustments made in month 5 as well as some bank retrospective bookings and backdated pay arrears processed in month 6 totalling £114k. Unfilled rates have remained high which is mainly impacting nursing and midwifery. It is expected that an increased number of new employee starting in October and November will improve the levels of fill for nursing and midwifery.

The ratio of fill for bank and agency continues to improve and has been above target for the last 4 months. Continuing on this trajectory, it is expected that 80% bank fill will be achieved by year end.

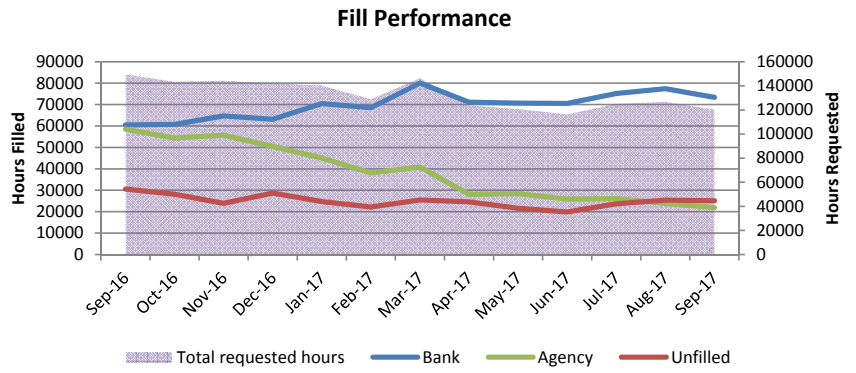
The reduction in agency hours and an increase in bank hours has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

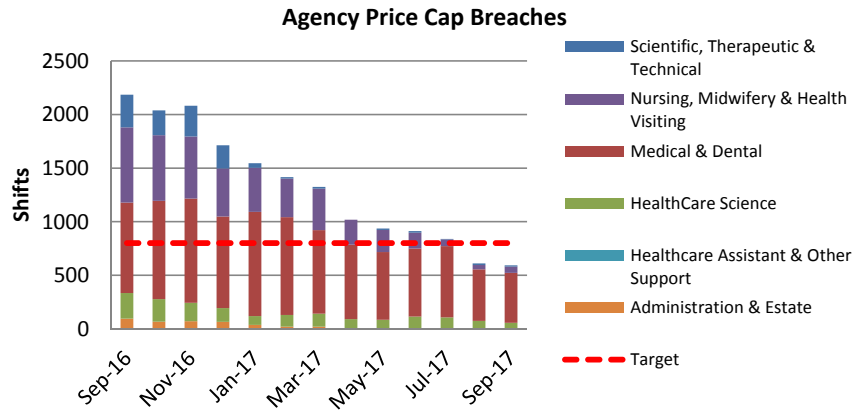
Shared bank: The first data set for the shared bank initiative has been reviewed and is showing some positive results against the set out measures of success. In the first month there were no bookings of agency staff employed by two of the member Trusts - ENHT and West Hertfordshire. Additionally, several of the trust staff had picked up shifts in neighboring Trusts on the bank that had not previously worked bank.

1b. Temporary Staffing

Confidence Rating

Strategy: To reduce agency pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To improve the efficiency and performance of the temporary staffing service, ensuring that processes, policies and guidelines are adhered to for optimal service delivery and financial control.





Headlines:

Internal Temporary Staffing Office, Doctors (TSOD): The team are working on reducing the unit cost of agency through increased negotiation and by maintaining the regional ceiling charge rates. There is currently work ongoing with the pan London procurement group to review the Hertfordshire ceiling rates with their rates with a plan of achieving some standardisation across the patch. Maintaining the agency ceiling charge rates under threat since changes to IR35 legislation which has made this difficult due to less locums available in the market. Bank recruitment is very positive with a large number of workers in the pipeline wanting to work for TSOD.

Agency restrictions/agency free zones: 'Padlocks', restricting agency, are now automatically applied to all shifts for nursing and midwifery and are only removed with approval from the Director of Nursing. Direct booking of agency has been switched off meaning all shifts are filled through the agency cascade.

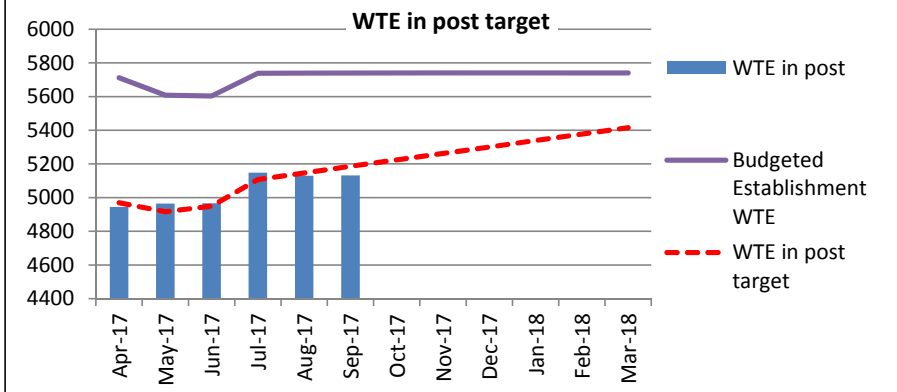
A recognition scheme has been set up to identify departments that have removed all agency, gaining 'Agency Free Zone' status. Quarter 2 results are now under review with further recognition awards to be distributed in October.

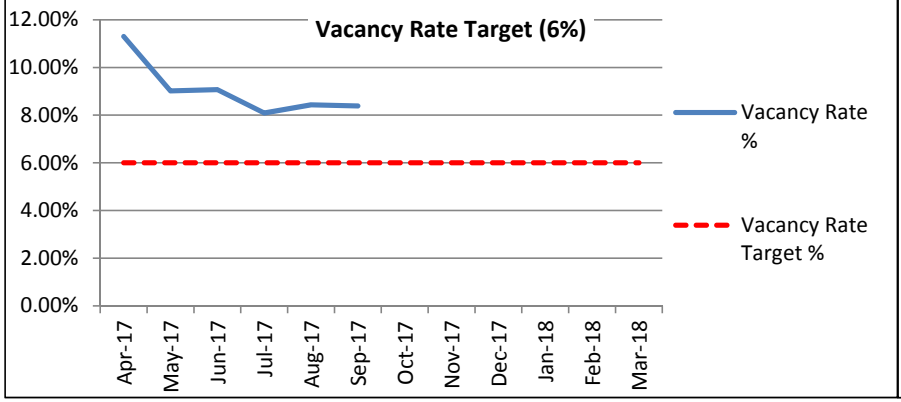
Agency unit cost and price management: All nursing critical care rate cards are now in line with NHSI price caps which has significantly reduced breaches in August and September. Additionally agency shifts have reduced for Doctors whilst other staff groups have maintained a minimal level of breaches. This has meant that the Trust is below the target number of breaches for the second month in a row. Providing that the agency bookings continue to reduce for doctors the year end target of an average of 800 price cap breaches per month will be achieved.

2. Resourcing

Confidence Rating

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.





Headlines:

Performance: The Trust achieved an additional 129.7 WTE starters in September and 110.4 WTE leavers (net 19.4 WTE). However due to adjustments in hours total WTE in post remained static in September compared to August. The vacancy rate at the end of September 2017 was 8.4% which is a marginal improvement on the previous month but indicates positive improvement form the start of the year (11.3%). Compared to the same month last year there has been an additional 198.3 WTE in post (excludes 132.2 WTE for TPP). There are currently 260.8 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust.

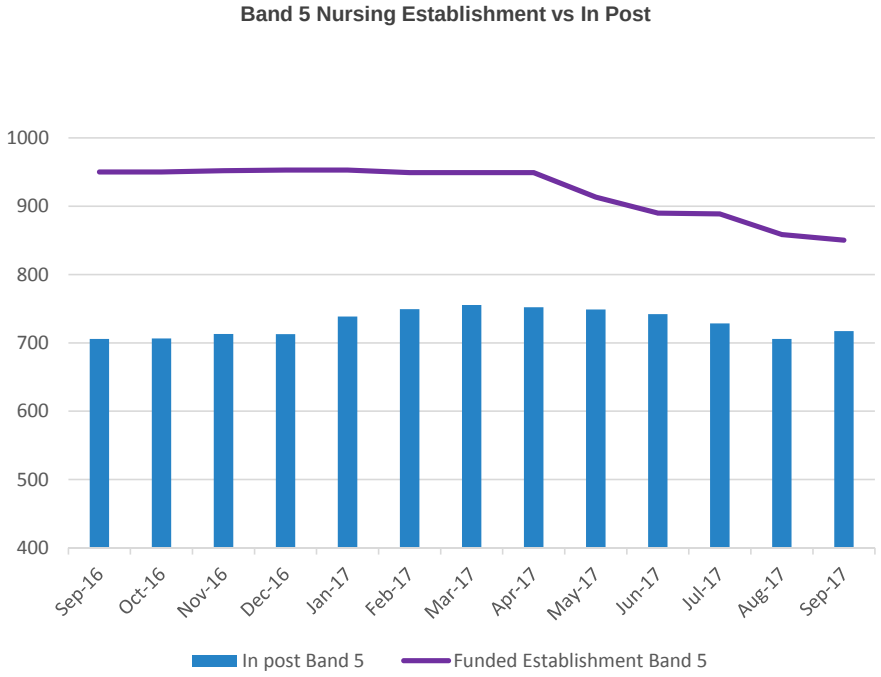
There is significant work being conducted with each Division to understand any blockages in the recruitment process and highlight areas of good practice. There is continued work being undertaken by each Division to drive down the overall Time to Hire across the Trust. Focused work on reducing the time lapse between a member of staff resigning to authorising the vacancy is proving positive in reducing the overall Time to Hire.

Candidate Attraction: Work is underway to enhance the branding of the Trust and Recruitment function by utilising a range of digital media options. Plans are currently being devised with each Division to enhance recruitment channels, attraction to the Trust and in particular hard to recruit posts.

2b. Resourcing - Non-Medical Band 5 Registered Nurses

Confidence Rating

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.



Headlines:

The Trust's vacant posts for band 5 registered nurses at the end of September 2017 was 132.9 WTE, this equates to an 15.6% vacancy rate which represents a decrease on August's 17.8% band 5 nurse vacancy rate. The forward view recruitment trajectory for band 5 registered nurses, predicts a decrease in the vacancy rate to circa 12.0% by March 2017.

There are currently 207.8 WTE external band 5 qualified nurse candidates undergoing pre-employment checks or awaiting to start with the Trust.

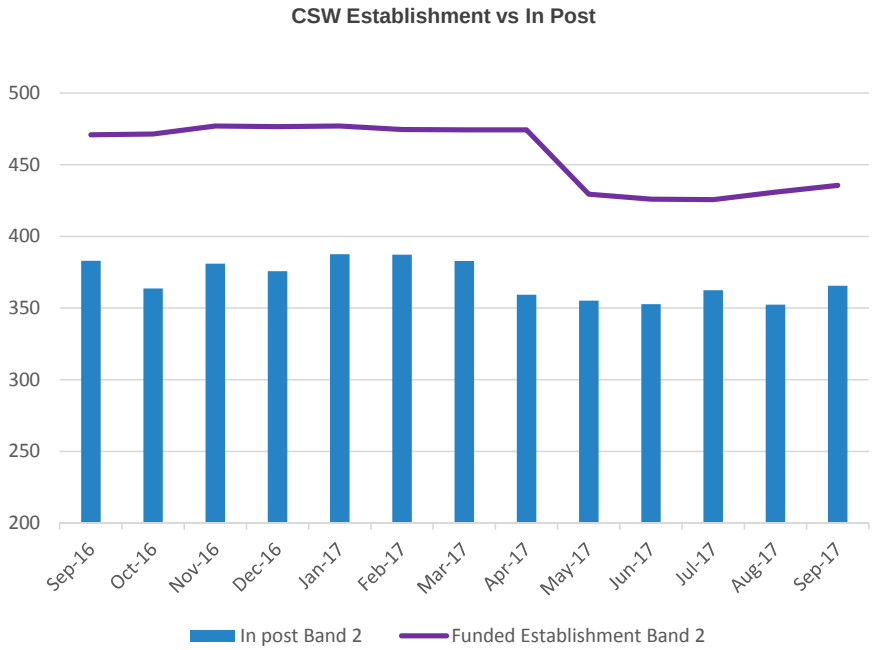
Acknowledging the current attrition rate for band 5 nurses at an average of 10 wte per month; the Trust requires an additional 5 WTE starters per month in order to be on target. Based on the recruitment pipeline it is expected that 54 WTE are will start in October.

In order to meet the demand of recruiting to Band 5 vacancies each Division has confirmed recruitment plans. Bespoke recruitment events have commenced for each division with events planned until the end of March 2018. Each recruitment event has is designed to display the opportunities available within the division with a focus on hard to recruit posts, training opportunities and rotational posts.

2c. Resourcing - Non-Medical CSW

Confidence Rating

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.



Headlines:

The Trust's number of vacant posts for band 2 Clinical Support Workers (CSWs) at the end of September 2017 was 70 wte, equating to an overall vacancy rate of 16.1% for CSWs. However, 37 WTE is being held by international band 5 nurses until receipt of their registration.

There are 365.5 WTE of Clinical Support Workers in post. There are currently 54.3 WTE CSW candidates going through pre-employment checks. In September 23.6 WTE band 2 commenced employment with a projected 29 WTE to commence by November 2017.

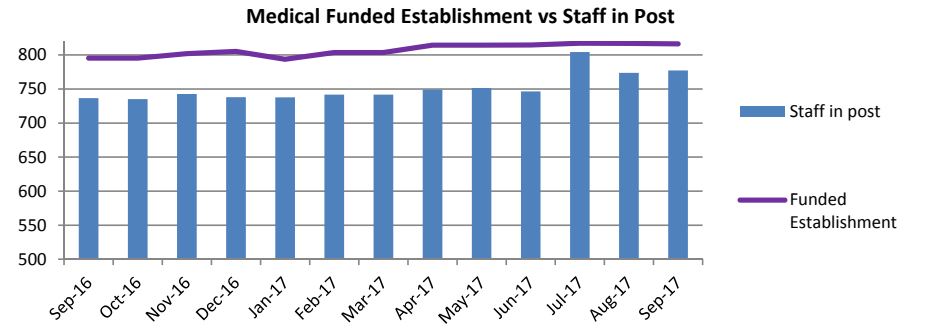
Attraction to the CSW role is challenging, however the increase in CSW in the reported recruitment pipeline can in part be attributed to the change in the contract from fixed term to permanent and the changes in the way the apprenticeship course is taught and assessed.

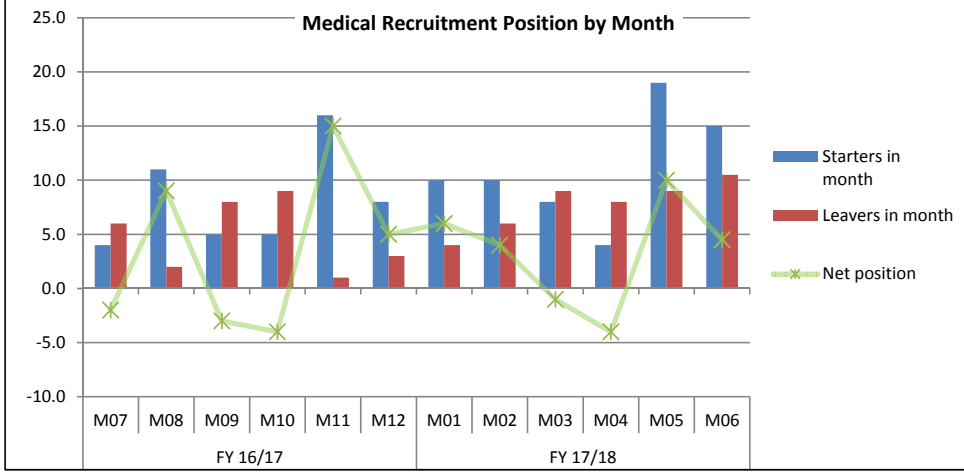
Bespoke CSW recruitment days are to be rolled out in line with divisional recruitment plans to attract candidates for specialties. The cohort recruitment assessment days continue to be held every two weeks, to increase the pipeline. Further work is currently underway, exploring other avenues of candidate attraction and explaining the apprenticeship scheme in detail in order to determine candidate and job profile compatibility.

2d. Resourcing - Medical

Confidence Rating

Strategy: To increase contracted medical post holders, reducing vacancy to below 5% and minimising agency, through innovative and efficient recruitment methods and by enhancing the East and North Hertfordshire medical brand.





Headlines:

15 new full time medical staff were appointed and in post in month 6 . In the same month, staff in post reduced by 10.5 WTE, leaving a net position of 4.5 WTE. Year to date there has been a net increase of 19.5 which is 4.5 away from the year end target. Achievement of this target will reduce the vacancy rate to below 5% based on current establishment.

The plan set out expects to meet the target by month 8 and then to maintain the recruitment to the same level as attrition until the end of the year. The key actions to ensure achievement of the target are:

Acute and ED workshop: Identified as an area with significant challenges for recruitment and with high volumes of agency, the Trust has set up a working group with lead consultants to focus on recruitment activity. An action plan is to be formally agreed focusing key areas including training opportunities, attraction package, marketing and networking.

Retention of staff: Ongoing work on retention following feedback gathered from new starters and leavers required. Focus required for new starters, specifically from overseas during week 4 to 8 of starting.

Recruitment partners: The Trust is engaging with agencies for international recruitment.

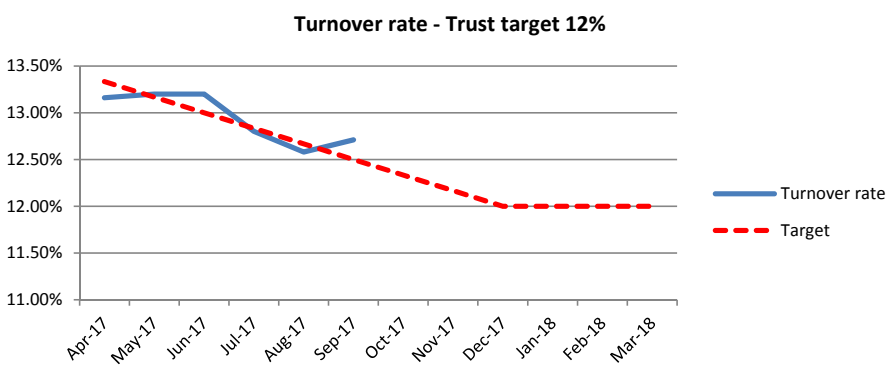
Candidate attraction: A promotional event is planned to be held at the AGM exhibition in November and is reviewing options for an enhanced promotional video and marketing material.

Threats to target: Increasingly the emphasis is on international recruitment to fill the gap in some specialties, this is an extensive process increasing the time to hire.

3. Staff Retention

Confidence Rating

Strategy: To develop and influence the organisational culture in order to create a working environment where staff want to attend work and feel happy, engaged, valued, supported and empowered to deliver effective and compassionate care.



Headlines:

Retention rate is showing positive progress since the start of the year remaining on track with target. In September, there was a slight increase to 12.7% from 12.6% in August 2017. With the continuation of the retention strategy the Trust expects to achieve the target by year end. This work will be replicated within other divisions across to the Trust.

The total number of new staff joining the Trust in September was 129.7 WTE, with 26.1 WTE qualified Nurses starting in month (compared to 19.8 WTE in August), and nurse leavers 20.8 WTE in month (compared to 13.6 WTE in August).

In September 2017, there were 81 individuals who voluntarily resigned from their posts, other leavers were in fixed term contracts or their contracts were terminated for other reasons. The most common reasons for leaving were retirement, relocation, better reward package and seeking better opportunities for flexible working.

A full retention strategy is being complete with key work streams to be finalised and confirmed.

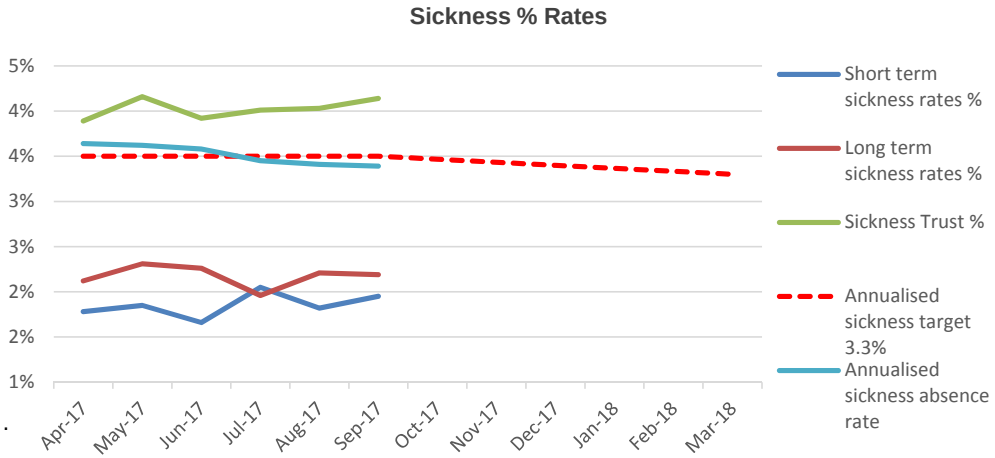
Retention action highlights:

- Bullying and Harassment Steering Group launched in September 2017 with joint Staff Feedback Sessions planned for November; key focus being bullying and harassment and retention.
- The Speak In Confidence service, designed to ensure staff have the opportunity to raise concerns, is under review to agree an extension and a relaunch plan to ensure the service is fully utilised.
- The divisions have developed plans focusing on retention in their areas. Evidence of the work is already showing in some divisions with Medical Division achieving 11.8% in September using early intervention clinics and staff recognition schemes.

4. ER Sickness Management

Confidence Rating

Strategy: To reduce sickness absence below 3.3% by March 2018. The approach to achieving this is by providing advice and support to both managers and employees to optimise health at work, reduce sickness absence and prevent work related ill health and injury therefore reducing the cost of sickness absence across the Trust.



Future Actions to reduce sickness absence:

- An Operational Review of the policy has been carried out to ensure that the policy is updated taking into account stakeholder feedback and that managers are sighted of proposed changes ahead of the policy being finalised and re-launched.
- The re-launch of the policy will be supported by a dedicated member of the Employee Relations Advisory Service; providing training sessions and departmental updates in relation to key changes and the requirements of the policy for line managers.
- The purpose of the review is to ensure robust and consistent management of sickness absence and to ensure that appropriate and timely support is provided.
- Review is underway of the Absence Assist Service.

Headlines:

Reduction in Sickness Absence: The aim over the 2017/18 financial year is to reduce the annualised sickness absence rate from 3.64% to 3.30% by the end of March 2018. This sickness reduction equates to 200 less sickness days per month.

It is estimated that this reduction would support the Divisions in achieving cost savings equivalent to £250k, as a result of the reduced need for temporary staffing cover. The attached graph shows the % of days lost per month due to sickness absence.

Between August and September 2017, there was a reduction in the number of days lost by 33 days in month and an overall reduction in the number of long term sickness cases. The annualised sickness absence rate has improved further and reduced to 3.39% as at the end of September 2017; this follows a reduction in sickness absence between January and April 2017, compared with last year, when increased measures were put in place in relation to the management of sickness absence. The key actions that have commenced in respect of this sickness absence cost saving plan are;

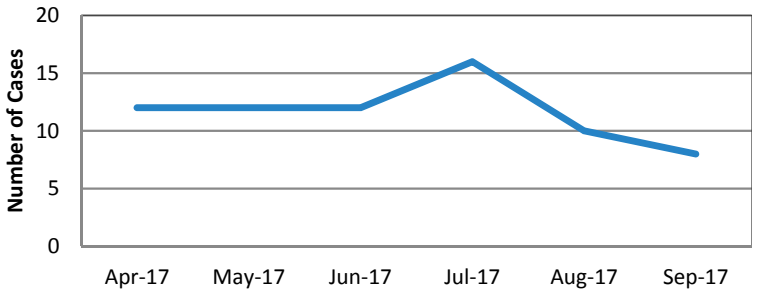
- Auto-enrolment of LTS cases.
- Focus on hotspot areas.
- Early intervention by Health at Work in respect of musculoskeletal and stress related sickness.
- Direct communications with individuals reaching informal triggers in respect of STS absence

5. Employee Relations

Confidence Rating

Strategy: to deliver a customer service focused ER function, providing both managers and staff with advice and support on all Employee Relations issues, managing of sickness and eradicating bullying and harassment.

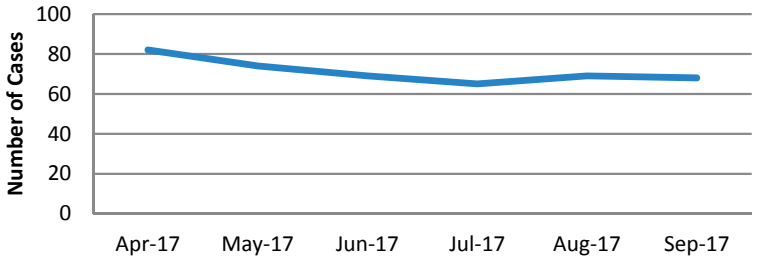
Dignity and Respect at Work Cases



Headlines:

- In September, the percentage of employee relations cases within the Trust was 0.2% and within the target range.
- The overall number of live employee relations cases decreased from 129 in August to 120 in September 2017.
- There has been no increase of B&H cases, with 8 ongoing cases as at month end. A Bullying and Harassment Steering Group has now been established, the first meeting took place on 15th August 2017. We are looking to launch open feedback sessions / forums to increase awareness of bullying and harassment and the support available to staff and managers.
- The team are currently reviewing the Speak in Confidence Service; the contract is currently under review for renewal.

Live Sickness Cases



- The number of sickness cases registered with ERAS for active support reduced to 68 as at the end of September 2017; the number of cases has reduced due to the manner in which STS cases are being recorded at present.
- For STS, the ERAS team with HRBPs are targeting hotspots areas using metrics for the highest number of staff reaching a formal trigger point.
- All LTS cases over 6 Months are automatically registered with ERAS and an ER Advisor assigned for consistency.
- The overall number of long term cases decreased from 121 in August to 108 as at the end of September 2017.
- Case information is shared with the operational teams to ensure full oversight of the cases within each Division.

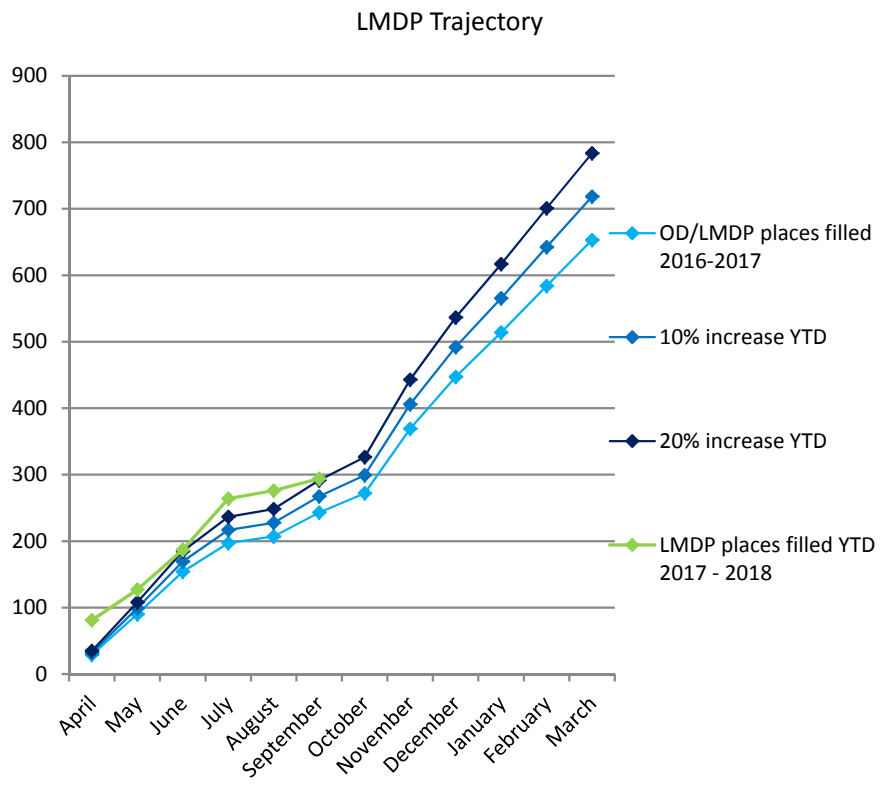
Policy Update:

- Ongoing discussion regarding the Dignity and Respect at Work Policy; reviewing the framework to be more consistent with Grievance Policy.
- Sickness Absence Policy under review.
- Capability Policy under review.

6. Capability of leaders

Confidence Rating

Strategy: The Culture Programme aims to improve staff engagement so the Trust is amongst the top 20% of acute hospital Trusts within three years. This will be achieved by embedding a strong leadership culture, leading to improved patient and staff experience and improved customer satisfaction with our services; this will lead to sustained improvements in services.



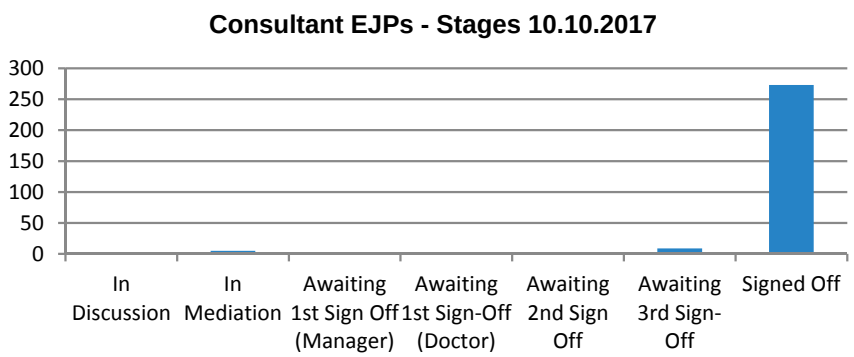
Headlines:

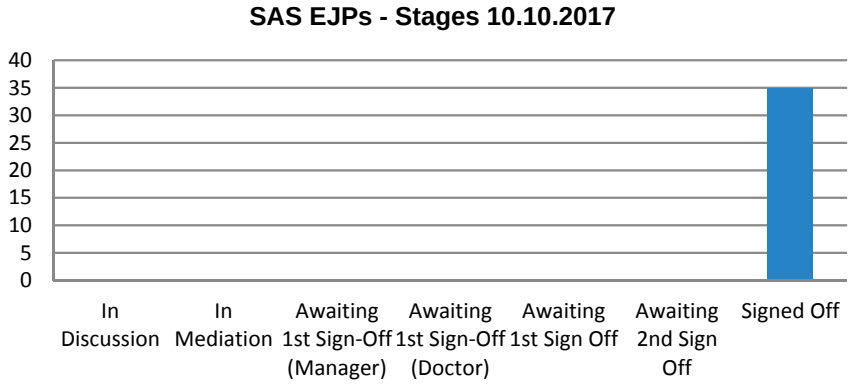
- The 2017 NHS National Staff Survey opened on 9th October. The Trust has moved to an all-online survey this year and early indications are that the response rates are good. There will be a Trust-wide communications programme throughout the survey, which will close on 1st December, and regular updates on divisional response rates will also be provided to enable more targeted communications. The intention is to share the survey results more widely this year and to improve how staff are engaged and involved in the development of Trust-wide and divisional action plans.
- The *Leadership & Management Development Pathway a*ttendance figures continue to exceed last year's, although there was a slight downturn in September and 2 courses had to be cancelled due to low numbers, due to the Lorenzo launch. Delegate evaluation of the programmes continues to be very good. A full evaluation of the LMDP will commence in late October, and the key findings will be shared.
- The Winter LMDP brochure will be launched in the Trust next month, covering all programmes up to July 2018 and including additional corporate specialism modules identified as part of the PMO and Model Hospital programmes. The new modules will be offered from late 2017.
- Bookings are now being taken for the Winder LEND sessions. The content of the sessions is currently being agreed and finalised.
- Work is now ongoing with CSLE, the new provider for the ADDS programme, and selection for the next cohort is on-track to take place in January 2018.
- The LMDP trajectory to be reworked following plans to hold on activity until it ready to be relaunched in the next year financial year.

7. Medical HR: Electronic Job Planning

Confidence Rating

Strategy: To ensure full compliance with Medical Terms and Conditions to mitigate risks to the organisation.





Headlines:

Consultant EJPs:

There are a total of 290 Consultant Electronic Job Plans which needed updating and sign off in the 2017/18 Financial Year. 273 have now been fully signed-off (94.14%), 2 remain in discussion stage with 10 at sign-off stage. 5 Job Plans are currently subject to mediation. All EJPs were published April 2017 and the timeframe for sign off had initially been extended to the end of July 2017. The steering group continues to meet weekly to review sign-off progress; chaired by the Medical Director.

SAS Grade:

100% of SAS Grade EJPs are now fully signed off. The EJP Team will continuing to provide additional training in respect of the new system and policy.

Guardian for Safe working:

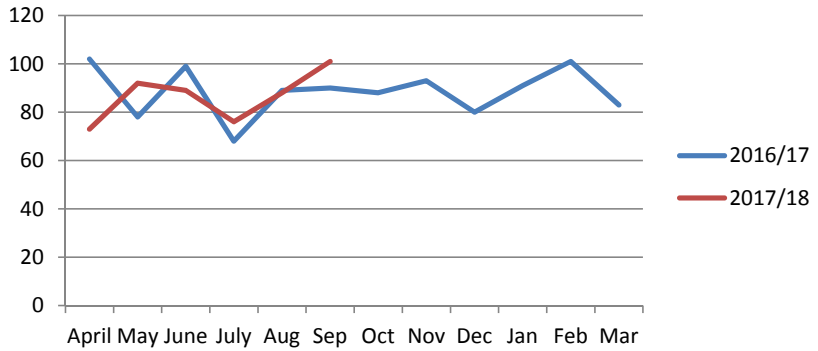
Provides quarterly board reports regarding exception reporting, for further information see Appendix 2

8. Staff Health and Well-being

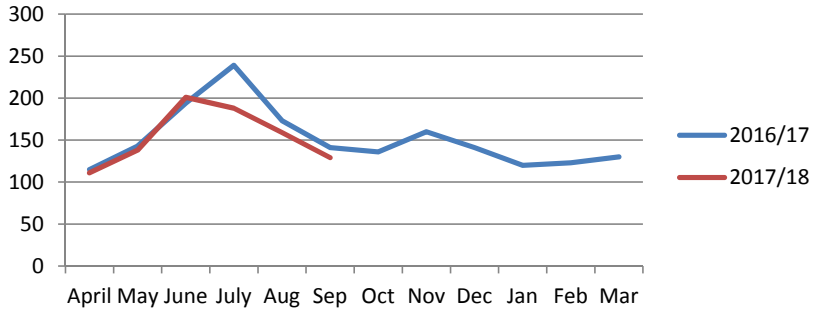
Confidence Rating

Strategy: To achieve the staff health and well-being CQUIN goal, to improve the support available for staff to help promote their health and well-being in order for them to remain healthy and well.

Number of referrals received from managers



Number of pre-placement assessments taken



Referrals to the Health at Work Service

H@W advice can be sought from managers and employees to support the improvement of health and wellbeing at work and reduce sickness absence.

101 referrals were received from managers in September, this represents a 15% increase in expected workload. Following attendance in clinic 100% of reports were issued within the 2 day target delivery time.

There was also an increase in self referrals, 68 employees telephoned the Health at Work Advice line to self-refer to the Health at Work Service, all these staff were offered advice about strategies to optimise their health at work within 1 day of the call.

Pre-placement health advice

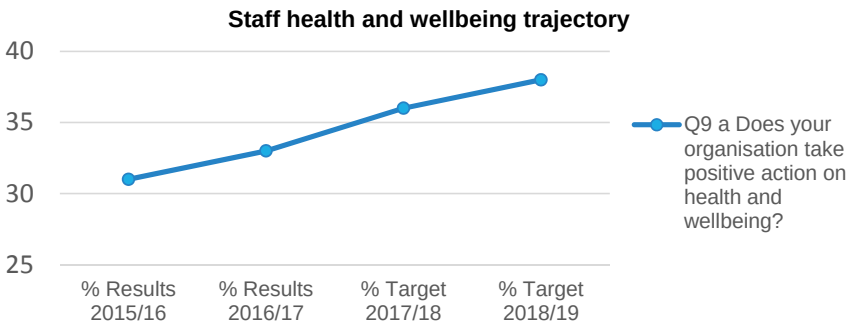
The Health at Work Service (H@W) provides the Trust with fitness for work advice on all new employees following an offer of a post.

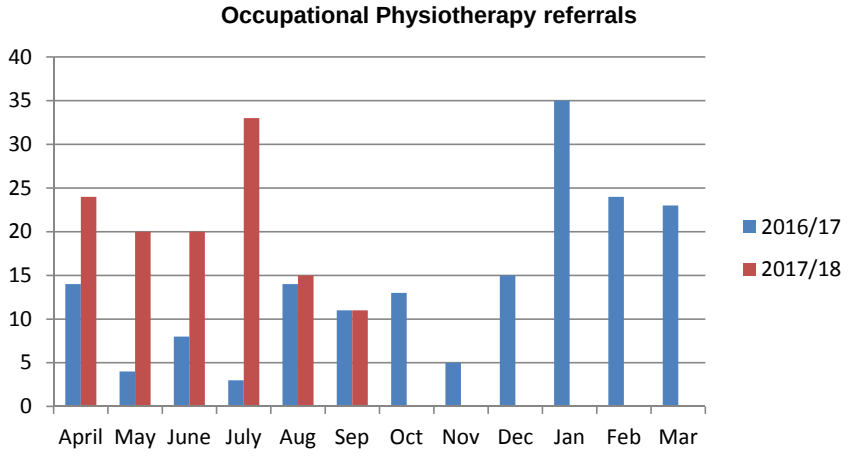
129 Preplacement health questionnaires were received in September, 80.6% of pre-placement health clearances were sent within 2 working days.

8b. Staff Health and Well-being

Confidence Rating

Strategy: To achieve the staff health and well-being CQUIN goal, to improve the support available for staff to help promote their health and well-being in order for them to remain healthy and well.





The Health at Work Service (H@W) are providing wellbeing initiatives and improving the support available for staff to help promote health and wellbeing.

Trajectory:
To achieve a 5% improvement in two of the three NHS annual staff survey questions on health and wellbeing.

To vaccinate 70% of front line healthcare workers against flu.

Performance

The staff flu vaccine campaign began on the 2nd October. Drop in clinics are being held in Lister Community Hub, at training events and in mobile clinics across the Trust. All managers have been asked to nominate a flu champion for their area to ensure greater access to the vaccine, so far 31 flu champions have been nominated. Regular communications are being sent to staff to publicise the campaign and explain the importance of being vaccinated. Weekly reports on the uptake of the vaccine will be provided.

On the 15th September a 'Know your numbers' event was held at Lister Community Hub to raise awareness of the importance of keeping a healthy blood pressure range. 61 employees attended for health promotion advice and a blood pressure check.

In September, 104 employees experiencing musculoskeletal issues and 30 employees with stress or mental health problems were telephoned by the Health at Work Service on their first day of sickness absence to provide early advice. 11 employees were referred for fast track occupational physiotherapy in September.

In September, 29 employees have telephoned the Trust Employee Assistance Programme, a further 4 have accessed help from the Workplace Options web site.

9. Workforce efficiency and capacity

Confidence Rating

Strategy: To deliver more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care.

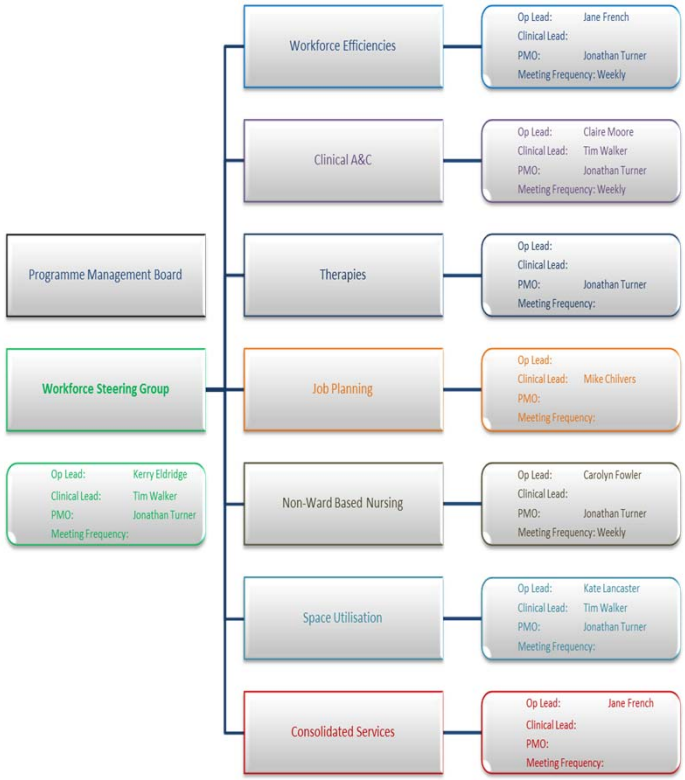


Fig 1. Workstream Organisation structure

Headlines:

As part of the Trust's Transformation programme, supporting the Model hospital agenda and development of a leaner Trust organisation structure, a workforce efficiency programme will develop an organisational design to align the demand, capacity and income of the Trust with more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care. In September and October, more efficient management of Fixed Term contracts, the tight control of vacancies, a MARS scheme and severance programme will deliver a leaner organisation as well as full year savings is £4.62 million. Staff side are being fully briefed and involved in the programme updates.

Performance and progress:

- The programme involves seven workstreams as detailed in the diagrammatic Fig 1. The A&C workforce efficiencies programme targets a 10% reduction of staff in scope, the full year effect for savings is £3.02 million. **Milestone:** The identification of savings reached £2.5 million in October, the delivery of the remaining £0.52million is on track for early November. The programme includes an estimated reduction of substantive posts of 115 wte, the strategy to limit any potential redundancy is the active management of vacancies, fixed term contracts and turnover to reduce the risk to substantive staff. **Milestone**: The MARS business case submission to NHSI was approved and Programme Board signed off the MARS scheme. Communication of the Scheme will be supported by a Manager information pack, and a presentation was delivered at DEC to the senior team. The next steps include the launch of the MARS scheme planned for the end of September, with MARS application window from the end of September to the middle of October. The modelling of MARS suggests a target of 80 MARS applications to deliver 35-40 approved applications. A 3 stage approval process is in place - 1) MARS panel, 2) review at the Rem Committee 3) approval from NHSI.
- The A&C clinical pathway will deliver co-located pods of staff supporting clinical delivery, the full year effect for savings is £1.6million. **Milestone:** The Divisional Director for CSS agreed to lead this pathway which will improve the successful delivery of this pathway. To understand barriers to implementation visits to Trusts including Reading are planned. A risk already identified is the requirement to engage fully with staff impacted by the pathway and the Medical consultant group. Actions include presentation at Divisional Boards in month 7. A further communication plan is in place for the next quarter. Further validation is underway to clarify the impact of WLI medical resource and nurse led clinics to ensure risks to income and capacity are protected.
- The e-job planning will support improved Medical capacity, this includes the delivery of the 42 week tracker to manage Medic PA capacity and performance. **Milestone:** Progress was made with the work identifying the mean costs for WLIs of £2,063 per session, OP at £816 (Medicine) and £742 (Surgery). The total opportunity from dropped theatre sessions is £561k and dropped clinics is £134K, this cost is still to be aligned with Budgets.
- The NWBN workstream objective is to improve cost efficiency of Senior Nurses in roles not directly clinical facing. **Milestone:** A diary exercise was completed by tranche 1 of the senior nurses. The next step is for senior nurses to replace qualified nursing shifts in October, the reduction in budgets will be realised in month 8. A further diary exercise is underway for tranche 2 of the senior nursing group. The plan is on track to deliver 88 ward shifts per month which will deliver a full year savings of £144k. Next steps include analysis of the diaries by the Director of Nursing for further actions.

11. Appendices

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1. ERAS Data
2. Medical Staffing Data
3. H@W Scorecard
4. Appraisal Data
5. Training Data
6. Benchmarking
7. Independent Contractors Quarterly Report

11. Appendices

1. ERAS Data

Source: ERAS	Total Live Cases as at 31-Aug-17	Total Live Cases as at 30-Sep--17	Surgery	Medicine	CSS	Women & Children	Cancer (inc R & D)	corporate
Headcount	5891	5881	1344	1461	926	761	658	731
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	21 (0.3%)	18 (0.3%)	3 (0.2%)	5 (0.3%)	4 (0.4%)	2 (0.3%)	3 (0.4%)	1 (0.1%)
Number of Grievances	7	6	0	3	1	0	1	1
Number of Capability cases	6	6	1	2	1	0	1	1
Number of B&H, discrimination and victimisation cases	10	8	1	0	1	0	2	4
Number of formal short term sickness cases including cases under monitoring	15	17	6	1	5	2	1	2
Number of formal long term sickness cases	54	51	10	17	3	9	5	7
Number of *MHPS cases (Medical cases)	2	2	0	2	0	0	0	0
Total number of cases in progress	115	108	21	28	15	13	13	16
Number of suspensions/medical exclusions (inclusive of over six months)	6	5	0	1	1	0	0	3
Number of suspensions lasting 6 months or longer	0	0	0	0	0	0	0	0
Number of appeals	5	2	2	0	0	0	0	0

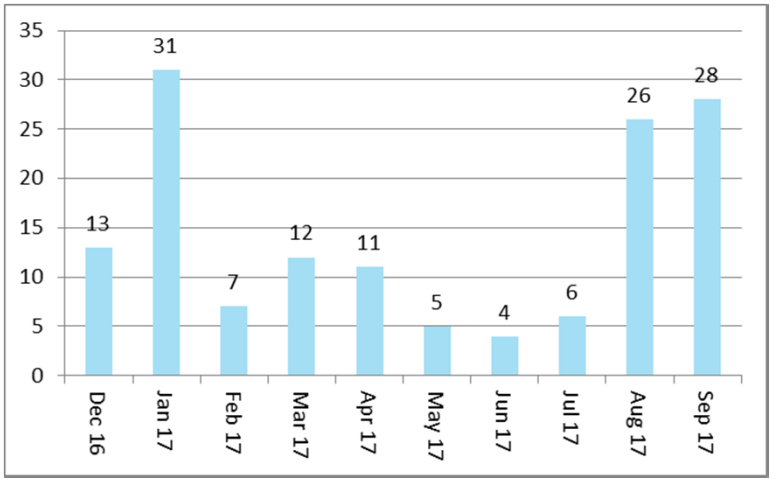
11. Appendices

2. Medical HR

Transition to the 2016 terms and conditions continues, in accordance with the nationally set timetable. As of September 2017, 93% of the Trust's doctor in training workforce is contracted to the new 2016 terms and conditions and all rotas are finalised as 'mixed economy'.

Exception Reporting increased in August 2017 with the increased number of doctors on the new contract.

Exception Reports Since Contract Implementation



Exception Report Division Summary Since August 2017 Changeover

	No. submitted reports	Total Additional Hours	Paid Enhanced Hours	Paid Basic Hours	Total Pay	Total TOIL Hours
Medicine Total	32	64.75	0	25.5	£389.19	20.75
Complete	19	47	0	25.5	£389.19	20.75
Pending	10	12.75				
Waiting For Doctor Agreement	3	5				
Surgery Total	21	75	0	0	£0.00	20.75
Complete	6	20.75	0	0	£0.00	20.75
Pending	15	54.25				
W&C Total	1	1.25	0	0	£0.00	0
Pending	1	1.25				
Grand Total	54	141	0	25.5	£389.19	41.5

11. Appendices

3. H@W scorecard

Core Activity	Avg last yr	Last month	This month
Trust			
Pre placement screened	**151**	159	129
Manager Referrals received	**89**	88	101
Immunisations and blood tests given	**365**	394	223
Health surveillance	**67**	79	72
Blood borne virus incident (sharps) reported	**13**	15	13
Phased return to work plan implemented	**24**	37	38
Self referrals	**20**	60	68
Total 'live cases' as at 02/10/2017		126	134
External			
Pre-placement	**84**	74	56
Manager referrals	**44**	27	34
Immunisations and blood tests	**152**	103	133
Health surveillance	**8**	1	6
Blood borne virus incident (sharps)	**4**	0	2

Wellbeing Promotion	Last month	This month
Early Intervention - Mental Health (S10)		
Phone advice offered, manager informed	7	16
Recently advised / wrong codiing/ not appropriate	4	2
Unable to contact, manager informed	11	12
Early Intervention - Musculo-skeletal (S11/12/28)		
Phone advice offered, manager informed	39	36
Recently advised / wrong codiing/ not appropriate	28	28
Unable to contact, manager informed	29	40
Number of physiotherapy referrals	15	11
Employee Assistance Programme (EAP) calls		
Calls to EAP	34	29
EAP Web hits	15	4

Performance	Avg last yr	Last month	This month
Trust			
Pre placement health screening processed within 2 working days of receipt	**92%**	**99.3%** **158/159**	**80.6%** **104/129**
HWS advisor appointment within 6 working days following receipt of fully completed manager referral	**90%**	75.3% 55/73	78% 64/82
HWS Physician appointment within 12 working days following receipt of a fully completed manager referral	**84%**	**80%** **8/10**	**71.4%** **10/14**
Medical report sent following consent within 2 working days of HWS appointment	**97%**	**100%** **74/74**	**100%** **79/79**
External			
Pre placement health screening processed within 3 working days of receipt	**86%**	**100%** **74/74**	**91%** **51/56**
HWS advisor appointment within 6 working days following receipt of fully completed manager referral	**80%**	**52%** **13/25**	**44%** **15/34**
HWS Physician appointment within 12 working days following receipt of a fully completed manager referral	**70%**	**50%** **1/2**	**0/0**
Medical report sent following consent within 3 working days of HWS appointment	**97%**	**96.5%** **28/29**	**100%** **30/30**

	Avg last yr	Last month	This month
Overall % of staff (client) satisfaction	**93.30%**	**96.75%**	**82.41%**
Overall % of manager satisfaction	**84.60%**	**72.64%**	94.64%

11. Appendices

4. Appraisals

Appraisal compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % November
Cancer Services	361	41	80	482	**89.80**
Clinical Support Services	490	96	280	866	**83.62**
Medicine	717	194	229	1140	**78.70**
Corporate	449	98	146	693	**82.08**
Research & Development	56	16	18	90	**77.78**
Surgery	676	206	151	1033	**76.64**
Women's and Children's	420	106	86	612	**79.85**
Grand Total	3169	757	990	4916	80.72

Appraisal by Payband Data

Band	Done	Not Done	Not Due But require review	Grand Total	Completion rate%
Band 1	103	16	20	139	**86.55**
Band 2	507	104	248	859	**82.98**
Band 3	424	103	151	678	**80.46**
Band 4	312	83	88	483	**78.99**
Band 5	658	165	212	1035	**79.95**
Band 6	618	116	140	874	**84.20**
Band 7	376	89	70	535	**80.86**
Band 8A	98	40	25	163	**71.01**
Band 8B	33	19	7	59	**63.46**
Band 8C	19	3	14	36	**86.36**
Band 8D	8	9	5	22	**47.06**
Band 9	2	2	3	7	**50.00**
SMP	10	8	3	21	**55.56**
Tupe	1		4	5	**100.00**
Grand Total	**3169**	**757**	**990**	**4916**	**80.72**

11. Appendices

5. Training

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	63.78%	61.51%	54.99%	63.60%	68.64%	75.74%	77.17%	69.92%
Statutory and mandatory training average compliance (Incl M&D)	86.41%	85.32%	83.00%	83.67%	91.01%	90.49%	93.83%	89.84%

11. Appendices

6. Benchmarking

Trust	Mandatory Training Rate Jun 17	Appraisal Rate Jun 17	Turnover Jun 17	Vacancy Rate Jun 17	In mth Sickness Jun 17	Agency Jun 17
Bedford Hospital	82%	81%	14.45%	8.90%	2.80%	5.90%
Herts Community	90%	85%	14.50%	11.70%	3.80%	8.90%
WHHT	92%	90%	16.10%	13.00%	2.90%	8.00%
East & North Herts	92%	84%	13.20%	9.60%	3.92%	3.80%
Luton & Dunstable	80%	78%	16.22%	13.10%	2.88%	8.50%
HPFT	84%	86%	13.60%	13.70%	4.27%	5.90%
ELF Bedford	84%	75%	16.16%	16.60%	6.75%	12.00%
ELF Luton	84%	86%	17.40%	18.40%	6.49%	7.30%
Princess Alexandra	75%	68%	16.60%	11.10%	3.45%	11.10%
CNWL FT	96%	91%	17.70%	14.70%	3.56%	4.40%
Milton Keynes UFT	91%	87%	13.10%	15.70%	3.89%	8.70%
Average	86%	83%	15.37%	13%	4.06%	7.68%

11. Appendices

7. Independent contractors (excluding high value agency workers) during all or part of the period of July 2017 to end September 2017

Division/Department	Duties	Contract Arrangement
Finance	Senior Contract Manager	Contract to: 31st March 2018
Medicine	Renal IT Systems Development	Awaiting further details
Medicine	Professional Supervision	Occasional service provision
Medicine	EEG cover service	Occasional service provision
Medicine	Neurophysiology Service	Occasional service provision
Medicine	Coaching service	Contract ended in July 2017
Estates	Specialist strategic Estates services	Contract to be issued to 31st March 2018
Estates	Estates Health & Safety Advisor	Contract to be issued to 31st March 2018
Workforce & OD	Interim Manager (Cancer)	Contract to 24th March 2018
Workforce & OD	Interim Manager (Cancer)	Contract to 24th March 2018
Workforce & OD	ADDS Consultant	Contract to 31st March 2018
Workforce & OD	Coaching & Leadership Consultant	Contract to 31st March 2018
Workforce & OD	Midlands and East Talent Management Programme	Contract to 31st March 2018
Workforce & OD	Interim Director of Operations	Contract to 31st March 2018

Agenda Item: 10

TRUST BOARD PART I – 1 NOVEMBER 2017

RISK AND QUALITY COMMITTEE – MEETING HELD ON 24 OCTOBER 2017
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the RAQC meeting of 24 October 2017.
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	CHAIRMAN OF RAQC
PRESENTED BY:	CHAIRMAN OF RAQC
AUTHOR:	CORPORATE GOVERNANCE OFFICER/ COMPANY SECRETARY
DATE:	OCTOBER 2017

We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement

RISK AND QUALITY COMMITTEE – MEETING HELD ON 24 OCTOBER 2017

SUMMARY REPORT TO BOARD – 1 NOVEMBER 2017

The following Non-Executive Directors were present:
Bob Niven (deputising as Chairman), Val Moore

The following core attendees were present:
Nick Carver, Jude Archer, Liz Lees and Jane McCue

The following points are specifically highlighted to the Trust Board:

Safe Nurse Staffing Levels
The Director of Nursing presented the latest Safe Staffing Report, which provided an update on monitoring of safe staffing levels by ward and the cumulative position in the month. The report included an analysis of red triggered shifts and those shifts that remained red. The analysis indicated a sustained increase in the number of shifts triggering red since June 2017, along with an increase in the shifts that remained red. Whilst the number of red triggered shifts that were unable to be mitigated had increased, the figure represented less than 0.35% of all shifts worked and it was noted that the decline had occurred within the context of agency fill reducing nationally. Nonetheless, the report detailed the actions that were taking place to drive improvement in this area. The report also highlighted that there had been a slight increase in the number of falls in September 2017. The Committee noted the report and agreed that performance should continue to be closely monitored.

Corporate Risk Register Report and Improvement Plan
The Company Secretary presented the Risk Register Report. The number of risks that had been formally approved had decreased compared to the previous report, as had the number that had been reviewed within their pre-defined timeframe. Progress against the improvement plan had slowed due to a vacancy in the risk management team. The possibility of remodelling this post was currently being explored. It was suggested that the relevant directors and Chair of RAQC should meet to discuss the current position and how best to make progress in this area. A report would then be provided back to a future RAQC meeting. It was also noted that the post implementation of Lorenzo would be escalated as a separate risk on the Board Assurance Framework. The Company Secretary was in the process of drafting the entry.
Post meeting note: The report and actions have been discussed with the Divisional Executive Committee.

Fire Safety Update and BAF Discussion (Estates)
The Director of Estates and Facilities provided an update on fire safety. It was reported that the Trust's largest estates risk item was being addressed in the current year so fire safety would be the top priority for the next year. He reported that the Trust had a good working relationship with the local fire inspectorate and the Trust's fire safety surveys were shared with them. Some further information had now been received from Hillingdon Hospitals Foundation NHS Trust regarding the fire risks at MVCC, although not to the same level as detail as the Trust held for its own sites. It was reported that there was currently a good working relationship with the new director of estates in post at Hillingdon.

The Committee also received the BAF entry regarding estates. It was noted that the entry would need to be updated in light of latest information regarding fire safety.

Outcomes:

Divisional Presentation – Medicine & ED
The Divisional Director, Divisional Chair and Nursing Services Manager from the Medicine Division provided a presentation for the meeting. The presentation included a brief overview of the Medicine Division, details of the top risks facing the Division and information on the Division's preparedness for a CQC inspection. The presentation included an overview of the findings of the CQC ED survey October 2016 – March 2017, in which the Trust's score had improved on the 2014 survey in the majority of areas. There was some discussion around how the Board could support the Division in terms of improving on its previous CQC rating. There was also some discussion around the rollout and impact of Nervecentre on the Division. The Committee noted the report.

Learning from Deaths Report
The Medical Director Presented the Learning from Deaths Report (formerly the Mortality Report). She considered that the report was generally reassuring. The SHMI for the period had temporarily stabilised at 102.69 ('as expected band 2'). The report included the latest information regarding the Trust's work in relation to the Learning from Deaths national requirements. The Trust's new Learning from Deaths and Mortality Case Record Review policies had now been issued. The report also included the Trust's Learning from Deaths dashboard. The Medical Director expected the Trust's figures to be in line with those of large studies as the new regime became embedded. An update was also provided regarding work towards providing 7 day services. This was continuing to progress, albeit slowly, and the Trust benchmarked average or better for all areas in the latest audit results.

Cyber-Security Report
The RAQC received a report on the outcome from the internal and external audits of cyber-attack vulnerabilities and mitigation steps post the cyber-attack of 12 May 2017. The report included details of the recommended actions arising from the audits. Some of the actions required a significant level of investment to implement. There was some discussion around the current process for the application of update patches. The Trust was in the process of implementing a vulnerability scanner and it was suggested that a further update could be provided for the Committee once that was in place. It was agreed that the RAQC would refer the 'must do' recommendations arising from the audits to FPC and capital resources group. The Committee noted the report and asked to be kept informed of progress.

Complaints, PALS and Patient Experience Report
The Committee received the quarterly Complaints, PALS and Patient Experience Report. The number of complaints received had increased from 246 in Quarter 1 to 281 in Quarter 2. The average response time was below the Trust's target of 80% but the year to date position was improving. Further analysis regarding response times would be provided in the next report. The complaints team were achieving the national mandatory timeframe of acknowledging and contacting all complainants within three working days. There had also been a significant increase in the number of concerns dealt with by PALS, rising from 676 in Q1 to 968 in Q2. The Committee noted that there had been a recent trend for complaints to be raised with regulatory bodies instead of, or as well as, with the Trust. The Committee considered the extent to which the results in this report matched data elsewhere, for example the recent CQC survey favourable comments on progress in ED. The report included the findings of the National Cancer Survey 2016 and Picker Maternity Survey 2017 results. The Committee were informed that actions were being taken to address the issues identified through these surveys. The Committee noted the report and would keep the position on Complaints and PALS under review.

Non-Medical Professional Education Annual Report
The Committee received the Non-Medical Professional Education Annual Report 2016-17. It was noted that the medical education update had been provided at the previous meeting but the Committee cycle would be amended so that in future a joint annual report would be produced. The report included updates regarding leadership courses, revalidation and the trainee nursing associate role. The Committee noted the position regarding reductions in funding for CPD and the options being explored to provide training in different ways in order to address this. The Committee welcomed the report.

The Non-Medical Professional Education Annual Report is appended to this report.

Clinical Audit
The Medical Director presented the mid-year Clinical Audit Report. She considered that the report was generally encouraging. This year had seen a significant increase in the total number of registered audits due to the inclusion of 454 nursing audits that were not previously included in the half yearly reports. It was noted that thanks to efforts by the clinical audit team, no audits had been abandoned so far this year. The Committee noted the report.

Workforce Report and Medical Recruitment Quarterly Update
The RAQC received the Workforce Report and Medical Recruitment Quarterly Update. Highlights from the workforce report included good progress being made in reducing temporary staffing levels in the year to date, an improvement in the annualised sickness absence rate and an improved position in terms of the WTE in post compared to the same month last year. Regarding the medical recruitment plan, it was now one year since the plan had been implemented. The net increase over the full 12 months was 39.5 WTE. Some difficult to recruit to posts required further work and alternative ways of recruiting to those posts were being explored. An update was also given on the staff 'flu vaccine and it was noted that the first meeting to review MARS applications had been held. The Committee noted the report.

Floodlight Scorecard / Exception Report
The floodlight scorecard was not included with the agenda due to issues with data collection.

The following reports were noted by the Committee:

1. **Clinical Governance Strategy Committee**
   The Committee noted the latest update report from the Clinical Governance Strategy Committee. The report included details of the CGSC's discussion regarding the executive decision to reduce the rolling half day provision for the year. The CGSC had been concerned by the decision and discussed the implications, whilst recognising the pressure on the organisation financially. It was reported to RAQC that the decision had been for half of the planned RHD sessions for the rest of the year to go ahead. The position for 2018 would be reviewed.

2. **Infection Prevention and Control Monthly Report**
   The Committee noted the Infection Prevention and Control monthly update. There had been 1 hospital associated MRSA bacteraemia in the year to date (against a target of 0 cases to year end). There were 15 cases of C.diff in the year to date (against a target of 11 cases to year end), though 6 cases to date had been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions as there were no identified gaps in practice. The report included additional information on the increase in reported cases of C.diff and the actions being taken in response.

3. **CQC Insight Dashboard Briefing**
   The RAQC noted the highlight report regarding the latest version of the CQC Insight dashboard (October release). The Trust's composite indicator score had decreased from the September dashboard. The main driver behind this was the impact of the key performance indicators.

4. **Emergency Preparedness Update**
   The Committee noted the Emergency Preparedness Update. It was noted that, having received the results of an internal audit regarding business resilience at their last meeting, the Audit Committee were keen to ensure the action plan was progressed with some urgency.

Avoidable Variation
The Committee recalled the discussion of this issue at its and the Board's previous meetings, noted the ways in which the Trust would be taking it forward and resolved to keep the issue under consideration.

Bob Niven
October 2017

East and North Hertfordshire NHS Trust

Non-Medical Professional Education

Annual Report

2016-17

Carolyn Fowler
Deputy Director of Nursing, Education and Research

October 2017

CONTENTS

1. Introduction

This report outlines the key activities and achievements within non-medical professional education during 2016-17. An annual report relating to medical education has been submitted by the Director of Medical Education to RAQC in September 2017. The education teams within the Trust have worked in collaboration to continue to deliver a robust education programme for our staff, our pre-registration students and our trainee doctors.

The Multi-professional Education Board meets bi-monthly. It oversees development and delivery of education within the organisation to gain assurance of quality. **Appendix 1** identifies the reporting framework.

A high level of involvement from the medical and nursing executive leads for education ensures robust governance of multi-professional education.

Role	Name and Job Title
Executive Director for Medical Education	Jane McCue Medical Director
Executive Director for Non-Medical Education	Liz Lees Acting Director of Nursing and Patient Experience
Director of Medical Education Chair of Multi-professional Education Board	Shahid Khan Director of Medical Education and Associate Medical Director
Deputy Director of Non-Medical Education	Carolyn Fowler Deputy Director of Nursing, Education and Patient Experience

The quality of the Trusts learning and teaching environment for trainees and pre-registration students and effective use of Continuing Professional Development funds is externally monitored by Health Education East of England (HEEoE).

Provision and delivery of high quality education is imperative to ensure safe patient care. This requires a quality framework that recruits to values which ensures that the pre-registration and trainee curriculum will equip healthcare professionals for the future.

Some of the key documents that shape our strategic direction are:

- The Health Education England (HEE) Mandate' Developing the Right people with the Right Skills and the Right Values' 2013. (Refreshed in April 2014).
- The Health Education East of England (HEEoE) 2020 Workforce Skills Strategy.
- The Trusts Vision, Strategic aim and objectives.
- Broadening the Foundation Programme Report 2014
- Raising the Bar, Shape of Caring: A review of the Future Education and Training of Registered Nurses and Care Assistants (2014)
- GMC *Promoting excellence: standards for medical education and training* January 2016.
- HEEoE Framework for the training, selection and appraisal of Educational Supervisors. Nov 2014
- HEEoE Framework for the training, selection and appraisal of Educational Supervisors. Nov 2014

The results of the National NHS staff survey 2015 showed significant improvement in the quality of non-mandatory training, learning and development the Trust being in the top 20% of acute Trusts.

1.1 Learning from Incidents

Learning from incidents is a key driver to developing and prioritising education. When an incident occurs the Trust is eager that where possible an incident is not repeated. Clinical staff conduct or participate in investigations; and based upon any recommendations a set of actions are agreed. During 2016-17 actions have included:

- Introduction of an improved process for managing tracheostomies in children including checklist and room set-up
- Introduction / Enhancement of training and review of policies
- Replacement of cots for better management of resuscitation
- Revision of the triage process within the urgent eye service
- Introduction of safety huddles

A summary of learning from incidents is shared via the 'learning points' for the rolling half day meetings and via the patient safety and medication safety newsletters circulated to all staff. Divisional Board meetings and/or Divisional Clinical Governance meetings discuss incident trends and details of serious incidents for assurance purposes to ensure actions are fully implemented.

2. Statutory and Mandatory Training and Compliance

Statutory and Mandatory Training has continued to be a priority for the education teams, and is monitored by the bi-monthly steering group.

Since the beginning of the Vital Statutory and Mandatory programme in 2013, compliance for staff having all nine statutory competencies has continued to improve from 38% to 68%. In 2016-17 overall coverage reached its highest point of 90% in January and February 2017, which is the Trusts target. The challenge for the upcoming year is to maintain the overall combined compliance at 90%.

The Trust remains in a good positon when benchmarked against neighbouring organisations. The aspiration to reach and maintain 90% will set the Trust ‘amongst the best’ within Health Education East of England. The greatest challenge has been to ensure that staff are compliant with the competencies that require renewal annually namely, fire, information governance and safeguarding children level 3. **Appendix 2** details compliance breakdown by staff group, division and overall compliance as at March 2017.

The Trust has continued to develop the safeguarding children’s training programme to reflect the expected outcomes of the ‘Safeguarding Children and Young People Inter Collegiate Document’ (2014). Compliance is reported monthly within the Trust floodlight scorecard and exception reports are presented by the Director of Nursing to the Finance and Performance Committee (FPC).

Capacity required for training all Trust staff is currently 400 places a month, for clinical and non-clinical for VITAL two yearly programme and VITAL yearly update.

There are four clinical mandatory compliances:

- Basic Life Support and Automated External Defibrillator (AED)
- Blood Transfusion
- Medical Gases
- Medicines Management

The Statutory and Mandatory training compliance workbook available on the knowledge centre continues to provide assistance for all staff groups to establish and monitor their compliance.

The Resuscitation Service and the Moving and Handling Department continue to be proactive to their approach to training and have introduced:

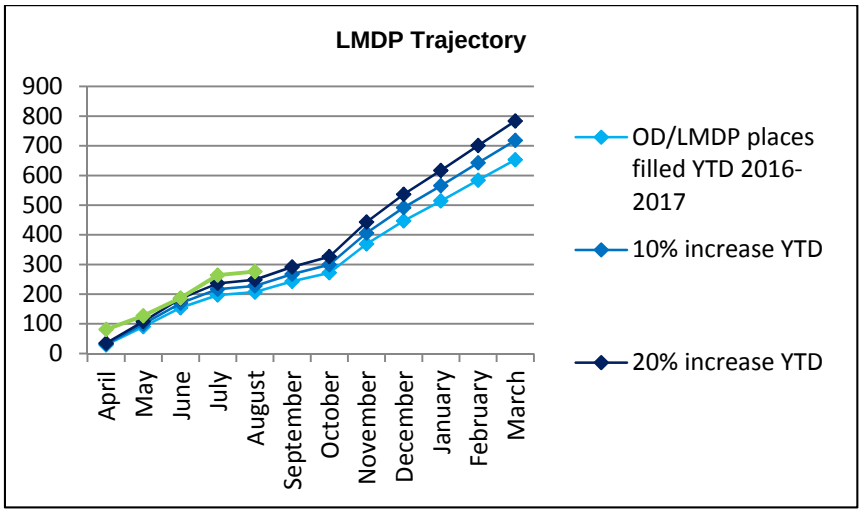
- National Early Warning Score (NEWS) and recognition of the deteriorating patient to all their training delivery (Resuscitation Service).
- Learning from incidents, scenario based (Moving and Handling Department).

3. Leadership

3.1 2016-17 Update

During 2016 the Trust launched a comprehensive internal Leadership and Management Development Pathway (LMDP). The series of programmes, events and bespoke interventions have been designed and run by leaders and facilitators within the organisation. The pathway has proven to be very successful and has influenced several organisational leaders and its success has led to award nominations and a further enhancement of the development made by the Trust.

"An absolutely fantastic course. I learnt loads and the group was great. I came in yesterday thinking I would hate the team exercises, but I actually really enjoyed them and learnt a lot – thanks"

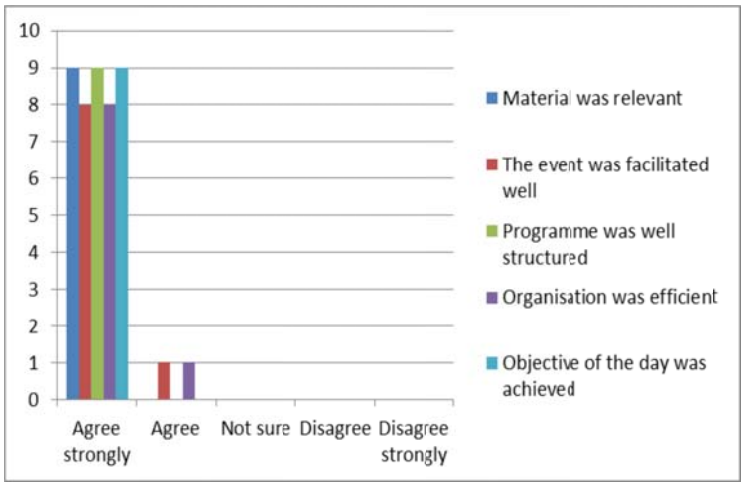


The launch of the pathway in 2016 saw the offer of leadership development reach out to all levels of staff – position is not an indicator of leadership ability of influence. This has seen a significant increase in both the numbers and the range of staff who have accessed leadership development.

"Good sessions, very informative, good course content and delivery"

The LMDP is designed and delivered with the leadership philosophy and the leadership behaviours of the organisation at its heart. The purpose of the philosophy and behaviours are to create an empowered workforce that believes it has both the permission and the ability to make a difference in the moment.

"Enjoyable and positive session with a good mix of theory and practical examples"



The evaluation of the programme has been exceptional and the example given is from a new programme 'Leadership Awareness'. Across the board the blended style of learning offered and the flexibility of the facilitators is appreciated and impactful.

"Jam packed with fantastic information and exercises"

The qualitative evaluation of the programmes has been outstanding and this example comes from the 'Effective Manager Programme'. It is indicative of the high quality programmes the team has designed and is capable of delivering.

"Enjoyed the contributions of the team, the conversations and openness of the course, meeting colleagues. Thank you"

The programmes on the LMDP were submitted for CPD certification in 2017 and were successful. The submission of all programme materials for review and inspection further confirmed the high-quality nature of the pathway.

To further enhance leadership and management development within the Trust a relationship has been established with the UoH Business School and this will further enhance the organisations offer and assist in further securing relevance and quality

As well as the LMDP the team have continued to support the *Accelerated Director Development Scheme* and a new provider has just been commissioned to develop the third cohort on this outstanding programme. Support for the Mary Seacole programme has also been undertaken and internal facilitators trained and developed. An internal 'On-Boarding' programme has been one of the highlights of the year and evaluation is currently underway but it is looking very impressive.

4. Non-Medical Education

Non-medical education is responsible for the education, training and support of approximately 3,000 clinical staff. It also supports the learning of pre-registration students on placement: Adult and Children's Nursing, Midwifery, Operating Department Practitioners (ODPs) and Radiographers. It works collaboratively with other Trust areas that manage student placements within the work place, i.e. Healthcare Scientists and Pharmacists. In 2016-17 the department continued to actively encourage and support students from other universities and countries to have elective placements and opportunities within the Trust.

4.1 Quality Performance Review (QPR) July 2016

The 2016 QPR identified good practice in relation to the Trusts governance structures for students and trainees. The visiting team identified excellent engagement with and learning opportunities for our students. Where areas for development were identified, an action plan has been developed that includes ensuring a robust system for student IT login, development of an ESR mentor register and the introduction of students being reflected on E roster.

An Induction programme was successfully delivered last December 2016 capturing over 100 students from different branches. All students who attended the induction were awarded a badge entitling them to reduced staff costs in the staff dining room.

Photograph of the students following a treasure hunt where they found different letters in departments

4.2 Continuing Professional Development (CPD)

ENHT received £293,236 funding from Bedfordshire and Hertfordshire Workforce Partnership for CPD commissioning for the year 2016-17, a 25% drop in allocated funding from 2015-16. Funding was allocated to the Trust by HEE in July 2016, resulting in a five month window to plan and commission, instead of the usual 11 months. Course cancellations by the providers at short notice and lack of capacity on some courses due to the July funding allocation resulted in returning £10,031 to HEE.

The table below shows CDP spend by education provider for 2016-17:

Provider	Initial allocation	Final Spend
Anglia Ruskin University	£ 24,218	£ 21,332
University of Bedfordshire	£ 42,693	£ 39,858
University of Herts	£226,325	£222,015
Total	**£293,236**	**£283,205**

162 university courses were commissioned. These included:

- Dissertation modules for the Advanced Nurse Practitioner an on-going role development in the Emergency Department.
- High Dependency Midwifery Care modules were also commissioned in support of service.
- Mentorship modules in support of our pre-registration student cohorts.
- Non-Medical Prescribing for nurses and Allied Health Practitioners looking to expand service delivery.
- Bespoke leadership programmes continued to run successfully, with another 36 attendees on the Anglia Ruskin University course for band 5-6 development and Skills for Clinical Leadership for band 6-7 development at University of Hertfordshire. These programmes were developed in-house to reflect the requirements of our clinical leaders.

The programme for bands 2-4 ‘Recognising the Deteriorating Patient’ simulation study day was again successfully commissioned at University of Hertfordshire (UoH) with 28 attendees and excellent feedback. Places were offered to West Herts Hospitals Trust in the spirit of collaborative STP working. Other short courses commissioned were End of Life in respiratory care, Dementia and Wound care.

The method of education delivery continues to be a challenge, with the workforce often struggling to leave the work environment. In response to this, flexible methods have been adopted and learning taken to the work place. In-house courses have also been provided, including a 5 day programme ‘Care of the Acutely Ill Ward Patient’ for registered nurses delivered by our clinical educational facilitators and again offered out across the STP.

4.3 Preparing for Electronic Observations and Nervecentre

The recording of patient’s vital signs is essential to enable effective recognition of a deteriorating patient. Education, both classroom and practical application, supports the acquisition and maintenance of this skill. In 2016-17 a refocus on this competency prepared the workforce for the introduction of Nervecentre in 2017. This toolkit enables electronic recording of patient observations. The software has pre-defined observation parameters, in line with the National Early Warning Score (NEWS), and the Trusts escalation process, enabling the instant notification of a deteriorating patient to senior nurses.

The education required to allow Nervecentre to be introduced to clinical practice has resulted in the training and assessing of over 1,117 Nurses and Clinical Support Workers, 379 Doctors and 84 Allied Health Professionals, which equates to 92% of all eligible staff. This programme of education ensures that staff have the required level of ability to undertake the measurement and recording of patient observations.

4.4 Revalidation

Following the implementation of the Nursing and Midwifery revalidation the Trust has continued to support registrants undertaking the process. A knowledge centre page is dedicated to providing resources to support and a database of revalidation dates is available. All registrants are notified by the Trust by email 3 months prior to their revalidation date. Nurse Education continues to facilitate revalidation workshops.

4.5 Pre-registration Non-Medical Students

The Trust continues to be involved in all aspects of the non-medical student experience. This includes Trust staff interviewing prospective students for places on degree courses, sitting on University Fitness to Practice and DBS panels, the audit of clinical placements and working on curriculum development in collaboration with partner Universities.

Student support continues to be a priority for the department, with students offered:

- Multi professional induction programme delivered in house for all students at beginning of their 3 year programme
- Welcome sessions for each new cohort to provide supportive information for the placements duration and to promote relevant Trust policies and expectations.
- Weekly student newsletter identifying news and learning opportunities for students.
- Weekly student forums. These are teaching sessions in subjects relevant to the placement experience such as Sepsis, Trust Values, Dementia and Tissue Viability. These are delivered by Trust specialists and the Education Team.
- Calculation workshops to assist students with this skill in practice.
- Weekly Student and Mentor Surgeries for Students to access on a drop-in basis to talk through concerns or discuss learning needs.
- Inclusion in three way communication between University, Trust and students.
- Attendance of mentors update to provide student perspective
- Inclusion in all Trust initiatives

The recruitment and retention of the student workforce has been a key focus for the education team in 2016-17. A simplified process of recruitment to encourage students to remain at the Trust is ongoing.

Darren Smith was shortlisted for the 2017 Nursi Times Student Nurse of the year award. Darre commenced his career as a Clinical Support Work at ENHT, he has progressed through th apprenticeship development route and has nc completed the Flexible Nursing pathway programm at the University of Bedfordshire, qualifying as Registered Nurse in August 2017.

4.6 Bands 1-4 Workforce and Apprenticeships

Apprenticeships are integral to the Trusts recruitment process of Bands 1-4. The Trust trained more apprenticeships again than any other provider in Bedfordshire and Hertfordshire in 2016-17. The Trust also remains one of the highest providers of apprenticeships in the East of England. Below details the number of apprenticeships commenced in 2016-17.

Apprenticeships	2016-2017
Number of candidates	228
Health Education England Target	228

The Apprenticeship at Level 2 in Clinical Health provides knowledge and skills for the development of the Clinical Support Worker (CSW) from the point of recruitment, in line with the Skills Pledge, striving towards having a workforce which is fit for practice. On successful completion of the Apprenticeship award, subject to a vacancy being available, a substantive post is gained by the CSW. A clear development progression pathway has been developed for CSW's from a Level 2 Apprenticeship qualification through to becoming a Registered Nurse.

The Finance department recruited two new employees 2016-17 and have created a career pathway for their development and will soon be progressing onto their higher Apprenticeship.

4.7 New Roles- Trainee Nursing Associate

The Trust was accepted in collaboration with the STP to be a pilot site for the Trainee Nursing Associate Programme, second pilot site wave to commence in April 2017. This is an educational work based learning programme aimed at CSW's. Educationally the successful candidates gain a foundation degree and clinical experience from clinical placements in other Organisations within the STP. 17 candidates commenced the two year programme, 64 trainees across the STP.

The Paediatric department also have five Trainee Nursing Associates undertaking a programme which is affiliated with Great Ormond Street Hospital.

4.8 Apprenticeship Levy

The Trust prepared for the introduction of the Levy, being introduced by the Government in April 2017. The Levy is designed to encourage employers to embrace apprenticeships as a way of meeting current and future skills needs. Apprenticeships will be available for all staff groups from a Level 2 qualification through to a Level 6 degree level. Apprentices must account for 2.3% of the workforce. In view of the reduction of CPD funding this will be an opportunity for the Trust to introduce Apprenticeship's across the Organisation supporting the training and development of all staff.

4.9 Ward Accreditation Programme/ Ward development and Improvement

The purpose of the ward accreditation programme was to support wards to understand their baseline positon in relation to patient safety and experience and develop an action plan to ensure improvement was monitored. The framework uses the CQC five lines of enquiry. The ward accreditation programme was a commissioning for quality and innovation (CQUIN) during 2015-16.

The Trust continues to support this programme, with six wards developed through this approach. A significant improvement has been demonstrated from the programme in the Nursing and Midwifery Quality Indicators, 15 Step Challenge and Friends and Family Test.

The programme is supported by an educational facilitator, who works with the teams on the wards. The essence of the programme is to develop, coach and support the ward manager to lead their team through the improvements required. Action plans are developed and monitored weekly, moving to monthly as assurance of improvement is evidenced. The action plan works in conjunction with any CQC action plan.

The ward development framework provides assurance to the Trust that the care delivered is of the highest quality and that, where identified, improvement and actions are identified and monitored leading to a sustainability action plan.

4.10 Non-Medical Clinical Tutor

This role was funded again by Health Education East of England (HEEoE) in 2016-17. The Trust has incorporated the responsibilities into the role of the Non-medical Education Lead, using the funding to support pre-registration students across the Trust.

This role has worked in collaboration with the Deputy Director of Nursing and Director of Medical Education Department to develop multi-professional learning for students and staff within the Trust.

4.11 Wider EU and Overseas Recruitment- Support and Development

During 2016-2017 ENHT recruited a total of 74 International nurses. These nurses have come mainly from the Philippines, Finland, Trinidad, Jamaica, Botswana and Nigeria. One of the Educational Facilitators supports the learning and training of these nurses, which is crucial to ensure a workforce fit to practice.

Of the 74 nurses recruited 69 have had to undergo and pass the CBT Part 2 (OSCE) examination to obtain their NMC PIN. A bespoke educational timetable of training and support for each nurse has enabled a smooth transition to clinical practice within the Trust. There is an 8 –10 week training programme for all OSCE candidates to attend to prepare them for their clinical NMC examination.

All training for the OSCE is conducted when possible in a simulation environment, presently 7A provides a suitable clinical environment for training. The purchase of a clinical mannequin funded by 'The Friends of Lister Hospital' has proved invaluable to clinical skills training.

Photograph on Ward 7A with The Friends of Lister Hospital and the mannequin

The success of the comprehensive induction and OSCE preparation programme for the international nurses has been reflected in our pass rate of 97%, in comparison to the national average 60% pass rate in achieving an NMC PIN number.

5. Research in Education

5.1 University of Hertfordshire

The first student nurse from the University of Hertfordshire (UH) has successfully completed a two week elective placement with the research teams. The student nurse produced an excellent reflective account of her experience. Due to this positive experience Research and Development are now on the elective placement option for students from UH.

A group of student nurses from Shanghai spent an afternoon with the research team and with the support of an interpreter were able to share research nursing practice experiences.

5.2 Research nurse training

- All new research nurses are expected to attend the ECRN fundamentals in research course. 70% of research nurse have completed the Advanced Research in Practice course.
- 90% of the research nurse workforce has achieved their mentorship qualification.
- Clinical research nurse competency sessions are successfully delivered two weekly to the research nurse workforce. This is complimented alongside the Research and Development educational programme for all research staff.

5.3 Research Nurse HEE award

- Julia Jonwood successfully presented her completed project at the HEE celebration awards in Birmingham March 2017.
- Carina Cruz completes her MRes in Autumn 2017. Her project is looking at the effect of smell training in post septoplasty olfactory dysfunction – 'The Sniffin Study'.
- Research nurse Victoria Oliver gained a place on the Mary Seacole leadership course 2017.
- All research nurses are given the opportunity to undertake the trust leadership two day coaching programme.

5.4 Principal Investigator Masterclass

Principal Investigator Masterclass - Training for new consultants to understand their roles and responsibilities within research as PI. Train the trainer now complete with 8 research nurses trained to deliver the PI masterclass either 1:1 or small groups at the convenience of the PI clinical workload. PIs will receive CPD points on completion.

5.5 Dementia research

Collaborative team work raising awareness of research at Lister Hospital:

6. Summary

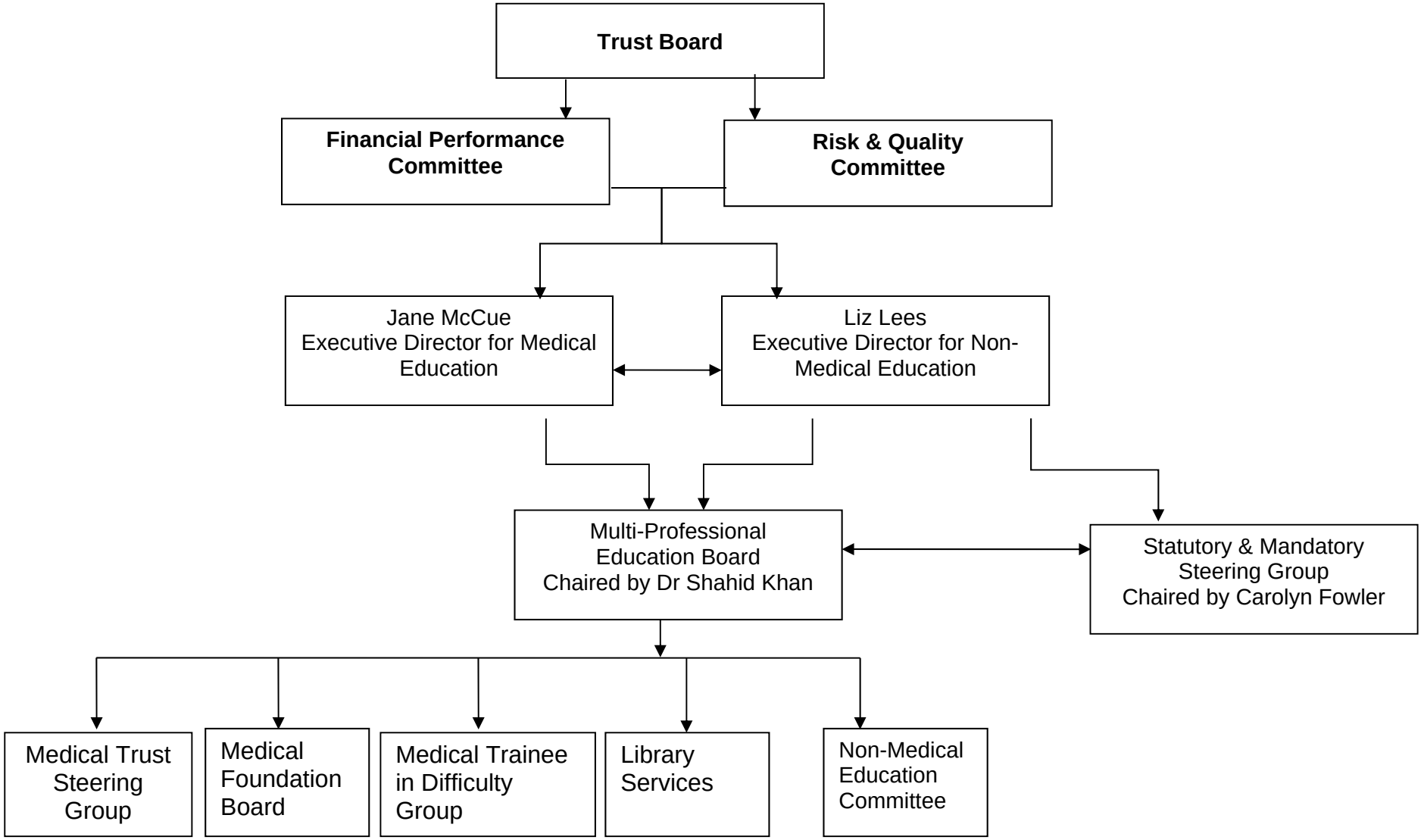
This report presents a summary of the key activity in education within the Trust for 2016-17.

During the coming year more innovative solutions to education and training will be developed to address the challenges of maintaining and further developing a workforce that is both competent and fit for practice. This will include implementing new and advanced roles such as Advanced Clinical Practitioners, Physician Associates and new degree apprenticeships across nursing and AHPs. The Trust hopes to offer more places to staff to undertake the Nursing Associate Programme.

Both the medical and non-medical education departments have been instrumental in improving, not only the quality of education provided, but the quality of the learning environment for all students and trainees on placement.

Appendix 1 : Multi-professional Education Board Framework

Accountability Framework for Multi-Professional Education



Appendix 2: Statutory Training – Compliance for nine core competencies (March 2017)

By Staff Group:

	Compliance %
Admin and Estates	**91.58%**
Clinical support	**95.02%**
Medical & Dental	**76.26%**
Nursing qualified	**92.43%**
Nursing unqualified	**89.18%**
ST and T	**93.79%**
Total	**89.70%**

By Division:

	Compliance %
Cancer	**93.06%**
Clinical Support Services	**94.51%**
Medicine	**87.55%**
Non-Clinical Support Services	**92.63%**
Research and Development	**92.81%**
Surgery	**87.10%**
Women's & Children's	**89.20%**
Total	**89.70%**

Average coverage compliance by competence (Trust)

	Compliance %
Equality & Diversity	**88.37%**
Infection Prevention & Control-Clinical	**92.52%**
Infection Prevention & Control-Non-Clinical	**94.28%**
Conflict Resolution	**93.14%**
Equality, Diversity and Human Rights	**64.42%**
Fire Safety	**84.69%**
Health and Safety	**93.63%**
Information Governance	**78.90%**
Moving and Handling	**94.14%**
Moving & Handling for People Handlers	**91.63%**
Safeguarding Adults Level 1	**91.68%**
Safeguarding Adults Level 2	**89.62%**
Safeguarding Children Level 1	**92.35%**
Safeguarding Children Level 2	**90.37%**
Safeguarding Children Level 3	**85.48%**
Total	**89.70%**

RAQC Report Appendix 2 – Extract from Medical Education Update (considered at RAQC in September) - GMC National Training Survey

GMC National Training Survey 2017: Results and Overview

The GMC National Trainee Survey results provides an overview of quality of education in the Trust. The Education Department carefully analyses the results and uses them along with other information to improve the quality of education and training in the Trust. The results are used for triangulation and quality assurance by HE EoE.

Detailed survey results are available at the GMC website:
http://www.gmc-uk.org/education/national_trainee_survey.asp.

The GMC 2017 Training Survey was conducted between March & May 2017 and the results were released online on the 4th July 2017. The Patient Safety and Undermining Exception reports were received by the Trust between April to June 2017.

Legend: Outlier Reports

Colour Key

Red	Pink	White	Light green	Green
A below outlier	Within the lower quartile (Q1), but not a below outlier	Within the middle quartiles (Q2-Q3, the inter-quartile range)	Within the upper quartile (Q4), but not an above outlier	An above outlier

Grey	Yellow
n<3, result not published	n=0, no result

Red *– The score for the indicator is significantly below the national score in the benchmark group. A score is defined as being a below outlier if it meets the following criteria.*
The upper 95% confidence limit associated with the indicator score must be below the lower 95% confidence limit of the benchmark indicator mean score.

Green *– The score for the indicator is significantly above the national score in the benchmark group. A score is defined as being an above outlier if it meets the following criteria.*
The lower 95% confidence limit associated with the indicator score must be above the upper 95% confidence limit of the benchmark indicator mean score.

White *– Result is within the inter-quartile range, suggesting that the result for this indicator is average.*

East and North Hertfordshire NHS Trust

Programme group by trust/board outlier summary

GMC Trainee Survey - Outliers for East and North Hertfordshire NHS Trust

			Patient Safety							Educational Development								
		Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Induction	Handover	Work Load	Reporting systems	Educational Governance	Educational Supervision	Adequate Experience	Feedback	Local Teaching	Regional Teaching	Study Leave	Supportive Environment	Teamwork	Curriculum Coverage
2017	CMT									B		B						
	Cardiology	D							D		D			D	D			D
	Clinical oncology					A						B	B					
	Clinical radiology	B			B		B		B	B	B	B		B	B		B	
	Core Anaesthetics													B				
	GP Prog - Emergency Medicine						B			B			A	A		B	B	
	GP Prog - Obstetrics and Gynaecology					A												
	GP Prog - Ophthalmology	A					A						B					
	GP Prog - Paediatrics and Child Health				A													
	GP Prog - Radiology						A											
	General Practice F2		A				A				A	A			A			
	Medicine F1							B	B								B	
	Medicine F2						B										B	B
	Obstetrics and gynaecology F2					A		A		A		A						
	Obstetrics and gynaecology												B					
	Paediatrics															B		
	Plastic surgery							A						U		A		
	Respiratory medicine			B														

East and North Hertfordshire NHS Trust

Programme group by trust/board outlier summary

GMC Trainee Survey - Outliers for East and North Hertfordshire NHS Trust

			Patient Safety							Educational Development								Training Environment / Infrastructure	
		Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Induction	Handover	Work Load	Reporting systems	Educational Governance	Educational Supervision	Adequate Experience	Feedback	Local Teaching	Regional Teaching	Study Leave	Supportive Environment	Teamwork	Curriculum Coverage	Undermining by the consultant [%]	Access to Educational Resources
2017	ACCS								-1											
	Acute Internal Medicine	-1			-1					-1	-1									
	Anaesthetics							-1									-1			
	CMT									-2		-2								
	Cardiology	-2	-1		-1				-2	-1	-2	-1		-2	-2	-1	-1	-2		
	Clinical oncology			1	-1	2			-1			-2	-2			-1		-1		
	Clinical radiology	-2		-1	-2		-2		-2	-2	-2	-2		-2	-2	-1	-2	-1		
	Core Anaesthetics				-1									-2			-1			
	Emergency medicine F2											-1						-1		
	Emergency medicine	-1	-1							-1		-1					-1			
	Endocrinology and diabetes mellitus				-1							-1								
	GP Prog - Emergency Medicine						-2		-1	-2	-1		2	2		-2	-2	-1		
	GP Prog - Medicine									-1										
	GP Prog - Obstetrics and Gynaecology					2				-1										
	GP Prog - Ophthalmology	2					2		1		1		-2			1	1	1		
	GP Prog - Paediatrics and Child Health				2			1												
	GP Prog - Radiology	-1	-1			1	2			-1	-1					-1		-1		
	Gastroenterology				-1							-1					-1			
	General Practice F2		2				2				2	2			2					
	General Surgery			-1																
	Medicine F1							-2	-2								-2			
	Medicine F2				-1		-2				-1					-1	-2	-2		
	Obstetrics and Gynaecology F2					2		2		2		2					1			
	Obstetrics and gynaecology												-2							
	Paediatrics		-1	-1					1		-1					-2	-1			
	Plastic surgery		-1		-1			2					1	-2		2				
	Respiratory medicine			-2		1				-1		-1								
	Trauma and orthopaedic surgery																	-1		

Not included

Not included

GMC Survey Trends for East and North Hertfordshire NHS Trust

There has been reduction in negative outliers (Red outliers) in many specialities thus reflecting improvement in response to action plans implemented in response to the GMC Trainee Survey in 2016. Paediatrics had 7 Red Flags in 2015 but had only 1 Red Flag in 2017 survey. Consistent improvement in many other specialities is evident by the number of Green and White Flags.

This year overall satisfaction was a negative outlier in only two specialities namely Cardiology & Radiology. There were no Red flags for clinical supervision in any speciality. There were significantly higher number of Green Flags and reduced Red Flags in Patient Safety section as compared to 2016 survey.

Action Plan in Response to GMC Survey results

The results have been discussed by the Trust Education Committee and outcomes will be monitored. Results have been circulated to the Medical Director, Members of the Education Committee and the Trust Trainee Committee Chair. All specialities with two or more Red Flags were contacted and an action plan was requested. Most specialities have submitted action plans which were reviewed by the Director of Medical Education. Where needed the DME has met up with the CDs and the College Tutor to discuss the results of the survey and outline action plans.

In conclusion, the key to improving GMC Survey results can be achieved by engagement of the trainees in the Trust Trainee Forum and the specialities to develop functional Education Faculty Groups with trainers and trainees discussing and resolving problems on a regular basis. The Trust Trainee Survey will be conducted in December 2017 and these areas will receive particular attention.

East and North Hertfordshire NHS Trust

Agenda Item: 10.1

TRUST BOARD PART I – 1 NOVEMBER 2017
Learning from Deaths Report

PURPOSE	To provide the Trust Board with an update on mortality
PREVIOUSLY CONSIDERED BY	Elements considered by the Trust Mortality Surveillance Group (Clinical Governance Committee) and RAQC.
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	As identified in the report
Healthcare/ National Policy (includes CQC/Monitor)	CQC Compliance
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	Medical Director
PRESENTED BY:	Medical Director
AUTHOR:	Clinical Improvement Lead / Deputy Medical Director
DATE:	October 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

***** tick applicable box

1. BACKGROUND

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work including the regular monitoring of mortality rates and outputs from our learning from deaths work that are continual, on-going processes throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018 (IPOS)* and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC).

Further information on the key metrics, developments and current risks summarised on this page can be found in Appendix 1. The full mortality report with a more in-depth study of mortality issues follows in Appendices 1-3.

2. KEY METRICS

Table 1 below provides headline information on the Trust's current mortality performance.

Metric	Result
Crude mortality	Crude mortality is 1.62% for the 12 month period to August 2017 compared to 1.67% for the latest 3 years
HSMR (data period Jul 16 – Jun 17)	HSMR for the 12 month period is **94.92** and is statistically **'as expected'**
SHMI (data period Apr16 - Mar17)	SHMI for the 12 month period is 102.69 - **'as expected band 2'**
HSMR – Peer comparison	E&NH is ranked 5th (out of 16) in the East of England Peer group compared to 6th out of 17 in the last report. It is noted that Hinchinbrooke and Peterborough & Stamford trusts have merged.

3. DEVELOPMENTS

- Publication of new Learning from Deaths Policy
- Publication of new Mortality Case Record Review Policy
- First report of information and data mandated by the National Guidance on Learning from Deaths published by the National Quality Board in March 2017
- Medical Director invited to present on mortality improvement and reviews to NHS I and joint meeting of Royal College of Physicians and Surgeons
- SHMI has remained stable within the 'as expected band'.

4. CURRENT RISKS

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
Acumen tool – Death in hospital currently unavailable	1.3
Gastroenterology – operational issues/elevated HSMR for specialty of discharge	1.6.5
Cardiology – elevation of AMI HSMR	1.6.7
Slow progress with 7 day service	1.8.2
Coding capability	1.9
Reduced frequency of the Rolling half days to discuss mortality reviews	1.10.2

Appendix 1

MORTALITY DETAILED UPDATE REPORT OCTOBER 2017

1.1 Introduction

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work including the regular monitoring of mortality rates and outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018* (IPOS) and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC). Patient safety indicators, as well as other Trust wide and clinical pathway mortality data, are included on the Mortality Improvement dashboard and can be seen in Appendix 2.

The National Guidance on Learning from Deaths published by the National Quality Board in March 2017 placed new requirements on Trusts regarding their approach to learning from deaths. Mandated data and information is contained later in this report.

The Trust also works in tandem with the CCG on specific mortality reduction initiatives via the Mortality Review Group. This forum provides our external partners with the opportunity to discuss and review all of the Trust's activities aimed at reducing mortality and to make requests and recommendations as appropriate. Worthy of note is the fact that the frequency of meetings has been reduced as a direct consequence of the increased confidence of our Commissioners in our mortality performance.

1.2 Mortality indicators

There are three main types of mortality indicator. Crude mortality is a simple analysis of the percentage of patients who died in hospital against the total number of discharges from hospital and makes no adjustment for patient acuity. The Hospital Standardised Mortality Ratio (HSMR) is a logistical regression calculation developed by Dr Foster to measure in-hospital mortality for 80% of the most common diagnosis categories resulting in patient deaths. It includes case-mix adjustment for a range of factors including patient age and patient acuity and for the delivery of palliative care.

The Summary Hospital Mortality Indicator (SHMI) is also based on a logistical regression model and measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. This measure is published by HSCIC. In additional to the different scope of this measure, the case-mix adjustment varies from HSMR in a number of ways with a key difference being that SHMI does not make an adjustment for palliative care.

Crude mortality is available within one day following the end of the month. HSMR is 3 months in arrears and SHMI 7-9 months in arrears.

1.3 Crude Mortality

Crude mortality is most useful in monitoring the performance of a defined clinical unit where the case-mix is expected to remain stable over time. It is less useful for comparing the performance of clinical units with differing case-mix where mortality varies. The Lorenzo implementation has meant the Acumen tool for daily mortality

data is currently not available but the expectation is that this will be accessible again very shortly.

Dr Foster is now comparing performance of crude mortality and reports that the average national crude inpatient mortality (for ordinary admissions excluding day cases) is 1.4% and 1.5% within the region. This compares to 1.7% within ENHT.

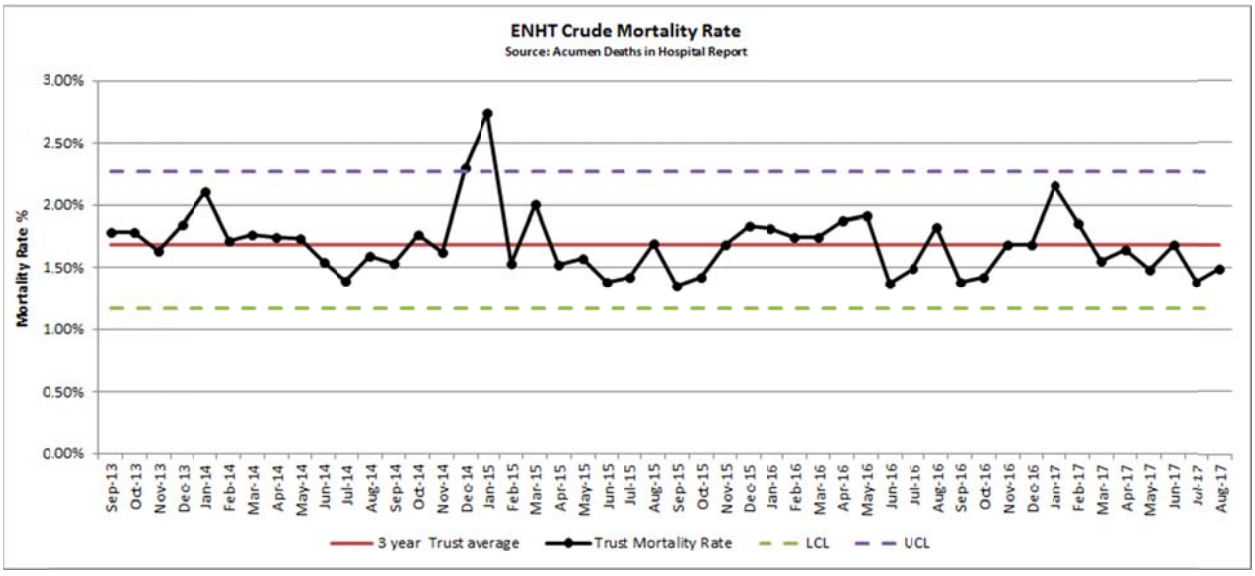
Dr Foster's Mortality Comparator also provides the ability to benchmark the Trust's performance against other non-specialist acute providers. The latest available information is provided below.

Table 1: Crude Mortality rate by where patient died for ENHT vs all non-specialist acute providers in April 2016 to March 2017

	ENHT	Non-specialist acute providers
All deaths	3.56	3.3
In-hospital deaths	2.49	2.35
Post discharge deaths	1.08	0.95

Figure 1 shows the Trust local crude mortality rate for the last four years along with the long-term mean over this period. This local crude mortality includes all the activity that happened at the Trust and is a simple calculation of deaths against the number of spells.

Figure 1: Trust Crude Mortality Rate September 2013 to August 2017



The 3 year average rate for crude mortality shown in figure 1 above is 1.67%.

Table 2 below provides the data for deaths, discharges and the crude mortality rate for the latest rolling year from September 2016 to August 2017 (1.62%) together with the current financial year 'YTD' position.

Table 2: Trust Crude Mortality August 2016 to August 2017

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	YTD 17/18
Trust Deaths	152	116	126	149	138	187	152	137	126	122	142	124	142	656
Trust Discharges	8301	8390	8830	8841	8177	8657	8170	8814	7635	8227	8401	8939	9493	42695
Trust Mortality Rate	1.83%	1.38%	1.43%	1.69%	1.69%	2.16%	1.86%	1.55%	1.65%	1.48%	1.69%	1.39%	1.50%	1.54%

Within these figures there can be considerable variation especially at site level and when there are changes in clinical pathways. Increased management of patients via ambulatory routes such as “hot’ clinics, may result in rising crude mortality.

There is normally strong seasonal variation in crude mortality across England but last year the usual sharp winter spike was replaced by a far less pronounced but protracted elevated trajectory which did not settle until June. While January 2017 did see a spike in mortality this did not compare to 2015.

1.4 Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a powerful measure of performance compared to crude mortality as it effectively benchmarks the performance of a trust against all English acute non-specialist hospital Trusts. It is at its most effective as a comparator when viewed at Trust level and for a twelve month rolling period to reduce the seasonal variation.

The Trust’s HSMR position for the last twelve months to June 2017 was **94.92.** The Trust’s position relative to its East of England peers is 5th (out of 16) and can be viewed in Appendix 3.

1.4.1 HSMR Performance

One of the strengths of the HSMR model is the ability to review the calculations for individual months and for units of analysis within a Trust. HSMR at the Trust is reviewed at both Trust level and for each Division against appropriate thresholds and reported on the Trust Board Performance Report showing rolling 12 month performance. Table 3 shows Trust and Divisional monthly HSMR performance RAG rated against internal targets.

1.4.2 HSMR Trends

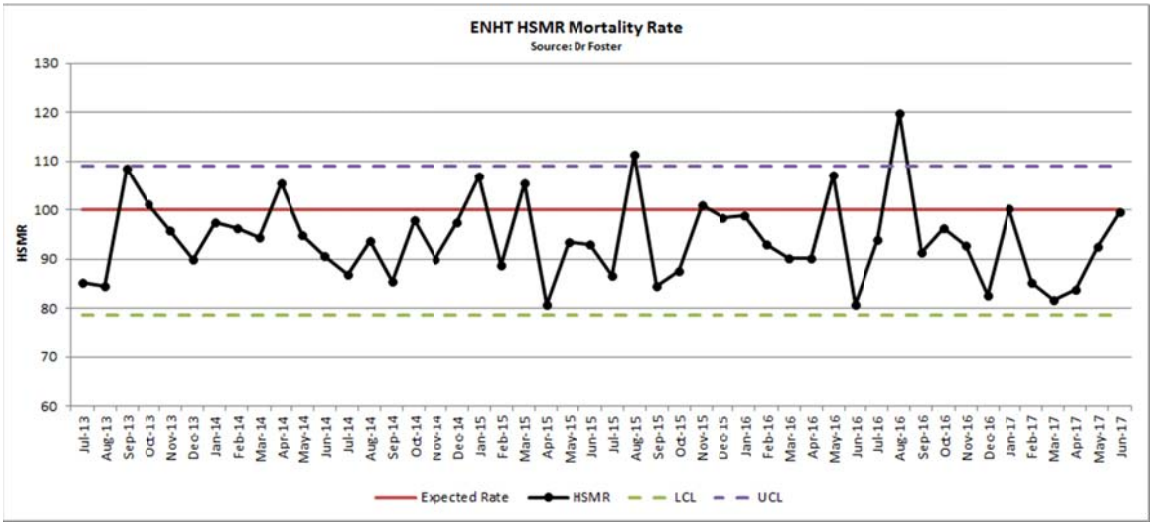
Table 3: Monthly Trust and Divisional HSMR Jul16 –Jun17

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Rolling 12M
Cancer	90.53	121.90	83.74	70.04	155.15	90.64	88.06	151.95	127.43	104.69	108.43	87.67	79.24	104.67
CSS	0.00	0.00	0.00	0.00	208.65	0.00	0.00	138.58	0.00	0.00	0.00	0.00	0.00	42.71
Medicine	80.28	92.61	126.94	98.49	89.86	98.71	80.96	98.34	86.89	89.01	86.13	87.49	101.97	94.33
Surgery	70.55	74.04	76.79	49.57	90.43	87.16	153.33	123.66	107.61	50.76	84.05	78.25	124.43	93.77
Women & Children	0.00	0.00	231.00	0.00	175.89	0.00	128.31	310.18	0.00	0.00	0.00	0.00	0.00	69.56
Trust	**79.71**	**93.06**	**118.58**	**89.85**	**96.96**	**95.97**	**89.13**	**105.59**	**91.39**	**86.14**	**87.25**	**85.78**	**100.17**	**94.92**

Source: Dr Foster Intelligence Quality Investigator

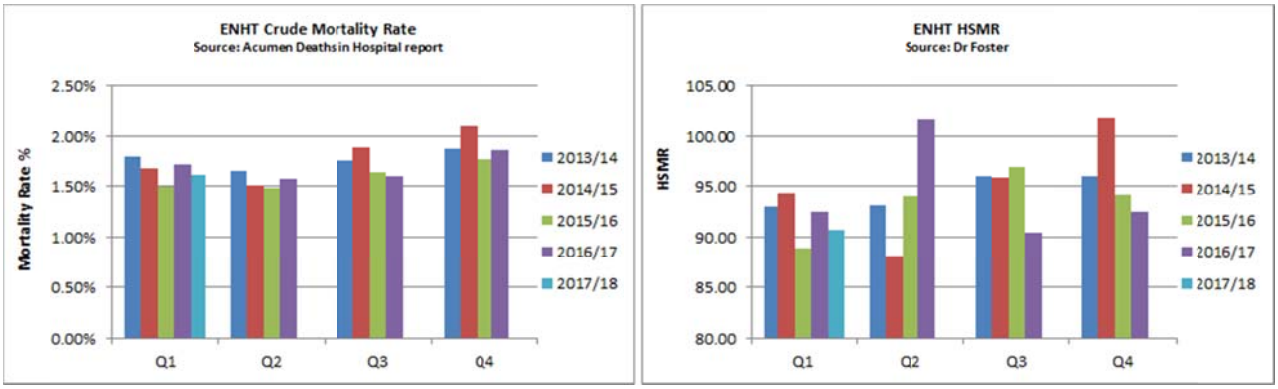
The monthly Trust-level HSMR is shown in Figure 2.

Figure 2: HSMR Trend by Month



The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation. The relationship between the levels of crude mortality and HSMR can be seen in figure 3 below. Crude mortality can be used as a useful predictor of coming HSMR performance.

Figure 3: Crude Mortality and HSMR



1.4.3 HSMR Outliers

With regard to HSMR for the rolling year, there is currently one diagnostic group attracting significantly higher than expected deaths at the 95% confidence level for relative risk where 6 or more deaths are observed (see 1.6.7 below).

Table 4: HSMR Negative Outlier July 2016 to June 2017

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
Acute Myocardial Infarction	140.67	60	43	17

Source: Dr Foster Healthcare Intelligence Portal

The Royal College of Physicians last week conducted an Invited Service Review of Cardiology and receive a substantial data pack before the visit. At the verbal debrief they concluded that they did not have a concern about cardiology mortality.

1.4.4 CQC CUSUM Alerts

There have been no new CQC CUSUM alerts since October 2013.

1.4.5 Key Quality Measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on quality of care provided by the Trust. Table 5 shows the index based on observed over expected values for HSMR, Length of Stay and Re-admission for the rolling year up to June 2017.

Table 5: Key Quality Measures July 2016 – June 2017

	Trust Total	Elective	Non-Elective
HSMR	94.9	107.5	94.7
Length of Stay	94.8	92.3	95.13
Readmissions within 28 days	110.0	116.1	108.6

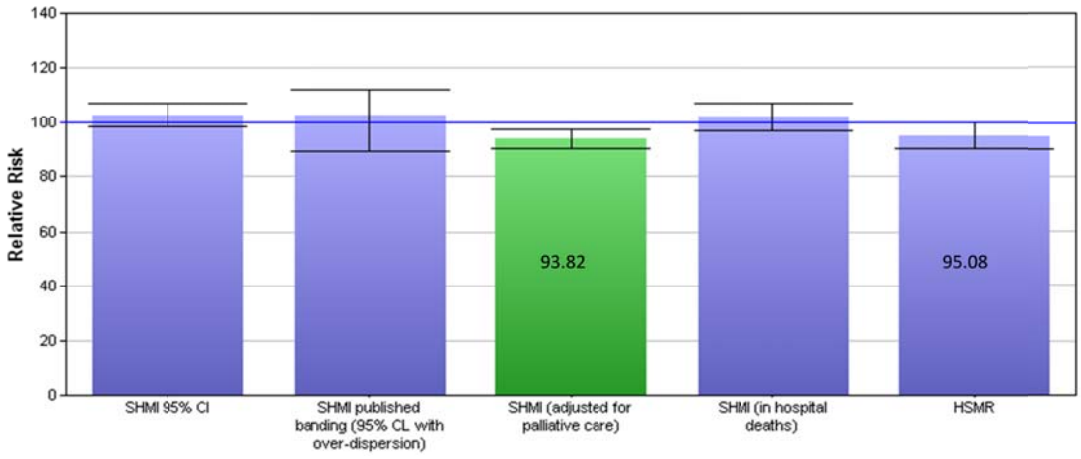
Source: Dr Foster Healthcare Intelligence Portal

HSMR mortality continues to show a good level of performance, falling within the 'as expected' band, and Length of stay has remained consistently below the expected levels meaning that overall we discharge patients sooner than expected for our case mix. Readmissions have remained relatively unchanged and continue to be above the national average.

1.5. Summary Hospital Mortality Indicator (SHMI)

SHMI alongside HSMR can be a powerful benchmarking tool. Historically the methodological differences between these two models have provided challenges for the Trust. However, as figure 4 below shows, over recent months the difference between these 2 indicators has narrowed down to around 8 points. The remaining discrepancy is partly accounted for by 7-day provision of palliative care services and in addition the Trust remains in a small minority that include a hospice. Figure 4 shows that when SHMI is adjusted for palliative care, it is now lower than HSMR and falls within the 'lower than expected' range.

Figure 4: SHMI (with adjustments) and HSMR for April 2016 to



Following consistent improvements in SHMI, the latest rolling 12 month period to March 2017 has shown the Trust's position stabilising with a marginal increase from

102.3 to 102.7. As figure 5 demonstrates this represents a 17.55 point reduction since our first SHMI was reported for the period July 2010 to June 2011.

Figure 5: Trust SHMI July 2010 to March 2017

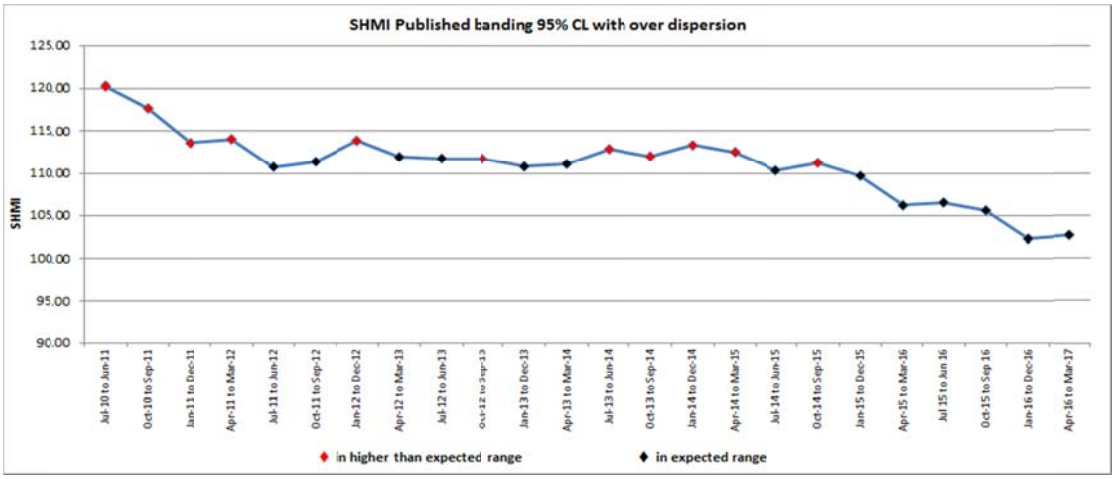
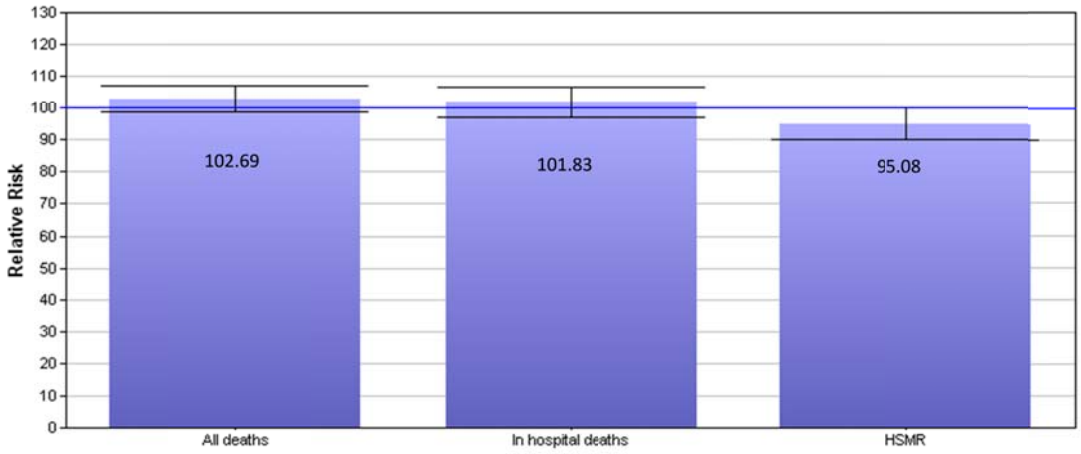


Figure 6 shows the relationship between SHMI (all deaths and in-hospital deaths) and HSMR for the period to March 2017.

Figure 6: SHMI (all deaths), SHMI (in hospital) and HSMR for all admissions to East and North Hertfordshire NHS Trust in April 2016 to March 2017



1.5.1 SHMI Mortality Triangulation

We use two approaches to identify areas for investigation into potential mortality problems: diagnosis groups with the highest number of deaths as small improvements in care could benefit a large number of patients; and diagnosis groups with high 'excess' deaths.

The five diagnoses resulting in the highest number of deaths during this period are Pneumonia, Acute Cerebrovascular Disease (which includes stroke), Urinary Tract Infections, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.

Table 6: SHMI Diagnosis Groups with highest death rate Apr16 – Mar17

CCS Group	Number of spells	Observed deaths	Expected deaths	Latest SHMI Apr16-Mar17	SHMI performance change
Pneumonia	1889	406	348	116.5	▼
Acute Cerebrovascular Disease	907	149	161	92.4	▼
Urinary Tract Infection	1767	112	111	101.1	▼
Congestive heart failure, non-hypertensive	569	92	85	107.8	▲
COPD	953	80	62	128.0	▼

Table 7 shows the five diagnoses with the highest number of "excess" deaths. Excess deaths are the actual number of deaths over the expected number for our population that have been calculated within the SHMI case-mix adjustment.

Table 7: SHMI Diagnosis Groups with highest excess Apr16 – Mar17

Diagnosis group	Number of spells	Excess deaths	Latest SHMI Apr16-Mar17	Previous SHMI Jan16-Dec16	SHMI performance change
Pneumonia	1889	58	116.5	116.0	▼
COPD	953	18	128.0	119.6	▼
Acute Myocardial Infarction	638	16	134.2	126.2	▼
Fractured neck of femur (hip)	488	12	126.5	125.8	▼
Pulmonary heart disease	222	10	166.9	112.3	▼

Measures in train to reduce deaths in these areas are explained in more detail in 1.6.

1.6 Specific Actions to Address High Mortality Conditions

1.6.1 Pneumonia, Acute Bronchitis & Chronic Obstructive Pulmonary Disease (COPD)

We continue to build on the many improvements implemented since 2012 and the focus now is on improving coordination with Primary Care. Details of current initiatives and updates are provided below:

- The Integrated Community Respiratory Service has been full established since May 2017. It works closely with Acute Chest Team to prevent admission and support early discharge
- The Community team continues to work with GPs to highlight frequent attenders and support early discharge from hospital
- Telephone community consultations (providing a point of access for GPs to engage respiratory consultants regarding complex community cases)
- Fortnightly the team inputs into target days with consultants going out to GP practices.

Despite the fact that the team still doesn't have a full complement of consultants, provision of a full service has been maintained via cross cover of rotas.

Some concerns had been raised regarding SHMI levels for Pneumonia and Respiratory failure. While the latest SHMI release shows a marginal deterioration in SHMI for Pneumonia, which remains elevated, a significant improvement has been seen in Respiratory failure and three other diagnosis groups including Acute Bronchitis (see table 8 below).

Reviews have demonstrated the challenges associated with the accurate coding of a number of respiratory conditions including Pneumonia and Respiratory Failure. Work in this regard remains ongoing.

Table 8: Respiratory Service SHMI Data

CCS Group	Observed deaths	Expected deaths	Latest SHMI Apr16-Mar17	Previous SHMI Jan16-Dec16	SHMI performance change
Pneumonia	406	348	116.5	116.0	▼
COPD	80	62	128.0	119.6	▼
Aspiration pneumonitis; food/vomitus	75	80	93.9	83.1	▼
Acute bronchitis	44	49	90.6	126.7	▲
Respiratory failure; insufficiency; arrest (adult)	23	20	117.2	159.1	▲
Pleurisy; pneumothorax; pulmonary collapse	20	19	104.2	129.1	▲
Other upper respiratory infections, disease,	8	14	55.2	96.3	▲

Source: NHS Digital

1.6.2 Acute Chest Team (Post CQUIN)

Now well embedded, the Acute Chest Team (ACT) has been operational as a 7 Day Service since April 2015. In additional to holding 3 'Hot' clinics a week it provides an excellent consultant led daily service from 8.30am-5.30pm with respiratory input being given to acutely admitted patients on ED, AMU and SSU. Following conclusion of the CQUIN, the ACT service continues to collect data for internal audit purposes as part of the on-going assessment of the Trust's respiratory service.

1.6.2.1 Seven Day Respiratory Service

As indicated in my last report we now look at mortality indicators relating to the specific respiratory diagnosis groups within the respiratory basket to try to assess the impact of moving to a seven day service.

Table 9 below shows that HSMR has broadly remained static over the last year, and stays within the 'as expected' range. While it is positive that HSMR remains in the "as expected" range, more significant improvement had been anticipated. This may relate in part to the difficulty in recruitment to the seven day respiratory service. For some time following the departure of a consultant in April the team was two consultants short and there now remains one vacancy to fill. Additionally, a key driver for improved respiratory care is the use of care bundles. While bundles are now in place for both COPD and Pneumonia, anecdotal evidence suggests their use has been inconsistent. Further information regarding ongoing work regarding care bundles is provided in 1.8.3 below.

Table 9: Respiratory Service HSMR Data

Respiratory Chapter (Diagnosis Group)	Jul15-Jun16 HSMR	Jul16-Jun17 HSMR	HSMR Performance Change
All	102.6	96.9	▲
Pneumonia	101.6	103.7	▼
Other upper respiratory disease	134.0	52.2	▲
Acute bronchitis	116.1	67.0	▲
Chronic obstructive pulmonary disease and bronchiectasis	99.7	104.5	▼
Other lower respiratory disease	112.2	73.5	▲
Pleurisy, pneumothorax, pulmonary collapse	113.6	59.6	▲
Aspiration pneumonitis, food/vomitus	91.4	79.5	▲
Respiratory failure, insufficiency, arrest (adult)	107.4	117.5	▼

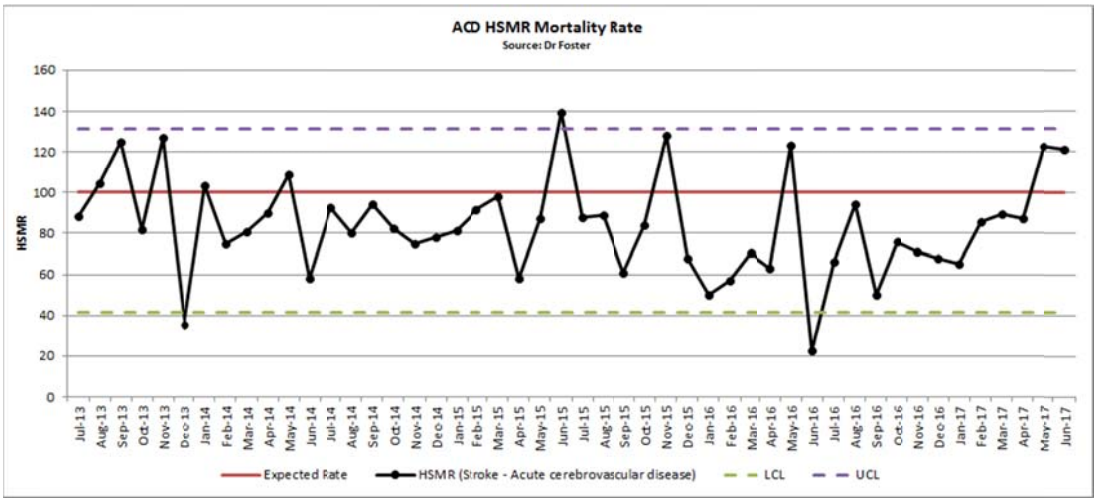
Source: Dr Foster (Benchmark month: Mar 2017)

1.6.3 Acute Cerebrovascular Disease (Stroke)

Stroke SHMI had been a cause for concern, rising to 124.08 for the period January 2015 to December 2015. However, SHMI releases in September and December 2016 saw significant falls in SHMI to 101.67 and 85.3 respectively. Although the latest release to March 2017 has seen an increase to 92.4, this is still a significant improvement on the 2015 position and within the 'as expected' range.

The HSMR fell to 73.3 (lower than expected range) for the rolling year to March 2017. While the value for 12 months to June 2017 has risen to 83.30, this is still in the 'lower than expected' range.

Figure 7: Acute Cerebrovascular Disease HSMR by Month



Recent reports to this Committee have outlined a variety of improvements that have taken place in Stroke care to improve outcomes for patients. The following are of note:

- For a second consecutive quarter, the Trust retained its A rating in the latest SSNAP audit report produced by the Royal College of Physicians, representing an excellent level of performance
- Two consultant positions have remained covered by Locums (2 out of 6). Unfortunately the anticipated August appointment did not occur as the candidate withdrew. There appears to be a national problem recruiting to substantive posts
- While our 24/7 HASU service continues, in the absence of a full substantive team, certain aspects have to be covered with the help of external bodies
- Following agreement of the Thrombolysis in-hospital pathway and action plan, CCGs continue to work on the pre-hospital pathway with feedback from our consultants regarding telemedicine
- Attempts continue to formalise Thrombectomy pathways in the region.

1.6.4 Sepsis

1.6.4.1 Sepsis CQUIN

Sepsis continues as a national CQUIN for 2017-18 with some changes to the targets, including new requirements regarding reduction in antibiotic usage. The national shortage of piperacillin-tazobactam, with the attendant need to rely on alternatives, has brought into question the feasibility of the trust achieving the set targets.

Table 10: Sepsis Key CQUIN Data 2017-2018

CQUIN Requirement	Target	Q1	CQUIN Met
Timely identification of sepsis in emergency departments and acute inpatient settings			
ED patients who needed screening for sepsis were screened	90%	96%	✓
In-patients who needed screening for sepsis, were screened	90%	97%	✓
Timely treatment of sepsis in emergency departments and acute inpatient settings			
Emergency department patients received IVABs within 1 hour of meeting Red flag criteria	90%	59%	Lower 50% threshold met
In–patients received IVABs within 1 hour of meeting Red Flag criteria	90%	50%	Lower 50% threshold met

To identify gaps and delays in identification of sepsis and administration of IVABs, a selection of patients' care has been mapped from arrival through to admission to analyse behaviour at variance with sepsis six care bundle with outcomes shared with relevant teams.

A wide range of improvement initiatives continue including:

- Focus on training remains a priority. So far in 2017, 502 individuals, including nurses, doctors CSWs and pharmacists, have received training in sepsis recognition and treatment, with future training planned to include focussed weeks on each ward/department
- Sepsis question added to the Datix incident reporting tool enabling the review of all relevant cases by the sepsis team
- The Trust continues to raise awareness of sepsis at all levels from clinical directors to all frontline staff, through ED, AMU, ACC and in-patient areas.

Initiatives have included involvement in study days, patient safety days, RAPID & ALERT training together with the development of a Sepsis page on the Trust's Intranet and recruitment of sepsis champions

- Work with the EEAST to ensure the use of a common language regarding the identification of Sepsis, including using the same Red and Amber Flags and NEWS scores.

1.6.5 Gastroenterology

Following previously elevated mortality, Gastroenterology mortality has been monitored closely both via the mortality review process and regular monitoring of Dr Foster. While there have been improvements in HSMR the latest release saw an increase in HSMR for Gastroenterology as speciality of discharge from 136.2 (as expected range) to 153.03 (above expected range). With anomalies investigated and inaccuracies reported the service is continuing to improve the accuracy of coding especially for general medical cases.

Discussions are taking place regarding the management of GI bleeds. Currently these are overseen by Gastroenterology and General Surgery. Consideration is being given as to whether it will be more effective for one of the Specialties to assume sole responsibility.

1.6.6 Acute Kidney Injury

The continuance and further development of the specialist AKI care service remains uncertain. The current AKI Lead nurse's contract runs until March 2018. Without longer term funding agreement the team's ability to plan service delivery and data collection is in jeopardy.

In the meantime the AKI team continues to promote AKI awareness and best care both within the hospital and wider community. Key points of note include:

- The Lister AKI team has demonstrated its effectiveness in reducing hospital acquired AKI: Despite 398 more non-elective ward admissions and 488 more AKI e-alerts there are 15 fewer admissions complicated by AKI
- The Lister Hospital has approximately 5000 AKI events in a year with 3500 community and 1500 hospital acquired AKI. Extrapolation of data suggests the Lister AKI team prevented 188 hospital acquired AKI last year
- With increasing impact through direct clinical in-reach, education and medications policy, further improvements are probable and will be measured
- A reduction in AKI incidence inevitably impacts on proven mortality and long length of stay associated with hospital acquired AKI.
- The AKI team continues to work collaboratively across directorates to reduce community acquired AKI incidence and to maintain the reduction in hospital acquired AKI.

1.6.7 Cardiology

HSMR has remained elevated at 140.67. The recent review of alerts regarding AMI patients indicated that these appeared to be the result of incorrect coding of cases. Work is ongoing to ensure correct/consistent coding of these patients. We await further refreshes of the Dr Foster data to see the benefit of the coding corrections made so far to the HSMR data.

The Royal College of Physicians has conducted an Invited Service Review of Cardiology. This took place on 11/12 October. Salient detail of the outcomes will be reported in due course.

1.7 Update on Strategically Important Pathways

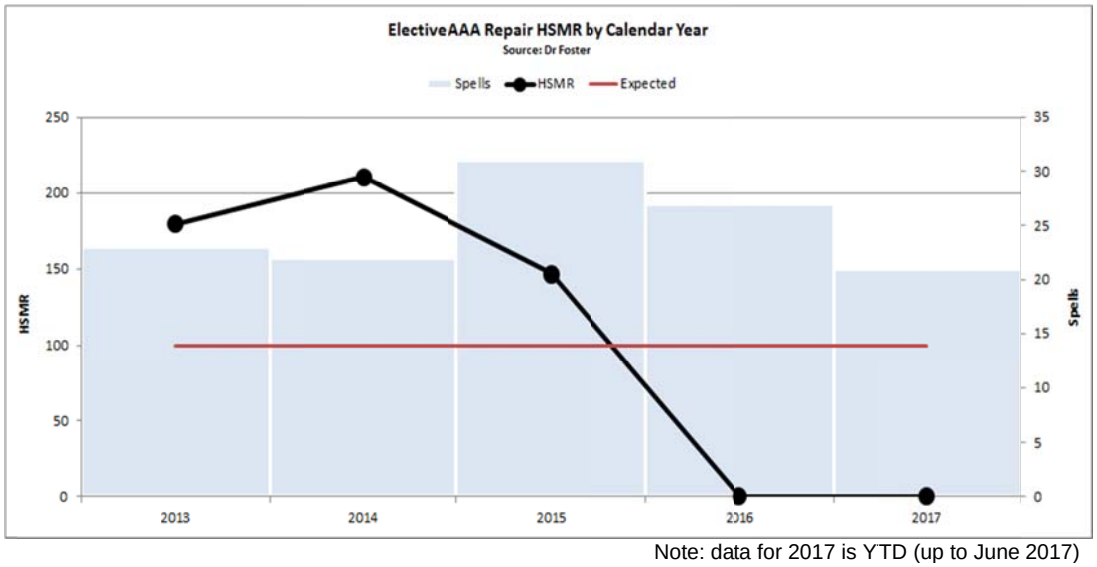
1.7.1 Elective Abdominal Aortic Aneurysm Repair (AAA)

The future of vascular surgery at the Trust had been uncertain for some time. This was set against a backdrop of historical mortality concerns at the Lister Hospital following elective AAA surgery, although with no elective surgical deaths for 2016 and 2017 (2017 year to date) performance has stabilised.

Following the Trust's recent successful bid for the creation of a Vascular hub at Lister servicing the whole of Hertfordshire and West Essex, the future is now looking more secure. Work is currently in progress regarding the development of the associated business case which is due for submission before the end of the year.

The chart below shows the annual relative risk trend for elective AAA procedures along with the total number of elective operations carried out (on the right). The relatively small numbers involved create more uncertainty in the indicative accuracy of the HSMR value.

Figure 8: Elective AAA Repair by Year



Note: data for 2017 is YTD (up to June 2017)

1.7.2 Deteriorating Patient Plan

Since February the Deteriorating Patient Plan (DPP) working group has been incorporated into the Patient Safety Committee. Current updates include:

- NerveCentre e-Obs has now been fully rolled out and is in use in all areas
- Resuscitation Lead Middle Grade Doctor SOP has been put in place within ED to clarify responsibilities regarding management of the sickest patients and for ensuring they are adequately stabilised before leaving the department
- The inclusion of a sepsis flag on Nerve Centre supports the more timely identification and management of sepsis
- Meridian audits showed Observation compliance of 97% for both Q1 and Q2.

1.8 Other Trust-wide reducing mortality initiatives

1.8.1 Improving Patient Outcomes Strategy 2015-18

The Improving Patient Outcomes Strategy 2015-18 (IPOS) which combines a strategy for clinical effectiveness and patient safety has now entered its final year. Objectives for 2017-18 have been confirmed and approved by the Clinical Governance Strategy Committee. A mid-year report will be provided to the Clinical Governance Strategy Committee with the usual end of year report presented to the Risk and Quality Committee.

1.8.2 Seven Day Services

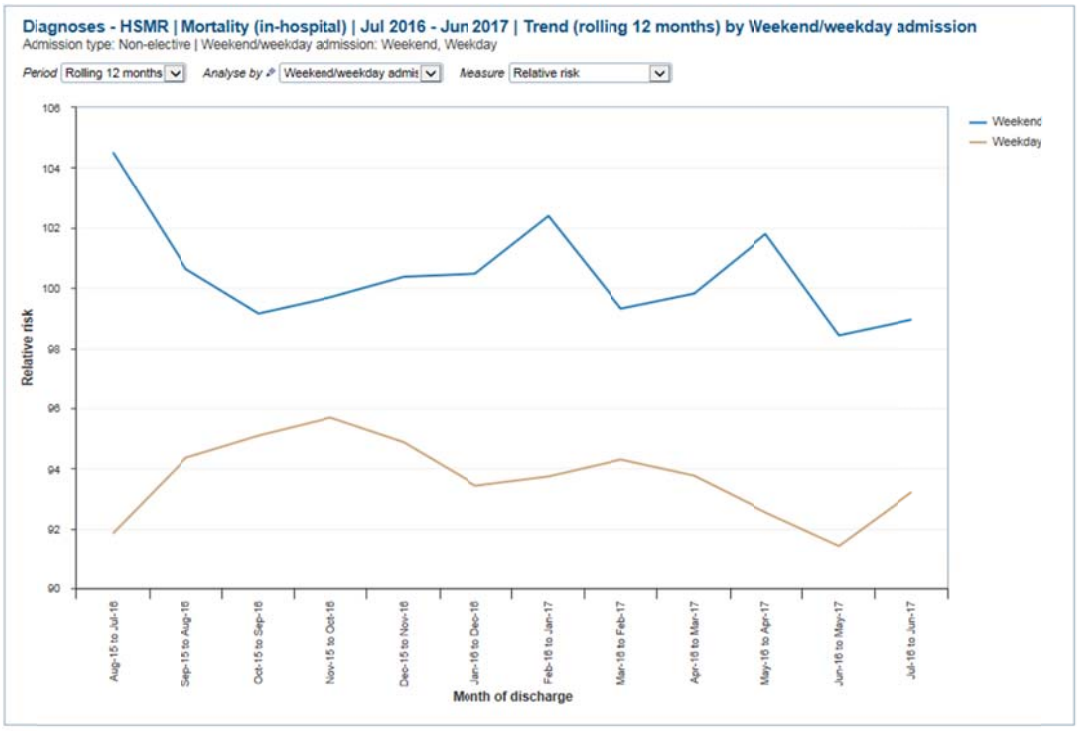
The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. ENHT has now had confirmation that it is in the tranche of trusts that are aiming to achieve compliance against the four prioritised standards by the end of March 2018 which will be an extremely challenging target. These four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

The Medical Director attended the Seven Day services day provided by NHS I in Cambridge in September. Like many other Trusts 7 day services are advancing slowly. The Q1 audit results have only just been published and will be covered in greater detail in my next report. Data collection has already commenced for the next survey.

There had been a widening divergence between weekday and weekend HSMR levels as figure 9 below shows. While this has narrowed there is still some movement in the data which will be monitored.

Figure 9: HSMR by Weekend/weekday admission: rolling 12 months Jul16 to Jun17



1.8.3 Care Bundles

Care Bundles either standalone or as part of an Integrated Care Plan are now in place for the following diagnostic groups:

- Pneumonia
- COPD
- Congestive cardiac failure
- Stroke
- Acute MI
- Decompensated cirrhosis
- Sepsis
- AKI

As part of the Improving Patient Outcomes Strategy we are committed to the implementation of ten care bundles by the end of 2017-18 and this work is now being led by the Associate Medical Director (Clinical Effectiveness). This work includes developing a more standardised format and appropriate guidance, with a subsequent Trust-wide awareness campaign. The ultimate aim is to transfer to electronic format. This work is strongly supported by the CCG via the Mortality Review Group.

1.9 Coding

The Head of Coding has continued to implement changes to improve the service. Recent developments have included:

- Implementation of OPCS 4.8 and new HRG 4+ grouper in April together with relevant training for the Coding team
- Coding awareness/education within the Divisions with a presentation to General Surgery at April RHD
- “The importance of coding” training and awareness to FY2 commencing 17 October and FY1 in January 2018
- Continued work to clear the coding backlog
- Lorenzo implementation and data amendments
- Clinical Coding refresher course for all coders planned for December 2017
- Information Governance Toolkit Audit planned for January 2018.

1.10 Learning from Deaths National Requirements

In December 2016 the CQC published its report ‘Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England’. Commissioned by the Secretary of State for Health in response to the very low number of investigations and reviews of deaths at Southern Health NHS Foundation Trust, it concluded that opportunities to improve care for future patients were being missed due to insufficient consideration being paid to learning from deaths in the NHS.

The Secretary of State accepted the report's recommendations, asking the National Quality Board (NQB) to translate the recommendations into a framework for implementation across the NHS. In March 2017 the first step in this programme was published in the form of the National Guidance on Learning from Deaths.

As the guidance is detailed, in places open to interpretation and impacts on multiple Trust processes and policies, work will remain ongoing over the coming months to ensure we take full account of all the recommendations not only to guarantee compliance but also to gain maximum benefit from the quality improvement recommendations.

The guidance contained four key requirement milestones. These are detailed below together with an indication of our current compliance:

Guidance Requirement	Current Compliance Status
From April 2017 Collection of quarterly information relating to deaths, reviews, investigations and resulting quality improvement	**Compliant** Corresponding detail provided in this report at 1.10.3 below.
By the end of September 2017 Publish an updated policy detailing how the Trust responds to and learns from the deaths of patients in its care	**Compliant** Policy drafted by 30 September; ratified by the Clinical Governance Strategy Committee on 4 October and published on Trust website on 5 October. A copy of the policy is attached at Appendix 4.
From Q3 2017 Publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meeting	**On track for compliance** Following consideration by RAQC the current report, which includes the new mandated content (see 1.10.3 below), will be presented at the next Board meeting on 1 November 2017, with papers subsequently published on the Trust website.
From June 2018 Publish an annual overview of the relevant information in the Trust's Quality Account, including a more detailed narrative account of the learning from deaths reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.	**On track for compliance** Those involved in the preparation of the Quality Account and those responsible for oversight of Mortality Surveillance are fully aware of the requirements.

1.10.1 Learning from Deaths Policy

The new national guidance required trusts to have published a Learning from Deaths Policy on their websites, compliant with the guidance, by the end of September. Our policy was developed within this timeframe and published on the Trust's website following approval/ratification by the Clinical Governance Strategy Committee on 4 October. A copy of the policy is attached at Appendix 4.

1.10.2 Mortality Case Record Review Process and Methodology

Following detailed consideration including consultation with our Mortality Reviewers, a decision has been made that the Trust will not adopt the Standardised Mortality Review Methodology which has been developed by the Royal College of Physicians. Key reasons underpinning this decision include:

- Although the RCP methodology pilot is now complete, the proposed Datix tool is not yet available. Additionally it has not been made clear what costs would be involved in its adoption
- Our own methodology is now well embedded

- It was felt that transfer to the proposed RCP tool would not allow for the continued collection of certain data that has proved of value to our quality improvement work.

Instead, once the post Lorenzo IT development freeze is lifted, our existing tool will be developed to take account of the best of the RCP and PRISM methodologies while maintaining the core of our current format. In the meantime our existing process does allow for compliance with the new reporting regime.

Our Mortality Case Record Review Policy has been updated to reflect developments in the light of the new national learning from deaths guidance. The Policy was approved by the Clinical Governance Strategy Committee on 4 October and is now available on the Trust's intranet site. A copy is included at Appendix 5.

We now have 31 trained mortality reviewers in place from across medical and surgical specialties. For the time being Areas Of Concern (ACONs) raised following Stage 1 reviews continue to be forwarded to relevant Specialties for Stage 2 review and discussion at Directorate RHDs, with final Stage 3 consideration, including a decision regarding the avoidability of death, conducted by the Clinical Governance Strategy Committee. A review of the efficacy of the current Stage 2 element of the process is underway and in any event, will need to change in Medicine, to reflect the reduced frequency of the Rolling Half Day programme.

1.10.3 Mandated Mortality Information

The Learning from Deaths framework states that trusts must collect and publish (from Q3), via a quarterly public board paper, certain key data and information regarding deaths in their care. This is the first report to Board to include this information, the detail of which follow below.

1.10.3.1 Learning from Deaths Dashboard
The National Quality Board provided a suggested dashboard for the reporting of core mandated information which we are currently trialling. This is attached at Appendix 6. As this dashboard does not cover all the data that the national guidance requires, once the new reporting regime becomes embedded, a bespoke report detailing all the required information may be developed. In the meantime additional detail is provided below.
1.10.3.2 Learning Disability Deaths
A Learning Disability mortality review process has been established in the Trust in line with the requirements of the new LeDeR national programme. Key initial actions have included:

- Implementation of associated Standard Operating Procedure
- Training of one nurse reviewer in national review process (a further reviewer has yet to be nominated)
- Deputy Director of Nursing is now a member of the Hertfordshire LD Mortality Review Steering group
- Confirmation of cases is triangulated via reference to cases reported to the national programme, inclusion of an LD question on our mortuary check list together with a weekly report based on coding
- Publication of an information leaflet for relatives to inform them of the national process.

Early indications are that the requirements of the external review process are challenging, being both complex and time consuming. Internally we will continue to

review learning disability deaths using our standard review process, the outputs of which will be provided to the national programme.

In the first quarter one learning disability death has been reported. As this was an expected death of a patient who died at Michael Sobel House Hospice, it did not fall within our previous mortality review criteria. However to comply with the new guidance a review will be conducted.

	Apri-17	May-17	Jun-17
Learning Disability deaths	0	0	1

1.10.3.3 Severe Mental Illness Deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. When we discussed this requirement with our Rapid Assessment, Interface and Discharge mental health team (RAID) they felt the inclusion of a mental health flag on the Trust's patient administration system ran counter to moves to change attitudes towards mental health by the removal of such labelling.

An alternative method of identification is via coding. However there are a multitude of potential condition/codes. As no clear indication was given in the national guidance regarding what definition should be attached to 'severe mental illness', clarification is being sought from the programme leaders. In the meantime, internal discussions are taking place to agree a working 'basket of conditions' that can be used to identify relevant deaths for review. There have been no known instances of any deaths in the first quarter of patients with severe mental illness.

1.10.3.4 Stillbirth, Children and Maternity Deaths

While the national guidance acknowledges that these deaths will be subject to special consideration, it requires that trusts include detail of relevant deaths in the quarterly reports and include reference to the associated processes in their Learning from Deaths Policy.

Our Policy has included the relevant detail and Q1 statistics are provided below:

	Apri-17	May-17	Jun-17
Stillbirth	3	3	1
Children	0	0	0
Maternity	0	0	0

Child deaths are rigorously reviewed via the Child Death Overview Panel and the Rapid Response Framework, both managed locally by the Hertfordshire Safeguarding Children Board. Learning is agreed and disseminated by the local Steering Group, attended by representatives from the Trust's Safeguarding team, with information cascaded to relevant Trust teams.

Maternal deaths, which are extremely rare, are all subject to investigation under the Trust's Serious Investigation (SI) framework with learning shared across the Trust via the formal SI process. In addition, all maternal deaths are reported to the national MBRRACE-UK programme which investigates maternal deaths and publishes an annual report which includes general learning which is used to inform the Trust's internal quality improvement work.

With regard to perinatal deaths, all intra-uterine deaths are reviewed by the MDT at the time of loss and subsequently by the Bereavement Group with discussion at the Clinical Governance Rolling Half Day (RHD). Lessons learnt are shared with the appropriate multi-disciplinary team. If themes are identified action plans are formulated and monitored at subsequent RHD meetings.

Additionally, feedback from bereaved parents from Local Support Groups and national guidance from organisations such as the Miscarriage Association and the Stillbirth and Neonatal Death charity provide learning and best practice to inform our standards of care.

1.10.3.5 Serious Incidents involving Deaths
The 2017 learning from deaths guidance requires that the number of Serious Incidents which have involved the death of a patient are included in the quarterly Board report. The relevant detail is provided below.

Serious Incidents involving the death of a patient	Apri-17	May-17	Jun-17
Serious Incidents reported	1	3	0
Serious Incidents – final report approved*	0	1	3

** the reports approved do not necessarily relate to the incidents reported*

Key learning from the above four Serious Incidents closed during this quarter:

- Use of interpreters for patients when English is not first language where the understanding of information is vital eg. around surgery
- Early involvement of LD nursing team for any patient admitted with learning disabilities. All staff to have good understanding of Mental Capacity Act and DoLs. Review of processes for referral to PEG team
- Further education for all medical staff (including haematology staff) who are prescribing on Chemocare on how to change or delete regimens. Haematology Registrar to join the morning Medical/Nursing Handover meeting when they have an inpatient on the ward; haematologists to be invited to chemocare training
- Physiotherapist to alert staff regarding the risk and safety of patients from the time of their assessment. Introduction of Safety Huddles and Baywatch on ward.

Following conclusion of investigations learning and feedback is provided to relevant Specialty Rolling Half Day clinical governance meetings for discussion and adoption of agreed actions. Inclusion of information in the Patient Safety Matters newsletter is also used to promote Trust-wide sharing of important learning and developments. The Patient Safety Committee is responsible for ensuring that key learning and themes inform the Trust's quality improvement initiatives. A detailed Serious Incident Report is provided to the Risk and Quality Committee on a quarterly basis.

1.10.3.6 Learning from Inquests
In addition to a number of types of death that must be reported to the Coroner, Doctors must report any death where, for any reason, they are unable to determine the cause of death. The Coroner's jurisdiction is limited to determining who the deceased was and how, when and where they came by their death. When the death is suspected to have been either sudden with unknown cause, violent, or unnatural, the coroner decides whether to hold a post-mortem examination and, if necessary, an inquest.

While it is not part of the Coroner's remit to indicate general learning points regarding care of the patient prior to their death, on extremely rare occasions, if significant failings in care are identified, the Coroner will issue a Regulation 28: Report to Prevent Future Deaths (PFD). Should such a report be issued, the Trust is duty bound to provide a response within 56 days with detail of actions taken/proposed. These reports are addressed to the Chief Executive and copied to the CQC. Due to their extremely serious nature, both the identification of appropriate remedial measures and dissemination of these across the Trust would be prioritised.

	Apri-17	May-17	Jun-17
Requests for a Report to the Coroner	7	2	9
Regulation 28: Report to Prevent Future Deaths	0	0	0

1.10.3.6 Key Issues and Themes from Mortality Reviews
Central to the topics covered at clinical governance Rolling Half Days are cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews. The RHD meetings provide a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

Key themes arising from the ACONs which were concluded in Q1 are detailed below. Throughout the year emerging themes will be monitored and will be used to inform quality improvement initiatives including the Improving Patient Outcomes Strategy.

- Importance of robust discharge planning including final checks and provision of a comprehensive discharge letter containing necessary advice and planned future care requirements
- Vital importance of all nursing staff being fully conversant with deteriorating patient and NEWS escalation protocols and the need to work closely with the Critical Care Outreach Team and for Junior Doctors to be provided with appropriate support when caring for unstable patients
- Importance of all relevant information being documented in a timely manner with appropriate communication between teams
- Value of the mortality review process in highlighting where policies may benefit from being revisited and developed in the light of emerging changes in processes and care requirements

- .**1.11 Summary of Key Mortality Issues**

- Crude mortality is 1.62% for the latest rolling year to August 2017
- Overall HSMR performance is good at 94.9 and the Trust's overall position for the latest rolling year is 5th out of 16 trusts in East of England
- The SHMI has temporarily stabilised at 102.7.
- Numerous mortality improvement initiatives as detailed in the *Improving Outcome Strategy 2015-18 (IPOS)* are in train
- New Trust Learning from Deaths Policy has been published
- The Trust's Mortality Case Record Review Policy has been updated
- Current report incorporates new national Learning from Deaths requirements
- Measures in train regarding the development of the Trust's Mortality Case Record Review methodology/process and database

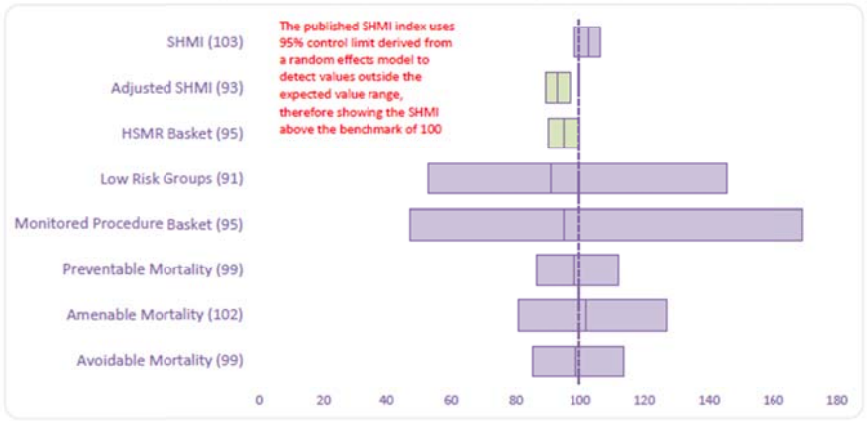
- Mortality monitoring is on-going with regular reporting to DEC, RAQC, Board, and CCG
- Regular joint meetings are held with ENH CCG to improve mortality rates.

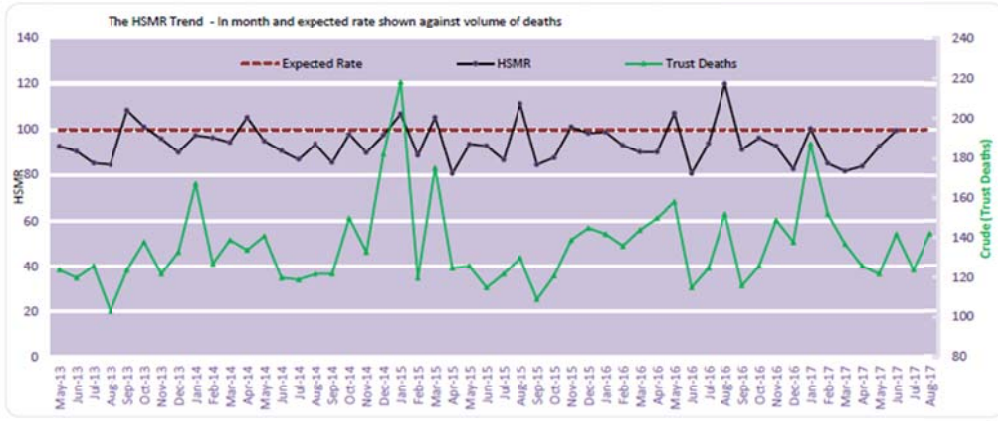
Appendix 2: Mortality Improvement Plan

Mortality Improvement Plan September 2017 update

This dashboard reports on the twelve month rolling period ending August 2017 for Crude Mortality, June 2017 for HSMR and December 2016 for SHMI (with the exception of the headline SHMI, which is March 2017).

The Trust will improve mortality and deliver HSMR and SHMI with the 'as expected' range or better





Patient Safety Indicators

Period: 12 months (Jul 16 to Jun 17)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	71273	56	83.3	0.8	1.2	67.2
Deaths after surgery	551	58	51.5	105.3	93.5	112.6
Deaths in low-risk diagnosis groups	34409	17	18.7	0.5	0.5	90.8
Decubitus ulcer	11044	326	542.2	29.5	49.1	60.1
Infections associated with central line	17421	0	0.6	0	0.0	0.0
Obstetric trauma - caesarean delivery	1406	3	5.3	2.1	3.8	56.5
Obstetric trauma - vaginal delivery with instrument	748	36	54.9	48.1	73.4	65.5
Obstetric trauma - vaginal delivery without instrument	3074	52	98.6	16.9	32.1	52.7
Postoperative haemorrhage or haematoma	23517	18	10.2	0.8	0.4	176.2
Postoperative hip fracture	29053	3	1.7	0.1	0.1	175.0
Postoperative physiologic and metabolic derangement	19496	4	2.1	0.2	0.1	188.2
Postoperative pulmonary embolism or deep vein thrombosis	23802	50	58.9	2.5	2.5	100.1
Postoperative respiratory failure	17193	10	13.7	0.6	0.8	73.0
Postoperative sepsis	607	6	5.4	9.9	8.9	111.4
Postoperative wound dehiscence	967	3	0.9	3.1	0.9	347.0

HSMR Performance (1=lowest HSMR 16=highest HSMR)	Latest rolling period	Previous rolling period	Performance
EoE Ranking Acute providers only (Jul16-Jun17, Dr Foster)	5	5	–

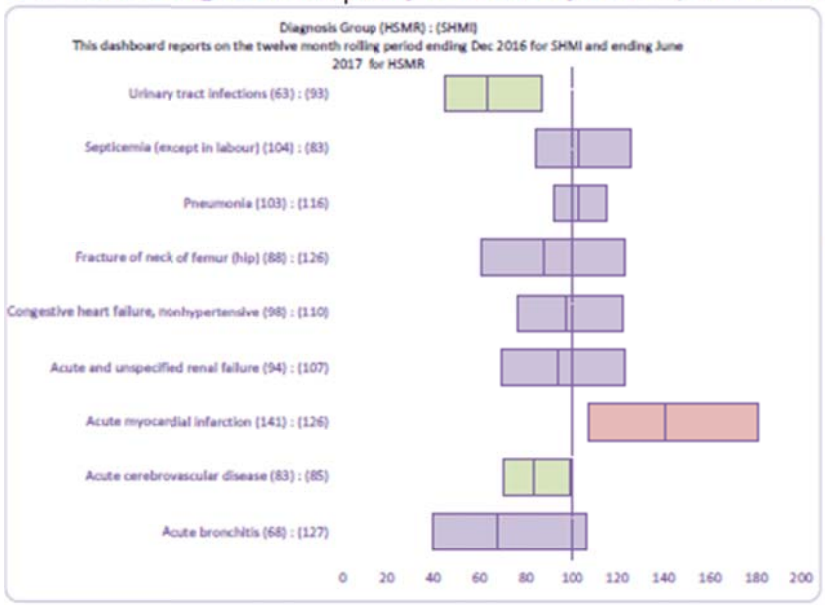
Leading Quality Indicators	Latest rolling period	Previous rolling period	Performance
Deaths in Residual Code Group (Jul16-Jun17, Dr Foster)	5	3	▼
Crude Mortality Rate (Sep16-Aug17, Acumen)	1.62%	1.65%	▲
Depth of Coding vs Upper Quartile YTD	4.70%	4.70%	–
Charlson rate as index of national 2017/18	90	90	–
Palliative Care Coding vs National FYTD	150.29%	151.03%	

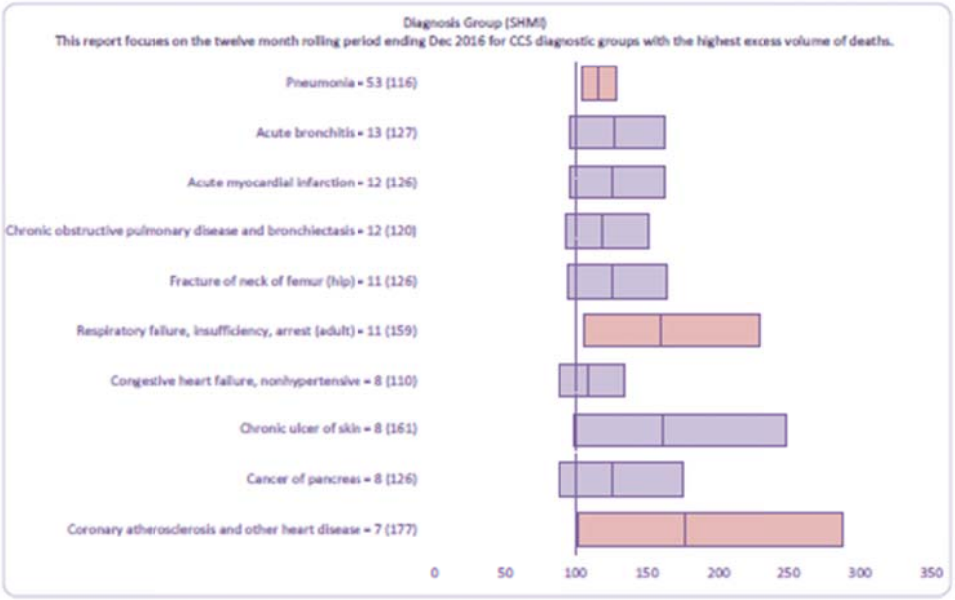
Note: SHMI figures quoted from Dr Foster Mortality Comparator

Mortality Improvement Plan September 2017 - v1_2

Appendix 2 (cont)

Selected Diagnosis HSMR / SHMI Report September 2017 update

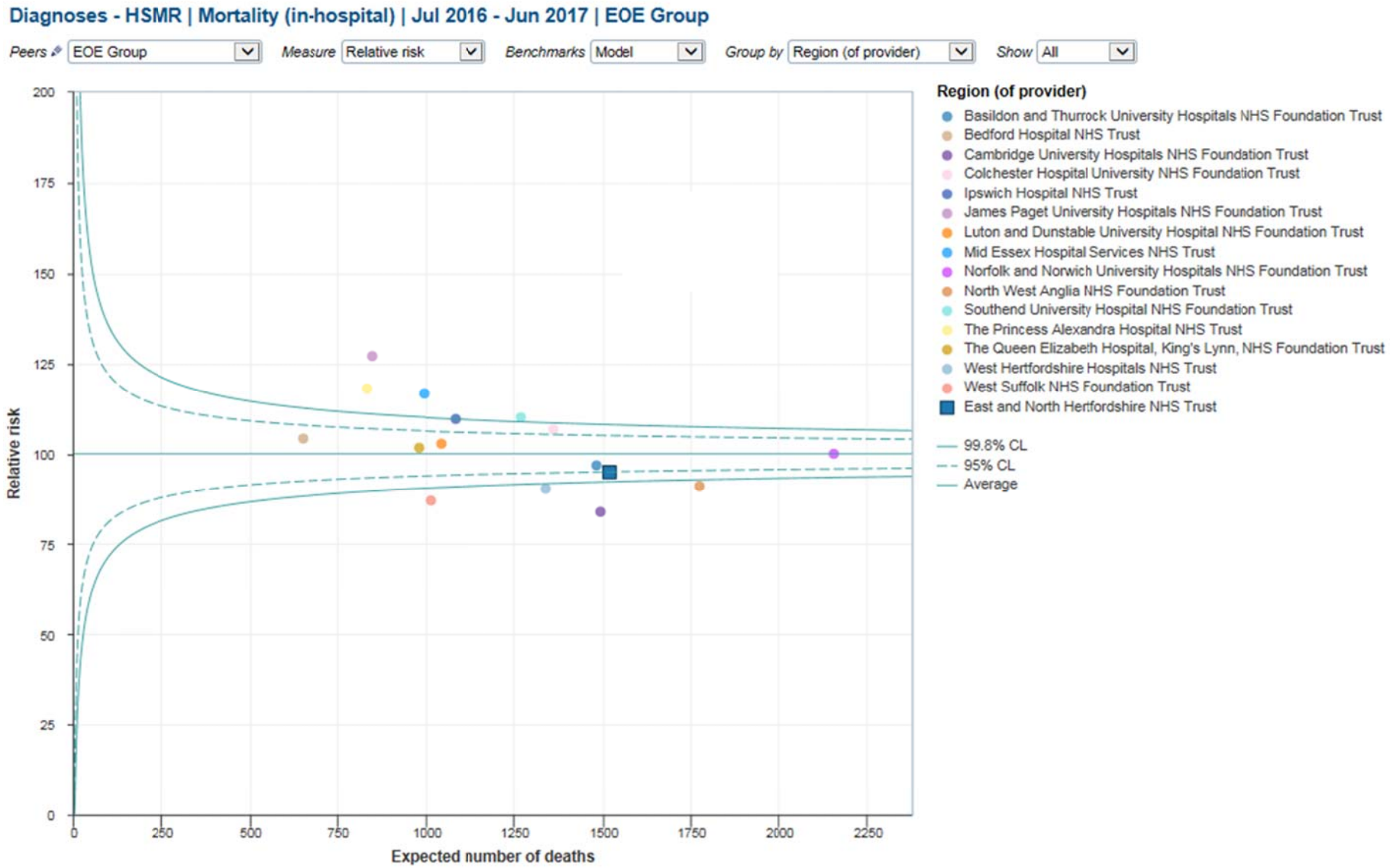




Note: SHMI figures quoted from Dr Foster Mortality Comparator

Appendix 3

HSMR by East of England Trusts: Funnel Plot
Period: July 2016 to June 2017



Appendix 4: Learning from Deaths Policy

Learning from Deaths Policy

(available on request from boardcommittees.enh-tr@nhs.net)

Appendix 5: Mortality Case Record Review Policy

Mortality Case Record Review Policy

(available on request from boardcommittees.enh-tr@nhs.net)

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard - June 2017-18

Department of Health

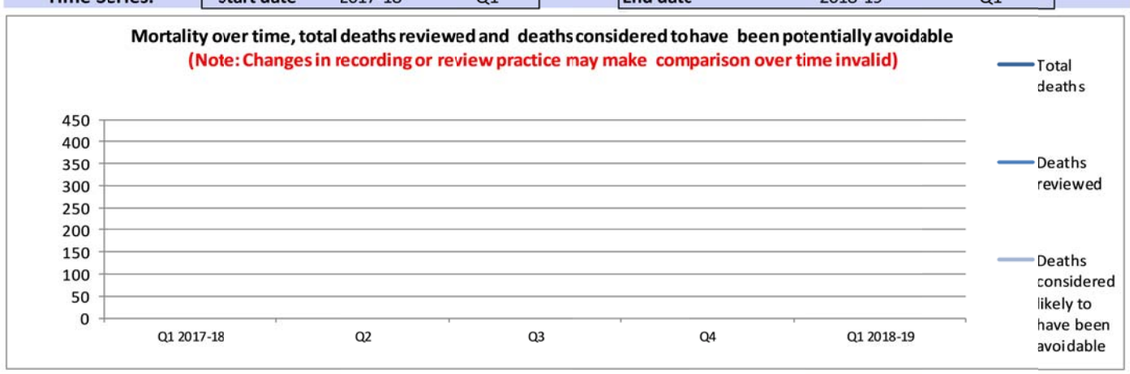
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose 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
149	137	109	61	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
422	0	198	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
422	0	198	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Total Deaths Reviewed by RCP Methodology Score

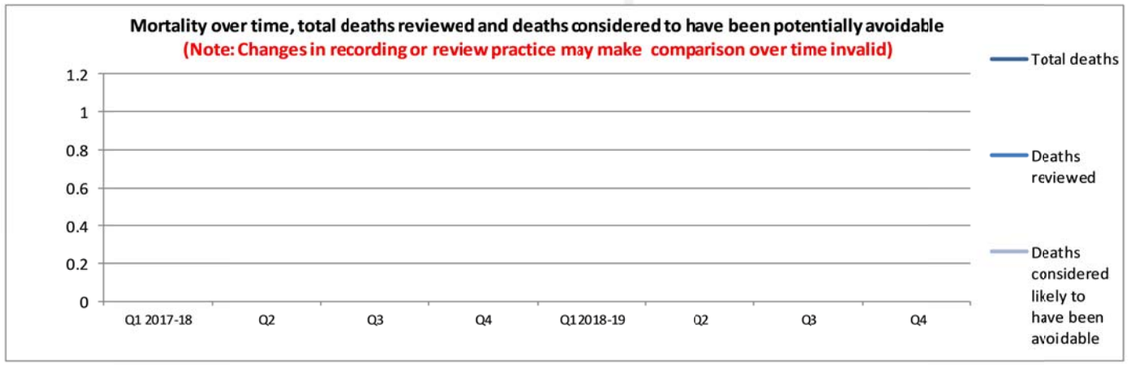
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	105	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.5%	This Quarter (QTD)	0	0.0%	This Quarter (QTI	186	99.5%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.5%	This Year (YTD)	0	0.0%	This Year (YTD)	186	99.5%

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
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	0	0	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q4



ENHT LfD Dashboard Jun-17

Agenda Item: 11

TRUST BOARD MEETING (PART I) – 1 NOVEMBER 2017

AUDIT COMMITTEE REPORT TO BOARD

PURPOSE	To inform the Trust Board of the decisions taken by the Audit Committee, and other outcomes, at its meeting of 23 October 2017.
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	✓ **1. Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ✓ **2. Developing new services and ways of working** – delivered through working with our partner organisations ✓ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance
CRR/Board Assurance Framework *	✓ **Corporate Risk Register** ✓ **BAF**

ACTION REQUIRED *

For approval	✓	For decision	
For discussion		For information	

DIRECTOR:	CHAIRMAN OF AUDIT COMMITTEE
PRESENTED BY:	CHAIRMAN OF AUDIT COMMITTEE
AUTHOR:	CORPORATE GOVERNANCE OFFICER/COMPANY SECRETARY
DATE:	OCTOBER 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

***** tick applicable box

AUDIT COMMITTEE – MEETING HELD ON 23 OCTOBER 2017

SUMMARY REPORT TO BOARD – 1 NOVEMBER 2017

The following members were present: Alison Bexfield, Bob Niven and Jonathan Silver

MATTERS REFERRED TO BOARD

Charity Accounts 2016/17 and External Auditor Report
The AC received the Annual Report and Financial Statements of the Trust's associated Charitable Fund for 2016/17 and the External Audit ISA 260 report. The report detailed the issues identified by External Audit and the adjustments that had been agreed and actioned. The accounts and report had been considered and endorsed by the Charity Trustee Committee in September. The Audit Committee noted the content of the reports and recommended the Accounts to the Trust Board, in their role as Corporate Trustee, for approval. Please see agenda item 12 for a copy of the report.

Review of Standing Orders and Standing Financial Instructions
The AC considered the annual review of the Standing Financial Instructions and Standing Financial Orders. The Committee endorsed the revised SFI's and SFO's for approval by Trust Board. A copy of the report is attached at agenda item 11.1.

OUTCOMES / DECISIONS TAKEN BY THE COMMITTEE

Managing Conflicts of Interest – Gifts and Hospitality and Conflict of Interest Registers
The AC reviewed the latest versions of the Gifts and Hospitality Register (2016/17 and 2017/18, April - August) and Conflicts of Interests Register for Board Directors. The AC was also informed of plans to promote the new Managing Conflicts of Interest Policy during November 2017. The AC approved the Hospitality Registers for 2016/17 and 2017/18 (to August) and Conflicts of Interests Register for Board Directors for publication. The Committee noted that the number of declarations of gifts and hospitality was smaller than they had expected, particularly in relation to sponsorship for attending events.

OTHER

Internal Audit Progress Report
The Committee received the latest Internal Audit Progress Report. The report detailed the findings of three Internal Audits:
Medicines Management – Partial Assurance
The AC noted that the previous audit of Medicines Management had also resulted in a 'partial assurance' opinion and that similar issues had been identified in the latest audit. It was agreed that an update on progress against the action plan would be provided for a future meeting.
Resilience Planning – Partial Assurance
An action plan had been developed and would be reported to RAQC on a monthly basis. The Director of Strategy would provide an update at the next AC meeting.
CIPs and Financial Forecasting – Reasonable Assurance
It was noted that the audit was regarding the tracking of delivery rather than of delivery itself and the audit was therefore not an indication of whether or not the Trust would meet its financial targets. There was some discussion regarding income assurance work that the Trust was undertaking at present. The Committee suggested that a short paper on the matter be produced for FPC.

Local Counter Fraud Specialist Progress Report
The AC discussed the latest counter fraud work undertaken at the Trust since the start of the current work plan. The Committee noted the report.

PwC Governance Review Report
The AC received the Governance review report that had been undertaken by PwC. The report had been discussed and supported at Board in October 2017. The AC discussed some aspects of the report and agreed there was a need to finalise an action plan for the Trust to implement. The AC could then track progress against the plan and consider what further assurance was needed.

Internal Audit Tracking Report
The report provided an update on progress made to date in implementing the recommendations made by the Internal Auditors. The AC noted the previous tracking report (for the July meeting) had incorrectly indicated that there were no actions overdue at that time and were concerned that a number of actions were now overdue for completion.

Alison Bexfield
Non-Executive Director

October 2017

East and North Hertfordshire NHS
NHS Trust

Agenda Item: 11.1

TRUST BOARD PART 1 – 1 NOVEMBER 2017

STANDING FINANCIAL INSTRUCTIONS AND STANDING FINANCIAL ORDERS

PURPOSE	To present the Board the annual review of the Standing Financial Instructions and Standing Financial Orders for consideration and approval. *(Tracked changes have been used for ease)*
PREVIOUSLY CONSIDERED BY	Review by Company Secretary, Financial Controller, Deputy Director of Finance, Procurement & LCFS. 23 October 2017 – Endorsed by Audit Committee – no additional changes.
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key element of the Trust's governance processes.
Healthcare/ National Policy (includes CQC/Monitor)	Supports compliance with Corporate Governance requirements. In line with best practice
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☑	For decision	☐
For discussion	☐	For information	☐

DIRECTOR:	Chief Executive
PRESENTED BY:	Chair of Audit Committee
AUTHOR:	Company Secretary/ Finance Team
DATE:	October 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

REVIEW OF STANDING FINANCIAL INSTRUCTIONS AND STANDING FINANCIAL ORDERS – 2017

1. EXECUTIVE SUMMARY

The Trust is required to have Standing Orders and Standing Financial Instructions and a scheme of delegation as part of its constitution. In March 2017, the Audit Committee and Board considered and approved a revised scheme of delegation and approval limits in order to strengthen the weakness identified by the new finance team in the financial control environment. The full scheduled annual review of standing financial instructions and standing financial orders has now been undertaken by the Finance, Company Secretary, LCFS, and procurement teams.

The key changes are outlined below:

- Incorporates the revised scheme of delegation that was approved and implemented in March 2017
- Reflects the new Managing Conflicts of Interests Policy
- Reflects the changes to the External Auditors and Auditor Panel
- Updated to reflect the new Business Development Committee and revised Capital Review Control Group that have been implemented in order to continue to strengthen our governance structures.

See appendix 1. Tracked changes have been used in the document to identify the key changes, these will be removed and the contents pages finalised once the content of the document has been approved.

The Executive and Finance teams continue to support compliance with the SFI's, SFO's and financial control.

The Audit Committee considered the revised SFI's and SFO's, appendix 1, at their meeting on 23 October and recommend them to Board for final approval without any additional changes.

East and North Hertfordshire NHS Trust

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: Company Secretary
Financial Controller
Head of Procurement
Local Counter Fraud Specialist

Approved by: Audit Committee
Mrs Alison Bexfield (Chairman), November 2017

Trust Ratification: Trust Board
Mrs Ellen Schroder (Trust Chair), November 2017

Policy issued: October 2017
To be reviewed before: October 2018
To be reviewed by: Company Secretary / Financial Controller
Doc Registration No. CG05 **Version No.** 7

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.

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 ~~Gifts and Hospitality~~ Policy
~~Conflicts of Interests 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. Non-compliance will result in investigation under the Trust Disciplinary Policy.

EAST AND NORTH HERTFORDSHIRE NHS TRUST

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

October 2017

Draft for consideration and approval by Audit Committee and Board October 2017

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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 Chairman 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 Company Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in 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 Chairman, officer and non-officer members of the Trust collectively as a body.

1.2.4 Bribery Act 2010 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 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. Appendix B is 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 of employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.7 **Chairman of the Board (or Trust)** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

1.2.8 **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. Appendix A is 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 Chairman.

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 Chairman 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 Chairman 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-Chairman** means the non-officer member appointed by the Board to take on the Chairman's duties if the Chairman 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 Governance and Risk Management Strategy. 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 Chairman of the Trust (Appointed by the NHS Appointments Commission/superseded by the Trust Development Authority in 2013 and NHS Improvement in 2016);

(2) Up to 5 non-officer members (appointed by the NHS Appointments Commission/superseded by the Trust Development Authority in 2013 and NHS Improvement in 2016);

(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 Chairman and Members of the Trust

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

2.3 Terms of Office of the Chairman and Members

(1) The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman 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-Chairman

(1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust may appoint one of their numbers, who is not also an officer member, to be Vice-Chairman, 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-Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).

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

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) **Chairman**

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

The Chairman shall liaise with the 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 Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

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.

(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 Chairman 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 as the Board may determine.

(2) The Chairman 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 Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 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 Chairman or by an officer authorised by the Chairman 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 Chairman 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 Chairman and Company 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 Chairman and Company 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, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

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 Chairman 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 Chairman.

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

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

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

ii) **Contents of motions**

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

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

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 Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(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 Chairman 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 Chairman of meeting

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

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

3.10 Chairman's ruling

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

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is 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 Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO 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.

3.12 Voting

(i) Save as provided in Standing Orders 3.l3 - Suspension of Standing Orders and 3.l4 - 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 Chairman of the meeting shall have a second, and casting vote.

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

(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 Chairman 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 Chairman 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 Chairman 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 Chairman 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 Chairman (or Vice-Chairman 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.

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 NHSI, CCG, or other Trusts consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(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 in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

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

4.4 Terms of Reference

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

4.5 Delegation of powers by Committees to Sub-Committees

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

4.6 Approval of Appointments to Committees

The 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 on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. 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 Rick and Quality 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 Terms of Service Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Terms of Service and Remuneration 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 advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

(i) setting the Remuneration Policy for the Chief Executive, Executive Directors and staff on Trust Pay
(ii) all aspects of salary (including any performance-related elements/bonuses);
(iii) provisions for other benefits, including pensions and cars;
(iv) arrangements for termination of employment and other contractual terms;
(v) to 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 and Performance Committee - The purpose of the Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS.

ii) Risk and Quality Committee - The purpose of the Committee will be to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, information governance, health & safety, staff governance and patient and public safety. The Committee will ensure that the Trust has an effective management and clinical governance framework which includes the

assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness.

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel ~~will be established~~ 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 not be required to convene in~~ensure the 2017/18~~, but this will be reinstated when the contract requires review. appointment is made by 31st December 2016.~~ The Terms of Reference are ~~will be~~ approved by the Trust Board and reviewed on a periodic basis. The committee is ~~to be~~ comprised of the Audit Committee Non-Executive Directors.

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 Trust's to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 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 Improvement (NHSI) or Clinical Commissioning Group (CCGs) ;

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

(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.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust 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.

5.2 Emergency Powers and urgent decisions

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

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

~~i)~~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 Company 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 Conflict's of Interest Policy.

7.1.2 Interests which are relevant and material

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

a) Outside Employment including Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies); Any other paid work including speaking at conferences, consultancy work and medico-legal work

b) Shareholdings and other ownership issues: Holding shares / other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might reasonably be expected to do, business with the Trust~~Shareholding of over 5% in any company operating in the same market as the Trust or with a substantial contract with the Trust;~~

c) Patents: Holding a patent and/or other intellectual property rights related to items to be procured or used by the Trust; Holding a patent and/or other intellectual property rights by virtue of your association with an organisation related to items to be procured or used by the Trust or On-going or new applications to protect related to items to be procured or used by the organisation. ~~Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;~~

d) Loyalty Interests: Position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions you take in your NHS role; Seat on an advisory group or other paid or unpaid decision making forum that might influence how the Trust spends taxpayers money; Involved in, or could be involved in, the recruitment or management of close family members and relatives, close friends and associates, and business partners and Aware that the Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.~~A position of Authority in a charity or voluntary organisation in the field of health and social care;~~

e) Donations: Donation made by suppliers or bodies seeking to do business with the Trust or Donation from another body.~~Any connection with a voluntary or other organisation contracting for NHS services;~~

f) Sponsorship: Sponsorship of an event by an appropriate external body; Involvement with sponsored or External sponsorship of a post. ~~Research funding/grants that may be received by an individual or their department~~;

g) Clinical Private Practice: Existing private practice (declare on appointment); New private practice (declare as it arises) Interests in pooled funds that are under separate management.

h) Other e.g. Any relevant position held by a spouse, partner or family member; or any influence over recruitment, or management (or other oversight) over family members, close friends or spouse/partner

(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 Chairman of the Trust or with the Trust's Company Secretary.

International Financial Reporting Standard (IAS 24) 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.

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 Chairman and Members in proceedings on account of pecuniary interest

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

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

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

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

(iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

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

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

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

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

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

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

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

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

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

(b) at a meeting of a Committee –

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

(ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the 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 now 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 chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

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 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 Company Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/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 Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to 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 Chairman 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 Chairman 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 Chairman 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 Company 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 CE on performance matters by exception.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will act in accordance with the Audit Committee Handbook 2016, 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. 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. 5 Monitor compliance with Standing Orders and Standing Financial Instructions; 6 Review schedules of losses and compensations and making recommendations to the Board. 7 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 TERMS OF SERVICE COMMITTEE (REMUNERATION COMMITTEE)	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust -

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. The Committee shall report in writing to the Board the basis for its recommendations. 8. Approve the Remuneration Framework for its subsidiaries. A full list of responsibilities can be viewed in the Terms of reference for this committee which are appended to this document
	RISK AND QUALITY COMMITTEE	The purpose of the Committee will be to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, financial risk, information governance, health & safety, staff governance and patient and public safety. Please note the Trust's Finance and Performance Committee will ensure the monitoring of financial risk, unless were there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny. The Committee will ensure that the Trust has an effective management and clinical governance framework which includes the assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document
	FINANCE AND PERFORMANCE COMMITTEE	The purpose of the Finance and Performance Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:- • overseeing the development and maintenance of the Trust's medium and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		long term financial strategy; • reviewing and monitoring financial plans and their link to operational performance; • overseeing financial risk management • scrutiny and approval of business cases and oversight of the capital programme • maintaining oversight of the finance function, key financial policies and other financial issues that may arise. The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS. 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. Each fortnight the Committee will meet as the Divisional Executive Committee in order to ensure engagement and decision making with the wider senior leadership across the organisation. 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.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		A full list of responsibilities can be viewed in the Terms of reference for the committee
	~~FOUNDATION TRUST COMMITTEE~~	~~The Committee has overall responsibility for monitoring the Foundation Trust application programme and identifying the risks to achieving authorisation by Monitor within the agreed timetable. The Committee is also responsible for monitoring the Trust's compliance with the timeline agreed with the NHS Improvement and Trust Board. It is acknowledged that the Committee will not be required to meet whilst there is not an active timeline but will be reinstated when required.~~ ~~A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document~~
	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
	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 not be required to convene in 2017/18, but this 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 Non-Executive Directors. ~~In line with the requirements of the Local Audit and Accountability Act 2014 the Auditor Panel was established in 2016 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~~

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~them. The Auditor Panel will ensure the 2017/18 appointment is made by 31st December 2016.~~ 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 & COMPANY 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 Chairman to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIRMAN	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the NHSI and the National Audit Office (NAO).

REF	DELEGATED TO	DUTIES DELEGATED
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 Chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the NHS England 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.
1.3.24	BOARD	It is the Board's duty to:

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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	CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chairman
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	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	CHAIRMAN & 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.
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~~n~~ 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.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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 PDB~~B~~C 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 ~~make short term borrowings~~ 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 ~~short term~~ borrowing application and documentation submission.~~approval~~.
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.
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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.
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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 and NHS Protect Regional Team in line with SoS directions.
26.2.2	DIRECTOR OF FINANCE	Notify NHS Protect and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused 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.
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.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.1.3	COMPANY 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.
30	COMPANY 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.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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 Litigation Authority 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 Litigation Authority 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 Litigation Authority 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.

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. Detailed delegated limits are outlined in Appendix 1 of this document.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Performance and Finance as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board secretary holds a record of circumstances that the Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8 For 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. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2016), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) 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;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the board

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Director of Finance in the first instance.)

11.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

11.3.3 The Head of Internal Audit or a representative from Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

11.3.4 The audit manager shall be accountable to the Audit Committee though the Head of Internal Audit and shall report to the Director of Finance for the operational delivery. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the audit manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor is appointed following a selection and appointment process overseen by the 'Auditor Panel'. The Audit Committee will be responsible for the effectiveness of the external audit function and will receive reports from the external audit partner. The contract will be reviewed at least every three years. If there are issues with the external audit, these should be raised with the external auditor in the first place. If the removal of the external auditor is considered, the 'Auditor Panel' will need to be convened and a recommendation made to the Board.~~was appointed by the Audit Commission and is paid for by the Trust. As the Audit Commission closed on 1 April 2015 this contract is managed by a 'transitional body', Public Sector Audit Appointments Ltd. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Public Sector Audit Appointments Ltd if the issue cannot be resolved. From 2017/18 onwards, NHS Trusts must have an 'Auditor Panel' to advise on the selection, appointment and removal of their External Auditors and on maintaining an independent relationship with them.~~

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the Health and Social Care Act 2012.

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the NHS Protect and the Regional Counter Fraud in accordance with the Department of Health Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

The Chief Executive as accountable officer and Finance Director as accounting officer are responsible for controls that ensure the Trust operates within resource limits set by the Department of Health or NHSI.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will compile and submit to the Board annually a Plan that takes into account financial targets and forecast limits of available resources. This will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

13.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

13.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

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

13.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.2 Budgetary Delegation

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

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

13.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

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

13.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

13.3 Budgetary Control and Reporting

13.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

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

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.3.2 Each Budget Holder is responsible for ensuring that:

(a) Value for money is obtained from the use of resources, ensuring that these are used to obtain economy and effectiveness for the Trust

(b) Resources are not spent unnecessarily even if the appropriate budget exists~~(a)~~

~~(a)~~(c) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

13.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's plans and a balanced budget.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

14.2 The Trust's annual accounts must be audited by the appointed external auditor.~~an auditor appointed by the Audit Commission (Currently managed by a 'transitional body', Public Sector Audit Appointments Ltd).~~ The Trust's audited annual accounts must be presented to a public meeting and made available to the public.~~ From 2017/18 onwards, NHS Trusts must have an 'Auditor Panel' to advise on the selection, appointment and removal of their External Auditors and on maintaining an independent relationship with them.~~

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK AND GBS ACCOUNTS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This may include operating through a shared business service. It will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking service accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

15.2 Bank and GBS Accounts

15.2.1 The Director of Finance is responsible for:

(a) bank accounts and Office of the Paymaster General (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

(c) the use of shared business service.

15.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.4 Tendering and Review

15.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be considered at least every five years. The results of the tendering exercise should be reported to the Board. This review is not

necessary for GBS accounts.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

16.2 Fees and Charges

16.2.1 The Trust shall comply with Department of Health tariffs in charging for activity that it has provided and follow the Department of Health's advice in the "Costing" Manual in setting prices for other NHS service agreements. ~~and comply with Department of Health set price tariffs.~~

16.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

16.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.2.4 The Director of Finance will put in place such systems and processes necessary to ensure that income due from transactions is recorded and accounted for in a timely and effective way.

16.3 Debt Recovery

16.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

16.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.5 2003 Money Laundering Regulations

Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempt to effect payment above this amount should be immediately notified to the Director of Finance.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 General

The Trust shall use Hertfordshire NHS Procurement for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. If the Trust does not use Hertfordshire NHS Procurement the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

17.2 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.3 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.4 Reverse eAuctions

Reverse eAuctions will be conducted in accordance with Trust policy and procedures in place for the control of all tendering activity carried out through this process.

17.5 Capital Investment ~~Manual~~ and other Department of Health Guidance

The Trust shall comply with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, including delegated limits, issued by NHSI as far as is practicable ~~with the requirements of the Department of Health "Capital Investment Manual"~~ and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts and temporary staffing contracts the Trust shall comply as far as is practicable with the requirements of NHSI.~~Department of Health guidance "The Procurement and Management of Consultants within the NHS"~~.

17.6 Formal Competitive Tendering

17.6.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

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

17.6.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.6.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the amounts set out in the procurement scheme of delegation. (see appendix to this report)

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

(d) where a national or regional arrangement is in place: CCS Crown Commercial Service framework agreements, collaborative procurement hub contracts, NHS Supply Chain framework and local agreements arranged through Hertfordshire NHS Procurement.

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

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

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

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

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

(i) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

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

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

~~(k) where allowed and provided for in the Capital Investment Manual.~~

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record endorsed in accordance with the Trust's procurement scheme of delegation.

17.6.4 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

17.6.5 **Items which subsequently breach thresholds after original approval**

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

17.7 Contracting/Tendering Procedure

17.7.1 **Invitation to tender – Paper Based Process**

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

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

(a) Submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.7.2 **Receipt and safe custody of tenders**

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the e-tendering System or endorsed on the unopened tender envelope/package.

17.7.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) The Buyer will send a notification of tender form indicating companies who have submitted together with costs and the successful bidder to the Chief Executive Office for recording in the Trust's register.

(iii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £1m. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

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

(v) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(vi) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Company Secretary will count as a Director for the purposes of opening tenders.

(vii) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(viii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(ix) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

17.7.4 **Admissibility**

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

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

17.7.5 **Late tenders**

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

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders

that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.7.6 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

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

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

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

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

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

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

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

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

(b) that best value for money was achieved.

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

17.7.7 Invitation to tender – Electronic Process

(i) All tenders will be undertaken through the Due North electronic tendering system. This shall enable: The required levels of calls for competition; a supplier information database; a process to request for prequalification information; evaluation of expressions of interest & prequalification questionnaires; creation of quotation/tender documents; invitation to tender; receipt of tenders; opening procedures evaluation award; contract management; and archiving of tender documentation

(ii) Tenders will be returned to an „electronic safe and locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the Head of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated representative. Should the Head of Procurement (Hertfordshire NHS Procurement) not be available, the task may be further delegated to a Hertfordshire NHS Procurement staff member trained in the use of Due North and otherwise not involved in the tender exercise.

(iii) The Head of Procurement (Hertfordshire NHS Procurement) as guardian for the Due North system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of: the name of all firms or individuals invited to tender; the names of firms or individuals from which tenders have been received; the date the tenders were opened; and the price shown on each tender.

(iv) There is generally no discretion to receive tenders after the due date. In exceptional circumstances the Head of Procurement (Hertfordshire NHS Procurement) may request the Chief Executive approve the inclusion of a late tender. The request will include an explanation of the exceptional circumstance and assurance that the tender process has not been compromised.

(v) Acceptance of tender: If for any reason the person opening the tender is of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

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

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

The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

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.

The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate / price current at the time the contract was awarded; and that best value for money was achieved.

(vi) The Head of Procurement (Hertfordshire NHS Procurement) as the Chief Executive nominated officer responsible for tendering will report to the Trust Board on an exceptional circumstance basis as required by the Chief Executive.

17.7.8 **Tender reports to the Trust Board**

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

17.8 Quotations: Competitive and non-competitive

17.8.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted because the intended expenditure or income does not exceed the amounts set out in the scheme of delegation.

17.8.2 Quotations

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

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

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

17.8.3 Quotations to be within Financial Limits

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

17.9 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as set out in the Trusts' procurement scheme of delegation (as per appendix 1 to this report).

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

17.10 Private Finance for capital procurement (see overlap with SFI No. 24)

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

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to NHSIthe appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.11 Compliance requirements for all contracts

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

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

(b) EU Directives and other statutory provisions;

(c) any relevant directions including NHSI the Capital Investment guidanceManual and, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.12 Personnel and Agency or Temporary Staff Contracts

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

17.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

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

17.14 Disposals (See overlap with SFI No. 26)

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

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.15 In-house Services

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

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

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1m, a non-officer member should be a member of the evaluation team.

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

17.15.4 The evaluation team shall make recommendations to the Board.

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

17.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within future plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.3 Commissioning

NHS England has published NHS Funding and Resource 2017-2019, as an annex to Next steps on the NHS Five Year Forward View, its Business Plan for 2017/18. ~~Putting Patients First to deliver high quality care for all, now and for future generations and t~~This sets out the commissioning upon which the Government's major reform agenda will be carried forward in line with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. The latest guidance can be accessed on www.england.nhs.uk

18.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

19. THIS SECTION IS NOT APPLICABLE TO NHS TRUSTS

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Agree the framework or broad policy for remuneration for Directors of the subsidiary

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 **Funded Establishment**

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department once agreed in the annual budget may not be varied without the approval of the Director of Finance.

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or delegated relevant Director;

(b) within the limit of their approved budget and funded establishment.

20.3.2 20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) putting in place procedures for the authorisation of the overall payroll file

(d~~c~~) making payment on agreed dates;

(e~~d~~) agreeing method of payment.

20.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. Current delegated limits are shown as Appendix to this document.

21.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services

(b) the maximum level of each requisition and the system for authorisation above that level.

21.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.1.4 Where the Trust has approved systems for obtaining goods and services, such as i-Procurement, Pharmacy systems or materials management systems, all officers and managers are required to use those systems. Contravention of systems must be supported by a waiver, which will be reported to the Audit Committee.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust by using the Trust's approved systems. Except in areas that are exempt from the process (such as Pharmaceuticals) ~~In so doing~~, the advice of the Trust's procurement department (Hertfordshire NHS Procurement) shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees authorised to certify invoices.

(ii) A process of electronic certification.

(iii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iv) A process for prompt 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.

(v) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.3 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.4 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.5 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) with regard to the Bribery Act 2010 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and Managing Conflicts of Interest Policy and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash and any other specific areas agreed by the Director of Finance

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

21.2.6 The Chief Executive and Director of Finance shall 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 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. EXTERNAL BORROWING

22.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Finance Director will maintain a list of employees (including specimens of their signatures) who are authorised to enact previously approved ~~make~~ short-term borrowings on behalf of the Trust.

22.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised signatory list. The Board must be made aware of all short-term borrowings at the next Board meeting.

22.1.6 All long-term borrowing must be consistent with the plans outlined in future plans and be approved by the Trust Board.

22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

22.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

22.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

23. FINANCIAL FRAMEWORK

23.3.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. The Trust's medium term and longer-term financial strategy, the planned sources of funding including any external borrowing and repayment plan.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges;

(d) shall ensure that there is consultation with commissioners regarding capital investment of a strategic nature, or which has a material affect on income streams

24.1.2 For every capital expenditure proposal (other than those described in 24.1.4 and 24.1.5 below) the Chief Executive shall ensure:

(a) that a business case (in line with the guidance issued by NHSI on Capital Investment for NHS Trusts~~contained within the *Capital Investment Manual*~~) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

~~24.1.3.1 Investment Committee (reports to the FPC through the Director of Finance)~~

~~(a) sets the Trust's Annual Capital Programme and submits it to the Finance and Performance Committee for approval;~~

~~(b)~~(a) ~~considers all capital expenditure proposals within the parameters of the Capital Programme approved by the Finance and Performance Committee (FPC). Has authority to approve schemes up to £500,000 with schemes above this limit being referred to the FPC.~~

~~24.1.4~~24.1.3 Capital Review Control Group, (reports to the FPC through the Director of Finance report)), meets on a monthly basis and performs the following functions:

(a) Considers applications for capital investment from Divisions and Corporate Directorates against risk of non-investment;

(b) Draws up a proposed capital programme for the next year for discussion and agreement at the Divisional Executive Committee;

~~(a)~~(c) Sets the capital budgets following approval by DEC;

~~(b)~~(d) monitors progress of capital projects against budget;

~~(c)~~(e) reports to the FPC on progress made on capital projects after each meeting

~~(d)~~(f) liaises with Divisions and Project Sponsors to aid the progression and management of capital schemes

~~(e)~~(g) monitors the procurement of donated assets valued over £100k and reports to the Charity Trustee Committee

~~(f)~~(h) review all capital risks at the Trust

~~(g)~~(i) ensures that the Capital Resource Limit (CRL is achieved at the Trust)

~~(h)~~(j) to review and verify assets held at the Trust ensuring that the Trust Asset register is accurate.

24.1.4 Business cases presented to the Business Development Committee and ~~Investment Committee and~~ Capital Review Group should consider sources of funding including purchase, private or other finance and ~~the use of~~ lease funding. The Trust uses Leaseguard Group Limited to support the management of its lease portfolio. All lease proposals must be organised by Leaseguard unless the Finance and Performance Committee specifically agree alternative arrangements. Leaseguard's recommendations will be reviewed by the user department and by Finance, but lease agreements can only be authorised in accordance with the Trust's Authorised Signatories for Lease Documentation.

24.1.5 On an annual basis the Deputy Director of Operations, Director of Estates and Head of IT collate ~~organises medical equipment~~ capital requests from the Clinical Divisions which are considered at a special Divisional Operations Committee meeting, together with requirements from their own areas. The ~~at which~~ applications are considered for inclusion on the Annual Capital Programme. A schedule of approved bids will prepared for review at the Capital Review Group.~~and final approval by the Medical and/or Nursing Director and the Investment Committee~~. Bids are to be made on a standard template which considers the following:

(a) the mitigation of clinical or operational risk

(b) the revenue consequences associated with the capital spend

(c) EBME advice

(d) infection control advice

(e) implications for clinical workload

(f) discussions with commissioners if the implications for workload materially impact on income streams

(g) any IT resource requirements or Information Governance considerations.

24.1.6 On an annual basis, the Head of Estates produces a schedule of backlog maintenance priorities using risk-based criteria. The schedule will be prepared for review and final approval at Capital Review Group~~Investment Committee~~.

24.1.7 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

24.1.8 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

24.1.9 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

24.1.10 The Director of Finance's report to the Finance and Performance Committee will detail major variations to the annual capital expenditure programme

24.1.11 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance ~~with "Estatecode" guidance and~~ these ~~Trust's~~ Standing Orders and Standing Financial Instructions.

24.1.12 The Business Development Committee shall review all business cases at each of the three key stages – Strategic Outline Case, the Outline Business Case, the Full Business Case. This is to support business decisions are taken which support the strategic objectives, support the development and sustainability of quality services; are in line with the Trust's core strategies; are based on the best available intelligence; are fully impact assessed; are made within the context of the developing market and the existing and potential partnerships which could be developed to best exploit this market.

The Business Development Committee will report its recommendations to the Executive/Divisional Executive committee and the business cases recommended for approval will be submitted to the Committee with the right level of authorisation as defined in the terms of reference.

24.1.13 The Finance and Performance Committee will evaluate, scrutinise and approve individual investment decisions including a review of Outline and Full Business Cases where there is:

(a) a capital scheme (including leased assets) with an investment value in excess of £500k

(b) all proposed fixed asset disposals where the value of the asset exceeds £500k

Where the scheme in question is in excess of £1 million, the Finance and Performance Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal

24.1.14 Where capital schemes are in excess of the Trust's delegated limits, they will require NHSI approval.

24.2 Private Finance (see overlap with SFI No. 17.10)

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 The minimum data set to be held within the Trust's register shall be sufficient to identify, locate and value assets appropriately.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Notification of project completion by the relevant project manager who is responsible for ensuring properly authorized and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

(b) Purchase and installation of equipment.

(c) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(d) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) that are the responsibility of the relevant budget-holder.

24.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be measured at its fair value in accordance with Trust's accounting policies.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified to reflect the consumption of the assets economic useful life in accordance with the Trust's accounting policies.

24.3.8 The Director of Finance of the Trust shall calculate and pay a dividend based the required return on assets in accordance with department of Health accounting policies, currently set at 3.5%.

24.4 Security of Assets

24.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss, including through theft, damage or obsolescence, of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses. A summary of such losses will be reported to the Audit Committee at least twice a year.

24.4.6 Where practical, assets should be marked as Trust property.

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance the value of all losses and any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note. Any discrepancies should be reported to NHS Supply Chain. The Director of Finance shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must refer to the Trust's Anti-Fraud and Bribery Policy and either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and NHS Protect regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (NHS Protect) and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

26.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

26.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

26.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

25.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

26.2.9 All significant losses and special payments must be reported to the Losses and Special Payments Committee who bi-annually report to the Audit Committee. Annually the Director of Finance will report all losses to the Audit Committee in support of the annual accounts approval process.

26.2.10 ~~The Financial Controller and the Deputy Director of Finance are the nominated officers authorised by the Director of Finance to approve requests to write off bad debts up to the limit of £3,000 and £15,000 per invoice respectively. Requests to write off invoices in excess of £15,000 require the approval of the Director of Finance.~~Approval of requests for write off of bad debts will be subject to the detailed Scheme of Delegation in the Appendix to this document. All bad debts written off must be reported to the next meeting of the Losses and Special Payments Committee, which must report to the Audit Committee on a twice-yearly basis.

26.2.11 Under delegated powers the Losses and Special Payments Committee can approve payments to patients, staff and members of the public in respect of approved personal property claims ~~of~~ up to the delegated limit~~£3,000~~ without recourse to the Director of Finance. These claims will form part of the twice-year report to Audit Committee.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Director of Finance

27.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance shall need to ensure 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 The Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

27.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

28.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the

Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Company Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff; Managing Conflicts of Interest Policy. This policy follows the national guidance on Managing Conflicts of Interest in the NHS 2017. ~~contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff'~~ and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts.

32. RETENTION OF RECORDS

32.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority 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.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the 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 which will not be reimbursed.

(3) ~~(3)~~ All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix 1

Detailed Procurement Process

Introduction

In deciding what goods and services to procure, the Trust must be able to demonstrate that it has obtained Value for Money and compliant with Public Procurement regulations. In all cases of doubt in the procedure to be adopted, The Trust's Procurement service provider should be consulted. The procedure below outlines the process to be followed only and does not cover who would be responsible for signing any resultant Purchase Order – these levels are covered in Appendix 2.

Exceptions from competitive purchasing procedures

In certain instances, there are national NHS contracts in force which mean that goods and services need to be sourced from a particular supplier. In other instances, procurement hubs have undertaken competitive tendering processes and due diligence for a generic range of goods and services. A list of approved suppliers under a framework has been developed by these organisations that the Trust can choose to use without the need for a further round of competitive process. The Trust's Procurement service provider can provide details of national contracts and approved supplier frameworks.

If, for any reason, the Trust opts not to go an approved framework, it will need to demonstrate that there has been fair competition. If, in the case of overwhelming reason, that there has not been a competitive process, a Waiver to Standing Financial Instructions must be completed and signed by the appropriate signatory before the contract is awarded. These waivers are reported to the Finance Performance Committee by the Head of Procurement.

Competitive procedures

Where a framework or national contract has not been used, the outline procedures below must be followed

Contract or purchase value below £10,000 (exc.VAT)

There is no formal requirement to undertake a competitive process. However, the overall requirement is to deliver the best value for the Trust. This may not necessarily mean that the cheapest product needs to be bought, but price against other factors such as longevity or fit with other products needs to be considered. This decision-making process is likely to be needed to be evidenced to authorising managers.

Contract or purchase between £10,001 and £50,000 (exc.VAT)

At least three competitive written quotations will need to be obtained. As above, the selection may not be the cheapest, but there should be an evidenced evaluation of value for money to the Trust. The selection will need to be endorsed by the Head of Procurement as well as the authorising manager. A Quotations Register is maintained by Procurement.

Contract or purchase between £50,001 and the OJEU limit (currently £106,047~~113,057~~) exc VAT

There will need to be a formal tendering exercise undertaken, managed by The Trust's Procurement service provider. Any waiver to this process will need to be endorsed by the Head of Procurement and approved by the Director of Finance (in his absence the Deputy Director of Finance).

The tender opening process will be managed by the Procurement Department. Electronic tenders will be recorded on the 'Due North' system and a register of tenders maintained by the Board Secretary.

Contract or purchase over OJEU limit (currently £106,047~~113,057~~)

An OJEU-compliant tendering process will need to be undertaken. There can be no waiver to this process. For tender values over £1m, a Board member will need to be present.

Appendix 2

Detailed Limits of Delegation Policy

Introduction - Authorisation Limits

Where Directors, managers and other staff are authorising transactions on the Trust's behalf, the presumption is that they are doing so within the remit of their position as defined below, and within agreed budgets. Anyone operating outside these parameters will be considered as acting without due authority and may be subject to formal disciplinary procedures.

The processes below do not replace the Procurement process which requires obtaining competitive quotations and tenders, except in defined circumstances. Once the competitive process has been completed, any associated order is subject to the approval process below.

1. **Trust Service Level Agreements**

The Trust is commissioned to provide both clinical services and non-clinical services to other NHS and non-NHS organisations. It also receives services from other organisations. Provision or receipt of services over a period needs to be supported by a formal Service Level Agreement. New services should be subject to Board, DEC or Exec approval through the Business Case process, and the Service Level Agreements for the extension of existing agreements need to be reviewed by the Senior Contract Manager within Finance before approval.

The values below are based over the lifetime of the contract, as the responsible officer will be committing the Trust to the terms of that contract. Circumvention of the approval process, by splitting the contract into smaller units e.g. monthly payments, will be viewed as a disciplinary issue.

Type	Amount	Responsible Officer	Current Limit
Patient Activity Service Level Agreements with Commissioners	Over £50,000,001pa	Chief Executive and Director of Finance	To be nominated by the Chief Executive, but no formal limits set in the existing limits of delegation
	Between £10,000,001 and £50,000,000	Director of Finance	
	Up to £10,000,000pa	Chief Operating Officer and Assistant Director of Finance (Financial Planning)	
Agreements for the provision of non-patient services to other organisations *	Over £5,000,001pa	Chief Executive and Director of Finance	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
Expenditure Service Level Agreements with other NHS bodies (Clinical)	Over £50,000,001pa	Chief Executive	
	Between £10,000,001 and £50,000,000	Director of Finance	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Divisional Director	
	Up to £10,000pa	Assistant Director of Finance and Divisional Director	
Expenditure Service Level Agreements with other NHS bodies (Non-Clinical)*	Over £5,000,000pa	Chief Executive and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People Officer for HR SLAs	
	Between £1,000,001pa and £5,000,000	Director of Finance and appropriate Executive Director i.e Chief Operating Officer for Estates or Chief People	

		Officer for HR SLAs	
	Between £10,001pa and £1,000,000	Deputy Director of Finance and Corporate Lead e.g. Estates, Finance, HR	
	Up to £10,000pa	Assistant Director of Finance and Corporate Lead e.g. Estates, Finance, HR	

*Note – any agreement in excess of three years will require Director of Finance sign-off

Contracts for the provision of Goods and Services (not included within a Service Level Agreement above) and Other Revenue Expenditure

Once the underlying contract has been approved, using the delegated limits below, the receipt of goods and services and payment of 'Non PO' invoices can be based on the periodic payments i.e. monthly or quarterly invoices. Purchase Orders includes those raised through Oracle, GRAMMs (Estates), Bedford/JAC (Pharmacy) and Saffron (Catering).

The amount of order value being considered for approval will be based on the agreed contractual value or, where the contract is over a period of years, the lifetime of the contract.

Please Note: The values below do not replace those for competitive quotations or waivers.

Type	Amount	Authorised Officer	Current Approver
Contracts and consequent Purchase Orders on first agreement of contract	Over £1,000,001	Subject to Board approval	Head of Procurement, Director of Finance, Director of Operations or Director of Estates (depending on type of supply) – Over £113,057 and up to any limit
	Over £750,001 and up to £1,000,000	Chief Executive	
	Over £250,001 and up to £750,000	Director of Finance	
	Over £100,001 and up to £250,000	Other Executive Director	
	Over £50,001 and up to £100,000	Deputy Director of Finance	General Manager or Supply Chain Manager
	Over £10,001and up to £50,000	Divisional Director/Divisional Chair/Assistant Director of Corporate area	Deputy General Manager or equivalent e.g Matron, Fin Mgr
	Up to £10,000	General Manager, Divisional Nursing Services Manager, Head of Service	Up to £5,000 – Budget Holder or nominated Deputy
Pharmaceuticals	Any value	Director of Finance, Chief Operating Officer	Unchanged

	Up to £50,000	Head Pharmacist	
Subsequent Catalogue or Non-Catalogue Orders, including Estates and Catering, once contracts have been agreed	Over £1,000,001	Director of Finance	Head of Procurement, Director of Finance, Director of Operations or Director of Estates (depending on type of supply) – Over £106,047~~£113,057~~ and up to any limit
	Over £500,001 and up to £1,000,000	Other Executive Director	
	Over £50,001 and up to £500,000	Deputy Director of Finance	General Manager or Supply Chain Manager up to £106,047~~£113,057~~, otherwise above
	Over £5,001 and up to £50,000	Divisional Director/Assistant Director of Corporate area	Deputy General Manager or equivalent e.g Matron, Fin Mgr
	Up to £5,000	General Manager, Divisional Nursing Services Manager, Head of Service	Up to £5,000 – Budget Holder or nominated Deputy
Pharmaceuticals	Any value	Director of Finance, Director of Operations	Unchanged
	Up to £50,000	Head Pharmacist	

2. Invoices excepted from the Purchase Order Process

Type	Amount	Authorised Officer	Current Approver
All payment types below	Over £250,000	Director of Finance	Any Director (over £106,047~~£113,057~~)
Utilities (Phones, Electric, Gas, Water, Waste Collections)	Over £50,001 and up to £250,000	Deputy Director of Finance	General Manager up to £106,047~~£113,057~~
	Up to £50,000	Head of relevant area (IT, Estates)	Deputy General manager
Rates	Over £50,001 and up to £250,000	Deputy Director of Finance	General Manager up to £106,047~~£113,057~~
	Up to £50,000	Director of Estates	Deputy General manager
Lease car invoices	Over £5,001 and up to £250,000	Deputy Director of Finance	General Manager up to £106,047~~£113,057~~
	Up to £5,000	Financial Controller	Deputy General manager
Computershare invoices (nursery vouchers)	Over £50,001 and up to £250,000	Deputy Director of Finance	General Manager up to £106,047 ~~£113,057~~
	Up to £50,000	Financial Controller	Deputy General manager

3. Other Payments

Payment Type	Amount	Responsible Officer	Current approver
All payment types below	Over £250,000	Director of Finance	Any Director (over £106,047~~£113,057~~)
	Over £50,001 and up to £250,000	Deputy Director of Finance	General Manager up to £113,057
NHS Supply Chain invoices for 'top up' of materials management	Up to £50,000	Approved by Financial Controller/Deputy Financial Controller	Deputy General manager
Payroll Payments	Main Trust Payroll	Director of Finance or Deputy in his/her absence	No current delegated limits documented
	Supplementary Payroll	Up to £30,000 Deputy Director of Finance or Financial Controller, otherwise Director of Finance	
	ENH Pharma Payroll	Pharma Director of Finance, Deputy Director of Finance or Financial Controller up	

		to £200,000, otherwise Trust Director of Finance	
	Garden House Hospice Payroll	As per Supplementary Payroll above	
Payroll deduction payovers, such as Union subs, Court Orders, Tax/NI and Pension Scheme payments	If these reconciled to approved payrolls as above	Deputy Director of Finance or Financial Controller	
'Faster' Payments , based on approved invoices or payroll requests	Up to £50,000	Financial Controller or Deputy Financial Controller	

4. **Capital Expenditure**

The Capital Review Group will recommend the capital programme for each financial year to Exec, who will approve this programme. Any capital expenditure outside this programme will need to be presented in a formal bid to CRG to ensure that all Estates, Equipment and IT implications have been considered before it can be presented to the Exec meeting for approval. This includes all potential revenue schemes which have a capital implication.

Once the schemes have been approved, approval limits for orders placed will follow the revenue limits above outlined in Section2.

5. **Payroll and Other Contractual Payments connected with Employment**

Budget managers have delegated authority to approve pay, subject to the payments being within their funded establishment. However, any payments outside normal contractual terms and conditions, not reserved for approval by the Remuneration Committee, can only be made with the approval of the Director of Finance.

Type	Amount	Authorised Officer	Current Approver
Timesheets, recruitment forms, change forms	Any within budgetary limits confirmations	Line manager	No change
Contractual payments on termination e.g. lieu of notice or redundancy	Over £10,001	Director of Finance	
	Up to £10,000	Chief People Officer	
Removal Expenses	Over £8,001	Director of Finance	
	Up to £8,000	Chief People Officer or Director of Workforce	

6. Non-Contractual Payments connected with Employment

Type	Amount	Authorised Officer	Current Approver
Extra contractual payments on termination (discretionary)	Any	None – these require approval by HM Treasury	
Payments in connection with Employment Disputes e.g. Employment Tribunals	Over £50,001	Trust Board (or Chair and Chief Executive on behalf of the Board)	
	Between £10,001 and £50,000	Chief People Officer and Chief Executive	
	Up to £10,000	Chief People Officer or Director of Workforce	

7. Credit Note Requests

The limits below relate to the raising of credit notes which, although valid, will impact on the amount of income reported. Where errors in raising invoices have been made, cancellation of the incorrect invoice can be authorised by the Financial Controller/Deputy Financial Controller on the provision of evidence that the invoice will be re-raised correctly.

Invoice Type	Amount	Responsible Officer	Current approver
SLA/NCA Income from Commissioners	Up to £1,000	Assistant Director of Finance (Income and Contracts)	No current documented limits
	Over £1,001 to £50,000	Assistant Director of Finance (Financial Planning) or Financial Controller	
	Over £5,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Other Operating Income raised through Management Accounts	Up to £5,000	Deputy Financial Controller	
	Over £5,001 and up to £50,000	Assistant Director of Finance or Financial Controller	
	Over £50,001 and up to £500,000	Deputy Director of Finance	
	Over £500,001	Director of Finance	
Private Patient/Overseas Visitors Invoices	Up to £5,000	Deputy Financial Controller	
	Over £5,001 and up to £50,000	Financial Controller or Assistant Director of Finance	
	Over £50,001 and up to £500,000	Deputy Director of Finance	

	Over £500,001	Director of Finance	

8. Losses and Special Payments

Category	Amount	Responsible Officer	Current approver
Bad debts Write-Off (must always have dual signatories)	Up to £1,000	Financial Controller plus One Assistant Director of Finance	Financial Controller £3,000 (per invoice) Deputy Director of Finance - £15,000 (per invoice) Director Finance – Any invoice above £15,000 One signature only required
	Over £1,001 and up to £5,000	Financial Controller or Assistant Director of Finance plus Deputy Director of Finance	
	Over £5,001 and up to £100,000	Financial Controller, Assistant or Deputy Director of Finance plus Director of Finance	
	Over £100,001 and up to £250,000	Chief Executive and Director of Finance	
	Over £250,001	Board	
Fraud/Theft	All values	To be reported to Audit Committee	No change
Other Losses	To be approved through the Losses and Special Payments Committee in line with the Losses and Special Payments Policy. A summary is to be provided to Audit Committee twice yearly.		No change

9. Charitable Funds

Before Charitable Funds income agreements (such as grant applications, acceptance of legacies and significant donations) and expenditure can be approved, it is expected that the Trust Business Case and governance processes have been adhered to. This will include confirmation of the support of divisions, identification of potential revenue issues for the Trust, compliance with Trust strategy and so on. In case of doubt, the Head of Engagement should be consulted.

Income and expenditure over the lifetime of the scheme or project should be considered

Category	Amount	Responsible Officer	Current approver
All income and expenditure agreements	Up to £5,000	Approved fundholder	No change
	Over £5,001	Charitable Trustees Committee	No change

10. ENH Pharma

Approval limits will be set by the ENH Pharma Board, under its own Scheme of Delegation. However, the Trust expects that the governance processes will take into account the underlying principles contained within its Standing Orders and Standing Financial Instructions

Agenda Item: 12

TRUST BOARD as CORPORATE TRUSTEE - 1 NOVEMBER 2017

Audit of Charitable Funds Report and Accounts

PURPOSE	To present to the Board in its role as Corporate Trustee, for approval the - Charity Annual Report and Accounts - Letter of Representation - And to note the External audit of the Annual Report and Financial Statements of the Trust's associated Charitable Fund for 2016/17
PREVIOUSLY CONSIDERED BY	**23 October 2017: Audit Committee – recommended.** **4 September 2017: CTC – recommended**
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial, governance,
Healthcare/ National Policy (includes CQC/Monitor)	Charity governance, Charity Commission
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	X	For decision	
For discussion		For information	

DIRECTOR:	Director of Finance
PRESENTED BY:	Financial Controller
AUTHOR:	Financial Controller / External Audit / Head of Engagement
DATE:	November 2017

We put our patients first We work as a team We value everybody We are open and honest
We strive for excellence and continuous improvement

Introduction

The audit of the East and North Herts NHS Trust Charity Annual Report and Accounts was completed in September. External Audit have issued their ISA 260 report, which details the issues identified and the adjustments that have been agreed and actioned.

The purpose of the paper is to present to the Board in its role as Corporate Trustee, for approval the

- Charity Annual Report and Accounts
- Letter of Representation
- And to note the External audit of the Annual Report and Financial Statements of the Trust's associated Charitable Fund for 2016/17

These have been reviewed and recommended for approval by the Charity Trustee Committee and Audit Committee.

Main issues from the External Audit Report

There were three main issues identified:

- The Charity had been informed of the existence of a substantial legacy which conferred an entitlement to part of an Estate to the Charity. Allowance for this was not included initially within the 2016/17 financial statements as the amount was not confirmed in value or received until early 2017/18.

  However, accounting standards state that an event after the Balance Sheet date that confirms the value of an asset or liability in existence at the Balance Sheet date should be adjusted within the financial statements. As the legacy was a receivable at the end of the 2016/17 financial year, the value of which was confirmed, it needed to be reflected in the 2016/17 Accounts.

  The income was therefore increased by the value of £723k, with a corresponding increase to the debtors value.

  The Charity has reviewed the way that it accounts for legacies to ensure that it includes them in line with appropriate accounting standards.

- The Charity accounted for the transactions through its one main bank account. However, one dormant account was identified as part of the audit process and the existence of another potential dormant account is in the process of being confirmed. Neither account has had any recent transactions and the balances are minimal.

  Additional funds of just over £1k were recognised within the financial statements. Both accounts will be closed and the funds transferred to the main account before the end of the financial year. Controls in place now would prevent any further accounts being opened.

- Two accruals were tested as part of audit process and a net overaccrual of £2.7k identified. This has been adjusted through the financial statements.

Nicola Peters
Financial Controller
16th October 2017

Annual Report and Accounts

For the year ended 31st March 2017

Registered Charity in England and Wales no.1053338

Contents

Welcome to our 2016-17 Annual Report

Chairman's Statement

I am delighted to be presenting this year's Annual Report and Accounts for East & North Herts Hospitals Charity. We have had a very strong year achieving income just under £1.9M – our strongest performance for a good many years!

Although 2016/17 was a year characterised by change, we continued to provide major support for patients, staff and visitors to our four hospitals with a total income of £1,877k and costs and expenditure of £1,082k. We have made good progress with our fabulous Forget-Me-Not Appeal in support of patients with dementia at the Lister Hospital. We also supported 300 volunteers at Mount Vernon Cancer Centre to work an amazing 770 hours every week. You can read more about these and other achievements in the main body of our annual report.

As with previous years, demands on our hospitals' NHS budgets increased again this year which meant the Charity Trustee Committee received a number of requests to fund equipment and services which might, in the past, have been funded by the NHS. We judged each request on its merits and, difficult as it was, we had to turn down some very worthwhile projects because they did not meet our charitable objectives. As budget pressures increase, we will continue to ensure we always adhere to our donors' wishes.

Our Head of Charity left unexpectedly during the year which inevitably had an impact on our operation. Nonetheless, our fundraisers stepped-up to deliver a c£1.9M income year - we would like to thank them for all their hard work. We were delighted to welcome our new fundraiser at the Lister, Sam; and our new Charitable Accountant, Daria.

Needless to say, we couldn't have helped a single patient, staff member or

visitor without the support of our donors, supporters, volunteers and fundraisers and we remain extremely grateful to each and every one of you. **Thank you.**

Bob Niven
Chair of the Charity Trustee Committee
On behalf of the Corporate Trustee

About the Charity

East & North Herts Hospitals Charity was registered in 1996 to support and enhance the fantastic care provided by staff at the hospitals within East and North Hertfordshire NHS Trust - the Lister in Stevenage, the new QEII in Welwyn Garden City, Hertford County Hospital in Hertford and Mount Vernon Cancer Centre (MVCC) in Northwood, North London. Today, more than 500,000 people are cared for at these four hospitals each year.

The Charity funds extra equipment, facilities, research and staff development which complement services provided by the NHS, helping the Trust to reach its objective of being *among the best* healthcare providers in the country.

We receive donations from grateful patients as a thank you to staff for the care they have received; from family and friends in memory of a loved one; from energetic fundraisers who organise and take part in events to support our work; from companies, Trusts and Foundations; and as legacies from those who wish to support our work in the future.

Despite the challenging economic climate, we continue to work in and with our local communities to support more patients, staff and visitors each year, helping to create a hospital experience of which they can be proud.

How did we do?

We have been extremely fortunate to receive support from a huge number of groups, individuals and organisations during the year; people who chose to do something special to support our patients, staff and visitors and to get others around them to join in. The following are just a selection of our fantastic fundraisers:

Our 2016 **Annual Golf Day** was a great success and raised over £5,000. We are grateful to all 50 participants who braved the terrible weather.

The **Neonatal Families Group** held a rowathon at the Lister Hospital in March which raised £2,181. Between them, the group did a remarkable 12 hours on the machine.

The Supermarket Chain **Ocado** made a very generous £1,800 donation towards purchasing interactive flooring for the Magic of Play Appeal. We are looking to purchase the flooring this year to provide stimulation and entertainment for our young patients.

The team at **Lee Warren Architectural Metal & Glass** raised an amazing £10,000 at their staff Christmas raffle for MVCC.

The team at **Morgan Sindall** involved their suppliers and rolled up their sleeves to transform the gardens of our Children's Unit into a safe, colourful, attractive space.

The amazing **Sue Williams** continued to fundraise for the Lee Haynes Research Institute in memory of her son, Lee. She continues to organise events and activities and has raised more than £56,000 over the years.

The generous Clare Lemon from **C J Barbers** in Croxley Green organised her second Fun Day to support our Magic of Play Appeal, raising more than £10,000 for two charities.

The Head and Neck Support Group at M VCC are very active fundraisers and have so far raised over £16,000, which includes an annual golf day by John Murphy, Christmas Ball and quiz night by Kylee Green and a round the Isle of Wight boat race by Rob Livingston.

Humphreys Data Management bought their portable shredding vehicle along to MVCC and for a donation, people were able to bring along their private documents. They also made MVCC one of the two benefitting charities for their Shredathon at their site in Watford in January, raising a total of £4,000.

The table below outlines how we performed against our targets in 2016/17:**Target**	**Outcome**
To achieve a gross annual income of £1.2m by March 2017 against a spend of £1.2m	We delivered income of £1.877m against a spend of £1.082m – we smashed our income target and so made a large operating surplus for the first time for a number of years to spend on charitable activities in 2017/18
To induct and support the new Head of Charity and Lister-based Fundraiser to ensure both are able to hit the ground running in order to increase income as soon as possible	Both posts were inducted and supported with mixed fortunes. Our Head of Charity left in November without warning. Our Lister fundraiser achieved £140k income with an additional £72k confirmed this year and banked in 2017/18
To revise the staff structure from 1 April 2016 to ensure all Charity staff, with the exception of the Charitable Funds Accountant, are responsible to the Head of Charity	This has been achieved and has already resulted in more joined-up, effective working. Fundraisers are increasingly working together, sharing skills and collaborating to deliver increased income across our operations
To strengthen the profile of the Charity both internally and externally. This will involve re-branding the Charity, creating a new website and improving the Charity's social media presence	We have not made as much progress on this as we would have wished. Our new strategy is prioritising the promotion and marketing of the Charity to deliver much greater visibility and presence
To improve donor data capture at the point of donation so donors can be promptly and accurately thanked	Again, though we have made good progress, there is more to do. Our financial and operational systems are working better together and so our contact management and follow-up are improving

To implement the new Harlequin database system, ensuring all staff are utilising it in order to capture donor details and increase the Charity's opportunities to secure repeat gifts	Harlequin is implemented and delivering much more effective donor management
To clarify the situation around other Charities fundraising on the Lister Hospital site. The issues on the other three hospital sites will need to be resolved as part of the Charity's longer term strategy	We have implemented a new policy which is both clear and fair and gives our hospital charity maximum opportunity to raise funds in our hospitals. We allow appropriate, complementary charitable organisations occasional opportunities to work in our hospitals.

The year ahead

We are constantly striving for the Charity to be bigger and better so we can support more patients, staff and visitors. We have set ourselves the following challenging targets for 2017/18:

- To raise at least £1.3m – this represents solicited income growth of 13%
- To recruit and induct a new Head of Charity
- To make best use of the successful **Forget-Me-Not Appeal** to ensure patients with dementia on our elderly care wards at the Lister are able to take advantage of an enhanced, appropriate care environment
- To make best use of the amazing gift that is the **John Bush legacy** by helping our patients at the MVCC
- To deliver a robust strategy which will enable the Charity to develop a sustainable income base for the future

Successes

Despite the challenging economic environment, there were so many successes this year. The following are just a selection:

Forget-Me-Not Appeal at the Lister Hospital

We have continued to make good progress on the Forget-Me-Not Appeal which has the aim of improving the hospital environment for dementia patients. The project was launched after evidence from the Kings Fund showed that hospital surroundings can accelerate the deterioration of the condition. We have made further improvements to the 1960s themed style reminiscence room in addition to purchasing specialist recliner chairs so that loved ones can stay with patients overnight, this is so important to patients in the first few nights after being admitted.

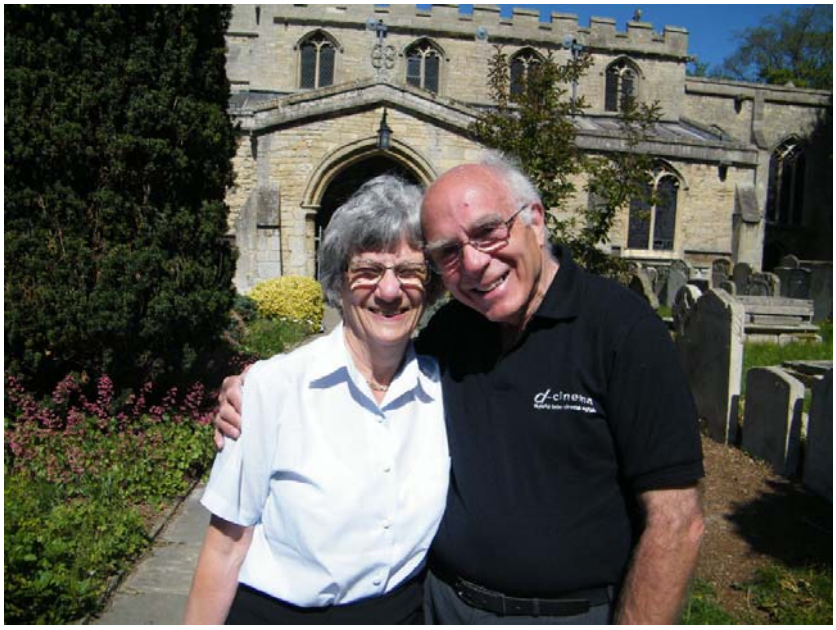
The Health Records Team came together for a grueling dragon boat race in Ware in June. The team raised over £700 towards the Forget-Me-Not Appeal. The team have been consistent and longstanding supporters of the Charity and we look forward to working closely with them in the coming years.

Hertford Lodge kindly donated over £750 to the Forget-Me-Not Appeal. The lodge handed over a cheque at their annual dinner in November.

We were delighted to receive a £72,885 donation to complete the project from the Morrisons Foundation and we greatly look forward to delivering the enhancements in 2017/18.

The Moor Park 10k & Junior Fun Runs continue to be the biggest annual fundraising event organised by the Lynda Jackson Macmillan Centre (LJMC) welcoming 1,800 runners of all ages and raising £50,000.

Ivan and Sheila French received a CBE in the 2017 New Year's Honours List for their services to MVCC. They have raised over £80,000 since 1998, with the final £20,000 going towards equipment for the Radiotherapy Department. We thank them for all their hard work over the years and wish them all the best in their retirement.



The LJMC was chosen as the charity to benefit from the final passing out parade at the Metropolitan Police's training centre at Hendon. Fundraising activities by the officers raised more than £2,500.

Former tennis professional, John Malpas, organised a fun day of tennis for all ages and abilities at West Herts & Watford Lawn Tennis Club and raised nearly £2,000. This event has now become an annual event for the LJMC.

Butterfly Appeal at the Lister Hospital

This financial year the Charity has taken responsibility for fundraising for the Butterfly Project. The project, which is volunteer-led, has the aim of ensuring nobody dies alone at The Lister. The Charity responded to evidence from the Trust that showed between 15-20 people a month were dying at the Lister Hospital with no family or friends present. The project is the first of its kind in that we are the first charity to provide companionship at end-of-life, on a hospital site, across all conditions. We have had notable success with our appeal to-date and we are currently recruiting for a volunteer coordinator in order to make 2,000 visits to end-of-life patients over the next twelve months.

We would like to take this opportunity to thank our wonderful volunteers who are working tirelessly to ensure that nobody passes without companionship at The Lister. We look forward to continuing our fundraising for this amazing project.

Equipment at MVCC

Thanks to St. Albans' Chamber of Commerce and Christine Emmerson, we have been able to install an electronic lock system on the in-patient wards which vastly reduces time spent by nurses locating medication cabinet keys and provides patients with their own bedside lockers.

Fantastic support has enabled us to purchase equipment many years before NHS budgets would have allowed, benefiting our patients with state-of-the-art clinical care. These include a stereotactic diode which enhances the efficiency of the CyberKnife machine and radiotherapy breast boards.

House of Lords Dinner

Following on from a successful House of Lords dinner in 2015, we repeated the event in October 2016, raising funds for MVCC. Baroness Cox kindly hosted once again in the stunning Cholmondeley Room. Guests included AD Architects, Vinci, TB+A as well as The Diamond Trust, who kindly sponsored the champagne reception. The evening began with a tour of the House of Lords, followed by champagne on the terrace, a three course dinner and an auction. Those who attended also heard a passionate speech from Joan Parsons, who spoke of the treatment and care she received at MVCC.

Our work in Action

Twintowns 1000

A group of dedicated cyclists teamed together to host a series of events in aid of the Elderly Care wards and the Childrens and Urology departments at The Lister Hospital. A majority of the cyclists have a deep personal connection with the hospital and so wished to fundraise for the charity to enhance patient care. The events, which ran throughout the year, included spinathons and quiz nights. These events were in preparation for the main cycle ride which took place in June (a 1,200 kilometer bike ride) from Stevenage to the twin towns of Autun in France and Ingelheim in Germany. The group raised an incredible £25,000 which will make a significant and sustainable impact on care at the Lister.

The Linda Jackson Macmillan Centre at MVCC provides a comprehensive support and information service to people affected by cancer. During the year, staff at the centre responded to more than 42,000 requests for help the team of patients.

Supporters provide a friendly welcome to MVCC, helping visitors and guiding them to their destinations. They also provide a refreshment service in the Chemotherapy Suite serving more than 4,000 cups of tea and coffee during the year.

The iPoint patient information service run by the LJMC celebrated its fifth anniversary. The satellite service is conveniently located near the main MVCC reception desk and is run by a dedicated team of volunteers. Most of the members of the team have worked at the LJMC since the service was established and have helped shape what has become an integral part of the way in which the LJMC provides information

This year we held a number of successful events at Mount Vernon, raising over £40,000 including the following:

Jazz Concert

In conjunction with another charity, Fighting Breast Cancer, run by two MVCC consultants, the event was a sell-out success with an audience of 500 people enjoying music by a Big Band as well as special star guest, Claire Martin OBE.

RunRowRide

Our inaugural signature event and the first of its kind in the UK challenged people of all levels at gyms across Hertfordshire raising a fantastic amount in sponsorship.

Participants walked over hot coals in a mind-over-matter challenge

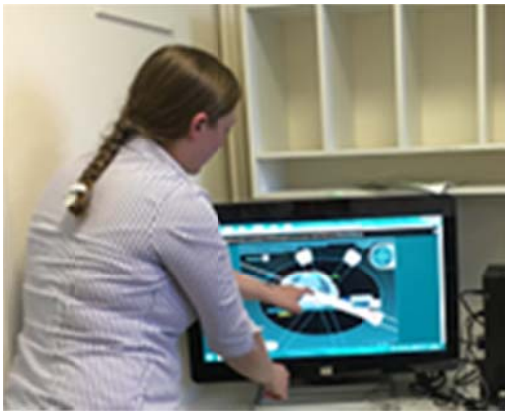
Volunteering

In January 2017 a new publicity campaign ‘Be Awesome in 2017’ was launched which resulted in a record 45 enquires in January alone. Open days for prospective volunteers continued to be held every month with new volunteers welcomed and inducted to a variety of roles over the year. Refresher training was delivered to a total of 260 volunteers at Mount Vernon and additional training courses for volunteers included an overview of cancer treatments and information on living with cancer and end of life care - these courses attracted 70 participants and provided them with valuable insight to better support patients and visitors.

'I really do value and appreciate being acknowledged and people taking the time to say thank you. I love volunteering at Mount Vernon as it is a friendly and positive team and I am very happy to be part of it' *complementary therapy volunteer*

Schools

In July 2016 over 80 local school children were welcomed on site for an exciting Science Evening. The event provided a unique opportunity for students to have access to all our science departments. Students took an escorted tour and learnt about the science and technology behind diagnosis and treatment of cancer. Students had an opportunity to talk to staff to gain an insight into careers in different specialist fields.



'I loved the morning in the pharmacy department, resuscitation session and the gynaecology MDT as they allowed me to see some of the most interesting parts of the NHS and taught me things I didn't previously know'

'The gynaecology team meeting was really interesting – especially to see the scans. It was fascinating to see what the doctors say about the patient's problem and how to treat it'

'Perhaps my favorite part was the chemotherapy tour as we spoke to a cancer patient who was really nice and cheerful'

Work experience student comments

Health and Wellbeing

By working together with local business and community groups, the volunteer team have been able to support a number of different initiatives for the benefit of staff and patient health and wellbeing. These have included Qigong, lunchtime walking and singing groups. Feedback from all participants has been positive and this will be an area of activity that we hope to continue to grow.

'The Qi Gong session was very helpful. Please can you suggest sending the leaflets for the exercise and also for the first part where we did the tapping. It would be brilliant if there was an after work session. Other staff were asking if there would be a lunch time session'

Staff member feedback on Qigong taster sessions which are now regular weekly sessions

'I feel blessed, like I have escaped for a short while'

Patient comment following a Qigong taster session

Corporates

Responding to the growing interest from corporates eager to support the cancer centre through their corporate and social responsibility programmes we were delighted to welcome on site a team of volunteers from Skanska UK who carried out a remarkable job cleaning and repainting the exterior of the LJMC. Skanska not only provided the team but all the expertise, material, equipment and project management….and have promised a return visit!

How can you help?

The Charity relies on donations from individuals and organisations to make a real difference to our patients, staff and visitors. Sometimes even the smallest donations have made the biggest difference. There are many ways in which you can support East & North Herts Hospitals Charity:

Donate

- online at www.justgiving…..
- by texting **EAST24 £10** to **70070**
- by sending a cheque (made payable to East & North Herts Hospitals Charity) to our address (see back Page)
- by cash or cheque at the Cashiers Office at the Lister Hospital or Mount Vernon Cancer Centre

- Join our **volunteer** team. We are seeking people with design and admin skills, people to promote our events in the local community and people to staff our fundraising events.

- **Follow us** on social media: search for ENHHCharity
- Organise an **event** or take part in one of ours
- Leave a gift in your **Will.** It's easier than you think - contact us for more details
- Support us through your **company** - choose us as your Charity of the Year, hold a Dress Down Day or organise your own event
- Set up a **Nightingale Fund** in memory of a loved one

Structure, Governance and Management

The Charity has a Corporate Trustee, the East and North Hertfordshire NHS Trust. The NHS Trust Board of Directors, which comprises six Non-Executive Directors (including Trust Chair) and five Directors, represent the NHS Trust in this matter. The NHS Trust Board, as Corporate Trustee, delegates responsibility to a Board Committee, the Charity Trustee Committee (CTC). This committee meets at least four times a year and the Chair of the Committee reports to the Trust Board, as Corporate Trustee, following each meeting.

The strategy of the East & North Hertfordshire NHS Trust Charitable Fund is to support East & North Hertfordshire NHS Trust by providing funds to benefit patients and staff. It does this by purchasing supplementary and complementary equipment or services that the Trust is unable to provide funding for through exchequer sources. The Charity carries out fundraising activities and relies upon the generosity of patients and their relatives and other donors who are familiar with, or who are sympathetic and generous in their support to, their local NHS service.

Individual fund managers are responsible for the day to day management of charitable funds, and the Trustee relies on those managers to ensure the effective use of charitable funds earmarked for their clinical areas by applying their local or specialist knowledge.

Trustee responsibility in relation to the financial statements

The Charity Trustee is responsible for preparing a Trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Charity Trustee to prepare financial statements for each year which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period. In preparing the financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently
- observe the methods and principals in the applicable Charities SORP
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures that must be disclosed and explained in the financial statements:
- the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the financial statements comply with the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations, and of the provisions of the Trust Deed. They are also responsible for the safeguarding the assets of the Charity and taking reasonable steps for the prevention and detection of fraud and other irregularities. The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website in accordance with legislation in the United Kingdom governing the preparation and dissemination of financial statements.

Constitution, objects and power

The Trustee has been appointed under section 11 of the NHS and Community Care Act 1990. The East and North Hertfordshire NHS Trust Charitable Funds held on trust are registered with the Charity Commission, number 1053338. The objects of the Charity are prescribed by section 93 of the National Health Service Act 1977 - in

particular for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the East and North Hertfordshire NHS Trust. All new Trustees are given appropriate induction on their responsibilities as a Trustee, as laid down in guidance by the Charity Commission.

Risk management

The Charity Trustee Committee, on behalf of the Trustee, ensures that the Charity has met its obligations for risk management as set out in the Trust's Quality Governance and Risk Management Strategy. It has established a framework for risk identification and has reviewed the strategic business and operational risks that the Charity faces. The Trustee regularly reviews the risks and the Charity Management Team ensures actions are taken to mitigate the risks and monitor these. The Charity will continue to review and strengthen its governance arrangements during 2017/18.

Public Benefit Statement

The Trustees confirm that they have complied with the duty in section 4 of the Charities Act 2006 and have due regard for the Charity Commission's general guidance on public benefit. Our Charity's objective is to support any charitable purpose relating to East and North Hertfordshire NHS Trust, including research. The Trustees ensure that this purpose is carried out for public benefit by working to the following aim. 'Our Charity's core function is to make a real positive impact on patient care within our Trust. We continue to help our hospitals innovate, improve and, most importantly, provide excellent care to our community above and beyond NHS funding. By supporting great science, excellent patient care and staff well-being within the East and North Hertfordshire NHS Trust, we are helping our local community to be healthier by providing the best care we can.' The Charity does not provide facilities directly to the public but provides facilities for the hospital and, in so doing, for the patients and staff of the hospitals.

Reserves and reserve policy

The Trustee recognises its obligation to ensure that funds received by the Charity should be spent effectively in accordance with the funds' objectives. The Charity's reserves comprise those funds that are freely available for its general purposes. The reserves are held at a level that will enable the charitable fund expenditure. The Trustee considers it prudent that reserves should be sufficient to avoid the necessity of realising fixed assets held for the Charity's use.

Investment Policy

The Investment Policy is to ensure the creation of sufficient income and capital growth to enable the Charity to carry out its purposes consistently year by year with due and proper consideration of future needs and maintenance of, if possible, an enhancement of the value of the invested funds while they are retained. The Trustee excludes the tobacco sector, as defined by those companies that derive their income from such trading, with regard to investments. During 2016 the Trust held a tender process to review the Investment Advisors. Rathbones were successful and the portfolio management was transferred in September 2016.

Expenditure on Charitable Activities

During the year the Charity paid £649k for patients' welfare, staff education, research, capital equipment and capital building schemes comprised of:

Patient welfare and amenities
Patient welfare expenditure totaled £330k and includes staff costs to support cancer patients and their families at the LJMC, part of the MVCC.

Staff education, welfare and amenities
Staff education, welfare and amenities expenditure totaled £55k and helped to finance staff education, training and development to further educate and to equip staff with additional relevant skills.

Research expenditure

Research expenditure totaled £36k and helped to finance research salaries at MVCC.

Wi-Fi Project

The expenditure to host the Wi-Fi Project was £15k for 2016/2017 which includes set-up costs. The project is still in its infancy, and being imbedded at The Lister with the possibility to roll out the service at other sites.

Community Engagement Service

The Community Engagement Service expenditure totaled £90k being provided at MVCC and consists mainly of staff costs. The team supports the volunteers at MVCC.

Capital equipment and building projects

The total expenditure on capital equipment and building projects of £123k includes:

- £110k for the RITA project which involved refurbishment of ward 6B for Renal Patients
- £13k for work on the Forget-me-Not project for the elderly care ward

Investment, Governance costs and Cost of raising funds

Included within the total resources expended of £1,082k shown in the Statement of Financial Activities are the costs to the Charity of administration (including staff costs), investments and its expenditure activities of £211k. £7k included in this cost is for the Independent Examiner Fee. The cost of raising funds for the Charity was £221k and includes the salaries for four fundraisers.

Reference and administrative information

Corporate Trustee

East and North Hertfordshire NHS Trust

Principal Office

Management Suite

Lister Hospital

Coreys Mill Lane

Stevenage

SG1 4AB

Auditors

BDO LLP

16 The Havens Ransomes Europark

Ipswich

Suffolk IP3 9SJ

Bankers

Lloyds Bank Plc Stevenage Branch

3 Town Square

Stevenage

SG1 1BG

Investment advisors

Rathbone Brothers PLC
8 Finsbury Circus,
London
EC2M 7AZ

Charity Number

1053338

Corporate Trustee

The Charity is the legal responsibility of a Sole Corporate Trustee – East and North Hertfordshire NHS Trust. The Non-Executive and Executive Directors for the Trust for the year ending 31 March 2016 were as follows:

Ellen Schroder	Chair
Nick Carver	Chief executive
Alison Bexfield	Vice-chair
Julian Nicholls	Non-executive director
Bob Niven	Non-executive director
John Gilham	Non-executive director
Val Moore	Non-executive director (from November 2016)
Vijay Patel	Non-executive director (designate) (until 31 January 2017)
Jane McCue	Medical director
Angela Thompson	Director of nursing (on secondment from 7 November 2016)
Tony Ollis	Director of finance (until end-June 2016)
Stephen Posey	Deputy chief executive (until end-October 2016)
Tom Simons	Director of workforce and organisation development
Martin Armstrong	Director of finance (from 31 October 2016)
Nigel Kee	Chief operating officer (from 7 January 2017)
Kate Lancaster	Director of strategy (from 1 February 2017)
Liz Lees	Acting director of nursing (from 7 November 2016)

The Board delegates responsibility for oversight of the Charitable Funds to the Charity Trustee Committee, the membership of which comprised:

Bob Niven	Non-executive director
Ellen Schroder	Trust chair
Val Moore	Non-executive director (from November 2016)
Martin Armstrong	Director of finance (from 31 October 2016)
Kate Lancaster	Director of strategy (from 1 February 2017)

Finance Report

Finances

In the 2016/17 financial year the Charity received a total income of £1,878k - £1,582k of donations, grants and legacy income, £233k from other trading activities and investment income of £63k. The Charity is indebted to the generosity of patients, their families and carers, well-wishers and friends who have donated so generously to the work of the Charity.

The overall financial performance of the Charity recorded a net increase in funds of £1,132k compared to the previous year figures. This is due to the level of legacies received and valuation of the investment fund being £333k higher than at the start of the year. This gain in valuation is considered as 'unrealised' until such point that the investments are sold and the valuation crystallises and should not be committed to expenditure. Systemic issues could cause a reduction in value, meaning that funds would be over-extended. There was a decrease in funds in 2015/16 of £390k.

Events since the year end and future plans

Confirmation of the value of a significant legacy that had been notified to the Charity in 2016/17 although not received until after year end led to the value of that legacy needing to be recognized in 2016/17. The Trustee does not expect any significant changes in the objectives of the Charity in the forthcoming year and intends to continue to manage all charitable income and expenditure within best practice guidelines of the Charities Commission. The Trustee continues to be mindful of the impact that NHS priorities may have on current charitable fund priorities.

Annual Accounts

East and North Hertfordshire NHS Trust Charitable Funds

Statement of Financial Activities for the year ended 31 March 2017

	Note	2016/17 Unrestricted Funds £'000	2016/17 Restricted Funds £'000	2016/17 Total Funds £'000	2015/16 Total Funds £'000
Income and endowments	**2.0**				
Donations, legacies and Grants	2.1	831	751	1,582	685
Income from other trading activities	2.2	233	0	233	180
Income from investments	2.3	63	0	63	74
Income from charitable activities		1,127	751	1,878	939
Expenditure on charitable activities	**3.0**				
Expenditure on raising funds		(316)	0	(316)	(484)
Expenditure on charitable activities	3.2	(738)	(20)	(758)	(703)
Other expenditure	3.3	(5)	0	(5)	(3)
Total Expenditure on charitable activities		(1,059)	(20)	(1,079)	(1,190)
Net (losses)/gains on investments		333	-	333	(139)
Net income/(expenditure)		**401**	**731**	**1,131**	**(390)**
Net movement in funds		401	731	1,131	(390)
Reconciliation of Funds					
Total funds brought forward		2,347	106	2,453	2,843
Movement of funds in year		401	731	1,132	(390)
Total funds carried forward		**2,748**	**837**	**3,585**	**2,453**

The notes at pages 4 to 8 form part of these accounts.

East and North Hertfordshire NHS Trust Charitable Funds

Balance Sheet as at 31 March 2017

	Notes	Unrestricted Funds £'000	Restricted Funds £'000	2016/17 Total Funds £'000	2015/16 Total Funds £'000
Fixed Assets	8.0				
Intangible assets	8.1	0	0	0	0
Investments	8.2	2,631	0	2,631	2,298
Total Fixed Assets		2,631	0	2,631	2,298
Current Assets					
Receivables	9.1	6	723	729	21
Cash at bank and in hand	9.2	317	114	431	817
Total Current Assets		323	837	1,160	838
Current Liabilities	10				
Payables: Amounts falling due		0	0	0	0
within one year		(206)	0	(206)	(684)
Net Current Assets/(Liabilities)		117	837	954	154
Net Assets		2,748	837	3,585	2,452
Funds of the Charity					
Unrestricted funds	12	2,748	0	2,748	2,347
Restricted income funds	13	0	837	837	106
Total Funds		2,748	837	3,585	2,453

The notes at page 4 to page 8 form part of these accounts.

Signed on behalf of the corporate trustee:

Signature

Print Name

Date:

Signature

Print Name

Date:

East and North Hertfordshire NHS Trust Charitable Funds

Statement of cash flows for the year ended 31 March 2017

	Notes	Total Funds 2016/17	Total funds 2015/16
		£'000	£'000
Net cash used in operating activities	11	(449)	(23)
Cash flow from investing activities			
Interest and dividends received		63	74
Proceeds from sale of investments		0	568
Purchase of investments		0	(267)
Citi Bank Balance		1	0
Net cash inflow/(outflow)from investing activities		64	375
CHANGE IN CASH AND CASH EQUIVALENTS IN THE YEAR		(385)	352
Cash and cash equivalents beginning of period		817	465
CASH AND CASH EQUIVALENTS AT END OF PERIOD		432	817

Notes

Note 1 Accounting policies

(a) Basis of preparation and assessment of going concern

The accounts (financial statements) have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to the accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice "Accounting and Reporting by Charities" preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) issued on 16 July 2014 and the Charities Act 2011.

The Charity constitutes a public benefit entity as defined by FRS102.

The Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern.

(b) Reconciliation with Generally Accepted Accounting Practice from prior year

In preparing the accounts, the Trustees have considered whether in applying the accounting policies required by FRS 102 and the Charities SORP a restatement of comparative items was needed. No restatements were required. In accordance with the requirements of FRS 102 a reconciliation of opening balances and net income/(expenditure) for the year is provided with the net income/(expenditure) under previous GAAP adjusted for the presentation of investment gains/(losses) as a component of reported income.

(c) Funds structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor or trust deed. There are twelve restricted funds held by the Charity, and the names of the funds and purpose is stated in note 13.1 to the accounts.

Unrestricted income funds comprise those funds which the Trustees are free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds where the Trustees, at their discretion, have created a fund for a specific purpose.

(d) Income recognition

All income is recognised once the Charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

Donations are recognised when the Charitable Trust has been notified in writing of both the amount and settlement date. In the event that a donation is subject to conditions that require a level of performance before the Charity is entitled to the funds, the income is deferred and not recognised until either those conditions are fully met, or the fulfilment of those conditions is wholly within the control of the Charity and it is probable that those conditions will be fulfilled in the reporting period.

Legacy gifts are recognised on a case by case basis following the granting of probate when the administrator/executor for the estate has communicated in writing both the amount and settlement date. In the event that the gift is in the form of an asset other than cash or a financial asset traded on a recognised stock exchange, recognition is subject to the value of the gift being reliably measurable with a degree of reasonable accuracy and the title to the asset having been transferred to the charity.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the Charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

(e) Expenditure recognition

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the Charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

All expenditure is accounted for on an accruals basis. All expenses including support costs and governance costs are allocated or apportioned to the applicable expenditure headings. For more information on this attribution refer to note (g) below.

Grants payable are payments made to third parties in the furtherance of the charitable objects of the Charitable Trust. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grant awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Trust.

(f) Irrecoverable VAT

Irrecoverable VAT is charged against the expenditure heading for which it was incurred.

(g) Allocation of support and governance costs

Support costs have been allocated between governance costs and other support costs. Governance costs comprise all costs involving the public accountability of the Charity and its compliance with regulation and good practice. These costs include costs related to statutory audit and legal fees together with an apportionment of overhead and support costs.

Governance costs and support costs relating to charitable activities have been apportioned based on the number of individual grant awards made in recognition that the administrative costs of awarding, monitoring and assessing research grants, salary support grants and postgraduate scholarships are broadly equivalent. The allocation of support and governance costs are analysed in note 3.4.

(h) Costs of raising funds

The costs of generating funds consist of Fundraiser salaries, merchandise purchases, raffle prizes and lotto winnings as well as direct costs to events.

(i) Charitable activities

Costs of charitable activities include governance costs, capital expenditure and an apportionment of support costs as shown in note 3.2.

(j) Intangible fixed assets and amortisation

All assets costing more than £1000 are capitalised and valued at historical cost. Amortisation is charged on a straight-line basis over the assets estimated useful lives. The Charity have not recorded any assets for 2016/2017

(k) Fixed asset investments

Investments are a form of basic financial instrument and are initially recognised at their transaction value and subsequently measured at their fair value as at the balance sheet date using the closing quoted market price. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors.

(l) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and their opening carrying value or their purchase value if acquired subsequent to the first day of the financial year. Unrealised gains and losses are calculated as the difference between the fair value at the year end and their carrying value. Realised and unrealised investment gains and losses are combined in the Statement of Financial Activities.

		Unrestricted Funds	Restricted Funds	Total 2016/17	Total 2015/16
2	**Income and endowments**	**£'000**	**£'000**	**£'000**	**£'000**
2.1	**Donations and legacies**				
	Donations	362	0	362	447
	Legacies	341	836	1,177	236
	Grants Received	43	0	43	2
		746	836	1,582	685
2.2	**Income from other trading activities**				
	Events	176	0	176	147
	Lottery and Raffles	27	0	27	28
	Merchandise Sales	29	0	29	5
	Gift Aid	1	0	1	0
		233	0	233	180
2.3	**Income from investments**				
	Income from Equity Investments	62	0	62	73
	Interest on cash deposits	1	0	1	1
		63	0	63	74
3.0	**Expenditure on charitable activities**				
3.1	**Expenditure on raising funds**				
	Fundraising event expenditure	38	0	38	51
	Fundraising/Management/Admin	137	0	137	345
	Printing/Stationary	9	0	9	9
	Travel Expenditure	2	0	2	0
	Overhead recharges	69	0	69	60
	Lottery	13	0	13	0
	Just giving charges	3	0	3	0
	Prizes & raffles	19	0	19	11
	Merchandise sales	11	0	11	3
	Wi-Fi Project	15	0	15	0
	Costs associated with investments	0	0	0	5
		316	0	316	484
3.2	**Expenditure on charitable activities**				
	Patient Welfare, Equip, Ward Extras and Services	498	20	518	464
	Management and Admin	24	0	24	23
	Staff Education, Training, Equipment	56	0	56	65
	Research Salary, Travel, Equipment & Training	36	0	36	70
	Capital Equipment/Building Works/Refurbishments	123	0	123	77
	Examiner's Fee	2	0	2	4
	Annual Report Expenditure	0	0	0	0
		738	20	758	703
3.3	**Other expenditure**				
	Fundraising Software	5	0	5	3
		5	0	5	3

All staff costs were paid by East and North Herts NHS Trust and recharged to the Charity

3.4 **Support and Governance Costs**

	Fundraising Activity £'000	Charitable Activity £'000	Governance Activity £'000	Total Cost 2016/17 £'000	Total Cost 2015/16 £'000
Examiner's Fee	0	0	2	2	4
Management /Fundraising	102	212	0	314	329
Training/IT	0	0	0	0	1
Event Expenses	1	0	0	1	62
Marketing Materials	0	0	0	0	12
Finance Support	0	97	0	97	29
	103	309	2	414	437

4 Details of certain items of expenditure

4.1 **Trustee expenses**
There were no trustee expenses during the current or prior year.

3.4 **Support and Governance Costs**

	Fundraising Activity £'000	Charitable Activity £'000	Governance Activity £'000	Total Cost 2016/17 £'000	Total Cost 2015/16 £'000
Independent Examiner's Fees	0	0	7	7	4
Management /Fundraising	103	212	0	315	329
Training/IT	0	0	0	0	1
Event Expenses	1	0	0	1	62
Marketing Materials	0	0	0	0	12
Finance Support	0	97	0	97	29
	103	309	7	419	437

4 Details of certain items of expenditure

4.1 **Trustee expenses**
There were no trustee expenses during the current or prior year.

4.2 **Fees for examination or audit of the accounts**

	Total 2016/17 £'000	Total 2015/16 £'000
Examiner's fee for reporting on accounts.	2	4
	2	4

5 Paid Employees
The Charity did not employ staff during the current or prior year.

6 Grant making Costs
The Charity made no grants during the current or prior year.

7 Tangible Fixed Assets
The Charity has no tangible fixed assets.

8 Fixed Assets

8.1 **Intangible Asset**

	Total 2016/17 £'000	**Total 2015/16 £'000**
	0	0
	0	0

8.2 **Investment Assets**

	Total 2016/17 £'000	**Total 2015/16 £'000**
Carrying (market) value 1 April 2016	2,298	2,738
Cash at March 2016	0	0
Add : Additions to investments at cost	0	0
Less : Disposals at opening value	0	0
Funds drawdown	0	(301)
(Loss) /gain on investments	333	(139)
Cash	0	0
Carrying (market) value at 31 March 2017	2,631	2,298

8.3 **Analysis of investments**

	Total 2016/17 Market value at year end £'000	Proportion %	Total 2015/16 Market value at year end £'000	Proportion %
UK Fixed Interest	345	13.10%	369	16.06%
Overseas Fixed Interest	0	0.00%	0	0.00%
UK Equities	910	34.60%	1,102	47.95%
Alternatives	381	14.50%	30	1.31%
Overseas Equities	900	34.20%	493	21.45%
Property	0	0.00%	181	7.88%
Cash	95	3.60%	123	5.35%
	2,631	100%	2,298	100%

Investment fixed assets are included at their mid-market price ex div at 31 March 2017.
Investments in equities and fixed asset securities are all traded on recognised stock exchanges.

All investments were transferred to a third party, Rathbones from Investec Wealth and Investment Limited and this is in accordance with the Charity's investment policy.

9 Debtors, prepayments and cash

	Total 2016/17 £'000	Total 2015/16 £'000
9.1 Debtors		
Prepayments	5	5
Accrued income	723	16
Other debtors	0	0
Total debtors falling due within one year	728	21
9.2 Cash at bank and in hand		
Current Account	6	-25
Deposit account	423	841
Petty cash	1	1
Citi Bank	1	0
Total cash at bank and in hand	431	817

10 Creditors falling due within one year

Accruals and other deferred income	206	684
Total creditors falling due within one year	206	684

11 Reconciliation of net movement in funds to net cash flow from operating activities

	Total 2016/17 £'000	Total 2015/16 £'000
Net movement in funds	1,131	(390)
Add back depreciation charge	0	3
Deduct interest income shown in investing activities	(63)	(74)
Deduct gains/add back losses on investments	(333)	139
Funds drawdown		
Decrease/(increase) in debtors	(707)	32
Increase /(decrease) in creditors	(478)	267
Net cash used in operating activities	(450)	(23)

12 Unrestricted Funds

12.1 **The following funds are unrestricted and have balances over £50,000**

Mount Vernon Cancer Centre - Patient & Staff Welfare, Medical Equipment, Research (2 separate funds exceeding £50k)
Lynda Jackson Macmillan Centre for Cancer Support & Information - Patient & Staff Welfare, Medical Equipment, Research
Lister Macmillan Cancer Centre (formerly Forster Suite) - Patient & Staff Welfare, Medical Equipment
Supportive Oncology Research at Mount Vernon - patients welfare - research into oncology

12.2 **Transfers between funds** None

13 Restricted Funds

13.1 **The following funds are restricted at 31 March 2017, and the objectives of these funds are stated below**

Analysis of Restricted Charitable Funds

	FUND NAME	OBJECTIVES OF FUND
A	Mount Vernon Restricted Fund	John Bush legacy
B	Magic of Play	Funds to be used for the new children's playroom at the Lister Hospital
C	Butterfly Appeal	Funds and Grants used for end of life care at Lister Hospital
D	Forget-Me-Not Appeal	Grants received for Ipads for chemotherapy patients
E	Forster Suite - Restricted	Funds used for Chemotherapy at Lister Hospital
F	Millie Apthorpe Restricted Fund	Grant received for a services delivered one day at week at Barnet Hospital
G	Twin Towns Cycle	Funds raised for specific projects within Prostate Cancer department

	Fund balance at 1.4.16 £'000	Incoming resources £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.17 £'000
Mount Vernon Restricted Fund	0	723	0	0	723
The Magic of Play Appeal	15	6	(7)	0	14
Butterfly Appeal	2	9	0	0	11
Forget-Me-Not Appeal	38	5	(2)	0	41
Forster Suite - Restricted	4	(0)	0	0	4
Millie Apthorpe Restricted Fund	47	(4)	(10)	0	33
Twin Towns Cycle	0	12	(1)	0	11
	106	751	(20)	0	837

13.2 **Transfers between funds** None

13.3

	Fund balance at 1.4.16 **£'000**	Incoming resources **£'000**	Outgoing resources **£'000**	Gains / (losses) **£'000**	Fund balances at 31.3.17 **£'000**
Fund totals	2,453	1,878	(1,079)	333	3,585

13.4 **Commitments and Contigencies**
The Charity has committed staff costs for Linda Jackson Macmillan Centre of £26k per month. There are active fundraising appeals to raise funds to continue this service at the Mount Vernon Hospital.

14 Transactions with related parties

14.1 No remuneration or other benefits were paid to a trustee.
14.2 No loans were made payable or due to the Charity.
14.3 Other transaction with trustees or related parties. No prior year comparative for Creditors balance to Corporate Trustee

Name of the trustee;	East & North Hertfordshire NHS Trust
Relationship to charity;	Corporate Trustee
Nature of transaction;	Contributions to NHS
Value: 2016/2017 £1,346k (2015/16 £484k)	
Included in Creditors is a balance of £201k owed to the Corporate Trustee	

Contact us

If you would like to know more about the Charity or have some ideas for fundraising to support patients, staff and visitors to our four hospitals, please contact us:

East & North Herts Hospitals Charity
Charity Office
L96
Lister Hospital
Coreys Mill Lane
Stevenage
SG1 4AB

T: 01438 285182

E: charity.enh-tr@nhs.net

W: www.enh-tr.nhs.net/get-involved/our-charity

Or find us on social media by searching for **ENHHCharity**

East & North Herts Hospitals Charity is the working name for East & North Hertfordshire NHS Trust Charitable Fund. Charity registered in England and Wales number 1053338.

BDO LLP

16 The Havens
Ransomes Europark
Ipswich
Suffolk
IP3 9SJ

1 November 2017

Dear Sirs

Financial Statements of East and North Hertfordshire NHS Trust Charitable Fund for the period ended 31 March 2017

We confirm that the following representations given to you in connection with your audit of the Charity's financial statements (the "financial statements") for the year ended 31 March 2017 are made to the best of our knowledge and belief, and after having made appropriate enquiries of the members of the Charitable Funds Committee and Officers of the Corporate Trustee.

We have fulfilled our responsibilities for the preparation and presentation of the financial statements as set out in the terms of the audit engagement letter, and in particular that the financial statements give a true and fair view of the financial position of the charity as of 31 March 2017 and of the results of its operations for the year then ended in accordance with Financial Reporting Standards FRS102, UK Generally Accepted Accounting Principles (UK GAAP) and for making accurate representations to you.

We have provided you with unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence. In addition, all the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and shareholders' meetings have been made available to you.

In relation to those laws and regulations which provide the legal framework within which our business is conducted and which are central to our ability to conduct our business, we have disclosed to you all instances of possible non-compliance of which we are aware and all actual or contingent consequences arising from such instances of non-compliance.

There have been no events since the balance sheet date which either requires changes to be made to the figures included in the financial statements or to be disclosed by way of a note. Should any material events of this type occur, we will advise you accordingly.

We are responsible for adopting sound accounting policies, designing, implementing and maintaining internal control, to, among other things; help assure the preparation of the financial statements in conformity with generally accepted accounting principles and preventing and detecting fraud and error.

We have considered the risk that the financial statements may be materially misstated due to fraud and have identified no significant risks.

To the best of our knowledge we are not aware of any fraud or suspected fraud involving management or employees. Additionally, we are not aware of any fraud or suspected fraud involving any other party that could materially affect the financial statements.

To the best of our knowledge we are not aware of any allegations of fraud or suspected fraud affecting the financial statements that have been communicated by employees, former employees, analysts, regulators or any other party.

We attach a schedule showing accounting adjustments that you have proposed, which we acknowledge that you request we correct, together with the reasons why we have not recorded these proposed adjustments in the financial statements. In our opinion, the effects of not recording such identified financial statement misstatements are, both individually and in the aggregate, immaterial to the financial statements.

There were no loans, transactions or arrangements between the charity and its directors and their connected persons at any time in the year which were required to be disclosed.

We have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware. We have appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of FRS102, the Charities Act 2011 and UK GAAP.

We have no plans or intentions that may materially affect the carrying value or classification of assets or liabilities reflected in the financial statements.

We consider that the charity is able to continue to operate as a going concern and that it is appropriate to prepare the financial statements on a going concern basis.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each members of the Charitable Funds Committee has taken all the steps that they ought to have taken as a director of the Corporate Trustee in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully
On behalf of the Trust Board, as Corporate Trustee

Date: ……..

East and North Hertfordshire NHS Trust Charitable Fund

REPORT TO THE AUDIT COMMITTEE

Audit for the year ended 31 March 2017

16 October 2017

CONTENTS

OVERVIEW

This report has been prepared solely for the use of the Trustees of the Charity and should not be shown to any other person without our express permission in writing. We do not accept responsibility for this report to any other person and we hereby disclaim any and all such liability. This summary covers those matters we believe to be material in the context of our work. However, you should read the entirety of this report, as there may be other matters raised that you consider important.

KEY AREA	SUMMARY
Financial statements	One material misstatement was identified as a result of our audit work. This misstatement has been corrected in the financial statements, and was in relation to legacy income being recorded in the incorrect financial year. Please see Appendix II for further details. We anticipate issuing an unqualified true and fair opinion on the financial statements for the year ended 31 March 2017. See page 2 for details of the items outstanding at the time of writing this report.
Audit risks	We identified one material misstatement in relation to the risk of revenue recognition in relation to legacy income noted above. Further testing of audit risks did not identify any errors. Please see Key Audit and Accounting matters for further information on page 5
Independence	We have not identified any potential threats to our independence as auditors.
Internal controls	We have identified one deficiency in internal control. This is detailed in Appendix VII on page 15.
Unadjusted audit differences	We are required to bring to your attention audit adjustments that we have identified, but we are not proposing to adjust, and which those charged with governance must consider. These are noted in Appendix II. We have not reported items under £460, which we consider to be trivial.
Materiality	Our materiality is set at £23,000.

OVERVIEW
Audit status and timetable to completion

We set out below the current status of the audit and our timetable to completion.

KEY AREA

We have substantially completed our audit work in respect of the financial statements for the year ended 31 March 2017, and anticipate issuing an unqualified audit opinion on the financial statements.

The following matters are outstanding at the time of drafting our report. We will update you on their current status at the Audit Committee meeting on 23 October 2017:

- Completion of subsequent events testing and confirmation that no subsequent events have occurred at the date of signing our audit report.
- Management representation letter, as attached at appendix V, to be approved and signed.

TIMETABLE TO COMPLETE

The anticipated timetable to complete is as follows:

ACTIVITY	DATE
Audit Committee meeting	23 October 2017
Approval of financial statements for signature	TBC

INDEPENDENCE

INDEPENDENCE

Under Auditing and Ethical Standards, we are required as auditors to confirm our independence to 'those charged with governance'. In our opinion, and as confirmed by you, we consider that for these purposes it is appropriate to designate the Charitable Funds Committee as those charged with governance.

Our internal procedures are designed to ensure that all partners and professional staff are aware of relationships that may be considered to bear on our objectivity and independence as auditors. The principal statements of policies are set out in our firm-wide guidance. In addition, we have embedded the requirements of the Standards in our methodologies, tools and internal training programmes.

The procedures require that audit engagement partners are made aware of any matters which may reasonably be thought to bear on the firm's independence and the objectivity of the audit engagement partner and the audit staff. This document considers such matters in the context of our audit for the period ended 31 March 2017.

A summary of fees for audit and non-audit services for 2016/17 is set out in the adjoining table.

	£
Audit fee	£2,363
Fees for Audit Related Services	nil
Fees for non-audit Services	nil
TOTAL FEES	**£2,363**

AUDIT SCOPE AND OBJECTIVES

SCOPE AND OBJECTIVES

Our audit scope covers:

- Audit in accordance with International Standards on Auditing (UK and Ireland) of the statutory financial statements.

To form an opinion on whether:

1. The financial statements give a true and fair view of the state of the Charitable Trust's affairs as at 31 March 2017 and of the charity's incoming resources and application of resources for the year then ended.
2. The financial statements have been properly prepared in accordance with UK GAAP.
3. The financial statements have been prepared in accordance with the Charities Act 2011.
4. The information given in the trustees' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

The Charities Act 2011 also requires us to consider whether:

1. The information given in the trustee's annual report is inconsistent in any material respect with the financial statements, or
2. Sufficient accounting records have not been kept, or
3. The financial statements are not in agreement with the acocuting records and returns, or
4. We have not received all the information and explanations we require for our audit.

KEY AUDIT AND ACCOUNTING MATTERS

SIGNIFICANT AUDIT RISK IDENTIFIED AT PLANNING: MANAGEMENT OVERRIDE	AUDIT RESPONSE
Under International Standards of Auditing (UK and Ireland) 240, there is a presumed significant risk of management override of the system of internal controls. ISA 240 states that: "Management is in a unique position to perpetrate fraud because of management's ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Although the level of risk of management override of controls will vary from entity to entity, the risk is nevertheless present in all entities. Due to the unpredictable way in which such override could occur, it is a risk of material misstatement due to fraud and thus a significant risk." As part of our audit work we document how management override of controls could occur within the charity and tailor our testing to address this risk.	We reviewed journals processed during the year and post year end journals. We did not find any indication of management override from the journals reviewed. However at the time of writing our report we were waiting for supporting documentation for a sample of journals reviewed. We will provide a verbal update to the Audit Committee. We also reviewed the accounting estimates used in producing the financial statements and found no indications of management override.

BDO CONCLUSION

We did not identify evidence of management override from the testing carried out over the processing of journals or over the accounting estimates used in producing the financial statements.

SIGNIFICANT AUDIT RISK IDENTIFIED AT PLANNING: REVENUE RECOGNITION	AUDIT RESPONSE
ISA (UK & Ireland) 240 The auditor's responsibilities in relation to fraud in an audit of financial statements requires us to presume that there are risks of fraud in relation to revenue recognition. These risks may arise from the use of inappropriate accounting policies, failure to apply the stated accounting policies or from an inappropriate use of estimates in calculating revenue. As a consequence our audit work will be designed to focus on these areas. We consider the main incentive for a charity is to understate revenue in order to attract more donations as there is little benefit for the charity to artificially inflate its revenue. Therefore we believe the risk is over the completeness of revenue rather than the existence of revenue.	We have completed the following testing on completeness of revenue: • Testing of a sample of donations to ensure accounted for in the correct financial year • Review of minutes to identify potential income not accounted for • Review of investment income against confirmations to confirm they were complete.

BDO CONCLUSION

We identified legacy income totalling £723,159.38 which had been recorded in the financial year 2017/18 when it should have been recorded within the 2016/17 financial statements. This is a material error and has been corrected in the financial statements. We identified no further errors from our testing over the completeness of revenue.

APPENDICES

APPENDIX I: DEFINITIONS

TERM	MEANING
The Charity	East and North Hertfordshire NHS Trust Charitable Fund
Management	The person(s) responsible for achieving the objectives of the Charitable Trust and who have the authority to establish policies and make decisions by which those objectives are to be pursued. Management is responsible for the financial statements, including designing, implementing, and maintaining effective internal control over financial reporting.
ISAs (UK & Ireland)	International Standards on Auditing (UK & Ireland)
'Those charged with governance'	The Charitable Funds Committee and the Trust Board, as sole corporate trustees of the charity.
Materiality	The size or nature of a misstatement that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable user of the financial statements would have been changed or influenced as a result of the misstatement.
SORP	Statement of Recommended Practice "Accounting and Reporting by Charities"(FRS 102 2015)

APPENDIX II: UNADJUSTED AND ADJUSTED AUDIT DIFFERENCES

Unadjusted audit differences

We are required to bring to your attention audit adjustments that those charged with governance are required to consider.

Through our testing of the current year we did not identify any errors above our triviality threshold that have not been corrected in the final financial statements.

Adjusted audit differences

We are also required to bring to your attention audit adjustments that have been corrected in the financial statements. A schedule of such adjustments is included below. Of these adjustments there is one adjustment above our materiality threshold noted. This was in respect of legacy income which should have been recorded within the 2016/17 ledger, however had been recorded within the 2017/18 ledger. The total value of legacy income which had been recorded in the incorrect financial year was £723,159 (one legacy transaction).

Through our testing of the current year bank letters received we identified an error in relation to a bank account which was not included within the financial statements. The bank balance per the bank letter is £1,473 and this had been incorrectly written off to expenditure in the prior year. This has been adjusted in the current year financial statements.

Through our testing of post year end payments we identified an error in relation to the completeness of creditors where £2,400 of expenditure related to 2016/17 but were not included in the 2016/17 ledger. The overall fund balance for 2016/17 was therefore overstated by £2,400. This has been adjusted in the current year financial statements.

Through our testing of the current year audit fee we identified an error in relation to the value of audit fees recorded which were overstated by £5,077. This has been adjusted in the current year financial statements.

A schedule of all adjusted audit differences and their impact on the fund balance for the year is included below.

UNADJUSTED AUDIT DIFFERENCES	£	SOFA DR £	SOFA CR £	BALANCE SHEET DR £	BALANCE SHEET CR £
Fund Balance for the year	**2,452,000**				
Impact of current year misstatements					
DR Receivables - Accrued income				**723,159**	
CR Revenue - Legacy income			**723,159**		
Being the legacy income which had been omitted.	**723,159**				
DR Bank				**1,473**	
CR Opening fund balance					**1,473**
Being the Natwest Bank account incorrectly written off to expenditure in the prior year	**1,473**				
DR Payables - Accruals					**2,400**
CR Expenditure - restricted		**2,400**			
Being the factual error in relation to creditors being understated for 2016/17.	**(2,400)**				
DR Payables - Accruals				**5,077**	
CR Expenditure - Audit fees			**5,077**		
Being the overstatement of audit fee accrual	**5,077**				
TOTAL ADJUSTED AUDIT DIFFERENCES	**727,309**	**2,400**	**728,236**	**729,709**	**3,873**
Fund balance for the year after adjustments	**3,179,309**				

APPENDIX III: MATERIALITY

MATERIALITY - FINAL AND PLANNING

Materiality was reviewed after planning materiality had been set. Final materiality values were as follows:

	MATERIALITY (FINAL)	CLEARLY TRIVIAL THRESHOLD
The Charity	£23,000	£460

Final materiality thresholds were based on 2% of incoming resources in the draft financial statements.

APPENDIX IV: INDEPENDENCE

INDEPENDENCE - ENGAGEMENT TEAM ROTATION		
SENIOR TEAM MEMBERS	**NUMBER OF YEARS INVOLVED**	**ROTATION TO TAKE PLACE IN YEAR ENDED**
David Eagles - Audit engagement partner	2	31 March 2025
Tim Byford - Audit manager	1	31 March 2026

APPENDIX V: DRAFT REPRESENTATION LETTER

BDO LLP
16 The Havens
Ransomes Europark
Ipswich
Suffolk
IP3 9SJ

XX October 2017

Dear Sirs

Financial Statements of East and North Hertfordshire NHS Trust Charitable Fund for the period ended 31 March 2017

We confirm that the following representations given to you in connection with your audit of the charity's financial statements (the "financial statements") for the year ended 31 March 2017 are made to the best of our knowledge and belief, and after having made appropriate enquiries of the members of the Charitable Funds Committee and officers of the Corporate Trustee.

We have fulfilled our responsibilities for the preparation and presentation of the financial statements as set out in the terms of the audit engagement letter, and in particular that the financial statements give a true and fair view of the financial position of the charity as of 31 March 2017 and of the results of its operations for the year then ended in accordance with Financial Reporting Standards FRS102, UK Generally Accepted Accounting Principles (UK GAAP) and for making accurate representations to you.

We have provided you with unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence. In addition, all the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and shareholders' meetings have been made available to you.

In relation to those laws and regulations which provide the legal framework within which our business is conducted and which are central to our ability to conduct our business, we have disclosed to you all instances of possible non-compliance of which we are aware and all actual or contingent consequences arising from such instances of non-compliance.

There have been no events since the balance sheet date which either requires changes to be made to the figures included in the financial statements or to be disclosed by way of a note. Should any material events of this type occur, we will advise you accordingly.

We are responsible for adopting sound accounting policies, designing, implementing and maintaining internal control, to, among other things; help assure the preparation of the financial statements in conformity with generally accepted accounting principles and preventing and detecting fraud and error.

We have considered the risk that the financial statements may be materially misstated due to fraud and have identified no significant risks.

To the best of our knowledge we are not aware of any fraud or suspected fraud involving management or employees. Additionally, we are not aware of any fraud or suspected fraud involving any other party that could materially affect the financial statements.

To the best of our knowledge we are not aware of any allegations of fraud or suspected fraud affecting the financial statements that have been communicated by employees, former employees, analysts, regulators or any other party.

We attach a schedule showing accounting adjustments that you have proposed, which we acknowledge that you request we correct, together with the reasons why we have not recorded these proposed adjustments in the financial statements. In our opinion, the effects of not recording such identified financial statement misstatements are, both individually and in the aggregate, immaterial to the financial statements.

There were no loans, transactions or arrangements between the charity and its directors and their connected persons at any time in the year which were required to be disclosed.

We have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware. We have appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of FRS102, the Charities Act 2011 and UK GAAP.

We have no plans or intentions that may materially affect the carrying value or classification of assets or liabilities reflected in the financial statements.

We consider that the charity is able to continue to operate as a going concern and that it is appropriate to prepare the financial statements on a going concern basis.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each members of the Charitable Funds Committee has taken all the steps that they ought to have taken as a director of the Corporate Trustee in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

On behalf of the Trust Board, as Corporate Trustee

Date: …….

APPENDIX VI: STATUTORY AND PROFESSIONALLY REQUIRED COMMUNICATIONS

COMMUNICATION REQUIRED	DATE COMMUNICATED	TO WHOM	METHOD
Potential effect on the financial statements of any material risks and exposures, such as pending litigation, which is required to be disclosed in the financial statements.	Not an issue	Not an issue	Not an issue
Misstatements, whether or not recorded by the entity.	September 2017	Charitable Fund Committee	This report
The final draft of the representation letter.	September 2017	Charitable Fund Committee	This report
Material uncertainties related to events and conditions that may cast significant doubt on the entity's ability to continue as a going concern.	Not an issue	Not an issue	Not an issue
Disagreements with management about matters that, individually or in aggregate, could be significant to the entity's financial statements or our audit report.	Not an issue	Not an issue	Not an issue
Expected modifications to our audit report or inclusions of emphasis of matter / other matter.	Not an issue	Not an issue	Not an issue
Significant deficiencies in internal control paragraph.	Not an issue	Not an issue	Not an issue
Any other matters warranting attention by those charged with governance, such as questions regarding management integrity, and fraud involving management.	Not an issue	Not an issue	Not an issue
Going concern issues.	Not an issue	Not an issue	Not an issue
Management judgements and accounting estimates.	September 2017	Charitable Fund Committee	This report
Other information in documents containing audited financial information.	September 2017	Charitable Fund Committee	This report
Consultation with other accountants.	Not an issue	Not an issue	Not an issue
Major issues discussed with management.	Not an issue	Not an issue	Not an issue

APPENDIX VII: RECOMMENDATIONS

CONCLUSIONS FROM WORK	RECOMMENDATIONS	MANAGEMENT RESPONSE	RESPONSIBILITY	TIMING
FINANCIAL STATEMENTS				
Undisclosed and unknown bank account Upon discussion with Daria Taylor of all the open bank accounts, we found an unused bank account with TSB. The bank balance is unknown and so it has not been disclosed in the accounts. Derek Wick has requested the bank to make no transactions from this account but no further information could be obtained, as this account was security protected with password by one of the Trust's staff (who left the charity many years ago and was not one of the staff who was authorised to open bank accounts). The process to change the signatory is still ongoing and it is unsure when it will be resolved.	We recommend that access be obtained to the bank account			

The matters raised in our report prepared in connection with the audit are those we believe should be brought to your attention. They do not purport to be a complete record of all matters arising. This report is prepared solely for the use of the company and may not be quoted nor copied without our prior written consent. No responsibility to any third party is accepted.

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DATA PACK

Contents

1. Data & Exception Reports:

FFT

Health & Safety Indicators

Friends and Family Test - September 2017

Appendix 1

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	96.88	0.00	19	12	1	0	0	0	32	70	45.71
5B	100.00	0.00	17	4	0	0	0	0	21	45	46.67
7B	89.61	2.60	40	29	6	2	0	0	77	192	40.10
8A	91.67	0.00	18	15	3	0	0	0	36	118	30.51
8B	90.24	2.44	25	12	0	1	0	3	41	105	39.05
11B	93.65	1.59	45	14	3	0	1	0	63	100	63.00
Swift	100.00	0.00	49	10	0	0	0	0	59	174	33.91
ITU/HDU	100.00	0.00	6	1	0	0	0	0	7	15	46.67
Day Surgery Centre, Lister	98.43	0.00	184	66	4	0	0	0	254	445	57.08
Day Surgery Treatment Centre	98.92	0.00	224	52	1	0	0	2	279	531	52.54
Endoscopy, Lister	99.13	0.87	207	22	0	0	2	0	231	826	27.97
Endoscopy, QEII	100.00	0.00	88	3	0	0	0	0	91	257	35.41
SURGERY TOTAL	97.57	0.50	**922**	**240**	**18**	**3**	**3**	**5**	**1191**	**2878**	41.38
SSU	96.43	0.00	20	7	1	0	0	0	28	115	24.35
AMU	94.29	1.43	55	11	3	1	0	0	70	125	56.00
Pirton	100.00	0.00	33	4	0	0	0	0	37	59	62.71
Barley	100.00	0.00	8	3	0	0	0	0	11	35	31.43
6A	100.00	0.00	1	1	0	0	0	0	2	69	2.90
6B	95.24	0.00	26	14	2	0	0	0	42	58	72.41
11A	100.00	0.00	35	14	0	0	0	0	49	72	68.06
ACU	93.10	0.00	23	4	2	0	0	0	29	123	23.58
10B	81.25	6.25	7	6	2	0	1	0	16	65	24.62
Ashwell	100.00	0.00	23	2	0	0	0	0	25	53	47.17
9B	98.08	0.00	36	15	0	0	0	1	52	52	100.00
9A	97.62	0.00	35	6	1	0	0	0	42	42	100.00
Cardiac Suite	100.00	0.00	81	6	0	0	0	0	87	126	69.05
MEDICINE TOTAL	97.14	0.41	**383**	**93**	**11**	**1**	**1**	**1**	**490**	**994**	49.30
10AN Gynae	94.29	1.43	41	25	2	1	0	1	70	89	78.65
Bluebell ward	95.92	2.04	25	22	1	0	1	0	49	179	27.37
Bluebell day case	NP	NP	0	0	0	0	0	0	0	11	0.00
Neonatal Unit	100.00	0.00	15	0	0	0	0	0	15	31	48.39
WOMEN'S/CHILDREN TOTAL	95.52	1.49	**81**	**47**	**3**	**1**	**1**	**1**	**134**	**310**	43.23
Michael Sobell House	100.00	0.00	24	0	0	0	0	0	24	37	64.86
10	100.00	0.00	2	0	0	0	0	0	2	337	0.59
11	100.00	0.00	12	3	0	0	0	0	15	130	11.54
CANCER TOTAL	100.00	0.00	**38**	**3**	**0**	**0**	**0**	**0**	**41**	**504**	8.13
TOTAL TRUST	97.36	0.54	**1424**	**383**	**32**	**5**	**5**	**7**	**1856**	**4686**	39.61

Continued over …..

Inpatients/Day by site	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister	97.16	0.58	1298	377	32	5	5	7	1724	3925	43.92
QEII	100.00	0.00	88	3	0	0	0	0	91	257	35.41
Mount Vernon	100.00	0.00	38	3	0	0	0	0	41	504	8.13
TOTAL TRUST	**97.36**	**0.54**	**1424**	**383**	**32**	**5**	**5**	**7**	**1856**	**4686**	**39.61**

Accident & Emergency	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister A&E/Assesment	91.91	1.73	91	68	10	2	1	1	173	8425	2.05
QEII UCC	100.00	0.00	6	0	0	0	0	0	6	3833	0.16
A&E TOTAL	**92.18**	**1.68**	**97**	**68**	**10**	**2**	**1**	**1**	**179**	**12258**	**1.46**

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	85.71	0.00	4	2	1	0	0	0	7	462	**1.52**
Birth	93.69	1.94	124	69	6	3	1	3	206	476	**43.28**
Postnatal	81.07	3.88	100	67	24	6	2	7	206	476	**43.28**
Community Midwifery	100.00	0.00	2	1	0	0	0	0	3	591	**0.51**
MATERNITY TOTAL	**87.44**	**2.84**	**230**	**139**	**31**	**9**	**3**	**10**	**422**	**2005**	**21.05**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	95.02	0.77	374	122	17	2	2	5	522
QEII	95.49	1.25	286	95	9	5	0	4	399
Hertford County	95.93	0.45	143	69	5	0	1	3	221
Mount Vernon CC	92.54	0.75	201	47	14	0	2	4	268
Satellite Dialysis	97.37	0.00	62	12	1	0	0	1	76
OUTPATIENTS TOTAL	**94.95**	**0.81**	**1066**	**345**	**46**	**7**	**5**	**17**	**1486**

Trust Targets	% Would recommend	% response rate
Inpatients/Day Case	96%>	40%>
A&E	90%>	10%>
Maternity (combined)	93%>	30%>
Outpatients	95%>	N/A

Key Performance Indicators Reported to RAQC														
2017/18		Financial Year 2017-18												
		April	May	June	July	August	September	October	November	December	January	February	March	Current Position YTD
Patient Incidents	RIDDOR incidents	0	0	0	0	0	0							0
	H&S public liability claims	0	0	0	0	0	0							0
	Slips, Trips & Falls (not including inpatient falls)	0	0	0	0	0	0							0
	Physical assault	0	0	0	1	0	1							2
Visitor Incidents	RIDDOR incidents	0	0	0	0	0	0							0
	H&S public liability claims	1	0	0	1	0	0							2
	Slips, Trips & Falls	2	2	4	3	4	0							15
The Workforce (Including Contractors) Incidents	RIDDOR incidents	2	3	5	4	4	1							19
	Slips, Trips & Falls	1	5	7	6	5	5							29
	Employer liability claims	0	2	1	1	0	0							4
	Sharps incidents	11	7	12	12	15	13							70
	Workplace stress	6	2	1	3	7	3							22
	Contact dermatitis/latex	0	0	0	0	0	0							0
	Musculoskeletal injuries	5	3	8	3	8	5							32
	Physical assault	4	0	10	9	12	9							44
	H & S training (Compliance) (YTD = Latest Available Position)	89%	88%	88%	87%	88%	86%							86%
	Significant workplace fires	1	0	0	0	1	0							2
	Total Staff	5514	5529	5532	5574	5562	5881							33592

Key Performance Indicators Reported to RAQC

Floodlight Health & Safety Metrics

The Rate is the percentage of incident per 1000 employees

Green is the output rate from last years figures, Amber is plus 5% and red is plus 10%

H & S Indicator		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average monthly total
RIDDOR Incidents		2	3	5	4	4	1	0	0	0	0	0	0	19
RATE %	Red < 0.36 Amber 0.36-0.33 Green > 0.33	0.363	0.543	0.904	0.718	0.719	0.170	0.000	0.000	0.000	0.000	0.000	0.000	0.566
Slips, Trips and Falls		1	5	7	6	5	5	0	0	0	0	0	0	29
RATE %	Red <0.86 Amber 0.86 - 0.78 Green >0.78	0.181	0.904	1.265	1.076	0.899	0.850	0.000	0.000	0.000	0.000	0.000	0.000	0.863
Sharps Injuries		11	7	12	12	15	13	0	0	0	0	0	0	70
RATE %	Red < 2.56 Amber 2.56-2.33 Green > 2.33	1.995	1.266	2.169	2.153	2.697	2.211	0.000	0.000	0.000	0.000	0.000	0.000	2.084
Mgr Referrals to OH for Stress		6	2	1	3	7	3	0	0	0	0	0	0	22
RATE %	Red < 0.96 Amber 0.96-0.87 Green > 0.87	1.088	0.362	0.181	0.538	1.259	0.510	0.000	0.000	0.000	0.000	0.000	0.000	0.655
Work related Musculosketal Injuries		5	3	8	3	8	5	0	0	0	0	0	0	32
RATE %	Red < 1.11 Amber 1.11-1.01 Green > 1.01	0.907	0.543	1.446	0.538	1.438	0.850	0.000	0.000	0.000	0.000	0.000	0.000	0.953
Physical Assault		4	0	10	9	12	9	0	0	0	0	0	0	44
RATE %	Red < 1.45 Amber 1.45-1.32 Green > 1.32	0.725	0.000	1.808	1.615	2.157	1.530	0.000	0.000	0.000	0.000	0.000	0.000	1.310
Total Staff		5514	5529	5532	5574	5562	5881	0	0	0	0	0	0	33592

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission (CQC) inspected the Trust as part of a comprehensive inspection programme, which took place on trust sites during 20 to 23 October 2015 with three unannounced inspections on 31 October, 6 and 11 November 2015. Following their initial visit, inspection chair, Sir Norman Williams, said that the Trust was, ”An organisation on an upward trajectory.”

Overall the CQC rated the Trust as ‘**requires improvement**’ with ‘**good**’ for caring. This does not reflect the whole picture:

- *Good* ratings were received for surgery, critical care, outpatients and diagnostics (all hospital sites), children and young person’s community services and radiotherapy at the Mount Vernon Cancer Centre.
- 19 areas of outstanding practice across the Trust were recognised.
- Six areas where improvement had to be made were identified.
- The Lister’s urgent and emergency services, along with the medical care pathway at the Mount Vernon Cancer Centre were rated as *inadequate* – actions were taken in October 2015 in to address the concerns raised by the CQC, including the development of an emergency services pathway steering board to support improvements across the whole pathway.

The areas of improvement, regulatory actions, were applied in March 2016. These are:

- Lister Hospital regarding compliance with regulations 12, 17 and 18. In brief the Trust must:
  - Ensure that the triage process accurately measures patient need and priority in both the emergency department and maternity services ***(Actions taken and internal monitoring in place)***
  - Ensure records and assessments are completed in accordance with Trust Policy ***(Actions taken and internal monitoring in place)***
  - Ensure that there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients ***(Actions taken and internal monitoring in place)***
  - Ensure that all staff in all services complete their mandatory training ***(Closed and internal monitoring)***

- Mount Vernon Cancer Centre regarding compliance with regulations 12 and 17. In brief the Trust must:
  - Ensure that patients requiring urgent transfer from Mount Vernon Cancer Centre have their needs met to ensure safety and that there are effective process to handover continuing treatment ***(Closed and internal monitoring)***
  - Ensure there is oversight and monitoring of all transfers ***(Closed and internal monitoring)***

A number of the actions have now been completed and are being monitored to ensure they are sustained. The aim was for all actions to be delivered by end of September 2016; these are in the process of being tested and audited to ensure consistency prior to closure. Progress in complying with these regulatory actions is monitored through action plans owned by the teams reporting to the Quality Development Board which reports in to the Trust Risk and Quality Committee and the Trust Board. Quality Workshops have been established with the Matrons and Sisters to support embedding quality improvement and our CCG have undertaken some quality visits which helps to provide us with external assurance.

The CQC revisited the Trust in May 2016 and undertook an unannounced inspection in Lister emergency department and the children’s’ ward. The report confirms significant progress made in both areas.

The Director of Nursing and Company Secretary are developing a Quality Improvement Programme to ensure and support continuous improvement. The new CQC Insight was released in July 17 and this in now being used across the divisions and corporate directorates to support monitoring.

Summary of the latest Inspection Outcome

Summary of the Trust's CQC Registration Status across all locations.

Regulatory Activity	Lister Hospital*	New QEII	MVCC	Hertford	Bedford Renal Unit	Harlow Renal Unit
Treatment of disease, disorder or injury	Registered with regulatory action	Registered	Registered with regulatory action	Registered	Registered	Registered
Surgical Procedures	Registered	Registered	Registered with regulatory action			
Maternity and midwifery services	Registered with regulatory action	Registered		Registered		
Diagnostic and Screening procedures	Registered	Registered	Registered with regulatory action	Registered	Registered	
Termination of Pregnancies	Registered	Registered				
Family Planning Services	Registered	Registered		Registered		
Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered	Registered	Registered			

*** Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital.**

3. Risk and Quality Committee Reports:

Safer Staffing

Infection Control Data

East and North Hertfordshire NHS Trust

Safe Nurse Staffing Levels

September 2017

Executive Summary

The purpose of this report is:

1. To provide an assurance with regard to the management of safe nursing and midwifery staffing for the month of September 2017.
2. To provide a summary report of quality metrics for the month of September 2017 as indicators of patient safety
3. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of September 2017.

East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', the percentage skill mix ratio of registered nurses to CSWs, and the number of staff per shift required to provide safe and effective patient care.

No	Topic	Measure	Summary	RAG
1.	**Patient safety is delivered though consistent, appropriate staffing levels for the service.**	Unify RN fill rate	The Unify submission for registered fill % decreased in September with the average day fill % for registered nurses falling from 93.6% in August to 92.1% in September.	
		Care hours per Patient Day - CHPPD	Overall CHPPD decreased form 7.1 in August to 6.9 in September.	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	The percentage of Red Triggered shifts increased from 8.90% in August to 10.62% in September.	
		% of shifts that remained partially mitigated	11 of the 344 that initially triggered red (0.34%) remained only partially mitigated	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	Red flags continue to be used to escalate staffing issues in the organisation.	
4.	**The Board are assured of safe staffing for nursing**	Board reports and discussion covering overview of safe staffing levels	The overall RN fill rate decreased due to a decrease in temporary staffing RN fill and slight increase in demand due to increased levels of sickness.	

1. Patient safety is delivered though consistent, appropriate staffing levels for the service.

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

1.1 Unify Safer Staffing Return

Following Lorenzo and Nerve Centre "Go Live" in September 2017 the Information Department have not yet been able to provide validated data to inform this report. The Trust's safer staffing submission has therefore not been submitted to Unify for September. Overall fill rates have been calculated using validated data; however the CHPPD data remains unvalidated at present and is discussed in further detail on page 6. Table 1 below shows the summary of overall fill %, the full table of fill % can be seen in Appendix 1:

Table 1 – Overall Unify Return fill rate

Day		Night	
Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
92.1%	92.3%	93.8%	113.1%

The Unify submission for registered fill % decreased in September with the average day fill % for registered nurses falling from 93.6% in August to 92.1% in September.

Factors affecting Planned vs. Actual staffing

- Ashwell was escalated above their planned 24 beds to 28 beds for the whole month of September; their planned staffing level for the Unify return is reflective of their 28 bed shift plan.

There are a number of other contributory factors which affect the fill rate for September. This, along with the summary of key findings by ward, can be seen below:

- **Ward 11** – The wards at Mount Vernon were merged in April following a review of the service model for these wards. The combined Oncology ward will be known as Ward 11 for the purposes of this report. Ward 11 ran below their planned patient numbers in September with their occupancy at 44.54% averaging 16 patients, therefore although their fill rate is below 90% the CHPPD delivered meets the required level of care.
- **Senior Nurses, Matrons and Specialist Nurses** – Senior Nurses, Matrons and Specialist nurses worked clinically to support wards where staffing fell below the minimum safe levels. The matrons and nurse specialists covered 45 clinical shifts for the month of September.
- **5B, 6A, 7B, 8A, 8B, 9A, 9B, 10B, 11B, Ashwell, Barley and SSU** – Had a high number of patients requiring enhanced care which resulted in increased CSW fill, some wards are assessed as requiring night cover only therefore CSW fill increased at night.
- **ACU** – Occupancy was 86.97%, the majority of shifts were worked with 4 RNs which will be their new shift plan following the establishment review from October.
- **Swift** - the average bed occupancy was 74.62% as at the 23:59 census period. Staffing levels were managed appropriately to the occupancy. CHPPD is 5.96 which is above the planned service model therefore we are assured that staffing is maintained appropriately. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with occupancy.
- **SAU** - Since the relocation of SAU in November 2016 the service adjusted staffing to meet service need as activity is lower in the early part of the day, but remained higher into the

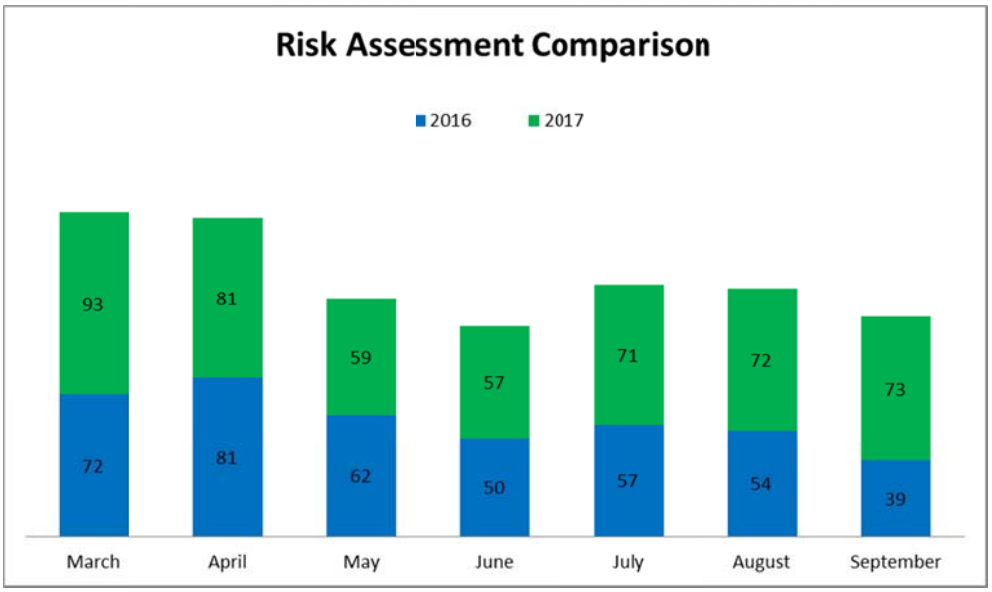
evening and night. The new service plan has been approved and was implemented on the 15th June. RN fill was low during the day as the forth RN shift was often unfilled as they recruit in to this vacancy.

- **Michael Sobell House** - RN day fill is recorded as 77.9% in September. The average bed occupancy for September was 62.5% as at the 23:59 census period. Staffing levels were flexed to reflect bed occupancy. This is demonstrated by 9.11 CHPPD which is above the planned service model therefore we are assured that safe staffing levels were maintained appropriately. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with bed occupancy.
- **Pirton –** RN day fill is recorded as 84.0% in September. The average bed occupancy for September was 83.79% as at the 23:59 census period. Staffing levels were managed appropriately to reflect the bed occupancy as the delivered CHPPD of 6.41 is within the required service model. It has also been noted that the Stroke wards tend to have reduced bed occupancy during the day; therefore CHPPD is greater during the day. In addition to the planned ward staff, the Stroke wards have support from the specialist Stroke Nurses and therapists which is not currently reflected in the Unify return. Work is on-going to capture the care hours provided by the Stroke Nurses and Therapists on this ward.
- **Bluebell –** RN day fill is recorded as 81.1%. The average bed occupancy was 67.71% in September based on their 16 bed shift plan. Bluebell flexed their staff in September across the Paediatrics service with additional support from the senior nursing team to ensure they delivered safe and quality care.
- **New Starters –** In addition to the clinical hours of work recorded for the Unify return, the wards were supported by in excess of 1200 hours worked by new starters in their supernumerary period. 6A, 9B, 11A, Ashwell, Critical Care and Pirton in particular had a high degree of supernumerary hours in September.

The Enhanced Nursing care team (ENCT)

The ENCT have streamlined the service for patients needing enhanced care and the team review the level of care requirement on each ward on a daily basis. Chart 1 shows that demand for enhanced care has increased slightly for the month of September with 1 more risk assessment received for enhanced care needs from the previous month. It also shows that there is a higher demand for enhanced care for the same period 2016.

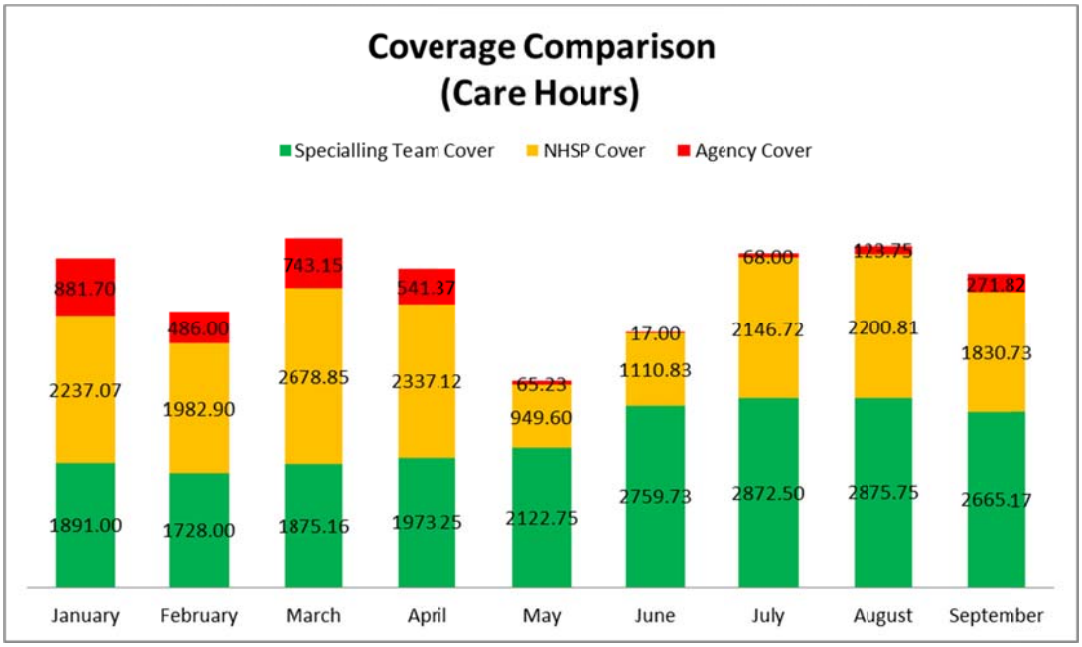
Chart 1



The Enhanced Nursing Care Team (Specialling team) continues to mitigate the risk and reduce the need to cover those patients requiring enhanced care with temporary staff, providing a higher level of care for less cost. The team has recruited 4 band 4 team leaders to manage the team out

of hours and continue to streamline the service. There is ongoing band 3 recruitment to bring the team up to full establishment by December 2017. The impact in terms of care hours delivered by the Specialling Team has reduced reliance on Agency staff can be seen in the Chart 2 below. A higher level of Agency was used in September due to reduced temporary staffing fill rates and a high demand for enhanced care.

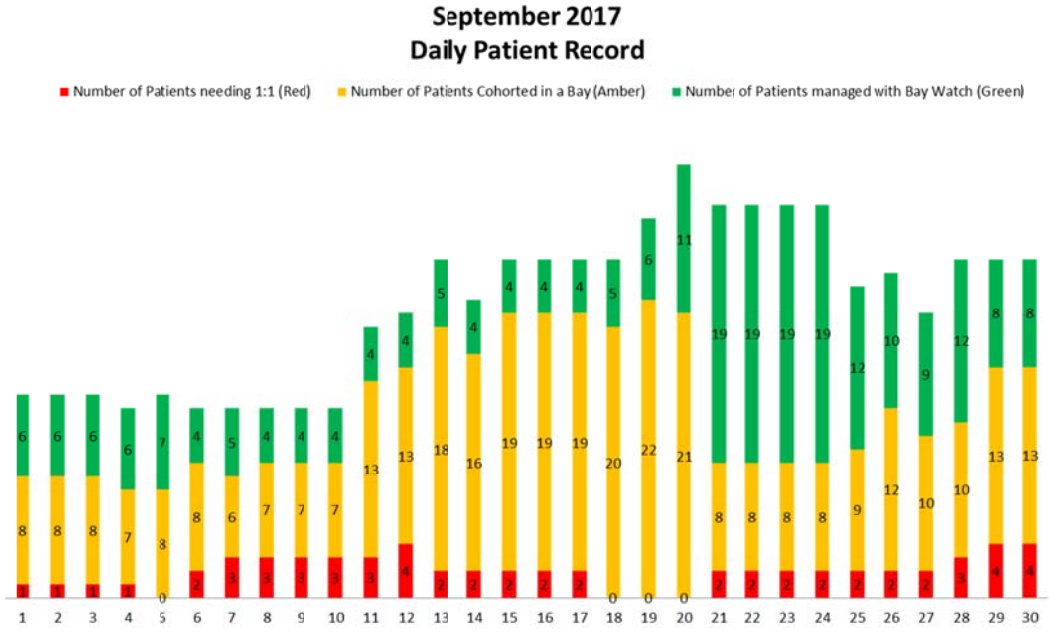
Chart 2



The ENCT review all patients requiring enhanced care on a daily basis and determine the requirement, covering parts of shifts with less staff and working with carers and volunteers to help support the care requirement. If they are unable to support a ward with the team, the shift will be sent to temporary staffing to be filled.

With the exception of the first six days of September the demand for enhanced care remained high for the month, therefore additional duties were requested to support the rise in requirement.

Chart 3



1.2 UNIFY Care Hours Per Patient Day (CHPPD)

From 1 May 2016 each Trust is required to report the number of Care Hours per Patient Day (CHPPD). This figure is calculated:

The total number of patient days over the month
(Sum of actual number of patients on the ward at 23:59 each day)
/
Total hours worked in month
(Total hours worked for registered staff, care staff and then combined)

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. The table below shows the CHPPD for September, this indicates overall CHPPD decreased form 7.1 in August to 6.9 in September.

Until validated bed data is available, through the new data warehouse, the CHPPD has been calculated using patient days data from the alternative data source of SafeCare for Medicine, Surgery and Paediatrics. Maternity patient data is based on an average of patient days taken over the last 6 months. This data therefore remains unvalidated although is based on an evidence based methodology.

Table 2 – Average Care Hours Per Patient Day

Trust-wide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	**4.4**	**2.5**	**6.9**

CHPPD is used to inform the bi-annual establishment reviews and the results are reported monthly on the Unify return. When benchmarked against similar trusts the CHPPD for the Trust fall within expected thresholds. A full list of CHPPD by ward can be seen in Appendix 2 of this report.

The NHS Improvement Model Hospital Portal includes the CHPPD metric and was used to Benchmark CHPPD against other Trusts for the April Establishment Review.

2. Staff are supported in their decision making by effective reporting

2.1 Daily process to support operational staffing

Three daily staffing meetings and twice weekly look ahead meetings continue to support the organisation in balancing staffing risk across the Trust. Each ward is rated as red, amber or green for each of the early, late and night shifts. This record is held electronically in the Staffing Hub which provides a central point to access the E-Roster and NHSP teams. The record is also shared with the Operations Centre and provides assurance on nurse staffing levels in the organisation.

2.2 Staffing levels and shifts that trigger red

The number of shifts initially triggering red increased from 298 shifts in August to 344 shifts in September. The percentage of Red Triggered shifts increased from 8.90% in August to 10.62% in September. Table 3 below shows the % of shifts that triggered red in month.

Table 3 – % of shifts triggering red

Month	% of shifts that triggered red in Month
Sep-16	7.72%
Oct-16	5.14%
Nov-16	4.35%
Dec-16	6.02%
Jan-17	5.32%
Feb-17	6.40%
Mar-17	7.44%
Apr-17	5.91%
May-17	6.13%
Jun-17	6.51%
Jul-17	8.24%
Aug-17	8.90%
Sep-17	10.62%

Comparison of red triggered shifts between September 2016 and September 2017 shows an increase of 2.9% in the number of shifts triggering red in month.

Out of the shifts triggering red, 11 of the 344 that initially triggered red (0.34%) remained only partially mitigated. This is an increase in the number of partially mitigated shifts from 5 in August. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 4 below shows the % of shifts triggering red in month; the % shifts triggering red has shown a linear increase. This is multifactorial and the reasons include, sustained levels of vacancies and sickness, controlled use of agency and unfilled temporary staffing shifts. These are discussed in section 2.3.

Chart 4

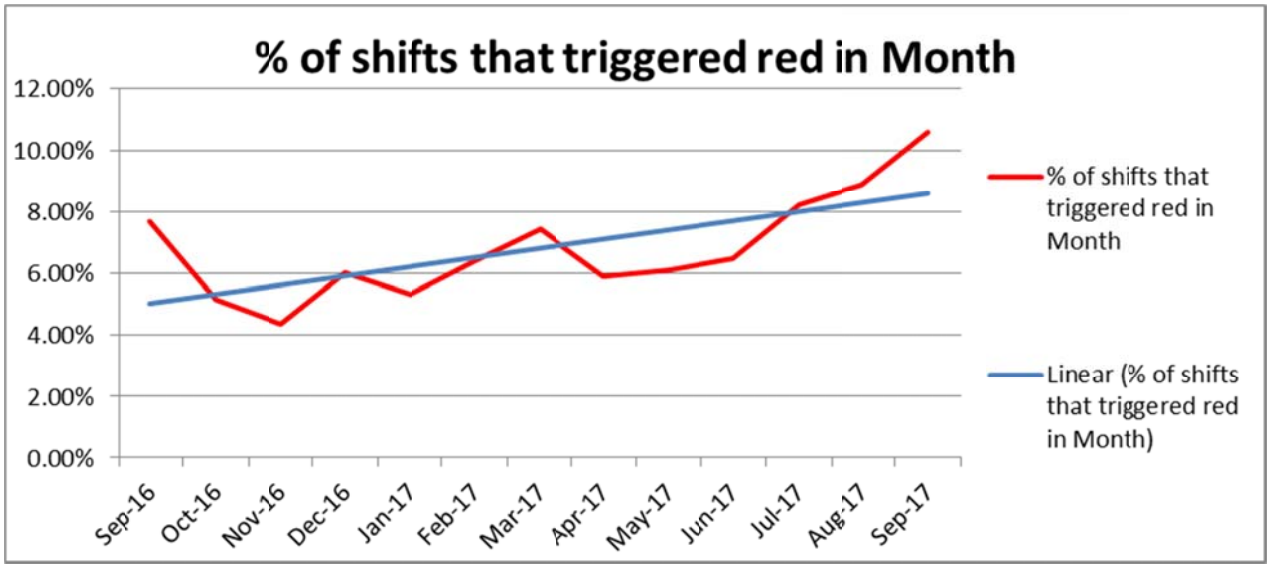
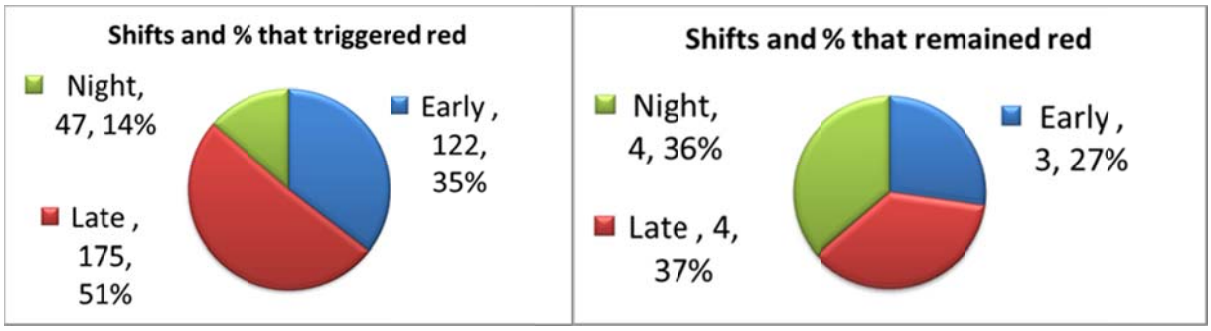


Chart 5 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

Chart 5 – Shifts initially triggering red & remained red



A list of all the shifts triggering red can be found in Appendix 3. 20 wards triggered red on 10% or more of the shifts in September which is an increase from 14 wards in August.

Generally, red shifts are mitigated by moving staff between wards to balance staff numbers and skill mix. Table 4 below shows the shift breakdown for each of these wards.

Table 4 – Wards triggering high number of red shifts

	INITIAL REDS				
Ward	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Barley	6	8	2	16	17.78
Pirton	4	4	2	10	11.11
6A	4	5	1	10	11.11
10B	8	11	2	21	23.33
11A	3	8	0	11	12.22
ACU	2	3	4	9	10.00
AMU-A	2	8	2	12	13.33
AMU-W	5	4	0	9	10.00
Ashwell	10	9	1	20	22.22
A&E	6	6	3	15	16.67
8B	11	12	2	25	27.78
SAU	1	6	2	9	10.00
11B	4	2	3	9	10.00
7B	4	9	2	15	16.67
5A	3	12	3	18	20.00
5B	10	13	2	25	27.78
Swift	2	6	2	10	11.11
Critical Care 1	3	2	4	9	10.00
10A Gynae	5	9	3	17	18.89
Mat CLU 1	7	9	0	16	17.78

In addition to the reactive daily support, this information is provided to ward managers and matrons to ensure proactive robust supportive measures can be put in place moving forward.

2.3 Summary of factors affecting red triggering shifts

Several key factors have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – Temporary staffing demand increased slightly in September, agency filled hours decreased by 1.5% and bank filled hours decreased by 0.5%. The percentage of unfilled hours increased from 23% in August to 25% in September. Overall fill rate in temporary staffing dropped by 2% from 77% to 75%. Agency filled hours accounted for 38.1% (35,800 hours) in September 2016 compared to 18.4% (13,837 hours) in September 2017. The Trust has identified a significant gap in agency fill in recent months and is taking steps to ensure that our Agency Nurse usage increases to match those wards where the demand is required due to vacancies and long term absences through the use of Long Line Agency bookings as the marked decrease in agency fill is impacting on the number of wards triggering red.
- Sickness – Sickness rate increased from 5.5% in August to 6.7% in September (taken from e-Roster) and remains above the 4% budget position.
- Specialling requirements impact on the care hours required on a ward on a shift by shift basis. If the specialling needs are not covered this may cause the ward to trigger red

3. Staffing risks are effectively escalated to an appropriate person

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

3.1 Red Flags

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.

Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags appropriate to the staffing challenges they need to escalate on a shift.

Chart 6 below shows the distribution of red flags by type. Total red flags raised increased from 166 red flags in August to 200 in September. This chart shows that Registered Nurse to Patient Ratio was the most commonly raised red flag with Shortfall in Care Hours being a close second. Matrons are expected to visit any ward that has raised a red flag within an hour to ensure any risk is mitigated.

Chart 6 – Red Flags raised by Type

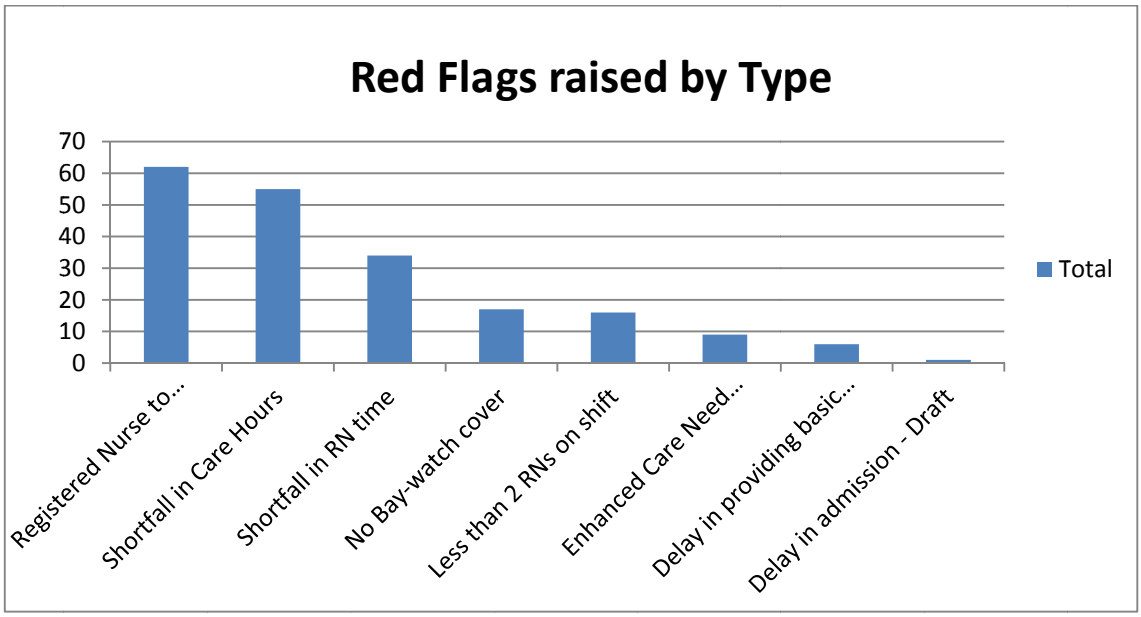
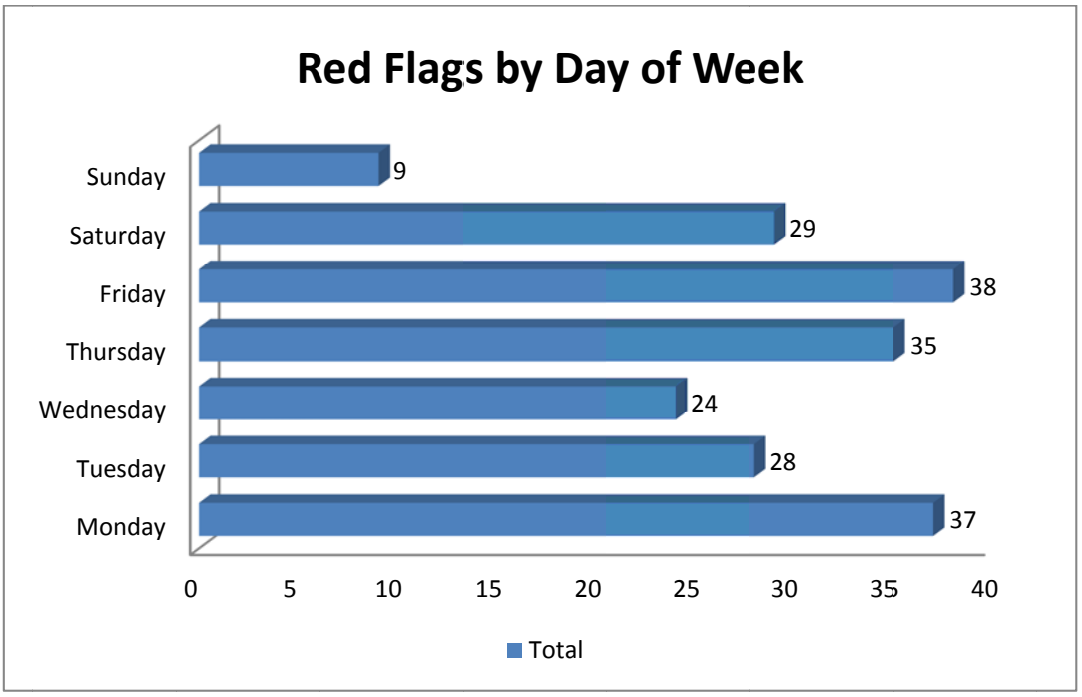


Chart 7 below indicates the red flags by day of the week; this shows that Mondays and Fridays had the highest number of red flags raised in September. This mirrors the days on which there is a higher number of unfilled shifts. Work is underway to review the reasons behind the staffing challenges faced on these days of the week and is focusing on the actions required to minimise the risk accordingly.

Chart 7 - Red Flags Day of Week



4. Quality Metrics

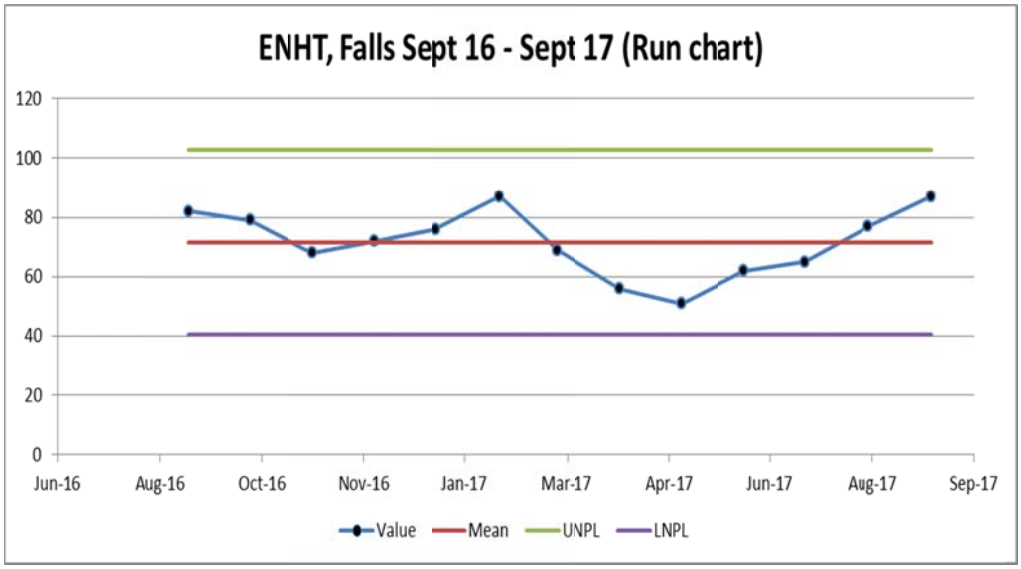
4.1 Safety Thermometer

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers (community and hospital acquired), harm from a fall in hospital, urine infection (in patients with a catheter) and new VTE.
Despite the increased bed capacity and higher number of patients requiring enhanced nursing care the proportion of patients with harm identified within the classic safety thermometer audit remains low. In September 2017 3.6% of patients were identified with harm, a slight increase from 3.1% in August 2017.

4.2 Falls

86 inpatient falls were recorded in the Trust during September which was the highest number per calendar month since February 2017, a total of 77 incidents were reported in August. The Trust is currently 5 incidents below the reduction trajectory set for 2017/18.
41.3% of all falls incidents occurred during the first eight days of September. Performance outliers were 10B with ten incidents, 11A with seven incidents, 6A with eight incidents, 6b with five incidents, 8B with five incidents. The ward managers for these areas have met with the Director of Nursing and an action plan put in place with support from the Falls Nurse.

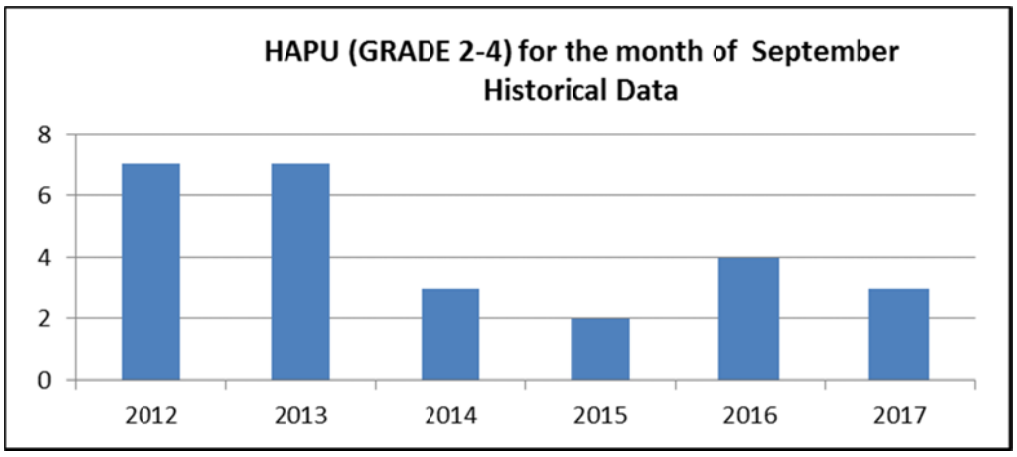
Chart 8



4.3 Pressure Ulcers

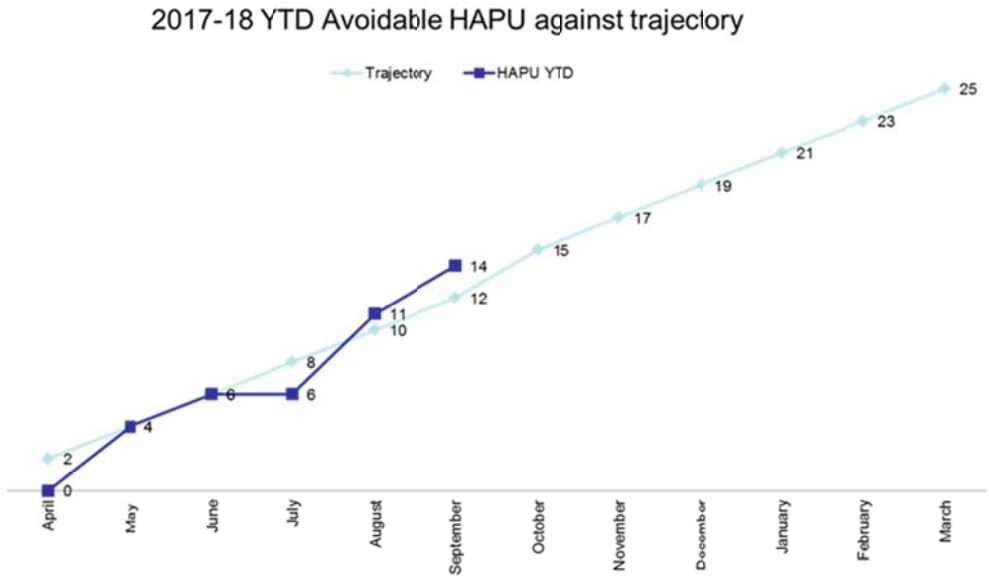
For the month of September 2017, 3 avoidable hospital acquired pressure ulcers grade 2-4 were recorded. The table below demonstrates the number of pressure ulcers in the month of September since 2012. In addition there were 3 hospital acquired avoidable suspected deep tissue injuries, (STDI)

Chart 9



The outcomes of the investigations suggest that the omissions were lack of documentation of position changes. All categories of damage are analysed inclusively. Data is reviewed on a monthly and annual basis by division, ward and anatomical location Themes from RCA's are also discussed, and action plans put in place.

Chart 10



September has seen a decrease in pressure ulcers and an increase in falls, although within expected range. The less than optimum staffing levels may have had an impact on patient safety. We understand the areas where quality may have been compromised. Work is being done with these wards with the support of nurse education and the specialist nurses to ensure patient safety is optimised.

The Trust is launching a "Get up, get dressed, keep moving" initiative which is supporting a National campaign to end pyjama paralysis and reduce recovery time for patients. The initiative encourages patients to get dressed in their own clothes and to get out of bed and keep moving as much as they are able to during their stay in hospital. By helping patients to get back to their normal routine as quickly as possible, we can support them to recover quicker, help them to maintain their independence and to get home sooner. In addition it is hoped that it may also support measurable

quality improvements in relation to a reduction in the incidence of hospital acquired pneumonia, hospital acquired pressure ulcers and reduced length of stay.

5. The Board are assured of safe staffing for nursing across the organisation

The overall RN fill rate decreased due to a decrease in temporary staffing RN fill and slight increase in demand due to increased levels of sickness. The CHPPD delivered in September also decreased. The maintenance of safe staffing levels on wards in September was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Matrons review and response to Red Flag events at the three Daily Staffing meetings with mitigations fed back to the wards via SafeCare in real time
- Regular patient acuity audits completed by Matrons
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Controlled release of unfilled shifts to agencies
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management by the Divisional / Duty Matron and support from Matrons and Heads of Nursing within the Divisions to review staffing requirements on a daily basis for identified wards
- Divisional Heads of Nursing, Matrons, Specialist Nurses and the Education Team working clinically where needed
- The introduction of the e-Roster operational support service in the evening to cover the handover of the night shift and support the Duty Matron with the mitigation of red shifts at night
- The e-Roster team contacting all Red wards to ensure that the planned mitigations have taken place and escalate to Matrons where appropriate

Appendix 1

	Day		Night	
Ward name	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
10B	86.6%	116.9%	87.4%	163.1%
11A	90.2%	98.1%	95.3%	107.1%
11B	90.4%	90.4%	100.7%	129.5%
5A	88.1%	86.4%	92.6%	106.5%
5B	92.7%	91.6%	91.3%	141.4%
6A	96.6%	104.7%	100.3%	145.0%
6B	96.4%	81.6%	102.4%	97.1%
10A Gynae	105.2%	97.8%	99.2%	102.7%
7B	90.6%	90.6%	89.7%	133.0%
8A	92.6%	81.6%	94.8%	100.1%
8B	89.9%	90.7%	89.3%	185.7%
9A	98.2%	106.2%	95.3%	150.4%
9B	91.3%	103.5%	95.8%	138.7%
ACU	103.5%	98.3%	99.5%	74.0%
AMU-A	88.2%	92.8%	85.2%	100.1%
AMU-W	91.7%	92.1%	97.8%	105.9%
Ashwell	99.5%	118.8%	104.4%	180.3%
Barley	98.6%	95.3%	98.9%	109.4%
Bluebell	81.1%	106.6%	82.0%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	103.0%	84.3%	92.3%	#DIV/0!
Gloucester	88.6%	73.6%	100.6%	94.1%
CLU	92.7%	77.0%	98.4%	97.0%
Mat MLU	101.2%	97.6%	94.3%	103.1%
Michael Sobell House	77.9%	78.3%	96.1%	103.6%
Pirton	84.0%	81.6%	95.8%	89.7%
SAU	76.9%	120.8%	95.0%	100.3%
SSU	97.8%	105.7%	96.1%	99.1%
Swift	80.3%	67.6%	92.6%	85.1%
Ward 11	90.3%	51.4%	61.4%	24.4%
Total	**92.1%**	**92.3%**	**93.8%**	**113.1%**

Appendix 2

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	2.64	3.20	5.84
11A	3.97	1.83	5.79
11B	3.45	2.75	6.20
5A	2.97	1.66	4.63
5B	3.05	2.66	5.70
6A	3.14	2.94	6.08
6B	3.71	2.34	6.06
10A Gynae	5.21	2.55	7.76
7B	2.84	1.75	4.58
8A	2.99	1.96	4.95
8B	2.99	1.79	4.78
9A	2.93	2.76	5.69
9B	2.95	2.40	5.35
ACU	4.78	2.03	6.80
AMU-A	5.45	3.60	9.05
AMU-W	4.00	3.26	7.26
Ashwell	3.05	3.56	6.61
Barley	3.36	2.28	5.63
Bluebell	6.85	2.26	9.12
Critical Care 1	15.83	2.05	17.87
Dacre	6.31	0.92	7.23
Gloucester	2.93	2.37	5.29
CLU	26.62	5.44	32.06
Mat MLU	23.56	8.07	31.63
Michael Sobell House	5.62	3.49	9.11
Pirton	4.32	2.09	6.41
SAU	5.63	3.33	8.96
SSU	3.32	2.35	5.67
Swift	3.56	2.40	5.96
Ward 11	5.73	1.65	7.38
Total	**4.4**	**2.5**	**6.9**

Appendix 3

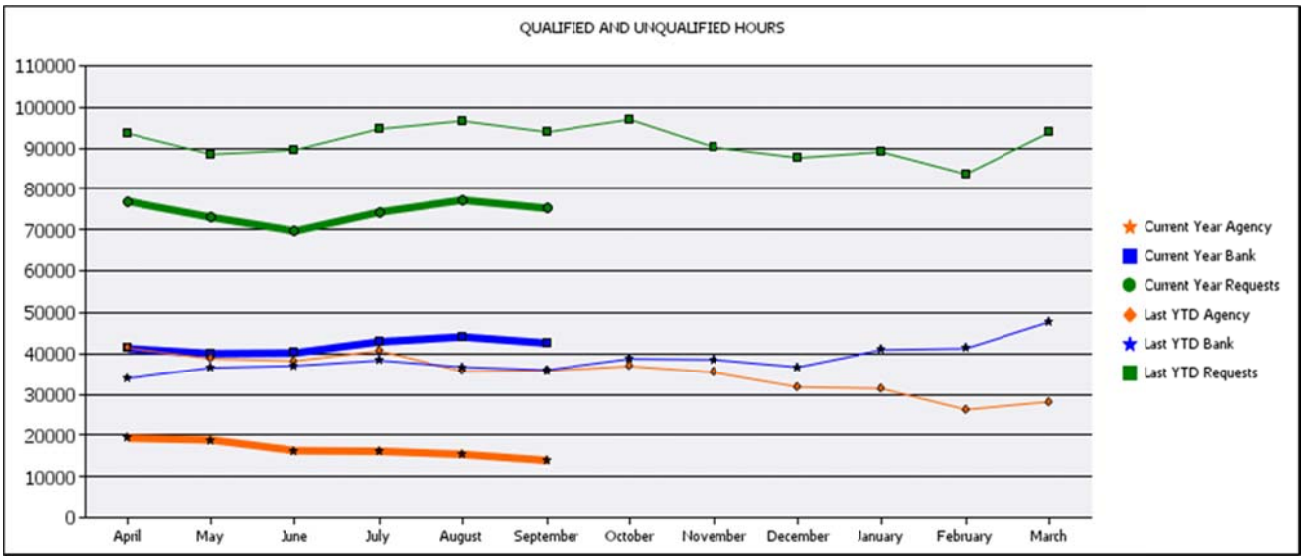
		INITIAL REDS				
Speciality	**Ward**	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
Care of the Elderly	9A	4	4	0	8	8.89
	9B	3	1	1	5	5.56
Stroke	Barley	6	8	2	16	17.78
	Pirton	4	4	2	10	11.11
General	6A	4	5	1	10	11.11
	10B	8	11	2	21	23.33
Respiratory	11A	3	8	0	11	12.22
	7AN	0	0	0	0	0.00
Cardiology	ACU	2	3	4	9	10.00
Acute	AMU-A	2	8	2	12	13.33
	SSU	4	4	0	8	8.89
	AMU-W	5	4	0	9	10.00
Renal	6B	1	1	2	4	4.44
DTOC / gastro	Ashwell	10	9	1	20	22.22
ED	A&E	6	6	3	15	16.67
	UCC	0	0	0	0	0.00
		62	**76**	**20**	**158**	**10.97**
General	8A	4	3	0	7	7.78
	8B	11	12	2	25	27.78
	SAU	1	6	2	9	10.00
Surgical Spec	11B	4	2	3	9	10.00
	7B	4	9	2	15	16.67
T&O	5A	3	12	3	18	20.00
	5B	10	13	2	25	27.78
	Swift	2	6	2	10	11.11
ATCC	Critical Care 1	3	2	4	9	10.00
	ASCU	0	0	0	0	0.00
		42	**65**	**20**	**127**	**14.11**
Gynae	10A Gynae	5	9	3	17	18.89
Paeds	Bluebell	2	2	2	6	6.67
	Child A&E	2	3	1	6	6.67
	NICU	0	1	0	1	1.11
Maternity	Dacre	0	3	0	3	3.33
	Gloucester	1	4	0	5	5.56
	Mat MLU	1	3	0	4	4.44
	Mat CLU 1	7	9	0	16	17.78
		18	**34**	**6**	**58**	**8.06**
Inpatient	Ward 10	0	0	0	0	0.00
	Michael Sobell House	0	0	1	1	1.11
		0	**0**	**1**	**1**	**0.56**
	TRUST TOTAL	**122**	**175**	**47**	**344**	**10.62**

Appendix 4

		FINAL REDS				
Speciality	**Ward**	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
Care of the Elderly	9A	0	0	0	0	0.00
	9B	0	0	0	0	0.00
Stroke	Barley	0	0	0	0	0.00
	Pirton	0	0	0	0	0.00
General	6A	0	0	0	0	0.00
	10B	0	0	0	0	0.00
Respiratory	11A	0	0	0	0	0.00
	7AN	0	0	0	0	0.00
Cardiology	ACU	0	0	0	0	0.00
Acute	AMU-A	0	0	0	0	0.00
	SSU	0	0	0	0	0.00
	AMU-W	0	0	0	0	0.00
Renal	6B	0	0	0	0	0.00
DTOC / gastro	Ashwell	0	0	0	0	0.00
ED	A&E	3	2	3	8	8.89
	UCC	0	0	0	0	0.00
		3	**2**	**3**	**8**	**0.56**
General	8A	0	0	0	0	0.00
	8B	0	0	0	0	0.00
	SAU	0	0	0	0	0.00
Surgical Spec	11B	0	0	0	0	0.00
	7B	0	0	0	0	0.00
T&O	5A	0	0	0	0	0.00
	5B	0	0	0	0	0.00
	Swift	0	0	0	0	0.00
ATCC	Critical Care 1	0	0	1	1	1.11
	ASCU	0	0	0	0	0.00
		0	**0**	**1**	**1**	**0.11**
Gynae	10A Gynae	0	0	0	0	0.00
Paeds	Bluebell	0	0	0	0	0.00
	Child A&E	0	1	0	1	1.11
	NICU	0	0	0	0	0.00
Maternity	Dacre	0	0	0	0	0.00
	Gloucester	0	0	0	0	0.00
	Mat MLU	0	1	0	1	1.11
	Mat CLU 1	0	0	0	0	0.00
		0	**2**	**0**	**2**	**0.28**
Inpatient	Ward 10	0	0	0	0	0.00
	Michael Sobell House	0	0	0	0	0.00
		0	**0**	**0**	**0**	**0.00**
	TRUST TOTAL	**3**	**4**	**4**	**11**	**0.34**

Appendix 5

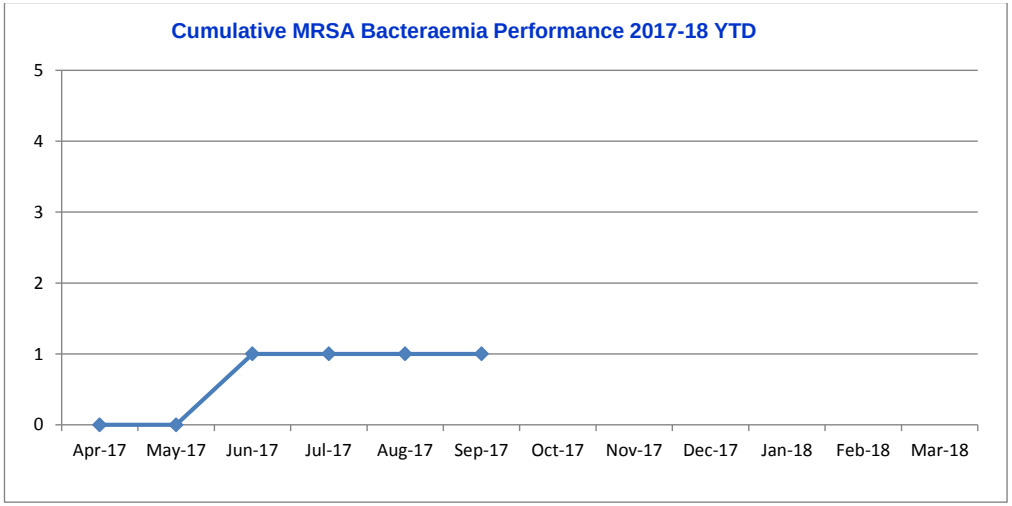
NHSP hours YTD report

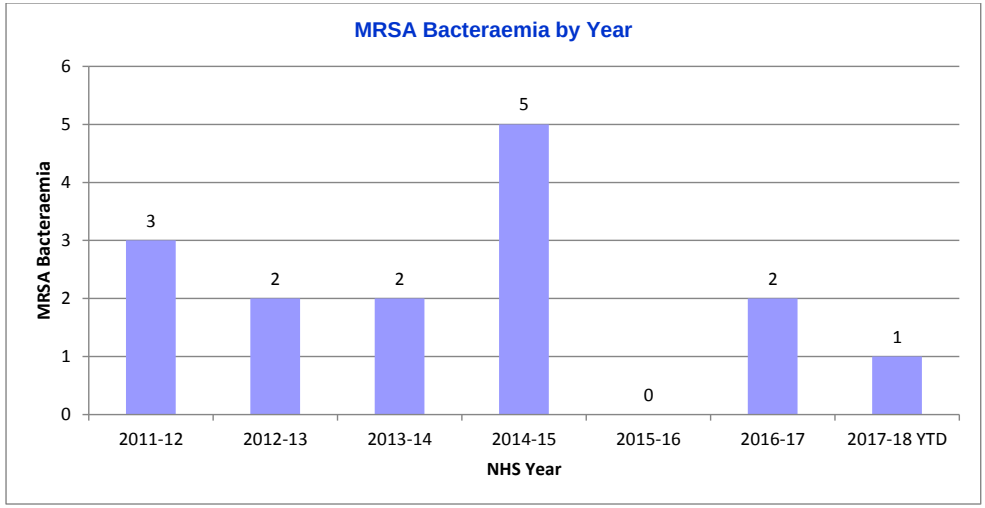


Infection Prevention and Control Board Report Objectives & Outcomes: September 2017

HCAI SURVEILLANCE	MRSA bacteraemias	0 hospital associated MRSA bacteraemia in September Year to date position is 1 Trust allocated case, (target 0 cases to year end)	Red
	C.difficile	2 Trust allocated *C.difficile* cases in September. Year to date position 15 cases. Ceiling target 11 cases to year end. 6 cases to date have been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions as there were no identified gaps in practice. Several further cases to be appealed in October. Recorded cases in the Trust have increased since 2016 – see page 7 for further details.	Amber
	MSSA bacteraemias	0 Trust allocated MSSA bacteraemias in September Year to date position is 10 cases (no target set)	Green
	Gram negative bacteraemia: National monitoring and reduction programme for E.*coli, Pseudomonas aeruginosa, Klebsiella species* – see page 10.	4 Trust associated E.*coli* bacteraemias in September Year to date position is 22 cases (no Trust target set)	Green
		0 Trust associated *Pseudomonas aeruginosa* bacteraemias in September Year to date position tbc (no Trust target set)	Green
		1 Trust associated *Klebsiella species* bacteraemia in September Year to date position tbc (no Trust target set)	Green
	CPE	1 new inpatient case and 1 outpatient case identified in September. Year to date position is 6 inpatient cases and 2 outpatient cases (no target set)	Green
	Outbreaks / Periods of Increased Incidence	No outbreaks or periods of increased incidence were identified in September	Green
	Surgical Site Infection	The Trust was identified as a high outlier for 2014-15 in all 3 categories monitored. Figures for 2015-17 to date indicate overall improvement, but the Trust remains a high outlier for Total Hip Replacement – see page 11. SSI action plan has been updated and was presented to September TIPCC. Key actions include: reducing theatre traffic during operations; monitoring core competencies eg scrubbing and draping; reviewing and improving antibiotic prophylaxis protocols; audit of patient surgical pathways.	Amber
CQUINs	Antimicrobial stewardship	1.4% reduction* ytd (Apr-Sept) in total antibiotic consumption (target 2% reduction on baseline data Jan-Dec 2016) 56% reduction* ytd (Apr-Sept) in piperacillin-tazobactam (target 2% reduction on baseline data Jan-Dec 2016) 30% reduction ytd (Apr-Sept) in carbapenems (target 2% reduction on baseline data Jan-Dec 2016) * Figures influenced by national shortage of piperacillin/tazobactam	Amber
		Review of sepsis patients on antibiotics who are still inpatients at 72 hrs. Q1: 75% of cases reviewed within 72 hrs (target 25%) Q2: 78% of cases reviewed within 72 hrs (target 50%)	Green
AUDITS	High Impact Interventions (HII)	HII audit scores in September were above 95% with the exception of Intravascular Devices Insertion, Renal Environment and MRSA screening.	Amber
ISSUES / EVENTS	ICNet	Potential solutions to resolve ongoing ICNet/TPP interface issue were presented to the IM&T Strategy Board in December 2016 and an outline business case for the reinstatement of the ICNet system has been prepared and is awaiting consideration. On Risk Register.	Red
	Infection in Critical Care Quality Improvement Programme (ICCQIP)	CCU are participating in the voluntary national surveillance programme which commenced in 2017 for blood stream infections in intensive care units, with the aim of reducing the number of such infections. Data will be presented quarterly from November.	Green

MRSA BACTERAEMIA – POST 48 HRS





MRSA Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	2	0	0	1	0	0	0							1
Surgical	0	0	0	0	0	0	0							0
Women & Children	0	0	0	0	0	0	0							0
Grand Total	**2**	**0**	**0**	**1**	**0**	**0**	**0**							**1**

MRSA – PHE Benchmarking Data (September 2017)

Public Health England

MRSA

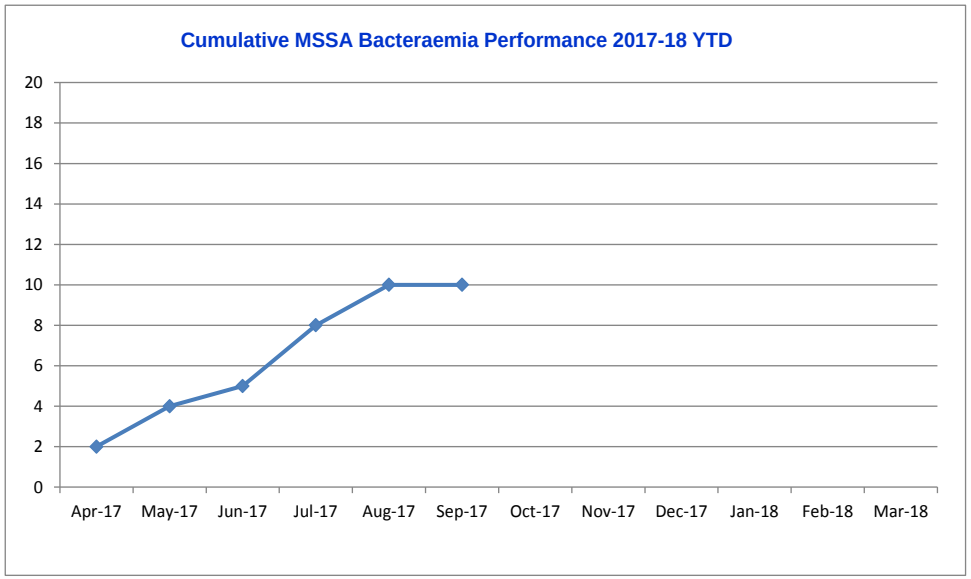
Count of trust PIR assigned cases per month

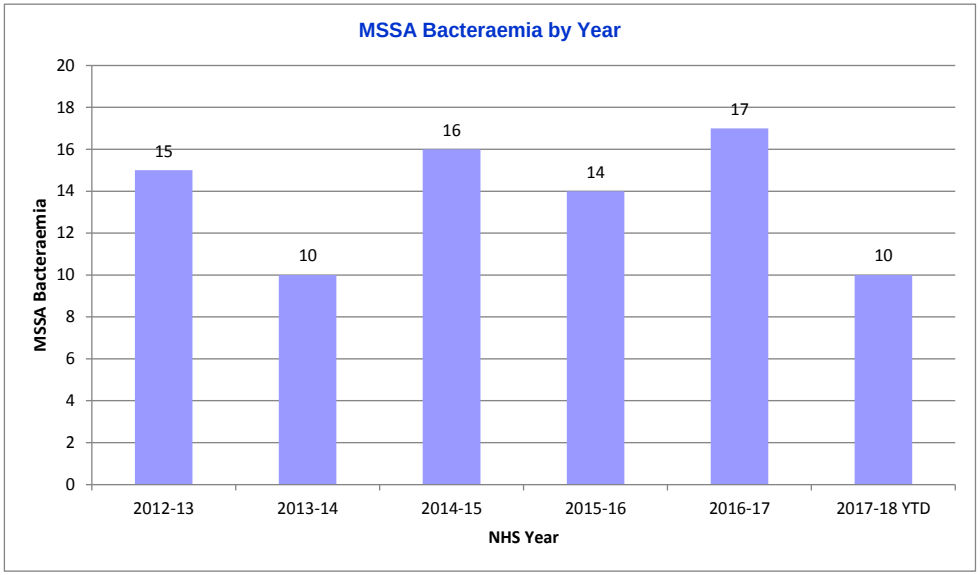
Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0	0	2	2	0							4
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0	0	0							0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	0	1	0							1
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	0	0	0	0							0
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	1	0	0	0							1
RGQ	Ipswich Hospital NHS Trust	N/A	0	1	0	0	0	0							1
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0							0
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0							0
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	0	0	0	0	0							2
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	0	1	0							2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0							0
RGN	North West Anglia NHS Foundation Trust	N/A	1	0	0	0	0	0							1
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0	0	1							1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0							0
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	0	0	1	2	0							4
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0							0
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	1	0	0							1
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	2							2
	East of England Total	**N/A**	**4**	**1**	**2**	**4**	**6**	**3**							**20**
	England Total	**N/A**	**32**	**29**	**26**	**23**	**30**	**22**							**162**

Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	10.44	10.44	0.00							3.54
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	3.76	0.00							0.64
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	6.01	0.00	0.00	0.00							0.99
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	5.89	0.00	0.00	0.00	0.00							1.00
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RQ8	Mid Essex Hospital Services NHS Trust	N/A	14.07	0.00	0.00	0.00	0.00	0.00							2.31
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.95	0.00	7.69	0.00							2.61
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RGN	North West Anglia NHS Foundation Trust	N/A	4.90	0.00	0.00	0.00	0.00	0.00							0.80
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	18.96							3.11
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RAJ	Southend University Hospital NHS Foundation Trust	N/A	7.17	0.00	0.00	6.94	13.88	0.00							4.70
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00	0.00	5.16	0.00	0.00							0.87
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	16.87							2.76
	East of England Total	**N/A**	**1.43**	**0.35**	**0.71**	**1.38**	**2.08**	**1.07**							**1.17**
	England Total	**N/A**	**0.91**	**0.82**	**0.74**	**0.65**	**0.85**	**0.62**							**0.76**

MSSA BACTERAEMIA - POST 48 HRS





Hospital acquired MSSA Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	10	0	1	0	1	0	0							2
Surgical	5	0	1	0	1	2	0							4
Women & Children	1	1	0	0	1	0	0							2
MVCC	1	1	0	1	0	0	0							2
Grand Total	17	2	2	1	3	2	0							10

MSSA – PHE Benchmarking Data (September 2017)

Public Health England

MSSA

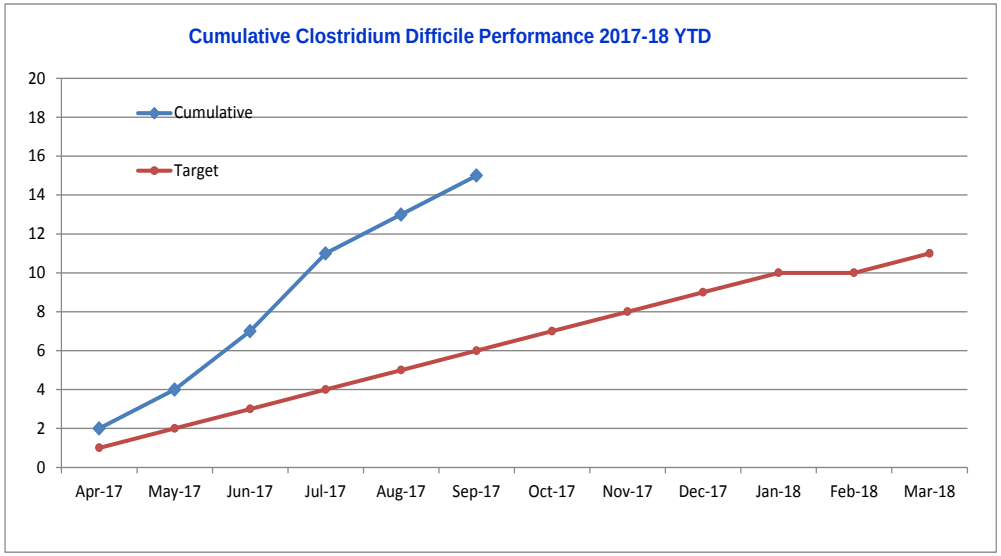
Count of all cases identified by acute trust per month

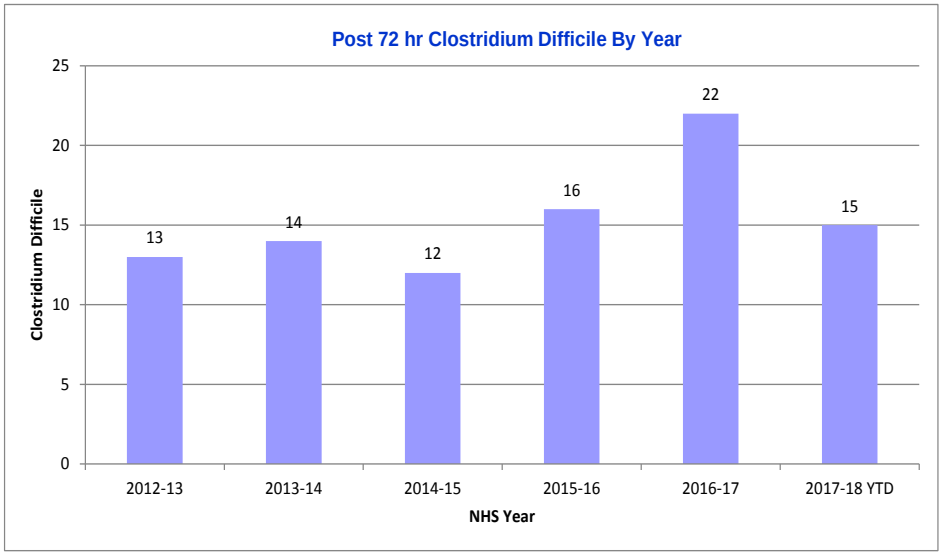
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	2	4	1	1	1							10
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1	0	1							3
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	0	1	0	1	5							9
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	2	2	2	2	1							10
RWH	East & North Hertfordshire NHS Trust	N/A	2	2	1	3	2	0							10
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	1	0	3	1							6
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	0	0	1							7
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	1	2	1							4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	1	2	2	0	3							9
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	2	2	4							13
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3	1	3	4	1	0							12
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	2	1	2							7
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	2	0	0	1	2							6
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	0	0	0							1
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	2	0	1	1	1							6
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	2	1	2	1							7
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	1	1	1	1							10
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	1	0	1	1							4
	East of England Total	**N/A**	**21**	**20**	**25**	**21**	**21**	**26**							**134**
	England Total	**N/A**	**255**	**295**	**264**	**248**	**270**	**252**							**1584**

Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.39	10.44	21.58	5.22	5.22	5.39							8.84
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	9.11	8.82	0.00	9.11							4.48
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.78	0.00	3.89	0.00	3.76	19.44							5.74
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.47	12.53	12.95	12.53	12.53	6.47							10.61
RWH	East & North Hertfordshire NHS Trust	N/A	12.02	11.63	6.01	17.44	11.63	0.00							9.85
RGQ	Ipswich Hospital NHS Trust	N/A	6.09	0.00	6.09	0.00	17.67	6.09							5.99
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	27.99	0.00	27.99	0.00	0.00	9.33							10.71
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	5.79	11.59	5.99							3.93
RQ8	Mid Essex Hospital Services NHS Trust	N/A	7.03	6.81	14.07	13.62	0.00	21.10							10.38
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.89	15.38	7.95	15.38	15.38	31.79							16.94
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	11.09	3.58	11.09	14.31	3.58	0.00							7.27
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	4.74	4.90	9.49	4.74	9.81							5.63
RGM	Papworth Hospital NHS Foundation Trust	N/A	18.96	36.70	0.00	0.00	18.35	37.92							18.65
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	7.65	0.00	0.00	0.00							1.25
RAJ	Southend University Hospital NHS Foundation Trust	N/A	7.17	13.88	0.00	6.94	6.94	7.17							7.06
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	8.46	17.48	8.46	16.92	8.74							10.03
RWG	West Hertfordshire Hospitals NHS Trust	N/A	15.99	15.47	5.33	5.16	5.16	5.33							8.74
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.16	8.43	0.00	8.16	8.43							5.53
	East of England Total	**N/A**	**7.51**	**6.92**	**8.94**	**7.26**	**7.26**	**9.29**							**7.85**
	England Total	**N/A**	**7.21**	**8.35**	**7.47**	**7.02**	**7.64**	**7.13**							**7.47**

CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Post 72 hr Clostridium Difficile by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	14	2	1	3	3	0	2							11
Surgical	8	0	1	0	1	2	0							4
Women & Children	0	0	0	0	0	0	0							0
MVCC	0	0	0	0	0	0	0							0
Grand Total	22	2	2	3	4	2	2							15

Summary of reviews of the 15 Trust allocated cases to end September:

- 6 cases have been provisionally accepted by the Appeals Panel for exemption from financial sanctions as there were no identifiable gaps in practice.
- Further cases to date will be submitted to the October Appeals Panel
- 4 cases to date had an avoidable delay in sending a stool sample and will not be appealed
- In 1 of the above cases antibiotics were inappropriately prescribed

C. difficile rates at East and North Hertfordshire NHS Trust

Trust-allocated[1] *C difficile* cases increased in 2015/16 compared with previous years, and more markedly in 2016/17, with 22 cases against our centrally set ceiling of 11 cases. This trend has continued with 15 cases at end September 2017.

Each case undergoes a comprehensive review to identify any learning. Cases deemed to be unavoidable with no lapses in care can be appealed to the CCG for exemption from the financial sanction of £10,000 for each case above the ceiling. A key factor is whether the stool sample was taken promptly and, if not, an appeal is unlikely to succeed. Last year, 11 cases were successfully appealed and therefore no financial sanctions were applied. This year to date, 6 cases have been successfully appealed and further cases will be appealed before the end of the financial year. 4 cases this year are not appealable due to delayed sending of a stool sample.

It is worth noting that our ceiling of 4.9 cases/100,000 bed days is the second lowest in the region, with the overall target rate for the East of England region being 13.7 cases per 100,000 bed days. Our current rate of 13.79 cases places us slightly below average for East of England Acute Trusts (14.59 cases).

Underlying factors contributing to increase in reported cases

- In February 2017, the Trust *C difficile* policy was changed to enable clinical teams to decide whether to test their patients, in line with DH guidance[2] that that all symptomatic patients should be tested for *C.difficile* as soon as possible if diarrhoea is not ***clearly*** attributable to an underlying cause, and the Microbiologist or Infection Control Team should be contacted if in doubt. Previously, all tests where a positive result would be assigned to the Trust required prior authorization by the Consultant Microbiologist. From 2016, this responsibility was extended to the IPC Nurses to prevent delays in diagnosis before being devolved to clinical teams. These changes have resulted in more samples being sent and identification of cases that may have been missed under the old policy. PHE data suggests we previously submitted fewer *C difficile* test requests than comparable Trusts. Of the 15 cases from April 2017 to date, only one is considered unlikely to be a clinical infection, indicating that in virtually all cases the sample was taken appropriately.

- There may be a genuine increase in *C difficile* infections in the Trust, particularly as there has been a marked increase in positive results in the East & North Herts local community since May this year. We investigate each Trust case to identify timelines and request ribotyping where appropriate, to ascertain whether cross infection may have occurred. No evidence of any cross infections or outbreaks has been identified.

- Antibiotic usage is a significant driver for *C.difficile*. A point prevalence study last year identified that 43.5% of our patients are exposed to antibiotics against a national average of 37%. A contributory factor may be our measured high prevalence of HCAI - 9.3% against a national average of 6.6%.

Actions taken to date

- Antibiotic stewardship rounds instituted. Audit processes around antimicrobial CQUIN targets are present and are on track.
- New Microbiologists and IPCNs are being recruited to vacancies.
- All patients with *C difficile* are reviewed to identify learning. Appeals against financial sanctions are submitted where appropriate.
- Post infection review held for all cases, now including identification of cases with an HCAI to help target actions
- Introduction of projects to reduce hospital acquired pneumonias (HAP) and catheter associated urinary tract infections (CAUTI).

[1] *C difficile* cases are assigned to the Trust if the positive sample is taken later than day 3, with the day of admission counted as day 1.
[2] Dept of Health Updated Guidance on the Diagnosis and Reporting of *Clostridium difficile* 2012

C.DIFFICILE – PHE Benchmarking Data (September 2017)

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	31	5	1	2	1	1	2							12
RC1	Bedford Hospitals NHS Trust	10	0	1	1	0	1	2							5
RGT	Cambridge University Hospitals NHS Foundation Trust	49	1	11	4	7	5	8							36
RDE	Colchester Hospitals University NHS Foundation Trust	18	0	3	3	1	1	2							10
RWH	East & North Hertfordshire NHS Trust	11	2	2	2*	4	2	2							14*
RGQ	Ipswich Hospital NHS Trust	18	1	3	1	8	2	1							16
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	2	3	3	1	0							9
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	2	1	1	1	1							7
RQ8	Mid Essex Hospital Services NHS Trust	13	8	3	2	5	7	3							28
RD8	Milton Keynes Hospital NHS Foundation Trust	39	1	0	0	1	3	0							5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	2	1	6	3	3	3							18
RGN	North West Anglia NHS Foundation Trust	40	7	4	4	4	3	7							29
RGM	Papworth Hospital NHS Foundation Trust	5	0	0	0	0	0	0							0
RQW	Princess Alexandra Hospital NHS Trust	10	1	0	1	4	0	3							9
RAJ	Southend University Hospital NHS Foundation Trust	30	5	2	4	1	3	2							17
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	2	3	4	5	3	5							22
RWG	West Hertfordshire Hospitals NHS Trust	23	1	1	4	0	0	0							6
RGR	West Suffolk Hospitals NHS Trust	16	3	0	0	1	0	2							6
	East of England Total	**413**	**40**	**39**	**42**	**49**	**36**	**43**							**249**
	England Total	**4483**	**346**	**372**	**411**	**467**	**402**	**409**							**2407**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated**

Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	13.60	26.97	5.22	10.79	5.22	5.22	10.79							10.61
RC1	Bedford Hospitals NHS Trust	8.30	0.00	8.82	9.11	0.00	8.82	18.22							7.47
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	3.89	41.40	15.56	26.34	18.82	31.11							22.95
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	0.00	18.80	19.42	6.27	6.27	12.95							10.61
RWH	East & North Hertfordshire NHS Trust	4.90	12.02	11.63	12.02*	23.26	11.63	12.02							13.79*
RGQ	Ipswich Hospital NHS Trust	9.40	6.09	17.67	6.09	47.11	11.78	6.09							15.96
RGP	James Paget University Hospitals NHS Foundation Trust	13.10	0.00	18.06	27.99	27.09	9.03	0.00							13.76
RC9	Luton & Dunstable Hospital NHS Foundation Trust	3.10	5.99	11.59	5.99	5.79	5.79	5.99							6.87
RQ8	Mid Essex Hospital Services NHS Trust	7.30	56.28	20.42	14.07	34.04	47.65	21.10							32.29
RD8	Milton Keynes Hospital NHS Foundation Trust	25.80	7.95	0.00	0.00	7.69	23.07	0.00							6.51
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	25.80	7.39	3.58	22.18	10.73	10.73	11.09							10.91
RGN	North West Anglia NHS Foundation Trust	tbc	34.32	18.98	19.61	18.98	14.23	34.32							23.31
RGM	Papworth Hospital NHS Foundation Trust	7.00	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RQW	Princess Alexandra Hospital NHS Trust	6.50	7.65	0.00	7.65	29.62	0.00	22.96							11.29
RAJ	Southend University Hospital NHS Foundation Trust	17.30	35.87	13.88	28.70	6.94	20.83	14.35							19.99
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	38.00	17.48	25.37	34.96	42.29	25.37	43.70							31.52
RWG	West Hertfordshire Hospitals NHS Trust	10.90	5.33	5.16	21.31	0.00	0.00	0.00							5.24
RGR	West Suffolk Hospitals NHS Trust	12.50	25.30	0.00	0.00	8.16	0.00	16.87							8.29
	East of England Total	**13.70**	**14.30**	**13.49**	**15.01**	**16.95**	**12.45**	**15.37**							**14.59**
	England Total	**13.13**	**9.79**	**10.52**	**11.63**	**13.21**	**11.37**	**11.57**							**11.35**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated**

CARBAPENEMASE-PRODUCING ENTEROBACTERIACEAE

Carbapenems are a class of broad spectrum intravenous antibiotics which are reserved for serious infections or when other therapeutic options have failed. One of the most concerning groups of Carbapenem Resistant Enterobacteriaceae (CRE) are those organisms which carry a carbapenemase enzyme that breaks down carbapenem antibiotics. This type of organism is called Carbapenemase Producing Enterobacteriaceae (CPE) and is the type which spreads most easily and has caused most outbreaks worldwide.

In accordance with PHE guidance, a screening programme was introduced in the Trust in June 2014 to identify patients at high risk of CPE carriage. This screening policy has now been expanded to include patients who have been admitted to any hospital during the past 12 months (UK or abroad) or undergone significant healthcare procedures, eg renal dialysis, abroad. Any such patients are then tested and patients are isolated until confirmed negative if they have had an overnight stay in any hospital in London, North West England or abroad, or received significant healthcare abroad. An enhanced screening programme for the Renal patient population has also been implemented as that patient group is in the highest risk category for CPE.

Carbapenemase-Producing Enterobacteriaceae - 2017-18

Division/Dept		2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD 2017-18
INPATIENTS	Renal Ward - Lister	3	0	0	1	0	0	0							1
	Medicine	3	0	1	0	0	0	0							1
	Surgery	7	1	0	0	0	1	1							3
	W&C	0	0	0	0	1	0	0							1
	MVCC	0	0	0	0	0	0	0							0
RENAL DIALYSIS UNITS	Lister	1	0	0	0	0	0	0							0
	L&D	0	0	0	0	0	0	0							0
	Harlow	0	0	0	0	0	0	0							0
	St Albans	0	0	0	0	0	0	0							0
	Bedford	0	0	0	0	0	0	0							0
OUTPATIENTS	Lister	0	0	1	0	0	0	1							1
	QEII	1	0	0	0	0	0	0							0
	HCH	0	0	0	0	0	0	0							0
	MVCC	0	0	0	0	0	0	0							0
TOTAL (TRUST PATIENTS)		15	1	2	1	1	1	2							8

The above figures do not differentiate between Trust-associated and Community-associated cases.

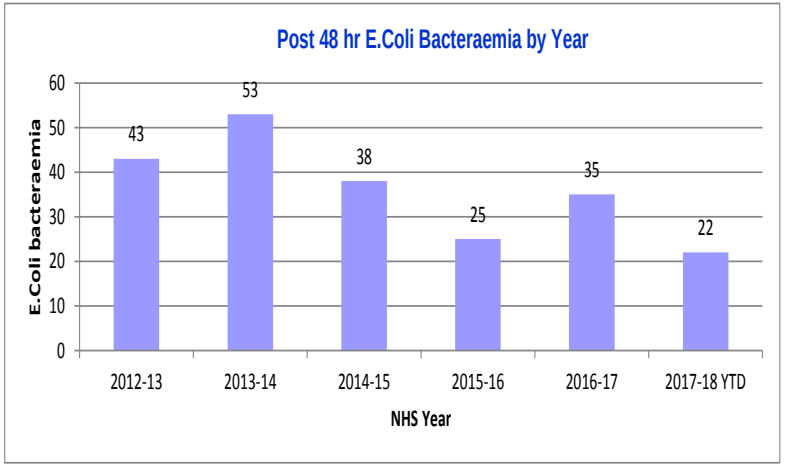
GP Patient Specimens (Not Trust Patients)	Not recorded	0	0	0	0	1	1								2

E.COLI BACTERAEMIA – POST 48 HRS

A new Quality Premium was introduced in July for a 10% reduction in E.coli bacteraemias attributed to each CCG, measured against 2016 performance data. Mandatory reporting of *Klebsiella species & Pseudominas aeruginosa* bacteraemias has also been introduced as part of a national requirement for a 50% reduction in gram negative bacteraemias by the beginning of 2021. The Trust does not have specific reduction targets at present, and Trust-associated cases make up less than 20% of reported cases. However, a number of strategies are being introduced in the Trust to minimise cases, including initiatives to reduce hospital acquired pneumonias (HAP) and catheter associated urinary tract infections (CAUTI).

Hospital acquired E.Coli Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	16	3	3	2	2	1	2							13
Surgical	16	1	2	1	1	0	2							7
Women & Children	1	0	2	0	0	0	0							2
MVCC	2	0	0	0	0	0	0							0
Grand Total	35	4	7	3	3	1	4	0	0	0	0	0	0	22



Public Health England

Escherichia coli

Note: PHE figures for E.coli are not split between hospital-acquired and community-acquired cases

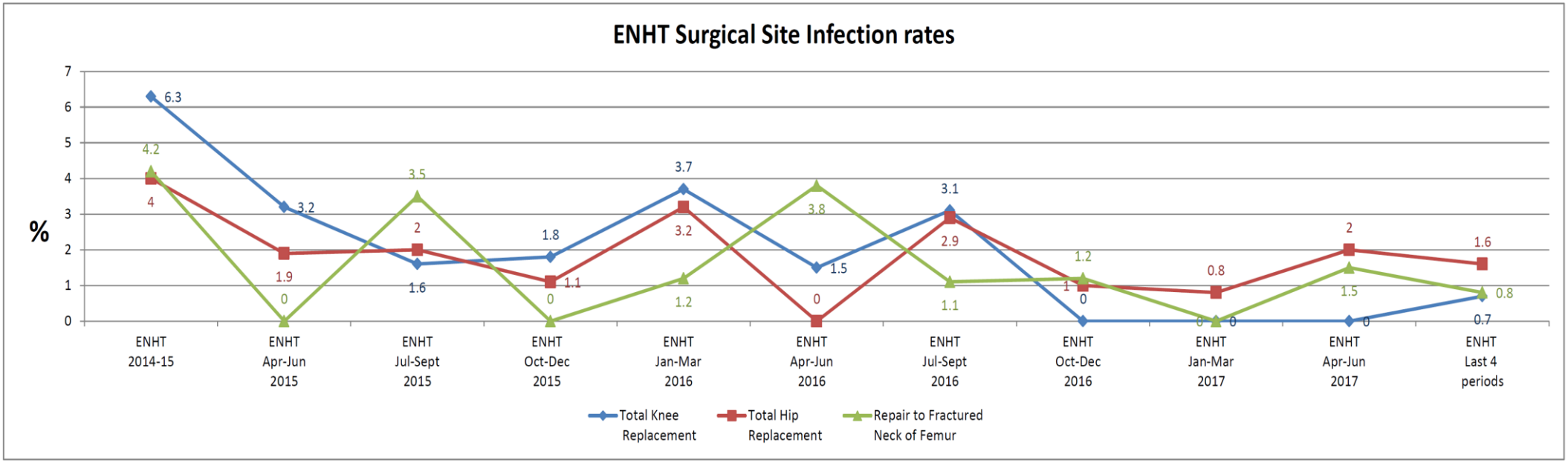
Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	18	22	19	16	23	33							131
RC1	Bedford Hospitals NHS Trust	N/A	12	12	12	13	15	11							75
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	32	22	33	32	35	30							184
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	16	25	27	26	38	28							160
RWH	East & North Hertfordshire NHS Trust	N/A	23	27	18	24	30	29							151
RGQ	Ipswich Hospital NHS Trust	N/A	27	21	23	12	17	13							113
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	19	23	20	11	18	16							107
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	13	12	22	13	23	13							96
RQ8	Mid Essex Hospital Services NHS Trust	N/A	16	17	18	21	22	19							113
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	21	13	12	27	21	23							117
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	29	24	36	27	29	43							188
RGN	North West Anglia NHS Foundation Trust	N/A	25	25	25	36	37	29							177
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	2	0	1							4
RQW	Princess Alexandra Hospital NHS Trust	N/A	13	10	13	11	25	13							85
RAJ	Southend University Hospital NHS Foundation Trust	N/A	19	21	23	26	18	25							132
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	18	18	20	17	17	18							108
RWG	West Hertfordshire Hospitals NHS Trust	N/A	18	14	26	28	24	24							134
RGR	West Suffolk Hospitals NHS Trust	N/A	12	11	16	15	11	17							82
	East of England Total	**N/A**	**331**	**318**	**363**	**357**	**403**	**385**							**2157**
	England Total	**N/A**	**3290**	**3391**	**3503**	**3727**	**3769**	**3490**							**21170**

Surgical Site Infection Rates

SSI figures over the last 4 periods (April 2016 – March 2017) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement, Total Hip Replacement & Repair of Fractured Neck of Femur), compared to the 2014-15 figures. However, the Trust remains a high outlier for Total Knee Replacement (TKR) and Total Hip Replacement (THR). The Surgical Site Infection Working Group is implementing the revised Surgical Site Infection Action Plan and is now using a national assessment toolkit.

Category / Quarter	Oct-Dec 14 ENHT	Apr-Jun 15 ENHT	Jul-Sept 15 ENHT	Oct-Dec 15 ENHT	Jan-Mar 16 ENHT	Apr-Jun 16 ENHT	Jul-Sept 16 ENHT	Oct-Dec 16 ENHT	Jan-Mar 17 ENHT	Apr-Jun 17 ENHT	* Last 4 periods ENHT	2012-2016 National Benchmarks
Total Knee Replacement	**6.3%**	**3.2%**	**1.6%**	**1.8%**	**3.7%**	**1.5%**	**3.1%**	**0%**	**0%**	**0%**	**0.7%**	**0.6%**
TKR infections/ops	5 / 80	2 / 63	1 / 64	1 / 57	2 / 54	1 / 66	2 / 65	0 / 85	0 / 77	0 / 60	2 / 287	
Total Hip Replacement	**4%**	**1.9%**	**2%**	**1.11%**	**3.2%**	**0%**	**2.9%**	**1%**	**0.8%**	**2%**	**1.6%**	**0.7%**
THR infections/ops	4 / 101	2 / 103	2 / 100	1 / 89	3 / 94	0 / 94	3 / 105	1 / 99	1 / 129	2 / 98	7 / 431	
Repair Fractured Neck of Femur	**4.2%**	**0%**	**3.5%**	**0%**	**1.2%**	**3.8%**	**1.1%**	**1.2%**	**0%**	**1.5%**	**0.8%**	**1.3%**
#NOF infections/ops	5 / 118	0 / 93	3 / 86	0 / 99	1 / 81	3 / 80	1 / 87	1 / 82	0 / 116	1 / 68	3 / 353	

* The last 4 quarters for which data has been collected are considered the most useful for identifying trends, due to the comparatively small number of operations per quarter



High Impact Intervention Audit Scores

High Impact Interventions	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD 2017-18	RAG rate (Month on Month)
Hand Hygiene	96.48%	96.48%	96.80%	96.44%	92.02%	94.89%	96.42%							95.54%	▲
Surgical Site Observation	93.13%	94.57%	96.46%	97.87%	97.49%	96.57%	95.85%							96.53%	▼
Intravascular Devices (Insertion)	93.58%	95.44%	96.16%	95.16%	96.05%	93.93%	94.63%							95.25%	▲
Intravascular Devices (Continuing Care)	91.65%	93.29%	94.26%	95.27%	94.42%	95.04%	95.97%							94.68%	▲
Urinary Catheter (Insertion)	96.39%	94.26%	99.31%	96.60%	97.14%	95.86%	96.85%							96.73%	▲
Urinary Catheter (Continuing Care)	93.82%	88.00%	98.63%	93.92%	97.83%	98.57%	97.56%							95.85%	▼
Renal Dialysis (Continuing Care)	96.70%	100.00%	100.00%	100.00%	100.00%	100.00%	99.67%							99.95%	▼
Ventilator (Continuing Care)	97.00%	100.00%	81.48%	100.00%	100.00%	100.00%	100.00%							96.18%	◀▶
Environment (Inpatients)	96.70%	96.54%	97.25%	96.74%	96.46%	95.63%	95.63%							96.40%	◀▶
Environment (Outpatients)	97.17%	96.96%	96.50%	97.62%	96.85%	96.29%	96.32%							96.75%	▲
Environment (Renal Dialysis)	89.24%	91.18%	93.56%	91.07%	90.39%	85.60%	86.81%							89.87%	▲
MRSA Screening Compliance	96.42%	90.25%	97.09%	95.61%	98.03%	95.69%	93.93%							95.09%	▼

Compliance scores are extracted from the Meridian database of Trust-wide fortnightly peer audits undertaken by nursing staff in their own departments