East and North Hertfordshire NHS Trust

Trust Board Part I

Post Graduate Centre, MVCC

7 November 2018 14:00 - 7 November 2018 15:45

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) 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. Draft Minutes from 5 September 2018 Trust Boar... 7	Chair	
6	Matters Arising and Actions Log For information 6. Actions Log - Board Part 1.pdf 21	Chair	
7	Annual Cycle For information 7. Board Annual Cycle 2018-19.pdf 23	Company Secretary	

#	Description		Owner	Time
8	Chief Executive's Report For discussion 8. Chief Executive's Board Report - November 2018...	29	Director of Finance on behalf of Chief Executive	
9	Finance and Performance Committee Report For discussion 9. (a) FPC Report to Board 26.09.18.pdf 9. (b) FPC Report to Board - 31.10.18.pdf	31 35	Chair of FPC	14.15
9.1	FPC Annual Review and terms of reference For approval 9.1 FPC Annual Review and Terms of Reference.p...	39	Chair of FPC	
9.2	Finance Report - Month 6 For discussion 9.2 Finance Report for Trust Board Part 1.pdf	51	Director of Finance	
9.3	Performance Report For discussion 9.3 Performance Report.pdf	59	Chief Operating Officer	
9.4	Workforce Report For discussion 9.4 Workforce Report.pdf	77	Chief People Officer	
10	Quality and Safety Committee Report For discussion 10. (a) QSC Report to Board - 25.09.18.pdf 10. (b) QSC Report to Board - 30.10.18.pdf	105 143	Chair of QSC	14:45
10.1	Quality Transformation Programme For discussion 10.1 QTP - Highlight Report.pdf	147	Director of Nursing	

#	Description	Owner	Time
10.2	Infection Prevention and Control Report For discussion 10.2 IPC Report.pdf 169	Director of Nursing	
11	Audit Committee Report to Board For discussion 11. Audit Committee Report to Board - 22.10.18.pdf 187	Chair of Audit Committee	
11.1	Review of Standing Financial Instructions and Standing Financial Orders For approval 11.1 Review of Standing Financial Instructions and... 191	Chair of Audit Committee	
11.2	Audit Committee Annual Review and Review of Terms of Reference For approval 11.2 Audit Committee Annual Review 2017-18 and... 317	Chair of Audit Committee	
12	Board Assurance Framework For discussion 12. Risk Management Strategy and Board Assuran... 331	Company Secretary	
13	Charity Trustee		
13.1	Charity Trustee Committee Report to Board For discussion 13.1 CTC Report to Board.pdf 363	Chair of CTC	
13.1.1	Charity Trustee Committee Annual review and terms of reference For approval 13.1.1 CTC Annual Review and Review of Terms of... 367	Chair of CTC	
13.2	Charity Trustee Annual Report and Accounts (to follow) For approval	Chair of CTC	
13.2.1	External Audit of the Charity Accounts (to follow) For information	Director of Finance	

#	Description	Owner	Time
13.2.2	Letter of Representation (to follow) For approval	Director of Finance / Company Secretary	
14	Data pack For information [P] 14. Data Pack.pdf 377	All Directors	
15	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
15.1	Commercial-in-confidence		
15.2	Governance Matters		
15.3	Personnel Matters		
16	Date of next meeting: 9 January 2019, Hertford County Hospital - 9 am		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 5 September 2018 at 2.00pm at the Lister Education Centre, Lister

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Mr Jonathan Silver	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Nick Swift	Non-Executive Director (arrived at 3.38pm)
	Mr Peter Carter	Non-Executive Director
	Dr David Buckle	Non-Executive Director (associate)
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Dr Michael Chilvers	Medical Director (arrived at 3.05pm)
	Ms Kate Lancaster	Director of Strategy (arrived at 3.05pm)
	Ms Rachael Corser	Director of Nursing
	Ms Chin Okunuga	Deputy Chief Operating Officer
In attendance from the Trust:	Mr Tom Pounds	Deputy Director of Workforce and OD
	Ms Jude Archer	Company Secretary
	Mrs Jane Chapman	Board Committee Secretary (minutes)
In attendance external to the Trust:	Ms Sharon Rouse	Project Lead East and North Herts Trust
	Mrs Beverley Worley	ADDs Admin and Project Coordinator East and North Herts Trust
	Ms Anne Wells	Royal College of Nursing – staff side representative
	Aspiring Directors Scheme:	
	Mr Sam Tappenden	Herts Community Trust
	Ms Liz Briggs	Herts Valley CCG
	Mr Darren Hobbs	Princess Alexandra Hospital
	Mr Robert Ayres	Princess Alexandra Hospital
	Ms Lynn Dalton	Herts Valley CCG
	Ms Debbie Greatarix	Cross Sector Leadership Exchange
	Mr Larry Shulman	Cross Sector Leadership Exchange

18/159 CHAIR'S OPENING REMARKS

18/159.1 Mrs Schroder welcomed members of the public to the meeting along with those on the Aspiring Directors programme. She also welcomed the two new Non-Executive Directors to the Board, Mr Peter Carter and Dr David Buckle.

18/160 APOLOGIES FOR ABSENCE

18/160.1 Apologies for absence were received from Tom Simons (Chief People Officer), Julie Smith (Chief Operating Officer) and Val Moore (Non-Executive Director).

18/161 DECLARATIONS OF INTEREST

18/161.1 There were no declarations of interest with regard the meeting. Mr

Carter and Dr Buckle, informed the Board of their links with other Trusts and highlighted that they have no conflicts of interest regarding the agenda. Formal declarations for the central register have been completed.

18/162 QUESTIONS FROM THE PUBLIC

18/162.1 There were no questions from the public.

18/163 MINUTES OF THE PREVIOUS MEETING

18/163.1 The Board reviewed and approved the draft minutes of the previous meeting.

18/164 CHIEF EXECUTIVE'S REPORT

18/164.1 The Chief Executive delivered his report, highlighting the following items:

- As part of the Aspiring Directors Development Scheme (ADDS) a number of this year's Aspiring Directors and providers of the course were welcomed to observe the Board meeting.
- The Trust held a 'Perfect Week' at the Lister, from 20 to 24 August 2018. The aim was to help remove blocks and barriers in real time whilst achieving best patient care by improving patient flow throughout the hospital. Reflection on the 'Perfect Week' will provide learning opportunities going forward. Running alongside this the number of escalation beds were safely reduced.
- As part of CQC's routine inspection programme, nine core services provided by East and North Hertfordshire NHS Trust were inspected. Services were across Lister Hospital, the New QEII Hospital and Mount Vernon Cancer Centre, and took place between 20 and 22 March 2018. CQC returned on 2 April 2018 for an unannounced follow-up inspection of the Surgery core service at Lister Hospital. A number of briefings with third parties have taken place advising that the CQC rating was in line with expectations; however, QEII Urgent Care Centre and Surgery ratings were not expected. Although the overall rating was in line with expectations, it is not in line with Trust ambitions and this is being addressed with enhanced accountability and capacity. It was noted the report was published in July and this was the first public Board since then.

18/164.2 Mr Silver enquired what the anticipated rating will be following completion of actions. The Chief Executive advised that the aim is for a rating of 'good' and anticipates this being achieved within two further inspections. The Company Secretary advised that recent Quality Improvement Board meetings have focused on 'must do' and 'should do' along with closing regulatory actions - these actions have now been completed or are all on task to deliver the improvements required. The aim is that the Trust is re-inspected and services inspected are seeking to achieve at least a 'good'. Some areas are already reviewing action plans with an aim to achieve 'outstanding'.

18/164.3 The Director of Nursing advised that the Changing Hospitals programme also looks at Quality and Safety and will be reporting

through the new Quality and Safety Committee this month. She advised that the Committee has ambition beyond CQC requirements.

18/164.4 Mr Niven stated that regular discussions at Board level would avoid slipping back and was encouraged by the level of ambition. The Chief Executive advised that knowledge of CQC requirements prior to their visit would enable the Trust to provide assurance of regular monitoring of the new investment into the governance teams will support this.

FINANCE AND PERFORMANCE

18/165 Finance and Performance Committee Report to Board

18/165.1 The Director of Finance delivered the Finance and Performance Committee Report. Key points to note include:

- The Trust is now being monitored against a revised control total, a deficit of £281k, following the NHSI plan resubmission on 20 June 2018. The reported position includes a 1% estimate for the pay award in accordance with NHSI guidance. New rates of pay will be paid to staff in July, with arrears paid in August 2018 for the backdated element to 1 April 2018. Notification has been received that there will be additional funding to support the pay award.
- The overall month 3 position is £75k favourable to plan. Year to date there is an actual £8.5m deficit compared to a year to date plan of £8.6m deficit. The Trust continues to work to secure capital funding to cover the capital costs via loan applications/STP bids.
- The Trust is currently over performing which carries a risk on activity plans with CCG.
- Although the CIPs gap has been reduced to £1.2m, there remain a significant number of plans still to be actioned.
- The Committee reviewed the CQUIN Assurance Framework for delivery of meaningful quality. A new framework now provides improved performance.
- Following a Service Line Deep Dive within the Maternity speciality the division demonstrated that they recognise a number of challenges and outlined their plan to move forward to deliver an efficient, high quality and profitable service. 'Out of area' births have increased significantly this year and a bespoke twin/multiple birth service is in the process of being established, both of which will improve income within the division.
- The Committee discussed the procurement hub to enable improved efficiency together with cost savings.

18/165.2 Mrs Schroder enquired whether procurement would be moving from Hertfordshire to STP wide. The Director of Finance advised that Hertfordshire Procurement had always had many partners; however, from 1 April 2019 the hub will have the challenge of all Trusts joining them for the benefit of the STP.

18/165.3 Mrs Schroder enquired what other procurement Hertfordshire Procurement undertakes and whether the Trust utilises the service effectively. The Director of Finance advised that the STP's strategy is to undertake more procurement through Hertfordshire Procurement which will reduce costs and add to other savings.

18/165.4 Mrs Schroder enquired of the volume that is procured centrally through Hertfordshire Procurement. The Director of Finance advised that around 50% is procured through them.

18/165.5 Mrs Schroder enquired whether there was a plan to move to Hertfordshire Procurement and monitor progress. The Director of Finance advised that this was the case; however, the Trust would not procure completely from them but will make a move to increase the volume that is currently being procured from them.

18/165.6 Mrs Schroder enquired whether the Trust benchmark against other STPs. The Director of Finance advised that procurement costs are benchmarked; however, this continues to be developed.

18/166 Finance Report Month 4

18/166.1 The Director of Finance delivered the Finance Report for month 4. Key points to note included:

- The Trust is reporting a £1.4m deficit position in month, compared with a £0.4m planned deficit.
- Actual Pay expenditure has increased from the previous month by £334k, of which, £263k is the estimated impact of the pay award for July relating to substantive staff. The impact of the pay award has been offset by central funding.
- The Pay variance to plan is £996k adverse in month, which is a significant increase when compared with prior months. This is largely due to a £789k step up in CIP targets for pay schemes. The planned corresponding decrease in pay expenditure is not fully evidenced.
- The Trust has not achieved the national Emergency Department performance target for July, and as a result, is not eligible for this element of PSF funding. This has resulted in a loss of £287k of funding for July (now £933k year to date).
- The adverse non pay variance of £422k is largely related to drugs and other activity related spend, as well as an increase in the cost of utilities.
- Pay and non-pay, Medical staffing has seen a c£400k overspend due to booking management.
- CIP performance remains marginally above plan, despite the step up in target in July. However, much of the CIP delivery is as a result of activity/income increases, rather than cost reduction. This may not be sustainable or affordable for the CCG and the Trust must focus on realising savings through cost reductions. 15% of CIPs have been phased in to date with a significant amount outstanding for delivery going forward through to quarter 4 in order to deliver to plan

18/166.2 When the plan was set, Lorenzo implementation did not anticipate the challenges with PTLs which compromised outpatients and theatres across the first three months of the year. Accordingly, the Trust has been over-performing against plan during the recovery period with a significant increase in activity across quarter 2 and quarter 3. Constraint to manage winter pressures must therefore be reviewed.

18/166.3 Mr Silver referred to theatre activity and productivity in relation to

Trauma and Orthopaedic data and he was interested to know how the number of late starts and early finishes will be mitigated. The Director of Finance advised that improved data is now available, an intuitive theatre dashboard and, theatre and Consultant levels have also improved. A theatre efficiency workstream has been established with subsets to review scheduling and theatre utilisation with a focus on Surgical. Improvements have been tracked over recent months; however, an increase in pace to drive forward further procurements is required. Changes will provide increased benefits to patients with regard to waiting lists along with increased treatment being carried out to improve patient experience. The Deputy Chief Operating Officer advised that the Consultant body has been engaged with the changes taking place and supporting the drive for improvements.

18/166.4 The Director of Finance advised that Trauma and Orthopaedics showed significant improvements during August 2018 compared to previous years. This follows improved monitoring of annual leave and activity and resulted in consistent levels of resources. Activity levels must continue to be maintained in order to allow good capacity for winter pressures.

18/166.5 Mrs Schroder enquired whether the PTLs are now functioning. The Director of Finance advised that these have been functioning for the last 3-4 months.

18/166.6 Mrs Schroder referred to the outpatient department and stated that systems must be functioning efficiently prior to the planned changes. The Director of Finance advised that DNA rates have reduced significantly; however, efficiency continues to be reviewed. The Deputy Operating Officer advised that having visibility of DNA levels has had a significant impact. Drumbeats are to take place three times a week to ensure no slippage and appropriate staffing levels in clinics.

18/166.7 Mrs Schroder enquired whether all other planned changes for outpatients are taking place. The Deputy Operating Officer advised that planned changes are gradually being implemented; however, Director Test and One Stop clinics are dependent on funding.

18/166.8 Mr Niven enquired whether CIPs allow time for cost reductions. The Director of Finance advised that the Trust is adequately prepared. The design and planning for 2018/19 programme began in December 2017 and continued through to the first quarter of 2018. All CIPs have been QIA checked and delivery monitored at weekly Executive meetings along with weekly divisional meetings. A strong support structure is also in place.

18/166.9 Mrs Schroder stated that she would like to see a focus on Pay CIPs following the continued increase of staff over the past year. The Director of Finance advised that a Deep Dive would take and report back to Board following the Finance and Performance Committee meeting. **Director of Finance**

18/166.10 Mr Silver referred to theatre activity and requested an update from the last presentation in order to identify progress. The Director of Finance advised that this would be reported to Board following the Finance and Performance Committee meeting. **Director of Finance**

18/167 Performance Report Month 4

18/167.1 The Deputy Operating Officer delivered the Performance Report for month 4. Key points to note included:

- ED - delivery against the 4 hour standard has been a challenge due to high attendance figures. Delays to patient flow out of ED due to bed capacity added to the challenge. The workforce skill mix due to temporary, bank and agency staffing adjustments whilst the booking system was updated also impacted on achieving the standard. Following stabilisation of the booking system, there has been a significant improvement in fill rates. These challenges resulted in July 4 hour ED performance slipping to 84.19%. With a reduction in attendances during early August, together with the implementation of actions following the "perfect week", a sharp recovery of the 95% target is expected in September.
- Cancer - in June 2018 the Trust achieved 2 of the 8 national targets; 31 day subsequent for drug treatments and 31 day first definitive for all Cancers. For the third month in a row the Trust failed to achieve the 2 week wait standard of 93%, mainly due to increasing demand across several tumour sites. Performance against the 31 day subsequent for radiotherapy is delivering against the agreed trajectory at 91.1% and is expected to be compliant with the 94% target in August 2018. 62 day performance for June was 75.4% above the revised recovery trajectory of 71.2% mainly due to a 5.7% uplift post breach sharing.
- RTT - the Trust remains off national reporting against this standard and will return to reporting in November, on October performance. There were 29 active 52 week breaches in the incomplete PTL at the end of July, a reduction of 12 from the June position.
- Stroke - performance against the 4 hour standard has been maintained, demonstrating sustained and consistent performance. Thrombolysis rate at 16.7% was reported with 100% of patients eligible for this treatment receiving it appropriately.
- Bed occupancy – following a meeting with NHSI the target is 92% (the Trust has reported up to 101%). The processing of patients on wards is under review to ensure discharges take place early in the day. From November, a 'bed bureau' will be in place allocating beds to patients prior to arrival. This along with other significant changes will prepare the organisation in readiness for winter pressures.

18/167.2 Dr Buckle referred to the Cancer waiting list, 62day referral and 52 week trajectory and enquired whether the Trust is confident with improvements. The Deputy Chief Operating Officer advised that there remain challenges with Lorenzo and accessing waiting lists; however, a strong data quality team is in place and numbers continue to decrease.

18/167.3 Mrs Schroder referred to the 62 day Cancer breaches and enquired what number of patients this represents. The Deputy Chief Operating Officer advised that she did not have this detail to hand and would provide this information outside the meeting. The number of 62 day patients that are to start treatment will be provided to Board. The Director of Nursing advised that potential Clinical harm has a robust process that is being refreshed across Cancer and non- **COO/ Deputy COO**

Cancer pathways, with input from other Trusts, to minimise harm.

18/167.4 Mr Silver referred to Urology being an outlier for a significant period of time and was interested to know when this would recover. The Deputy Chief Operating Officer advised that there are plans for the end of the financial year involving substantive staff and job plan changes. 31 breaches are around MDTs. She advised that it is anticipated that the Trust will cease to be an outlier by March 2019. Mrs Schroder enquired of the reason for the 31 day surgery failure. The Deputy Chief Operating Officer advised that these breaches are reducing as changes to the pathways are embedded.

18/167.5 The Chief Executive advised that the Chief Operating Officer, Beverley Flowers, Chief Executive East and North Herts CCG, and himself met with Paul Watson from NHS England last month in relation to capacity and demand. A further meeting is to take place next month, by which time it is anticipated that the Trust will be able to evidence improvements.

18/167.6 Mr Niven referred to the 'Perfect Week' and enquired whether transport is a contributory factor for delayed discharges. The Deputy Chief Operating Officer advised that the CCG has the contract for Trust transport and 2 weeks prior to the 'Perfect Week' provisions were changed in readiness for winter pressures resulting in a knock-on affected to the Trust. The Trust has requested visibility of the contract without success and this is now being mitigated. Mrs Schroder stated the issue must be escalated to the Chair of the CCG if mitigation is not successful.

18/168 Workforce Report Month 4

18/168.1 The Deputy Director of Workforce and OD delivered the Workforce Report for month 4. Key points to note included:

- There has been an improvement in the recruitment position with a reduction in the vacancy rate from 8.7% to 8.2%; however, staff in-post numbers are not being maintained against target with the exception of recruitment improvement in medical and nursing groups. With a strong pipeline for clinical areas this is expected to improve.
- Agency spend is under ceiling by £8k year to date. Demand increased in month 4 reflecting operational demands and both bank and agency fill increased in response to this.
- Staff turnover and sickness increased which represent an underlying challenge to be addressed in relation to the level of staff satisfaction.
- Appraisal and training rates are good and rising as Friends and Family Test results improve. The next results will be available October 2018.
- The end of quarter 2 and quarter 3 are critical in relation to workforce efficiencies with challenges in all areas; however, improvements are becoming evident.

18/1682 Mr Silver enquired whether Junior Doctors affect the figures. The Deputy Director of Workforce and OD advised that this is a crude result that will have an impact. Mrs Schroder enquired whether the removal of the Junior Doctors figures would flatten. The Deputy Director of Workforce and OD advised that this was a possibility; however, it would not have the level of impact hoped.

18/168.3 Mr Niven was interested to know whether the Efficiency and Transformation Indicators are expected to continue fluctuating in quarter 3. The Deputy Director of Workforce and OD advised that these should settle by the end of the second quarter following the impact from changes.

18/168.4 Dr Buckle stated that knowledge of themes in relation to sickness and leavers would be beneficial following staff interviews together with the strategy for the next staff survey. The Deputy Director of Workforce and OD advised that he would discuss this further with Dr Buckle outside of the meeting and report back to Board. The Director of Strategy advised that cultural development throughout the organisation is included within the 5 year strategy. **Deputy Director of Workforce and OD**

18/168.5 The Director of Nursing advised that following the government's removal of the bursary scheme a review is underway to assess the impact in relation to the number of Student Nurses applying to join the Trust and how this can be mitigated through the STP. The outcome of the review will be reported back to Board. **Director of Nursing/ COO/ Deputy COO**

18/169 Audit Committee Report to Board

18/169.1 Mr Silver delivered the Audit Committee Report. Key points to note included:

- The latest Internal Audit Progress Report had been received with two final reports issued: Consultant Job Planning and Financial Planning Process. Reasonable assurance was received in relation to these audits and no key actions were identified in relation to the latter.
- The Internal Audit Tracking Report indicated some improvement in terms of overdue actions.
- The Medicines Management update in relation to the Medicines Management Internal Audit action plan highlighted areas of progress and further work. Good progress had been made implementing actions.
- A Data Quality Improvement Plan has been produced and processes are gradually improving with recording errors being identified and corrected. Training is to be provided to reduce human errors.
- There were 29 tender waivers in the period 1 April to 30 June 2018, 12 of which were avoidable. A procurement strategy to manage out a number of recurrent waivers across East and North Herts Trust and West Herts NHS Trust is being developed.
- Recruitment of a permanent Data Protection Officer and Information Governance Officer is due to commence.
- With regard to Freedom to Speak Up, work continues with the development of an open culture. CQC highlighted concerns regarding the lack of awareness of the role by staff and capacity of the Freedom to Speak Up Guardian.

There were no comments from the Board.

18/170 Annual Audit Letter

18/170.1 The Board noted the Annual Audit Letter from the external auditors.

RISK AND QUALITY

18/171 Risk and Quality Committee Report Month 4 (and annual reports - Patient Experience and Complaints)

18/171.1 Mr Niven delivered the Risk and Quality committee report for month 4 together with the annual reports for Patient Experience and Complains. Points to note include:

- Stillbirth Annual Audit / MBRRACE Report - stillbirth rate is lower than the national average. The Trust performed well in offering women post mortems for stillbirths; however, the Trust does not currently meet the requirements for Carbon Monoxide screening during the antenatal period due to scanning capacity.
- Better Births - one key challenge for the Trust is the Continuity of Carer ambition (the ambition being for 20% of women booking to receive continuity by 2019).
- Following the recent CQC report, action plans including key actions arising have been developed for all areas. Key themes are to be communicated to staff. Whilst some actions can be implemented quickly, there are also some that will take longer to fully embed.
- Learning from Deaths Report - crude mortality continued to fall and reported 1.47% for the 12 month period to May 2018 compared to 1.58% for the previous three years. HSMR has reduced to 99.21. SHMI reported for the 12 month period October 2016 to September 2017 at 102.91.
- Infection Prevention and Control report - June performance was good, with no MRSA bacteraemias or Trust allocated C.difficile cases reported.

18/171.2 Dr Buckle was interested to know about the openness of Datex (Trust wide incident reporting system) reporting within the Trust. The Director of Nursing advised that she would update Dr Buckle of the history in this regard outside of the meeting.

18/172 Patient Experience Report

18/172.1 Mr Niven delivered the Patient Experience Report. Key points to note include:

- The report is in the final year of the strategy plan and reflection on the final round is now underway. It was agreed that ambitions are required to be more creative and will be a focus for next year. Ability to achieve ambitions this year is being mitigated.
- The Carers lead has been nationally recognised for their work, launching numerous tools for carers, young carers, patients and volunteers.
- There is a year on year increase of complaints and the themes remain consistent. All complaints are mitigated and support is being provided with learning from cases and themes.

18/172.2 Mr Silver referred to the 3 red and 1 amber indicators and enquired whether these were related to a lack of communication. The Director

of Nursing advised that all Serious Incident are related to poor communications. Consideration is being given to focus on the key aim of addressing communications, both verbal and internal written. Mrs Schroder advised that improvements with technology will support this.

18/172.3 The Director of Strategy advised that the Cancer division is now undertaking significant changes to improve patient experience. A focus within the strategic priorities is to improve ease of access to systems and processes that affect patient experience.

18/172.4 Mr Niven advised that he had been informed that patients trying to contact the Trust by telephone must join a significantly long queuing system which is not good for the patient experience. He advised that improvements to communications would not only improve patient experience, it would also be beneficial to the Trust. The Director of Strategy advised that a text service is now available to patients and has been well received in regard to outpatient appointment reminders; however, this is only accessible once the Trust has made contact with the patient. All communication processes are under review.

18/172.5 Mr Silver noted that nursing complaints have increased from 73 to 80. He was interested to know the reason for this and when numbers will return to the target of 55. The Director of Nursing advised that this is once again related to communications. The 'so what' element is being reviewed and broken down into areas with quality indicators and ward Matrons will be advised of the patient level. Mr Silver enquired when these measures would come into effect. The Director of Nursing advised that a new dashboard would go live by the beginning of October and Accountability Review meetings will support this.

18/172.6 Mr Niven enquired whether n praise for the Trust and staff had been received. The Director of Nursing advised that significant praise is received via various routes; however, this is more of a challenge to evidence. The Chief Executive agreed that this would be a challenge. Mrs Schroder advised that is would be beneficial to capture some of this information.

18/173 Learning from Deaths

18/173.1 The Medical Director delivered the Learning from Deaths report. Key points to note include:

- There has been a reduction in crude mortality which is reported at 1.47% for the latest rolling year to May 2018.
- HSMR and SHMI are as expected with a slight increase at 99.21. HSMR remains within the 'as expected' range, with the Trust's overall position within the region remaining strong at 7th out of 16 Trusts in the East of England. The SHMI has remained stable at 102.9.
- Sepsis national standards have undergone some changes to targets, including new requirements regarding reduction in antibiotic usage. Focus has remained on providing Sepsis training and continuing to raise awareness of the importance of appropriate and timely action regarding the identification and management of Sepsis.
- The 7 Day Services Audit for May 2018 indicated

improvement for patients being seen by a Consultant within 14 hours of admission from 40% to 68%.

- Training for Doctors is taking place in relation to correctly coding information. Joint coding from Senior Clinicians and coders is now taking place.
- In quarter 4, four deaths have occurred of patients with a learning disability. All have been reported to the national LeDeR programme. Two of these deaths have been reviewed with no concerns raised. The remaining two are currently being investigated as Serious Incidents.

18/173.2 Dr Buckle enquired why the Trust is not using the same mortality review process as others Trusts. The Medical Director advised that a number of Trusts use alternative review processes. A review of the Trust's assessment tool and physiology, together with another, was undertaken 2-3 years ago and it was decided that the tool chosen fitted the Trust's mortality reviews and was more cost effective. Although there are some limitations at present, discussions with a third party are taking place to improve its abilities including linking across other organisations.

18/173.3 Dr Buckle advised that deaths from learning disabilities will have increased media attention. The Medical Director advised that these deaths are often patients with severe mental illness. With regard to learning disabilities the Trust has made significant improvements in terms of management and this is reflected in the reduced number of deaths.

18/173.4 Mrs Schroder stated that Dr Foster advised CQC in relation to elevated Sepsis and she was interested to know whether this had had any impact on the Trust's standards. The Medical Director advised that this was prior to the CQC visit. The Company Secretary advised of the need to focus on the Quality Improvement Plan that CQC sighted and raised and was also raised on the monthly report; however, no issues have been proved and therefore the mortality review team were not required to make any further enquiries.

18/173.5 The Medical Director advised that previously a number of patients were labelled as Pneumonia being the cause of death whereas now they are labelled Sepsis. Therefore, the review is very interesting in relation to how the Trust monitors and records patients. The Medical Director advised that although labour intensive, the results provide very informative data.

18/174 Revalidation

18/174.1 The Medical Director delivered the Revalidation report for approval. He advised the Committee that there are now two trained revalidation Officers and the system is robust and fully operational.

The Committee APPROVED the report.

18/175 RAQC Annual Review and Terms of Reference

18/175.1 Mr Niven delivered the Risk and Quality Annual Review and Terms of Reference for approval.

The Board **APPROVED** the changes to the Terms of Reference and the Committee to be changed to the Quality and Safety Committee.

18/175.2 The Board was asked to note that a mid-year review of the Quality and Safety Committee will take place in order to review the impact of the new underpinning governance Committees. The Director of Nursing advised that the new structures are in place from September and they can still reflect comments from the new Chair.

18/176 THE TRUST VISION AND STRATEGIC PRIORITIES

18/176.1 The Director of Strategy delivered the Trust Vision and Strategic Priorities report. Key points to note include:

18/176.2 Now that a Case for Change and vision have been developed the Trust is now responding to the Case for Change from 5 strategic priorities. Engagement has taken place with all Clinical services to develop how they should look in response to the 5 priorities, along with the requirements to achieve this stage of the 5 year strategy. Attendance for the sessions was positive and outcomes from the sessions are now being triangulated within divisions to build into an overall Clinical Strategy. The vision will be informed by divisions, the Director of Nursing and the Medical Director. Finance, Workforce, Estate and the Quality Improvement Board are developing the vision and strategic priorities. Mr Niven advised the Board that the document will be delivered to the Quality and Safety Committee over the coming months. The Director of Strategy advised that this process is also being monitored by the Clinical Strategic Board prior to the Finance and Performance Committee for quality and financial input.

18/176.3 Mrs Schroder enquired how evidence of how stakeholder support and planning through Committees would be evident. The Director of Strategy advised that this will be evident at Clinical Service level. By December, external experts will visit to provide advice, check and challenge plans and the Cancer Alliance, Specialist Commissioning Group and STP will be sighted on the Trust's direction of travel.

18/176.4 The Chief Executive advised that there is a risk in relation to convergence for STP formation which is a significant challenge at present. The Director of Strategy advised that the Trust must have sight of the STPs vision and consider how the two will fit together. The Chief Executive advised that the strategy must be formulated over the next 5 weeks with the STP. Mrs Schroder advised that other providers should be contacted to ensure consistency across Trusts such as Princess Alexandra Hospital. The Director of Strategy advised that the methodology for this is being shared.

18/176.5 Mr Swift enquired whether being in a position to signal commissioning intention by the end of September was achievable. The Director of Strategy advised that the deadline is 28 September 2018 and the detail to the commissioners is high level. The Trust must signal intent to review models by this date.

18/177 BOARD ASSURANCE FRAMEWORK

18/177.1 The Company Secretary delivered the Board Assurance Framework for discussion.

18/177.2 Mrs Schroder referred to risk 7. The risk that the governance structures in the Trust do not facilitate visibility from Board to Ward along with appropriate performance monitoring and management to

achieve the Board's objectives. She stressed the importance that this remains a living document and is scrutinised each month. The Company Secretary advised that all risks are reviewed monthly by Executive leads and then the Quality and Safety Committee (previously RAQC) and Finance and Performance Committee where they are tested. Mrs Schroder requested this to be a focus at the next Board meeting when key controls and assurance controls can be reviewed for accuracy.

18/177.3 The Trust Board reviewed risk 8. There was a recommendation to maintain a rating of 12 with a Core Standards Review being finalised for presentation to the Quality and Safety Committee in October for final assurance. The Director of Strategy advised the Board that a work plan around emergency planning is underway and will culminate in October when this risk can be reviewed by the Board. It is anticipated that the risk will be reduced at this point. Mr Niven raised concern with the scoring method as there appeared to be discrepancies with the scoring and indicators. The Director of Strategy advised that this will be reviewed and factored in.

18/178 MATTERS ARISING AND ACTIONS LOG

18/178.1 The Board reviewed and noted the Action Log.

18/179 ANNUAL CYCLE 2018/19

18/179.1 The Board noted the Annual Cycle for 2018/19.

18/180 DATA PACK

18/180.1 The Board noted the data pack.

There being no further business the Chair closed the meeting at 4.06pm.

Ellen Schroder
Trust Chair

September 2018

	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 2018 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 July 2018	18/141.4	Performance – Cancer	Data to provide details in patient numbers for clarity of the number of patients presenting and that have been diagnosed with the month.	**November 2018:** To be included in the next Performance Report to FPC on 28 Nov.	COO	November 2018
5 Sept 2018	18/166.9	Finance - CIPs	To carry out a Deep Dive into Pay CIPs and report back to Board.		Director of Finance / Chief People Officer	January 2018
5 Sept 2018	18/166.10	Finance – Theatre Activity	To provide the Board with an update on theatre activity.	**November 2018:** Considered at FPC – see FPC summary report. COMPLETE	Director of Finance	November 2018
5 Sept 2018	18/167.3	Operational Performance – Cancer	To provide the Board with data indicating the 'number' of 62 day patients awaiting first treatment.	**Oct 2018:** incorporated into November report. COMPLETE	COO/Deputy COO	November 2018
5 Sept 2018	18/168.4	Workforce – staff interviews	To provide details of themes that appear following staff interviews in relation to sickness and leavers etc.	**30.10.18:** report due to be provided at the 27 November Quality & Safety Committee.	Director of workforce and OD	November 2018
5 Sept 2018	18/168.5	Workforce – Student Nurses	To report to Board the impact of the number of Student Nursing joining the Trust following the government removal of the Student Nurse Bursary.		Director of Nursing/ COO/Deputy COO	January 2019

Board Annual Cycle 2018-19
- A Formal Board is held on alternate months

Items	*Apr 2018	May 2018	*Jun 2018	Jul 2018	Aug 2018	Sep 2018	*Oct 2018	Nov 2018	*Dec 2018	Jan 2019	*Feb 2019	Mar 2019
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 [ii]												
Audit Committee Report		x	x			x		x				
CTC Report	x		x					x		x		
FPC Report [iii]	x	x	x	x				x		x		x
RAQC Report	x	x	x	x				x		x		x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*										x (TBC)		
Development of the Trust's Strategy				x Trust vision				x (TBC)				
Sustainability and Transformation Plan (STP) (Part 2)				x		x		x		x		x

Board Annual Cycle 2018-19
- **A Formal Board is held on alternate months**

Items	***Apr 2018**	**May 2018**	***Jun 2018**	**Jul 2018**	**Aug 2018**	**Sep 2018**	***Oct 2018**	**Nov 2018**	***Dec 2018**	**Jan 2019**	***Feb 2019**	**Mar 2019**
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 – Deferred to November (report due to be considered at AC in October)		x				
Quality Account and External Auditor's Report			x									
Raising Concerns at Work						x						x
Review of SO and SFI								x				
Charity Trustee Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review								x				
Finance and Performance Committee												
Draft Floodlight Indicators and KPIs				x								
Finance Update (Part 1 and Part 2)				x		x		x		x		x

Board Annual Cycle 2018-19
- A Formal Board is held on alternate months

Items	***Apr 2018**	**May 2018**	***Jun 2018**	**Jul 2018**	**Aug 2018**	**Sep 2018**	***Oct 2018**	**Nov 2018**	***Dec 2018**	**Jan 2019**	***Feb 2019**	**Mar 2019**
FPC TOR and Annual Report						X – Deferred to November (report due to be considered at FPC in September)		X				
IM&T strategy review – Stabilisation and optimisation plan (Part 2)				X		X		X		X		X
Market Report								X - Deferred to 27.11.18 FPC		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				X		X		X		X		X
Equality and Diversity Annual Report and WRES						X – Deferred to November (report due to be considered at RAQC in September)						
Gender Pay Gap Report												X

Board Annual Cycle 2018-19
- **A Formal Board is held on alternate months**

Items	***Apr 2018**	**May 2018**	***Jun 2018**	**Jul 2018**	**Aug 2018**	**Sep 2018**	***Oct 2018**	**Nov 2018**	***Dec 2018**	**Jan 2019**	***Feb 2019**	**Mar 2019**
GMC National Training Survey *(subject to change as dependant on national release)*								x (considered at QSC on 25.09.18)				
Health and Safety Strategy Review				x								
Improving Patient Outcomes Strategy				x (See RAQC Report)								
Learning from Deaths		x		x						x		
Nursing and Midwifery Strategy Review												x
Nursing Establishment Review				x						x		
Patient Experience Strategy Review						x						
Nursing - PQAF / Education report										x		
RAQC TOR and Annual Review						x						
Research and Development Annual Review			x (See RAQC Report)									
Responsible Officer Annual Review						x (RAQC)						
Safeguarding Children Annual Review				x								
Patient Safety and Incident Report (Part 2)								x		x		
University Status Annual Report			x (See RAQC Report)									
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [iv]		x		x								x

Board Annual Cycle 2018-19
- A Formal Board is held on alternate months

**Approved at extraordinary AC/Board meeting on 23 May 2018

[i] The Data Pack will include the Friends and Family Test, Health and Safety Indicators, CQC Outcomes, Safer Staffing Data and Infection Prevention and Control Data.
[ii] Escalation reports will be circulated monthly by email for Board member awareness and formally considered at the next public meeting.
[iii] The FPC Report will include the Committee Report, the Finance Report, Performance Report and Workforce Report for the month.
[iv] 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.

The Board Annual Cycle will continue to be reviewed in year in line with best practice and any changes to national scheduling.

East and North Hertfordshire NHS Trust

Chief Executive's Report

November 2018

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1. Corporate Update

Thomas Simons, our Chief People Officer, is to leave the Trust in February next year. Tom has been appointed as Director of Human Resources and Organisational Development at Chelsea and Westminster Hospital NHS Foundation Trust. He has achieved a great deal for the organisation and we wish him well in his new role.

Kate Lancaster, the Trust's Director of Strategy, has been appointed as Chief Executive of the Royal College of Obstetricians and Gynaecologists. After two successful years with the Trust, she will be leaving the Trust in January 2019 to take up her new role in March 2019 to lead this important organisation

It is fitting with the tradition of the Trust that they both have grown and developed here and go in to new roles.

Stabilisation Programme

Finally, a new programme of work is beginning across the Trust. The implementation of Lorenzo had a big impact on everyone and as a result there are variations to how people work in some areas. The Stabilisation Programme has been launched to address this with teams across all our sites.

Highest Recruiting Trust for Research Project

The Trust's research team has recruited the highest number of patients in England to a national study looking at whether a new ultrasound method will help reduce the number of patients needing a diagnostic operation. The study was led at the Trust by consultant head and neck surgeon Mr George Mochloulis and consultant radiologist Dr Kanchana Rajaguru. This is another example of how our teams are working to put innovative patient care first.

Making changes to deliver better outcomes for patients

Working with other trusts and NHS Improvement, the team on ward 6A at the Lister has been involved in a project helping nursing staff and therapists work together in different ways to improve patient experience.

The results were remarkable: length of stay reduced from 4.7 days to 2.19 days, 46% more patients were up and dressed on the ward each day, and there was a 17% increase in patients admitted from home returning back home.

We are now looking to see how what we've learned from the project can be transferred to other wards. Thanks to all involved.

Urology one-stop clinic launched at Lister

A new one-stop urology clinic has been launched at the Lister, which aims to improve patient experience and make the service more efficient. Patients referred to the clinic will have a consultation with a doctor and be able to get diagnostic tests done in a single visit. For patients, this means fewer visits to hospital and a quicker diagnosis. The new clinic will also significantly improve cancer pathway and referral to treatment (RTT) waiting times.

2. Our Staff

Staff Awards

Recognising the fantastic work carried out by our colleagues and volunteers, the Trust's staff awards took place on Friday evening (26 October).

Arranged by the Trust's Charity and the communications team, the awards received over 220 nominations and recognised the dedication of 90 colleagues who have worked at the Trust for 25 years, as well as 24 volunteers who have given their time for over 15 years.

The Charity secured sponsorship from several partners who were also at the event. The award winners were announced as:

- The Friends of Lister Hospital clinical team of the year award - **Special schools nursing team**
- Indigo team leader of the year award - **Ollie Morley, head of IT**
- Patient experience award - **Adam Hazel, trainee nursing associate, bluebell ward**
- Ryalto innovation and research award - **Ana Gaspar, respiratory and sleep team**
- Quality and safety award - **Anne Hunt, senior sepsis nurse**
- Hospital charity fundraiser of the year award - **James Hemmings, oncology nurse**
- The Jane Kasler Foundation volunteer of the year award - **Joan Eames, Mount Vernon Cancer Centre**
- G4S non-clinical team of the year award - **Ganymede patient feeding team**
- Public nomination award - **Denny Cody, midwife**

Enhanced nursing care team shortlisted for national award

The enhanced nursing care team has been shortlisted for the Our Health Heroes Workforce Planning Team Award.

The team has introduced a robust process for enhanced care and specialling. This improves the quality and experience of care our most vulnerable patients receive by using an innovative, specially trained, flexible team. The Trust has also seen a significant reduction in agency spend for specialling and is recognised nationally as a best practice service.

Agenda Item: 9 (a)

TRUST BOARD – 7 NOVEMBER 2018

FINANCE AND PERFORMANCE COMMITTEE – 26 SEPTEMBER 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Finance and Performance Committee (FPC) meeting of 26 September 2018
PREVIOUSLY CONSIDERED BY	
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:	SEPTEMBER 2018

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 – 26 SEPTEMBER 2018

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 7 NOVEMBER 2018

The following Non-Executive Directors were present:
Jonathan Silver (on behalf of FPC Chair), Ellen Schroder (Trust Chair) and Bob Niven (for part of the meeting).

The following core attendees were present:
Nick Carver (Chief Executive Officer), Jude Archer (Company Secretary), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer) and Kate Lancaster (Director of Strategy).

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 at this meeting.

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

Financial Recovery
Reports received:

- Finance Report Month 5
- CQUIN update
- Reference Cost Submission 2017/18
- Theatre Productivity Update Assessment
- Service Line Deep Dive - Cancer

The FPC considered the Finance Report for month 5. The overall month 5 income position is a favourable variance of £4.7m but this has been offset by overspends on pay and non-pay. Although the SLA income is over performing the income target for private patient activity is £0.4m behind plan. Activity for August was improved on the same period in 2017 due to advanced planning that allowed for a consistent level of resources during the annual leave period.

The FPC discussed CIPs and the need for a greater focus throughout the Trust to ensure increased delivery for Q2, Q3 and Q4. The plan is below target by £0.8m for the year to date raising concern when the target for the year to date accounts for only 28% of the overall annual target and at month 5 the Trust is 42% of the way through the financial year. This reflects the Trust's expectation that savings delivery will escalate as the year progresses; Increased challenges will be present for Q2, Q3 & Q4 as the CIP plan is weighted with significantly increased targets during these periods. The Trust will also be required to provide evidence for over performance to the commissioners.

The FPC discussed the CQUIN Assurance update and noted that the Trust is on trajectory for Q1 of 2018/19.

The FPC discussed the Reference Cost Submission for 2017/18 which is, in summary, c4% more expensive than other Trusts. Data from this will be built into the strategy programme going forward and used to inform future CIP programmes. The Committee requested a work plan and to be kept informed of progress/changes.

The FPC received a detailed Service Line Deep Dive from the Cancer speciality. The division acknowledged they have a number of challenges. Pathways have been reviewed and redesigns are taking place. Review meetings are in place to ensure that actions meet target dates. Monthly Cancer Board meetings are also scheduled to take place and will be chaired by the Cancer Divisional Chair. Although many positive actions have taken place, the division

acknowledges that further actions and improvements are to be undertaken with progress becoming evident by October 2018 which is reported in December.

The FPC received a Theatre Productivity update Assessment from the Divisional Director for Surgery. Theatre utilisation continues to be a key focus with plans being driven forward. The data for late starts and early finishes was noted as a focus for improving productivity further. Clinical engagement has been recognised as a key driver to delivery which assumes greater efficiencies during the remainder of the year. Divisional Director is leading the programme. YTD, better vacation planning, an increase in the depth of coding and more attendances had led to improvements and the division is confident that it will achieve plan once further efficiencies are implemented over the coming weeks. Weekly monitoring will be taking place to support progress. The FPC requested an update of progress at the end of Q4.

Operational Performance

Reports received:

- Performance Report Month 5
- Strategic Update - Cancer
- Floodlight Scorecard Month 5

The FPC received the Performance Report for month 5. ED 4 hour performance is reporting at 87.6% month to date. Paediatric and minors performance remain strong at 96% and 98% respectively. Expectation from NHSE/I is that both these cohorts will be delivering at 100% compliance. Attendances were down in August 2018/19 in comparison to July 2018/19 by approximately 1k patients. During August there have been workforce challenges in relation to the provision of a consistent skill mix and medical rota which is being mitigated. Two ED Consultants have been appointed and will take up post by the end of October.

Cancer performance achieved 4 of the 8 national targets in July 2018. The Trust has returned to compliance for the 2 week wait standard of 93%. Performance is expected to exceed the 93% target for August going forward. 31 day subsequent for radiotherapy exceeded against the agreed trajectory of 89.9% and the target of 94% with 94.1% and compliance is expected to be maintained going forward. Due to the significantly higher volume of breaches treated in month, 62 day performance for July was 66.9%, which is below the revised recovery trajectory of 69.5%.

Cancer has been operating with 3.5 consultants less than plan but expects 3 to start in October. Cyber Knife is operating below plan due to the loss of a referral pathway.

Deep Dive on Key Performance Measures – ED 4 hour Target

The FPC received a detailed Deep Dive from the ED team. It was noted that breaches had been overstated therefore understating past performance by an estimated 2 to 3%. Following the redesign of the ED pathway, the 4 hour target is beginning to show signs of improvement and has reported above 90% in the past week although it was noted that there had been a reduction in referrals to the GP from the front door streaming process from a few months ago. The challenge is to sustain the recent overall improvement. Work continues to make further improvements. Resources are being reviewed to enable staff to maximise their skill base within the department.

Strategic update – Cancer

The FPC received a strategy implementation update from the Cancer division. There have been significant operational challenges with the workforce and pathway redesign which has resulted in changes to the strategic priorities. A Delivery Group has been implemented and will be chaired by the Director of Strategy at MVCC.

Floodlight Scorecard
The FPC noted the Floodlight Scorecard and discussed the variation in the mortality rate. It was noted that following improvements with coding there has been a rise in SHMI; however, HSMR improved in the latest release.

Strategy
Reports received:
- Strategic Projects Report
- New Strategy Development Programme Highlights Report
- Clinical Strategy Guiding Principles

The FPC noted the Strategic reports.

Support Strategies
Reports received:
- Workforce Report Month 5
- Digitalisation Strategy - Stabilisation and Optimisation Report

The FPC received the Workforce Report for month 5. The Committee noted the following trends: the Trust's vacancy rate increased in month 5 predominantly as a result of a high turn-over of staff. Improved levels of sickness resulted in the Trust being back on target with the planned improvement trajectory. Improved scores in both areas of the Friends and Family test indicate a positive change in staff engagement and culture. The FPC noted that the Trust's utilisation of temporary staff has increased; however, following a recruitment drive it is anticipated that improvements will be evident for October reporting. The Trust is still reporting ahead of plan in relation to the agency target. Sickness continues to improve and remains on trajectory.

Digitalisation Strategy – Stabilisation and Optimisation Report
The FPC received an update on the Stabilisation and Optimisation programme. A third party provider has now been appointed to support implementation of the next stage of the stabilisation programme and mobilisation of the Optimisation plan is now taking place. A successful launch of the ERS system took place on 31 August which was supported by CCG. All GP practices are compliant and a minimal number of referrals have been returned. All actions raised have now been closed and Steering Group meetings and Operational Group meetings are taking place. A bespoke training programme continues to be delivered throughout the Trust.

Reports noted by the Committee:
- **Board Assurance Framework update**

The FPC approved the changes and the risk rating was agreed.

Financial Forecast and Improvement Plan
The FPC discussed the latest Financial Forecast and Improvement Plan in detail. This will be discussed further at the Divisional Executive Committee and the next Board Development meeting.

Jonathan Silver
on behalf of Committee Chair
26 September 2018

East and North Hertfordshire NHS Trust

Agenda Item: XX

TRUST BOARD – 7 NOVEMBER 2018

FINANCE AND PERFORMANCE COMMITTEE – 31 OCTOBER 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Finance and Performance Committee (FPC) meeting of 31 October 2018
PREVIOUSLY CONSIDERED BY	
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:	OCTOBER 2018

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 – 31 OCTOBER 2018

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 7 NOVEMBER 2018

The following Non-Executive Directors were present:
Jonathan Silver (FPC Chair) and Ellen Schroder (Trust Chair).

The following core attendees were present:
Nick Carver (Chief Executive Officer), Jude Archer (Company Secretary), Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer), Mike Chilvers (Medical Director) and Tom Simons (Chief People Officer).

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 at this meeting.

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

BAF
The FPC went over the BAF risks acknowledging that the October papers covered the key risks allocated to the FPC for monitoring, except for Risk 12 (development of MVCC) and Risk 13 (the impact of BREXIT) which would not be covered in any detail at this meeting but would be in the November meeting.

A number of targets for the risks identified would be updated to reflect the current position.

Financial Recovery
Reports received:

- Finance Report Month 6
- Outturn Forecast and Financial Improvement Plan
- Service Line Deep Dive – Medicine
- Workforce Report Month 6
- STP Medium Term Financial Plan

The FPC considered the Finance Report for month 6. Reported position is a deficit of £12.2m against a plan of £10.8m, thus an adverse variance to plan of £1.3m. The year to date position excluding the impact of provider sustainability funding (PSF) is a small favourable variance to plan of £0.2m. The overall income position shows a favourable variance of £5.2m year to date. SLA activity accounts for a £5.8m income over performance offset in part by a £0.6m shortfall against plan for private patient income.

The FPC considered the Outturn Forecast and Financial Improvement Plan update. Further forecasting has been carried out regarding assumptions and mitigations resulting in a forecast deficit gap of c£10m. The forecast has been shared with NHSI. NHSI have attended a number of meetings to observe how the Trust is planning to improve financial delivery. Feedback from NHSI was positive as they can identify that activity is taking place towards mitigating the deficit against the plan.

The FPC received a Service Line Deep Dive from the Medicine division. The division's income is above plan by £2.9m YTD; however, higher income is offset by higher pay and non-pay costs. The pay CIP is a significant challenge with regards to medical and nursing staff . Although recruitment is good, there is a high turnover of staff which the Division is working hard to address.

The FPC considered the Workforce Report for month 6. It is anticipated that the medical trajectory will be achieved and return to plan for permanent recruitment; however, nursing staff

is proving a challenge with regard to registered nurses. Temporary staffing position is positive with a continued reduction in numbers. Retention is also beginning to show signs of improvement.

The FPC agreed that the STP Medium Term Financial Plan was a matter for the Board as a whole and would be discussed at the November Trust Board meeting, part II.

Operational Performance

Reports received:

- Performance Report Month 6
- Floodlight Scorecard Month 6
- Deep Dive on Key Performance Measures - RTT

The FPC received the Performance Report for month 6. An update on the Emergency Department action plan to address internal and external factors affecting performance was discussed. The plan anticipates improvement through the acute pathway re-design and emergency village. September performance reported 87.28% lower than the trajectory of 90%; however, between 20 September and 7 October cumulative performance was above 90%, with some days reaching 94%. Attendances in September were slightly increased on August at +462. Since 8 October performance has deteriorated with month to date performance of 85.3% (trajectory 90%) but this was beginning to improve again. The Committee were informed of a recent 12 hour trolley breach where the patient should have been moved to CDU but the escalation policy had not been enacted. Assurance was provided that the patient received the appropriate care during this time and learning from this was been undertaken.

In August the Trust achieved 4 of the 8 national targets for Cancer performance with the average wait for first appointment now at 10 days. The 2 week wait standard has been maintained for July and August. Reported 62-day performance for August was 76.7% pre-breach/compliance sharing and 78.5% post, above the revised recovery trajectory of 70.2%. For the first time in a number of months (excluding Urology) the Trust is compliant at 85% and this has been noted by CCG. The Committee noted the current work on capacity and demand modelling will be reported through to the FPC with recommendations in December 2018.

The Trust remains off national reporting against the RTT standard and is scheduled to be reporting in November (on October performance), subject to continuing improvements in data quality. The Trust remains off national reporting against the Diagnostic standard but remains committed to a return to reporting of the DM01 position in November on October performance. Stroke performance for September indicates an improvement against the 4-hour standard compared to the previous month but is still only amber and not green. The Committee noted the Stroke action plan to support further improvements.

The FPC noted the Floodlight Scorecard. The new draft Integrated Performance Report will be presented to the November Board Committees.

Deep Dive on Key Performance Measures – RTT

The FPC received a detailed Deep Dive from the Operations Consultant. Evidence of a significant improvement, largely due to a step-up in data quality and indicating that the majority of services are now compliant, reporting above the national average and some above the required standard. The Committee discussed the areas that remain challenged, the need to further engage the Operational team to drive performance to the next level and the need for effective demand and capacity modelling. The active 52 week breaches have reduced slightly to forty and these are actively managed and tracked daily by the operational teams and weekly by the Access Board but will need to come down much further and be eliminated to meet the March 2019 deadline of zero breaches.

Support Strategies
Reports received:

- Digitalisation Strategy - Stabilisation and Optimisation Report

The FPC received an update on the Stabilisation and Optimisation programme. Stabilisation launched on 23 October 2018. This was a week behind plan however, the FPC were advised that the programme will run to schedule. Clinicians are now being shadowed ("elbow to elbow") to allow designers to observe the day to day practice and to assist with the system redesign. Staff engagement is generally positive. The Committee requested future reports to include examples of how things are improving and the outcomes of the users' feedback taken through the design authority.

Strategy
Reports received:

- Strategic Development Programme & Report from Strategy Programme Board

The FPC noted the significant progress made in engaging the clinical staff in review of the clinical strategy and developing the Trust's new Five Year Strategy to September.

The timeline for the delivery of the Strategic Development Programme has been reviewed as the IFD (improving financial delivery) meetings are placing competing demands on management and clinical resource. It was proposed that:

- Production of a narrative Trust Clinical Strategy during November for testing with staff, patients and key stakeholders during December, prior to Trust Board approval in January 2019
- Further refinement of clinical directorate Directions of Travel in the round with external specialty experts, workforce, quality, finance and PMO input; this will inform the development of more detailed, quantified clinical directorate and divisional clinical strategy priorities in line with the development of the Trust's Operating and Financial Plans for 2019/20.

The FPC acknowledged this revised approach but emphasised that all possible steps should be taken not to lose the benefits of the the recent clinical engagement in this process.

It was also recognised that further work will need to be undertaken to consider the workforce model and financial planning in line with the proposed National tariff changes.

Reports noted by the Committee:

- **Board Assurance Framework update**

The FPC briefly reviewed the Board Assurance Framework following a new format to the FPC. Risks are to be considered at the beginning of the meeting and risk ratings reviewed following agenda discussions. The Committee endorsed the changes.

- **FPC Annual report and review of Terms of Reference**

The FPC noted the report for discussion and approval at the November Trust Board.

Jonathan Silver
on behalf of Committee Chair

31 October 2018

East and North Hertfordshire NHS Trust

Agenda Item: 9.1

TRUST BOARD PART 1 –7 NOVEMBER 2018

Finance and Performance Committee Annual Report 2017/18

PURPOSE	To present the FPC Annual Report for 2017/18 and Terms of Reference for approval. The report is designed to provide an overview of the Committee's operation, demonstrating the extent to which it has met its Terms of Reference.
PREVIOUSLY CONSIDERED BY	FPC
Objective(s) to which issue relates *	[X] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [X] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [X] **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 and assurance processes.
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is in line with best practice in corporate governance.
CRR/Board Assurance Framework	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED

For approval	✓	For decision	
For information		For discussion	

DIRECTOR:	Chief Executive
PRESENTED BY:	Company Secretary
AUTHOR:	Board Committee Secretary / Company Secretary
DATE:	November 2018

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
Annual Review 2017/18

Executive Summary

The Finance and Performance Committee (FPC) is a key assurance Committee of the Trust Board. As set out in its Terms of Reference, the purpose of the FPC 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 achievement of financial targets, business objectives and the financial stability of the Trust. The Committee reviews and monitors financial plans and their link to operational performance, oversees financial risk management, provides scrutiny and approval of business cases and the capital programme and maintains oversight of the finance function, key financial policies and other financial issues that may arise. The Committee also oversees the IM&T strategy transformation programme which has a focus toward improving data quality and hospital efficiency to ensure the Trust is prepared for the major financial challenges facing the NHS.

This is the annual review of the FPC which considers how it has met its duties under its Terms of Reference. A review of the Committee's minutes, its reports to Board, a review of the Trust's Standing Orders and Scheme of Delegation and a self-assessment survey of the effectiveness of the FPC was completed by Committee members and attendees and were used to inform this report.

This review concludes the Committee has met its duties and continues to provide challenge, recognising that in considering overall financial performance the Committee moved to a focus on Operational Performance to increase the Trust's activity and income. Appendix 1 sets out the revised FPC Terms of Reference for consideration by the Board. Please note that the responsibilities for data quality, Sustainability Development Management Strategy and the Guardian of Safe Working moved to the Audit Committee in 2018/19.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- To continue to strive for a greater focus and effective scrutiny of performance and data quality and IM&T.

- Short reports providing an overview of agenda items would allow for greater discussion time.

- Scrutiny and approval of business cases and oversight of the capital programme require greater focus in order to provide clarity.

The Board is asked to:

- Note the report and consider and approved the revised terms of reference.

Summary of Key Findings

Meetings and Membership
The FPC met monthly during 2017/18, with the exceptions of May 2017 due to a major internal incident and August when no Board Committees were routinely scheduled. All meetings were quorate under the current Terms of Reference. During 2017/18 Julian Nicholls retired as Chair of the Committee following the July FPC meeting and Nick Swift was appointed the new Chair of the Committee on 20 November 2017. Alison Bexfield, Non-Executive Director, retired from the Committee at the end of January 2018 and was replaced by Jonathan Silver who was appointed on 16 October 2018.

Although the NED membership has remained consistent, there have been a number of changes to the Executive team and therefore changes to the Committee with three of the key core attendees - Chief Operating Officer, Director of Nursing and Medical Director. These are reflected within the Trust annual report.

The new Chair has introduced a number of changes to the Committee. The FPC now has a monthly 'Deep Dive' presentation from a Division with the Trust to monito and support progress and improvements. Divisional allocation is on the annual cycle although this is subject to change if a Division comes to the Committee's attention.

Following a referral from the Audit Committee, after the cyber-attack, in February 2018 the Lorenzo Stabilisation programme has become a significant focus for the Committee.

The efficacy of the FPC has, once again, been assessed by sending a questionnaire to Committee members and others who regularly attend meetings. Invites to complete the survey were sent to the 12 members of the Committee and regular attendees. Responses were received from 4 people. Key findings were:

- The agenda and annual cycle have improved since last year following a review; however, there remains scope to streamline the agenda to enable the appropriate time allowance to all items ensuring adequate focus.
- Discussions have become more open with all Committee members taking part and feeling comfortable to challenge other members of the Committee and the Trust.
- Discussions on the medium and long term financial strategy and strategic financial risks are improving and will become stronger once the strategy is developed. Financial plans are discussed in depth whilst consideration is given to the risks.
- Summaries of discussions and conclusions are improving; however, there remains scope for more clarity.

Following the 2017/18 survey and comparing to results from the 2016/17 survey, four areas have been reviewed and developed and identified to support the strengthening and effectiveness of the Committee:

- Revision of the agenda and annual cycle
- In depth discussions of the financial plans and risks
- Discussions allow confidence for members to challenge
- Monthly 'Deep Dives' from Divisions

The Committee can evidence that it has met its responsibilities as set out in the Terms of Reference in the following ways:

Key Financial Areas

<u>Finance Planning</u>
The Trust continued to experience significant financial challenges in 2017/18. The Trust reported a year end position of a £27.3m deficit, excluding impairment and inclusive of STF. This represented an adverse variance of £19.6m to Control Total Plan. Exclusive of STF the reported deficit was £28.6m which represented an adverse variance to plan of £10.7m. The

year end position was an improvement on the forecast position. The actual outturn of £28.6m excluding STF compared with the forecast of £29.9m on a similar basis. This was predominately driven by stronger than anticipated activity throughput during March combined with an earlier than expected de-escalation of unplanned winter pressure expenditure. CIP performance during March was below plan, but was broadly in line with forecast.

Financial Reporting
The FPC monitored monthly variances to forecast for income, pay, non-pay expenditure, monthly cashflow and capital positions. Financial risks were also monitored on a monthly basis.

Financial Planning 2017/18 and 2018/19
The FPC considered and approved the final budget of the financial plan 2017/18 and continued to vigorously monitor monthly updates on the plan.

Floodlight Scorecard
The FPC continued to monitor the Trust's monthly floodlight scorecard in detail. Although a business intelligence model has progressed a revised dashboard that enables targets and monthly accumulative trajectory reports in order to provide greater detailed information remains partially complete. This is due to a number of competing priorities along with changes within both the information team and operationally. Progress on the development of the new integrated performance report is now a focus for 2018/19.

Agency Expenditure
The FPC continued to undertake a robust scrutiny of the monthly agency expenditure. The Trust ended the year with £12,424k expenditure on agency which was £4,256k under the agency ceiling target for the year (positive variance of 26%). The 'Bank Network' is now embedded with three Hertfordshire Trusts and a review is now taking place in relation to how this could be expanded further including a review of the software available to facilitate the scheme.

Income Recovery
The FPC continued to receive regular updates on the Income Assurance Plan for revenue capture and recognition. Income recovery would continue to be a key area of scrutiny in 2018/19 with Grip & Control being key.

The Pathology Partnership (TPP)
The FPC has continued to oversee transition plans for tPP. CCG are requesting a networked scheme which is currently under review by the CCG, the Trust and local partnerships.

IM&T Strategy/Lorenzo Stabilisation
The FPC continued to monitor development of the Trust's IM&T Strategy together with possible risks. The Trust experienced an internal major incident in April 2018 due to hardware failure. This was mitigated at a nominal cost. In January 2018, following the migration of Lorenzo, an Interim Stabilisation Director replaced the Chief Information Officer to undertake the stabilisation and optimisation stage of the Lorenzo and Nervecentre project together with the support of external agencies.

Procurement
The FPC continued to monitor progress against savings targets, tender waivers and key strategic tenders. A Procurement Group has been established to ensure compliance with the Model Hospital, Financial Recovery and Financial Improvement Plan. Divisions are identifying where changes to leases can be made and ensure they are up-to-date and relevant and whether alternative options are available at a reduced cost.

CIP Performance
The CIP programme continues to be monitored closely. The Trust has delivered £19.5 savings year to date against a full year plan of £23.3m. This represents an adverse variance to plan of £3.8m. The overwhelming majority of the CIP over-performance is concentrated on the schemes within the 'Model Hospital' portfolio. The Theatre and Outpatient efficiency schemes in

particular are not delivering to the level anticipated. There continues to be weekly Information Assurance meetings and CIP meetings.

Further key financial areas of scrutiny included:

- Regular meetings with NHSI continue to ensure that an effective recovery programme is in place and being actioned;
- Continued monthly progress reports on Data Quality have taken place; however, it was agreed that this will now be monitored by the Audit Committee;
- The Trust's Financial Improvement Programme 2017/18.

Performance

The FPC scrutinised performance data during 2017/18. Key headlines included:

- ED Performance
  At 2017/18 year end ED Performance indicated continued improvements reporting 80.21% against the 95% standard, national performance across NHS England was 84.6%. The Trust did not achieve the 4 hour A&E standard, delivering 80.21% against the national standard of 95%. Following publication of the technical guidance for the 2018/19 Acute Contract, the Trust is required to achieve a minimum of 90% by September 2018 and 95% by March 2019, against the A&E standard. With the Acute Pathway Transformation and continued work within the Divisions, continued improvements are expected for 2018/19.

- RTT Performance
  Following the implementation of Lorenzo and the redesigning of PTLs the Trust was unable to begin reporting until April 2018 and the Trust continues to work towards returning to national reporting by November 2018, reporting on October 2018 performance, subject to the ongoing stabilisation programme. Although the Trust is off national reporting, there are a number of patients that have exceeded the 52 week wait for treatment from referral. Using the incomplete PTL from 11 April the Trust confirmed that a total of 80 patients had waited over 52 weeks from referral for their first definitive treatment and of those, 45 of the patients have subsequently been treated or their pathways closed, 35 patients continue to wait for treatment. With regard to ambulance handover time the Trust continued to be the highest achiever nationally.

- Stroke Performance
  ENHT achieved a SSNAP A rating, despite a reduction in 4 hoor performance during the winter period. Improvement in Thrombolysis rates and reduction in time to Thrombolysis have helped to retain the A rating. There has been a significant improvement in 4 hour performance to 77%. ENHT is the busiest HASU in the East of England seeing more confirmed strokes per month on average.
  The Trust's 60 minute to scan performance has improved. In May, the service introduced Stroke Nurse Specialist CT Scan requesting and this contributed to the improvement. The trial is due to complete at the end of July and will be evaluated.
  The Trust continues to successfully send patients to Charing Cross for Thrombectomies. This is soon to become a 24 hour service. Patients who have had Thrombectomies have had excellent outcomes.
  Once Red to Green was embedded it led to greater bed turnover and reduction in length of stay, particularly for patients over 20 days. The Early Supportive Discharge service is well established supporting more patients back to their own home and also contributes to the length of stay improvements.

- Cancer Performance
  The Cancer Division has been unable to report performance against the RTT standard following the Trust's migration to Lorenzo. PTLs are being redesigned and it has been agreed with NHSI that the Trust will return to reporting in November 2018 on October 2018 data. Delivery of standards has varied throughout the year. This is partly due to the level of

Data Quality following the migration to Lorenzo and partly to Divisional resources. Both are in the process of mitigation and it is anticipated the Trust will be achieving trajectory during the coming year.

- Theatre Usage
  The utilisation of Theatres and the Theatre Pathway continue to be developed. A review of resources is also being undertaken to ensure consistency of quality, activity and performance throughout the year.

- Data Quality Metrics
  The Committee has closely monitored the Data Quality metrics throughout the year. The migration of Lorenzo highlighted a significant challenge to validate patient pathways and ensure the need for correct data entry. Since the new Head of Data Quality has been in post mitigation of this has been taking place and significant progress has been made.

Junior Doctor Contract

- The FPC continued to monitor the Junior Doctor Contract on a quarterly basis.

Workforce

The FPC scrutinised Workforce data during 2017/18. Key areas of focus included:

- Temporary staffing, including the successful development of the 'Bank Network' which resulted in the Trust ending the year with a £12,424k expenditure on agency which was £4,256k under the agency ceiling target for the year (positive variance of 26%). Following the success of the 'Bank Network', it is now being expanded geographically. 'Agency Free zones' have now been established within the Trust.
- The vacancy rate ended the year at 8.4% (469.7 WTE).
- Managing sickness absence undertook a significant review and an action plan was developed that included the launch of a revised policy that provides a more consistent and robust framework for managing sickness absence. The new policy was launched on 26 March 2018.
- Following the positive 2016/17 Staff Survey, the 2017/18 Survey saw a significant decline putting the Trust in the bottom 20% nationally. This is being mitigated and a Survey Action Group has been established to respond to staff comments together with 'Online Staff Survey Workshops' open to all staff and themes for improvements have been identified.

Under the Workforce Efficiencies Plan, the MARS scheme (Mutually Agreed Redundancy Scheme) was established and took place in January 2018. The scheme was for specific areas within the Trust and enabled a significant reduction in pay expenditure.

A new Leadership, Management and Coaching Development Pathway (LMDCP) was launched in January 2018 to improve attrition figures.

Other duties

Market Report
The Committee received quarterly market reports providing a summary of the Trust's market and competitive position, including the possibility of the negative impact of Urgent Treatment Centres on ED performance. Following the agreement of the FPC, the Market Report is now utilised in a greater capacity as a forecasting tool that supports operational strategic decisions and responses.

Strategic Projects and Sustainability
The FPC has been monitoring the development of the Trust's new 5 Strategic Plan (including sustainability) and endorsed the new 'Vision'.

BAF and Corporate Risk Register

Following the agreement of the FPC the BAF and Corporate Risk Register is now monitored on a monthly basis to ensure it remains a 'live' and up to date register.

Reporting Arrangements

The Committee considered financial, performance, Workforce and strategic information through individual reports at each meeting. The Committee Executive Summary reports to Trust Board demonstrated that it the Committee has monitored key areas, including risks to the Board after each meeting.

The FPC Actions Log provided a clear audit trail of agreed actions together with closure of those actions. It was monitored by the Committee at each meeting. Actions referred to FPC by Trust Board and the Audit Committee were added to the FPC Actions Log and monitored through to completion by the Committee.

Conclusion

The overall conclusion was that the Committee had discharged its duties under its Terms of Reference during the year 2017/18 but recognises it should continue to enable balance of time across all agenda items by members submitting succinct summary papers. The FPC Terms of Reference were last reviewed and approved in July 2017 and have been updated to reflect this.

A suggestion to extend the length of meetings was made; however, the Committee felt that this would not be an efficient use of time. The new Chair has amended timings on the agenda to address this and the Committee has agreed to confer outside of meetings more regularly.

The minutes demonstrated clear challenge and questioning to gain assurance. Progress throughout the year was well documented and discussed at Trust Board and FPC meetings.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- Reduce the length of reports submitted to enable a greater focus on discussions to ascertain the route forward.

- Continue to enable greater focus and more time to ensure effective scrutiny of performance, Data Quality and IM&T.

The Board is asked to:

- Note the report and consider and approved the revised terms of reference.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

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 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.

2. Status & Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

Chief Executive
Director of Finance
Chief Operating Officer
Director of Strategy
Chief People Officer
Medical Director *(moved to core attendee)*
Company Secretary

Attendees:

Director of Nursing
Chief Information Officer/ Stabilisation Director
Deputy Director of Finance

All other Non-Executive Directors/Directors are welcome to attend.

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either:

- Director of Finance or in their absence
- Chief Executive and a designated Finance representative

5. Frequency of meetings

The Committee will meet every month with the exception of August. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities

To determine or approve:

- The Trust's Marketing strategy and review and monitor progress against this;
- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To recommend to the Board:

- The Trust's Integrated Business Plan, develop and approve a financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy and the Long Term Financial Model and recommend its adoption to the Board;
- Approve proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities and recommend to the Board;
- Receive the annual plan and budgets for revenue and capital and recommend adoption by the Board;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- Recommend the Cost Improvement Programme to the Board and refer any potential concerns on quality to the Quality and Safety Committee for scrutiny.

To monitor and review:

- Enabling strategies and their impact on the Medium Term Financial Strategy and the Long Term Financial Model;
- The capital programme and work of the Capital Review Committee;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- The performance of Divisions and Services;
- Progress against the Sustainability and Transformation Partnerships;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:

- A Treasury Management Policy including delegated arrangements and recommend its adoption by the Board.

To monitor and review:

- Reports as appropriate from the Director of Finance on transactions undertaken on behalf of the Trust.

6.3 Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHSI Single Oversight Framework. This review should include:

To determine or approve:

- In conjunction with the Audit Committee agree the timetable for the Annual Accounts and receive the External Auditors report and review and monitor the associated action plan.

To recommend to the Board:

- The application of contingency funding where appropriate;
- A review of the performance of the Trust against the NHS Improvement (NHSI) Oversight Framework and other national targets and local priority measures on the Trust's Integrated Performance Report.

To monitor and review:

- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects;
- To monitor the benefits realisation of major projects.

6.4 Other duties

To recommend to the Board:

- The Information Management and Technology Strategy and monitor the implementation against the implementation plan.

To monitor and review:

- The people/workforce strategy and key indicators in relations to finance and performance;
- Procurement activities, progress against savings targets, tender waivers and key strategic tenders.

6.4 Financial Risk Reporting

The Committee will regularly receive financial risk register reports for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting.
It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- FPC annual evaluation and review of its terms of reference.

9. Support

The Company Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

Reviewed July 2018.

East and North Hertfordshire NHS Trust

Agenda Item: 9.2

TRUST BOARD PART I – 7 NOVEMBER 2018

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	☐

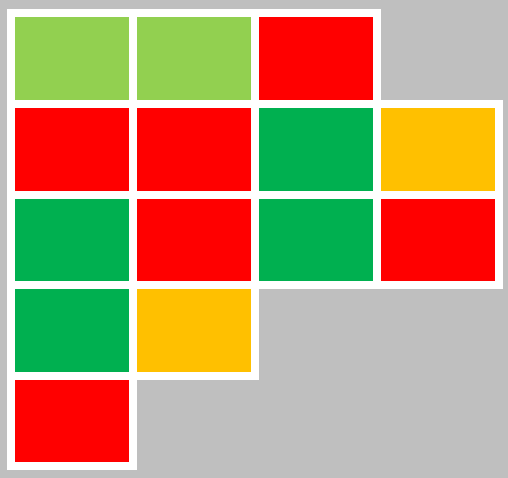
DIRECTOR:	Director of Finance
PRESENTED BY:	Director of Finance
AUTHOR:	Director of Finance
DATE:	November 2018

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 - 2018/19

Mth 6 - Finance Report - Commentary

EXECUTIVE SUMMARY

- The Trust's reported position at M6 is a deficit of £12.2m against a plan of £10.8m, thus an adverse variance to plan of £1.3m. The year to date position excluding the impact of the provider sustainability funding (PSF) is a small favourable variance to plan of £0.2m.
- The overall income position is a showing a favourable variance of £5.2m for the year to date. SLA income is responsible for a £5.8m overperformance but the impact is reduced owing to a £0.6m shortfall against plan for private patient income.
- Pay is currently showing a £2.0m adverse variance to target, £1.7m of which relates to medical staffing, despite the fact that the impact of the 18-19 medical pay award has yet to be included in the position. (This is in accordance with NHSI instructions.)
- It should be remembered that the planned position at this point of the year is a sizeable deficit, owing to the phasing of the activity/income and savings expectations. The plan anticipates that the second half of the year will see a significant increase in CIP delivery and a rise in SLA income, to bring the Trust back to the agreed control total by the end of the financial year. This means that the focus for the remainder of the year needs to be on delivering the planned activity and driving through cost reductions and CIP delivery.

KEY MONTH 6 ISSUES

- The Trust has failed to achieve the A&E element of the PSF funding for Q2. Whilst this does not impact upon the measurement of the control total excluding PSF it does mean that the overall control is not met. It also means that the Trust does not recieve the cash funding associated with this performance measure.
- Pay expenditure continues at previous levels but pay CIPs have not been achieved, this has resulted in a significant adverse variance to plan - £0.6m for the month.
- Savings delivery continues to fall sort of target. The impact of shortfalls in pay efficiencies are being offset by sizeable over performance on income / activity delivery.

EXCEPTIONAL ITEMS

- In M6 an amendment was made to the centrally approved funding for the Agenda for Change pay award. This resulted in a reversal of a previous deduction from the funding stream related to a Department of Health 'scaling factor'. The result being additional income of £10k, for the year, £53k for the year to date.

Mth 6 - Finance Report - Commentary

SLA INCOME PERFORMANCE

- SLA income showed a year to date overperformance at M5 of £5.8m, which is an increase in over performance from last month of £0.6m.
- Activity for both non elective, elective and outpatient follow up activity maintained the run rate exhibited since M2.
- T&O income is showing an over performance for elective inpatients and day cases of £644k. The casemix of activity being undertaken is also more complex than planned. Trauma activity has been exceptionally high for this time of year and is over performing by £1.1m year to date.
- A&E attendances was similar this month compared to the previous months' run rate. Year to date over performance is 3,562 (4.9%) above plan. Compared to the same point last year, activity has increased by 1.4%. The biggest change to last year seems to be from Bedfordshire CCG, where activity is up 11.5%.
- Maternity bookings are lower this month but slightly ahead of plan overall for the YTD.
- Emergency activity LOS has increased to 4.2 days from 4.0 days in August. Elective LOS is stable at 2.6 days.
- Adult critical care is showing an underperformance against plan of £441k for the year to date. After low activity in earlier months, activity is now fluctuating around the plan level for the last four months. However, still of concern is the casemix, which is being reviewed at present, as it seems much lower than expected.
- Low levels of neonatal critical care cot days have been experienced in the first half of the year, although still 16% below plan YTD.

DIVISIONAL FINANCIAL PERFORMANCE

- The Estates Department is reporting £0.5m adverse variance to plan, £0.4m of which is non pay in nature. A significatnt part of which relates to increases in energy costs. Problems with gas meter readings are current y under review.

- Womens and Childrens Division is now showing a £0.8m adverse variance to plan. £0.3m of which relates to nursing pay costs.

- Surgery Division is £0.5m adverse to plan. Whilst the Divison is overperforming on SLA incoem the direct costs of deliverying the activity are currently outstripping the income achieved.

YEAR ON YEAR COMPARISON

- All outpatient and day case activity is showing a significant increase on 17-18 but elective activity is down.

- Medical staffing pay costs are £2.1m higher than in 17-18 despite the fact that the 18-19 medical pay award has yet to be applied. The Emergency Department and Radiology account for a large part of this increase.

Mth 6 Finance Report - Commentary

PAYBILL PERFORMANCE

- Pay expenditure for M6 has remained consistent with month 4 levels. (Month 5 figures included agenda for change arrears payments and is therfore not a like for like comparison.) However, the plan assumed pay related CIPs would be realised in month 6 which means that the variance to plan is actually £0.6m adverse.
- Medical Staffing is £0.6m adverse to plan in the month, £0.4m of this is in the Surgery Division which continues to incur sizeable waiting list initiative costs in T&O and Urology. Planned theatre list and OP sessions need to be optimised to reduce the need for these premium payments.
- Medical staffing costs in the Emergency Department continue to be a source of concern with costs of £779k for the month being the highest months expenditure for the year to date.

CIP PERFORMANCE

- The delivery against the year to date CIP target is a shortfall of £133k. This is against a year to date target of only £8.6m out of a full year target of £24.1m. The annual plan assumes a significant increase in pace of delivery over the second half of the year.
- The year to date delivery has mainly been achieved through over delivery of income related savings.
- The Cancer Division is falling behind target by £0.3m for the year to date. A large proportion of which is failure to generate private patient income as planned.

CASH, CAPITAL & BALANCE SHEET

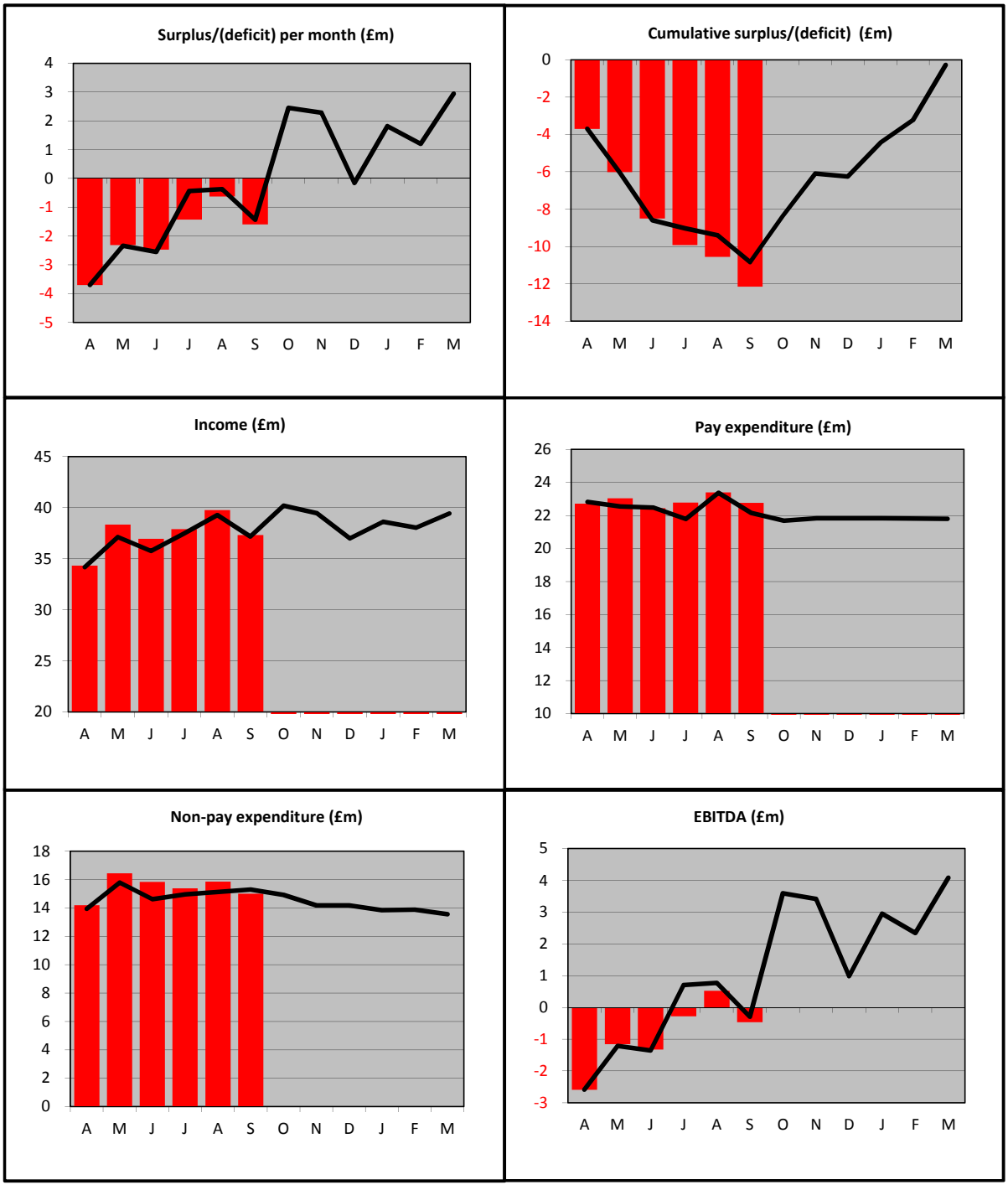
- **Balance sheet** - the movement in retained earnings relates to the income and expenditure deficit as at M6. Increase in Trade & Other Receivables is attributable to year to date performance invoices to Commissioners and CNST prepayment. The creditors falling due more than one year relates to additional support loans that the Trust has had to access in order to enable payment of Trust expenditure less capital loan repaid in September.
- **Capital** - The Trust continues to await approval of funding for the Lorenzo project and the balloon payment relating to MV bunkers. Whilst uncertainty remains about the funding sources for these two projects, the Trust is continuing the Lorenzo project at a risk. Internally generated funds through depreciation have been robustly prioritised. This means that spend during the first half of the year has been light but the Trust anticipates utilising all available funding by the end of the financial year.
- **Cash** - The Trust continues to access support from the centre in the form of drawing down loans. This requirement will need review against the agreed cash flow plan once the forecast outturn position has been calculated. The agreed plan currently assumes that CIP delivery and income performance will bring the Trust back into financial balance, thus lessening the requirement for cash support in the second half of the year. However, unpaid SLA income overperformance and payments relating to the Lorenzo project are currently putting the Trusts cash position under strain and mean that careful management of the creditors position is required.

PRODUCTIVITY IMPROVEMENTS

- As can be seen on the Productivity Improvement sheet the key metrics for theatres efficiency have declined since 17/18. The average number of cases per session has fallen and the late starts and early finishes have risen. A deep dive into theatre efficiency is underway.
- The trend of monthly referrals is showing a drop since July 18.

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	439.3	36.2	36.7	**0.4**	215.9	221.1	**5.2**
Pay	-265.9	-22.2	-22.8	**-0.6**	-135.2	-137.2	**-2.0**
Non Pay	-174.3	-15.3	-15.0	**0.3**	-89.7	-92.8	**-3.0**
EBITDA	**-1.0**	**-1.2**	**-1.1**	**0.1**	**-9.0**	**-8.8**	**0.2**
Financing Costs	-13.7	-1.1	-1.1	**0.0**	-6.9	-6.9	**0.0**
Retained Deficit exc. PSF	**-14.6**	**-2.4**	**-2.3**	**0.1**	**-15.9**	**-15.7**	**0.2**
PSF Monies	14.4	1.0	0.7	**-0.3**	5.0	3.5	**-1.5**
Retained Deficit	**-0.3**	**-1.4**	**-1.6**	**-0.2**	**-10.8**	**-12.2**	**-1.3**



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	1,256	104	102	104	104	99	110	107	110	3	612	622	10
High Cost Drugs Income	38,041	3,126	3,484	3,434	3,141	3,629	2,918	3,170	2,918	-252	19,020	19,732	712
NHS Non Patient Care Income	2,187	169	209	215	245	198	165	180	165	-15	1,106	1,201	95
NHS Patient Care Income	343,697	27,230	28,675	29,145	29,236	30,029	28,923	28,234	28,923	689	168,172	173,239	5,067
Other Income Category C	27,643	868	3,062	1,886	2,033	1,923	1,996	2,301	1,996	-305	13,749	11,769	-1,981
Pay Award Funding	0	0	0	0	296	1,184	349	0	349	349	0	1,829	1,829
Other Patient Care Income	164	20	31	23	30	-99	72	13	72	59	86	78	-8
Private Patients	5,218	278	374	370	327	366	255	446	255	-191	2,522	1,969	-552
R&D Income	5,198	438	414	421	427	435	479	433	479	46	2,599	2,613	15
RTA Income	1,138	140	18	52	89	93	117	95	117	22	569	509	-60
PSF Monies	14,362	718	718	72	670	670	670	958	670	-288	5,026	3,518	-1,508
Training & Education Income	14,755	1,238	1,260	1,235	1,288	1,240	1,265	1,230	1,265	36	7,484	7,527	42
Income Total	**453,658**	**34,330**	**38,347**	**36,957**	**37,886**	**39,765**	**37,321**	**37,168**	**37,321**	**153**	**220,945**	**224,606**	**3,661**
Admin Staff	-39,419	-2,977	-3,374	-3,119	-3,289	-3,539	-3,291	-3,376	-3,291	86	-20,120	-19,589	531
Ambulance Service Staff	-0	-2	2	0	0	0	0	-0	0	0	-0	0	0
Ancillary Staff	-9,129	-672	-699	-681	-717	-867	-721	-759	-721	38	-4,538	-4,356	182
Clinical Support Staff	-17,646	-1,400	-1,431	-1,406	-1,463	-1,745	-1,490	-1,553	-1,490	63	-8,809	-8,934	-125
Maintenance & Works Staff	-943	-72	-70	-70	-68	-71	-69	-79	-69	10	-472	-420	52
Medical Staff	-81,663	-7,596	-7,323	-7,226	-7,237	-7,213	-7,322	-6,729	-7,322	-593	-42,220	-43,917	-1,697
Nursing Staff	-78,260	-6,633	-6,725	-6,493	-6,637	-7,109	-6,610	-6,635	-6,610	25	-39,288	-40,207	-919
Other Staff	-78	0	0	0	-3	1	0	-2	0	2	-67	-2	65
Pay Reserves	242	-325	-337	-319	-156	631	-82	229	-82	-312	-37	-588	-551
Scientific Theraputic & Technical	-33,655	-2,670	-2,694	-2,712	-2,796	-3,075	-2,804	-2,786	-2,804	-19	-16,837	-16,751	86
Senior Managers	-5,346	-370	-394	-410	-406	-406	-379	-468	-379	89	-2,756	-2,363	392
Social Care Staff	-40	-3	-3	-7	-3	-3	-3	-3	-3	0	-20	-23	-3
Pay Total	**-265,937**	**-22,720**	**-23,048**	**-22,441**	**-22,775**	**-23,395**	**-22,771**	**-22,159**	**-22,771**	**-611**	**-135,165**	**-137,151**	**-1,986**
Admin Expenses	-24,382	-2,186	-2,046	-2,518	-2,048	-2,064	-2,005	-2,029	-2,005	24	-12,269	-12,865	-596
Catering	-1,959	-174	-148	-188	-157	-174	-165	-164	-165	-1	-985	-1,006	-22
Commissioning Expenditure	-120	-42	-11	-13	-11	-16	-4	-10	-4	6	-60	-97	-37
Drugs, Blood & Lab Consumables	-27,208	-1,558	-3,522	-2,376	-2,641	-2,591	-2,363	-2,233	-2,363	-129	-13,895	-15,051	-1,156
Energy & Utilities	-2,149	-104	-147	-205	-271	-222	-218	-169	-218	-48	-1,004	-1,167	-163
High Cost Drugs Expenditure	-38,041	-3,126	-3,484	-3,434	-3,141	-3,629	-2,918	-3,170	-2,918	252	-19,020	-19,732	-712
IM&T Costs	-3,330	-470	-220	-239	-225	-244	-239	-260	-239	20	-1,772	-1,636	136
Medical Consumables	-17,751	-1,608	-1,684	-1,563	-1,824	-1,743	-1,626	-1,476	-1,626	-150	-8,944	-10,047	-1,103
Non Pay Reserves	-2,965	-139	-259	-175	-114	-131	-434	-1,025	-434	590	-3,129	-1,253	1,876
Property Costs	-5,503	-429	-463	-419	-476	-396	-564	-453	-564	-111	-2,719	-2,746	-27
Purch & Maint of Equip - Medical	-16,131	-1,404	-1,441	-1,480	-1,454	-1,441	-1,430	-1,345	-1,430	-84	-8,105	-8,651	-545
Purch & Maint of Equip - Non Medical	-1,544	-114	-68	-148	-211	-87	-153	-128	-153	-25	-773	-782	-8
Purchase of Healthcare - Non NHS	-5,223	-407	-533	-526	-469	-501	-556	-438	-556	-119	-2,627	-2,993	-366
Recharges In / Out	-1,189	-94	-99	-93	-107	-98	-100	-99	-100	-1	-595	-591	3
Services from Other NHS bodies	-13,301	-1,172	-1,167	-1,162	-1,197	-1,203	-1,171	-1,141	-1,171	-30	-6,844	-7,071	-227
Site Support Services	-13,124	-1,100	-1,116	-1,234	-976	-1,225	-997	-1,090	-997	93	-6,557	-6,648	-91
Training Costs	-798	-74	-46	-71	-68	-85	-71	-65	-71	-6	-444	-416	28
Non Pay Total	**-174,318**	**-14,201**	**-16,452**	**-15,844**	**-15,390**	**-15,850**	**-15,014**	**-15,296**	**-15,014**	**282**	**-89,743**	**-92,752**	**-3,008**
Depreciation	-8,681	-701	-755	-728	-738	-738	-722	-728	-722	6	-4,373	-4,383	-10
Dividend	-303	-33	-33	-11	-25	-25	-25	-25	-25	0	-152	-152	0
Interest Payable	-4,724	-383	-383	-415	-394	-394	-394	-394	-394	0	-2,362	-2,362	0
Interest Receivable	25	6	5	6	6	6	9	2	9	7	12	38	26
Financing Total	**-13,683**	**-1,111**	**-1,165**	**-1,147**	**-1,151**	**-1,151**	**-1,132**	**-1,145**	**-1,132**	**13**	**-6,874**	**-6,858**	**16**
Grand Total	**-281**	**-3,703**	**-2,319**	**-2,476**	**-1,431**	**-630**	**-1,596**	**-1,432**	**-1,596**	**-164**	**-10,837**	**-12,154**	**-1,317**

East and North Hertfordshire NHS Trust

Agenda Item: 9.3

TRUST BOARD PART 1 – 7 NOVEMBER 2018
PERFORMANCE REPORT MONTH 6

PURPOSE	To update the Trust Board on: • Progress against Operating Standards, Contractual standards and local performance measures.
PREVIOUSLY CONSIDERED BY	
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, 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	☐

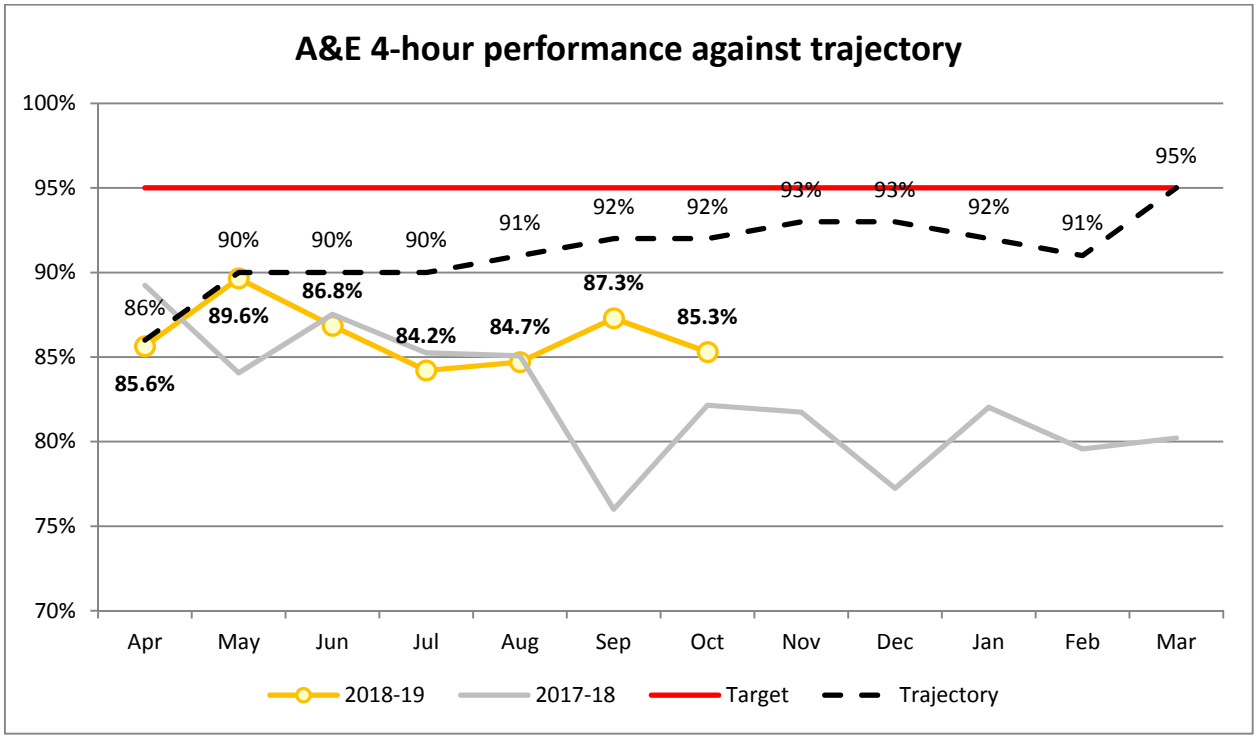
DIRECTOR:	CHIEF OPERATING OFFICER
PRESENTED BY:	CHIEF OPERATING OFFICER
AUTHOR:	CHIEF OPERATING OFFICER
DATE:	OCTOBER 2018

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. Executive Summary

1.1 Emergency Care Standard



Month	2018-19	2017-18	12-hour trolley waits
Apr	85.64%	89.24%	0
May	89.65%	84.07%	0
Jun	86.85%	87.53%	0
Jul	84.21%	85.24%	0
Aug	84.71%	85.06%	0
Sep	87.29%	76.00% *	0
Oct	385.30%	82.16%	0

* Sep-17 performance was not submitted to NHSE. This figure is based on internal reporting only.

At the start of September, the ED team developed an action plan to address the internal and external factors affecting ED performance. The action plan identified a 5% worth of improvement through shop floor efficiencies within the emergency department and a further 5%+ through the acute pathway re-design and emergency village (increase assessment flow and early bed availability).

September performance was 87.28% against a trajectory of 90%. However, between 20th September and 7th October cumulative performance was above 90%, with some days reaching 94%.
Attendances in September were slightly high than August (+462). There has been an increase in the daily average attendance since August.

August average daily attendance: 418 patients per day
September average daily attendance: 437 patients per day
October to date average daily attendance: 462 per day

Since the 8th October, performance has deteriorated, with the month to date performance of 85.3% (trajectory 90%).

Factors affecting performance in October:

- Reduced AMUA and SAU flow. Regularly managing an emergency department with no flow into assessment units throughout the night. Both units full each morning with up to 13 DTAs.
- Discharges before midday limited / discharges delayed due to TTOs not being completed on time.
- Daily failed discharges due to transport.
- 50% less IDT patients leaving the Trust daily. Usually 30 patients per day. The last three weeks has seen that reduced to around 15 per day.
- Nurse staffing in ED has been a challenge, with short notice cancellations affecting corridor nursing

Plans to improve October Performance:

- Reset week planned for week commencing 22nd October. A low-key, hard-hitting week of robust early escalation of blocks to assessment and discharge, in order to relieve the lack of flow currently being experienced. Key staff members identified to assist with the medicine teams working evenings and weekends to provide senior cover out-of-hours.

1.2 Cancer performance (August)

In August 2018 the Trust achieved 4 of the 8 national targets for cancer performance: 2WW GP referral; 31-day subsequent for drug treatments, radiotherapy and surgery.

Following non-compliance for the 2WW standard in Q1, the Trust has maintained compliance in July and August. In August 2018, the Trust-wide average days wait for first appointment continues to be maintained at 10 days. Breast, Lung and Skin are below the average at 9 days. H&N and Urology have an average of 8 days.

Reported 62-day performance for August was 76.7% pre-breach/compliance sharing and 78.5% post-, which is above the revised recovery trajectory of 70.2%.

1.3 RTT

The Trust remains off national reporting against this standard. Current plans to return to reporting in November (for October performance) remain on-track, subject to the continuing improvements in data quality being maintained.

Incomplete performance and backlogs remain static in September. Improvements are observed in October and the Trust expects to report an incomplete position of 86% at the end of October.

There were 41 active 52-week breaches in the incomplete PTL at the end of September, a reduction of 4 from the August position.

1.4 Diagnostics

The trust remains off national reporting against this standard. The Trust remains committed to a return to reporting of the DM01 position in November on October performance.

Operational sign off of DM01 logic will be in place in the 1st half of October.

1.5 Stroke

There was improvement in September performance against the 4-hour standard compared to August 18.

Thrombolysis rate at 9.50%. There has been a drop in performance compared to previous month. Plans are being arranged for the Stroke Nurses to work with the Ambulance Crew – awaiting confirmation for mid-October, to help with early attendance to A&E within onset time.

There has been a significant increase in 60-min to scan and 12hrs to scan performance

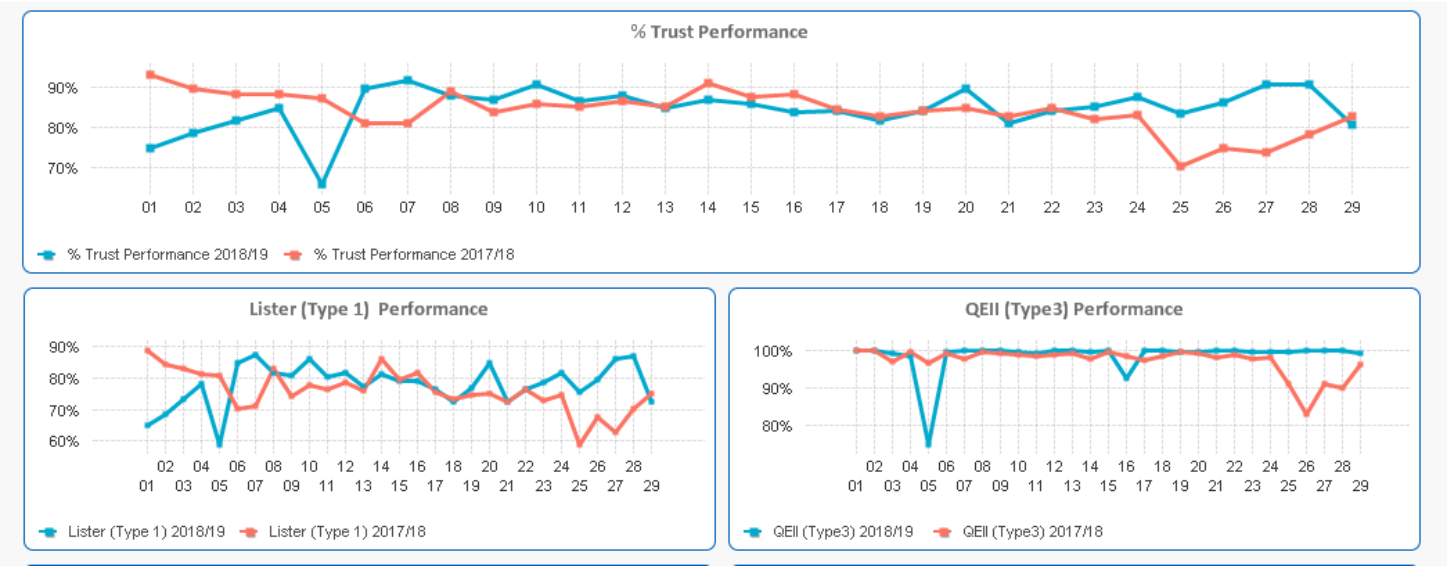
Early supported discharge again stayed strong at 54.3% above the target of 40%.

Charing Cross thrombectomy service is now available seven days per week until 23:00hrs for our patients.

2. ED Performance

2.1 Performance Breakdown

Financial Year Week No.	% Trust Performance 2018-19	% Trust Performance 2017-18	Lister (Type 1) 2018-19	QEII (Type3) 2018-19
Wk. 01	74.94%	92.94%	65.14%	100.00%
Wk. 02	78.56%	89.46%	68.36%	99.88%
Wk. 03	81.62%	88.31%	73.13%	99.35%
Wk. 04	84.77%	88.14%	78.07%	98.32%
Wk. 05	65.93%	87.07%	58.82%	75.00%
Wk. 06	89.62%	81.10%	84.73%	99.50%
Wk. 07	91.47%	80.91%	87.23%	100.00%
Wk. 08	87.70%	88.74%	81.68%	100.00%
Wk. 09	86.93%	83.74%	80.59%	99.88%
Wk. 10	90.52%	85.73%	86.02%	99.65%
Wk. 11	86.52%	84.92%	80.37%	99.30%
Wk. 12	87.63%	86.54%	81.62%	100.00%
Wk. 13	84.68%	85.00%	77.41%	100.00%
Wk. 14	86.82%	90.89%	81.03%	99.50%
Wk. 15	85.60%	87.43%	78.93%	99.76%
Wk. 16	83.82%	88.22%	79.20%	92.63%
Wk. 17	84.18%	84.43%	76.58%	100.00%
Wk. 18	81.52%	82.85%	72.61%	100.00%
Wk. 19	84.19%	84.12%	76.72%	99.62%
Wk. 20	89.44%	84.72%	84.63%	99.73%
Wk. 21	81.13%	82.51%	72.55%	100.00%
Wk. 22	83.93%	84.88%	76.32%	99.87%
Wk. 23	85.08%	81.97%	78.51%	99.60%
Wk. 24	87.51%	83.05%	81.80%	99.61%
Wk. 25	83.31%	70.31%	75.37%	99.63%
Wk. 26	86.13%	74.72%	79.67%	99.88%
Wk. 27	90.52%	73.82%	85.82%	100.00%
Wk. 28	90.65%	78.23%	86.71%	99.87%
Wk. 29	80.60%	82.51%	72.54%	99.26%



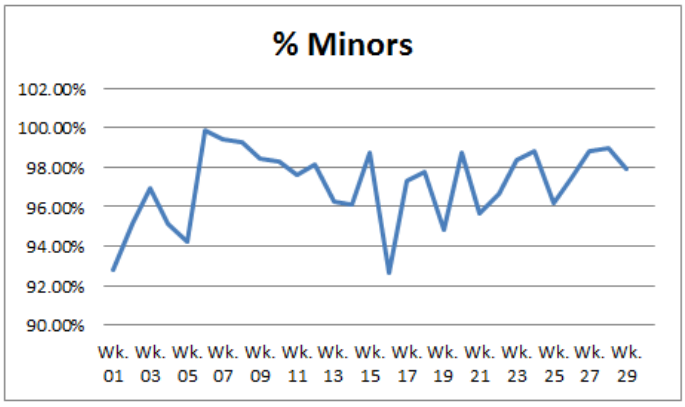
2018-19 year-to-date by week number.

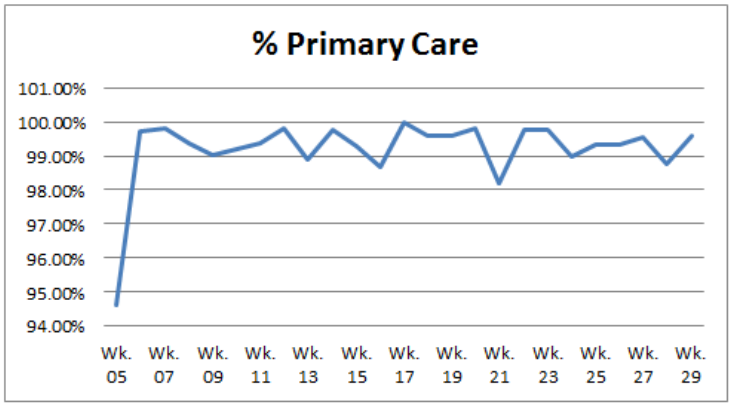
ED Performance

PeriodView	Total Attendance	% Trust Performance 2018/19	% Trust Performance 2017/18	Lister (Type 1) 2018/19	Lister (T1 Major) 2018/19	Lister (T1 Minor) 2018/19	QEII (Type3) 2018/19
MTD	6,940	85.30%	81.26%	79.16%	65.82%	96.67%	99.59%
QTD	6,940	85.30%	81.26%	79.16%	65.82%	96.67%	99.59%
YTD	60,846	85.51%	82.70%	78.98%	65.86%	94.89%	99.36%

October 2018-19

Type 1 Minors/Primary Care breakdown



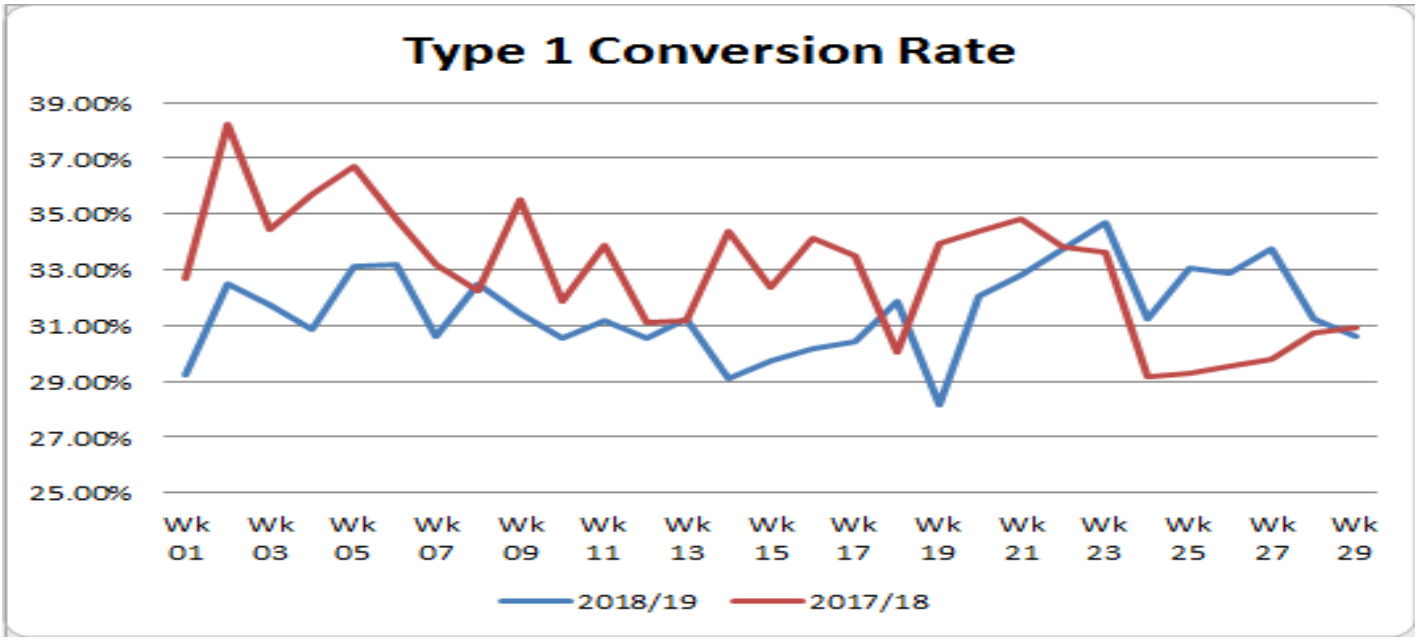


Fy Week #	Minors Attendanc	Minors Not Breac	Minors Breac	Minors Performan	Primary Care Attendanc	Primary Care Not Breac	Primary Care Breach	Primary Care Performan
Wk. 01	83	77	6	92.77%				
Wk. 02	779	741	38	95.12%				
Wk. 03	853	827	26	96.95%				
Wk. 04	962	915	47	95.11%				
Wk. 05	679	640	39	94.26%	168	159	9	94.64%
Wk. 06	804	803	1	99.88%	375	374	1	99.73%
Wk. 07	823	818	5	99.39%	486	485	1	99.79%
Wk. 08	817	811	6	99.27%	475	472	3	99.37%
Wk. 09	769	757	12	98.44%	514	509	5	99.03%
Wk. 10	776	763	13	98.32%	501	497	4	99.20%
Wk. 11	805	786	19	97.64%	467	464	3	99.36%
Wk. 12	866	850	16	98.15%	467	466	1	99.79%
Wk. 13	829	798	31	96.26%	452	447	5	98.89%
Wk. 14	881	847	34	96.14%	438	437	1	99.77%
Wk. 15	897	886	11	98.77%	423	420	3	99.29%
Wk. 16	840	778	62	92.62%	448	442	6	98.66%
Wk. 17	784	763	21	97.32%	497	497	0	100.00%
Wk. 18	807	789	18	97.77%	485	483	2	99.59%
Wk. 19	855	811	44	94.85%	483	481	2	99.59%
Wk. 20	735	726	9	98.78%	476	475	1	99.79%
Wk. 21	761	728	33	95.66%	446	438	8	98.21%
Wk. 22	835	807	28	96.65%	458	457	1	99.78%
Wk. 23	724	712	12	98.34%	446	445	1	99.78%
Wk. 24	768	759	9	98.83%	480	475	5	98.96%
Wk. 25	762	733	29	96.19%	446	443	3	99.33%
Wk. 26	824	803	21	97.45%	450	447	3	99.33%
Wk. 27	779	770	9	98.84%	462	460	2	99.57%
Wk. 28	692	685	7	98.99%	488	482	6	98.77%
Wk. 29	761	745	16	97.90%	487	485	2	99.59%

Please note: Wk.01 only accounts for one day (01.04.2018), Also, Primary Care data were unavailable between Wk.01-04

2.2 Admitted Activity

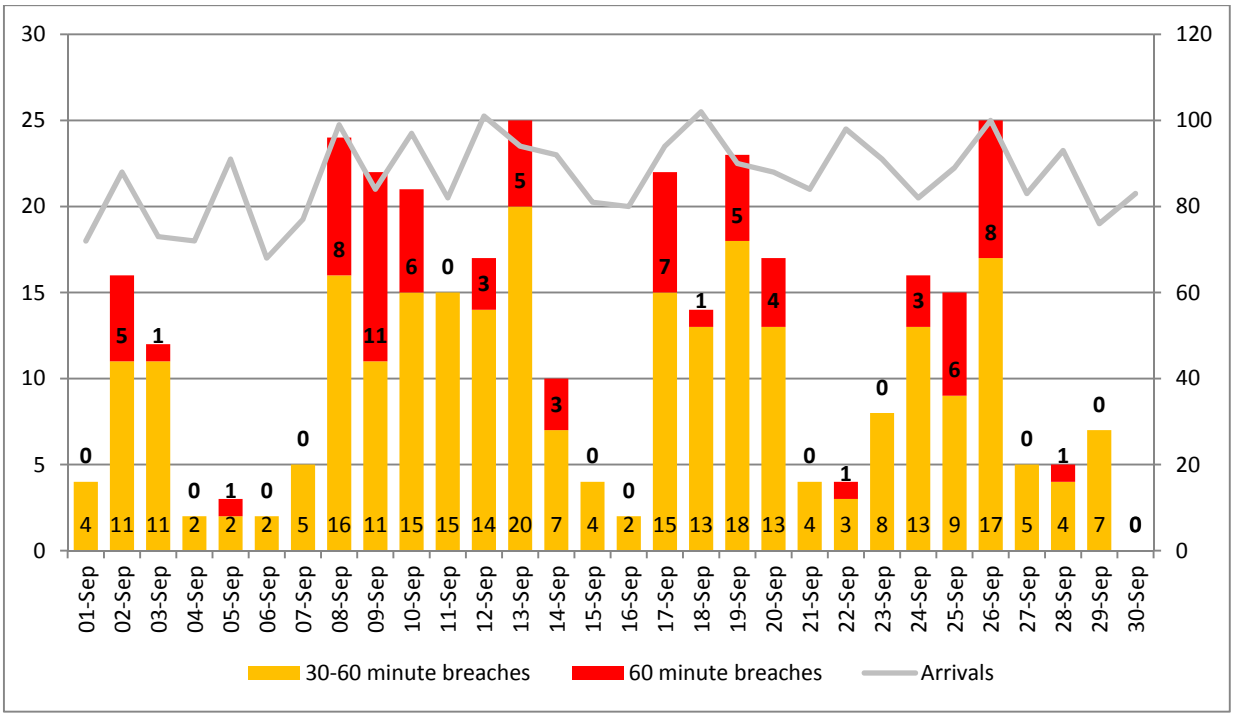
Fy Week	Total Attendance	Type 1 Attendance	Admission via A&E	Conversion Rate 2018/19	Coversion Rate 2017/18
Wk 01	395	284	83	29.23%	32.71%
Wk 02	2995	2026	658	32.48%	38.23%
Wk 03	3030	2054	652	31.74%	34.42%
Wk 04	3164	2134	659	30.88%	35.72%
Wk 05	3017	2018	668	33.10%	36.72%
Wk 06	3120	2095	696	33.22%	34.81%
Wk 07	3199	2138	654	30.59%	33.19%
Wk 08	3204	2151	699	32.50%	32.24%
Wk 09	3221	2164	680	31.42%	35.51%
Wk 10	3100	2082	636	30.55%	31.84%
Wk 11	3302	2236	697	31.17%	33.91%
Wk 12	3162	2127	650	30.56%	31.09%
Wk 13	3178	2156	673	31.22%	31.19%
Wk 14	3179	2188	637	29.11%	34.39%
Wk 15	3250	2212	657	29.70%	32.37%
Wk 16	3343	2293	692	30.18%	34.11%
Wk 17	3142	2122	646	30.44%	33.48%
Wk 18	3035	2048	652	31.84%	30.07%
Wk 19	3036	2049	577	28.16%	33.95%
Wk 20	2850	1945	624	32.08%	34.41%
Wk 21	2920	2007	659	32.84%	34.85%
Wk 22	2975	2014	680	33.76%	33.81%
Wk 23	2896	1996	692	34.67%	33.61%
Wk 24	3019	2055	642	31.24%	29.17%
Wk 25	3044	2050	678	33.07%	29.27%
Wk 26	3215	2189	720	32.89%	29.52%
Wk 27	3049	2038	688	33.76%	29.82%
Wk 28	3123	2189	684	31.25%	30.74%
Wk 29	3330	2331	713	30.59%	30.95%



2.3 Performance Trajectory

A&E Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance 17/18	89.19%	84.91%	87.49%	87.92%	85.06%	Non Reporting	82.16%	81.74%	77.24%	82.16%	79.64%	80.29%
Trajectory 18/19	86%	90%	90%	90%	91%	92%	92%	93%	93%	92%	91%	95%
Performance 18/19	85.47%	89.52%	86.85%	84.19%	84.71%	87.29%	85.30%					

2.4 Ambulance handover breaches



Ambulance handover performance remains a significant challenge, particularly on days where the department is already overcrowded and more than 6 vehicles arrive within an hour. Performance improved towards the end of September, in line with overall ED performance. A very junior nursing workforce has meant that we create a “bottle neck” at the handover bays. A rapid turnaround in training (DARTing) will improve this but it will be December before the majority of staff are trained and able to accept ambulance arrivals into their empty cubicles. Limited ‘corridor nurse’ uptake as bank shifts continues to be a factor affecting offloading performance. We are working with HR to review current bank rates, which if increased will give greater fill.

3. Cancer

Cancer performance is reported retrospectively. August’s finalised position for all 8 standards is shown below.

Standard	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	National Average Performance *
2 week GP referral to 1st outpatient *	93%	97.1%	97.6%	97.6%	97.5%	97.6%	97.4%	89.3%	91.9%	91.8%	95.5%	95.1%	93.2%
2 Week wait - Breast symptoms - Cancer not initially suspected	93%	90.1%	96.2%	92.3%	94.4%	100.0%	93.6%	93.9%	91.8%	84.0%	97.3%	91.2%	91.0%
31 day second or subsequent treatment (Anti Cancer Drug Treatments)	98%	98.4%	95.6%	99.0%	90.5%	97.0%	97.2%	99.4%	99.3%	98.3%	99.3%	98.3%	99.3%
31 day second or subsequent treatment (Surgery)	94%	74.1%	96.8%	80.8%	84.6%	92.3%	91.3%	88.5%	95.8%	60.0%	64.0%	100.0%	94.9%
31 day second or subsequent treatment (Radiotherapy Treatments)	94%	69.5%	89.9%	93.7%	88.0%	93.6%	92.4%	91.7%	90.6%	91.1%	94.1%	95.0%	97.1%
31 day diagnosis to 1st definitive treatment for all cancers	96%	91.6%	96.3%	96.4%	95.3%	92.4%	96.6%	94.9%	92.4%	96.7%	90.8%	90.7%	97.5%
62 day referral to treatment from screening	90%	57.9%	77.8%	92.3%	42.9%	100.0%	89.3%	84.6%	73.9%	76.5%	60.7%	72.7%	90.6%
62 days urgent referral to treatment of all cancers	85%	76.8%	75.5%	79.9%	71.4%	80.3%	79.1%	67.2%	70.6%	69.7%	62.0%	76.7%	84.5%

3.1 Cancer performance against recovery trajectories:

The Trust is ahead of its agreed trajectories for 31-day subsequent treatment for drug and radiotherapy. Compliance was maintained in August for 31-day subsequent treatment for drug and the Trust maintained compliance for 31-day subsequent treatment for radiotherapy for the second consecutive month.

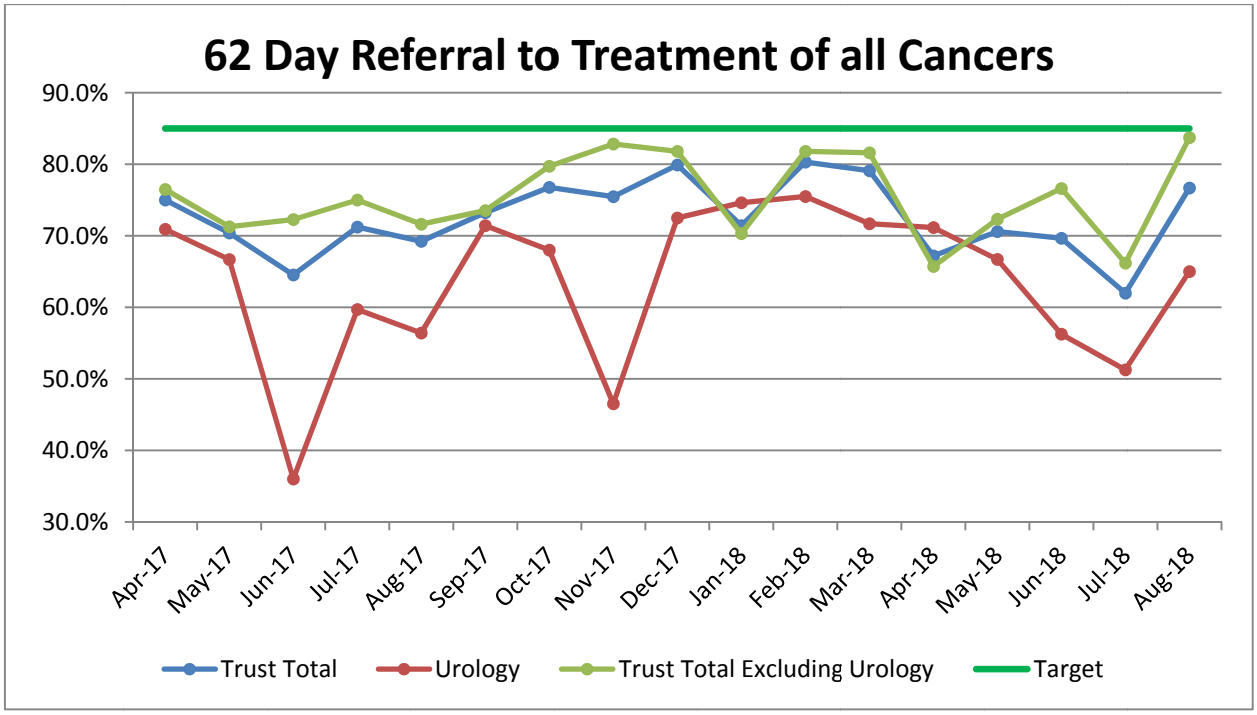
The Trust also achieved against the 62-day revised recovery trajectory of 70.2% post-breach sharing.

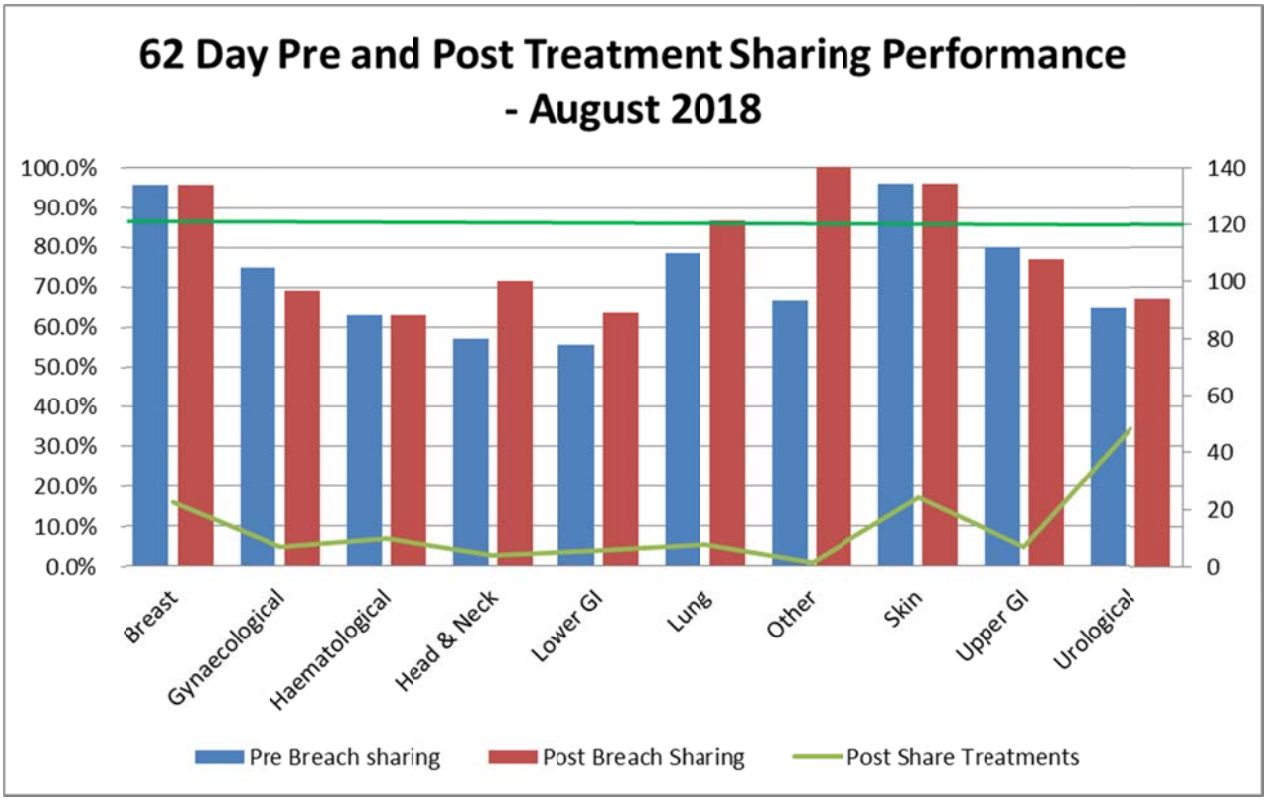
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
31 Day second or subsequent treatment (Anti Cancer Drug)												
Trajectory	87.0%	89.6%	93.5%	95.4%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
Actual	90.5%	97.0%	97.2%	99.4%	99.3%	98.3%	99.3%	98.3%				
31 Day second or subsequent treatment (Radiotherapy)												
Trajectory	85.7%	88.4%	87.2%	85.7%	88.6%	85.9%	89.9%	94.7%	94.0%	94.0%	94.0%	94.0%
Actual	88.0%	93.6%	92.4%	91.7%	90.6%	91.1%	94.1%	95.0%				
62 Days Urgent Referral to Treatment of all Cancers												
Trajectory Post Sharing	78.3%	82.5%	85.0%	85.0%	85.0%	71.2%	69.5%	70.2%	76.3%	80.9%	84.1%	86.6%
Post-breach sharing actual	76.6%	84.4%	80.9%	71.6%	72.7%	75.4%	66.9%	78.5%				

3.2 62-day performance

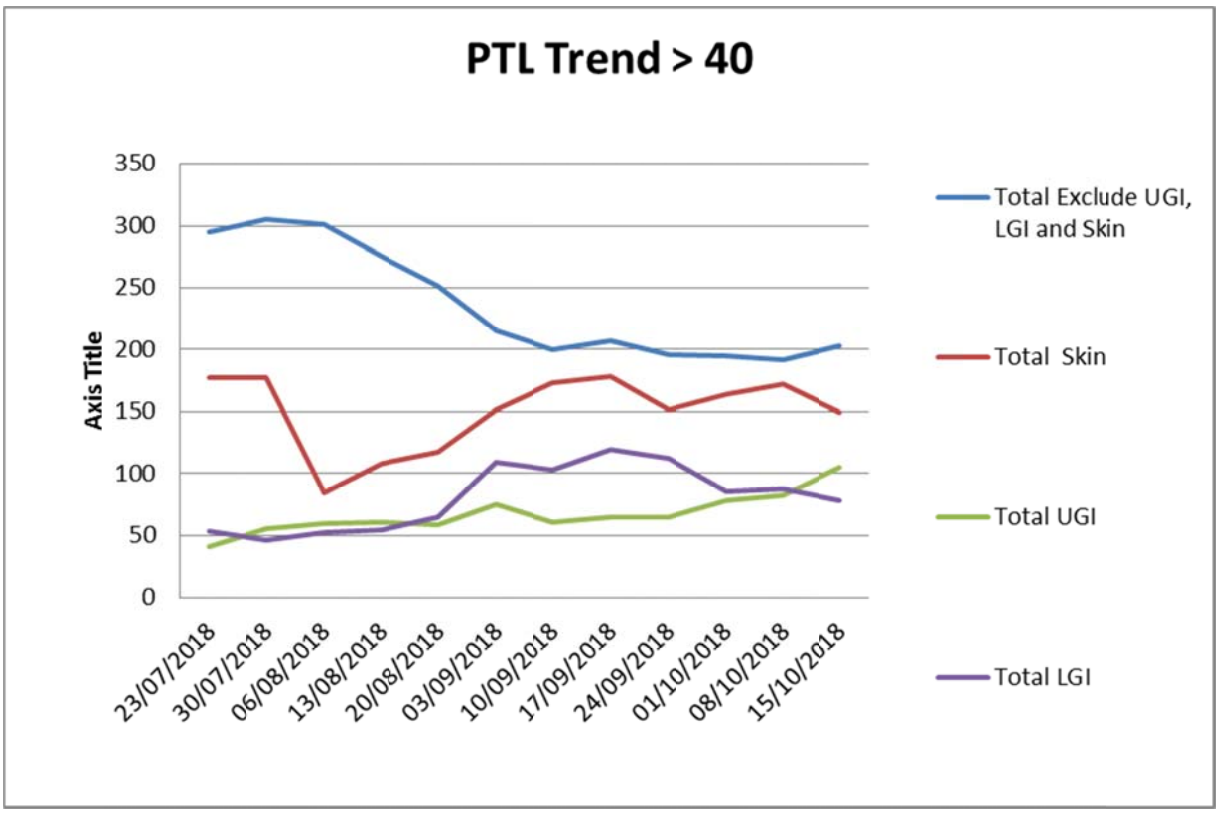
Pre- and post-treatment sharing 62-day performance for the trust is non-compliant with the national standard and is less than the national average for March 2018. 62-day performance post-breach/compliance sharing for all cancers excluding Urology is compliant for the first time this year at 85%.

In August, 150 patients were treated with an OE value of 133, 40 of which were treated after day 62 (OE value 31). Only 8 of the 15 breached incoming referrals weren't treated within 24 days. 6 of these were avoidable (4 RALP and Brachy) and 2 unavoidable.





The backlog position (>40 days) continues to improve, with the exception of UGI.



3.3 Recovery action plan update

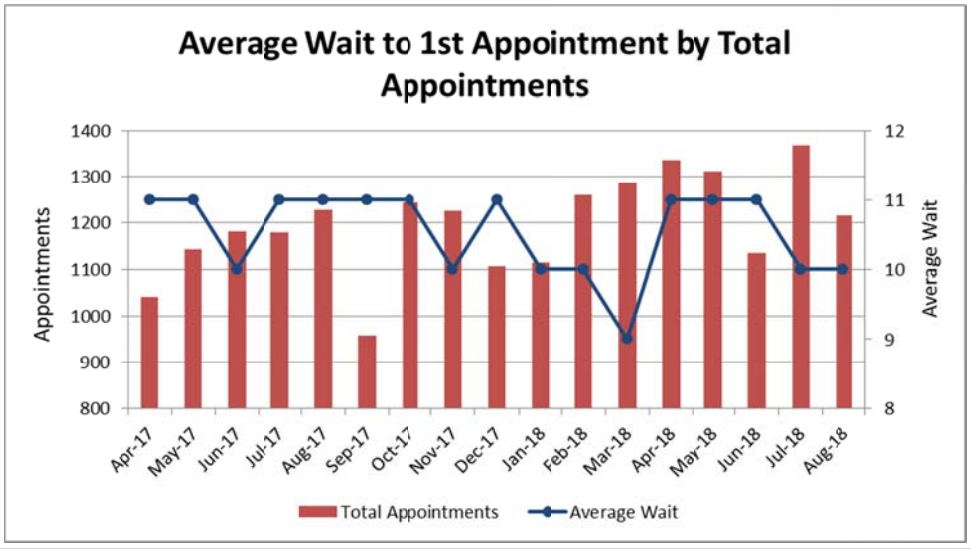
The tumour site recovery plans target the following key pathway indicators:

- First attendance
- Diagnosis
- MDT
- Treatment capacity.

The main focus for recovery is reducing the wait for diagnosis, which is much greater than the nationally desired 28 days.

3.3.1 First Attendance

2WW performance in August remained compliant. Trust-wide, the average days wait for 1st attendance has been maintained at 10. Haematology, LGI, UGI and Testicular exceeded this average in August. The specialities with the shortest average wait were urology and H&N at 8 days.



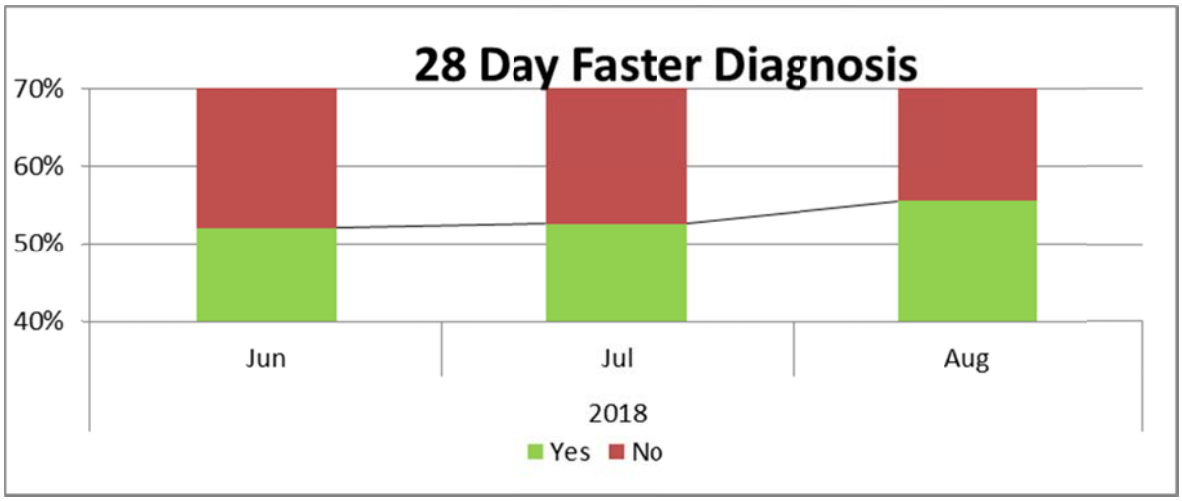
3.3.2 Diagnosis

Since February 2018, the Trust has been recording the wait to diagnosis (cancer and no cancer) in preparation for the new 28 day standard which requires Trusts to diagnose patients on cancer pathways within 28 days. The data set is not complete but current indicators suggest that the Trust is diagnosing c.55.5% of patients on cancer pathways within 28 days. This has increased when compared with June and July.

Urology one-stop went live at the start of October. Gynaecology is on plan to go-live with the direct-to-US in October and CNS triage. Permission has been granted to procure mobile CT capacity and will be in place from October onwards, this will help to reduce the backlog and average waits.

The upgrade pathway has gone live in October for lung patients with a possible cancer identified at direct-to-chest X-ray.

The business case for STT in LGI has been approved in principle and the new nursing roles will be advertised in October. The expected start date is still January 2019.



3.3.2 MDT

In August 2018, tumour sites continued to make progress with live requesting and booking in MDT. Lorenzo booking training has taken place in July and August for all MDT co-ordinators and now more detailed training is happening with the specialities.

As part of NHSI onsite support, a member of their team has been shadowing some MDT meetings and will feedback finding to the Trust in October. Recommendations for improvement will be included in speciality RAPs.

3.2.3 Treatment Capacity

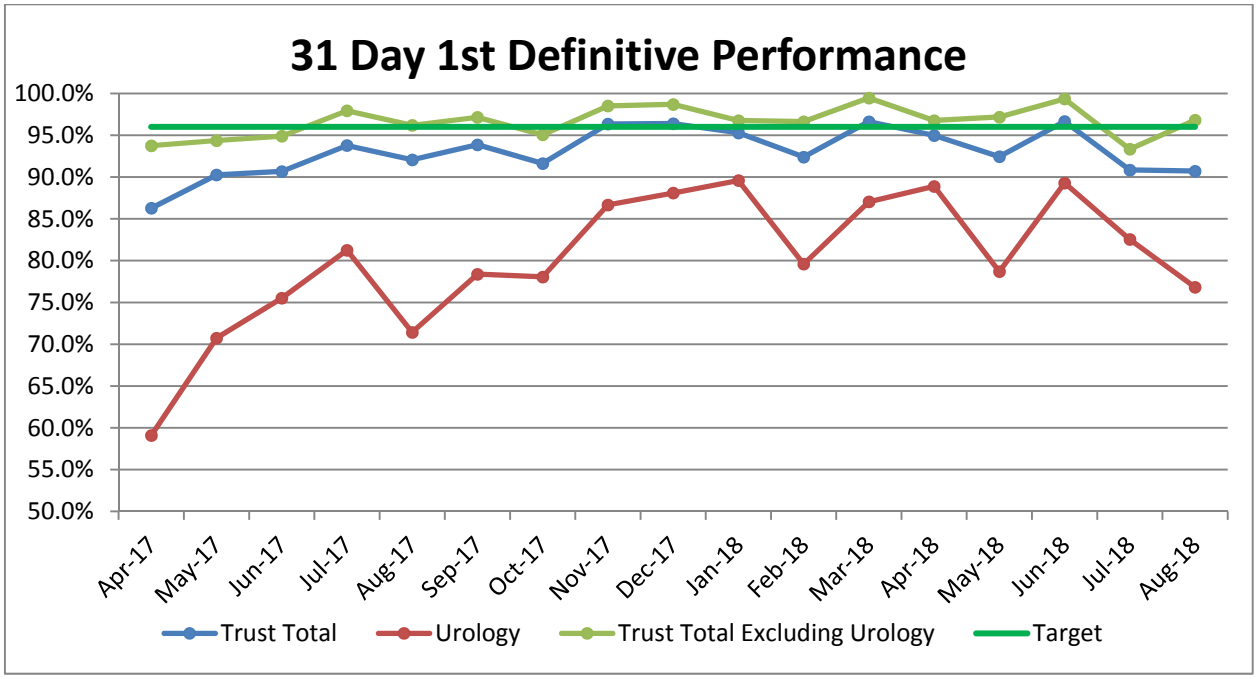
Following underperformance against the 31-day target in July when excluding Urology, the Trust has returned to compliance in August. Of the 21 breaches, 76% belonged to Urology.

In September, an agreement was reached to make alterations to the theatre timetable to allow urology access to the robotic theatre 5 days a week. A trial will commence in November. The first 3-session day took place in September and was extremely successful. Moving forward this will be a monthly occurrence.

A demand and capacity modelling exercise started in October, with 2ww being the first area to be modelled. Action plans will be developed where gaps in services are identified.

The CCG has agreed to review the clinical criteria for robotic prostatectomy and will make a recommendation for demand management to NHSE, as the commissioner for this procedure.

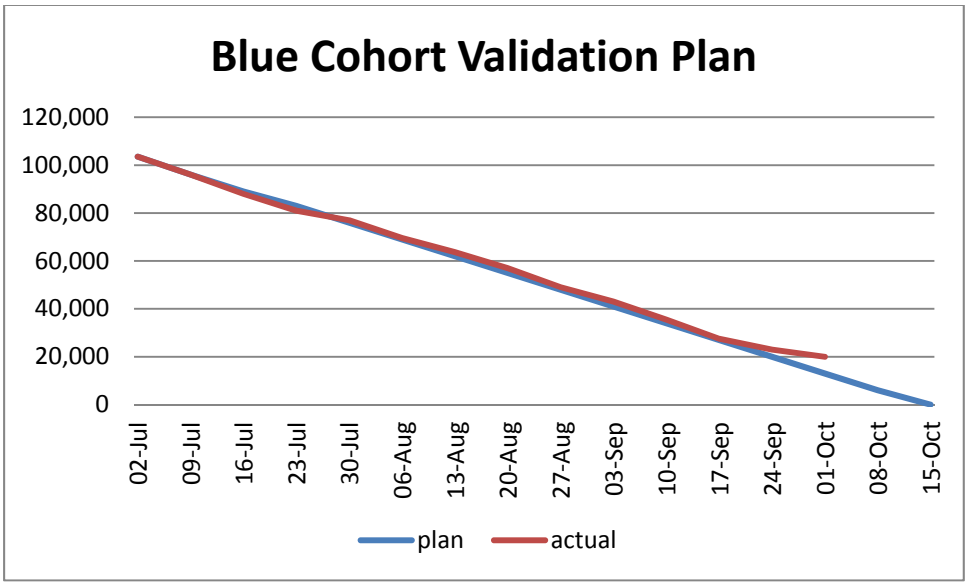
Ad-hoc brachy capacity continues to be identified. The SLA for the permanent additional lists was signed by the Trust in September and went live in October.



4. Referral to Treatment (RTT)

4.1 Validation report

The development of the Superview PTL using correct business logic has identified 230K open referrals requiring further validation. This group of patients (Blue Cohort) have been stratified in terms of risk. This will inform the validation strategy which will employ a mixture of sampling, direct patient contact and full 100% audit. Our current estimate is that 103K of these referrals will require validation.



The numbers of pts converting to an RTT is now very low. Of the last 25K validations only 30 have required an RTT clock start.

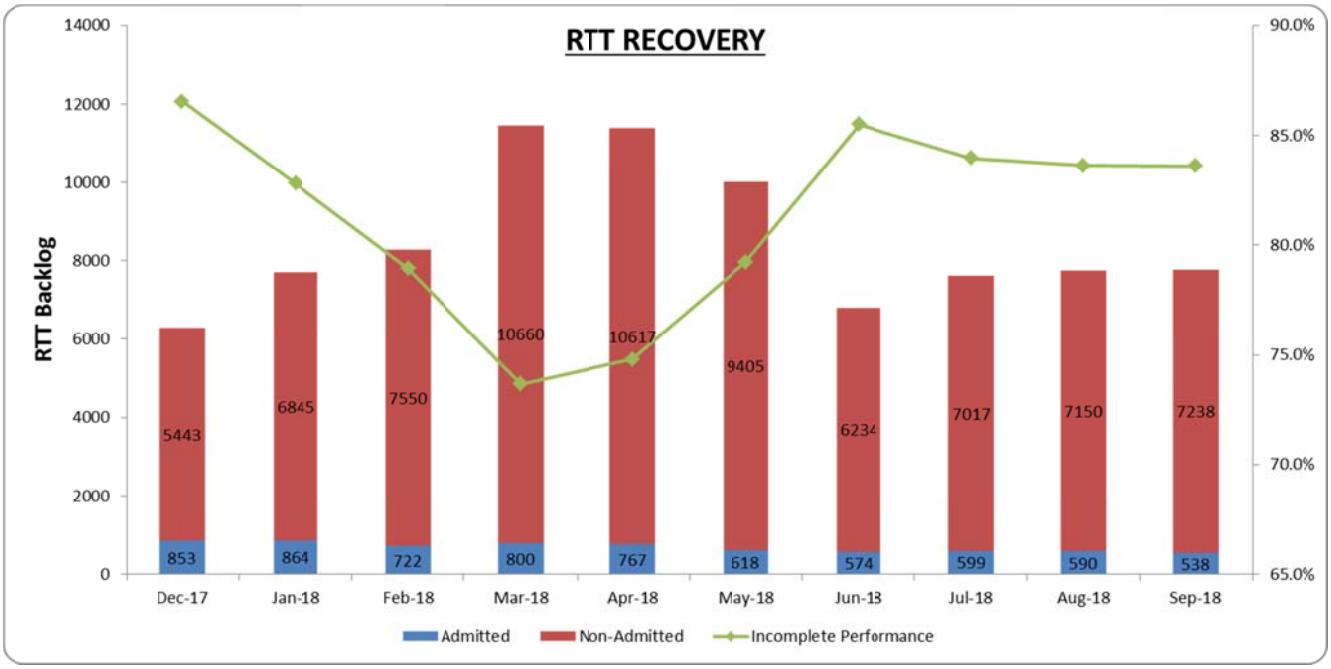
The slow-down in validation against the plan reflects this position. Validation resource has been diverted to active long-wait pathways.

The risk that the current validation program will delay our return to reporting is considered to be very low. To date 86,000 of the 103K have been validated and only 655 patients have required an RTT clock to be opened. 3 of these patients had breached 52 weeks.

4.2 Patient tracking and performance

Whilst the Trust is not reporting RTT performance externally, the new Superview PTL allows us to track movements in backlog and shadow incomplete performance.

Performance is expected to improve to 86% when we return to reporting at the end of October



Operational improvements are yet to have a material impact on overall performance.

Additional resource has been deployed in surgery to support operational delivery. The Surgical PTL is now being tracked at Consultant level for all patients in the surgical backlog. It is critical at this stage that surgery manages its long wait position more pro-actively and establishes shorter waits to first appointment. The demand and capacity work supported by IST will inform planning.

4.3 Operational delivery

As the positive impact of validation diminishes it is expected that Operational Teams will deliver the further improvements required to achieve a compliant position for RTT. This will be measured through stages of treatment:

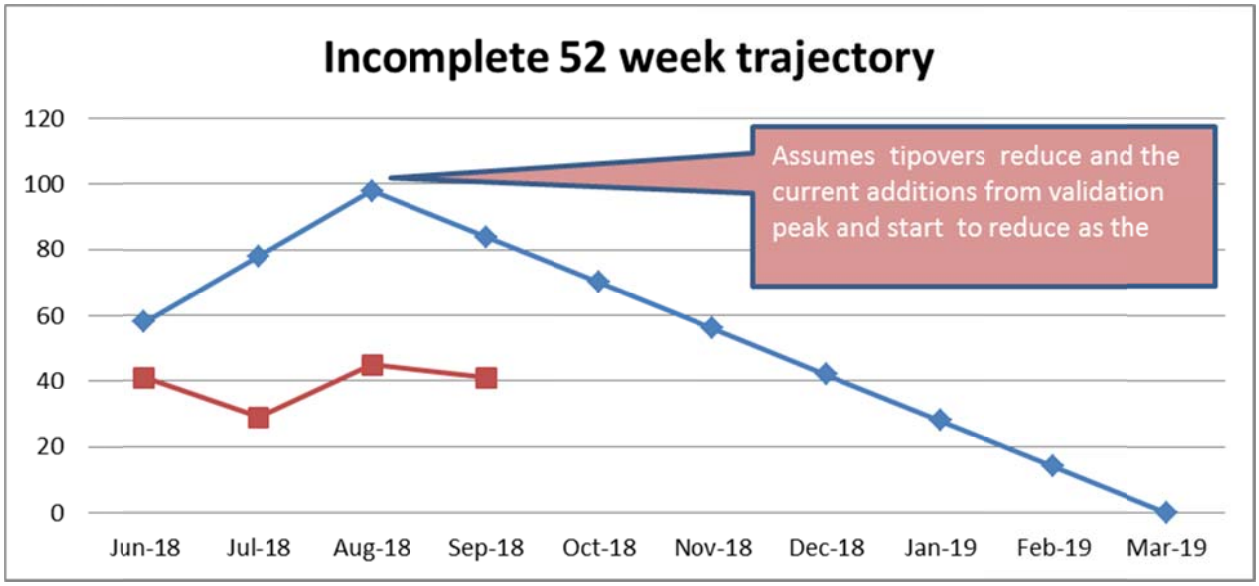
- 1st OP
- Diagnosis
- Follow Up
- Treatment

Typically each stage will be allocated a timeframe for completion. Reports are being developed to accurately report waits for each stage of treatment.

Surgical specialties 1st OP should be dated within 6 weeks and 10 weeks for non-surgical specialties.

4.4 52-week breaches

Whilst the September position is below our trajectory, improvements are not being observed. Patients are tracked individually at weekly Access Board. Exercising tighter grip at operational level is expected to contribute to an improving position from November onwards.



5. Diagnostics Waiting Times (DM01)

The diagnostic dashboard incorporating our first iteration of DM01 reporting was released on 21st June for user acceptance testing, which is almost completed.

The future state for DM01 is linked to the development of access plans (Stabilisation program) ahead of this waiting list size and DM01 waits will be measured using existing information resources wherever possible. Operational teams will sign off business logic for November reporting in the 1st half of October.

6. Stroke

Stroke performance is as reported for September.

6.1 Stroke Performance

Metrics	Sept ' 17	Oct '17	Nov '17	Dec '17	Jan '18	Feb'18	Mar '18	Apr'18	May '18	June'18	July'18	Aug-18	Sep-18
Trust SSNAP Grade	A	A	A	A	A	A	A	A	A	A	A		
Stroke Discharged with AF on anticoagulants (ASI 1)	62.50%	62.50%	66.70%	61.50%	85.70%	100%	100%	100%	91.70%	92.90%	100%	87.50%	100%
Stroke – 4 hours direct to stroke unit from ED	71.60%	71.20%	70.60%	78.50%	67.20%	56.90%	60%	63.20%	77.60%	80.60%	79.70%	65.20%	72.10%
No. Confirmed Strokes in Month on SSNAP	67	73	68	65	58	72	96	74	69	66	60	69	63
Stroke – 80% of patients spent 90% of time on the stroke unit	88.90%	79.70%	84.90%	87.30%	82.10%	84.80%	85.10%	86.80%	86.60%	85.90%	93.30%	85.30%	93.50%
Stroke – 60 min to scan from time of arrival – target 50%	56.90%	51.90%	66.20%	55%	51.70%	52.90%	56.30%	51.40%	56.50%	57.10%	56.70%	46.40%	61.90%
Stroke – scanned within 12 hrs (all strokes) target 100%	100%	100%	100%	95%	93.30%	98.60%	94.80%	94.40%	95.70%	98.40%	100%	97.10%	98.40%
Total Thrombolysis Rate for confirmed strokes	11.30%	6.30%	16.90%	11.40%	13.70%	11.40%	8.30%	12.50%	7.20%	4.80%	16.70%	10.10%	9.50%
Thrombolysed within 60 mins of arrival					57.10%	75%	87.50%	77.80%	60%	66.70%	60%	42.90%	33.30%
Stroke – discharged with JCP – target 80%	98%	98%	97.70%	96.20%	100%	97.90%	96.70%	91.50%	98%	95.60%	100%	88.80%	97.80%
Stroke –discharged with ESD target 40%	34%	35.80%	30.60%	41.50%	41%	47.90%	47.60%	50%	46.90%	45.70%	59.20%	50%	54.30%

- Improvement in Sep-18 4-hour performance compared to Aug-18.
- Training being arranged with ED doctors, to ensure that there is early escalation and referrals are being made to the Stroke team.
- Thrombolysis rate at 9.50%. There has been a drop in performance compared to previous month. Plans are being arranged for the Stroke Nurses to work with the Ambulance Crew – awaiting confirmation for mid-October, to help with early attendance to A&E within onset time.
- There has been a significant increase in 60-min to scan and 12-hrs to scan performance.
- Table above now showing the 33.3% of thrombolysis received in less than 60 minutes as this is the gold standard, however up to 4.5hrs from onset time is NICE guidance approved.
- Continuous outstanding ESD performance at 54.3%.
- Charing Cross thrombectomy service now available 7-days per week til 23:00
- As from 23/10/2018 established monthly meeting with regards to A&E pathways and process – with action log being developed to help improve the Stroke Performance
- TIA performance within 24-hrs signficantly reduced due to 52.6% patient choice breaches.

6.2 <u>24-hr TIA performance</u>

Month	Referrals received in-month	Confirmed TIAs	Patients seen < 24-hrs from referral	Patients seen < 48-hrs	Patients seen < 72-hrs	Patient choice breaches	Late GP referral breach reasons	Breaches due to hospital capacity
Aug-17	101	38	54	36	11	10	11	26
Sep-17	108	63	45	32	31	25	13	25
Oct-17	111	52	52	22	37	19	10	30
Nov-17	109	48	43	30	36	31	9	26
Dec-17	90	58	36	23	19	18	14	10
Jan-18	107	49	50	37	20	18	5	34
Feb-18	88	38	29	15	44	17	15	27
Mar-18	96	52	28	23	45	24	11	33
Apr-18	105	52	16	20	69	35	9	45
May-18	103	50	24	19	58	31	11	37
Jun-18	84	49	21	21	42	36	9	18
Jul-18	76	35	20	17	39	33	6	17
Aug-18	91	35	27	15	49	24	4	36
Sep-18	104	51	24	11	69	22	6	52

Increase of number of referrals received in September compared to previous months.

- Review of capacity to manage demand taking place and meeting scheduled with Radiology on 18th October for the diagnostic access for appropriate scans and capacity to provide Hot Clinic capacity for A&E referrals on the same day.
- As from 23/10/2018 established monthly meeting with regards to A&E pathways and process – with action log being developed to help improve the TIA Performance and appropriate management of referrals.

TIA breach reasons breakdown:

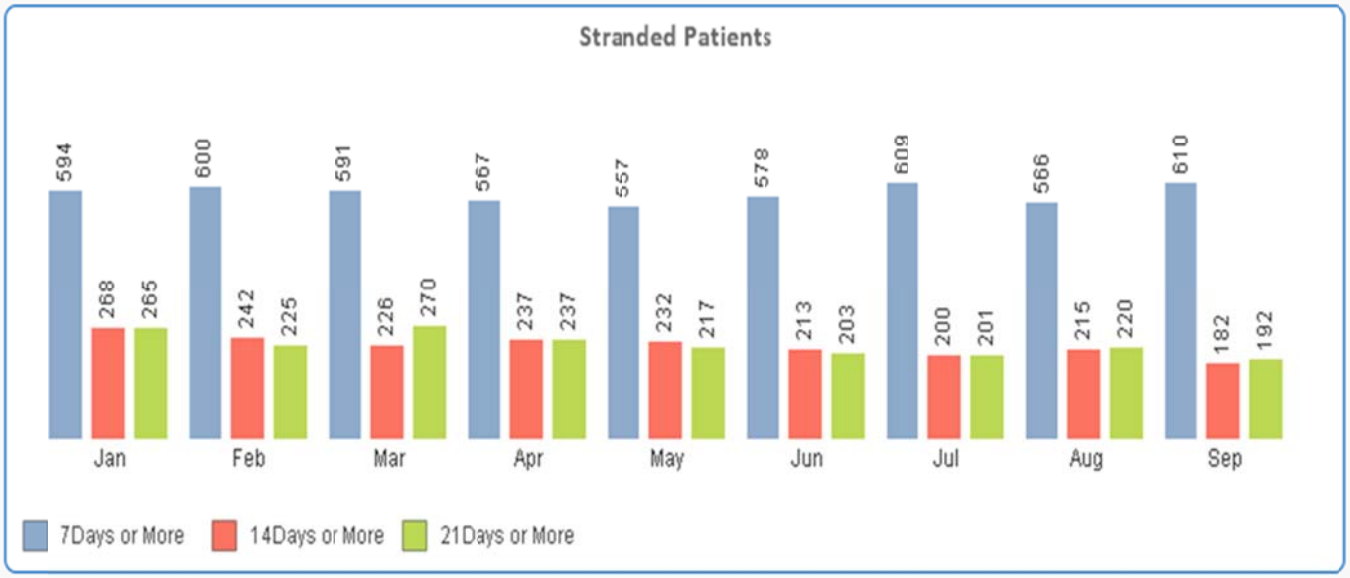
- Patient related – 22
- Late referrals/ errors in referrals – 6
    - 1 from PAH
    - 1 from nursing home
    - 4 from GP (1 Peartree, Park Lane Surgery Broxbourne, 1 Burville House ,1 TBC)
- Capacity issues – 52 (no scan slots, working with radiology)

Comparison of E&N Herts stroke performance compared to other acute providers:

Dec-17 - Mar-18	E&N Herts	Addenbrooke's	Luton & Dunstable	Norfolk & Norwich	Watford	King's London	St. George's London
SSNAP Rating	**A**	C	D	B	B	C	B
SSNAP Score	**86.0**	61.2	59.0	72.0	76.0	69.3	78.5
No. of patients	**313**	207	268	400	196	250	474
4-hrs	**C**	D	E	E	D	D	B
Scanning	**A**	B	A	C	B	A	A
Thrombolysis	**B**	B	D	C	D	C	A
O/T	**A**	C	C	B	A	C	A
Physio	**A**	B	C	B	A	A	D
S&LT	**A**	C	E	C	A	D	C

- Lister outperforming all stroke units within EoE.
- Lister seeing 2nd highest number of strokes within the region (next to N&N).
- Significant improvement in thrombolysis rating, B currently (D grade this time last year).
- Best performing trust against the 90% for 4hrs within the EoE.
- A-grade across the therapies board demonstrates high quality once a stroke is admitted alongside quick intervention at the front door.
- Excellent collaboration ongoing with Charing Cross Hospital for thrombectomy. Service now available until 23:00 seven days per week (currently Mon-Fri 9-5). Excellent outcomes recorded for patients who have received thrombectomy through this arrangement.
- TIA appointments offered within 24-hrs 7 days a week for patients. Uptake variable. Performance patient choice related.

7. Stranded Patients



The Trust has seen a slight improvement in the number of stranded and super stranded patients. This patient cohort is reviewed through the patient flow steering group.

8. Delayed Transfers of Care (DToCs)

Detail	Level	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Delayed transfers of care to be at a minimum level	National	<=2.5%	2.8%	1.8%	2.9%	3.2%	1.9%	3.0%	Not available	1.9%	1.6%	1.5%	1.2%	2.2%	1.5%	1.6%	1.5%	1.3%	1.7%	Data not Available

*Data as per national submission and reported within CCG performance report.

The Trust continues to perform strongly against the DToC standard. There have been community capacity issues within the month resulting in reduced numbers of complex discharges. However, plans are in place to increase capacity through the allocation of significant funds of £240 million for social care provision. ENHT COO to meet with Director of Operations at ENHT county council to ensure social care provision plans are in place for the winter as part of the system plans.

Report ends

Agenda Item: 9.4

TRUST BOARD PART 1 – 7 NOVEMBER 2018

Workforce & OD Board Report – Month 6

PURPOSE	To present an update to the Trust Board on Workforce and OD key work streams and issues.
PREVIOUSLY CONSIDERED BY	QSC 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
DATE:	October 2018

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 2018

BASED ON MONTH 6 DATA

Key Headlines

Executive Summary

The trends for the Trust workforce report for month 6:

- Agency spend reduced by £138k in month, there is confidence the end of year ceiling target will be delivered
- The vacancy rate decreased to 8.7% in month 6, Nursing and Midwifery staff in post decreased by 4 wte, and the trajectory for month 7 indicates 30 domestic new starters plus 10 International starters
- Improved management of sickness resulted in the Trust, for the first time in 12 months, sickness fell below the 4% threshold
- The newly launched staff engagement app is being well received by staff with over 500 staff signed up and news feed articles were opened 1,300 times, and 139 bank shifts booked through this application

Workforce Board Report

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2. Developing Our Culture and People
3. Workforce Efficiencies and Transformation
4. Appendices

1. People Performance

Strategy:
To ensure that we have the people we need to deliver safe, consistent and quality services whilst making optimal use of resources. This will be delivered through the achievement of the resourcing strategy which targets a vacancy rate of 6%; reducing temporary staffing costs through the Trust control environment; improving employee health and well-being and reducing absence due to sickness

- *Vacancy rate (all staff groups)-* 8.7% ⬇
- *Nursing and Midwifery vacancy rate –* 9.7% ⬆
- *Clinical support worker vacancy rate-* 18.2% ⬆
- *Medical vacancy rate –* 6.5% ⬇
- *Bank spend –* 9.7% ⬆
- *Agency spend –* 4.4% ⬇
- *Variance to agency ceiling – 6.8%* under ⬇
- *Sickness in month –* 3.9% ⬇

People Performance

Recruitment and attraction

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.

Actions: Vacancy rate for all staff groups decreased by 0.3% to 8.7% (previously 9%). The number of new starters in M6 was lower than M5 due to the new intake of deanery doctors in M5. There was 123 WTE new starters, this is a gap against target of 34 WTE for nurses and 9 WTE for doctors. The nurse trajectory for M7 indicates a cohort of 30 domestic new starters plus 10 international new starters which will close the gap to meet the target for final year position.

For medical recruitment there was 38 WTE new starters, including deanery trainees, and 29 WTE leavers, giving a net positive position of 9 WTE in month. The medical pipeline for October indicates 12 WTE are due to start. There are a total of 31 WTE doctors in the total pipeline with confirmed start dates for 8 WTE.

Seven candidates have accepted offers for Emergency Medicine Middle Grade posts with start dates ranging from October 2018 – January 2019 with further interviews being scheduled. The increase in recruitment activity for ED Middle Grades means the projected vacancy rate will reduce to 6.5 WTE by February 2019. Two successful appointments for Emergency Medicine Consultant took place on 17th September, of which 1 candidate will commence in October 2018 and the second candidate in January 2019.

From November the CSW recruitment events will be held on Saturdays in tandem with the scheduled Band 5 recruitment events. This is to enable candidates who cannot attend the weekday events which will deliver an increase in the recruitment pipeline.

Temporary staffing

Strategy: To reduce temporary staffing pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To maintain a positive variance to the agency control total. 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.

Actions: Agency spend reduced by 138k from September, Medicine saw the largest reduction in spend of £113k less on agency than the previous month followed by Cancer (£33k) Surgery (22k), W&C (£20k) and CSS (£11k). Corporate increased agency spend by 41k than previous month. Demand reduced across all divisions in M6, both Medicine and Surgery saw the highest reduction in hours with over 3,000 less being requested compared to the previous month. Year to date the Trust is under the agency ceiling by £1k, with further control measures (agency free zones) and a revised operational shortfall plan being implemented in October, Temporary Staffing are confident of meeting year end target.

Although agency spend reduced in M6, the number of breaches increased by 139, the largest increase was seen within A&C (52) vs M5, Medical (38), HCS (30) and N&M (13). ST&T breaches were 12 fewer. The driver for this is the increase in scrutiny over contracts. A revised Temporary Staffing action plan is developed to actively manage price caps breaches across all staff-groups to ensure the target is met at year end, the plan will involve additional weekly challenge and further intelligence on incoming substantive posts to support agency reduction.

Bank pay rates have been reviewed with a view to moving closer to national wage

caps and better alignment with the Herts & Beds consortium. All areas of N&M are included, a paper of recommendation to be submitted to DEC in late October for approval. Overtime activity is also being reviewed to ensure that it is appropriately used across the Trust, a separate paper is currently being drafted with a view to ceasing excessive overtime and capturing activity via the bank in line with any new pay rates.

The Trust continue to report against East of England ceiling rates for Medical staff and continue to be in a healthy position to commence the ratchet down programme commencing in October. The Direct Engagement (DE) project continues to gain momentum, September reporting shows a 67% compliance to DE for new bookings (from a starting position of 41% in June)

A steering group is underway for staffing during winter months when additional capacity is required, the bank team are actively working with agencies to 'lock in' staff who can commit to shifts for a 3 months period on our Winter Ward for Bands 2 and 5, there are currently 13 staff being allocated to wards. Temporary Staffing team are reviewing potential Christmas & New Year incentive modelling with NHSP on dates which are showing an early shortfall following allocation of roster.

The Department of Health pilot continues to make good progress, Workstream 1 (staff engagement app) went live on 10th September and weekly figures show over 570 staff to date have downloaded the app and actively use it for opening articles and reading the daily newsfeed. Workstream 3 (Medical Tech stack) continues to make progress and go-live is expected around November

Absence management

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. To reduce sickness absence to a monthly average of 3.4%.

Actions: Sickness absence has reduced for the second month in a row, not far from the trajectory target and falling below the 4% threshold for the first time in 12 months. There is still considerable work to be carried out, to improve on these figures as the winter months are approaching however a number of new sickness cases coming into the team has continue to rise which indicates that momentum is still high since the launch of the new policy. The WF team continue to drive improved performance in sickness management.

Monitoring of return to work interview compliance has been taking place on a divisional basis which has shown a high level of return in those divisions audited (70% and 88% respectively). Some divisions have also reviewed the quality of the interviews revealing evidence of appropriate discussions taking place and in one division employees were asked to comment on whether they felt the decisions were useful and supportive (80% said yes). This was a useful exercise and there will be value in repeating periodically to ensure there is no drop in quality or compliance.

Targeted training courses have been delivered on site in certain departments and over the next month we will be analysing sickness data in a team and department level in order to identify where further targeted training may be beneficial.

Employee wellbeing

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.

Actions: The staff flu vaccine campaign began on the 1st October and will continue

to February 2019. The organisation aims to vaccinate all frontline healthcare workers, any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine are asked to anonymously mark their reason for doing so.

Last year the vaccine uptake in frontline staff was 70.3%, this year's target linked the staff health and wellbeing CQUIN is 75%.

Vaccines are being administrated by the Health at Work Service in drop in clinics across Trust sites and by a network of peer vaccinators. Weekly reports on vaccine uptake will be provided to managers from the middle of October until the end of February.

The Health at Work service is delivering a range of services that promote employees physical and mental health and wellbeing. Early advice is being offered for staff unable to work due to a musculoskeletal issue, stress related or mental health issue and following injuries at work. Advisors undertake an early assessment, offer advice, signpost staff to appropriate sources on ongoing support and where appropriate refer to fast track physiotherapy, refer to counselling, or online CBT.

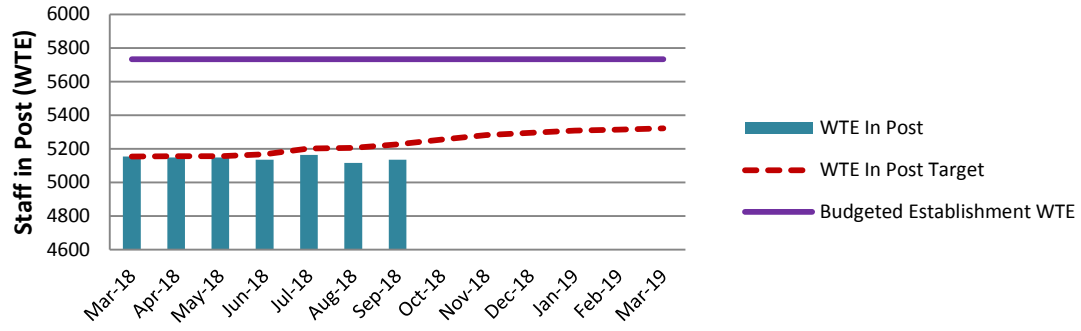
In Sep, 72 employees referred themselves to the Health at work Service, a further 88 referrals were received by managers. Early advice and support was offered to 101 employees who required time off work due to musculoskeletal, stress or mental health issues. In September 11 employees who reported a workplace injury on Datix were offered early post injury advice and support.

In September 15, employees were referred to fast track physiotherapy, 17 employees have self-referred to Workplace Options for advice and counselling.

Staff wellbeing promotion events are held every month to encourage staff to make healthy lifestyle choices. On 13th September the Health at Work Service held a winter wellbeing event at Lister Community Hub to support staff to prepare protecting themselves during the winter.

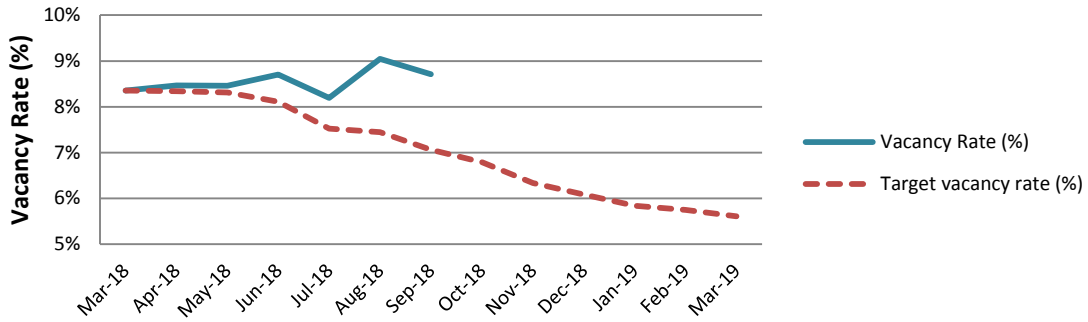
People Performance

WTE in Post Target



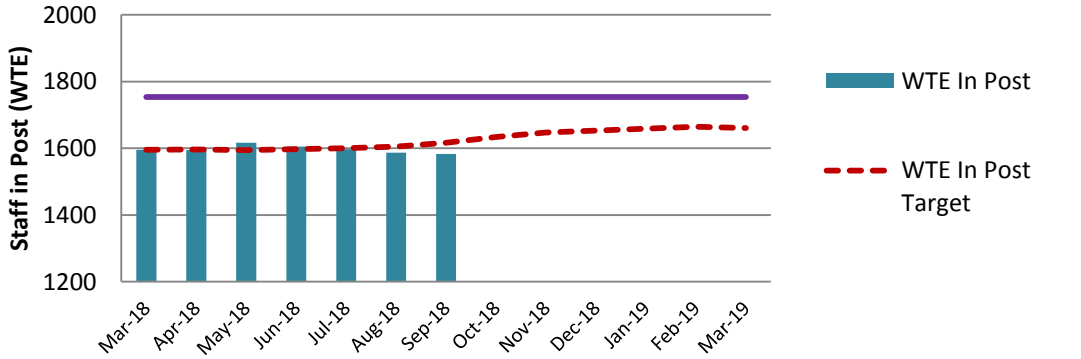
- Staff in post (SiP) increased in M6 by 18.6 WTE compared to M5
- 123 WTE starters coming into the Trust in M6

Vacancy Rate- All Staff Groups



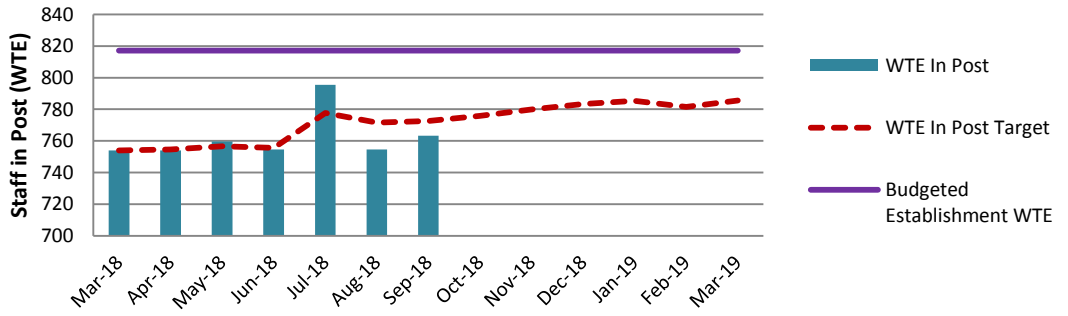
- Vacancy rate decreased from 9% to 8.7%
- Vacancy rate is based on budget at year end 17/18 – 18/19 budgets going through re-validation with finance

Nursing and Midwifery WTE in Post Target



- Nursing and Midwifery Staff in post decreased by 4 WTE in M6, which resulted in the Trust being 34 WTE below target
- Target set to increase staff in post by 65 WTE over 12 months

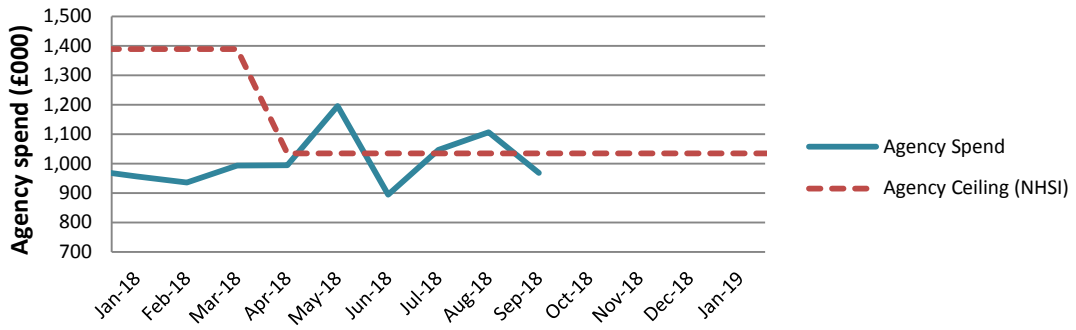
Medical WTE in Post Target



- Staff in post increased by 9 WTE in M6 resulting in 9 WTE below the in month target
- Target increase of staff in post of 32 over 12 months (15 in medicine, 10 in Surgery and 7 in CSS)

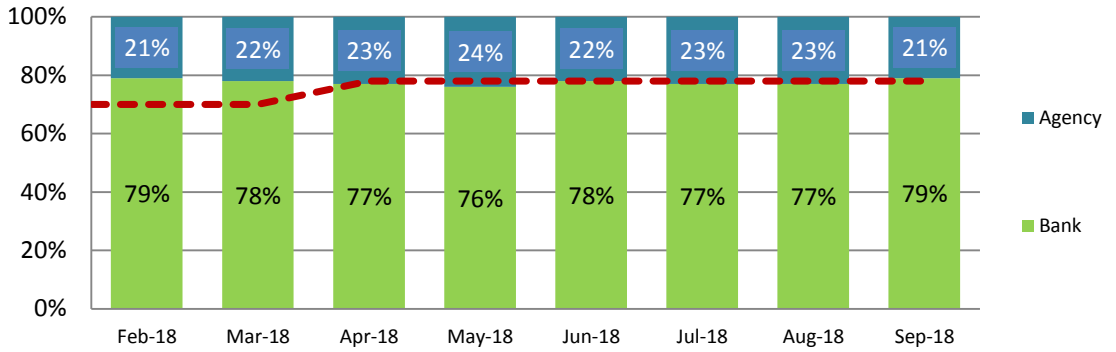
People Performance

NHSI Agency Ceiling Target



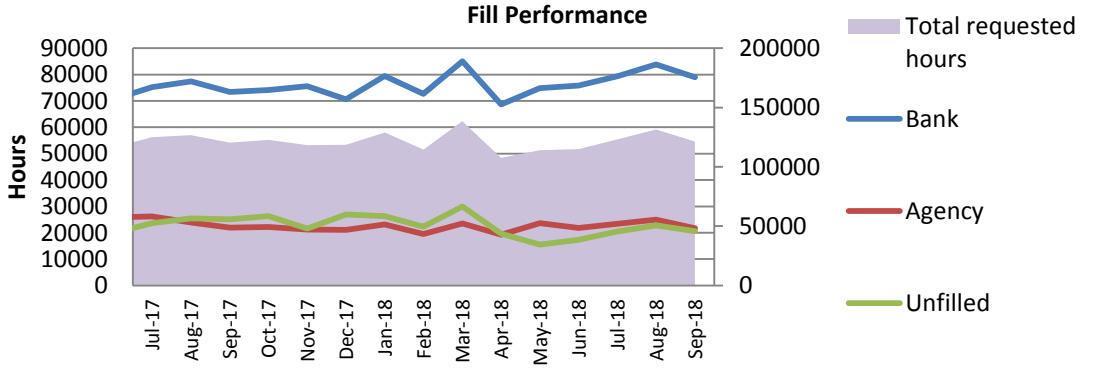
- Agency ceiling target for 18/19 set at £12.4m (monthly target of £1,035k)
- Decrease of £138k in agency spend (Medicine accounted for 19% reduction)
- Positive variance to ceiling target of £66k
- Year to date the Trust is under the agency ceiling target by £1k

Bank and Agency Fill Performance



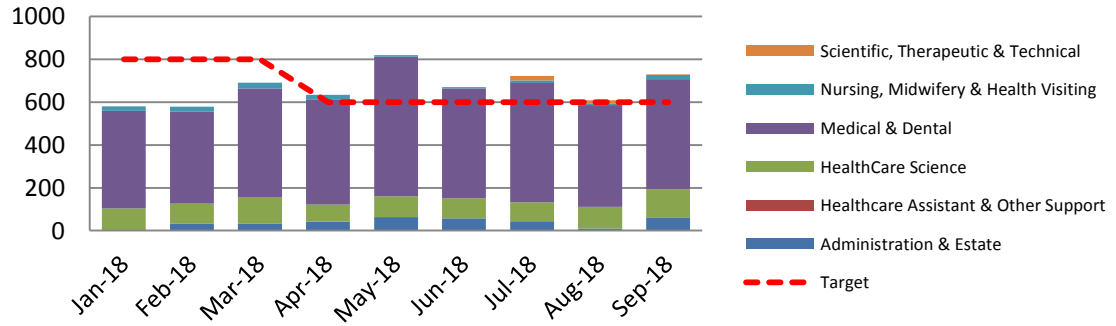
- Bank fill exceeded target in M6 with agency activity reducing by 2%
- Surgery reduced agency activity by 2,060 hours

Fill Performance



- 7% reduction in demand for M6 for total requested hours in line with vacancies reducing by 18 WTE.
- Unfilled reduced by over 2000 hours
- M6 recorded just short of 79k hours of bank fill

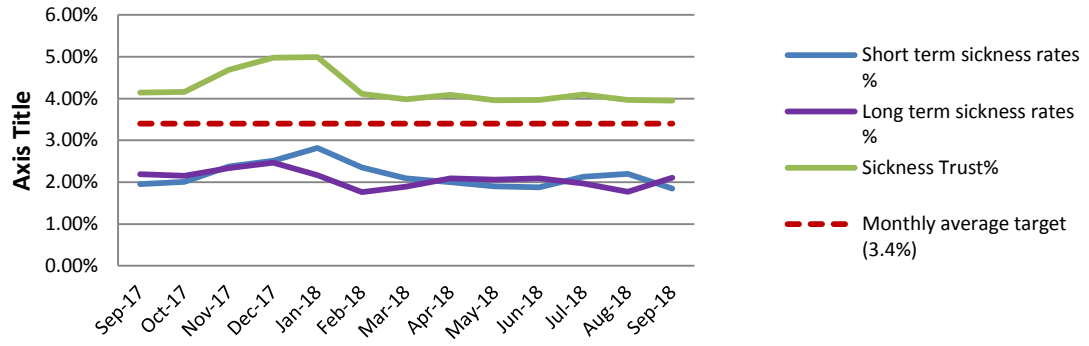
Agency Price Cap Breaches



- Number of breaches increased by 139
- Largest increase was seen within A&C (52), follow by: Medical (38), HCS (30) and N&M (13). ST&T had 12 fewer breaches

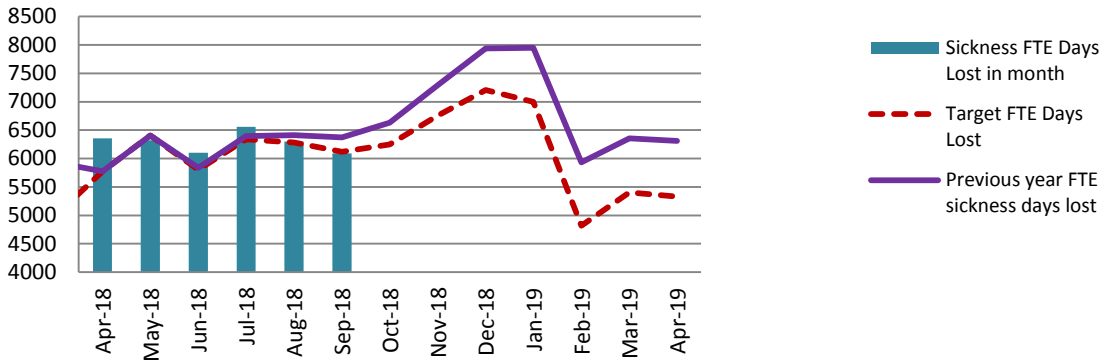
People Performance

In Month Sickness



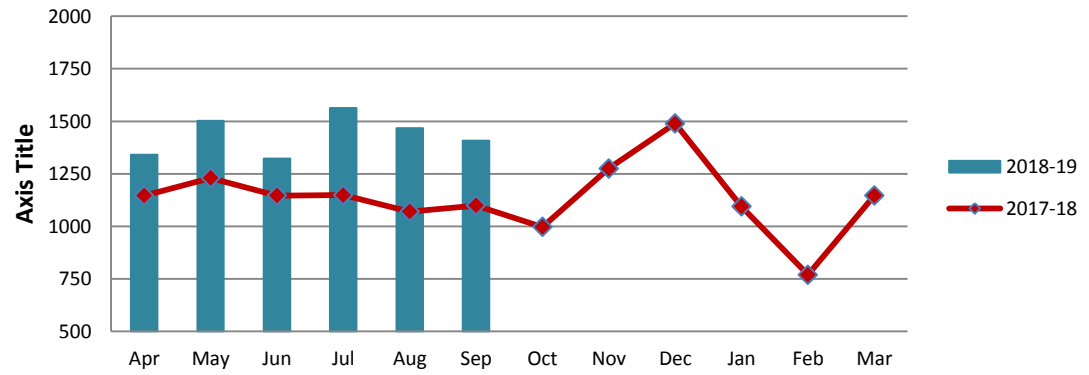
- In month sickness level was 3.9% falling below the 4% threshold for the first time in 12 months
- Short term sickness decreased by 0.35% compared to previous month however this was countered by a slight increase in long term sickness

FTE Sickness Days Lost



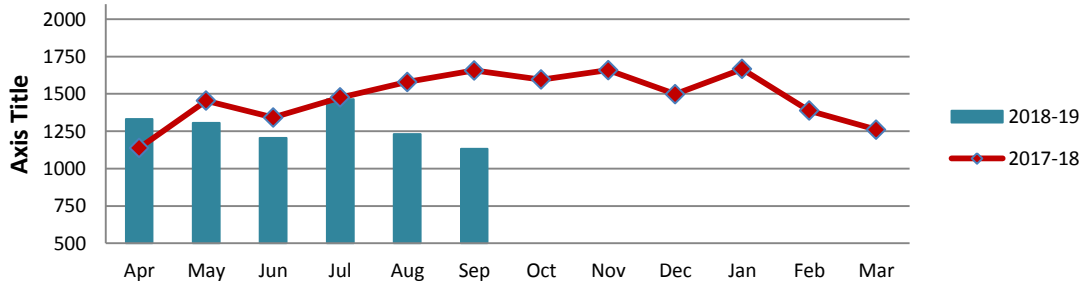
- WTE sickness days lost was 6089– decrease of 209 days
- Positive variance of 27 against planned trajectory.

FTE Days Lost Due to Sickness Caused by Mental Health Issues



- The number of WTE days lost due to stress related and mental health issues has decreased again in September, although is 28% higher than 2017.

FTE Days Lost Due to Sickness caused by MSK Issues



- The number of WTE days lost due to musculoskeletal issues has decreased again in September and is 31% lower than in September 2017.
- Through delivery of the range of services in place the Trust targets a 10% improvement compared to last year in 12 months

2. Developing our culture and people

Strategy: To implement a Leadership model that develops and embeds a culture that enables our people to deliver great care that they, and our community, are proud of. To make East and North Hertfordshire the preferred employer in healthcare locally by creating an environment that makes the experience of working for the organisation easy, recognises, rewards and develops staff which drives high performance.

- *Turnover rate* – 14.1% ⬇
- *Appraisal* – 82.9% ⬇
- *Mandatory training* – 89.4% ⬆
- *LMCDP Evaluation Score* – 4.5 (target 4.5) ●
- *Attendance of LMCDP* – 13 (target 54) ●
- *Engagement score* – 3.6 (bottom 20%) ●

Developing Our Culture and People

Staff Retention

The staff retention steering group takes place monthly which receives reports from four sub-groups covering the following:

- Improved experience of staffing levels on wards
- Improved Clinical Management and Team Development
- Enhanced employment offer and staff benefits
- Improved career pathways and development

A new ENHT staff engagement app has now launched which provides a news feed messaging functionality linked with the ability to book bank shifts. Use of the app is steadily growing with continued promotion. Work is now ongoing to develop the app and look at how further content can be added which provides information and benefits for staff.

The steering group approved the use of an external service to conduct exit interviews which will build on the intelligence of why staff are leaving and enable the Trust to track trends in reasons for leaving. A testing phase has commenced for which feedback will be concluded by the end of October.

The Trust has been reviewing options for training and appraisal systems. A business case is being developed for completion by the end of November. The aim is to improve processes increasing ease of use and enhancing feedback and development conversations. The system can also be used to support the improvement of talent management.

2018 NHS National Staff Survey

The National Staff Survey launched on 1 October 2018, offering either paper or online surveys, depending on staff group and role. The divisions have increased ownership of the survey distribution from previous years. Leaders and line managers have taken increased responsibility for the distribution of the surveys to their teams, with a managers' guide to support them with this. Communications on local actions taken in response to last year's survey are also being used within the divisions. The response rate currently stands at 23.8% which is the best response rate at this point in recent years. More paper than online surveys have been returned, which is unusual at this stage of the process, and could be an early indicator of increased engagement from some patient-facing staff groups.

Staff Friends and Family Test

The Quarter 2 national results will be published at the end of November 2018. The Quarter 2 Staff Friends and Family Test showed a marked improvement in both response rate and results. Responses were received from 413 staff, the highest response rate since March 2015. Additional completion modes were offered this quarter, including paper forms and running the Staff FFT on the homepage of the Knowledge Centre, and the increased response rate. The result for *Recommend for Care,* 75%, is the best result since Quarter 1 2017-18, while the result for *Recommend for Work,* 52%, in the best result since Quarter 2 2017-18. The response rates and results have been distributed to the divisions for information and action. Themes from the comments are similar to those from previous quarters: under *Recommend for Care* these include many positive comments about the quality of care provided and the compassion and competence of the staff. Under *Recommend for Work,* there were many positive comments about the friendliness and team working within the Trust, while negative comments expressed concerns about feeling unsupported by leaders and managers and workload pressures.

Developing Our Culture and People

Randomised Coffee Trials (RCT)

When people get together, meet and network amazing opportunities emerge. This has been he story of the Randomised Coffee Trial. From help with projects, greater understanding of the organisation and mutual support – a real success story.

People attending have had support with projects, decided to stay in the organisation, gained greater understanding, increased income as they realised they were not billing for activity – and enjoyed a coffee and a conversation.

LEND Session Autumn 2018

The 8th LEND Session over a two year period was launched. Post these sessions there will be an evaluation which looks at how best to create and develop appropriate forums for the organisations leaders. The theme will be Ambition, Pride, Compassion and Talent.

University of Hertfordshire and the Apprentice Levy

Our first Apprentice MBS is Oliver Shoffren from MVCC – more will follow.

Mary Seacole

Following the formal evaluation of the programme and the outstanding contribution to its success by ENHT Facilitators and trainers, the STP LWAB has agreed that it will become an STP wide programme in which staff from all STP organisations will have an opportunity to mix and network as well as work on real issues concerning pathways and projects.

Talent Management

Aspire Together nomination complete and ADDS to be planned for. Talent Management Lead to be recruited ASAP

Culture

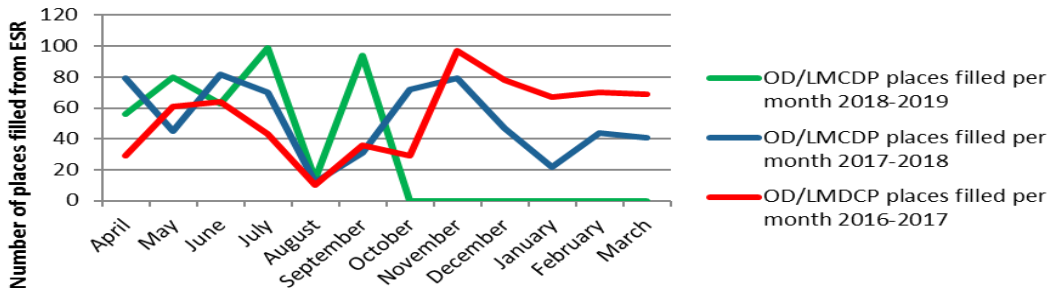
A paper on Talent Management and Culture was passed by the Board – this included identification of 12 workstreams. Discussions about these workstreams and the timeframes is underway and will form 'Developing Culture Through Leadership.'

The cultural statements:

1. We have leaders that empower staff to deliver and enhance performance
2. We place quality and compassion at the centre of how leaders behave and act
3. We create an environment where staff have pride in the care delivered
4. We are clear on our role and purpose in improving performance and efficiency
5. We believe that finance and performance are core elements to improving patient care
6. We welcome feedback as a continuous process of improvement
7. We live our Trust and leadership values through our choices, actions & behaviours
8. We believe the development of staff is a core responsibility of leaders work and we nurture talent
9. We provide a safe climate for challenge and speaking out

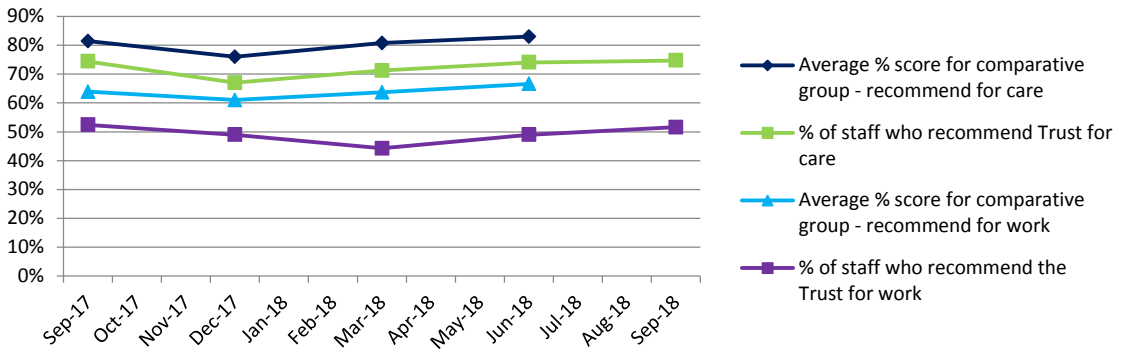
Developing Our Culture and People

LMCDP: Total Attendance for the Month of September 2018



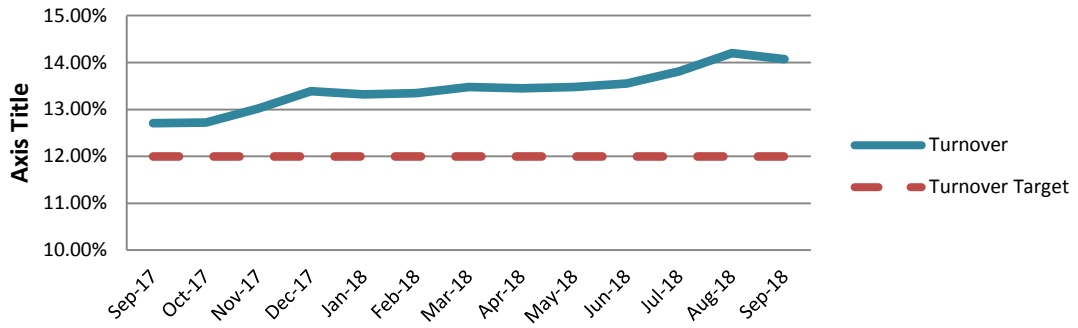
- After the seasonal dip in August attendance figures were back up in August recover over the whole 12 months.

Staff Friends and Family Test



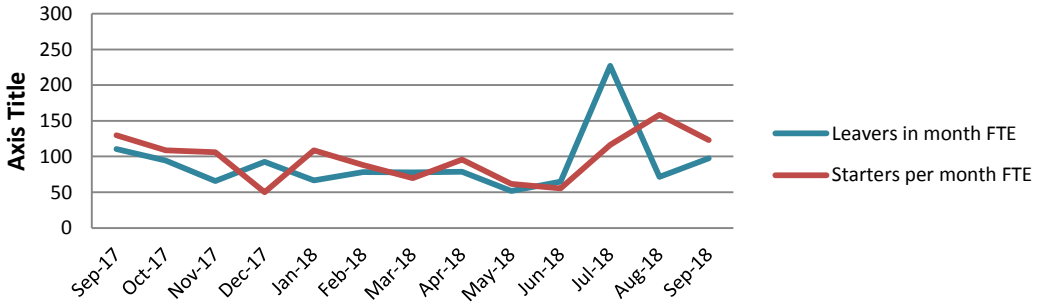
- Friends and Family Test results showed an increase in the percentage of staff who would recommend the Trust as a place to work from 49% to 52%
- 'Recommended for care' also increased to from 74% to 75%

Staff Turnover



- Staff turnover decreased by 0.14% to 14.07% in M6
- The turnover for Nursing and Midwifery is showing a concerning increase up to 13% from 12.8%

Starters and Leavers



- 97 staff left the Trust in M6
- Of the voluntary resignations the most common reason was enhanced job opportunity at 29%. The second highest reason disclosed was salary (13%)

3. Workforce Efficiency and Transformation

Strategy: To deliver more efficient workforce models, within a reduced pay envelope to achieve financial stability and quality patient care, informed by the unwarranted variance in the Model Hospital benchmarking and other comparison information.

Corporate workstream delivered pye savings to target of £580k 

A&C redesign workstream aligned to Lorenzo Stabilisation plan target £343 pye 

Therapy contract review workstream £343 target pye 

Recruitment and Retention workstream slippage, target of £1.4m pye 

Workforce Efficiency and Transformation

Programme Impact and opportunity

The workforce efficiency programme is designed to deliver against three main objectives:

1. Improvement in quality for patients
2. Improving performance
3. Reduction in pay spend

The savings plan was informed by the model hospital benchmarking and other comparison data with the objective of reducing unwarranted variation. The programme includes four 'core' workstreams, there are four core workstreams within the programme:

1. Corporate redesign
2. Recruitment, Retention & sickness reduction workstream
3. Nursing management and Therapies - contract review to improve service levels and reduce LOS, reconfiguration of Nursing organisation designs
4. Admin and Clerical staff redesign to improve the inpatient and RTT pathway and performance

Programme savings and cost plan

The workforce efficiency programme plans to deliver £5.5m (pye) savings, and a net savings of £2.775 (pye)

The programme 4 'core' workstreams savings plan:

1. Corporate redesign net savings - £580k (pye)
2. Divisional A&C redesign net savings – £325k (pye)
3. A Recruitment, Retention & sickness reduction workstream which aims to deliver net savings - £1.5m (pye)
4. Therapies – Notice given to terminate the HCT contract to support a new model of delivery of OT teams and reduce LOS, net savings - £343k (pye)

A specific workforce efficiency team is in place to deliver the plans, supported by a PMO programme manager.

Programme A&C update

- The A&C redesign model will be developed in tandem with the Lorenzo Stabilisation plan
- An element of the Lorenzo stabilisation plan is to reduce the number of manual A&C operational processes and a reduction in unnecessary activity which will be an important input into the Workforce A&C redesign
- The plan, update of the redesign and savings will report firstly to the newly created IFD A&C weekly meeting and then to the Programme Board
- To ensure the savings of £325k are delivered in year, a review is underway into A&C temporary staffing spend linked to vacancies and budget

Corporate workstream Update

Corporate function savings opportunity is £4.1m. The programme savings target is £3.1m (fye) and £580k (pye), with £414k pye delivered in month 5. There are challenges in delivering pay savings from all Directorates. A WF&OD team consultation launched in month 6, with anticipated savings of £300k fye and £151k pye. The detailed savings plans validated by the Finance team are for savings of £756k (fye). The project team continue to progress actions to deliver further opportunities for savings across the Corporate areas.

The new IFD Corporate review weekly meeting will focus on pay spend for substantive and Consultancy staff and identify opportunities for further Corporate savings.

Workforce Efficiency and Transformation

Therapies

This workstream involves a contract renegotiation/termination to improve service levels and reduce LOS. The projected net savings are £343k, detailed discussions between the HCT and the Trust are underway to review in detail the contract. To progress the changes in the service and under the DON's direction, a new Head of Therapies was seconded to lead the Therapy review and was in place in September. The therapy strategy will deliver an improved therapy service to support not just current pathways in the respective divisions but also revised services designed to support effective patient care and flow, this will be a service at a reduced cost and impact on reductions in Length Of Stay. The ward 6a pilot delivered very positive results with a decreased LOS from 4.7 to 2.19 days, a 17% increase in patients going home, and 46% of inpatients being dressed. Next steps include visits to Buckinghamshire and West Hertfordshire Trust to review the therapy models to input into the new service design.

Recruitment and Retention workstream update

The scheme aims to reduce temporary staffing expenditure through improved recruitment and retention rates and reduction sickness days lost. Each division is working to an improvement trajectory which receives oversight and scrutiny as part of the People Oversight Group (POG). Local divisional plans are also supported by central schemes and initiatives.

There were minimal savings identified in quarter one as schemes do not have an impact until quarter two. To date the saving is not on target meaning over-achievement is required in quarter 3 to bring this back on target. A recovery plan has been presented and there is now weekly scrutiny on progress against targets.

Clinical role redesign

A workshop with Divisions including Divisional Chairs was successful in a review of the new clinical models of care and related roles e.g. Advanced Clinical practitioners. The workforce team are providing input in the design, organisation modelling and staffing profile to meet new models of care. Initial areas for review are the Orthopaedic service and Palliative care teams. A clinical diagnostic tool was delivered by the Transformation team to enable Divisions to review future resource models and HRBPs are providing detailed support. This work through an increase in AHPs and senior nursing teams will support clinical savings and help mitigate the change in shortages of the medic staff pipeline. This work is closely linked to the Trust activity defining the future clinical strategy.

Emergency pathway and Patient flow system

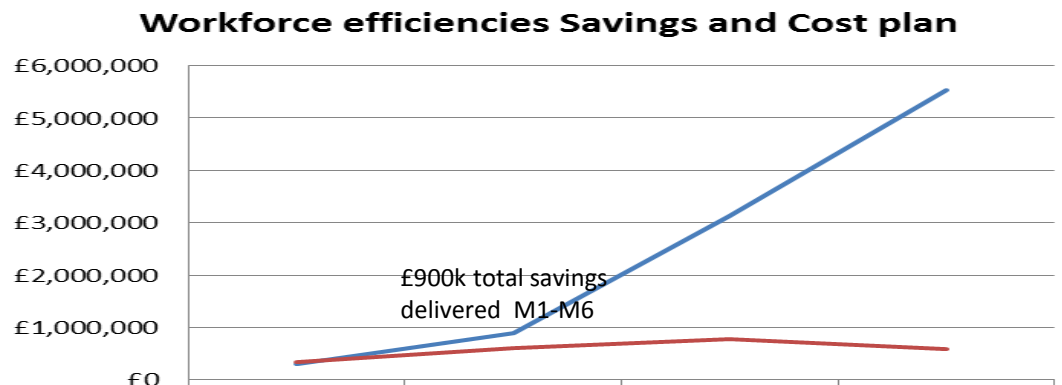
Work continues on the transformation of non-elective pathways within the trust and an Emergency Village is progressing . As part of the initiative, a Bed Bureau has been created and commenced on 17th Sep 2018. The first phase of this model is successfully reducing time spent by consultants on the phone to GP's and allowing for a nurse lead team to develop links to other service providers in the community.
The Bed Bureau will reduce the Medics workload in ED through the Acute Care hot line and ED streaming, the focus for this service is - ED Gen med and ED referrals.
A full trial inclusive of General Surgery is proposed to start on the 5th Nov 2018.

Nursing management review

A review of Corporate Nursing team delivered a savings of £51k fye. A further planned Nursing restructure will deliver greater efficiencies in how services are delivered, a better patient experience, improved staff development including career progression and a reduction of £67k fye. This delivers savings of £118k fye.

Workforce Efficiency and Transformation

2. Programme savings and cost plan



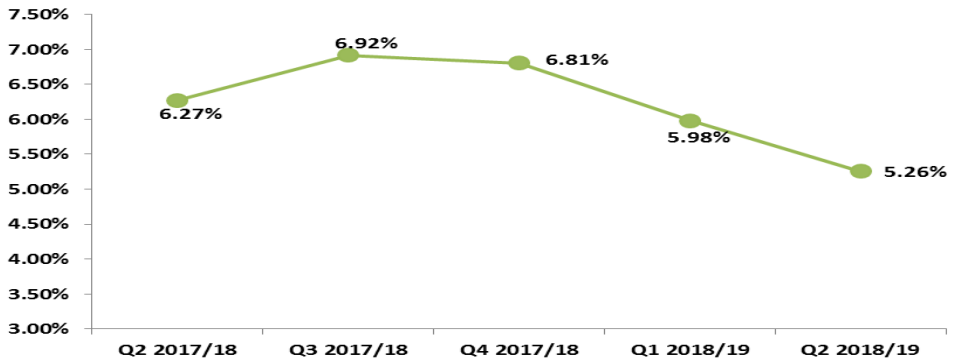
	April to June	July to Sept	Oct to Dec	Jan- March
Savings	£297,000	£900,000	£3,119,000	£5,528,000
Costs	£345,000	£607,500	£772,000	£587,500

3. Programme Workstream Objectives

Quality	• Enhanced patient access to RTT pathways • Standardisation of divisional structures providing parity and equality • Provide a safe staffing environment through retention, reduction of sickness and turnover
Performance	• Improved patient response times • Support delivery of RTT targets • Support clinic efficiencies • Improved performance against Model hospital benchmarking
Finance	• Reduction in Pay spend • Reduction in budgeted WTE • Align with benchmark peers for service costs

Steering Group	Exec Sponsor	Delivery Group	Savings Target PID FYE (Gross) 18/19	Savings Target PID PYE (Gross) 18/19	Savings Target PID PYE (Net) 18/19	Current projected savings
Admin & Clerical	Julie Smith	A&C Redesign	£ 900,000	£ 450,000	£ 325,000	£ 200,000
		Divisional Operational Management redesign	£ 500,000	£ 450,000	£ 78,000	£ -
Nursing & AHP	Rachael Corser	NWBN	£ 147,000	£ 147,000	£ 147,000	£ -
		Nurse Management Review	£ 151,000	£ 75,500	£ 55,500	£ 51,000
		AHP's	£ 80,000	£ 80,000	£ 75,000	£ 35,000
		Therapies Review	£ 340,000	£ 340,000	£ 340,000	£ 247,000
Consolidation & Efficiencies	Tom Simons	Reduction in Temporary Staffing Costs	£ 3,000,000	£ 3,000,000	£ 1,800,000	£ 1,300,000
Corporate Back Office Functions	Rachael Corser	Back Office Functions	£ 3,100,000	£ 1,380,000	£ 580,000	£ 578,000
TOTAL			**£8,218,000**	**£5,922,500**	**£3,400,500**	**£2,411,000**
Pure WFE			£5,218,000	£2,922,500	£1,600,500	£1,111,000

A&C workstream redesign - Divisions A&C Band 2-6 sickness wte



Staff engagement 'pulse' KPIs :

- The programme will track and set a trajectory for reduced for first quarter 2019-2020 of annualised 4.5% sickness and 2 wte less leavers each month

4. Appendices

Index

1. Recruitment Data
2. ERAS Data
3. ERAS Data part 2
4. Medical HR Data
5. Appraisal Data
6. Training Data
7. Benchmarking

4. Appendices

4.1 Recruitment Data

Staff Groups	Wte in Post	Recruitable Establishment	Vacancies	Vacancy Rate %
Admin and Clinical Support (Combined)	1742.10	1810.49	68.39	3.78%
Medical and Dental	763.36	816.14	52.78	6.47%
Nursing Qualified	1582.52	1752.72	170.20	9.71%
Nursing Unqualified	532.06	650.26	118.20	18.18%
St and T	514.39	594.83	80.44	13.52
Total	5134.42	5624.44	490.02	8.71%

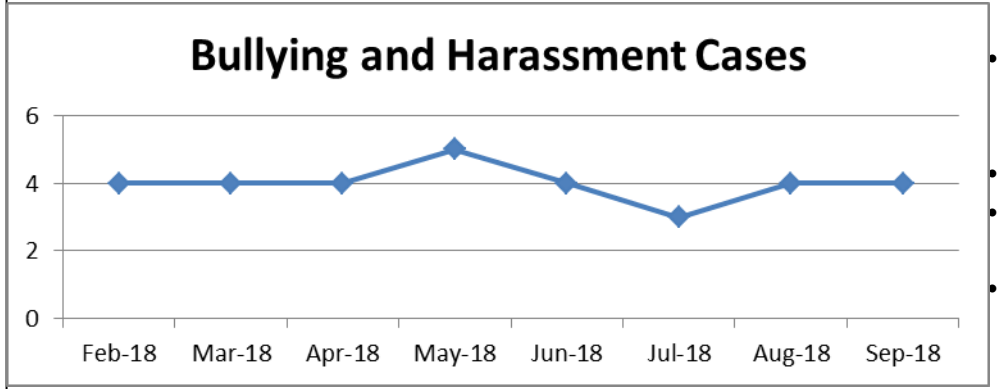
4. Appendices

4.2 ERAS Data

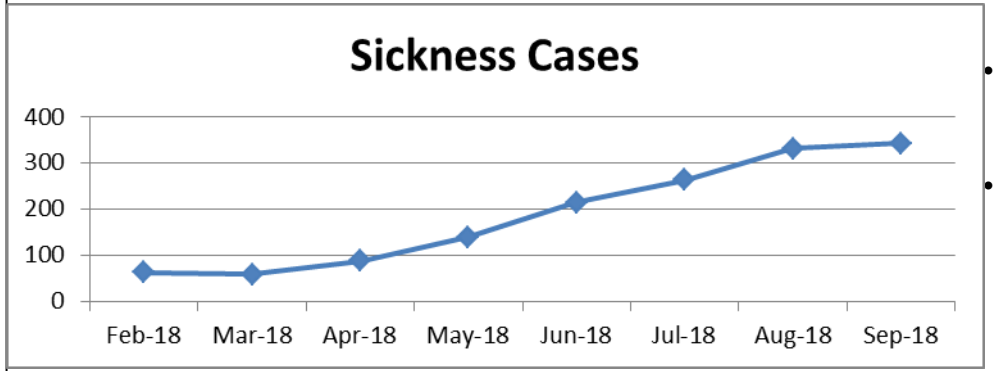
Source: ERAS	Total Live Cases as at 31 August 2018	Total Live Cases as at 30 September 2018	Surgery	Medicine	CSS	Women & Children	Cancer (inc R & D)	corporate
Headcount	5855	5870	1375	1415	938	778	606	758
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	23 (0.4%)	23 (0.4%)	4 (0.3%)	7 (0.5%)	4 (0.4%)	1 (0.1%)	2 (0.3%)	5 (0.6%)
Number of Grievances	10	12	2	2	1	1	4	2
Number of Capability cases	2	2	0	0	0	0	1	1
Number of B&H, discrimination and victimisation cases	4	4	1	1	0	0	2	0
Number of formal short term sickness cases including cases under monitoring	242	259	59	66	57	37	1	39
Number of formal long term sickness cases	90	84	20	26	10	15	3	10
Number of *MHPS cases (Medical cases)	3	2	1	0	0	1	0	0
Total number of cases in progress	374	386	87	102	72	55	13	57
Number of suspensions/medical exclusions (inclusive of over six months)	4	4	1	2	0	0	0	1
Number of suspensions lasting 6 months or longer	2	2	1	0	0	0	0	1

4. Appendices

4.3 ERAS Data part 2



- In September, the percentage of employee relations cases based on headcount within the Trust was 6.5% % which sits above the expected range of between 1% and 3%. There were 402 open cases at month end including; Sickness Absence , Grievance, Disciplinary, Capability and Appeals.
- There was no new case opened in relation to Dignity and Respect at Work.
- Work is continuing to address bullying and harassment concerns and dates are being finalised for future drop-in sessions at each of the Trust sites.
- The re-launch of the Trusts' Speak in Confidence Service will commence in the next 2 months; to notify staff of key changes to the service and increase overall awareness.



- The number of sickness absence cases registered with ERAS for active support have increased in September 2018; we have seen an increase in both STS and LTS cases being referred to the team following the recent policy launch.
- We continue to review all disability related cases to ensure a careful and considered approach is taken. To ensure continuity of all of our services we are unable to entirely discount sickness cases where the disability related absence is unsustainable. The ERAS team are currently reviewing each case on an individual bases to support this process on-going.

Policy Update:

- Focus is currently placed on updating the Trusts Dignity and Respect at Work Policy.
- The Trusts Disciplinary, Sickness Absence and Change Management Policy have all now been signed off.

4. Appendices

4.4 Medical HR Data

Exception Report Division Summary April 2018 - March 2019

April 2018 - September 2018						
	No. submitted exception reports	Total Additional Hours	Paid Enhanced Hours	Paid Basic Hours	Total Pay	Total TOIL Hours
Medicine	**89**	**134.75**	**0**	**37.25**	**£508.22**	**8.75**
Complete	46	55.25	0	37.25	£508.22	6.25
Pending	29	42.75	0	0	£0.00	0
Waiting for doctor agreement	6	8	0	0	£0.00	2.5
Unresolved	8	28.75	0	0	£0.00	0
Surgery	**39**	**114.75**	**0.5**	**36**	**£487.07**	**1**
Complete	15	39.5	0.5	36	£487.07	1
Pending	23	73.25	0	0	£0.00	0
Unresolved	1	2	0	0	£0.00	0
W&C	**1**	**1**	**0**	**1**	**£17.49**	**0**
Complete	1	1	0	1	£17.49	0
Grand Total	**129**	**250.5**	**0.5**	**74.25**	**£1,012.77**	**9.75**

4. Appendices

4.5 Appraisals

Appraisal compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate %
Cancer Services	352	51	52	455	**87.34%**
Clinical Support Services	548	144	180	872	**79.19%**
Medicine	773	145	208	1126	**84.20%**
Corporate	445	120	155	720	**78.76%**
Research & Development	48	7	17	72	**87.27%**
Surgery	728	153	157	1038	**82.63%**
Women's and Children's	473	76	82	631	**86.16%**
Grand Total	**3367**	**696**	**851**	**4914**	**82.87%**

Appraisal by Payband Data

Band	Done	Not Done	Not Due But require review	Grand Total	Completion rate%
Band 1	105	10	27	142	**91.30%**
Band 2	534	120	193	847	**81.65%**
Band 3	489	65	136	690	**88.27%**
Band 4	337	79	65	481	**81.01%**
Band 5	705	132	209	1046	**84.23%**
Band 6	635	112	112	859	**85.01%**
Band 7	369	107	59	535	**77.52%**
Band 8A	117	32	21	170	**78.52%**
Band 8B	32	13	13	58	**71.11%**
Band 8C	27	4	6	37	**87.10%**
Band 8D	8	7	5	20	**53.33%**
Band 9	3	4	2	9	**45.86%**
Trust Pay	3	11	3	17	**21.43%**
Tupe	3			3	**100.00%**
Grand Total	**3367**	**696**	**851**	**4914**	**82.87%**

4. Appendices

4.6. Training

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	64.76%	61.22%	62.17%	63.95%	65.19%	72.18%	65.75%	71.27%
Statutory and mandatory training overall compliance (Incl M&D)	89.39%	87.81%	88.52%	88.23%	91.94%	90.94%	94.30%	91.19%

4. Appendices

4.7. **Benchmarking- Q1 2018/19**

Trust	Mandatory Training Rate Jun 18	Appraisal Rate Jun 18	Turnover Rate Jun 18	Vacancy Rate Jun 18	Sickness Rate Jun 18	Agency Rate Jun 18
Bedford Hospital	87%	78%	15.30%	10.60%	3.50%	6.90%
Herts Community	92%	93%	14.00%	12.90%	2.80%	
WHHT	85%	77%	17.10%	10.70%	3.10%	4.80%
East & North Herts	87%	85%	13.50%	8.70%	3.97%	4.00%
Luton & Dunstable FT	79%	80%	16.00%	14.40%	3.20%	
HPFT	87%	86%	16.30%	15.10%	4.10%	5.80%
ELF Bedford	85%	61%	18.60%	20.10%	7.00%	14.50%
ELF Luton	88%	80%	17.80%	17.60%	4.90%	12.80%
Princess Alexandra	87%	76%	13.00%	12.60%	3.30%	6.60%
Herts Valleys CCG	94%	59%	21.90%	22.80%	1.96%	
Milton Keynes UFT	90%	84%	12.70%	13.50%	3.60%	6.20%
Central North West London FT	96%	93%	18.70%	11.00%	3.60%	6.10%
East & North Herts CCG	91%		18.30%	0.112	1.90%	
Luton CCG	90%	40%	16.00%	14.20%	1.60%	
Bedford CCG	90%	38%	22.80%		3.11%	
Average	89%	74%	16.80%	14.01%	3.44%	7.52%

Our vision: "To be amongst the best"

East and North Hertfordshire NHS Trust

Agenda Item: 10 (a)

TRUST BOARD PART 1 – 7 NOVEMBER 2018

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 SEPTEMBER 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the QSC meeting of 25 September 2018.
PREVIOUSLY CONSIDERED BY	
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:	SEPTEMBER 2018

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 25 SEPTEMBER 2018

SUMMARY REPORT TO TRUST BOARD – 7 NOVEMBER 2018

The following Non-Executive Directors were present:
Bob Niven (Chair), Peter Carter and Val Moore

The following core attendees were present:
Jude Archer, Nick Carver, Michael Chilvers, Rachael Corser and Tom Pounds

The following points are specifically highlighted to the Trust Board:

Emergency Preparedness Report
The Director of Strategy presented the EPRR Report. The paper sought approval from the Committee of the EPRR Core Standards and Assurance Return, which provided an overall compliance level against the standards of 'substantial'. The Committee were informed that a significant amount of work relating to EPRR had taken place over the last year and progress had been made in a number of areas, including the development of departmental BCPs.
The Committee endorsed the:

- Core Standards Self-Assessment
- Trust Business Continuity Plan
- Major Incident Plan
- EPRR Policy Statement

Patient Safety and Incident Report
The Committee received a paper which provided an update on incidents and serious incidents together with an update on falls, pressure ulcers and the safety thermometer. The paper would continue to develop with the aim of providing a comprehensive overview of patient safety across the organisation. It was noted that it was the intention to provide a patient safety and incident dashboard for the next meeting. The Committee also received an update regarding discharge summaries. Of the cases reviewed to date, no patient harm had been identified. The Committee noted the report and actions taking place regarding discharge summaries.

IPC Report
The Director of Nursing presented the IPC Report. The Committee were informed of the latest updates regarding IPC, including the visit by NHSI that took place in August. It was reported that this was an area where further work was required and NHSI would be undertaking another inspection in the coming months. The Committee noted the seriousness of the issues and the steps being taken. Monthly updates would continue to be provided to the Committee.

Equality and Diversity Annual Report and WRES
The Committee received the latest Equality and Diversity and Workforce Races Equality Standard (WRES) Annual Report. The purpose of the report was to provide the QSC and the Trust Board with the annual equality, diversity and inclusion update. The report also summarised the action taken over the last year to provide assurance that the Trust continues to meet the requirements relating to equality and diversity. The Committee was informed that further work was planned for the coming months, including the launch of staff networks. The Committee also discussed the need to ensure unconscious bias did not occur within the Trust and the possibility of undertaking outreach work in the community. The Committee endorsed the Equality and Diversity Annual Report and WRES for publication.

Outcomes:

Cervical Screening Update
The Committee received a presentation from the Cervical Screening Lead. The presentation set out the current challenges and recent achievements regarding the service. The presentation also detailed the actions being taken to overcome the challenges faced. It was highlighted that the early rollout of primary HPV screening would be taking place in November 2018 for the Trust. The Committee noted the presentation.

Surgery and Critical Care Presentation
The Divisional Director, Divisional Chair and Head of Nursing for the Surgical Division provided a presentation regarding the Division's current position, areas where progress had been made and the challenges faced. The presentation also included an update on the work that had taken place following the Trust's CQC inspection and details of risks and incidents affecting the Division. There was some discussion regarding the findings of the CQC inspection report, including some of the specific actions that had been taken as a result.

New Strategy Development Programme Highlights Report
The Committee received an update on the progress with developing the Trust's new 5 year strategy. The Committee noted the report.

Clinical Strategy Guiding Principles
The Committee received a paper which set out the draft guiding principles for the Trust's new clinical strategy which had been developed in consultation with divisional teams and the Medical Director and Director of Nursing. The Committee welcomed the opportunity to consider the paper and commended the process of engagement with the Trust's clinical staff. There was some discussion regarding the link with patient experience and quality. It was felt that the guiding principles would help to provide a coherent narrative with the Trust's strategy. The Committee noted the report.

Maternity Risk Management Strategy
The Director of Nursing presented the refreshed Maternity Risk Management Strategy. The Committee noted the report.

The Maternity Risk Strategy is attached as Appendix 1.

Cyber Security Update
The Committee were informed that the Trust's current status alert had reduced and zero critical actions remained open. Further actions were planned for the next few weeks which it was anticipated would reduce the status alert level further. The Committee noted that there had recently been an internal audit regarding cyber security, the findings of which would be presented to the Audit Committee in due course. The Committee noted the report.

BAF Discussion and Corporate Risk Register Report
The Committee reviewed the latest version of the BAF and the entries that had been assigned to the QSC. The Committee also received the Risk Register Report which provided an update on progress with the actions and training required to deliver the Trust Risk Management Procedure Detailed Implementation Plan. The Committee discussed that risks had not yet reduced as much as had been hoped, but work was ongoing.

Safer Staffing Report
The QSC received the Safe Staffing Report for August 2018. It was reported that there had been a significant increase of risk assessed patients requiring 1-1 care that displayed particularly challenging behaviour and a high number of wards requiring enhanced care. The Unify submission for registered fill % decreased slightly in August with the average day fill %

for registered nurses decreasing from 95.8% in July to 95.3% in August. There was also a brief discussion regarding the long-term issues relating to staffing nationally.

Clinical Harm Reviews Update
The Committee received the Clinical Harm Review Update which set out the overarching principles for the identification and management of potential harm as a result of a waiting list or discharge summary delay; leading to incident investigation where required. There had been no breaches of discharge summary delays reported on Datix that had resulted in harm during August. It was recommended that whilst there was evidence of good reporting of breaches on Datix, there needed to be closer alignment with the performance and access processes to ensure reliability. The Committee noted the findings of the report.

Quality Transformation Programme
The Director of Nursing provided a verbal update regarding the Quality Transformation Programme which continued to progress.

Staff Engagement Programme Update
The Committee received an update on the work that had taken place following the Trust's last staff survey. Key highlights from the report included the forthcoming staff awards, the recent launch of an employee app and the staff pharmacist referral system. The Committee noted that the next staff survey would commence in October and discussed the importance of ensuring that as many staff as possible completed the survey.

Compliance and Regulation Report
The Committee received an update on compliance and regulation, including on compliance with CQC requirements and feedback from the internal and external assessment programmes. It was noted that positive meetings had taken place with the CQC and the management teams for the UCC and Surgical Division. There was a brief discussion regarding the possible future inspection programme for the Trust. It was noted that the quality development dashboard was still under development. The Committee noted the report.

Nursing Competency Assurance Report
The Committee received a paper which provided details of a review of competencies, skills and reporting systems across the Trust in order to ensure a robust system for recording and monitoring of nursing competencies and skills. The data had previously been recorded in a number of different places and work was taking place to bring the information together in one system. The Committee welcomed the update.

Medical Education Report
The Committee received the Medical Education Annual Report. The paper provided an overview of educational activities within the Trust, including an update on the GMC Trainee Survey 2018. Overall results from the GMC Trainee Survey had been good, with only one speciality with repeated Red Flags year on year. Specialities with Red / Green Flags in the Trust had submitted action plans against each outlier. There were some challenges highlighted in the report, including in relation to education and training space, but it was felt that the overall position was stable.

The following reports were noted by the Committee:

1. **Clinical Effectiveness Committee Report**
   The Committee noted the Clinical Effectiveness Committee Report which informed the QSC of matters escalated from the CEC.

2. **Maternity Dashboard**
   The Committee noted the latest edition of the Maternity Dashboard.

Bob Niven
September 2018

East and North Hertfordshire NHS Trust

Agenda Item: 10

QUALITY AND SAFETY COMMITTEE – 25 SEPTEMBER 2018

Maternity Risk Strategy 2018

PURPOSE	To present to the RAQC the Maternity Risk Strategy for 2018
PREVIOUSLY CONSIDERED BY	The RAQC in 2016
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)	The maternity service has a responsibility to imbed risk management within the service in order to continuously improve the maternity care that the service provides.
Healthcare/ National Policy (includes CQC/Monitor)	Care Quality Commission
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Divisional Director – W&C
PRESENTED BY:	Head of Midwifery
AUTHOR:	Clinical Governance Coordinator for Women's Services
DATE:	September 2018

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

MATERNITY RISK STRATEGY 2018

September 2018

EXECUTIVE SUMMARY

The Maternity Risk Management Strategy sets out the principles, processes and strategic direction of Clinical Risk Management for Maternity Services within the Division of Women's & Children's Services. The document is devised for the use of all the members of the multidisciplinary team who are involved in the delivery of maternity care to women and their families. It also sets out the maternity services plan for the identification, prevention and management of risk throughout the unit.

2. CONTEXT/BACKGROUND

The Maternity Risk Strategy:

- Describes the process of risk management within the maternity service
- Demonstrates how the Maternity Risk Strategy is integrated within the overall Trust Board Assurance framework
- Provides a framework within the maternity service through which risk is identified and acted upon to minimise adverse outcomes for service users and staff
- Provides an open culture and proactive approach to risk management to enable practitioners to learn and develop their practice in order to provide high quality care

The Maternity Risk Strategy is reviewed by the Women's Services Clinical Governance Group. The objectives are proposed by the group and approved by the Divisional Board. Outstanding objectives from the previous year are escalated to the Divisional Board and, if necessary, the Risk Register.

3. ISSUES FOR 2016-18

3.1 Objectives for 2018-20 Specifically

1. Decrease the incidence of failure to carry out antenatal screening for women who have consented to this and decrease the incidence of failure to follow up results
2. Increase the number of obstetric consultants in order to be able to meet consultant ward round and medical review standards
3. Attain a rating of "Outstanding" for maternity services at the next CQC inspection and maintain the standards required to achieve this rating.
4. Achieve the requirements of national drivers such as Better Births and the Maternal and Neonatal Health Safety Collaborative and continue to meet the requirements for NHS Resolutions
5. Ensure all staff are released from the clinical areas in order to attend mandatory training and training that is nationally driven and measured.

3.2 Compliance with CQC Standards

A member of the Women's and Children's Division senior management team have been appointed Specialist Advisors to the CQC. Knowledge gained in the fulfilment of this role will continue to be utilised to prepare the maternity service for CQC inspections. The Head of Midwifery, Midwifery Matrons, Clinical Governance Coordinator, Divisional Chair and Clinical Director continue to lead on ensuring guidelines and processes are adhered to and ensuring that there is a maintained focus on quality and safety in practise.

East and North Hertfordshire NHS
NHS Trust

WOMEN'S AND CHILDREN'S SERVICE
OBSTETRICS & GYNAECOLOGY
MATERNITY RISK MANAGEMENT STRATEGY

Produced by:	Douglas Salvesen – Divisional Chair for Women's Services Palmer Winstanley – Divisional Director for Women's and Children's Services Katie Chilton – Head of Midwifery/Nursing and Midwifery services Manager Mary Pollen – Clinical Governance Coordinator for Women's Services
Date updated:	September 2018
Ratified by:	**……Date 06.09.18** Miss. J Leonce – Clinical Director for Women's Services
……	**……Date…06.09.18** Katie Chilton – Head of Midwifery/Nursing and Midwifery services Manager
Policy to be reviewed:	September 2020
Policy to be reviewed by:	Clinical Governance Group
Policy to be used in conjunction with:	Trust Risk Management Strategy Trust Policy for Adverse Incident Reporting & Investigation
Issue number:	12

Version	Date	Comment
1	Sept 2003	First version
2	Dec 2004	Scheduled review
3	Sept 2007	Scheduled review
4	Sept 2008	Scheduled review
5	Aug 2010	Scheduled review
6	Aug 2011	Scheduled review
7	Aug 2012	Scheduled review
8	Aug 2013	Scheduled review
9	Aug 2014	Scheduled review
10	Sept 2015	Scheduled review
11	Sept 2016	Scheduled review
12	Sept 2018	Scheduled review

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 (Intranet). 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:
East and North Hertfordshire NHS Trust: *Risk Management Strategy*
East and North Hertfordshire NHS Trust: *Adverse Incident Reporting and Investigation*
East and North Hertfordshire NHS Trust: *Management of Serious Incidents (SIs) Procedure*
East and North Hertfordshire NHS Trust: *Trust-wide Procedure for Risk Management*

Review
This document will be reviewed within two years of issue, or sooner in light of new evidence.

Key Messages

- East and North Hertfordshire NHS Trust Women's and Children's Board understands that the provision of activities associated with the provision of maternity care and services can incur risks, some of which cannot be easily avoided.
- The Maternity Service is committed to having a risk management culture that underpins and supports the work of the service and the improvement of maternity care and safety and the safety of our staff, women, babies and visitors.

1. I NTRODUCTION

This Maternity Risk Management Strategy sets out the principles, processes and strategic direction of Clinical Risk Management for Maternity Services within the Division of Women's & Children's Services. The document is devised for the use of all the members of the multidisciplinary team who are involved in the delivery of maternity care to women and their families. It also sets out the maternity services plan for the identification, prevention and management of risk throughout the unit. This document should be used in conjunction with the Trust Risk Management Strategy, Trust-wide

Procedure for Risk Management and any local or national documents and guidelines relating to risk within the organisation. It reflects the commitment of the maternity service to improving the quality of care by taking positive action to eliminate, reduce and manage clinical risks identified. The service recognises that risk management must be embedded in order for the service to function safely and effectively. All staff have a responsibility to be familiar with the Maternity Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce and manage risk.

2. SCOPE

The management of risk applies to all staff in the maternity service, contractors, volunteers, students, locums, agency and staff employed with honorary contracts.

3. PURPOSE

- To describe the process of risk management within the maternity services.
- To demonstrate how the maternity risk management strategy is integrated within the overall Trust Board Assurance Framework (Appendix 1).
- To provide a framework within the Maternity Services through which risk is identified and managed in order to minimise adverse outcomes for service users and staff.
- To provide an open culture and proactive approach to risk management to enable practitioners to learn and develop their practice in order to provide high quality care.
- To encourage and support innovation and service developments within a framework for risk management.

4. DEFINITION

Risk management is a systematic process of risk identification, analysis and evaluation and correction of potential and actual risks to a patient, visitor or member of staff.

Although the retrospective review of adverse events provides important information on how systems and procedures can be improved, there must also be ongoing examination of services to predict where latent risk exists.

5. DUTIES

Trust Executive
The Chief Executive has overall accountability and responsibility for risk management within the Trust, and following the implementation of a system of Director line-accountability in 2007, he has delegated responsibility for providing assurance on all areas of risk to individual Executive Directors. The Director of Nursing and Patient Experience is the lead executive director representing the maternity service at Trust Board level.

The Executive Directors are held to account for progress with mitigating identified risks by the Risk and Quality Committee, while the Trust's Audit Committee provides assurance to the Board on the overall process for identification, assessment and management of risk.

Maternity services, for the purposes of risk management and compliance with the CQC standards reports through the Director of Nursing and Patient Experience to the Trust Board.

The Director of Nursing and the Medical Director have joint responsibility for determining the level of investigation following potential adverse or serious events, using information provided by the clinical teams, and declaring an SI or internal review investigation, as appropriate.

The designated Assurance Committees of the Trust Board are the Risk and Quality Committee the Finance and Performance Committee and the Audit Committee. They are supported by the Executive Committees.

The Director of Nursing and Patient Experience is responsible for the implementation of the maternity service risk management strategy. The Director of Nursing reports on the delivery of the strategy to the Risk and Quality Committee. The Trust's Audit Committee provides an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

Responsibilities of all staff

Commitment to risk management is a non-negotiable requirement at all levels of the organisation. All staff throughout the Trust, including contractors and temporary staff, are expected to participate in risk management processes. Specific duties and responsibilities are outlined in the Trust Risk Management Strategy.

All staff, including locums, agency and honorary contracted staff have a personal and professional responsibility to be familiar with the Trust Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce risk (see East and North Hertfordshire NHS Trust Policy for Adverse Incident Reporting and Investigation).

All clinicians and midwives

Medical, Midwifery, Nursing and Allied Health Professional staff have responsibility to assess the risks of the clinical services they offer. They must follow Trust policies and procedures; ensure that identified risks and incidents are dealt with swiftly and effectively; report all incidents and near misses to the Risk Management Department; and undertake mandatory training.

They must inform patients of all common or serious risks relevant to the treatment offered and ensure appropriate consent is sought.

Permission must be sought for the introduction of all new interventional procedures, they must be assessed for risks and appropriate training must be undertaken by the operator before they are commissioned.

Clinical consultants and senior midwives should raise any clinical concerns or risk through appropriate procedures / routes (e.g. Specialty or Divisional meetings, RAQC).

Divisional Chair, Divisional Director and Head of Midwifery and Gynaecology

The Divisional Chair, Director and Head of Midwifery and Gynaecology are responsible for ensuring that effective risk management processes, as described within the Trust's Risk Management Strategy, are in place and implemented within the Division. The Divisional Chair is responsible for leading and monitoring clinical governance issues with relevant staff.

The Divisional Chair

Is responsible for leading and monitoring clinical governance issues with relevant staff.

Head of Midwifery and Gynaecology

The Head of Midwifery and Gynaecology is responsible for providing professional and managerial leadership for midwives and nurses within the Specialty. Professionally she/he reports directly to the Director of Nursing and Patient Experience on all matters relating to midwifery practice within the Trust and is responsible for developing the strategic direction for midwifery and gynaecological nursing.

She/he is responsible for operational management and leadership for Maternity Services and Gynaecology Nursing. One of the responsibilities is to ensure risk management policies and procedures are in place within Women's Services and that all staff understand and are aware of their role in minimising clinical and non-clinical risks.

Clinical Directors
The Clinical Directors are accountable for clinical governance performance of the speciality and in conjunction with the Head of Midwifery for the implementation of policies and procedures for risk management in their speciality area; that is Women's services. They must ensure that risk assessments are undertaken and preventative action is carried out when necessary.

Lead Obstetrician for the Consultant Led Unit (CLU)
The Lead Obstetrician for CLU matters is responsible for providing clinical leadership and organisation for all medical staff working in the labour ward this includes ensuring risk management procedures and policies are implemented, monitored and adjusted to ensure clinical risk is minimised within the service. In conjunction with the Midwifery Matron for Inpatients and the Training Development Midwife he/she is responsible for organising multidisciplinary training, standard setting and ensuring good inter-professional relationships are maintained.

Clinical Governance Coordinator
The Clinical Governance Coordinator for Women's Services supports the Clinical Directors and Head of Midwifery in the implementation of the Trust risk management agenda. She/he co-ordinates risk management activities within the maternity department. This role also provides a link with the Trust Risk Management team and ensures effective communication on risk management issues amongst medical and midwifery staff and the complaints and litigation department. He/she shares responsibility on the prompt reporting of all Serious Incidents (SI) to the Trust Clinical Governance Team and Director of Nursing. The Clinical Governance Coordinator is responsible for the co-ordination of the clinical incident reporting system and, where appropriate, undertakes the lead investigator role when dealing with incidents or litigation claims. He/she ensures that the recommendations and action plans of adverse and serious incidents are communicated to the Women's Specialty group, the Specialty Clinical Governance Group and at the Clinical Governance Rolling Half Day meeting. Any exceptions are escalated to the Divisional Board and, if necessary, the Divisional Risk Register.

Midwifery and Gynaecology Matrons
The Midwifery Matrons are responsible for providing clinical leadership and operational management of defined clinical areas within the maternity and gynaecology service, this includes ensuring risk management procedures and policies are implemented, monitored and adjusted to ensure clinical and non-clinical risk is minimised within the service. They, in conjunction with the Head of Midwifery, Clinical Directors or the Clinical Governance Co-ordinator, are responsible for organising and undertaking investigations of all incidents within the clinical areas, following Trust procedures and policies. This will include implementation and monitoring of agreed action plans and recommendations for change in midwifery or gynaecology nursing practice. They will provide regular progress reports on achievement against action plans to the Head of Midwifery and Gynaecology through the Divisional risk management structure. They will ensure appropriate communication is maintained, involving the relevant personnel in the event of a serious or adverse incident. The operational managers are responsible for undertaking assessments of clinical and non-clinical risk within maternity and gynaecology services.

Midwifery Matron for the Consultant Led Unit
The Midwifery Matron for the CLU is responsible for providing clinical leadership and organisation of all CLU midwifery, nursing and support staff. She supports the lead obstetrician in ensuring good inter-professional relationships and, with the Training Development midwife, provides support in the organisation of multidisciplinary training and standard setting for CLU.

Midwifery Matron for the Midwifery Led Unit (MLU)
The Midwifery Matron for the MLU is responsible for providing clinical leadership and organisation of MLU midwifery and support staff. She supports the lead obstetrician in ensuring good inter-professional relationships when medical staff are asked to attend the MLU and with the Training Development midwife, provides support in the organisation of multidisciplinary training and standard setting for MLU.

Consultant Obstetric Anaesthetist
The Consultant Obstetric Anaesthetist is responsible for providing expert clinical leadership and advice to the obstetric anaesthetic team, implementing any recommended changes to clinical practice, escalating risk management issues to the appropriate group or committee and providing feedback to members of their team.

Lead Obstetric Sonographer.
The Lead Obstetric Sonographer is responsible for promoting excellence in ultrasound practice to ensure the effective delivery of the Obstetric Ultrasound service. She/he will attend the risk management group and clinical governance group meetings on invitation of the Chair. He/she will undertake investigation of the ultrasound element of any incidents or complaints, implement any recommended changes to clinical practice, escalate risk management issues to the appropriate group or committee and provide feedback to the members of their team.

6. Statement of philosophy

The Maternity Service will engage in proactive risk management as part of a systemic approach to risk assessment and in line with the clinical governance agenda by utilising and fostering:

- An open transparent culture (NHS Improvement 2017 & Health and Social Care Act 2014) which supports a learning environment
- Evidence based practice and guidelines
- Practice development
- Continuous professional education and learning.
- Clinical audit and effectiveness
- Research and development

Risk Funding

The Trust obtains cover through the Clinical Negligence Scheme for Trusts and the Non Clinical Risk Pooling Scheme operated by the NHS Resolutions. Both of these schemes have excess levels where the Trust is prepared to underwrite some of its own losses.

Maternity Service Objectives (see Appendix 2 & 3)

1. <u>2018/20 objectives</u>
   - 1.1 Decrease the incidence of failure to carry out antenatal screening for women who have consented to this and decrease the incidence of failure to follow up results
   - 1.2 Increase the number of obstetric consultants in order to be able to meet consultant ward round and medical review standards
   - 1.3 Attain a rating of “Outstanding” for maternity services at the next CQC inspection and maintain the standards required to achieve this rating.
   - 1.4 Achieve the requirements of national drivers such as Better Births and the Maternal and Neonatal Health Safety Collaborative and continue to meet the requirements for NHS Resolutions

1.5 Ensure all staff are released from the clinical areas in order to attend mandatory training and training that is nationally driven and measured.

2. On-going objectives

2.1 Maintain and continually seek to improve the quality of maternity care provided by the service through the identification, control and minimization of risk and the provision of a safe environment for patients, staff and visitors.

2.2 Through the process of revalidation, promote excellence in midwifery and thereby a culture of safe, effective care.

2.3 Promote active risk management and the reporting of adverse/serious incidents with all staff by providing support which encourages reflective review, a positive learning experience and improvements or changes in practice via the application of lessons learned from incidents within the department/division, the Trust and nationally.

2.4 Encourage a culture of accountability and openness in a safe, fair and supported environment

2.5 Ensure risk management systems and processes are clear and understood by all staff and that risk assessments are carried out in accordance with the Trust's risk management process.

2.6 Review and where appropriate implement recommendations from national guidance e.g. NICE (National Institute of Clinical Excellence), MBRRACE, Better Births.

Risk Management Structure and Procedure for Maternity Services

1 East and North Hertfordshire NHS Trust Maternity Services risk management structure follows the Trust policies and procedures for management of clinical and non-clinical risk.

2 All adverse/serious incidents and near misses must be reported by a member of staff in accordance with the East and North Hertfordshire NHS Trust Policy for Adverse Incident Reporting and Investigation.

The Trust and maternity service operate a 24-hour on call rota in the event that a member of staff needs to escalate an incident or obtain advice from a manager or executive.

The Head of Midwifery/ Deputy, Divisional Chair/ Clinical Director, Clinical Governance Coordinator a Midwifery Matron will carry out a multi-disciplinary review of any incident within 24 hours which has or could have resulted in serious harm in order to ascertain whether this needs further escalation and investigation.

When a high risk / serious incident has occurred, a follow-up report is required and should be presented to the Director of Nursing and Medical Director as soon as possible and within a maximum of 3 days (72 hours) of the event. The Patient Safety Manager should also get a copy of this report. This information is recorded onto Datix (East and North Hertfordshire NHS Trust Policy for Adverse Incident Reporting and Investigation). These reports are then presented at the Trust SI review meetings. All Serious Incidents (and Incidents Requiring Investigation (IRI)) undergo root cause analysis. Once declared by the Director of Nursing or Medical Director the Clinical Risk Management Department coordinates all onward regional and national reporting of all Serious Incidents.

3 Completed incident reports are assigned to the appropriate handler for the clinical area. Incidents will be graded using the Datix Web grading matrix. The most appropriate

personnel, e.g. the Midwifery Matron, Consultant Obstetrician or Clinical Governance Coordinator will ensure appropriate action is taken to remedy the situation and address any identified risks in the clinical area. They will involve the relevant personnel in this process. They will initiate investigations, obtaining statements from staff involved in clinical incidents. They will liaise with the Head of Midwifery, Clinical Director and Clinical Governance Coordinator to ensure appropriate clinical investigations of adverse incidents, near misses or serious incidents are initiated and undertaken. It is expected that an initial assessment of the incident will be completed within 24 hours.

Once grading has been completed and initial action taken to address the incident the completed form will be reviewed by the Clinical Governance Co-ordinator for Women's Services and the Patient Safety Manager; it is expected that this will be completed within 48 hours of the incident.

4 The Clinical Governance Coordinator reviews the completed incident reports. She/he will ensure that the form has been completed appropriately and follow up with Midwifery Matrons or Consultants to ensure the appropriate investigation has been initiated, ensuring that statements are obtained from and/or interviews are conducted with staff involved in an incident.

The Clinical Governance Coordinator will support the Midwifery Managers and Consultants to undertake investigations of clinical incidents and will assist in identifying and developing action plans and recommendations to address risks within the Division.

She/he will co-ordinate, analyse and collate risk management information and incident reports and will provide reports for the risk management group, clinical governance group and Divisional Board.

5 If an incident occurs which may affect a patient or group of patients (including those who witnessed an incident), the Consultant / Midwifery Manager must ensure that they are informed of any potential effects and offered appropriate support. See East and North Hertfordshire NHS Trust Policy for Adverse Incident Reporting and Investigation. A 'Duty of Candour' policy should be implemented and includes notification of investigations following incidents and a named person that the patient/ family can contact.

6 Staff involved in an investigation of an adverse or serious incident will be offered support from a senior professional of their choice. In the case for junior medical staff this support will be offered by a Supervisory Consultant, for Associate Specialists or Consultants appropriate support would be agreed with the Divisional Chair or Medical Director. For midwives, support would normally be provided by their Midwifery Matron. If this is not considered appropriate, alternative support would be offered from another Midwifery Matron. Staff should also be offered support via the Employee Support Programme (Tel 0800 243 458) and Counselling Service.

7 **Women's Services Specialty and Neonatal Risk Management Groups**
See appendix 6 & 7 Terms of Reference and membership

8 **Women's Services Specialty Clinical Governance Group**
See appendix 8 Terms of Reference and membership

Relationships between Assurance Standards, Incidents, Complaints, Claims and Clinical Governance.

The Maternity Services Risk Management Structure reflects and supports the Trust's holistic and integrated approach to managing all risks.

Safety and Security

The arrangements for safety and security within the Division reflect the arrangements in the Trust Risk Management Strategy. Incident reports regarding safety and security in the Division are automatically notified to the Safety and Security department via the electronic Datix system.

Reporting arrangements and Communication

- The Clinical Governance Coordinator reports to the Trust's Patient Safety Committee the progress of action plans from all Serious Incidents. The Patient Safety Committee reports to the Clinical Governance Strategy Committee which reports to the Trust Board via the Risk and Quality Committee. The Clinical Governance Coordinator will report back to Clinical Governance Group.
- The Divisional Chair and Director attend the Clinical Governance Strategy Committee which is held monthly chaired by the Medical Director. This committee reports to the Risk and Quality Committee which reports directly to Trust Board. The Head of Midwifery also represents nursing and midwifery for the Division on the Clinical Governance Strategy Committee.
- Women's services provide a monthly report including clinical governance issues to the Divisional Board.
- Women's services also report clinical governance or patient quality issues through the Assurance meetings held every month with the executive team.

Feedback to staff

Feedback to all staff regarding lessons learnt from all incidents, complaints and claims is achieved through a standing item on each staff meeting agenda, Clinical Governance notice board and the Clinical Governance Newsletter. The newsletter is sent to all staff via email, published on the Knowledge Centre and all medical, midwifery and nursing, ancillary and clerical staff are alerted to its' publication and encouraged to access it. Hard copies of the newsletter are distributed in the clinical areas. Learning from case reviews is detailed in the newsletter and discussed at the monthly Clinical Governance Rolling Half Day meeting. Cases of interest for both maternity and neonatal staff are discussed at the monthly perinatal meetings. Individual feedback will be given to those clinicians who have reported incidents via the incident reporting system.

Implementation of the Risk Management Process

1. **Risk identification**

   Risks can be identified following the reporting of an adverse incident or through a proactive approach by undertaking risk assessments. Risks may be identified by comparing practice against standards and guidance on best practice. Incident reporting is encouraged from all levels of staff and is assisted by the development of a trigger list (see appendices 5 & 6).

2. **Incident Reporting System**

   - Access to computers for reporting incidents is available in all clinical areas and via the extranet for community staff. The Maternity Risk Management Strategy and Adverse Incident Reporting and Investigation Policy are available on the Knowledge Centre.
   - Incidents that have, or could have resulted in serious harm or death must be escalated immediately to a Senior Manager, the Director of Nursing and/or the Medical Director and the Risk Management Department. The incident should reported via the Datix web system on the day of the occurrence or when it becomes known.

3. Risk assessment

The Maternity Services will undertake a planned and systematic approach to managing and minimising risk. Information from risk assessments, incidents, complaints, audit, claims and other relevant internal and external sources will be used to improve safety and facilitate learning. The specialty will identify and measure hazards and a valued judgment based on objective criteria as to whether suitable control measures are in place will be reviewed and revised where appropriate. The specialty will maintain a local Risk Register in accordance with the Trust-wide Procedure for Risk Management and it will be reviewed monthly at the Women's Specialty meeting and Divisional Board meeting. Issues that remain unresolved and those of high risk will be incorporated within the Corporate Risk Register. The active Risk Register will be communicated to the Trust Clinical Risk Management Department via the Datix system. The risk register will be formally reviewed as part of the Accountability process. At these meetings the Divisions report on their top risks rated 15 and above, and present action plans for minimising and managing these risks. The top risks will be escalated to form the Corporate Risk Register which will be subjected to review and challenge by the Executive Team and Risk and Quality Committee. Evidence will be maintained to demonstrate that recommendations and action plans have been developed and changes implemented accordingly. The Risk and Quality Committee will report monthly, on an exception basis, to the Board and the Board itself will review the Corporate Risk Register on at least an annual basis (E & N Herts NHS Trust Quality Governance and Risk Management Strategy). The risk management accountability arrangements from specialty level to Board can be seen at Appendix 9.

4. Clinical Audits

The audit leads identify audit topics from e.g.:

- Recommendations made in the national confidential enquiries, including CEMD, NCEPOD, CISH and MBRRACE.
- Mandatory audit topics from the Trust Audit Department
- Reported adverse incidents
- Complaints and litigation
- Risk Assessments
- National Service Frameworks
- Clinical Guidelines
- Weekly caesarean section discussion meetings
- Perinatal discussion meetings.

. Training

1. **Risk Management**

   All staff have access to the Maternity Risk Management Strategy, Trust Risk Management Strategy and Adverse Incident Reporting and Investigation Policy which are all available on the Knowledge Centre. Risk management awareness sessions are included in the in-service training programme and the orientation programme for new staff.

2. **Trust mandatory, PROMPT and fetal monitoring training**

   See East and North Hertfordshire NHS Trust: Maternity Training Needs Analysis

Maternal and Child Enquiries, NICE Guidance, National Service Frameworks, Better Births, Spotlight on Maternity and Saving Babies Lives

Documents pertinent to Maternity Services are discussed at the Clinical Governance Rolling Half Day Audit meetings. Actions plans to fulfill recommendations are put in place. Feedback on progress and outstanding issues are monitored in the Clinical Governance Group.

7. MONITORING COMPLIANCE

The strategy will be reviewed and approved on a biannual basis by Risk and Quality Committee and ratified by the Clinical Governance Group.

The Clinical Governance group will seek assurance that risk management activities and systems are being appropriately identified and managed through the following key performance indicators:

- Achievement of the service's annual and ongoing objectives for managing risk
- Evidence of appropriate management of the risk register in line with the maternity service and organization-wide risk management strategies
- Evidence of involvement of and communication with individuals, committees, sub-committees and groups identified in the strategy as having responsibility for risk management within the maternity service and the organisation as a whole.
- Evidence of key individuals fulfilling their duties as described in the maternity risk strategy including the lead executive at board level, the Divisional Chair, the Divisional Director, the Clinical Director, the Head of Midwifery, the Clinical Governance Coordinator, the Consultant Obstetric Labour Ward Lead, the Midwifery Matron for the Consultant Led Unit, the Lead Obstetric Anaesthetist and Lead Obstetric Sonographer.
- Evidence of communication with and assurances given to the board lead executive
- Evidence of appropriate utilization of the service and organizational risk management structure
- Evidence of immediate escalation of risk management issues to board level when appropriate
- Evidence of reporting of incidents detailed in the trigger list, review and discussion of incidents, complaints and claims (by the named groups/committees) and learning from them and from experience and case reviews
- Evidence of root cause analysis and appropriate external review of SIs and of board assurance that lessons learnt from Sis are implemented and monitored.
- Agenda and minutes of meetings and publication of the Clinical Governance Newsletter evidencing that learning has been from all incidents, complaints and claims has been effectively disseminated to all staff

The Divisional Chair will be responsible for ensuring systems and processes are in place to monitor the effectiveness of the Maternity Risk Management Strategy at least quarterly (via the Clinical Governance Group) and report through to the Board Committees. If any deficiencies are found, an action plan will be formulated, reviewed and monitored by RAQC.

8. R EFERENCES

1. Care Quality Commission (2015): *Regulation 20: Duty of Candour.* CQC. Newcastle Upon Tyne

2. NHS Improvement (2017): *Improving safety and quality in healthcare: safety culture.* NHSI. London

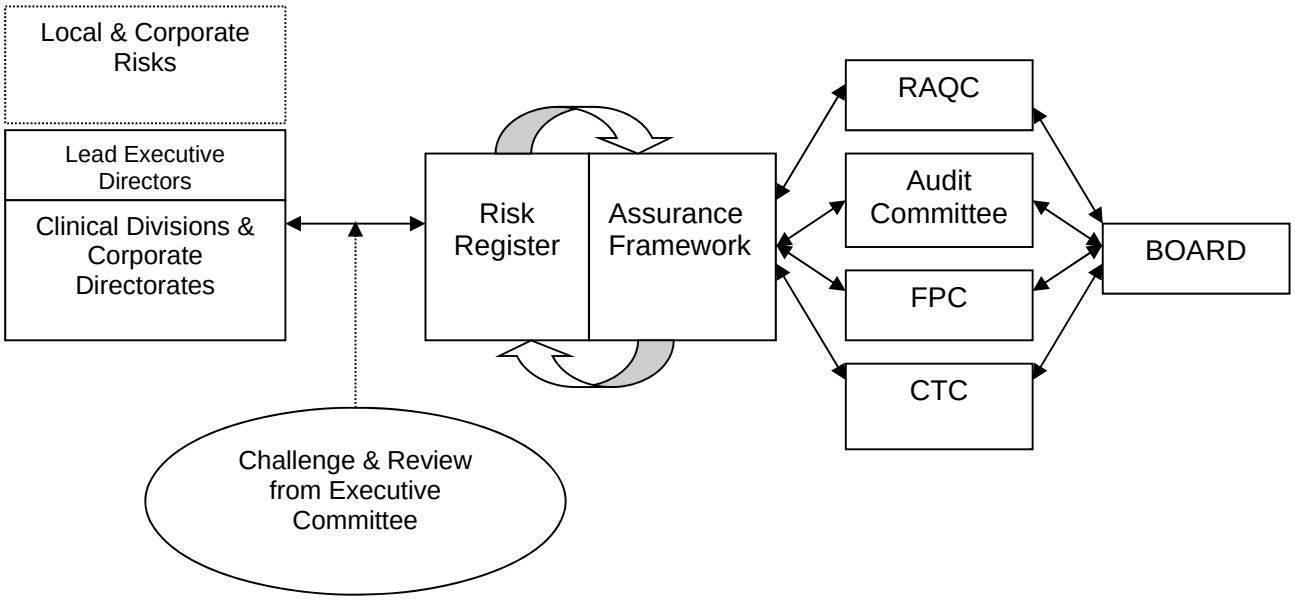
3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20: Duty of Candour.

4. NHS Litigation Authority (2012): *Clinical Negligence Schemes for Trusts Maternity Clinical Risk Management Standards*. Willis. Bristol

5. Royal College of Obstetricians and Gynaecologists (2009). *Clinical Advice No. 2: Improving patient safety: Risk management for maternity and gynaecology.* RCOG. London.

Ap pendix 1

An overview of the assurance process is illustrated in the two figures below.



Appendix 2 **Maternity Risk Management Strategy**

Action Plan 2018-20

	Objectives	Planned Action	Responsible
1.1.	Decrease the incidence of failure to carry out antenatal screening for women who have consented to this and decrease the incidence of failure to follow up results	• Embed a system of recording women's screening results in the maternal records, including screening preferences for women who have accepted or declined screening • Embed a process of continual follow ups for women who are identified as not declining screening but do not have a screening result • Embed a system of women who are not suitable for first trimester screening due to advanced gestation of 19 weeks or over being offered alternative screening on the same day as the scan.	Midwifery Matron for Antenatal Clinic Screening Specialist Midwives Antenatal Clinic Coordinator
1.2	Increase the number of obstetric consultants in order to be able to meet consultant ward round and medical review standards	• A business case has been prepared and discussed at the Accountability meeting and will now be escalated by the Divisional Director with a decision expected by September 2018	Divisional Director
1.3	Attain a rating of "Outstanding" for maternity services at the next CQC inspection and maintain the standards required to achieve this grade.	• Continue to achieve objectives identified on the Quality Development Plan	Head of Midwifery Clinical Director for Obstetrics Midwifery Matrons Clinical Governance Coordinator. Training Team. Audit Lead and Audit Midwife. Senior Midwives Divisional Director Divisional Chair

1.4	Achieve the requirements of national drivers such as Better Births and the Maternal and Neonatal Health Safety Collaborative and continue to meet the requirements for NHS Resolutions	• Appoint a project midwife for Better Births • Maintain assistance for risk management to free up time to complete Mat Neo Collaborative quality improvement work	Head of Midwifery Clinical Governance Coordinator Clinical Director for Obstetrics
5.1.5	Ensure all staff are released from the clinical areas in order to attend mandatory training and training that is nationally driven and measured..	• Present Trust Board with paper in support of uplift in percentage allowance for training	Head of Midwifery
	Ongoing objectives		
2.1	Maintain and continually seek to improve the quality of maternity care provided by the service through the identification, control and minimization of risk and the provision of a safe environment for patients, staff and visitors.	Promote staff awareness and understanding of risk management and incident reporting through local induction and compliance with the maternity training needs analysis.	Midwifery Matrons Clinical Governance Coordinator & Patient Safety Manager Training and Skills Development Midwife
2.2	Through the process of revalidation, promote excellence in midwifery and thereby a culture of safe, effective care.	Promote midwifery awareness of the requirements of the revalidation process. Provide opportunities for reflective discussion with midwifery colleagues. Provide confirmers with time to undertake sign off process	All midwives Professional Midwifery Advocates
2.3	Promote active risk management and the reporting of adverse/serious incidents with all staff by providing support which encourages reflective review, a positive learning experience and improvements or changes in practice via the application of lessons learned from incidents within the department/division, the Trust and nationally.	Continue risk management awareness training session in the monthly In-service midwives mandatory training and in the orientation programme for all new staff. Debriefing following incidents Reflective review sessions	Clinical Governance Coordinator Patient Safety Manager

2.4	Encourage a culture of accountability and openness in a safe, fair and supported environment	Monthly Perinatal meeting Risk Management meetings Risk management awareness during in-service training and orientation programme. Clinical governance newsletter Incident, complaints and claims trends and summary discussed at Clinical Governance Group meeting and displayed on clinical governance board	Clinical Governance Lead Consultants Clinical Governance Coordinator & Patient Safety Manager Clinical Governance Coordinator & Trust Legal Services Manager
2.5	Ensure risk management systems and processes are clear and understood by all staff and that risk assessments are carried out in accordance with the Trust's risk management process.	Continue risk management awareness training session in the monthly In-service midwives mandatory training and in the orientation programme for all new staff.	Clinical Governance Coordinator & Patient Safety Manager
2.6	Review and where appropriate implement recommendations from national guidance e.g. NICE (National Institute of Clinical Excellence), MBRRACE – UK (Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK), Better Births, Saving Babies' Lives.	Compliance with Trust Guideline CSEC 019 "Responding to National Clinical Guidance".	Clinical Governance Coordinator

Appendix 3 **Maternity Risk Management Strategy**

Action Plan Update September 2016 – September 2018

Planned Action	Action Undertaken	Achievement
Continue to improve patient experience and safety of care in the Triage area of Maternity	• Two midwives allocated to triage during the day shift and one MSW 10.00-18.00 Monday to Friday resulting in more timely review. • Midwifery led pathways introduced and embedded resulting in women not having to wait for medical review in appropriate cases. • "Traffic light" system of classification of women visiting Triage fully embedded • System of early assessment of women presenting with history of reduced fetal movements fully embedded	Achieved
Fetal and newborn screening: • Embed guidelines for detection of SGA and increase capacity for ultrasound scans to meet Growth Assessment Protocol (GAP) guidelines. • Implement NIPE Smart	• GROW training and competency assessment continues • Briefing paper outlining need for increased scanning capacity presented but declined by the CCG • Improved detection rate for SGA • NIPE Smart implemented • Lead for managing data input to achieve KPI identified	Achieved
Increase midwifery staffing establishment in line with national recommendations.	• Staffing paper presented to the executive • Secure executive agreement in principal • Secure agreement to finance recruitment • Commission Birth Rate Plus Workforce Analysis	Partially achieved

Attain a grading of “Good” for maternity services at the CQC inspection and maintain the standards required to achieve this grade.	• Increased staff awareness of incidents and risks which impact the safety of our service users and the measures in place to mitigate these • Continued to encourage the PIVOT aim of putting the patient first. • Continued to encourage staff to develop innovations in maternity care • Continued to respond to patient feedback and develop robust action plans to address • Continued to develop staff and provide them with support via appraisal and informal feedback.	Achieved
Ensure incidents are actioned in a timely manner	• Senior midwives have Datix access to all incidents that occur in their area. • Obstetricians and gynaecologists have been trained to handle Datix. • Compliance with Datix management is monitored.	Achieved

Appendix 4

MATERNITY
INCIDENT REPORT INDICATORS/TRIGGERS

Guide for completing the 'Clinical Harm Review' box on DATIX reports

No personal injury/Minimal	Moderate	Severe/death

Where an incident has more than one possible rating the grade of harm will depend on the individual reason or outcome for that particular incident.

Incident	Grade	Incident	Grade
Maternal death		Fetal laceration at caesarean section	
Eclampsia		Fetal/neonatal birth trauma	
Undiagnosed breech by end of 37th week		Apgar < 7 at 5 minutes	
Shoulder dystocia	If injury	Cord pH < 7.05 arterial or < 7.1	
Unsuccessful forceps or ventouse		Base excess > -15	
3rd & 4th degree tears		Neonatal seizures	
Uterine rupture		Term baby admitted to neonatal unit	
Blood loss > 1500mls		Undiagnosed fetal anomaly	Only if missed
Return to theatre		European Congenital Anomalies and twins (Eurocat)	Only if missed
Hysterectomy/laparotomy		Unavailability of health record	
Anaesthetic complications		Delay in responding to call for	
Retained swab or instrument		Unplanned home birth	
Intensive care admission		Faulty equipment	
Venous thromboembolism		Conflict over case management	
Pulmonary embolism		Potential service user complaint	
Readmission of mother		Medication error	
Stillbirth > 500g		Health care acquired infection	
Neonatal death		Violation of local protocol	
Delay in active 2nd stage > 2hrs		Pathology incident	

Ref RCOG 2009

This list is not exhaustive. Any other incident considered by staff as serious regardless of eventual outcome (near miss) should be reported.

Consider further investigation, photocopying of relevant documents and informing the Midwifery Matron.

Appendix 5

GYNAECOLOGY
INCIDENT REPORT INDICATORS/TRIGGERS

Guide for completing the 'Clinical Harm Review' box on DATIX reports

No personal injury/Minimal	Moderate	Severe/death

Where an incident has more than one possible rating the grade of harm will depend on the individual reason or outcome for that particular incident.

Damage to structures (e.g. ureter, bowel, vessel)		Unplanned return to theatre	
Delayed or missed diagnosis (e.g. ectopic pregnancy)		Unplanned return to hospital within 30 days	
Anaesthetic complications		Delay following a call for assistance	
Venous thromboembolism		Faulty equipment	If no harm caused
Failed procedures (e.g. termination of pregnancy, sterilisation)		Conflict over case management	
Unplanned intensive care admission		Potential service user complaint	
Omission of planned procedures (failure to insert IUCD after a hysteroscopy)		Medication error	
Unexpected operative blood loss > 500ml		Retained swab or instrument	
Moderate/severe ovarian hyperstimulation (assisted conception)		Violation of local protocol	
Procedure performed without consent (e.g. removal of ovaries at hysterectomy)			

Ref RCOG 2009

This list is not exhaustive. Any other incident considered by staff as serious regardless of eventual outcome (near miss) should be reported.

Consider further investigation, photocopying of relevant documents and informing the Gynaecology Matron

Appendix 6

WOMEN'S SERVICES SPECIALTY

RISK MANAGEMENT GROUP

TERMS OF REFERENCE

Aims and objectives

- Review of incidents reported since the last meeting
- To recommend further actions or investigations for specific incidents
- Review outstanding actions from specific incidents identified during the previous meeting
- Review reports of actions recommended from previous meeting and investigations
- Identify trends in clinical incidents
- Review incidents scored as moderate of high level of harm
- Ensure learning from these incidents or near misses is implemented within the service
- Report to Women's Services Clinical Governance Group 4 times a year

Membership

- Clinical Directors for Obstetrics and Gynaecology
- Consultant Lead for Labour Ward
- Consultant Anaesthetist for Obstetrics
- Neonatologist or neonatal nurse
- Clinical Governance Coordinator (Chairperson)
- Head of Midwifery and Gynaecology or Deputy Head of Midwifery
- All Matrons for Women's Services
- Senior midwife/nurse from each clinical area
- Practice Development Midwife or Practice Facilitator Midwife Other individuals will be co-opted as appropriate
- Consultant Midwife
- Other individuals will be co-opted as appropriate

Working arrangement

- The meeting will be held at least monthly.

- Incident summary will be provided by the Clinical Risk Department / Clinical Governance Coordinator for discussion.
- Specific incidents will be analysed and action plan will be decided as appropriate
- Recommendations and summary of actions will be reported to the Clinical Governance Group.
- Actions and recommendations identified from the meeting will inform practice and may initiate audit and/or review of protocols and guidelines
- Actions and recommendations from the meeting will be disseminated to staff via staff meetings, memos, clinical governance newsletter and clinical governance notice board.
- Responsibility of action for meeting
    - Keep action notes
    - Matrons, the senior neonatal nurse and consultants are responsible for the assessment and action following through of the incidents that occurred in their area
    - Matrons, the senior neonatal nurse and the consultants are responsible for reporting to the meeting the actions that were taken

Quorum

Four members will be deemed quorate including:
A member of the consultant team
A member of the midwifery management team
Clinical Governance Coordinator

Appendix 7

Women's & Children's Division

Neonatal Incident Review Meeting
TERMS OF REFERENCE

Purpose

1. To review incidents that have occurred from previous meeting.
2. To recommend further actions or investigations for specific incidents.
3. To review reports and recommend actions from previous meeting.
4. To ensure action plans are implemented and embedded in clinical practice.
5. Learning lesson from unanticipated / avoidable admissions will be reported at the NNU Incident Review meeting and monthly Perinatal meeting.
6. To provide reports and present to the Neonatal Clinical Governance Steering Group and RHD - trends, summary and incidents for escalation / risk register.
7. Review Unit's Incident Trigger List annually.

Chairperson

Neonatal Consultant, with Risk Management Lead responsibility

Deputy Chairperson

Senior Sister responsible for Risk Management

Membership

Midwifery Clinical Governance representative
Neonatal Consultants
Neonatal Lead Nurse
Representatives from Neonatal SPRs and SHOs
Neonatal Practice Development Facilitator
Advanced Neonatal Nurse Practitioner
Neonatal Senior Sisters
Band 6 and Band 5 representatives
Band 7 Senior Sister Postnatal Ward

Dates of meetings

Frequency: monthly, third Thursday of every month, except on the third Thursday 3 monthly, when replaced with Neonatal Clinical Governance Steering Group meeting
Time: 1400 – 1530 hours
Venue: Neonatal Seminar Room, Lister

Working arrangements

Minutes of the meetings will be recorded and cascaded to staff and escalated as appropriate.
Summary of action points and investigations undertaken from previous meeting are discussed and recorded.
Actions and recommendations identified will inform practice and may initiate audit and / or a review of guidelines.
All incidents will be analysed and action plans decided on as appropriate.
Learning points discussed and documented.

Quorum

A minimum of **4** members or representatives of the membership should be present at the meeting:
Must be Chaired by Chairperson or Deputy Chair

Neonatal Nursing Manager / Practice Development Facilitator / ANNP
Neonatal Consultant / Associate Specialist / Sister
(if Deputy Chair is leading the meeting, 1 other Consultant needs to be in attendance)

Appendix 8

WOMEN'S AND CHILDREN'S SERVICES DIVISION

WOMEN'S SERVICES SPECIALITY

CLINICAL GOVERNANCE GROUP

TERMS OF REFERENCE

Aim

- Provide a forum for developing strategy for the Specialty as a result of incidents reported through risk management, complaints or litigation claims
- Monitor trends identified through risk management reports, monitor implementation of action plans and ensure the Specialty is taking appropriate action to minimize risk to service users and staff to prevent reoccurrence
- Identify practice development required to improve service delivery and clinical quality
- Identify and monitor the actions required to achieve the above.

Membership

- Divisional Chair for Women's Services (chairperson)
- Clinical Directors for obstetrics and gynaecology
- Infection Control Lead for the Specialty
- Head of Midwifery and Gynaecology
- Neonatologist and Lead Nurse for neonatal services (when appropriate)
- Consultant Anaesthetist for Obstetrics (when appropriate)
- Divisional Director for Women's and Children's Services
- Trust Patient Safety Manager
- Trust Claims and Inquests Manager
- Clinical Governance Coordinator for Women's Services
- Deputy Head of Midwifery and Midwifery Matrons.
- Matron for Gynaecology
- Other individuals will be co-opted as appropriate
- If any individual unable to attend, a nominated deputy should take their place

Working arrangement

- The group will meet 3 monthly
- Review action points from previous meeting
- Receive summary reports of clinical and non-clinical incidents occurring in the Specialty in the previous quarter – identifying trends in incidents and actions taken to minimize risk or prevent recurrence from Women's Specialty Risk Management Group and NICU Risk Management Group.
- Report from the Trust Patient Safety Manager/Clinical Governance Coordinator of trends and analysis of adverse incidents, SI & IRI cases, learning from incidents across the Trust and any good practice that has been adopted by the Trust or other Divisions
- Review and update the Specialty risk assessments and risk register
- Report from Claims and Inquests Manager updating progress on clinical claims and changes in practice identified through clinical claims
- Monitor implementation of staff training and development programme identified from risk management issues at least 6 monthly
- Receive update on Specialty position with regard to infection control policy adherence

Communication

- Unresolved risks which have been entered onto the specialty and corporate risk registers will have action plans formulated and will be escalated to the Divisional Board by the Clinical Director/Head of Midwifery. The responsibility for resolution still lies within the Division.
- Ongoing reports to Specialty meeting
- Women's Specialty Risk Management Group
- Labour Ward Forums
- Senior Midwifery Managers meetings
- Staff meetings
- Clinical Governance notice board

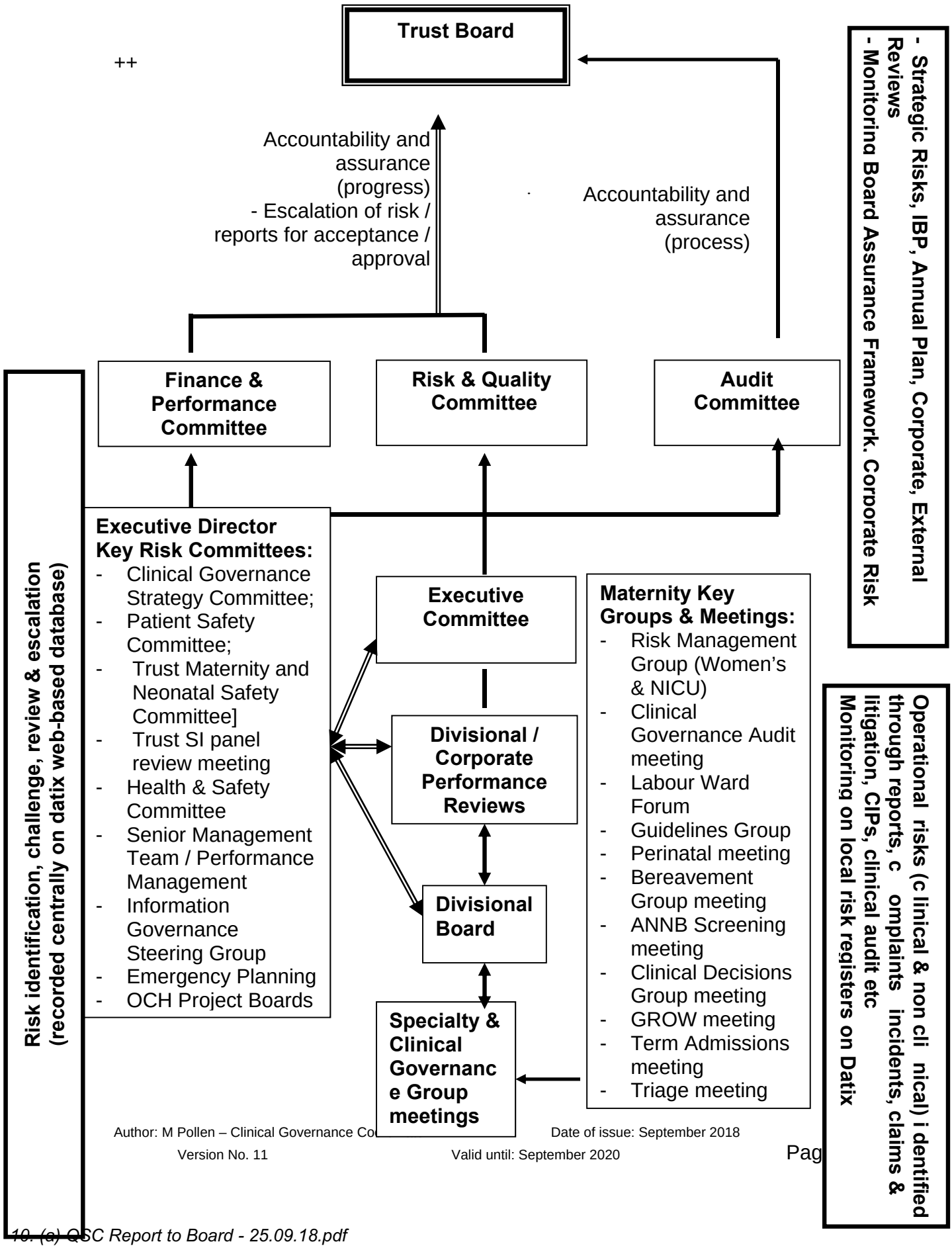
Quorum

Four members will be deemed quorate:
Clinical Chair/Clinical Director
Clinical Governance representative
Head of Midwifery/Midwife Manager
Gynaecology representative

Administration

The minutes of the meeting will be circulated to all members within 2 weeks of the meeting
The agenda will be circulated 7-10 days before the meeting
Agenda items should be forwarded to the chair at least 14 days before the meeting

Appendix 9 Board accountability arrangements – Risk Management



Maternity Risk Strategy – September 2018
Distribution list:

Divisional staff
Chief Executive
Non-Executive Lead
Divisional Chair for Women's & Children's Services
Divisional Director, Women's & Children's Services
Deputy General Manager, Women's & Children's Services
Clinical Director Obstetrics
Clinical Director Gynaecology
All Obstetrics & Gynaecology Consultants
Head of Midwifery/Nursing and Midwifery Services Manager
Midwifery Matrons
LSA Officer, Eastern Region West
Medical Director, Chairperson of Clinical Governance Strategy Committee
Director of Nursing and Patient Experience
Chief Pharmacist
Lead Consultant Microbiologist
Clinical Director Anaesthetics,
Clinical Director Critical Care
Clinical Director for Pathology Services
Clinical Director Neonatology & Acute Paediatrics
Clinical Director Community Child Health & Child Protection
Nursing Services Manager Children's Services
Lead Nurses, Neonatal Services
Head of Quality and Patient Safety
Named Nurse for Child Protection
Patient Safety Manager
Claims and Inquests Manager
Safety & Security Manager
Head of Risk Management, East & North Herts CCG
Chairperson of Maternity Voices
Clinical Quality and Patient Safety, Patient and Carer Experience Lead, East of England Strategic Health Authority
Clinical Quality Manager, East of England Ambulance & Paramedic Service NHS Trust

East and North Hertfordshire NHS Trust

Agenda Item: 10 (b)

TRUST BOARD PART 1 – 7 NOVEMBER 2018

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 30 OCTOBER 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the QSC meeting of 30 October 2018.
PREVIOUSLY CONSIDERED BY	
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 2018

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

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 30 OCTOBER 2018

SUMMARY REPORT TO TRUST BOARD – 7 NOVEMBER 2018

The following Non-Executive Directors were present:
Peter Carter (Chair), David Buckle (Associate Non-Executive Director), Val Moore, Bob Niven and Ellen Schroder

The following core attendees were present:
Jude Archer, Michael Chilvers, Rachael Corser and Tom Pounds

The following points are specifically highlighted to the Trust Board:

Quality Transformation Programme Report
The Director of Nursing provided an update regarding the Quality Transformation Programme. The programme consisted of five key pillars with 32 separate work streams. Many of the work streams were already well established but would be brought together under the programme. The report also included key deliverables and milestones for the QTP. The Trust was in the process of strengthening the teams to support the programme. It was the intention to hold a future Board Development session regarding the Trust's quality strategy. There was also some discussion regarding national quality programmes and initiatives and the opportunity for shared learning and initiatives through the STP.

Quality Dashboard and CQC Update (Including Insight Dashboard)
The Committee reviewed the draft version of the new quality dashboard that was being developed. The Committee supported the proposed dashboard.

The Committee also received the latest CQC Insight Dashboard and highlight reports from the CQC must do and should do action plans. Regarding the Insight Dashboard, the Trust's composite indicator score was -2.3 and remained within the range of trusts that typically rated as 'Requires improvement'. The number of never events over the previous 12 months had led to a declining position for some pathways. The Committee also received an update on the progress with actions taken to address the CQC must do and should do recommendations and the Committee were reminded that there had recently been positive informal visits by the Trust's CQC inspector to the areas they had previously raised concerns regarding.

Workforce Report
The Deputy Director of Workforce and OD presented the Workforce report. The key points highlighted from the report were:

- There had been a reduction in agency spend in month and there was confidence the end of year ceiling target would be delivered.
- The vacancy rate had decreased in month.
- The sickness rate had improved in month.
- Staff engagement activities were ongoing, including the launch of a new staff engagement app.
- The latest staff survey had recently commenced and the completion rate was improved compared to the same point in the previous year.

The Committee discussed the impact of reducing agency usage to fund increases in WTE. It was also discussed that the Trust might need to look at different staffing models to address vacancy issues. It was agreed that a report on exit interview themes would be provided for the next meeting.

Outcomes:

Cancer Services Presentation
The Divisional Chair for Cancer Services provided a presentation regarding the Division's current position and recent challenges and achievements. The presentation also included an update on the work that was taking place following the Trust's CQC inspection (including relating to the End of Life Care pathway) and details of risks and incidents affecting the Division. The Mount Vernon estate remained a key challenge but progress was being made. The Committee also discussed engagement with clinical staff and the importance of ensuring that Board members were accessible and visible to staff based at Mount Vernon.

Cyber Security Update
The Committee were informed that the Trust's current status alert had reduced. There were no critical actions outstanding and the number of high actions had also reduced. It was noted that an updated patching plan was being prepared and would be presented to FPC in November. It was noted that good progress had been made in terms of improving the Trust's cyber security but it would remain an ongoing challenge.

BAF Discussion and Corporate Risk Register Report
The Committee reviewed the latest version of the BAF and the Risk Register Report. The latter provided an update on progress with the actions and training required to deliver the Trust Risk Management Procedure Detailed Implementation Plan. It was noted that the BAF risk target scores had been reviewed and updated. The Committee noted that the Deanery's plans to reduce the rotation of medical trainees to DGHs was a significant risk to the Trust. It was also reported that the Trust was looking to develop a risk management dashboard.

IPC Report
The Director of Nursing presented the IPC Report. IPC remained an ongoing challenge for the Trust and the Trust continued to work towards the agreed improvement targets. The follow up visit by NHSI was scheduled for later in the year and NHSI was supporting the Trust by providing masterclasses for staff. The year to date position (as at end of September) for C.difficile was 15 reported cases against the ceiling target of 10 cases for the year. The year to date position for MRSA bactraemias was 2 Trust attributed cases against a ceiling target of 0 cases. It was noted that a Board Development session had recently been held regarding hand hygiene. The Committee noted the update.

Safer Staffing Report
The QSC received the Safe Staffing Report for September 2018. The number of shifts initially triggering red decreased from 256 in August to 228 in September, which equated to 7.86% in August and 7.44% in September. The Committee also discussed the impact of an increase in risk assessed patients requiring 1-1 care that displayed particularly challenging behaviour and a high number of wards requiring enhanced care. The Committee noted the challenge of providing safe nurse staffing levels at the best cost to the Trust.

Clinical Harm Reviews Update
The Committee received the Clinical Harm Review Update which provided an update on developments relating to the harm review process. The Committee was asked to note progress and to take assurance from the outcomes to date. No harms had been identified from the cases reviewed regarding delayed or unsent discharge summaries. A risk stratification approach was recommended. It was agreed that a summary of the whole harm process would be provided at a future QSC.

Clinical Audit Update
The Committee received the latest Clinical Audit Update. It was reported that nursing audits were now included (and consequently a year on year comparison was not possible). The

report included key achievements related to clinical audit. The Committee discussed the Rolling Half Day programme and the impact of the compulsory audits.

Complaints, PALS and Patient Experience Report
The QSC received the quarterly update report regarding complaints, PALS and patient experience. The Complaints team had now been fully recruited to which would help to improve response times and enable more qualitative work to be undertaken. Regarding the friends and family test (FFT), it was noted that there were limited resources available meaning that the method of collection was not as thorough as it could be. The Committee also noted the findings of the staff FFT and discussed whether the findings would be reflected within the staff survey (which was currently underway).

Non-Medical Education Annual Report
The Committee received the Non-Medical Education Annual Report. The possibility of joining together the Trust's separate education services was being considered. The Committee discussed the Trust's use of apprenticeships and the costs and savings associated with these roles. The Committee also considered the impact of the reduction in CPD funding.

The following reports were noted by the Committee:

1. **Patient Safety Committee Report**
   The Committee noted the escalation report from the Patient Safety Committee. The items escalated were all classed as 'for information'.

2. **CQC- State of Health and Social Care in England Briefing Paper**
   The Committee noted a briefing paper regarding the CQC's report regarding the state of health and social care in England.

3. **Maternity Dashboard**
   The Committee noted the latest edition of the Maternity Dashboard.

Peter Carter
October 2018

Agenda Item: 10.1

TRUST BOARD PART 1 - 7 NOVEMBER 2018

QTP HIGHLIGHT REPORT

PURPOSE	To update the Trust Board on the progress being made against the Trust Quality Transformation Programme
PREVIOUSLY CONSIDERED BY	Q&SC
Objective(s) to which issue relates *	[x] 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)	None to report in this period
Healthcare/ National Policy (includes CQC/Monitor)	CCG, CQC and NHSI
CRR/Board Assurance Framework *	[x] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[x]	For information	[ ]

DIRECTOR:	Director of Nursing
PRESENTED BY:	Director of Nursing
AUTHOR:	Quality Improvement Project Lead
DATE:	01st November 2018

EXECUTIVE SUMMARY

The following report submitted includes:

- An update on the progression of the Trust Quality Transformation Programme (QTP)
- An update on the current status on each of the deliverables which define the process of delivering the QTP.
- A table highlighting the QTP pillars, workstreams, workstream owners and the stage that each workstream is currently at
- A report (attached as appendix) detailing the successes that our workstreams have had this year along with their QTP milestones and focuses.

As part of governance for the programme, we have established a fortnightly steering group and developed a standard operating procedure.

The QTP is currently working parallel to the work around the new governance committee structures as well as the development of the quality and safety metrics dashboard

BACKGROUND

Our Quality Transformation programme (QTP) is made up of four pillars which will underpin the Quality Strategy. The Quality strategy will be one of the five priorities of the Trust Vision and Strategic Priorities 2019 – 2024 that will launch next financial year.

Our Quality Strategy will be designed to ensure that we deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion. The four pillars underpinning the Quality Strategy will be:

- Valuing the basics
- Quality governance and risk
- Keeping our patients safe
- Patient experience

There are a total number of 32 workstreams which are spread between the pillars. Some of the workstreams are already well developed and part of corporate function and or national agendas. Other workstreams are newly developed and have been established to give the Trust a new drive and focus in some of the areas where we are not performing as well in.

QUALITY TRANSFORMATION PROGRAMME HIGHLIGHT REPORT

PERIOD: Q2 - July to September 2018

Executive Sponsor: Rachael Corser **Programme Lead: Sapna Patel**

OVERALL CONFIDENCE RATING	Progress vs workstream plan	Actions delivered vs agreed (previous reporting period)	Resolving risks and issues	Expenditure v Budget	Escalated items to note / for discussion
					No

Total no of workstreams	No. of meetings with workstream leads	No. of outstanding meetings	No. of workstreams with milestones & action plans	No. of workstreams awaiting milestones from
32	29	3	20	9

Scope		
Progress vs work stream plan and agreed milestones	**Key milestones / deliverables**	**Key milestones/ deliverables current position**
	Meeting with workstream leads	On track – There are three outstanding workstream leads to meet with. This will be completed by early Nov.
	Establish milestones and action plans for all workstreams	On track – Currently 20 of the workstreams have milestones and actions plans. The remaining will be established by end of Nov
	All workstream leads to use uniform project plans	Not started - 20 workstreams have established their milestones and already have their own version of action plans in place. We would like them to move over to a uniform project plan template so they can begin to easily provide quality monthly highlight reports which will initially feed into the QTP Steering Group and ultimately feed into the new governance structure.
	Monthly high level reports from all workstreams divisions	To start in Nov
	Metrics and evidence to be collected for each workstream	There are many actions with evidence against them, however they are not yet being captured within the QTP work programme. This will begin by end of Nov.

		We recently recruited a Head of Information and Business Intelligence Lead and a wider review on performance monitoring is underway. The QTP is currently running in parallel with the Quality and Safety Dashboard.
	Monthly reporting to Quality and Safety Committee	QTP steering group will initially hold strategic overview of workstreams whilst the new governance structure and committees are becoming full established
	Implementing actions into business as usual	There are actions within workstreams that are performing at high level and are running as BAU, however they are not yet being captured within the QTP work programme. This will begin by end of Nov.
Key actions delivered in this reporting period	• Meetings with 84% of workstream leads. • Over half of the workstream leads have milestones and action plans agreed and are actively working against them. • Governance and reporting structure for Quality Transformation Programme have been established.	
Key actions outstanding from this reporting period	• Three remaining workstream leads still require a meeting • Milestones and action plans to be established and developed with nine of the workstream leads.	
Key actions planned for the next reporting period	• Uniform project plans to be socialised amongst workstream leads as well as high level reports • Complete meetings with all workstream leads • Establish milestones and project plans with all workstream leads	
Expenditure v budget	• While some of the costs will fall in BAU, we do not have a separate costs or budget for the new QTP workstreams	
New / escalating risks and mitigations	• None reported at this time	
Key Issues	• To streamline project plan and reporting for maternity & newborns so they do not have to replicate information as they currently report to a various number of external and internal bodies.	
Items for consideration/ discussion/ Action	• See issues above	

WORKSTREAM LEADS & PROJECT PLANS

PILLAR	WORKSTREAMS	WORKSTREAM LEAD	CURRENT STAGE
VALUING THE BASICS	Harm Free Care Collaborative	Susan Wilkinson / Karen Cameron	Yes – Workstream has a project plan
	• Falls	Enda Gallagher	Yes – Workstream has a project plan
	• Tissue viability (pressure ulcers)	Joanna Walker	Yes – Workstream has a project plan
	Infection Prevention & Control	Ian McCabe / Jenny Pennell	Yes – Workstream has a project plan
	Documentation, Communication and Handover between services	Karen Cameron / Tim Walker	Some information received for 'Documentation' Meeting to be arranged for discussion of communication and handover between services
	Medicines Management	Andrew Hood / Selina Jiwani	Yes – Workstream has a project plan
	Safeguarding (Children's)	Cheryl Lewis	**Meeting to be arranged**
	Safeguarding (Adults)	Bernadette Herbert	Yes – Workstream has a project plan
	Medical Devices and Use of Equipment	Hamid Khan	**Meeting to be arranged**
QUALITY GOVERNANCE AND RISKS	Structure & Reporting – team and infrastructure	Rachael Corser / Michael Chilvers	Yes – Workstream has a project plan
	Audit and Effectiveness	Alison Norfolk / Deirdre Miller	Yes – Workstream has a project plan
	Policies and Procedures	Jacqui Evans / Jude Archer	Yes – Workstream has a project plan
	Management of incidents and learning from them	Jacqui Evans / Deirdre Miller	Yes – Workstream has a project plan
	Duty of Candour	Jacqui Evans / Deirdre Miller	Yes – Workstream has a project plan
	Risk Management Process	Sarah Cauchi	Yes – Workstream has a project plan
	Data and Reporting	Rachael Corser / Michael Chilvers	Milestones pending
	Learning from incidents to be shared across all areas	Jacqui Evans / Deirdre Miller	Yes – Workstream has a project plan
KEEPING OUR PATIENTS SAFE	Caring for our most unwell patients	Sue Wilkinson & Salva Kumar	**Meeting to be arranged**
	Sepsis Compliance	Anne Hunt	Yes – Workstream has a project plan
	Safer Surgery	Deirdre Miller (interim)	Yes – Workstream has a project plan
	End of Life Care	Kelly McGovern	Yes – Workstream has a project plan
	Maternity and our new-borns	Mary Dollimore / Katie Chilton	Yes – Workstream has a project plan
PATIENT EXPERIENCE	Improving experience at beginning, middle and end of stay	Jenny Pennell	Yes – Workstream has a project plan
	Learning from complaints and patient feedback	Kim Clark	Milestones pending
	Carers	Jodie Deards	Yes – Workstream has a project plan
	Volunteers	David Brewer	Milestones pending

QUALITY STRATEGY	Define Model of quality improvement and reduction in avoidable harm	Rosie Connolly	Yes – Workstream has a project plan
	Safety Culture Survey	Jacqui Evans	Yes – Workstream has a project plan
	Quality Strategy 2018 and beyond	Rachael Corser / Michael Chilvers	Milestones pending
	Clinical Excellence Framework – Ward Accreditation	Karen Cameron	Milestones pending
	Compliance Framework	Jude Archer	Yes – Workstream has a project plan
	Evaluate Improving Patient Outcomes Strategy 2015 – 2018	Sarah El Sharnoubi	Yes – Workstream has a project plan
	Knowledge Centre – Induction for Staff	Sapna Patel (interim)	Milestones pending
	Training and Development	Jacqui Evans & Rosie Connelly / OD team.	Milestones pending
	Well Led	Jude Archer	Milestones pending

APPENDIX

PROGRESS MADE AND MILESTONES COMMITED FOR EACH OF OUR PILLARS

Valuing the Basics Pillar

Harm Free Care (HFC) - What we have achieved so far

- **Quality programme and assurance** to reduce harm in falls. Our quality programme is based on the British Geriatrics Society 'Fallsafe' project and assurance is provided with shared learning that is captured within our newly formed Harm Free Care (HFC) strategy group and HFC panel group.
- Our newly formed **Harm Free Care (HFC) strategy group and a HFC panel group** both meet once a month. The HFC Panel will invite ward matrons on a rolling basis to review their cases of harm; this review will then feed into the HFC strategy group to inform and share learning. The HFC strategy group was established in Aug 18 and the Panel Group began in July 18. Both groups have met twice and are still at the stages of evolving.
- **Newly devised form** that captures key information and data so that teams can effectively review if the pressure ulcer was unavoidable. A similar form is also now available for falls. Both forms will allow for data to be gathered in a way that will provide the Trust with user friendly snapshot data.
- The Trust has a **Falls policy that also sets out the Falls Prevention strategy** which is based on the British Geriatrics Society 'Fallsafe' project and has been historically successful in achieving reductions in inpatient falls. The Trust was an early adopter of the Fallsafe bundle approach and has achieved a reduction in falls of greater than 50%.
- Based on the reduction in falls occurring in the Trust over the course of that last 6 years it is likely that the combination of ward to board performance management system, fallsafe, falls prevention policy, the employment of a falls prevention practitioner have **saved the organisation £3million a year based on NHSI costings.**
- **Falls Improvement Collaborative** - This collaborative is based on the IHI Breakthrough Series Collaborative model which provides a framework to enable rapid testing of changes to learn, adapt and plan for scale up and spread of the work. The ENHT was one of 19 trusts who participated in NHSI national falls prevention collaborative in 2017. The aim of the collaborative was for NHSI to support 19 volunteer trusts to implement or consolidate evidence based falls prevention practice.
- During the program the trust implemented safety huddles, an improved system for monitoring postural blood pressure, Baywatch. (90 day cycle approach)
- Staff involved in benefited from specialist education on the methodology required to implement patient safety initiatives through the use of PDSA cycles and run charts.
- **Education and training** on falls is frequently delivered to wards and also given to Nurses and Clinical Support Workers (CSW) at induction. **Bespoke training** is offered to our overseas nurses.
- Data collected from 2012 onwards show a **year on year decrease of pressure ulcers** in the Trust with 2016-17 being our lowest on record at 50 pressure ulcers. 2017-18 showed a slight increase at 53. There have been no category 4 pressure ulcers since October 2011
- We recently received a report from NHSI outlining 28 recommendations for Pressure Ulcers (July 2018). A gap analysis showed that we are **currently compliant with 11 of the 28 NHSI recommendations** listed in the report. An action plan has been created to comply with the outstanding recommendations.
- Pressure Ulcer Lead Nurse has developed a thorough 2018/19 programme with key milestones including
    - Accurate measuring and reporting of pressure ulcers
    - Engage on a national level to ensure team are up to date with changes in pressure ulcers
    - Equipment used to prevent pressure ulcers are clinically effective and contracts are fulfilled to support patient need
    - Workforce to receive education to inform and promote good pressure ulcers prevention care
    - Improve the quality of documentation

- Develop guidelines and pathways to guide staff on the care of wounds
- Develop the link nurses to assist TVT in the management of wounds
- Increase the use of medical photography
- Collaborate with national TV networks in order to stay up to date on national wound care strategy
- Collaborate with STP lower limb project

Harm Free Care – Milestones and future focuses

- HFC to be a part of an approved **Trust training programme** - so that it captures a wider staff base of learning and promote the importance of insuring that falls are perceived as a multidisciplinary issue and prevention is a shared responsibility.
- Work with divisions to **improve quality of reporting and documentation** – which will improve learning from reports and data, helping divisions identify trends and share learning from RCAs, SIs, IRIs.
- Produce **better care plans** for wounds (all nursing documentation)
  Link the Duty of Candour process to Falls – to insure falls are viewed as clinical incidents as opposed to accidents.
- **Rollout of new forms** (pressure ulcer and falls) to all wards
- **Revise strategy** and work on a pressure ulcer reduction quality improvement plan
- **Develop guidelines and pathways** to guide staff on the care of wounds
- **Engage and collaborate** on a national level / collaborate with national agendas (Pressure ulcers)
- Create a **quality programme and assurance** similar to the falls strategy, to reduce pressure ulcers and thrombosis. From quality assurance we can then set trajectory and targets.
- **Map pressure ulcers against the Serious Incident (SI) framework** - All Grade 4 PUs would be reported as a SI. Anything else would be reviewed and decided at HFC Panel.

Infection Prevention and Control (IPC) - What we have achieved so far

- Extensive **Trust-wide IP&C improvement programme** implemented in response to C.difficile outbreak on a medical ward. Affected ward fully refurbished
- **IPC improvement group** established in May-18 which continue to meet fortnightly
- **Improvement action plan** developed and reviewed monthly.
- IPC workstream for **10 criterion in Code of Practice for IPC** drafted.
- IPC have a workstream process in place to **improve environmental cleanliness**. Key successes so far include:
  - **NHSI Masterclass led by Debra Adams** held 23 May attended by 11 Matrons and 3 members of IPC team. Additional masterclass scheduled for 30 Oct 2018 for Matrons and open presentation for Ward Managers/Matrons.
  - **Cleaning policy reviewed and strengthened** to include roles & responsibilities, cleaning definitions and joint auditing protocol.
  - **Cleaning schedule** for nursing team (weekend cleaning) and **Bed space checklist** introduced on all wards.
  - **Trajectory for improving ward cleanliness** for 'very high risk' areas and 'high risk' areas agreed with the CCG. Monthly updates on progress are being presented to the Trust IPC Committee and the CCG quality review meeting.
  - **Trajectory for improving the proportion of ward cleanliness audits** accompanied by a member of the nursing team has been agreed with the CCG. Monthly updates on progress are being presented to the Trust IPC Committee and the CCG quality review meeting.
  - Matron's checklist which includes **check of environment cleanliness** has been piloted and rolled out to all Matrons from Aug-18. The checklist has also been recorded on Meridian system. Discussed at Nursing & Midwifery Executive Committee and agreed Matrons to carry out minimum of 2 checks per month to Dec-18, then 4 times per month on their own wards.
- IPC have a workstream process in place to ensure **patient equipment is fit for purpose** and to improve equipment cleanliness. Key successes so far include:

- All **mattresses examined and damaged mattresses replaced**. **Pressure Care Equipment Management policy** updated to include checking mattress cleanliness.
- **Patient equipment review** undertaken which identified 79% of patient equipment in good condition, 4% in need of repair and 17% in need of replacement.
- **Equipment open day** arranged with procurement to invite staff, patients and carers to drop in to evaluate range of equipment. Following open day evaluations, Equipment Procurement Group approved standardised equipment for ordering by ward managers
- **Peer inpatient environment audit tool developed**, audit protocol developed as well as schedule for ward managers to carry out audit on a ward in a different division. New audit launched 1 Oct 2018. New audit process presented to NMEC.

- IPC have a workstream process in place to improve **hand hygiene compliance**. Key successes so far include:
  - **Newly enhanced audit programme** rolled out across Trust.
  - **Hand hygiene competency** package developed and competency training carried out on 14 Sept 2018 with 23 ward managers and matrons. Additional training sessions have been booked.
  - **Hand hygiene observation tool** developed on Meridian which will only be carried out by staff who have undertaken the competency training.
  - **Trajectory for improving hand hygiene compliance** for Moment 1 (before patient contact) and Moments 1-5 (WHO) agreed with CCG. Monthly updates on progress presented to the Trust IPC Committee and the CCG quality review meeting.
- IPC have a workstream process to improve proportion of patients on antibiotics for more than 72 hours being reviewed. Key successes so far include:
  - **Antimicrobial point prevalence audit** undertaken in June 2018.
  - **Trajectory for improvement** in proportion of patients reviewed within 72 hours agreed with CCG. Monthly updates on progress presented to the Trust IPC Committee and the CCG quality review meeting.
  - **Audit of a sample of patients** on each ward undertaken two-monthly ongoing since Sept 18. Audit results reported and reviewed at Divisional IPC meetings. Comprehensive prevalence audit to be carried out annually.

Infection Prevention and Control - Milestones and future focuses

- Programme to **improve environmental cleanliness** - including implementation of cleaning assurance process, dynamic mattress cleaning / decontamination assurance
- Ensure **patient equipment is fit for purpose** - which will include replace equipment unfit for purpose, old/ damaged equipment and equipment cleanliness
- **Hand hygiene** competency and compliance - including revising key quality indicators for hand hygiene as part of Trust programme to revise other key quality indicators
- Review of patient who are being **treated with antibiotic within 72 hours**
- **Waste streams** and management
- **Board support** for improvement programme
- **Preparation for NHSI visit** on 11th December 2018

Documentation, Communication and Handover between services – What we have achieved so far

- The aim of the documentation group was to review existing nursing documentation and introduce a suite of care plans designed to give individualised care planning. The initial group commenced back in April with representation from Nurse Education, TVN, Infection Control, Matrons and Ward Managers. Initially one medical and surgical ward was chosen to pilot the new care plans and revised nursing assessment proforma. This was then extended to a further 2 wards. The initial pilot wards were 8b, SSU 5b and Pirton
- 17 Care Plans introduced through the pilot wards, this included the revising the Essential Nursing Care Bundle.
- A documentation audit review was conducted in September. A total of 20 set of nursing records were reviewed and on the whole the care plans were been used appropriately. The plan now is to

roll out the suite of care plans Trust wide.
- Further information on patient e-records, communication and handover between services to be discussed in a joint meeting with clinician Tim Walker.

Documentation, communication and handover between services – Milestones and future focuses

- **Roll out of 17 care plans** (nursing assessment and care plans according to patients holistic needs) Trust wide will commence at the beginning of December. MVCC will implement the care plans in November.
- In the future the **nursing care plan record will be as an electronic version**. Further work to happen through the stabilisation transformation group.
- Documentation Lead & Associate Director of Nursing, Karen Cameron to link in with Pressure Ulcer Lead Nurse, Jo Walker and work with the Emergency Department to improve their documentation for skin inspection
- Further milestones and focuses to added once meeting with joint clinical lead of this workstream takes place

Medicines Management - What we have achieved so far

- The **peer reviews for surgery** have been successfully completed on a weekly basis with reports sent to the division. Improvement has been seen in wards in relation to the safety and security of medicines.
- The following **medicines management topics** were discussed at the Safety Huddle in September 2018 - Delays and omissions of critical medicines & documentation of allergy status. Improvements have been seen.
- The **Hospital Pharmacy and Medicines Optimisation Assessment Framework** was completed and presented at the July 2018 Clinical Effectiveness Committee.
- **Ambient temperature log books** have been approved at NMEC in September 2018
- The **IV administration policy** has been updated and approved at NMEC on 12th September 2018 subject to the addition of radiographers and medical practitioners.
- The **medicines management nursing quality indicators** have been developed onto the meridian format. Testing is underway to ensure the reports produced via Meridian are correct.
- **Transdermal patch chart** approved at TPC in September 2018. Next steps are in progress with the launch of the transdermal patch chart
- Order has been placed for **125 ambient thermometers**. Discretionary funding form completed and sent to G&C. The order has been approved and placed.

Medicines Management – Milestones and future focuses

- The development of the **Trust Medicines Optimisation Strategy** which incorporates the Trust Quality Management System and Medicines Optimisation Framework produced by NHS Improvement
- **Safe & secure storage of medicine** - To implement peer review audits on medicines management across the Trust.
- To implement the **Transdermal Patch Chart** across the Trust for all in-patients
- **Ambient Temperatures** - Daily monitoring of ambient temperatures in all ward and clinical areas
- Change of process for the **administration of IV medications** in clinical areas
- Ensure **oxygen is correctly prescribed** for adults and paediatrics
- To develop the **medicines management nursing quality indicators** and the medicines management indicators for the patient quality & safety dashboard

Safeguarding our most vulnerable patients - What we have achieved so far

- Safeguarding team are actively working against an **action plan based on eight recommendations which have come from a Mental Capacity Act (MCA) review** completed by an Sylvia Manson an

Independent Consultant for Health & Social Care. The recommendations are based on:

- Culture, Leadership and Workforce
- Systems and structures supporting MCA
- Involvement and maximising decision making
- Assessing capacity and best interest decision making
- Managing restrictions and restraint and deprivation of liberty

- Safeguarding team achieved against recommendation 6. **'**Review roll out of new DNACPR form to ensure mental capacity assessment is included' in March 2018. The **Trust's DNAPCR now includes a MCA assessment**
- Safeguarding team are actively working against an action plan **based on four standards set by a NHSI report 'The learning disability improvement standards for NHS trusts'** published in June 2018. The recommendations are based on:
  - Respecting and protecting rights
  - Inclusion and engagement
  - Workforce
  - Specialist Learning Disability Services
- Against these standards safeguarding have achieved the following:
  - **Acute Liaison Nurses are in post** employed by Herts County Council (HCC). Memorandum of Understanding and honorary contracts in place to outline agreed role and functions. Service is available Monday to Friday 09.00-17.00
  - **LeDeR Mortality Review process** in place in Hertfordshire as well as **Standard Operating Procedure (SOP)** for LeDeR reviews
  - **Trust Mortality review** process in place and includes patients with learning disabilities
  - Mortality reviews are part of the Trust governance processes
  - **Two senior nurses trained** for LeDeR mortality reviews
  - Adult Safeguarding Named Doctor is member of the Herts learning disability (LD) mortality review panel
  - **Learning is shared** through the Trust clinical governance processes and clinical governance half days
  - Links are established between the Trust mortality review team and the HCC local area contact to share information about deaths of people with LD
  - **Mortality review board** in place with CCG involvement

Safeguarding our most vulnerable patients – Milestones and future focuses

- **2018/2019 Action Plan for safeguarding** includes a total of 41 projects around the following themes:
  - Assurance, SAR/MASIR/DHR, Policy Updates, Champion Roles, Hertfordshire Safeguarding Adult Board (HSAB) and sub groups, Learning from Incidents, Adult Safeguarding investigations, MARAC information, Training workforce, IT systems, Mortality reviews. Learning disability, Clinical supervision. Safeguarding information on Trust intranet
- **Actions based on the NHSI report 'The learning disability improvement standards for NHS trusts'** include:
  - **Admission Pathway for people with Learning Disabilities** requiring admission for investigations/treatment under sedation/anaesthetic
  - **Electronic patient records and patient information systems** have the ability to record LD alerts and to report using the alerts
  - **Explore use of Serious Case Reviews (SCR)** to provide information about people's disabilities and access requirements
  - Information from the **Hertfordshire Mortality Review Steering group** to be shared with the Trust and fed into Trust wide learning systems
  - Refresh and review role of **LD champions** and re-invigorate the profile of the role
  - Demonstrate how Trust **involves people with LD and Autism in service design** and improvement work including staff recruitment processes for key roles
  - **Review processes for involving people with LD and autism** in co-design and engagement work and consider how effective partnership working can be achieved through the Herts wide LD forum networks

- Services to commit to achieving **Purple Star accreditation**
- **LD training Needs** to be incorporated at induction for all staff

- **Action plan based on eight recommendations which have come from a Mental Capacity Act (MCA) review** include:
  - Develop a **Trust competency framework** based on the National MCA competency framework document. Agree implementation plan with Divisional Leads and Education teams
  - Develop a **competence based workbook** for staff. Agree implementation plan with Divisional Leads and Education teams
  - **Update Trust MCA policy** with Hertfordshire policy and implement use of the Hertfordshire MCA forms
  - **Electronic patient records** to include functionality to support use of MCA and DoLS
  - Patient records show evidence of completion of the personalised information for patients and use in **individualised care plans and care planning** which takes account of taking account of the patient's mental capacity and their best interests decisions
  - **Behaviour observation records** to include personalised care plan for the person to aid staff with interventions that help to reduce anxiety, agitation, distress or aggression in an individual.

Quality Governance and Risks

Audit and Effectiveness - What we have achieved so far

- **Audit Database**
  - Changes made to the design and functionality of the **Trust internal audit database** which facilitates improved monitoring of implementation of audit actions.
  - Inclusion of a "Current" Guidance tab on the **Clinical Effectiveness database**, once this work has been fully completed it will enable information on the number of NICE/National Reports are currently relevant and applicable to the Trust so that our % of compliance can be more accurately monitored and measured.
- **Audits**
  - Audit department participate in **100% of NCEPOD audits**
- **Action Plans**
  - Greater focus has been placed on monitoring the **quality of audit action plans** received, challenging clinicians when poor or incomplete action plans are received.
  - Completion and submission of the spring round of the **7 Day Services Audit** on behalf of the Trust.
- **Risk Register**
  - Increasing the awareness and importance of **adding audits and GAAP's to the Risk Register** where the standards/recommendations have not been met, to ensure the risk is sighted and managed appropriately.
- **QA (Quality Account) audits**
  - Introduced **quarterly monitoring of data submissions** to the national QA audits. Included the 1st QA progress summary in the half yearly Quality & Patient Safety Committee. Previously this was only reported at the end of the financial year for inclusion in the QA report.
- **Rolling Half Days**
  - Managed the **re-launch of the Rolling Half Day programme** in 2018/19, which has evidenced increased attendance and improved meeting content.
- **Audit reports**

- **Greater use of run charts and infographics** introduced, where possible, which has rejuvenated the look of the reports and created a simplified presentation of data to facilitate quick and easy visual reading of complex data.

- **Meridian**
  - Review of the current **Meridian audit and patient experience** survey system in comparison to other competitor systems, to help with the retendering process which is currently in progress.
- **Team Development**
  - The Senior CAE Facilitator is currently completing the **Leadership Academy Mary Seacole programme**
  - This has all been achieved during a period of significant personnel changes with 3 CAE staff leaving and the recruitment and induction of 2 new Band 5 Clinical Audit and Effectiveness Facilitators. We are still out to advert for 1 Band 3 CAE Administration Officer
- **From the CQC report**
  - "Local and national audits were completed and action was generally taken to improve care and treatment provision, when indicated."

Audit and Effectiveness – Milestones and future focuses

- **Update and combine the Clinical Audit & Clinical Effectiveness policies** into 1 succinct and simple policy. To include clear guidance on when NICE guidance audits should be run & why & when re-audits required. To include QI in the "Definitions of Clinical Audit" sections and get CE Committee support for QI – November 2018
- **Raise awareness of Clinical Audit & Effectiveness in the clinical audit week 19th – 23rd Nov** with daily features in the daily news, photo to promote the clinical audit team on the daily news masthead, training events to be run during the week, promotion of QI and get interest/sign up for QI projects.
- Clinical Audit priority guidance to CE Committee for consideration and agreement of Trust Mandatory audits for 2019-2020. Ensure common issues/themes from SI's, risks, complaints, claims, HAT's & mortality reviews is available to help inform these decisions – 1st draft Nov 18
- Greater scrutiny and focus on Specialty Quality Account audit participation and inclusion of Quality Account progress in reports to Q&S Committee (RAQC) – Oct 18.
- Greater promotion of success of new Interventional procedures as evidenced by audit results to promote the Trusts service innovation and growth – April 2019.
- Roll-out new 7 Day Services measurement system to facilitate greater Board oversight of the 4 priority clinical standards. Encourage greater speciality involvement and ownership for identifying and delivering changes to lead to service improvement – awaiting NHSI update
- Review of current IT database system for recording CA & CE to identify if a better system available (DATIX CA system not yet live) – Mar 2019

Management of Incidents and Learning from them – What we have achieved so far

- **Serious Policy and Management of Incident Policy merged and ratified** at Patient Safety Committee. To be further disseminated by the newsletter. The merging of this policy will allow for clearer guidance on management of incidents supported by clearer standards, KPIs and monitoring of policy by dashboard.
- **Updated investigation process** which will facilitate timely review of incidents allowing us to take appropriate action as per Trust policy. This is supported by revised templates using CAD methodology and bespoke 1:1 training.
- Set up of **senior Serious Incident (SI) Panel with TORs and 72hr report template**. This is an exec led committee to declare SI's and agree the level of investigation. They take place twice a week and are minuted and actioned.
- Monthly SIRC meeting and monthly Harm Free Care panel
- **Management of Duty of Candour** included in the Terms Of Reference (TOR) for SI panel
- **Recruitment of 3 x Patient Safety Leads** (2x B7 & 1 x B6). B6 will work on quality checking the backlogs (bank member of staff currently doing this role). The B7s will assist with Duty of Candour

and incidents. 1 x B7 will start near end of October and 1 x B7 mid-November.

- The recruitment of **Divisional Quality Managers (DQM).**
  - Medical Care have a DQM from Bank. A permanent staff member will start in 2 months.
  - Surgery DQM post was filled last month.
  - Clinical Support Services DQM will start in Dec 17.
  - Cancer DQM has been recruited. Start date TBC.
  - Maternity DQM is in post
  - Children & Young People DQM is part time and in post.
- Daily Incident Reports

Management of incidents and learning from them – Milestones and future focuses

- **Updated investigation progress**
  - Restart bespoke 1:1 training
  - Review the revised CAD templates to simplify process and avoid duplication
- **Trained investigators**
  - Review the list of trained investigators - to establish a smaller number of SI investigators and a larger number of RCA investigators.
- **Overdue Incidents**
  - Review and analyse the overdue backlog and target these areas
  - Formal process / protocol to be established by each division to sign off incidents.
  - Board to complete a trajectory on how to bring this down.

Duty of Candour – What we have achieved so far

- **80% compliance** with Duty of Candour stage 2 letter in October 2018
- Much improved **allocation of Duty of Candour leads**
- **Management of Duty of Candour** included in the Terms Of Reference (TOR) for SI panel
- **Recruitment of 3 x Patient Safety Leads** (2x B7 & 1 x B6) will allow for more capacity and greater ownership and management of incidents. B6 will work on quality checking the backlogs (bank member of staff currently doing this role). The B7s will assist with Duty of Candour and incidents. 1 x B7 will start near end of October and 1 x B7 mid-November.
- **Monitoring compliance** and adding compliance metrics to the Quality and safety Dashboard.

Duty of Candour – Milestones and future focuses

- **Monitoring compliance** and adding compliance metrics to the Quality and safety Dashboard.
- **Review and ratify Duty of Candour policy** - This will be supported by the Divisional Quality Manager and Patient Safety Team and will be monitored in the Patient Safety Committee
- **Duty of Candour fields in Datix** to capture regulation requirements
- Link the **Duty of Candour process to Falls** – to insure falls are viewed as clinical incidents as opposed to accidents.

Risk Management Process – What we have achieved so far

- Progress has continued with reviewing non-clinical areas' **risk management processes, risk registers and communications** with Strategic Development and IM&T remaining. Meetings are planned.
- **Risk clinics/review meetings** have continued to be facilitated in all areas of the Trust along with delivery of risk management training at all levels.
- The **risk management training needs analysis** describes the range of training that is being provided at divisional board, SMT, ward/department and individual levels.
- **Risk management training** has been delivered to 109 Trust leadership roles so far including:
  - 11 Directors (Risk Management Training overview sheet Directors/Senior Managers –

ensuring risk processes/arrangements/culture are in place)
    - 56 Senior Management Team personnel (30 minutes condensed risk management training – covering risk principles, process, culture and quality checking risks)
    - 40 Consultants/clinicians and Band 7s (1 hour An Overview of Risk Management in Practice – covering detailed management of risks and group work on cultural barriers etc.)
- Several other staff have also received personal **Datix facilitation**.
- Board meetings are structured to address the BAF and there is a clear link between BAF and divisional risks.
- Monthly new risks & thematic analysis of risks >15 sent to Risk and Quality Committee.
- Specific risks to **non-compliance with regulatory quality standards** are monitored and included in monthly RAQC risk reports.
- Formalised Company Secretary & Interim Head of Risk meetings in Risk Management Procedure.
- Developed ongoing work plan to ensure **Risk Management Strategy and Trust-wide Procedure for Risk Management** are fully implemented and embedded.
- Reviewed **Internal Audit documentation and reports** to ensure relevant recommendations are incorporated into risk processes.
- **Scheduled Risk Clinics** to support divisions' review of the quality and scoring of risk register entries, facilitating and supporting mitigations and closure, incorporating risk groupings/theme development.
- **Risk clinics** (review meetings) are now held in divisions and are in place for Surgery, Medicine, W&C, Corporate Nursing, HR, Finance, Estates & Facilities, Engagement and Clinical Support Services. Risk clinics (review meetings will be held in Corporate Information Governance once re-structuring has occurred

Risk Management Process – Milestones and future focuses

- **Board review of risk appetite** and tolerances planned for December/February 2019. It is planned the risk appetite will be published annually.
- Review is planned of how the Trust can best assess its organizational capacity to handle risk E.g. monitoring and reporting on the effectiveness of risk escalation, KPIs etc.
- A **Trust Risk Culture plan** will be developed, as part of an overall Trust cultural programme. The plan will include how the risk culture is measured.
- Facilitation of committees' discussion and review of risks is planned E.g. Patient Safety Committee etc.
- Divisional Quality Manager **training and engagement** in risk monitoring is planned once they are available from SI work.
- The Interim Head of Risk plans to discuss with the Director of Strategic Development if there are any gaps in business continuity arrangements.
- **Future Trust risk reports** will include periodic analysis of low risks and divisional reports will explore mapping controls against risks Etc.
- The **risk report** will include measurement of the movement of risk over time and comment on assurance on compliance with the Risk Management Strategy and Procedure.
- Review and identification of any gaps in risk management coverage is planned of contractors (non-Estates), volunteers, students, agency and locum staff and staff with honorary contracts.
- Inclusion of whether senior managers disseminate results of complaints, incidents, SI s, audits and lessons learned is planned in the Interim Head of Risk's forthcoming audit of specialty meetings.
- Develop dashboard for the KPIs.

Learning from incidents to be shared across all areas – What we have achieved so far

- Sharing of learning enhanced through the revamped **safety matters newsletter** and the twice weekly safety huddles
- **'Rolling half days'** - clinical reviews of data, incidents and audits

Learning from Incidents to be shared across all areas – Milestones and future focuses

- Review effectiveness of rolling half days
- Monthly Newsletter
  - Assess effectiveness of newsletter
  - Develop the Monthly newsletter which provides useful tools, focuses on excellence and shares best practice.
- Capture how divisions share their learning
- Review to learn from complaints and audits

Structure and Reporting – Team and Infrastructure – Milestones and future focuses

- New structure of quality governance committee
- Develop the quality and safety dashboard
- New team structure within Corporate Governance and Quality & Safety team

Policies and Procedures – Milestones and future focuses

- Appointment of a **Band 7 document manager** from April 2019. This position will help provide some oversight of the policies and procedures. There are approximately 1000+ docs of which 235 have expired (compared with 107 in August). This is due to the vast number prepared prior to the CQC assessment in 2015, which have now passed their 3 year review dates.
- **Review the process of managing documents** and establish a long and short term process.

Keeping Our Patients Safe

Sepsis Compliance – What we have achieved so far

- Sepsis team have placed posters on walls which shows where all emergency medical equipment for treating sepsis is
- Role of Sepsis Nurse has been within the Trust for 4 years, based in the Emergency Department (ED) and funded by CQUIN. Initially Sepsis was checked only in ED. Sepsis lead is **now rolling out sepsis compliance to inpatients.**
- Sepsis lead **raises awareness** by going from ward to ward, targeting staffing groups and attending meetings to disseminate information. They have accessed a number of staff including FY1s and FY2s who are easier to reach due to protected teaching time, Children's nurses regarding expectations of screening, specialling team and critical care outreach team. ED received training in Sept 18, Maternity in Oct 18.
- Biggest focus is within the Emergency Department – particularly around unwell patients who are waiting in corridor or chemo patients. **Two new sepsis nurses** will start in Nov and they prioritise this focus. Sepsis lead also introduced for an ED Nurse allocated to each shift to be a sepsis nurse

Sepsis Compliance - Milestones and future focuses

- **Improve recognition & timely management of sepsis** - Reduce mortality 8% by Dec 2018 and 12% by Dec 2019
- **Analyse audit data** to see which patients are not treated or screened and why they were missed
- **Consultant buy in** from senior level.
- Ensure sepsis paperwork and nervecentre support best practice
- **Reliable recognition & assessment**
  - Reliable screening
  - Reliable communication of high risk patients
  - Timely rescue by competent teams

- **Reliable care delivery**
  - Delivery of sepsis 6 within 1 hour
  - Source control
  - Reliable escalation of septic patient
  - Improve antimicrobial stewardship – 2 day review
- **Training & awareness**
  - Education on burden of illness & current performance
  - Training – knowledge & skills
- **Culture of safety**
  - Executive sponsorship
  - Clinical leadership
  - MDT working
  - Measurement frameworks for improvement
- **Patient / family centred care**
  - Involvement of patients & families

End of Life Care - What we have achieved so far

- End of life Lead has written and developed a **three year strategy for End of Life Care** services which involves five key enablers:
  - Advance Care Planning (ACP)
  - Electronic Palliative Care Coordination Systems (EPaCCS) formerly known as end of life care locality registers
  - AMBER care bundle
  - Rapid Discharge Home
  - Priorities of Care from 'One Chance to Get it Right'
- And will be driven by:
  - Personalised care planning
  - Education and training
  - Evidence and information
  - Shared records
  - 24/7 access
  - Co-design
  - Involving, supporting and caring for those important to the dying person
  - Leadership
- 5 key enablers should be practiced throughout all departments from A&E, AMU, Critical Care, and all wards.
- East & North Hertfordshire CCG have also developed an **EOLC community based strategy** which features ENHT

End of Life Care - Milestones and future focuses

- Staffing and structures
- **'Getting it right at the door'** - Team of people within A&E trained on EOLC and Palliative Care
  - Training on how to have difficult conversations
  - Escalation plans / plans of care
  - Meet with Brighton and Sussex University Hospital as they have a good model of care on 'getting it right at the front door'
- **System 1** – Computer system linked to Community and GP
- Stronger focus on **End of Life Strategy Group** along with a senior executive to chair / support
- Rapid Discharge team to have access to Lorenzo
- Nurses to drive projects and strategies

Safer Surgery – What we have achieved so far

- Established monthly meetings which will be chaired by ENT consultant. The group will report to Clinical Effectiveness Committee.
- A compliance grid to establish baseline has been completed for NatSSIPPs. This details a list of procedures that fit with the definition of evasive procedures and the specialities they sit under.
- A Human Factors Review was completed by Jane Carthey (an external Human factors and Patient Safety Consultant) in 2016. The Trust created an action plan based on the back of this review and all actions have been completed. The next steps are to now review and provide assurance that actions are embedded into business as usual. This will be one of the elements of the Safer Surgery Collaborative Group. Another key part of the new group will be to map out an implementation plan ideally using a driver diagram approach.
- 4 x NatSSIPP baseline reviews have been completed for the following services:
    - Respiratory (Dec 2017)
    - Cardiology (Nov 2016)
    - Endoscopy (Apr 2017)
    - Radiology (Oct 2017)
- Kathy Mcerlain from NHSI will help support this workstream and the Trust will arrange for Kathy to have an informal walkabout within these departments.
- Midlands and East are organising a safety collaborative on Nov 21st to share best practice. Margaret Devaney (Associate Director of Quality) and Michael Chilvers (Medical Director) are scheduled to attend.
- Theatres are completing regular WHO audits auditing all elements as in Safety brief, WHO checklist and De brief and also complete a qualitative audit - the audit team are working with them to refine the methodology, sample size and reporting to move to a run chart approach. The audit team are also clarifying with the relevant service areas what auditing they are undertaking.

Maternity and Our Newborns – What we have achieved so far

- **LMS - Local Maternity Systems (LMS)** which will be the drivers of transformation. By the end of March 2017 all of the LMSs will be established and by October 2017 all are expected to have a transformation plan.
- After understanding the population's needs, taking into consideration the recommendations of the National Maternity Review (Better Births), as well as our current maternity services provision, Herts and West Essex Local Maternity System have identified the key priority areas as the following (NB. Only quality improvement workstreams are listed here):
- **Safer Care** - Improving culture of safer care and learning throughout the system. We hope to improve safety standards by establishing a LMS wide Governance forum sharing best practice, peer reviewing Serious Incidents and imbedding learnings into action plans across LMS organisations.
- **Saving Babies Lives** - Ensuring that our Maternity Services are doing everything they can to reduce the number of stillbirth as well as neonatal and maternal deaths. Each of our maternity service providers have within the Schedule 4 of their contracts the quality requirements and metrics relating to the Saving Babies Lives Care Bundle, and are monitored and evaluated by the CCGs. Our system partners have come together to identify common challenges and share plans to overcome them, and to share best practice.
- Induction of Labour - Develop a consistent pathway for induction of labour that can be rolled out throughout the LMS.

In addition to the above our LMS has identified the following workstreams to achieve the ambitions of Better Births:

- **Personalised Care** - Ensuring women and their families receive care tailored to their needs and are empowered to make informed choices about their care. In this workstream we want to review, monitor the quantity and quality of the current Personalised Care Plans offered to women in Herts and West Essex, against national standards. This will identify where any gaps, variation, and inconsistencies there may be across the system enabling us to scope, plan and deliver on the required changes.

- **Continuity of Carer** - Building on a holistic approach to care delivering services at the right time in the right place. Focusing on midwifery delivery models for continuity of carer, we are reviewing our current services and scoping plans to achieve our ambition of providing continuity of the midwife caring for most women throughout their ante-natal, intrapartum and postnatal care.
- **Better Perinatal Mental Health, Postnatal and Neonatal Care** - Delivering a higher quality of care throughout the maternity care pathway. Having two relatively new specialist perinatal mental health teams within Herts and West Essex we are ensuring that pathways and services are consistent and equitable, in addition to identifying current gaps in service provision and scoping plans to address them.
- **Working across Boundaries** - to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed. This workstream focused on reducing unwarranted variation across the LMS but also on reducing any duplication between services. It also provides the opportunity to look at maternity services across the patch as well as neighbouring LMSs, and plan for the commissioning of outcomes focused services.
- **Co-production with Service Users** - Ensuring transformation reflects the needs of service users. We aim to work with our Maternity Services Liaison Committees, regularly collate service user feedback to inform our plans, and also scope plans to establish a Maternity Voice Partnership across the LMS.
- **Prevention** -
  - Empowering and supporting women and their families to make healthier choices
  - Reducing complications during pregnancy.
  - Reducing health inequalities
  - Giving babies the best start in life.

  In order to achieve the above stated aims for preventions we will be working as an LMS with our collogues in Public Health and Maternity Services to identify gaps and areas for improvement as well as develop strategies to provide targeted interventions.

Maternity and Our Newborns – Milestones and focuses

- Please see above section for Maternity and Our Newborns.

Patient Experience

Improving experience at beginning, middle and end of stay - What we have achieved so far

- **Whose Shoes engagement event** took place for Maternity with the focus being on 'continuity of carer'
- **Welcome packs** with overnight essential and ward information folder created for childrens services
  - Overnight essential packs are available upon request.
  - Ward information booklets at every bed space in bluebell.
  - Information booklets for childrens assessment unit are being developed
  - Neonatal unit already have welcome packs and unit information guide for parents
- Surgery
  - Weekly meetings with Divisional General Managers / service coordinators for each speciality regarding **waiting lists**
  - **Welcome cards re-launched** to ensure all inpatient have a completed and updated welcome card
  - All wards to achieve their targets in sending patients to the discharge lounge
- Medicine
  - **Embed Red to Green methodology** - All medical and elderly care wards rolled out and embedded Red to Green.
  - **Nervecentre updated live** during daily board rounds.

Improving experience at beginning, middle and end of stay - Milestones and Focuses

- **Feedback** - Expand on the methods available for patients / carers to provide feedback to the Trust including Reviewing current protocol for collection of patient / carer stories and scope for involving volunteers
- **Maternity** - Increase the number of women receiving continuity of carer. Develop effective pathways of care to support the provision of safe continuity of carer models. Improve the experience of women and their families throughout the maternity care pathway.
- **Cancer** - Cancer patients given the name of the Clinical Nurse Specialist who would support them throughout their treatment - Increase CNS MDT presence in clinic. CNS contact cards. Business case to review increasing CNS resource to ensure all patients feels supported during their pathway. Now have CNS support in all tumour sites although some vacant posts. Project to review model of peer support by patient volunteers.
- **Children & Young People** - Patients and families fully orientated to childrens ward
- **Surgery** - Minimise the effect of waiting times through clear communication and reasons for any delays - Ensure staff keep patients informed on expected treatment timelines. Ensure all inpatient have a completed and updated welcome card. Discharge planning to be initiated on admission by liaising with health and social care teams.
- **Improve patient flow pathway** - Implement SAFER on all wards using a multi-disciplinary approach. Plan and implement EDD with engagement of patient and families/carers. Embed Red to Green methodology. Work with the Model Hospital Patient Flow task group to review and implement communication strategy, both verbal and written, with patients and family/carers in order to support effective discharge. Engage with consultants, junior doctors, therapists with principles of safe effective discharge including planning in discussion with families.

Carers - What we have achieved so far

- **Carers passport** gives discount in coffee shops, pharmacy, restaurant and allows for overnight stay and open visiting.
- **Implementing Carers Pathway –** A 5 step pathway that has been adopted across Hertfordshire for supporting carers.
- **Carers Snack Bags –** Offered to carers in the evening when restaurants are closed.
- **Young Carers App** available in Hertfordshire:
    - Provides info for young carers
    - Directs them to right service without having to use health professionals
    - Currently a android app but will be available on iPhone within the next 6 months
- Governance including Carers Policy, Carers handbook and Implementing Carers Pathway – a 5 step pathway and Referrals to Care / Voluntary
- Current alliances are West Herts, HPFT (Mental Health) and HCT (Community)

Carers – Milestones and future focuses

- Increase the number of carers completing **carers survey** to provide better feedback
- **Register of staff who are carers** - Having a proper register will support workforce planning and allow for correct support to promote resilience and not reach crisis point.
- All staff to be held accountable in **referring carers to community and third sector**
- Education to carers for **early diagnosis symptoms** ie urine, diabetes, respiratory, to avoid escalation and possible hospital stay
- Establish **quality markers for Carers** or divisions to have an action plans which are specifically carer related.
- **Staff education** to include:
    - Filling in carers details on Lorenzo instead of next of kin. This would allow the Trust to record the number of carers.

- Update Carers Lead on fast track patients
- Log on E-Roster staff who have taken carers leave instead of logging it as sick leave. Can also add this onto appraisals.
- Exit interviews for staff who are carers so we can understand if they are leaving because of the pressure of juggling work and their care responsibilities.

- Review **Trust flexible policy** and adapt it to be flexible for carers.
- **Touch and book system** records carers who have been directed from GPs to secondary care. IT to code this so we are aware of the numbers.
- **Fast track patients** who are sent home to die. Create pathway that supports the family.
- Visit Surrey who have a good model of care for Carers

Quality Strategy

Define model of Quality Improvement (QI) – Milestones and future focuses

- **Gap analysis** to highlight Trust's baseline position – this will give us an idea of what we need to do for next steps
- **Staff education** on following Quality Improvement Methodology
- **Board Development Session** - to discuss what is QI and to build strategy
- Quality Improvement page on **Knowledge Centre** with central resources

Safety Culture Survey - Milestones and future focuses

- Evaluation of SCORE survey in Maternity
- Agreement on **methodology for Trust assessment** and undertake first survey
- National staff survey:
  - Improve score for KF30 fairness & effectiveness of procedure for reporting errors, near misses & incidents >3.56
  - Improve score for KF31 staff confidence and security in reporting unsafe clinical practice >3.54

Compliance Framework – Milestones and future focuses

- Review **best practice compliance framework** and create one of our own
- Review **external reviews** and how the play into the framework
- **CQC compliance** to Must and Should actions
- Preparing for **CQC inspection**
- Pro-active testing of compliance framework action plan and building into Business as Usual and Quality Transformation Programme.
- CCG Assurance Visits, NHSI Visits, Safety Huddles, Fundamental Fridays, 15 Steps, Mini Mocks and Valuing The Basics
- **Detailed planning on services** to be inspected in 2019
- **Recruitment** of Compliance Manager and Facilitator

Training and development (on Quality Improvement - QI) - Milestones and future focuses

- Review **current QI training provision**
- Agree **plan for delivery** in 2019/20 to include organisation development team, projects team & maternity re human factors

- Identify staff who have undertaken **QI training & establish outcomes**

Agenda Item: 10.2

TRUST BOARD PART 1 – 7 NOVEMBER 2018
Infection Prevention & Control Report

PURPOSE	To inform the Board of infection prevention and control performance for the period ending 30 September 2018.
PREVIOUSLY CONSIDERED BY	Trust Infection Prevention & Control Committee Quality and Safety Committee
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)	Failure to act upon outcomes may increase risk to patients and staff and place the Trust at risk of breaching registration requirements set out in the Health & Social Care Act 2008. Risk of not delivering on national targets for MRSA bacteraemia & Clostridium *difficile*. The *Clostridium difficile* target for the Trust has been reduced from 11 to 10 for the year 2018/19 and the Trust is developing an improvement plan to reduce Trust-associated cases. Loss of income due to not meeting IP&C targets. Risk of not maintaining the reduction of surgical site infection (SSI) rates to the national benchmark in the three categories off orthopaedic procedures which are subject to surveillance of SSI. Actions being taken include a deep dive into all identified SSI cases to ensure all learning points are identified and addressed, auditing against national (NICE) guidance and taking measures preventing unnecessary theatre staff movement.
Healthcare/ National Policy (includes CQC/Monitor)	Compliance with Code of Practice and Adult Social Care on the Prevention and Control of Infections
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Director of Nursing / DIPC
PRESENTED BY:	Director of Nursing / DIPC
AUTHOR:	Assistant Director, Infection Prevention & Control (ADIPC)
DATE:	November 2018

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

Infection Prevention and Control Board Report Objectives & Outcomes: September 2018

Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

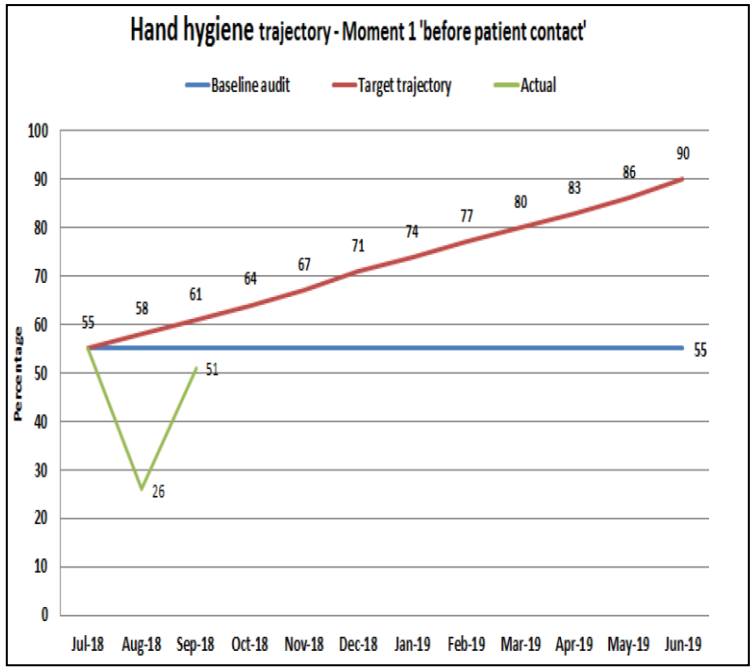
HCAI SURVEILLANCE	MRSA bacteraemias	0 hospital associated MRSA bacteraemias in September. Year to date position is 2 Trust attributed cases. RAG rating based on target of 0 cases.	Red
	C.difficile	1 Trust allocated *C.difficile* case in September. Year to date position is 15 reported cases against the ceiling target of 10 cases for 2018-19. All cases are reviewed by an internal panel to ensure learning is implemented, and to identify cases for appeal for exemption from financial sanctions. To date, 2 cases have been identified for appeal and 6 cases are to be reviewed by the internal panel in October. NHSI, PHE & CCG revisited the Trust on 14 August following the visit in April in response to the *C.difficile* outbreak on a medical ward. Although improvements were evident, the Trust remains at red for IP&C on the NHSI matrix. An action plan is in place and a report was submitted to the September Trust Board. Improvement trajectories have been agreed for hand hygiene, equipment, environmental cleanliness and antimicrobial stewardship – see Contract Performance Trajectories section on pages 3-4. RAG rating based on position year to date against the ceiling target and NHSI Red rating for IP&C. The Trust rate per 100,000 bed days is 13.67 cases against EoE average of 13.35 cases (data for April-Sept)	Red
	MSSA bacteraemias	2 Trust allocated MSSA bacteraemias in September. Year to date position is 10 cases (no target set). RAG rating based on Trust rate of 9.11 cases per 100,000 bed days against EoE average of 6.91 cases (data for April-Sept 2018).	Amber
	Gram negative bacteraemia: National monitoring and reduction programme for E.*coli*, *Pseudomonas aeruginosa*, *Klebsiella species*.	3 Trust associated E.*coli* bacteraemia in September. Year to date position is 19 cases (no target set). RAG rating based on Trust rate of 17.33 cases per 100,000 bed days against EoE average of 17.60 cases (data for April-Sept 2018).	Green
		0 Trust associated *Pseudomonas aeruginosa* bacteraemias in September. Year to date position is 3 cases (no target set). RAG rating based on Trust rate of 2.73 cases per 100,000 bed days against EoE average of 3.40 cases (data for April-Sept 2018).	Green
		1 Trust associated *Klebsiella species* bacteraemia in September. Year to date position is 7 cases (no target set). RAG rating based on Trust rate of 6.38 cases per 100,000 bed days against EoE average of 6.97 cases (data for April-Sept 2018).	Green
	Carbapenemase Producing Organisms (CPO)	0 new inpatient cases and 0 outpatient cases identified in September. Year to date position is 7 inpatient cases and 2 outpatient cases (no target set). RAG rating based on cross-transmission in a clinic setting and several readmissions to open bays of patients previously identified as positive for CPO. New screening guidance issued in August following notification of an outbreak in Leicestershire.	Amber

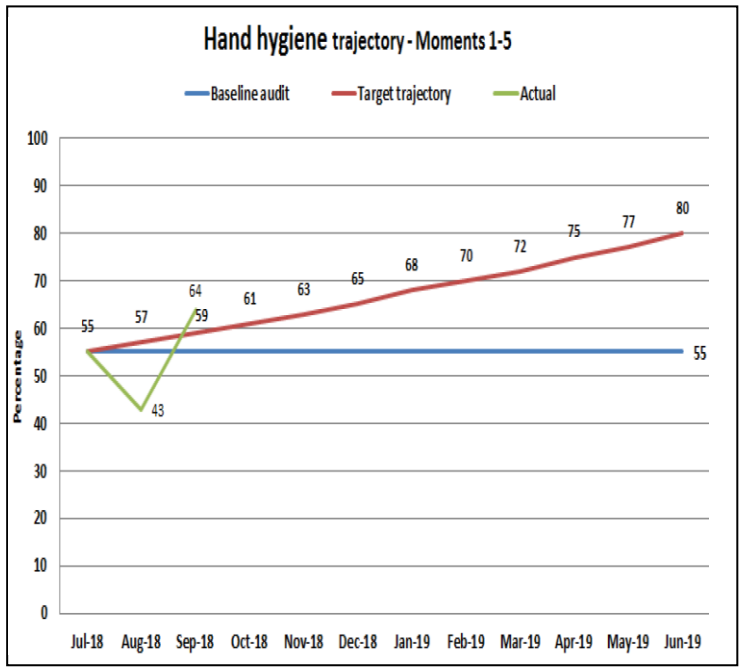
	Outbreaks / Periods of Increased Incidence	No outbreaks or periods of increased incidence identified in September.	Green
	Surgical Site Infection	For the quarter of Apr-Jun 2018, the infection rate for Total Knee Replacement increased to 3.1% (benchmark 0.5%) and this requires further analysis. Infection rates for Total Hip Replacement and Repair Fractured Neck of Femur remain at or below the national benchmarks. See page 16 for full details. RAG rating based on increase in TKR rate in Apr-Jun 2018 and need to maintain reductions in other categories.	Amber
CQUINs	Antimicrobial stewardship	2018-19 target to not exceed baseline of 4928 total Defined Daily Doses (DDD) per 1000 admissions. April-September = 4182 DDD/1000 admissions (15% reduction). RAG rating based on performance against target.	Green
		2018-19 target to not exceed baseline of 79 for Carbapenem DDD per 1000 admissions. April-September = 86 DDD/1000 admissions (8.9% increase). RAG rating based on performance against target.	Amber
		2018-19 target of 3% increase on baseline of 39.1% for proportion of usage of antibiotics on the 'Access' list. April-September usage proportion = 34% (8.1% reduction). RAG rating based on target of 3% increase.	Amber
		Review of inpatients on antibiotics at 72 hrs by senior clinician, with one of five documented outcomes and also documented IV to oral switch assessment. Q1: April-June compliance = 59% (target 25%) Q2: July-September compliance = 60% (target 50%) RAG rating based on quarterly targets.	Green
AUDITS	High Impact Interventions (HII)	HII audit scores in September as recorded on Meridian by ward nursing teams, were above 95% with the exception of Intravascular Devices Insertion, Urinary Catheter Insertion & Continuing Care, Ventilator Continuing Care and Renal Environment. Hand hygiene audits currently undertaken by ward staff show average compliance of >90%. However, these results do not correlate with observations by external inspections nor audits by the IPC Team. In light of this, a new hand hygiene audit tool has been developed and additional training is being provided to auditors who will be supported by the IPC Team. Reporting based on the new process will commence in October – see Contract Performance Trajectories section on pages 3-4. RAG rating based on scores exceeding 95% in 6 out of 11 categories monitored.	Amber
SURVEILLANCE PROCESSES	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 for first 2 quarters (August 2017-January 2018) has been published and was presented to TIPCC in July. Twelve months' data will be required to enable benchmarking to take place.	Target TBC

IP&C IMPROVEMENT PLAN TRAJECTORIES – see graphs on page 4 below.	Hand Hygiene: World Health Organisation (WHO) Moments 1-5 1. Before patient contact 2. Before clean/aseptic procedure 3. After exposure to body fluids 4. After patient contact 5. After contact with patient surroundings)	Target to increase compliance for WHO Moment 1 to 90% by June 2019, from 55% baseline in July 2018. Compliance to be measured using a rigorous auditing process commencing in September 2018 for full implementation from October 2018. August: 26% (based on limited data available during training/implementation phase) (target 58%) September: 51% (target 61%). IP&C Team are continuing to deliver training sessions to increase compliance.	Amber
		Target to increase compliance for WHO Moments 1-5 to 80% by June 2019, from 55% baseline in July 2018. Compliance based on a rigorous auditing process commencing in September 2018 for full implementation in October 2018. August: 43% (based on limited data available during training/implementation phase) (target 57%) September: 64% (target 59%). IP&C Team are continuing to deliver training sessions to increase compliance.	Green
	Equipment cleanliness / condition	An audit in June 2018 found that 4% of patient equipment is in need of repair and 17% is in need of replacement. An equipment open day was held in September 2018 to select standardised bedside lockers, over-bed tables, patient chairs and commodes. A new monthly environmental peer audit tool and protocol will be launched in October 2018 to ensure a robust and objective audit of equipment cleanliness in the Trust and this will provide the baseline data for developing the trajectory for equipment cleanliness & condition.	Target TBC
	Environmental cleanliness	Very high risk areas: Target to increase pass rate to 98% by September 2018 then maintain, from baseline of 96.87% in June 2018. Compliance measured by audits carried out by cleaning contractor with attendance required by member of nursing team. July: 97.7% (target 97%), Aug: 97.35% (target 98%), Sept: 97.37% (target 98%)	Red
		High risk areas: Target to maintain pass rate of 95% (baseline of 96% in June 2018. Compliance measured via audits by cleaning contractor with attendance required by member of nursing team. July: 94.54% (target 95%), Aug: 95.05% (target 95%), Sept: 96.07% (target 95%)	Green
		Nurse attendance at cleaning contractor audits: Target to increase attendance by nurse to 95% by December 2018, from baseline of 80% in June 2018 July: 82% (target 82.5%), Aug: 71% (target 85%), Sept: 72% (target 87.5%)	Red
	Antimicrobial review	Target to increase review of antibiotics within 72 hrs for all inpatients to 90% by March 2019, from 59% baseline in June 2018. Compliance to be monitored every 2 months by Pharmacy team. September 2018 compliance 52% (target 67%). More comprehensive audit will be carried out in October and increased presence on wards of antimicrobial pharmacist. November 2018 (target 75%), January 2019 (target 82%), March 2019 (target 90%). RAG rating based on reduced compliance compared with baseline.	Red

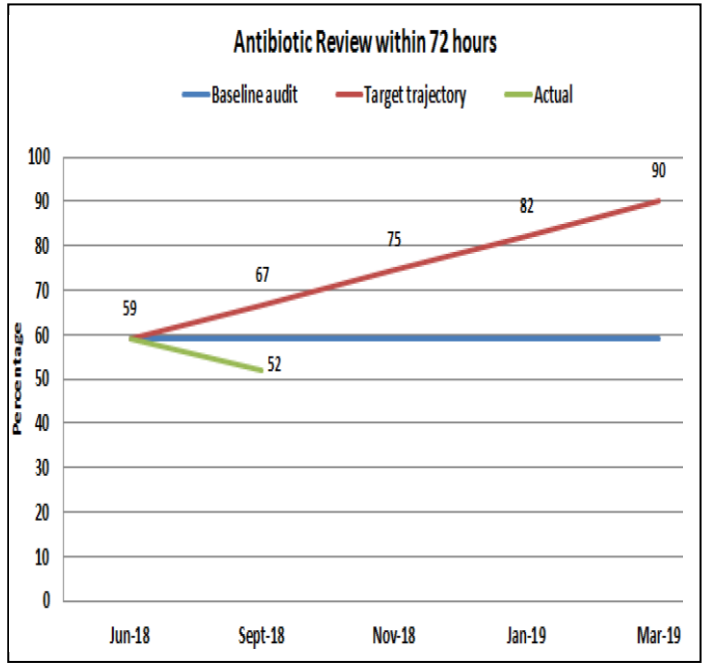
IP&C Improvement Plan Trajectories

Hand hygiene

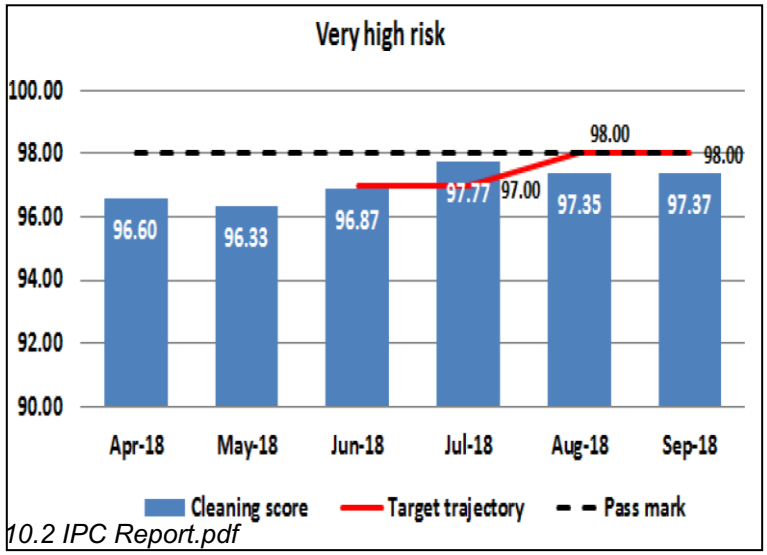


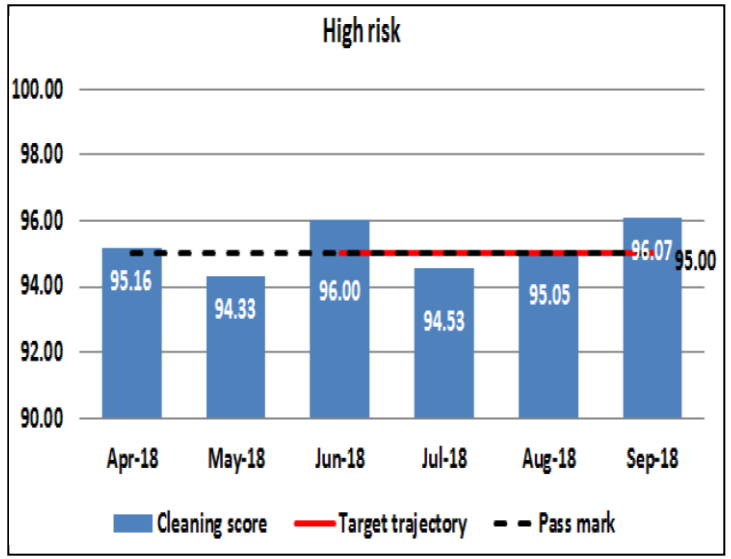


Antimicrobial stewardship

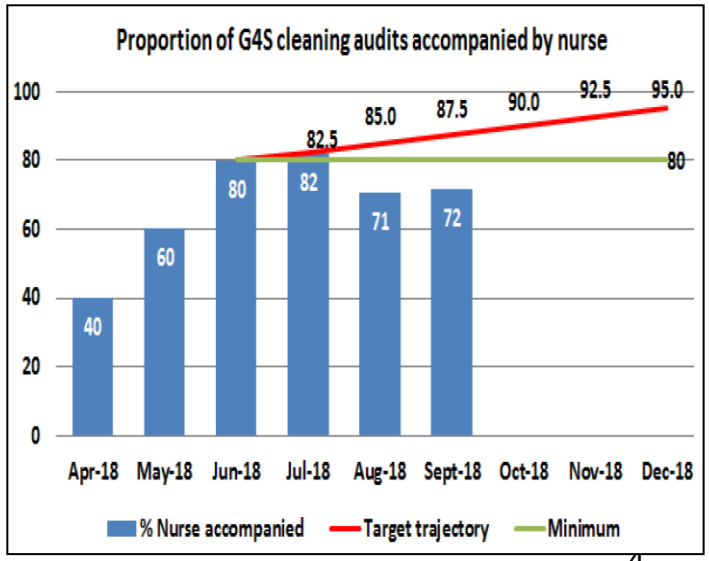


Cleaning audits: First time audit pass rates for very high risk and high risk areas

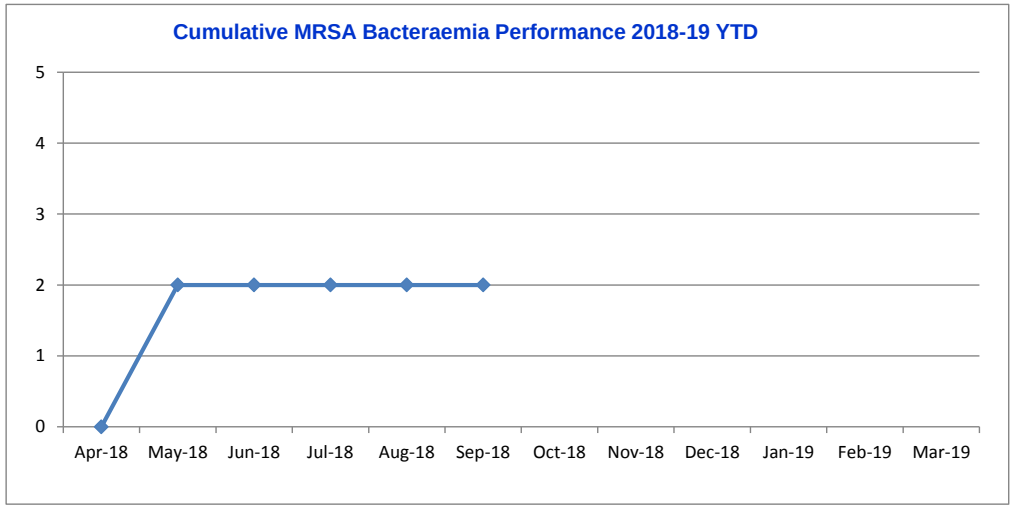


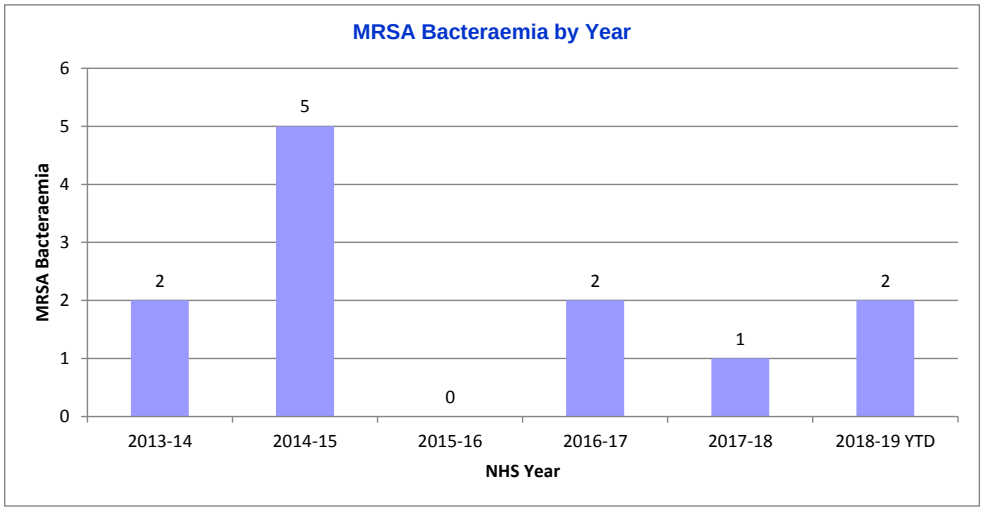


Cleaning audits: Attendance by nursing staff



MRSA BACTERAEMIA – POST 48 HRS



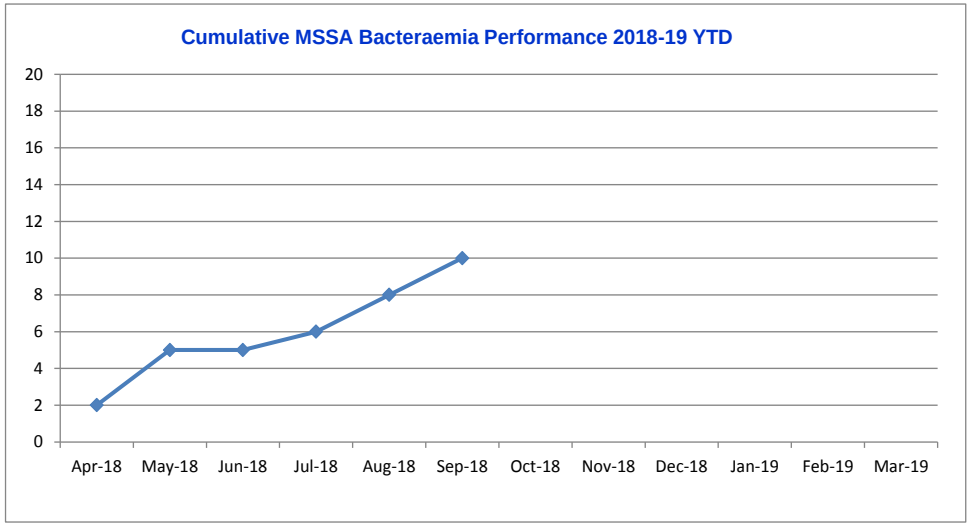


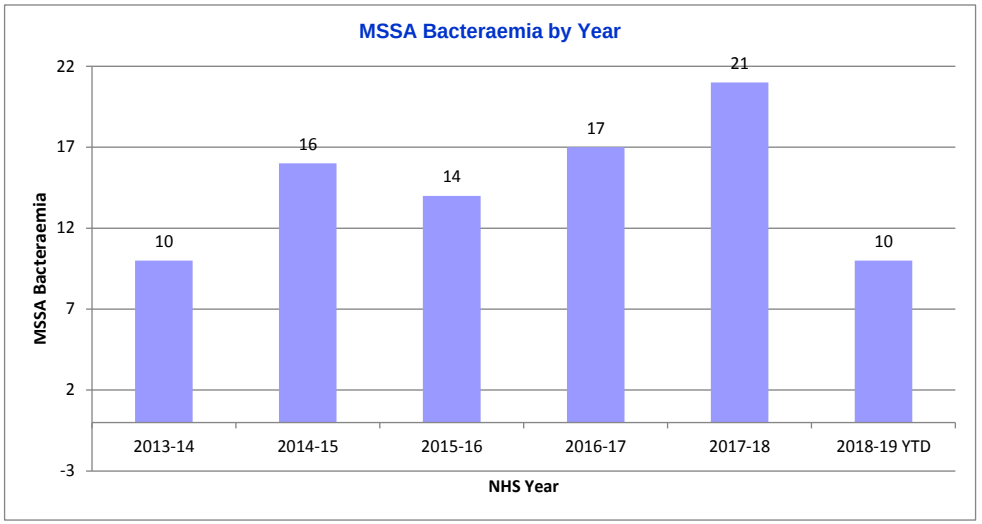
MRSA Bacteraemia by Division

Division	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	1	0	0	0	0	0	0							0
Surgical	0	0	1	0	0	0	0							1
Women & Children	0	0	1	0	0	0	0							1
Grand Total	1	0	2	0	0	0	0							2

PHE benchmarking data for MRSA bacteraemias is no longer available due to changes in the recording system introduced in April 2018.

MSSA BACTERAEMIA - POST 48 HRS





Hospital acquired MSSA Bacteraemia by Division

Division	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	5	2	2	0	1	2	1							8
Surgical	11	0	0	0	0	0	1							0
Women & Children	3	0	0	0	0	0	0							0
MVCC	2	0	1	0	0	0	0							1
Grand Total	21	2	3	0	1	2	2							10

MSSA – PHE Benchmarking Data

Public Health England

MSSA

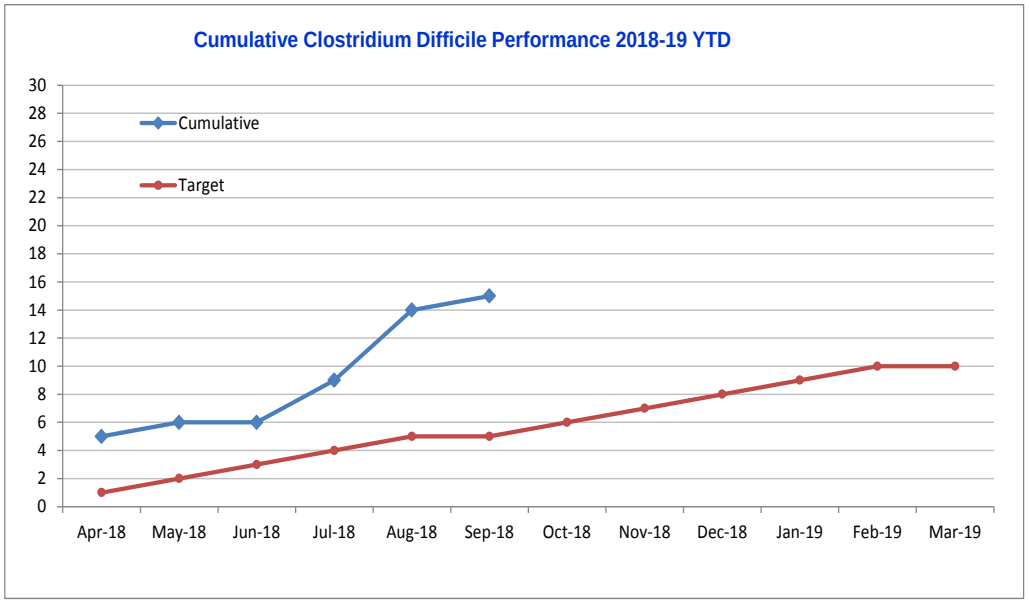
Count of all cases identified by acute trust per month

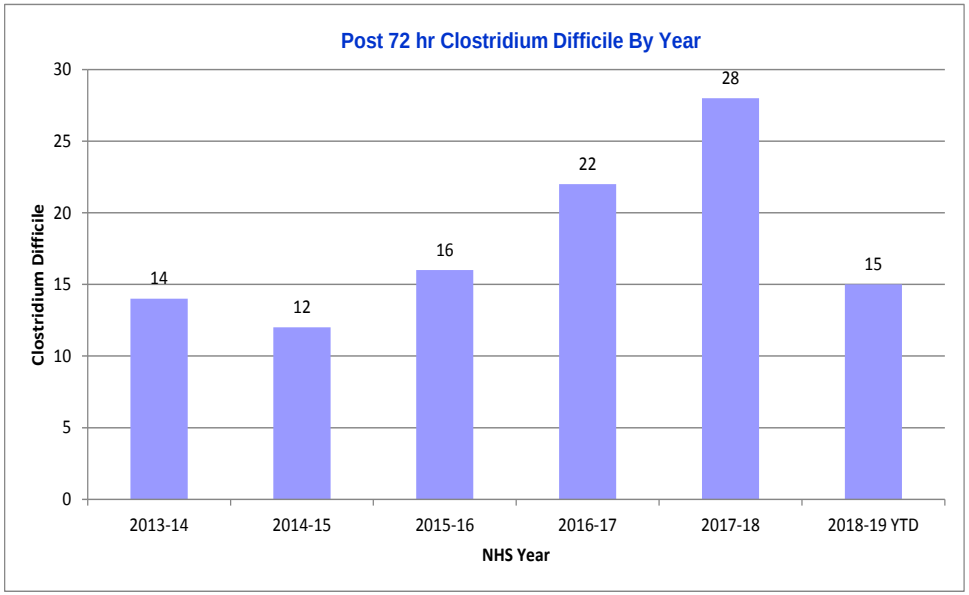
Trust Code	Acute Trust Name	Trajectory	2018									2019			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	2	1	2	2	3	4							14
RC1	Bedford Hospitals NHS Trust	N/A	2	0	1	3	0	0							6
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	3	4	2	1	3							17
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	0	2	0	0							2
RWH	East & North Hertfordshire NHS Trust	N/A	2	3	0	1	2	2							10
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	0	0	0	1							2
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	1	1	1							9
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	1	1	0	0							2
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	3	0	1	1	3							8
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	2	1	4	2							9
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	1	0	2	3	3							10
RGN	North West Anglia NHS Foundation Trust	N/A	2	4	2	1	1	1							11
RGM	Royal Papworth NHS Foundation Trust	N/A	0	1	0	0	1	1							3
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	1	3	0							5
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	1	1	2	0							4
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	1	1	0							3
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	3	0	1	2							12
RGR	West Suffolk Hospitals NHS Trust	N/A	1	2	0	0	0	0							3
	East of England Total	**N/A**	**22**	**21**	**20**	**20**	**24**	**23**							**130**
	England Total	**N/A**	**268**	**304**	**248**	**273**	**292**	**258**							**1643**

Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2018									2019			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	10.30	4.98	10.30	9.97	14.95	20.60							11.82
RC1	Bedford Hospitals NHS Trust	N/A	17.35	0.00	8.67	25.19	0.00	0.00							8.53
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	14.18	10.29	14.18	6.86	3.43	10.64							9.88
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0.00	0.00	0.00	11.39	0.00	0.00							1.93
RWH	East & North Hertfordshire NHS Trust	N/A	11.12	16.14	0.00	5.38	10.76	11.12							9.11
RGQ	Ipswich Hospital NHS Trust	N/A	5.46	0.00	0.00	0.00	0.00	5.46							1.79
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	23.01	0.00	23.01	7.42	7.42	7.67							11.32
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	5.28	5.11	0.00	0.00							1.73
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	18.83	0.00	6.28	6.28	19.45							8.50
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	15.48	7.49	29.96	15.48							11.42
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3.72	3.60	0.00	7.19	10.79	11.15							6.09
RGN	North West Anglia NHS Foundation Trust	N/A	8.55	16.55	8.55	4.14	4.14	4.27							7.71
RGM	Royal Papworth NHS Foundation Trust	N/A	0.00	14.42	0.00	0.00	14.42	14.90							7.33
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	6.80	6.58	19.75	0.00							5.58
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	6.19	5.99	11.99	0.00							4.06
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	7.32	0.00	0.00	7.08	7.08	0.00							3.60
RWG	West Hertfordshire Hospitals NHS Trust	N/A	14.75	14.28	14.75	0.00	4.76	9.84							9.67
RGR	West Suffolk Hospitals NHS Trust	N/A	7.32	14.18	0.00	0.00	0.00	0.00							3.60
	East of England Total	**N/A**	**7.14**	**6.59**	**6.49**	**6.28**	**7.53**	**7.46**							**6.91**
	England Total	**N/A**	**8.75**	**9.60**	**8.10**	**8.62**	**9.23**	**8.42**							**8.79**

CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Post 72 hr Clostridium Difficile by Division

Division	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2017-18 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	20	5	1	0	3	2	1							12
Surgical	7	0	0	0	0	3	0							3
Women & Children	0	0	0	0	0	0	0							0
MVCC	1	0	0	0	0	0	0							0
Grand Total	**28**	**5**	**1**	**0**	**3**	**5**	**1**							**15**

A panel including the Medical Director, Director of Nursing, ADIPC & Consultant Microbiologist/Infection Control Doctor (or deputies) meets to review all hospital-associated cases for assurance that learning is being implemented and to identify cases for appeal. Of the 15 cases to date, 2 cases have been identified for appeal and 6 cases will be reviewed by the panel in October.

C.DIFFICILE – PHE Benchmarking Data

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	30	6	0	4	3	2	1							16
RC1	Bedford Hospitals NHS Trust	9	1	1	0	0	5	0							7
RGT	Cambridge University Hospitals NHS Foundation Trust	48	4	10	1	9	9	8							41
RDE	Colchester Hospitals University NHS Foundation Trust	17	2	1	3	2	6	2							16
RWH	East & North Hertfordshire NHS Trust	10	5	1	0	3	5	1							15
RGQ	Ipswich Hospital NHS Trust	17	0	3	5	3	1	2							14
RGP	James Paget University Hospitals NHS Foundation Trust	16	3	3	1	0	1	1							9
RC9	Luton & Dunstable Hospital NHS Foundation Trust	5	0	1	0	0	0	0							1
RQ8	Mid Essex Hospital Services NHS Trust	12	5	3	5	1	8	2							24
RD8	Milton Keynes Hospital NHS Foundation Trust	38	1	0	2	1	3	3							10
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	48	3	4	1	4	5	2							19
RGN	North West Anglia NHS Foundation Trust	39	6	2	2	3	6	1							20
RGM	Royal Papworth NHS Foundation Trust	4	1	1	0	1	3	1							7
RQW	Princess Alexandra Hospital NHS Trust	9	2	2	1	1	1	0							7
RAJ	Southend University Hospital NHS Foundation Trust	29	0	7	3	3	2	2							17
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	52	3	1	0	4	6	1							15
RWG	West Hertfordshire Hospitals NHS Trust	22	3	1	0	3	2	0							9
RGR	West Suffolk Hospitals NHS Trust	15	1	0	0	1	1	1							4
	East of England Total	**420**	**46**	**41**	**28**	**42**	**66**	**28**							**251**
	England Total	**4503**	**401**	**347**	**333**	**423**	**435**	**361**							**2300**

Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	12.50	30.90	0.00	20.60	14.95	9.97	5.15							13.51
RC1	Bedford Hospitals NHS Trust	6.30	8.67	8.40	0.00	0.00	41.98	0.00							9.95
RGT	Cambridge University Hospitals NHS Foundation Trust	14.70	14.18	34.31	3.55	30.88	30.88	28.37							23.83
RDE	Colchester Hospitals University NHS Foundation Trust	8.60	11.77	5.70	17.66	11.39	34.18	11.77							15.44
RWH	East & North Hertfordshire NHS Trust	4.70	27.79	5.38	0.00	16.14	26.89	5.56							13.67
RGQ	Ipswich Hospital NHS Trust	7.90	0.00	15.86	27.32	15.86	5.29	10.93							12.54
RGP	James Paget University Hospitals NHS Foundation Trust	11.60	23.01	22.27	7.67	0.00	7.42	7.67							11.32
RC9	Luton & Dunstable Hospital NHS Foundation Trust	2.20	0.00	5.11	0.00	0.00	0.00	0.00							0.87
RQ8	Mid Essex Hospital Services NHS Trust	6.40	32.42	18.83	32.42	6.28	50.20	12.97							25.51
RD8	Milton Keynes Hospital NHS Foundation Trust	22.60	7.74	0.00	15.48	7.49	22.47	23.22							12.69
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	14.80	11.15	14.38	3.72	14.38	17.98	7.43							11.57
RGN	North West Anglia NHS Foundation Trust	15.00	25.65	8.27	8.55	12.41	24.82	4.27							14.02
RGM	Royal Papworth NHS Foundation Trust	6.50	14.90	14.42	0.00	14.42	43.26	14.90							17.10
RQW	Princess Alexandra Hospital NHS Trust	5.10	13.60	13.16	6.80	6.58	6.58	0.00							7.81
RAJ	Southend University Hospital NHS Foundation Trust	16.70	0.00	41.96	18.58	17.98	11.99	12.39							17.26
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	34.40	21.96	7.08	0.00	28.34	42.50	7.32							18.00
RWG	West Hertfordshire Hospitals NHS Trust	9.40	14.75	4.76	0.00	14.28	9.52	0.00							7.26
RGR	West Suffolk Hospitals NHS Trust	10.60	7.32	0.00	0.00	7.09	7.09	7.32							4.80
	East of England Total	**10.80**	**14.92**	**12.87**	**9.08**	**13.19**	**20.72**	**9.08**							**13.35**
	England Total	**12.42**	**13.09**	**10.96**	**10.87**	**13.36**	**13.74**	**11.79**							**12.31**

CARBAPENEMASE-PRODUCING ORGANISMS (CPO)

Carbapenems are a class of broad spectrum intravenous antibiotics 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 it 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/CPO carriage. This screening policy was later 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/CPO.

In August 2018, following notification of an outbreak in Leicestershire, the Trust policy of isolating high risk patients pending screening results was extended to include patients who have received healthcare or had an inpatient stay in Leicester University Hospitals or Cambridge hospitals during the past 12 months, or who have been resident in specified high risk countries during the past 12 months.

The August outpatient case is being investigated as a likely cross-transmission linked to the 3 cases identified in late 2017 / early 2018 in a clinic setting.

Several incidents of known CPO positive patients being readmitted to open bays have been identified in recent months. A project team is managing the introduction of an electronic surveillance system to ensure that known infectious patients are identified on readmission, to reduce the risk of cross-transmission on the ward.

Carbapenemase-Producing Organisms - 2018-19

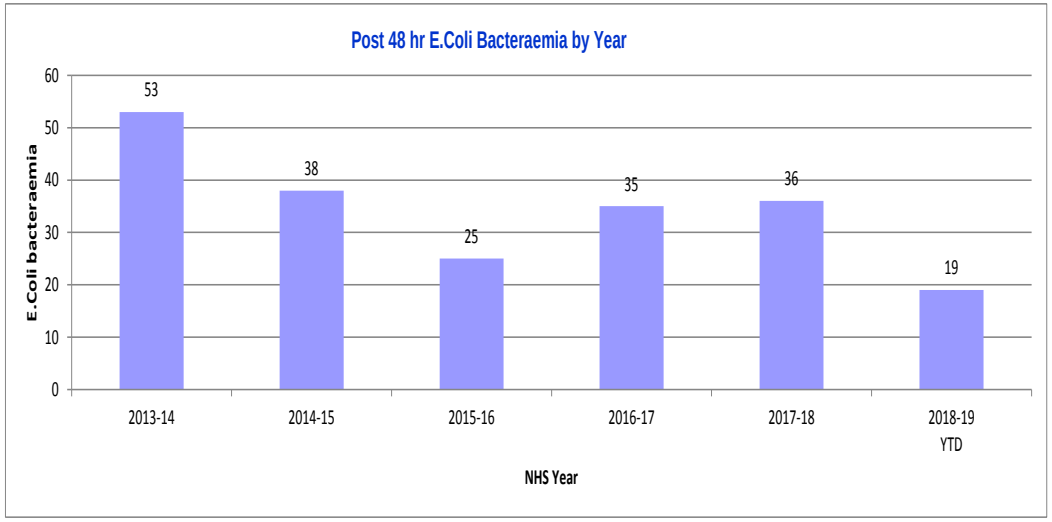
Division/Dept		2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD 2018-19
INPATIENTS	Renal Ward - Lister	2	0	1	1	0	1	0							3
	Medicine	1	0	0	0	0	1	0							1
	Surgery	6	0	0	1	1	0	0							2
	W&C	1	1	0	0	0	0	0							1
	MVCC	0	0	0	0	0	0	0							0
RENAL DIALYSIS UNITS	Lister	0	0	0	0	0	0	0							0
	L&D	0	0	0	0	0	0	0							0
	Harlow	1	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	5	0	0	1	0	1	0							2
	QEII	0	0	0	0	0	0	0							0
	HCH	0	0	0	0	0	0	0							0
	MVCC	1	0	0	0	0	0	0							0
TOTAL (TRUST PATIENTS)		17	1	1	3	1	3	0							9

The above figures do not differentiate between Trust-associated and Community-associated cases.

GP Patient Specimens (Not Trust Patients)		2	0	0	0	0	0	0							0

E.COLI BACTERAEMIA – POST 48 HRS

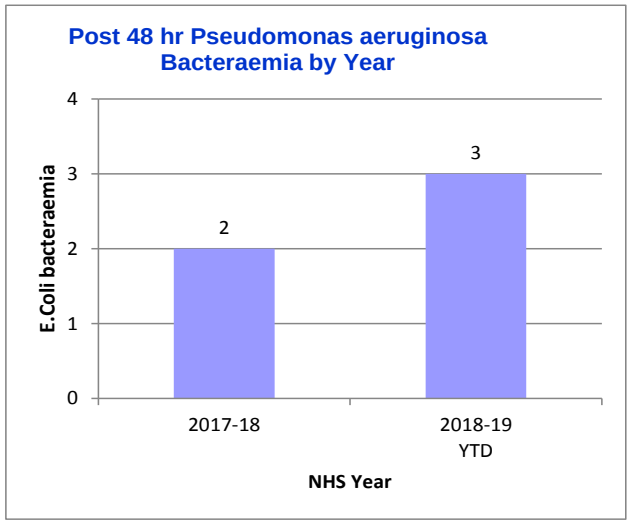
A new Quality Premium was introduced in July 2017 for a 10% reduction in E.coli bacteraemias attributed to each CCG, measured against 2016 performance data. Mandatory reporting of *Klebsiella species* & *Pseudomonas aeruginosa* bacteraemias has also been introduced as part of a national requirement for 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	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	19	1	2	2	2	0	1							8
Surgical	12	3	2	0	1	1	2							9
Women & Children	3	0	0	1	1	0	0							2
MVCC	2	0	0	0	0	0	0							0
Grand Total	36	4	4	3	4	1	3							19

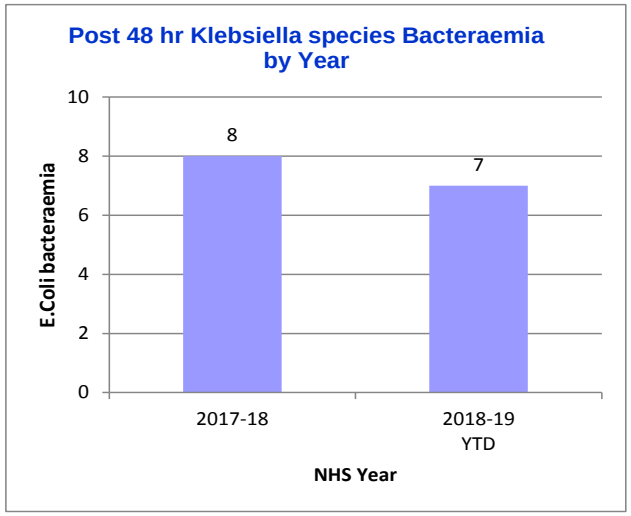
PSEUDOMONAS AERUGINOSA BACTERAEMIA – POST 48 HRS



Hospital acquired Pseudomonas aeruginosa Bacteraemia by Division

Division	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	1	0	0	1	0	1	0							2
Surgical	1	1	0	0	0	0	0							1
Women & Children	0	0	0	0	0	0	0							0
MVCC	0	0	0	0	0	0	0							0
Grand Total	2	1	0	1	0	1	0							3

KLEBSIELLA SPECIES BACTERAEMIA – POST 48 HRS



Hospital acquired Klebsiella species Bacteraemia by Division

Division	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-19 YTD
Cancer	0	0	0	0	0	0	0							0
Medicine	7	1	0	0	0	1	0							2
Surgical	1	1	1	0	0	2	0							4
Women & Children	0	0	0	0	0	0	0							0
MVCC	0	0	0	0	0	0	1							1
Grand Total	8	2	1	0	0	3	1							7

E.coli – PHE Benchmarking Data

Public Health England

Escherichia coli

Hospital onset cases per month (sample taken later than day following admission)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	1	5	3	3	6							21
RC1	Bedford Hospitals NHS Trust	N/A	2	2	1	1	1	4							11
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	8	10	11	9	10							52
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	3	0	6	7	6	3							25
RWH	East & North Hertfordshire NHS Trust	N/A	4	4	3	4	1	2*							18*
RGQ	Ipswich Hospital NHS Trust	N/A	4	2	3	2	1	1							13
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	4	3	6	2	6	1							22
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	3	4	3	2	6	2							20
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	6	0	4	4	1							16
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	5	1	4	4	3	1							18
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	4	4	7	4	2	8							29
RGN	North West Anglia NHS Foundation Trust	N/A	2	0	3	4	3	4							16
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	1	0	1	0							2
RQW	Princess Alexandra Hospital NHS Trust	N/A	3	0	1	2	1	0							7
RAJ	Southend University Hospital NHS Foundation Trust	N/A	4	4	4	5	1	3							21
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	2	1	3	5	2	3							16
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	1	2	3	5	2							16
RGR	West Suffolk Hospitals NHS Trust	N/A	1	2	2	1	1	1							8
	East of England Total	**N/A**	**52**	**43**	**64**	**64**	**56**	**52**							**331**
	England Total	**N/A**	**627**	**641**	**643**	**651**	**667**	**666**							3895

*** Figures shown for ENHT exclude 1 case in September due to a data error which is being corrected**

Monthly rate per 100,000 occupied bed days (hospital onset cases only)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	15.45	4.98	25.75	14.95	14.95	30.90							17.73
RC1	Bedford Hospitals NHS Trust	N/A	17.35	16.79	8.67	8.40	8.40	34.70							15.64
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	14.18	27.45	35.46	37.74	30.88	35.46							30.23
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	17.66	0.00	35.32	39.88	34.18	17.66							24.13
RWH	East & North Hertfordshire NHS Trust	N/A	22.23	21.51	16.67	21.51	5.38	11.12*							16.40*
RGQ	Ipswich Hospital NHS Trust	N/A	21.86	10.58	16.39	10.58	5.29	5.46							11.64
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	30.68	22.27	46.02	14.84	44.53	7.67							27.66
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	15.85	20.46	15.85	10.23	30.68	10.57							17.33
RQ8	Mid Essex Hospital Services NHS Trust	N/A	6.48	37.65	0.00	25.10	25.10	6.48							17.01
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	38.69	7.49	30.95	29.96	22.47	7.74							22.83
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	14.86	14.38	26.01	14.38	7.19	29.72							17.66
RGN	North West Anglia NHS Foundation Trust	N/A	8.55	0.00	12.82	16.55	12.41	17.10							11.21
RGM	Royal Papworth NHS Foundation Trust	N/A	0.00	0.00	14.90	0.00	14.42	0.00							4.89
RQW	Princess Alexandra Hospital NHS Trust	N/A	20.40	0.00	6.80	13.16	6.58	0.00							7.81
RAJ	Southend University Hospital NHS Foundation Trust	N/A	24.78	23.98	24.78	29.97	5.99	18.58							21.33
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	14.64	7.08	21.96	35.42	14.17	21.96							19.20
RWG	West Hertfordshire Hospitals NHS Trust	N/A	14.75	4.76	9.84	14.28	23.79	9.84							12.90
RGR	West Suffolk Hospitals NHS Trust	N/A	7.32	14.18	14.65	7.09	7.09	7.32							9.61
	East of England Total	**N/A**	**16.87**	**13.50**	**20.76**	**20.09**	**17.58**	**16.87**							**17.60**
	England Total	**N/A**	**20.47**	**20.25**	**20.99**	**20.57**	**21.07**	**21.74**							20.85

*** Figures shown for ENHT exclude 1 case in September due to a data error which is being corrected**

Pseudomonas aeruginosa – PHE Benchmarking Data

Public Health England

Pseudomonas aeruginosa

Hospital onset cases per month (sample taken later than day following admission)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	1	2	0	0	1							5
RC1	Bedford Hospitals NHS Trust	N/A	1	0	0	1	0	0							2
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3	1	3	2	3	2							14
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	1	0	0	0							1
RWH	East & North Hertfordshire NHS Trust	N/A	1	0	1	0	1	0							3
RGQ	Ipswich Hospital NHS Trust	N/A	0	0	0	0	0	0							0
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	1	0							1
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	1	0	3	0							4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	0	1	1	1	1							4
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	0	0	0							5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	4	0	0	2	1	3							10
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	1	1	3							7
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	0	0	0	0							0
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0							0
RAJ	Southend University Hospital NHS Foundation Trust	N/A	2	2	1	2	0	0							7
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	0	0	1							1
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0							0
	East of England Total	**N/A**	**14**	**7**	**12**	**9**	**11**	**11**							**64**
	England Total	**N/A**	**124**	**103**	**124**	**149**	**127**	**145**							**772**

Monthly rate per 100,000 occupied bed days (hospital onset cases only)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.15	4.98	10.30	0.00	0.00	5.15							4.22
RC1	Bedford Hospitals NHS Trust	N/A	8.67	0.00	0.00	8.40	0.00	0.00							2.84
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	10.64	3.43	10.64	6.86	10.29	7.09							8.14
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0.00	0.00	5.89	0.00	0.00	0.00							0.97
RWH	East & North Hertfordshire NHS Trust	N/A	5.56	0.00	5.56	0.00	5.38	0.00							2.73
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	7.42	0.00							1.26
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	5.28	0.00	15.34	0.00							3.47
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	0.00	6.48	6.28	6.28	6.48							4.25
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.48	14.98	7.74	0.00	0.00	0.00							6.34
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	14.86	0.00	0.00	7.19	3.60	11.15							6.09
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	4.14	4.27	4.14	4.14	12.82							4.91
RGM	Royal Papworth NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
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	12.39	11.99	6.19	11.99	0.00	0.00							7.11
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	0.00	0.00	4.92							0.81
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00							0.00
	East of England Total	**N/A**	**4.54**	**2.20**	**3.89**	**2.83**	**3.45**	**3.57**							**3.40**
	England Total	**N/A**	**4.05**	**3.25**	**4.05**	**4.71**	**4.01**	**4.73**							**4.13**

Klebsiella species – PHE Benchmarking Data

Public Health England

Klebsiella species

Hospital onset cases per month (sample taken later than day following admission)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	3	1	2	1	3							10
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1	1	1							4
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	1	4	1	4	2	2							14
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	2	0	5	1	0							9
RWH	East & North Hertfordshire NHS Trust	N/A	2	1	0	0	3	1							7
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	2	4	0	1							8
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	1	0	0	0	0							2
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	2	1	2	1	1							7
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	1	2	3	3	0							9
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	1	3	0	4	1							9
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	2	0	2	4							8
RGN	North West Anglia NHS Foundation Trust	N/A	0	2	1	2	0	2							7
RGM	Royal Papworth NHS Foundation Trust	N/A	1	0	0	1	1	1							4
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	2	1	1	0							5
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	2	0	2	2	1							7
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	3	1	2	0							7
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	1	5	1	2	2							11
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	2	0	0							3
	East of England Total	**N/A**	**9**	**21**	**24**	**31**	**26**	**20**							**131**
	England Total	**N/A**	**239**	**246**	**247**	**295**	**290**	**312**							**1629**

Monthly rate per 100,000 occupied bed days (hospital onset cases only)

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	14.95	5.15	9.97	4.98	15.45							8.44
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	8.67	8.40	8.40	8.67							5.69
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3.55	13.73	3.55	13.73	6.86	7.09							8.14
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	5.89	11.39	0.00	28.49	5.70	0.00							8.69
RWH	East & North Hertfordshire NHS Trust	N/A	11.12	5.38	0.00	0.00	16.14	5.56							6.38
RGQ	Ipswich Hospital NHS Trust	N/A	5.46	0.00	10.93	21.15	0.00	5.46							7.17
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	7.67	7.42	0.00	0.00	0.00	0.00							2.51
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	10.23	5.28	10.23	5.11	5.28							6.06
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	6.28	12.97	18.83	18.83	0.00							9.57
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	7.49	23.22	0.00	29.96	7.74							11.42
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00	7.43	0.00	7.19	14.86							4.87
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	8.27	4.27	8.27	0.00	8.55							4.91
RGM	Royal Papworth NHS Foundation Trust	N/A	14.90	0.00	0.00	14.42	14.42	14.90							9.77
RQW	Princess Alexandra Hospital NHS Trust	N/A	6.80	0.00	13.60	6.58	6.58	0.00							5.58
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	11.99	0.00	11.99	11.99	6.19							7.11
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	7.08	21.96	7.08	14.17	0.00							8.40
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	4.76	24.59	4.76	9.52	9.84							8.87
RGR	West Suffolk Hospitals NHS Trust	N/A	7.32	0.00	0.00	14.18	0.00	0.00							3.60
	East of England Total	**N/A**	**2.92**	**6.59**	**7.79**	**9.73**	**8.16**	**6.49**							**6.97**
	England Total	**N/A**	**7.80**	**7.77**	**8.06**	**9.32**	**9.16**	**10.19**							**8.72**

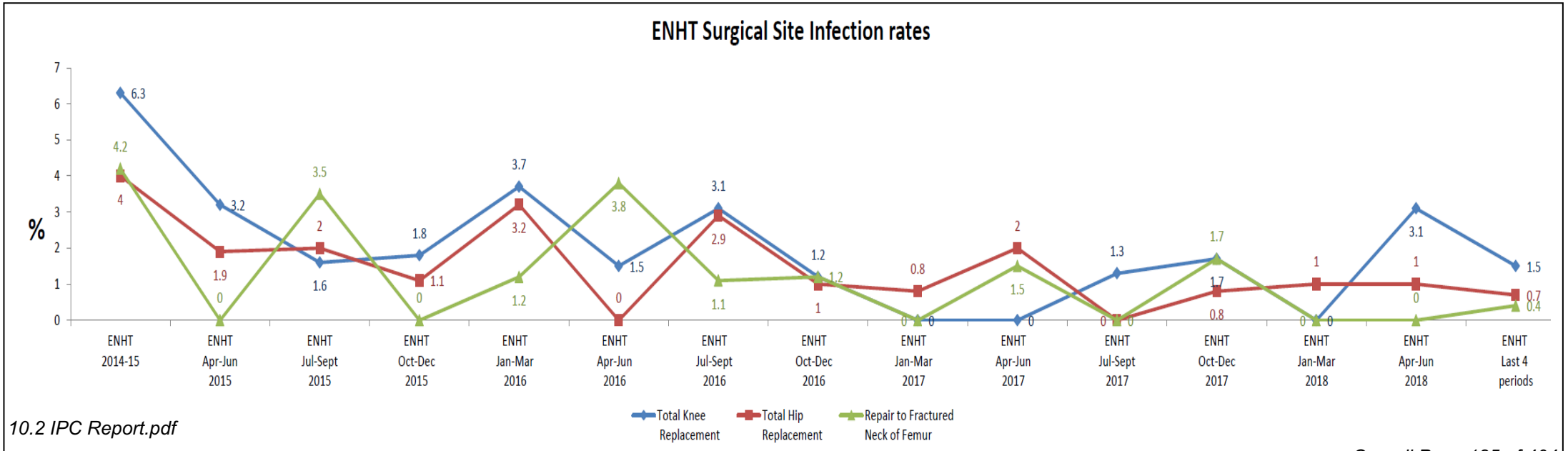
Surgical Site Infection Rates

SSI figures over the last 4 periods (Jul 17-Jun 2018) 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 TKR infection rate in Apr-Jun 2018 showed an increase to 3.1% (benchmark 0.5%) which requires further analysis. Infection rates for THR and #NOF remain at or below the national benchmarks.

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	Jul-Sept 17 ENHT	Oct-Dec 17 ENHT	Jan-Mar 18 ENHT	Apr-Jun 18 ENHT	* Last 4 periods ENHT	National Benchmarks2 013-2018
Total Knee Replacement	**6.3%**	**3.2%**	**1.6%**	**1.8%**	**3.7%**	**1.5%**	**3.1%**	**1.2%**	**0%**	**0%**	**1.3%**	**1.7%**	**0%**	**3.1%**	**1.5%**	**0.5%**
TKR infections/ops	5 / 80	2 / 63	1 / 64	1 / 57	2 / 54	1 / 66	2 / 65	1 / 85	0 / 77	0 / 60	1 / 76	2 / 119	0 / 97	3 / 98	6 / 390	
Total Hip Replacement	**4%**	**1.9%**	**2%**	**1.1%**	**3.2%**	**0%**	**2.9%**	**1%**	**0.8%**	**2%**	**0%**	**0.8%**	**1%**	**1%**	**0.7%**	**0.6%**
THR infections/ops	4 / 101	2 / 103	2 / 100	1 / 89	3 / 94	0 / 94	3 / 105	1 / 99	1 / 129	2 / 98	0 / 111	1 / 132	1 / 101	1 / 105	3 / 449	
Repair Fractured Neck of Femur	**4.2%**	**0%**	**3.5%**	**0%**	**1.2%**	**3.8%**	**1.1%**	**1.2%**	**0%**	**1.5%**	**0%**	**1.7%**	**0%**	**0%**	**0.4%**	**1.2%**
#NOF infections/ops	5 / 118	0 / 93	3 / 86	0 / 99	1 / 81	3 / 80	1 / 87	1 / 82	0 / 116	1 / 68	0 / 80	1 / 60	0 / 61	0 / 56	1 / 257	

* 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

Note: An additional TKR SSI case for Oct 2017 was recently identified and added to Oct-Dec 17 figures.



High Impact Intervention Audit Scores

High Impact Interventions	2017-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD 2018-19
Surgical Site Observation	96.47%	96.68%	94.84%	96.11%	96.12%	94.67%	97.99%							96.05%
Intravascular Devices (Insertion)	94.93%	96.31%	95.69%	94.94%	92.66%	94.16%	93.33%							94.55%
Intravascular Devices (Continuing Care)	95.15%	94.43%	95.91%	95.62%	97.29%	97.18%	96.88%							96.19%
Urinary Catheter (Insertion)	96.45%	97.35%	96.64%	97.67%	96.27%	96.09%	93.08%							96.12%
Urinary Catheter (Continuing Care)	96.24%	98.64%	96.55%	94.92%	94.62%	97.46%	94.23%							96.07%
Renal Dialysis (Continuing Care)	99.48%	100.00%	98.38%	98.96%	94.37%	98.56%	100.00%							98.53%
Ventilator (Continuing Care)	97.47%	76.92%	92.31%	96.15%	94.74%	100.00%	91.30%							92.23%
Environment (Inpatients)	96.27%	96.68%	95.76%	94.93%	95.34%	96.16%	95.20%							95.72%
Environment (Outpatients)	96.77%	96.80%	97.26%	96.47%	96.94%	98.09%	96.41%							97.02%
Environment (Renal Dialysis)	89.49%	85.66%	86.78%	85.38%	88.32%	85.64%	84.81%							86.11%
MRSA Screening Compliance	95.61%	96.84%	96.09%	95.72%	94.71%	96.54%	95.01%							95.85%

Compliance scores are extracted from the Meridian database of Trust-wide fortnightly audits undertaken by nursing staff in their own departments.

The hand hygiene audits currently undertaken by ward staff show an average compliance of >90%. However, these results do not correlate with observations by external inspection teams nor with audits by the IPC Team. In light of this, a new hand hygiene audit tool has been developed and additional training is being provided to auditors who will be supported by the IPC Team. Reporting based on the new process will commence in October.

Agenda Item: 11

TRUST BOARD PART 1 – 7 NOVEMBER 2018

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 on 22 October 2018.
PREVIOUSLY CONSIDERED BY	
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:	CHAIR OF AUDIT COMMITTEE
PRESENTED BY:	CHAIR OF AUDIT COMMITTEE
AUTHOR:	CORPORATE GOVERNANCE OFFICER/COMPANY SECRETARY
DATE:	OCTOBER 2018

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 22 OCTOBER 2018

SUMMARY REPORT TO BOARD – 7 NOVEMBER 2018

The following members were present: Jonathan Silver (Chair) and Bob Niven

MATTERS REFERRED TO BOARD

External Audit of the Charity Accounts
The External Auditors presented their report regarding the Trust Charity Annual Report and Account. Three risks were highlighted related to revenue recognition, management override and legacy income. No control issues had been identified. The Committee noted the report and recommended the letter of representation to the Trust Board for approval.

Charity Annual Report and Accounts
The Audit Committee reviewed the Charity Annual Report and Accounts. It was noted that there were some errors on the 'Corporate Trustee' page. Subject to the correction of these errors, the Audit Committee recommended the Charity Annual Report and Accounts to the Trust Board for approval.

Audit Committee Annual Report and Review of Terms of Reference
The Audit Committee reviewed the Audit Committee Annual Report (2017-18) and Review of Terms of Reference. The review concluded that the Committee had met its duties under its terms of reference. Only minor changes were proposed to the Committee's terms of reference. A minor amendment to the body of the annual review was requested in relation to the External Audit section. Subject to that amendment, the Audit Committee recommended the Annual Report and Review of Terms of Reference for approval the Trust Board.

OTHER

Internal Audit Progress Report
The Committee received the latest internal audit progress report. Since the last Audit Committee meeting four final reports had been issued as follows:

- Discharge Management, including Red to Green initiative
- Additional Duty Payments
- Data Quality – Emergency Admissions Unit
- Data Quality – Theatres

The Internal Auditors had issued 'reasonable assurance' opinions in relation to the Additional Duty Payments and Data Quality – Theatres audits. 'Partial assurance' opinions had been issued in relation to the Discharge Management and Data Quality – EAU audits. The Chief Operating Officer attended the meeting to discuss the actions being taken in relation to the discharge management audit. Regarding the Data Quality – EAU audit, it was discussed that the Trust was in the process of moving towards an improved position in terms of data quality and a data quality strategy was to be considered later in the meeting. It was considered that it would be beneficial to undertake a reassessment once further work had taken place regarding data quality.

The Committee also discussed the IA plan for the remainder of the year and the time to complete reports.

Internal Audit Tracking Report and PwC Governance Review Action Plan Update
The Committee received the latest version of the Internal Audit Tracking Report and PwC Governance Review action plan.

Regarding the PwC Governance Review, the AC requested that one of the actions proposed for closure remained on the log at present and requested a continued focus on the ambers and red actions.

Regarding the Internal Audit Tracking Report, the Committee noted that a number of actions remained open and overdue, with the greatest number of overdue actions assigned to the Director of Finance. It was acknowledged that this was in part because more of the audits related to finance and IM&T. It was noted that the target dates needed to be set appropriately at the outset and it was suggested that the actions could be considered more regularly, such as at Finance and Performance Committee.

The Committee also noted a benchmarking report provided by the Internal Auditors related to audit assurance levels and actions resulting from internal audit findings.

Local Counter Fraud Specialist Progress Report and Fraud Risk Assessment
The Committee received the LCFS Progress Report which provided an update in respect of counter fraud work since the previous meeting. There was some discussion as to how the Trust compared in terms of fraud resulting from overseas patients. The Internal Auditors would provide further information for the next meeting. The Committee noted the report.

Trust Charity and ENH Pharma Annual Report and Accounts Progress Report
The External Auditors provided a verbal update regarding the external audit of the ENH Pharma Accounts. Three issues were reported but all were due to be resolved. One issue had been the change of pharmacy IT system in year which had slowed down the audit process. The Committee discussed the process for approval of the accounts and suggested alternative arrangements were considered for the 2018/19 accounts.

ENH Charity ISA 260 Planning Letter
The Committee noted the ENH Charity ISA 260 planning letter.

Cyber Security Update
The Audit Committee received an update regarding Cyber Security. Since the previous update, more risks had been closed and the overall risk rating had reduced. The Committee had some concerns regarding the extent of the work programme that was required and requested some feedback on the timeframe for overdue actions and the updated level of risk and for the next report. They also requested some information on work to improve staff awareness of cyber security. It was agreed that more regular updates would be reported to the Quality and Safety Committee and / or Finance and Performance Committee.

Data Quality and Clinical Coding Update
The Audit Committee received an update report regarding Data Quality and Clinical Coding. The Committee also received the draft Data Quality Policy and Data Quality Improvement Strategy. The Committee discussed the strategy and felt that Board level support and encouragement would likely be needed in establishing and embedding the strategy. It was suggested that a summary document or poster based on the policy would help to make it accessible to staff. The Committee also requested that the Internal Auditors liaised with the Data Quality team regarding some of the findings of their recent internal audits.

Review of Standing Orders and Standing Financial Instructions
The Audit Committee reviewed and approved the updated Standing Orders and Standing Financial Instructions. It was noted that it was the intention to carry out a more thorough review of the structure of the SOs and SFIs in future.

Fixed Asset Verification Progress Report
The Audit Committee received an update on the work to carry out a full asset verification exercise. It was anticipated that the work would be ongoing for several months. An update was requested for the May or July 2019 Audit Committee meeting.

Reference Costing Report
The Committee noted the Reference Costing Report which had been considered by the Finance and Performance Committee on 26 September 2018.

Risk Management Strategy and Board Assurance Framework
The Audit Committee received reports regarding the Risk Management Strategy and Board Assurance Framework. Work on implementing the new strategy was progressing and the training provided for staff would be reviewed. The overall number of risks has not increased significantly.

The Committee also reviewed the latest Board Assurance Framework. It was suggested that the target scores for some of the entries should be reviewed.

Review of Conflicts of Interest and Gifts and Hospitality Registers
The Audit Committee approved the Conflicts of Interest and Gifts and Hospitality Registers for publication on the Trust website. The policy had been reviewed in 2017 and the number of declarations had increased under the new policy.

Internal Audit and External Audit Survey Feedback
The Committee noted the feedback from a survey of AC members and attendees regarding the performance of the Internal Auditors and External Auditors in 2017/18.

Quarterly Junior Doctor Contract Update
The number of exception reports had decreased from the previous quarter, though it was noted that number could increase in the current quarter as winter pressures began to take effect. The Committee noted the update.

Sustainability Report
The Committee noted the Sustainability Report. It was considered that it would be challenging for the Trust to meet the target for a 34% reduction in its carbon emissions be 2020. The Committee noted the report.

Jonathan Silver
Non-Executive Director

October 2018

East and North Hertfordshire NHS
NHS Trust

Agenda Item: 11.1

TRUST BOARD PART 1 – 7 NOVEMBER 2018

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

PURPOSE	To present annual review of Trust's SFIs to the Trust Board for approval
PREVIOUSLY CONSIDERED BY	Audit Committee, October 2018 – recommend approval.
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)	There is a risk to the financial performance of the Trust if there is not a robust governance process in place.
Healthcare/ National Policy (includes CQC/Monitor)	The Trust is required to have Standing Orders, Standing Financial Instructions and a Scheme of Delegation as part of its constitution.
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Director of Finance & IM&T
PRESENTED BY:	Interim DDoF/Company Secretary
AUTHOR:	Financial Controller, Company Secretary
DATE:	October 2018

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

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

1. Introduction

1.1 Attached to this paper are the standing orders, reservation and delegation of powers and standing financial instructions with proposed amendments.

1.2 NHS Trusts are required by law to make Standing Orders (SOs) and Standing Financial Instructions (SFIs), which regulate the way in which the proceedings and business of the Trust will be conducted and this should be reviewed regularly to keep them up to date.

1.3 This revision has arisen as a result of the requirement to carry out an annual review.

1.4 This review has identified some minor amendments required to the information on the Board Committees and organisational changes within the NHS bodies and the regulator.

1.5 The Audit Committee have reviewed the changes and recommend to the Board for final approval.

2. Key changes

Below are the key amendments to this document and a reference to sections updated

Page No.	Section	Key changes
Various	General	Amend Chairman to Chair
15 (S2.1)	The Trust Board	Amend regulatory body to NHS Improvement
25 (S4.8.1)	Audit Committee	update the function of the Audit Committee to include all Trust system of internal control
26 - 27, 41	Risk and quality committee	Changed to Quality and safety committee and update the purpose of the committee
62, 112, 113	Authorities / duties delegated	Changed NHS Litigation Authority to NHS Resolution
63, 69, 112	Finance Director, Director of Performance and Finance	Changed to Director of Finance
73	Bank and GBS Accounts	Insert reference to cash and treasury management policy
100	Director of Operations	Changed to Chief Operating Officer

3. Recommendations

The Board is requested to approve the revision to the Standing Orders, Standing Financial Instructions and a Scheme of Delegation as illustrated in the appendix

Financial Controller/ Company Secretary
October 2018

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

Mr Jonathan Silver (Committee Chair), October 2018

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair), November 2018

Policy issued: October 2018
To be reviewed before: October 2019
To be reviewed by: Company Secretary / Financial Controller
Doc Registration No. CG05 **Version No.** 8

Version	Date	Comment
1	2010	
2	2012	
3	2013	Scheduled review: Updated to reflect the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. Loss and compensation section updated. Delegated Limits reviewed.
4	October 2014	Scheduled review – Minor changes. Delegated limits reviewed.
5	October 2015	Scheduled review. Revised to reflect Capital Review Group Update to include revised process regarding centralisation of documents on the KC; improved escalation process and inclusion of a wider range of documents
6	October 2016	Scheduled review. Revised to ensure supports Board meeting moving to bi- monthly, include the Auditor Panel and strengthen procurement.
7	October 2017	Scheduled review. Updated in line with Organisational changes.
8	October 2018	Scheduled review. Updated in line with Organisational changes.

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

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

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

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

Key messages

1. The consolidated document provides a single source of the key rules under which the Trust is managed and governed.

2. The regulations which determine the way that the Trust Board operates and the Trust is governed are spelt out in the Standing Orders.
3. Financial responsibilities and authorities are described in the SFIs and SoDA
4. All employees of the Trust need to be aware of their responsibilities and authorities described in this document. 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 2018

Draft for consideration and approval by Audit Committee October 2018 and Board November 2018 (need to update footer)

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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 Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive or 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 Chair, 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 **Chair of the Board (or Trust)** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chair of the Trust” shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

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

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

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

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

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

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

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

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

1.2.16 **Fraud** any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. 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 Chair.

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

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

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

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

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

1.2.23 **Officer member** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

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

1.2.25 **SFIs** means Standing Financial Instructions.

1.2.26 **SOs** means Standing Orders.

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

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

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

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

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

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

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

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies. Furthermore the Trust has delegated powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation..

(6) The Code of Accountability for NHS Boards (DH, revised April 2013) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

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

1.2 NHS Framework

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

(2) The Code of Accountability for NHS Boards (DH, revised April 2013) requires that, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

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

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions. The Standing Orders and Standing Financial Instructions will be reviewed annually

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance and other best practice guidance including the Healthy Board will continue to be incorporated in the Quality 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~~Chair 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 the Trust's ~~Chairman~~Chair and Members of the Trust

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

2.3 Terms of Office of the Chair and Members

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

2.4 Appointment and Powers of Vice-Chair

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

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

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

2.5 Joint Members

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

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

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

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

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

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

2.6 Patient and Public Involvement

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

2.7 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

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

(3) **Director of Finance**

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

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

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

The Chair shall liaise with the NHS Improvement - Appointments over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

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

2.8 Corporate role of the Board

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

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

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

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

2.9 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

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

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

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

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

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

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

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

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair and 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 Chair 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 Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

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

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

3.6 Emergency Motions

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

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

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

ii) **Contents of motions**

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

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

iii) **Amendments to motions**

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

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

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

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

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

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

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

In those cases where the motion is either that the meeting proceeds to the ‘next business’ or ‘that the question be now put’ in the interests of objectivity these should

only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

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

3.8 Motion to Rescind a Resolution

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

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

3.9 Chair of meeting

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

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

3.10 Chair's ruling

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

3.11 Quorum

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

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

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

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 Chair of the meeting shall have a second, and casting vote.

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

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

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

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

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

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

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

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

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

3.14 Variation and amendment of Standing Orders

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

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;

- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

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

3.16 Minutes

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

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

3.17 Admission of public and the press

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

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

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

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

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

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

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

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

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

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

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

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 Chair 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 "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

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 ~~with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.~~ an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation.

The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis. Assurances with regards to the ongoing management of risk are within the duties of the ~~Rick and~~ Quality and Safety 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 and Safety Committee - The purpose of the Quality and Safety Committee will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee will also be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the strategic objectives and quality transformation plan.~~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 to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors.

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 Chair after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chair shall be

reported to the next formal meeting of the Trust Board in public session for formal ratification.

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

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

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.

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.

e) Donations: Donation made by suppliers or bodies seeking to do business with the Trust or Donation from another body.

f) Sponsorship: Sponsorship of an event by an appropriate external body; Involvement with sponsored or External sponsorship of a post. ;

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 Chair 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 Chair and Members in proceedings on account of pecuniary interest

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

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

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

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

(iii) "Pecuniary interest"

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

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

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

iv) Exception to Pecuniary interests

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) at a meeting of a Committee –

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

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

(3) Application of waiver

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

It will apply to:

(i) A member of the East and North Hertfordshire NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation; or

(b) services in connection with a pilot scheme under the 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 Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

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

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

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

The removal is subject to the following conditions:

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

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

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

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

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

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

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

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

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

7.4 Standards of Business Conduct

7.4.1 **Trust Policy and National Guidance**

All Trust staff and members of must comply with the Trust's Values and Standards of Business Conduct and 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 Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

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

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the 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, 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 AND SAEFTY COMMITTEE	The purpose of the Quality and Safety Committee will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee will also be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the strategic objectives and quality transformation plan. 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 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

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• 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. A full list of responsibilities can be viewed in the Terms of reference for the committee
	CHARITY TRUSTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives

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

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 Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS England and the Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSI and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct, Trust Values and coaching culture.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
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	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer

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	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	DIRECTOR OF FINANCE	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board a delivery plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.4	BUDGET HOLDERS	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
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 PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.1	BOARD	Will approve the Trust's plans for applications for short-term or longer-term borrowings and loans
22.1.2	BOARD	Approve a list of employees authorised to make applications and sign loan documentation on behalf of the Trust. (This must include the CE and DoF.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising at least one other member for loan and borrowing application and documentation submission..
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
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~~ Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS ~~Litigation Authority~~ Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS ~~Litigation Authority~~ Resolution for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

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 Company 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 Chair 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~~2018), 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 Chair 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 Chair 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.

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~~Director of Finance 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

(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. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

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 GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements, developing a cash and treasury management policy 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~~GBS 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 prior 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.

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 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 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..

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.

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 NHSI for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

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 Capital Investment guidance and Estate code;

(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 2018~~7~~/19~~8~~. 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~~Chair 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) making payment on agreed dates;

(e) 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~~fulfil 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), 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 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 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.

(a)

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;

(c) Sets the capital budgets following approval by DEC;

(d) monitors progress of capital projects against budget;

(e) reports to the FPC on progress made on capital projects after each meeting

(f) liaises with Divisions and Project Sponsors to aid the progression and management of capital schemes

(g) monitors the procurement of donated assets valued over £100k and reports to the Charity Trustee Committee

(h) review all capital risks at the Trust

(i) ensures that the Capital Resource Limit (CRL is achieved at the Trust)

(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 Capital Review Group should consider sources of funding including purchase, private or other finance and 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 Chief Operating Officer~~Director of Operations~~, Director of Estates and Head of IT collate capital requests from the Clinical Divisions which are considered at a special Divisional Operations Committee meeting, together with requirements from their own areas. The applications are considered for inclusion on the Annual Capital Programme. A schedule of approved bids will be prepared for review at the Capital Review Group.~~.~~ 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.

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 these 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 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 up to the delegated limit 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~~ the 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 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~~NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by ~~the~~ NHS Resolution ~~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 NHS Resolution~~the Litigation Authority~~. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the ~~Finance Director~~Director of Finance 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 Resolution~~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~~ Resolution 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) 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) 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)

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	Unchanged

		Operating Officer	
	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 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, 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)
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
	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
	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
	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
	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)
	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: 11.2

TRUST BOARD PART 1 – 7 NOVEMBER 2018

AUDIT COMMITTEE ANNUAL REVIEW 2017/18

PURPOSE	To present the Audit Committee Annual Review 2017/18 and Review of Terms of Reference for approval. Note: A further update has been added to the Terms of Reference since the report was considered by the Audit Committee .This is highlighted in yellow under 'Other Assurance Functions'.
PREVIOUSLY CONSIDERED BY	Audit Committee (22.10.18)
Objective(s) to which issue relates *	[X] 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 aspect of the Trust's assurance process
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is considered to be best practice and is in line with the recommendations made in the Audit Committee Handbook.
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[X]	For decision	[ ]
For discussion	[ ]	For information	[ ]

DIRECTOR:	CHIEF EXECUTIVE
PRESENTED BY:	COMPANY SECRETARY / CHAIR OF AUDIT COMMITTEE
AUTHOR:	CORPORATE GOVERNANCE OFFICER / COMPANY SECRETARY
DATE:	OCTOBER 2018

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
ANNUAL REVIEW 2017/18

Executive Summary

The Audit Committee is a key assurance committee of the Trust Board. Its purpose is to provide an independent and objective review of the Trust's system of internal control, including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

This annual review considers how the Audit Committee has met its duties under its Terms of Reference. The findings of this review are based on a review of the Committee's minutes and its reports to the Board, the Annual Governance Statement 2017/18 and a review of the Trust's Standing Orders and Scheme of Delegation. In addition to this, Committee members, regular attendees and the internal and external auditors completed a questionnaire considering how the Audit Committee performed in 2017/18 and how its operation could be improved.

This review concludes that the Committee met its duties under its Terms of Reference, though it is also recognised that there are areas where improvements can be made. The Terms of Reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- For the Audit Committee to maintain a greater focus on risk management (the planned regular reports on the implementation of the Risk Management Strategy should help to ensure this recommendation is addressed).
- For further work to take place on improving the quality of reports (the executive summary section in particular).
- To continue to invite the lead director to attend for 'no assurance' / 'partial assurance' internal audit reports.

Summary of Key Findings

- **Meetings and Membership**

The Audit Committee met formally on five occasions during 2017/18 and held an extraordinary meeting in March to review the proposed risk management and BAF process. All of the meetings, including the extraordinary meeting, were quorate.

The membership of the Committee changed during the course of the year as two of the three Non-Executive Director members of the AC left the Trust during this period. Mr Nicholls left the Trust at the end of July 2017 and Mrs Bexfield's term as a NED at ENHT came to an end at the end of January 2018 (having served the maximum permitted number of years as a NED at the Trust). As a result, the Trust recruited two new Non-Executive Directors in autumn 2017. Mr Nick Swift commenced in post in November 2017 and replaced Mr Nicholls on the Audit Committee (and as Chair of the Finance and Performance Committee). Mr Jonathan Silver joined the Trust as a designate Non-Executive Director in October 2017 and replaced Mrs Bexfield as Chair of the Audit Committee when her term came to an end in January 2018. Mr Niven remained a member of the Committee throughout the period.

The Company Secretary and Director of Finance (regular attendees at the meetings of the Audit Committee) remained in post throughout 2017/18.

The Committee met in private with the external auditors prior to the meeting in May 2017 and with the internal auditors following that meeting. Whilst the Committee did not meet in private with the auditors again during 2017/18, Mr Silver was in contact with the auditors prior to the meetings.

A review of the Committee's minutes demonstrated an appropriate level of scrutiny and challenge could be evidenced throughout its meetings.

Whilst the Chief Executive did attend the AC meeting on 22 May 2017, in 2018 to date he has only been able to attend the extraordinary meeting regarding the risk management process on 7 March. Encouraging greater attendance from the Chief Executive is highlighted as one area where the Committee can improve in 2018/19.

- **Committee Survey**

The efficacy of the AC has been assessed by issuing a questionnaire to Committee members and others who regularly attend meetings. There were a total of seven responses, including from all three Non-Executive Directors. A summary of the findings are provided below:

- The Committee were generally in agreement that the agenda covered the right items and all agreed there was good test and challenge.
- When asked how the quality of discussions could be improved, the Committee members felt that the discussions were already good and robust challenge was achieved. Suggestions for improvement included ensuring that the lead director attended when issues were raised on a specific Internal Audit, more focussed papers and more sensible timescales for actions so that less time was spent covering actions that had not been completed.
- Several of the respondents felt a greater focus on risk management would be beneficial.
- It was felt that the appropriate people were at most of the meetings. It was noted that the Chief Executive had been unable to attend the year-end meetings and it was felt this would be beneficial in future years.
- The respondents agreed that there was sufficient time for discussion on individual agenda items.

- The Committee members were asked how well the Committee had performed against the recommendations made in last year's review:
  Recommendation 1: To consider inviting the relevant lead director for 'no assurance' / 'partial assurance' internal audits
  The general consensus was that this had improved.
  Recommendation 2: To continue to support improvements to the quality of papers, in particular the executive summary section.
  It was noted that this could be improved further and that the new Committee Chair had brought in some new ideas which were still being worked through.
  Recommendation 3: To consider an increased linkage to the Trust's risk profile and BAF
  It was felt this had improved but could be enhanced further.
- When asked how the Committee had added value to the Trust's operations over the last year, responses suggested this had been achieved by insightful challenge of the control framework, a focus on cyber-security / IT and close attention to the organisation's follow-up to audits.
- Not all respondents answered the final question regarding how the Committee's effectiveness could be improved. The suggestions received included better implementation of audit actions a more coordinated effort with other committees as to sources of assurance.

On the whole, the responses received were positive regarding the efficacy of the Committee.

➢ **Areas for improvement highlighted in 2016/17 Annual Review**

The following table details the areas identified for improvement in the 2016/17 annual review and details how those recommendations have been addressed:

	Areas for improvement	Addressed by
1.	To consider inviting the relevant lead director for 'no assurance' / 'partial assurance' internal audits.	This process has been in place since it was proposed in the last annual review. The Director of Finance was in attendance for the findings of the procurement and key financial controls audits and the Interim Director of Nursing attended the meeting when the findings of the medicines management internal audit were considered. There was one occasion when the lead director was unable to attend the meeting, but an update report was provided for the following meeting.
2.	To continue to support improvements to the quality of papers, in particular the executive summary section.	The current Committee Chair has discussed the content and style of reports with the auditors to try to find the right balance. The findings of the survey suggest that this is an area where further improvements could continue to be made.
3.	To consider an increased linkage to the Trust's risk profile and BAF.	The risk register and BAF process underwent a comprehensive review in early 2018. The new process is for the Audit Committee to have oversight of the process and for the RAQC (now

		Quality and Safety Committee) and FPC to have oversight of individual risks assigned for their oversight. The new approach was endorsed by the Audit Committee at an extraordinary meeting in March and subsequently approved by the Trust Board. It is the intention that the BAF will be included on the agenda for every AC meeting, as well as a review of progress with the implementation of the risk management strategy.

Performance against the responsibilities set out in the terms of reference:

- **Governance, Risk Management and Internal Control**

In February 2017 the Trust Board asked the Audit Committee to review how previous errors had occurred in relation to accounts reconciliation and to seek external assurance on the current control processes. Following this request, the Trust initially commissioned PwC to undertake a financial governance review, however as the work programme developed it was considered that it would be more helpful to expand the scope of the review and consider the Board Governance arrangements currently in place - including a focus on risk management and the Board Assurance Framework. The report was considered at the Board Development and Audit Committee meetings in October 2017 and included a number of recommendations. The Trust developed an action plan which is still being monitored by the Audit Committee in relation to the findings of the report. One of the key conclusions drawn by PwC was that the remit of some of the Board sub-committees was not clear, in particular in relation to risk management activity. The Trust consequently undertook a review of strategic risks in 2017 which led to a review of the risk management strategy, the BAF and process for review and scrutiny across all Board committees. In March 2018, an extraordinary meeting of the Audit Committee was held to review the work to refresh and develop the Trust's approach to the management of risk, including the development of a new risk management strategy and Board Assurance Framework. The new process is for the Audit Committee to have oversight of the process and for the RAQC and FPC to have oversight of individual risks. The new approach was endorsed by the Audit Committee at an extraordinary meeting in March and subsequently approved by the Trust Board. It is the intention that the BAF will be included on the agenda for every AC meeting.

The Audit Committee's review of the Trust's systems of governance, risk management and internal control culminated in its consideration of the Annual Governance Statement (AGS). In May 2017 the AC reviewed and endorsed the final draft of the Annual Governance Statement 2016/17 which was submitted to the auditors as part of the Trust's Annual Report and Accounts submission to NHSI. The overall opinion provided in the AGS was that '…no significant control issues (i.e. issues where the risk could not be effectively controlled) have been identified in respect of 2016/17'. The AGS concluded that the Trust had a generally sound system of internal control that supported the achievement of the organisation's objectives, though acknowledged that the internal control environment could always be strengthened and this work would continue over the year with a focus on financial governance. In May 2018 the Committee recommended the Annual Governance Statement 2017/18 for approval by the Trust Board. The report concluded that there were no significant control weaknesses.

As part of its governance responsibilities, the Audit Committee reviewed the declarations of interest and gifts and hospitality register for 2016/17 and received an update on declarations of interest received to date in 2017/18. The Committee reviewed and endorsed a revised Conflicts of Interest Policy in July 2017 (approved by Trust Board on 26 July 2017). The revised policy combined the current Conflicts of Interest Policy and Gifts and Hospitality Policy and was applicable to a wider number of staff. The Audit Committee is due to receive the next update on the Conflicts of Interest Policy and latest versions of the declarations of interest and gifts and hospitality register at the meeting in October 2018.

Key policies approved by the Audit Committee included:

- Raising Concerns at Work Policy
- Managing Conflicts of Interest Policy
- Anti-Fraud and Bribery Policy

➢ **Internal Audit**

The Committee received regular progress reports from its internal auditors (RSM) on internal audit work during 2017/18 including a summary of reports issued. The audits received by the Committee over the year covered areas including procurement, medicines management and resilience planning. On the latter two audits, the AC requested update reports to advise the Committee of progress that had been made following the audits. As noted in the Head of Internal Audit Opinion, the internal auditors did not issue any 'no assurance' opinions during the year. The Internal Audit Plan for 2018/19 was approved by the AC in March 2018.

The AC regularly monitored performance indicators regarding whether audits commenced on time and when the report was finalised within six weeks. This was an area where it was felt improvements could be made, with more than half of the 2017/18 reviews taking longer than six weeks to finalise.

The Committee also felt that performance in terms of the timely completion of actions arising from audits required improvement. They recognised that this was a key mechanism for internal audits to add value to the Trust's operations. Part of the problem had been a high level of turnover in senior management roles. The Committee requested that the internal auditors provide a summary report of any relevant audits and actions for any incoming directors.

➢ **External Audit**

The AC received several reports providing updates on the preparation of the 2017/18 annual accounts. These reports included updates on key issues which it was believed would be relevant to the audit of the financial statements, use of resources and Quality Account of the Trust for the year ending 31 March 2018. The Committee also received an update on IFRS changes which impacted on the disclosure requirements for the Trust in 2017/18

An extraordinary meeting of the Audit Committee was held on 23 May 2018 to review the Trust's annual accounts 2017/18 and EA report on the year-end accounts. The Committee noted that the audit had identified no material misstatements and no significant deficiencies in internal controls. The audit opinion would include an 'except for' reference to sustainable resource deployment. Following consideration of the reports, the extraordinary meeting was reconvened as a Trust Board meeting and the following reports were approved:

- The Trust Annual Report and Accounts,
- The Annual Governance Statement,
- The Letter of Representation.

The Trust Board also noted the External Audit ISA260 Report.

As well as undertaking the audit of the Trust's accounts, the external auditors also undertake an audit of the Quality Account each year. For 2017/18 it was the intention to align the audit of the Quality Account with the audit of the accounts. The Audit Completion Report considered by the AC at the extraordinary meeting on 23 May included a section on the Quality Account. The Quality Account was ultimately approved at the Board Development meeting on 6 June, along with the Letter of Representation regarding the Quality Account.

The Committee also received updates regarding the Trust Charity and ENH Pharma Ltd accounts. The audits of the Charity and ENH Pharma accounts 2017/18 are due to be completed in September / October 2018.

- **Other Assurance Functions**

The Committee sought assurance regarding cyber security on a regular basis throughout 2017/18. The WannaCry cyber incident occurred in May 2017 and the Committee discussed the incident at the meeting on 22 May. The internal auditors carried out an advisory review regarding cyber security and reported their findings in January 2018. The Associate Director of IT attended the meeting on 26 March 2018 to present regarding the action plans drawn up following internal and external reviews. The Committee recommended that the RAQC and FPC received reports regarding cyber security to consider the risks relating to their specific areas of focus.

In July 2017 and January 2018 the Committee received reports regarding the Trust's significant losses/special payments. In July the AC had been concerned that the reporting of IT losses was not necessarily fully reflective of the position. The Committee subsequently received an update report specifically regarding IT losses at the January 2018 meeting and also a separate report regarding a specific settlement.

The FPC closely monitored the raising concerns (whistle-blowing) log, noting open cases, themes and actions being taken. The AC also reviewed the Raising Concerns policy, recommending the report to Board for approval in July 2017.

At each meeting, the Committee reviewed the internal audit report log (and PwC governance review action plan from January 2018), monitoring implementation of recommendations made by the auditors and PwC. The Committee noted that there were some issues with completing the actions by the target date and have encouraged senior management to make improvements in this area.

- **Counter Fraud**

The Audit Committee continued to monitor the work of the Local Counter Fraud Specialist (LCFS) throughout the year, a service provided by internal audit.

The AC received a regular LCFS progress report at its meetings throughout the year, detailing the work of the LCFS. This included details of local proactive exercises that were undertaken as well as details of any counter fraud cases. The AC received a draft LCFS work plan for 2018/19 at the meeting in March 2018 and approved the final plan at the meeting in May 2018. In May 2017 the AC received the Local Counter Fraud Specialist Annual Report 2016/17. The report provided an annual summary against NHS Protect's anti-fraud standards, based upon the work performed in line with the agreed annual work plan. Based on the self-review tool, the Trust's overall rating for the year was 'Green'.

- **Management**

The Committee continued to monitor the adequacy and timeliness of management responses in relation to all reports received, and challenged these when necessary. The AC also requested attendance by the relevant director or senior manager whenever it considered a report provided less than adequate assurance.

- **Financial Reporting**

One of the key duties of the Audit Committee is to review the annual report and accounts before submission to the Board. At the extraordinary meeting in May 2018 the Committee endorsed the Trust's Annual Report and Accounts for publication on the Trust's website and final approval by Trust Board.

- **Reporting Arrangements**

The Audit Committee has provided an executive summary report to the Trust Board after each meeting which has highlighted the key issues to the Board.

Conclusion

This review demonstrates that the Audit Committee has discharged its duties under its terms of reference.

The terms of reference have been reviewed and some minor changes are suggested. The proposed Terms of Reference are appended to this report (Appendix 1).

The Committee is asked to consider this Annual Review and approve the Terms of Reference for final approval by Board.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- For the Audit Committee to maintain a greater focus on risk management (the planned regular reports on the implementation of the Risk Management Strategy should help to ensure this recommendation is addressed).
- For further work to take place on improving the quality of reports (the executive summary section in particular).
- To continue to invite the lead director to attend for 'no assurance' / 'partial assurance' internal audit reports.

Appendix 1

AUDIT COMMITTEE TERMS OF REFERENCE

Purpose

The purpose of the Audit Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

Status and Authority

The Audit Committee is established as a formal committee of the Board. It is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

Three Non-Executive Directors (excluding the Chair of the Trust Board), one of whom shall be appointed Chair by the Board.

Quorum

Any two members of the Committee are required to be present.

Attendance

The Director of Finance, the Company Secretary, and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement (AGS). He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. Other executive directors should be invited to attend, particularly when the Committee is discussing the areas of risk or operation that are their responsibility. Other senior managers may be required to attend as needed.

Frequency of Meetings

The Committee will consider the appropriate frequency and timing of meetings to allow it to discharge all its responsibilities, but it will not meet less than five times

during the year. The external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

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.

In particular, the Committee will review the adequacy of:

- the policies and processes for preparing the Board Assurance Framework including the quality of the evidence for assurance provided by Internal and External Audit, management and other sources
- to review and monitor the Board Assurance Framework
- all risk and control related disclosure statements (in particular the AGS), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions to test the effectiveness of the framework, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

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

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- an annual review of the effectiveness of internal audit

External Audit

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

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit,
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy,
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee,
- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

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

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (eg the Care Quality Commission, etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

The Committee will also undertake the following additional duties:

- To approve the Data Quality Strategy and monitor delivery against the indicators,
- To approve the Trust's Sustainability Development Management Strategy and plan and monitor progress to ensure national requirements are met.
- To monitor compliance to ensure the Trust meets its obligations under the Guardian of Safe Working.

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the ~~Risk and~~ Quality and Safety ~~Committee~~ (~~RAQC~~QSC), the Finance and Performance Committee (FPC), and the Charity Trustee Committee (CTC).

In reviewing the work of the ~~Risk and Quality Committee~~Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud

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

Management

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

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

Financial Reporting

The Audit Committee shall review the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the AGS and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting.

Reporting Arrangements

Following each meeting, the Audit Committee will submit a report to the Board, using the approved reporting form. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the AGS, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Account.

Process for Review

The Committee will complete an annual review of its terms of reference and conduct a self-assessment of its effectiveness on an annual basis, in line with the requirements of the Audit Committee Handbook ~~2013~~.

Support

The Company Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent issues/areas.

East and North Hertfordshire NHS Trust

Agenda Item: 12

TRUST BOARD – 7 NOVEMEBR 2018

RISK MANAGEMENT STRATEGY AND BOARD ASSURANCE FRAMEWORK

PURPOSE	The purpose of this paper is to present an update to the Board on the implementation of the Risk Management Strategy particularly in relation to the leadership and Board Assurance Framework. The Board are also asked to review the BAF, approve the changes endorsed by the Board Committees and make any further recommendations.
PREVIOUSLY CONSIDERED BY	Divisional Executive Committee 25 October 2018 – BAF changes and target scores reviewed. Audit Committee, 22 October 2018 –recommended review of target scores Executive Leads, October 2018 The Board Assurance Framework is considered at each FPC,QSC & Public Board
Objective(s) to which issue relates *	[X] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [X] 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)	• The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected • The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk is based upon the support and leadership offered by the Trust Board
Healthcare/ National Policy (includes CQC/NHSI)	CQC Well Led Domain Single Oversight framework
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[x]	For information	[ ]

DIRECTOR:	Director of Strategy
PRESENTED BY:	Associate Director of Corporate Governance
AUTHOR:	Associate Director of Corporate Governance
DATE:	October 2018

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 MANAGEMENT STRATEGY AND BOARD ASSURANCE FRAMEWORK

Executive Summary

The purpose of this paper is to present an update to the Board on the implementation of the Risk Management Strategy particularly in relation to the leadership and Board Assurance Framework. The wider implementation of the Risk Management Strategy and Risk Register procedure/ improvement plan across the Trust was presented to the Audit Committee and Quality and Safety Committee.

Since the previous report in July 2018 the structures to support risk management across the Trust have been reviewed and are in the process of being fully implemented. In summary, risk management will now sit in corporate governance within the portfolio of the Director of Strategy and led by the Associate Director of Corporate Governance (Company Secretary). An interim Risk Manager is in post and the permanent post is being recruited into; this post had previously been reported in to the Patient Safety team and the banding of the role has been reviewed to ensure the post holder has the correct level of expertise and competency. It is envisaged that the revised structure will support the delivery of the Risk Management Strategy and embedding risk management across the organisation. The Corporate Governance Team will also continue to work closely with the Quality and Safety Teams and Director of Nursing and Medical Director. To support this, risk management forms one of the work programmes under the quality transformation programme.

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the principal risks which might compromise the achievement of the Trust's strategic objectives. Following a Board Development workshop facilitated by RSM In December 2017, the Board Assurance Framework and principles risks were reviewed and approved through the Audit Committee and Board in March 2018 alongside a new Risk Management Strategy.

The process is fully established for a monthly review of the BAF by the Executive Leads, Associate Director of Corporate Governance through to Divisional Executive Committee/Executive Committee, prior to consideration at the Board Committees and at each public meeting of the Board. The Board Committee and Board agendas are reflective of the strategic risks and remain under regular review. A Board Development session to develop the Board's risk appetite is currently scheduled for February 2019.

The full BAF September 2018 is presented as appendix 1 and key points summarised below. This includes an increase of the risk rating for risk 3 *(Unable to achieve financial performance)* to 20 and risk 13 *(Brexit)* to 16. The Divisional Executive Committee endorsed these changes and undertook a review of the target risk ratings for year-end, as per discussion at the Audit Committee and Quality and Safety Committee.

The Internal Audit on the Assurance Framework and Risk Management is scheduled for November 2018. The outcome of the audit, together with a review of the latest best practice examples will be used to inform any amendments to the BAF going forward and areas for focus to continue to embed risk management across the organisation.

A full report on the implementation of the wider risk management strategy and risk register procedure/ improvement plan across the Trust was presented to the Audit Committee and Quality and Safety Committee. In summary the structures, processes, visibility and discussion of risk have been strengthened considerably over the six months but there is further work and training required to embed risk management across the Trust. This will remain a key priority over the next 18 months. The current risk register KPI's will be reviewed with a vision to develop a risk management dashboard at Trust and Divisional/Directorate level in quarter 4.

Board Assurance Framework

The latest version of the BAF is attached as appendix 1. The heat map has remained unchanged for the last 3 months although a new risk regarding the risk that the Trust is adversely affected by the UK's departure from the EU was added in September 2010. A summary of the key issues and changes reflected in the BAF presented to the Quality and Safety Committee and Finance and Performance Committee for September 2018 are outlined below:

- Review of Current risk scores:

  - **Risk No 003/2018** - There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income - is recommended to be increased to 20 following a review of the forecast outturn. A Financial Improvement plan has been developed and implemented to close the gap and is monitored through the weekly Programme Board and FPC and Board.

    Risk Lead Director of Finance / FPC

  - **Risk No 013/2018 -** There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured – Based on the latest national position and information released it is recommended that this risk rating is increased to 16.

    Risk Lead Director of Strategy / FPC

  - No other changes to the current risk scores are recommended for this month, however all risks have been reviewed and updated and recommendations for changes to target risk scores are listed below.

- Review of target Risk Scores:

  Audit Committee and Quality and Safety Committee feedback – To further consider if the current target risk ratings and timelines for achievement are realistic and the actions identified will support the delivery.

  Following discussion and review at Divisional Executive Committee the following changes are recommended to the year-end target risk ratings. Actions are in place to continue to mitigate the risks and there remains an ambition to seek to reducing these risks going forward.

  The Committee are asked to review recommendations made by the DEC:

  - **Risk No 003/2018** *(Unable to achieve financial performance)* – current risk rating increased to 20 / Year-end target risk rating increased from 12 to 16. This is due to the increased level of risk as outlined above.

  - **Risk No 006/2018** *(Insufficient Capital)* – current risk rating 20 / Year-end target risk rating increased from 8 to 16. Availability of capital has remained challenging throughout the year and continues to be prioritised on the high risks. On reflection the risk target for year end was unrealistic. The wording on the risk has been updated to read - There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment.

  - **Risk No 007/2018** *(governance structures)* – Current risk rating is 12 / year end risk rating to increase from 9 to 12. Although significant work has been undertaken to review and strengthen the Corporate and Quality and Safety Governance Structures

during 2018 these continue to be embedded and refined. The full teams to support the new strucutres will not be in post until April 2019.

- **Risk No 010/2018** *(health economy plans not effective/impacting on the trusts ability to manage demand)* – current risk rating 12 / Year-end target risk rating increased from 6 to 12. On reflection the risk target for year-end was unrealistic at the point of it being set and recognising the workstreams from the STP will take longer to deliver the change.

- No risks are rated as 25

- The following other four risks remain rated as 20

  See appendix 1 for the full details on the actions, updated with gaps in assurance and controls.

  - **001/18: There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards**

    Updated to reflect the additional funding social care have received for winter planning.
    (Executive Lead: Chief Operating Officer, Board Committee Lead: FPC)

  - **005/18: There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way**

    (Executive Lead: Director of Finance/ Chief Operating Officer Board Committee Lead: FPC)

  - **006/18: There is a risk that there is insufficient capital funding to address all estates backlog maintenance, including fire estates work, and funding for medical equipment**
    Updates provided above.
    (Executive Lead: Director of Finance, Board Committee Lead: FPC)

  - **011/18: There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience**

    (Executive Lead: Director of Nursing /Medical Director Board Committee Lead: RAQC)

  - **009/18: There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered impacting on the Trust's ability to deliver the required improvements and transformation.**

    (Executive Lead: Chief People Officer / Board Committee Lead: QSC)

The Board are asked to discuss and make any further recommendations and to note the plans to continue to develop risk management across the organisation.

Board Assurance Framework: October 2018 Updated
(25.10.18 post Divisional Executive Committee)

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading

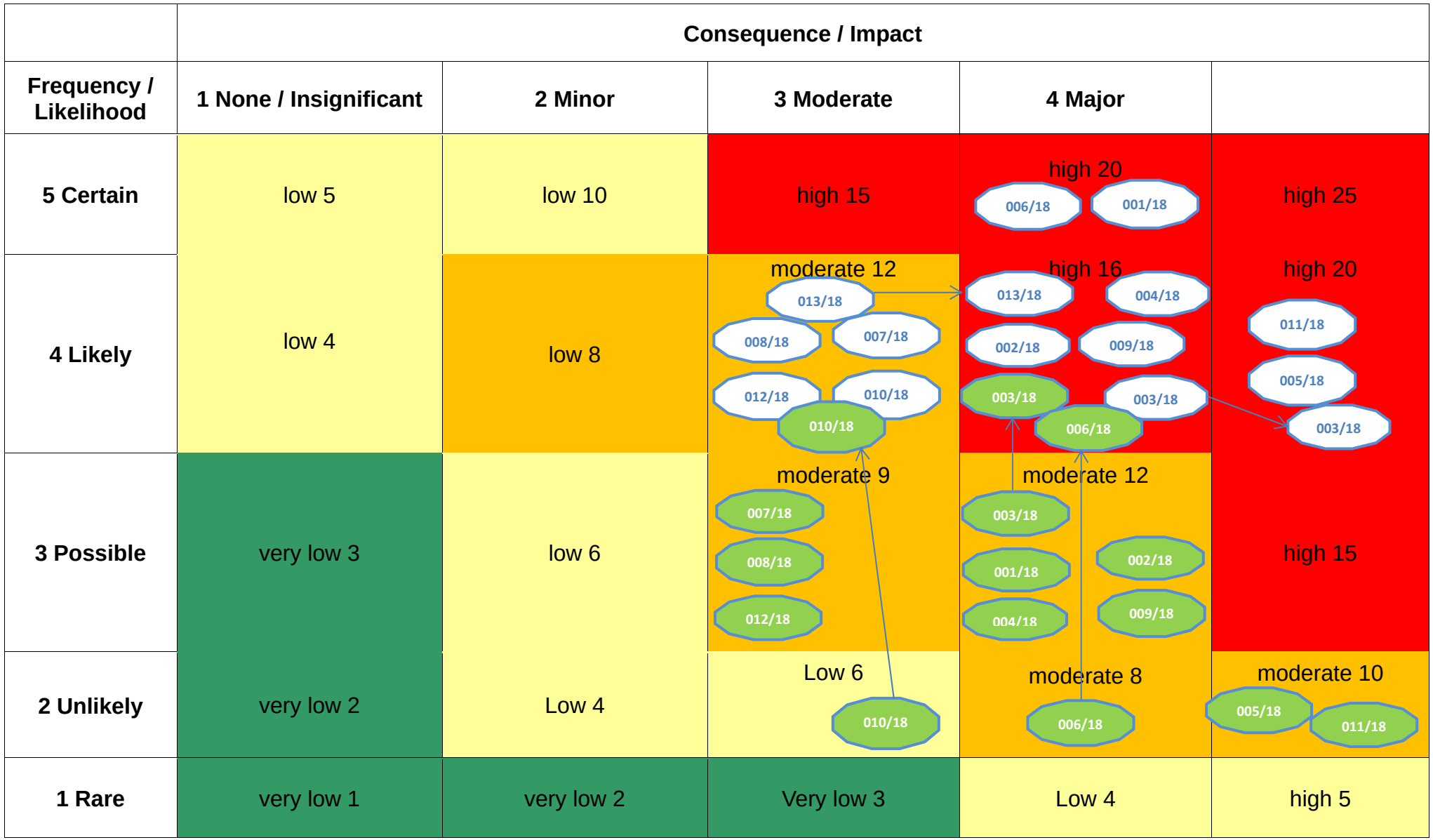
Impact	Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Last Month	3 months ago	6 months ago	Target Score	Date added
Corporate objective 1: Delivering our promise on value and quailty									
001/18	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	20	20	20	20	12	01-03-18
002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.	Director of Nursing /Medical Director/Chief People Officer	QSC	16	16	16	16	12	01-03-18
003/18	There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.	Director of Finance	FPC	20	16	16	20	Revised from 12 to 16	01-04-17
004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 18/19	Director of Finance	FPC	16	16	16	20	12	01-04-17
005/18	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way	Director of Finance/ Chief Operating Officer	QSC	20	20	20	20	10	01-04-17
006/18	There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment	Director of Finance	FPC	20	20	20	16	Revised from 8 to 16	01-03-18
007/18	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	Board of Directors	12	12	12	12	Revised from 9 to 12	01-03-18
008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency	Director of Strategy	QSC	12	12	12	12	9	01-03-18
013/18	There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.	Director of Strategy	FPC	16	12	n/a	n/a		19-09-18
Corporate objective 2: New ways of caring									
009/18	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & QSC	16	16	16	16	12	01-03-18
010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	FPC	12	12	12	12	Revised from 6 to12	01-03-18
011/18	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Director of Nursing /Medical Director	QSC	20	20	20	20	10	01-03-18
Corporate objective 3: Develop the Mount Vernon Cancer Centre									
012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	FPC	12	12	12	12	9	01-03-18

Board Assurance Framework Heat Map – Updated October 2018



BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	001/18	**There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards**

20

Strategic aim	**Delivering our promise on value and quality**
Latest review date	October 2018

Lead Executive	Chief Operating Officer
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	4	5	20
Current (Oct 18)	4	5	20
Target (Feb 19)	4	3	12

Change since last month

⟺

Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
002/18	16	Risk to patient care & safety due to lack of nursing &medical staffing

Key controls

- ED Patient flow improvement steering group
- Three times weekly workstream meetings including Red to Green
- Weekly ED Team/COO meeting
- Length of Stay consultant led reviews
- Daily system telephone conference
- Weekly access meeting chaired by COO
- Three tier cancer tracking meeting; Divisional PRMs
- Trust representation on A&E delivery Board/ Cancer Board/ STP
- Integrated Care Team engagement
- Additional management resource secured to support delivery of cancer timed pathway programme

Assurance on controls

- A&E Delivery Board (L1)
- System Resilience Group (L2)
- Reports to FPC and Board of Directors (L3)
- Floodlights scorecard (L1)
- NHSI PRM(L3)
- Cancer Board (L2)
- Daily and weekly ED sit-rep reporting
- Monthly breach validation audits
- Monthly Performance Deep Dives considered by FPC – e.g. ED in June 2018
- NHSI – Deep dive – cancer recovery plan (L3)

Gaps in control	**Gaps in assurance**	**Actions to address gaps in controls and assurances**	**Due date**
Bed Occupancy and LOS reductions not being delivered consistently across specialities. Sufficient surgical capacity to deliver cancer treatments within required timeframes Demand and capacity modelling for all tumour sites not complete. Funding received	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity • Demand and capacity profiling by tumour site not available • Confirmation from HCC that the additional	• Implementation of the accountability framework • Develop the floodlights score card • Implementation of ED patient flow improvement programme • Information team working in partnership with cancer and access team to map demand and activity profiles across 2018/19 and provide data intelligence to inform recovery plans • DMO1 reporting (diagnostic PTL) to be external reported	March 2018 (Implementation date now May) May 2018 October 2018

Funds received for winter planning by HCC not in the director control of the trust Access to funding streams from the cancer alliance allocation	funding received in social care as part of the winter planning will deliver	from November • Develop and implement - Reducing LOS project • COO liaison with HCC to again assurance on the projects following the additional allocation of social care funding for winter planning	

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20					

BAF risk	002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.

16

Strategic aim	Delivering our promise on value and quality
Latest review date	October 2018

Lead Executive	Chief Nurse/Medical Director/Chief People Officer
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (Oct 18)	4	4	16
Target (March 19)	4	3	12

Change since last month
⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
001/18	20	Insufficient capacity for timely patient flow
003/18	20	The Trust is unable to achieve financial performance
008/18	12	Governance arrangements do not facilitate delivery

Key controls

- Monthly nursing and midwifery workforce steering group
- Safe care – 3 times daily staffing reviews
- University of Hertfordshire recruitment
- Rotation of band 5 nurses to aid retention
- NHSI Wave 2 retention programme
- Eroster
- Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be.
- Retention Strategy
- NHSI Retention programme

Assurance on controls

- Report to RAQC on medical staffing (L2)
- Report to Board of Directors via RAQC on safer staffing (L2)
- Workforce report to FPC (L2)
- Eroster reports (L2)
- NHS Professionals continuously recruiting to nursing and midwifery band 2 and band 5 roles.
- Development of joint recruitment and attraction strategy with STP.
- Launch of retention strategy focusing on band 5 nurses and band 2 CSWs.
- Local retention targets and plans

Gaps in control	Gaps in assurance
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Embedding Accountability Framework • Staff leavers higher than expected in some areas • Specific targeted recruitment required for some specialities / specialists	• Data consistency and quality • Improved retention rates • Recruitment in specialty / hard to recruit areas

Actions to address gaps in controls and assurances	Due date
• Hertfordshire wide recruitment and retention programme for temporary workers, e.g. Bank Network	Ongoing
• Daily review of patient safety concerns	April 2018
• Senior matron support out of hours to support clinical teams with maintaining patient safety and early escalation of patient safety concerns	February 2018
• Trust wide recruitment plans and targets	On going
• The changes from Home Office re Tier 2 visa restrictions should benefit the organisation in respect of number of visas applied	On going

• Deanery plans reduction in rotation of medical trainees to DGHs		for that are approved. • Planned launch of Trust/DHSC pilot to trial flexible working • Opportunities for bank workers. • 3 key workstreams to achieve retention plan and targets – Improved Clinical Management and Team Development, Enhanced Employment Offer and Benefits, Improved Career Pathways – monthly board updates and progress reports with clear targets and deliverables including an employee engagement app, internal transfer policy, improved data on reasons for leaving	June start date June start date

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	16	16					

BAF risk	003/18	There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.

20

Strategic aim	Delivering our promise on value and quality
Latest review date	30 September 2018

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (Sept 18)	4	5	20
Target (March 19)	4	4	16

Change since last month

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
FIN9	20	CIP Plan Non Delivery
FIN1	20	Effective Management of Trust Cash Flow

Key controls

- Establishment of PMO function approved by the Board in Dec-16. At full establishment from Q2 17/18.
- Weekly workforce People Oversight Group review sessions in place
- Weekly divisional CIP development and monitoring sessions
- Industry standard CIP development methodology deployed in Q1 17/18
- Weekly cash flow management meetings in place with DoF
- Appropriate senior approval of all payment runs
- Cash Diagnostic Report undertaken by PWC with supporting action plan
- Cash reporting schedules to FPC and Trust Board each month
- Development of Qlikview Debtors and Creditors reports
- BI Steering Group established to co-ordinate development

Assurance on controls

- Weekly Financial Recovery Programme Board in place attended by all execs(L1)
- Monthly CIP / Financial Recovery updates provided to Finance Committee and NHSI (L1)
- CIP tracker in place to monitor delivery achievement (L1)
- Submission and approval of WC load required to agreed timetables (L1)
- Monthly cash reporting to FPC / Trust Board and NHSI(L2)
- Monthly Accountability Framework PRMs including finance (L1)
- Internal Audit – Financial Planning Process L3 +)
- Monthly Financial Assurance Meetings & PRM with NHSI (L1)

Gaps in control	Gaps in assurance
• Pace of progressing moving CIP schemes through development pipeline • Delay in development and enhancement of Qlikview reports • Update to date and comprehensive outturn forecast and scenario model with associated	• Some divisional CIP schemes remain unidentified

Actions to address gaps in controls and assurances	Due date
• Escalation / Progress reports to FPC and DEC	Ongoing
• Briefing reports to weekly PMB meetings in respect of actions to improve Model Hospital Scheme delivery	Ongoing
• Expanded debtor management meetings to be introduced	8th March 18
• BI Steering Group established to co-ordinate development	In place
• Outturn Forecast presented to Sep FPC	Sept 18
• Weekly Improving Financial Delivery Meetings in place	Commenced October 18

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20						

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 18/19

16

Strategic aim	Delivering our promise on value and quality
Latest review date	30 Sept 2018

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (Sept 18)	4	4	16
Target (March 19)	4	3	12

Change since last month: ⇔

Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
FIN2	20	Non Payment of SLA
FIN 3	20	Delivery of SLA Activity

Key controls

- Qlikview SLA income and activity application developed and in place
- Monthly SLA income reports to FPC / DEC and Divisions
- Weekly Information Assurance Group (IAG) in place to review deliver
- Monthly CQUIN meetings to review progress in place
- Contract monitoring meetings in place with all commissioners
- Key monitoring metrics reflected in new divisional PRM dashboards

Assurance on controls

- Independent reviews of coding and counting practice undertaken in 17/18 (L3)
- Actions plans to address findings in place and reviewed at IAG(L1)
- Regular Data quality and Clinical Coding updates to IAG and FPC (L2)

Gaps in control	Gaps in assurance
• Potential challenge from commissioners in respect of volume of planned work undertaken • Comprehensive bed model and associated demand & capacity modelling • Implementation of pathway change and the understanding of financial impacts • Requirement to support discharge summary remedial activity impacting upon DQ team capacity to respond to CCG challenges and	Lack of demand and capacity modelling

Actions to address gaps in controls and assurances	Due date
• weekly IAG meeting attended by appropriate Executives, Corporate and Divisional Officers to review weekly activity delivery and agree appropriate remedial action where required.	Ongoing
• The IAG also reviews the impact of recommended pathway change	Ongoing
• New CQUIN governance framework agreed for implementation	April 2018
• Business Impact Group set up to review the financial impact of Emergency Pathway redesign project	Ongoing
• D&C and bed modelling project launched	May-18 Aug 18

queries			

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20						

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	005/18	The Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way

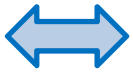
20

Strategic aim	Delivering our promise on value and quality
Latest review date	September 2018

Lead Executive	Director of Finance/ Chief Operating Officer
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	5	4	20
Current (Sept 18)	5	4	20
Target (March 19)	5	2	10

Change since last month



Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance
004/18	20	The Trust is unable to deliver target levels of patient activity
6114	20	Continuing failure to send Discharge Summaries electronically to the GP for every patient discharged

Key controls

- The Trust has developed a Lorenzo Stabilisation plan
- The Stabilisation plan is monitored and co-ordinated through a bi-weekly Stabilisation Committee
- Monthly progress reports are provided to the Trust Board and FPC
- The Trust has appointed a stabilisation director and project managers to co-ordinate activity
- Bi-monthly RTT oversight group
- Weekly Trust access meetings with CCG attendance
- ERS implementation plan in place –developed with Channel 3 and signed off by SRO 02/06/18

Assurance on controls

- The Trust was reviewed its Stabilisation plan with regulators (inc NHSI, NHSD)(L3)
- Regulators are included within the Stabilisation Committee membership (L2)
- Monitoring of key safety and quality indicators through PRM's (L2)
- Reports to Executive Committee, FPC and Board (L2)
- RTT oversight group reports into stabilisation board
- NHSI consultancy approval given in respect of C3 support spend.

Gaps in control	Gaps in assurance

Actions to address gaps in controls and assurances	Due date

• Tracker in respect of key stabilisation activities to allow performance management • Validated and reviewed PTL's • Consistency and compliance in application of new processes on the systems • Initiation of Stabilisation project • Development of credible ERS implementation plan • Optimisation of Discharge Summary Processes	• Development of DQ dashboard to track stabilisation activity progress • Progress on delivery of ERS implementation plan in line with agreed timelines • Staff engagement in new systems and compliance with processes • Timeframe for Discharge Summary process optimisation	• Activity tracker to be monitored at future stabilisation committee meeting • Super view PTL reports to be in place • Validation support in place to support review of records • Implementation of Lorenzo Stabilisation Plan • Business Case to NHSI for consultancy / funding support • DMO1 report (diagnostic PTL) due for release • Weekly compliance report being developed that will provide full visibility of error rates and reasons and support targeted training • Discharge summaries – serious incident review, task/finish operational group & stakeholders group / review of process as part of stabilisation programme / clinical harm review process • Deployment of DXC resource to support Discharge Summary process optimisation	8th March In place Ongoing Ongoing June 2018 Sept 2018 Sept 2018 Sept 2018

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20						

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	006/18	There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment

20

Strategic aim	Delivering our promise on value and quality
Latest review date	October 2018

Lead Executive	Director of Finance/Chief Medical Officer
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (Oct 18)	4	5	20
Target (March 19)	4	4	16

Change since last month: ⇔

Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Six Facet survey undertaken in 17/18
- Capital review Group meets monthly
- Prioritising areas for limited capital spend through capital plan
- Fire policy and risk assessments in place
- Major incident plan
- Mandatory training
- Equipment Maintenance contracts

Assurance on controls

- Report on Fire Safety to Executive Committee (L2)
- Report on Fire and Backlog maintenance to RAQC(L2)
- Reports to Health and Safety Committee (L2)
- Capital plan report to FPC (L2)
- Annual Fire report (L3)
- PLACE reviews (L3)

Gaps in control	Gaps in assurance
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan • Finalisation of Stabilisation Business Case • Capital requirement link through to LTFM	• Availability of capital

Actions to address gaps in controls and assurances	Due date
• Estates strategy to support the five-year trust strategy	Dec 2018
• Review, risk assess and prioritise equipment replacement for 2018/19	March 2018
• Review ongoing risks through RM processes / structures	Ongoing
• Develop capital equipment replacement plan	(TBC)
• Replacement plan integrated with CTC support intentions	May 2018
• Refurbishment and fire compliance work MVCC wards 10 and 11 completed end August	July/August 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**

	20	20					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	007/18	**There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives**

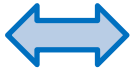
12

Strategic aim	**Delivering our promise on value and quality**
Latest review date	October 2018

Lead Executive	Chief Executive
Board monitoring committee	Board of Directors

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (Oct 18)	3	4	12
Target (March 19)	3	4	12

Change since last month



Related BAF & Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Monthly Board meeting/Board Development Session/ Board Committees
- Annual Internal Audit Programme/ LCFS service and annual plan
- Standing Financial Instructions and Standing Financial Orders
- Each NED linked to a Division (from January 2018)
- Commissioned external reviews – PwC Governance Review September 2017
- Review of external benchmarks including model hospital , CQC Insight and stethoscope – reports to FPC and RAQC
- Board Assurance Framework and monthly review
- Performance Management Framework/Accountability Review meetings monthly

Assurance on controls

- Visibility of Corporate risks and BAF as Board Committees and Board (L2)
- Internal Audits delivered against plan, outcomes report to Audit Committee
- Annual review of SFI/SFOs (L3)
- Annual review of board committee effectiveness and terms of reference (May-July) (L3)
- PwC Governance review (included well led assessment) (L3)
- Annual governance statement (L3)
- Counter fraud annual assessment and plan (L3)
- Annual self-assessment on licence conditions FT4 (L3)
- CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+)
- Use of resources report July 2018 – requires improvement (L3 _/+)
- September 2018 Progress report on CQC actions and section 29a (L2 +) to CQC & Quality Improvement Board
- Annual review of RAQC to Board (L2 +)

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
• Limited visibility and challenge of corporate risks and BAF through Board committee • Development of an integrated performance report • Limitations of current performance monitoring and management forums and frameworks • Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations	• Embedded risk management - CRR and BAF • Integrated performance report • Evidence of timely implementation of audit actions • Consistency in the effectiveness of the governance structure's at all levels • Capacity to ensure proactive approach to compliance and assurance	• Implementation of revised Risk Management Strategy and BAF • Follow up on actions from Internal Audits –process to review of outstanding actions agreed with IA including fortnightly updates to DEC and defining clearer line of accountability • Follow up on actions from other external audits (PwC governance action plan) • Review of Divisional Board and PMF/PRM Terms of reference • Development of an integrated performance report • Annual review of effectiveness of Board Committee in line with governance review and new Committee Chairs • Review of clinical governance structure by DoN & MD – recruitment in progress/ structures implemented in September • CQC improvement plans – reviewed monthly • Observational Audit of Board effectiveness under well led framework • Recruitment into revised corporate governance structures • Undertake review of well led developmental guidance	7 March 2018 completed Monthly Monthly Review October 2018 Q1 2018/19 October 2018 July 2018 August 2018 and monthly monitoring Sept 2018 Q3/Q4 November 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency

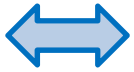
12

Strategic aim	Delivering our promise on value and quality
Latest review date	October 2018

Lead Executive	Director of Strategy
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (Oct 18)	3	4	12
Target (March 19)	3	3	9

Change since last month



Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
005/18	15	The Trust's IT systems are not sufficiently embedded/stabilised

Key controls

- EPRR Plan in place to gain compliance with the Core Standards
- Business Impact Assessment process underway with Divisions
- CBRN plan and equipment in place
- Support in place by EPRR manager from Basildon NHS Trust
- Cyber security – firewall, testing, antivirus – internal and external testing on controls; work plan
- On call rotas on rotawatch

Assurance on controls

- EPRR Committee Chaired by AEO (Director of Strategy) (L2)
- Regular reports on progress against EPRR plan to RAQC(L2)
- Annual EPRR Core Standards Assurance process including external visit by NHSE(L3)
- Regular Attendance at LHRP(L2)
- Internal and external review of Cyber security (L3)
- Reports to audit committee, RAQC and Board (cyber) (L2)
- Organisational response to cyber incident (L1)
- Monthly update considered by RAQC
- Investment received for Cyber Security – NHSD risk rating reduced (L3)
- NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3)

Gaps in control	Gaps in assurance
• Currently partially compliant with NHSE Core standards • Full training and awareness programme to be developed • Testing programme to be developed • Ability to implement all cyber security requirements • Current on call structure does not fully provide enough senior	Availability in capital to invest in cyber security and delivery against agreed plan (some investment received)

Actions to address gaps in controls and assurances	Due date
• EPRR Officer in post	Sept 2018
• Delivery of action plan in full	Sept 2018
• Training for Gold, Silver and Bronze commanders (commenced)	May/June 2018
• All Business Continuity plans in place for Trust. Trust wide BCVP to be considered/approved by RAQC in September	April 2018
• Major incident plan and Emergency planning policy statement to be considered/ approved by RAQC in September	Sept 2018 Sept 2018

leadership on site		• NHSE To consider the Trust's Core Standards submission • Monitor and review of cyber security actions and explore funding options • Consultation to review on call structure (commenced)	Oct 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	009/18	**There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered impacting on the Trust's ability to deliver the required improvements and transformation**

16

Strategic aim	**New ways of caring**
Latest review date	October 2018

Lead Executive	Chief People Officer
Board monitoring committee	FPC and QSC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	4	4	16
Current (Oct 18)	4	4	16
Target (March 19)	4	3	12

Change since last month

⇔

Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity
003/18	20	The Trust is unable to achieve financial performance

Key controls

- LMCDP Leadership, Management and Coaching Development Pathway
- LEND Sessions
- Organisational Values (PIVOT) / Leadership Behaviours (LEND)
- Health and Well Being Strategy
- Dedicated Associate Director of Leadership and Change
- HR Policies including Raising Concerns Policy
- ERAS teams and Freedom to Speak Up Guardian
- People Strategy
- Update May 2018 – A series of indicators will be agreed by CPO Simons, senior workforce and OD team members and the Board on how we should measure and assess our culture.
- Staff Engagement Group, launched May 2018
- Staff Experience Workshops were launched in April 2018

Assurance on controls

- Workforce reports (includes culture) to RAQC, FPC, Board (L2)
- LEND sessions quarterly (L1)
- LMCDP evaluation
- FFT (L1) – Improved position June 2018 – 49% rec place to work/ rec for care 74%
- Raising Concerns report to Audit Committee and Board (L2)
- Workshops – face to face and online (L1)
- Review of Insight and Model Hospital
- Board Development session July 2018 – (culture)
- Culture dashboard under development and will become part of Board report.

Gaps in control	**Gaps in assurance**
• Culture change approach • Talent management lead • Senior leadership training • Talent management Post • Senior leadership programme	• Outcomes of the actions being taken

Actions to address gaps in controls and assurances	**Due date**
• Review of LEND and leadership behaviours in a challenging environment	May 18
• Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Mar 18- Completed
• Development of innovative online workshop for use as crowd sourcing platform	May 18 - Completed
• Develop and implement action plan following staff survey	

		feedback – Executive sponsors to core issues and suggestions from staff - Staff Engagement Group, launched May 2018	Apr 18- Completed
		• Talent management job is agreed and a TM strategy will be developed and post recruited to	Oct 18
		• Senior leadership programme developed for 2018 following ADDS	Oct 18
		• Undertake discovery phase of NHSi culture change programme.	June 18-
		• Board Development session held to discuss staff survey, underlying causes and actions.	
		• SEG now established and actions have commenced as a result.	Completed
		• LEND behaviours reviewed post staff feedback and presented to SEG.	
		• NHSi discovery phase 1 Presented to Board.	On going
		• Board agreed to develop an ENHT specific response to culture change rather than the NHSi toolkit	Complete
		• Senior leaders offered access to high level formal training through University of Hertfordshire and through ADDS.	Underway
			Pathway agreed and recruitment underway

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
16	16	16	16	16	16	16	16
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	16	16					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services

12

Strategic aim	New ways of caring
Latest review date	October 2018

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (Oct 18)	3	4	12
Target (March 19)	3	4	12

Change since last month: ⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
001/18	20	The trust has insufficient capacity to sustain patient flow

Key controls
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting • Early work in place to work with PAH on fragile and back office services • Vascular Hub project with West Herts and PAH • Cancer work stream of STP and representing STP Cancer Alliance • Model Hospital redesign work • Integrated discharge team • External partner to support development of STP

Assurance on controls
• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3)

Gaps in control	Gaps in assurance
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	

Actions to address gaps in controls and assurances	Due date
• Work programme of external partner to support development of STP	June 2018
• Development of STP wide strategy	Oct 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	011/18	There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience

20

Strategic aim	New ways of caring
Latest review date	October 2018

Lead Executive	Chief Nurse/Medical Director
Board monitoring committee	QSC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	5	4	20
Current (Sept 18)	5	4	20
Target (March 19)	5	2	10

Change since last month
⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity

Key controls
• Clinical governance strategy group • Patient Safety Committee • Quality Improvement Board • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations • Monthly patient safety newsletter • Bi-weekly IPC improvement board • Strengthened TIPCC membership and ToRs • Quality and safety visits • Safety huddles • Policies and procedures • New Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly)

Assurance on controls
• Reports to RAQC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical Governance Strategy Committee(L2) • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Transformation Programme – framework presented to RAQC, March 18 (L2) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review (L3 -/+)

Gaps in control	Gaps in assurance
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity • Gaps in compliance with IPC Hygiene Code leading to C-difficile outbreak in April 2018 and MRSA bacteraemia in May 2018 • Gap in compliance with CQC standards warning notice section 29A – Surgery Lister and UCC QEII	• Consistency in following care bundles • Implementation of action plans • Embedding of learning from SIs/Learning from Deaths • Data quality • Inconsistent audit and monitoring programme • Delivery against CQC improvement plan

Actions to address gaps in controls and assurances	Due date
• Review and relaunch of care bundles	July 2018
• Complete Gap analysis on GIRFT reports and develop and monitor action plans	June 2018
• Revised Clinical Governance structures – September implementation	July 2018
• Divisional Clinical Governance facilitators	July 2018
• Implementation of quality transformation programme/workstreams	March 2018
• Bi-weekly Quality Transformation Steering Group in place	April 2018
• Delivery and monitoring of IPC Improvement plan through b-weekly IPC improvement board	Review October
• Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII	End of July 2018
• CQC improvement plans – reviewed monthly	August and Monthly monitoring

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	20	20	20	20	20
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	20	20					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC

12

Strategic aim	Develop the Mount Vernon Cancer Centre
Latest review date	October 2018

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (Oct 18)	3	4	12
Target (March 19)	3	3	9

Change since last month

⇔

Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Monthly meetings with CEOs and Chairs of ENHT and Hillingdon NHS FT
- Clinical strategy for MVCC
- Development of a five-year strategy for the Trust
- Development of SLAs with MVCC
- Clinical and Academic Partnership in place with UCLH and MVCC, Board Established and has met to develop work plan
- Clinical strategy for MVCC

Assurance on controls

- Regular reports to FPC and the Board of Directors (L2)
- Regular reporting into the strategy Board (L2)
- Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2)

Gaps in control	Gaps in assurance
• Hillingdon has no long-term plan for the MVCC site	

Actions to address gaps in controls and assurances	Due date
• SLA for Estates and Facilities at MVCC with Hillingdon	April 2018 (now Oct 2018)
• MOU with Hillingdon for sale of the MV site	Oct 2018
• Development of a lease with Hillingdon for MVCC	Nov 2018
• Ongoing meetings of UCLH/MVCC Partnership Board	Ongoing
• Ongoing meetings MVCC strategy implementation group	Ongoing

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12	12	12	12	12
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12					

BOARD ASSURANCE FRAMEWORK: OCTOBER 2018

BAF risk	013/18	**There is a risk that the Trust is adversely affected by the United Kingdom's departure from the European Union, particularly in the event of no deal being secured.**

16

Strategic aim	Delivering our promises on value and quality
Latest review date	October 2018

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (Sept 18)	4	4	16
Target (March 2019)			

Change since last month

Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance
002/18	16	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.

Key controls

- EPRR Committee, will lead on the business continuity arrangements, reviewing existing plans to ensure they respond to the possibility of a 'no-deal' Brexit.
- 23rd August SoS guidance and five technical notices published by UK Government
- Overseas recruitment mostly from outside Europe.

Assurance on controls

- Regular reports to FPC and the Board of Directors (L2)
- NHSE check and challenge session on EPRR core standards including Brexit Preparedness (L3)

Gaps in control	**Gaps in assurance**
• Absence of clear deal in place between UK and EU post 29th march 2019	

Actions to address gaps in controls and assurances	**Due date**
• Updating of the departmental BCPs – including review of specific plans relating to supplies, medicines, consumables and pathology reagents	October 2018 September 2018
• Workforce team have written to all staff to determine how many staff are from European countries outside the UK.	
• Review of technical notices/ advice as it is published by the Government / NHSI/NHS Providers	Ongoing

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**
	September 2018	**October 2018**	**November 2018**	**December 2018**	**January 2019**	**February 2019**	**March 2019**
	12	12					

Key to assurance on controls

- Level 1 (Management) L1
- Level 2 (Oversight functions) L2
- Level 3 Independent (Audits / Reviews/ Inspections etc.) L3

East and North Hertfordshire NHS Trust

Agenda Item: 13.1

TRUST BOARD – 7 NOVEMBER 2018

Charity Trustee Committee – 10 September 2018
Executive Summary Report

PURPOSE	To present to the Trust Board the report from the Charity Trust Committee meeting of 10 September 2018
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	[x] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [x] 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 CTC
PRESENTED BY:	Chairman of CTC
AUTHOR:	Board Committee Secretary/Company Secretary
DATE:	September 2018

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 10 SEPTEMBER 2018

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (Committee Chairman), Kate Lancaster (Director of Strategy), Rachael Corser (Director of Nursing), Jude Archer (Company Secretary)

Key Decisions made under delegated authority:

The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approvals for expenditure over £5,000
The Committee discussed a range of approvals for expenditure both under £5,000 and over £5,000. The Committee also discussed suggested fundraising projects. The following expenditure and fundraising project were approved:

Expenditure over £5,000
£31,950 - Cancer - 2 x Ultrasound Machines
£15,080 - Cancer - Swartz rounds (excluding refreshments)
£74k (tbc)- Cancer - EBUS machine at Lister (from the general fund)
£8,000 - Women & Children's - Bancroft gardens

Proposed Fundraising projects
The following proposals were agreed in principle subject to further scrutiny and business cases where relevant:
£74k tbc - Cancer - Rapid arc at MVCC
£9,500 - Medicine - Telemedicine Hub.
£20,000 - Nurse Education - Carers activities
£4,000 - Medicine - Sepsis awareness song for people with learning disabilities (working with Herts County Council)
£78,000 - Medicine - Frailty Pathway
£50,000 - Strategic Development - Empathy Project

Two further requests for, Medicine – Blood Gas Analyser £70k and, Strategic Development – Minibus £25k, were made; however, further supporting evidence to support these is being sought to ensure appropriate governance through the Divisions and Divisional Executive Committee.

Other outcomes:

Investment Portfolio Update
The Committee received an update as at 31 August 2018 from the investment advisors (Rathbones) who were in attendance. The portfolio had pretty much kept in step with the benchmark over the last quarter. The CTC was advised that the emerging issues within the market, such as Brexit, are containable and are not expected to have an adverse effect on the portfolio. The Charity is considering a drawdown of funds to the value of c£500k. For future updates, the Committee requested an executive summary of key points. The balance of the portfolio will continue to be kept under review.

Cancer Division Fund Management Report
The Deputy Head of Nursing for Cancer Services presented the current position on Charity funds for the Cancer Division. It was noted that the Division holds 29 funds with a total balance of £679k after commitments. The division is endeavouring to determine reasons behind restrictions on funds in order to consolidate. Going

forward donors will be invited to donate to a choice of 6 projects at MVCC and donors through the Lister site will be invited to donate to 4 areas (3 specific projects together with any of the Cancer specific appeals). A key concern was the emerging deficit of the Linda Jackson Centre.

Charity Management Team Update
The Head of Charities presented the Charity Management Team Update. The Charity has pledged to transform Charity operations and become a 'Best in Class £3m+ Hospital Charity' by 2020. The Charity successfully won the NHS70 Parliamentary Awards in the 'Care and Compassion' regional category for the 'Butterfly' project. Strong media coverage followed the launch of the 'Lister Neonatal Big Build Appeal'. The Consultation phase of the new Charity website is complete. The new 'Charity Hub' in the Lister main entrance is now operating on a daily basis staffed by fundraisers and volunteers. The Charity will fund the 2018 Staff Awards allowing for increased visibility of the Charity profile together with the development of corporate relationships.

Charity Finance Report
The Committee received the Charity Finance Report reflecting on financial performance of the Charity to 31 July 2018 (Month 4). The initial income target for 2018/19 was £2.2m and the expenditure budget £2.856m. The adverse variance of £656K reflected legacy income received prior to 2018/19 but planned to be spent in the current year.
To end-July, income achieved this financial year was £221k and expenditure £403k. Now that the expanded Charity team is in place, a significant increase in income activity is expected in Q3 and Q4. Expenditure was below plan given the longer-than-expected time to recruit the new team and delays in purchasing larger capital equipment as well as some smaller items.

The current revised end-year forecast for income is £1.5m and for expenditure £2.07m (including the purchase of a MRI scanner). A full reforecast will be presented to the Board in December. It is likely that the Charity will wish to draw £500k from its portfolio investment to enable the purchase on time of larger capital items.

Legacy update
The Committee received an update on a key large legacy settlement worth some £500,000 to the Trust but where a relatively small proportion was being sought by a relative. The aim is to seek conclusion prior to closure of the external audit of the overall Charity accounts.

Bob Niven
CTC Chair

September 2018

East and North Hertfordshire NHS Trust

Agenda Item: 13.1.1

TRUST BOARD PART 1 – 7 NOVEMBER 2018

Charity Trustee Committee Annual Report and Review of Terms of Reference

PURPOSE	To present the 2017/18 annual review of the Charity Trustee Committee and terms of reference for approval.
PREVIOUSLY CONSIDERED BY	CTC, September 2018.
Objective(s) to which issue relates *	[X] 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 aspect of the Trust's assurance process
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is considered to be best practice and is in line with the recommendations made in the Charity Trustee Committee Handbook. Charity Commission
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**
ACTION REQUIRED *	For approval [X] For decision [ ] For discussion [ ] For information [ ]

DIRECTOR:	CHIEF EXECUTIVE
PRESENTED BY:	COMPANY SECRETARY
AUTHOR:	BOARD COMMITTEE SECRETARY / COMPANY SECRETARY
DATE:	AUGUST 2018

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

Charity Trustee Committee
Annual Review 2017/18

EXECUTIVE SUMMARY

As set out in the Terms of Reference the Charity Trustee Committee (CTC) is a Committee of the Board in its role of Corporate Trustee and with responsibility:

- to ensure a robust strategy for the 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 East & North Herts Hospitals Charity (registered charity no. 1053338).

This is the annual review of the CTC which considers how the Committee has met its duties under its Terms of Reference. A review of the minutes and reports to Board, a review of the Trust's Standing Orders and Financial Instructions and self-assessment survey have been used to inform this report. The overall conclusion of this annual review is that the Committee has discharged its duties under its Terms of Reference during 2017/18. The CTC continues to champion and raise awareness of the Charity and its development, both externally and within the Trust, provides stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies.

The efficacy of the CTC has, once again, been assessed this year by sending a questionnaire to Committee members and others who regularly attend meetings. The conclusion of the survey findings highlights that the Charity has achieved the following against the 2016/17 recommendations:

- the agenda now covers the correct items;
- that sufficient time is now being allocated to the development and delivery of the Charity's strategy along with the engagement of Non-Executive Directors to explore alternative options.
- That following the appointment of the new Head of Charity, the CTC has made significant improvements to champion the charity internally and plans are in the pipeline to promote the Charity externally.

The Committee and team are committed to continue to strengthen the Charity through implementation of the strategy, and further development of reporting and governance arrangements during 2018/19. To support the strengthening and effectiveness of the Committee in 2018/19 the following recommendations are highlighted from the review:

- Develop a clear statement of charity criteria and priorities, which is currently under consideration
- To have draft minutes and action log available to CMT and CTC within two weeks of the meeting to support the work programme progressing
- Explore with the Investors more concise reports

The Board is asked to approve the report and the revised Terms of Reference which have been reviewed and minor changes made with consideration to strengthening finance representative at the committee. Appendix 1 CTC Terms of reference attached.

SUMMARY OF KEY FINDINGS

Meetings and Membership

The CTC met four times during 2017/18 and all meetings were quorate under the current Terms of Reference. The new Head of Charity took up post in November 2017 and has had a significant impact on the development of the Charity. Membership attendance is recorded in the Trust Annual Report; the Director of Finance has been unable to attend three out of four of the meetings; however, the Financial Controller and Charity Finance Manager have both been attending regular meetings providing good financial representation on his behalf. The minutes demonstrated where scrutiny and appropriate challenge had been presented during meetings.

The Committee can evidence that it has met its responsibilities as set out in the Terms of Reference in the following ways:

Key survey findings were:

Strengths:

- All respondents felt that the agenda covers the correct items;
- The majority of respondents felt that reports provide the correct level of information;
- The majority of respondents felt able to challenge the Trust at meetings and that there are enough open discussions with other Committee members other than those presenting;
- Respondents felt that sufficient time is dedicated to the development and delivery of the strategy along with other key areas of the Committee's remit;
- The CTC has supported the Charity in approving the purchase of significant capital items and the continued delivery of charitable projects. By providing capital equipment, more patients have received an improved quality of service which has added value to patient experience;
- The CTC has provided support to divisional fund owners in the consolidation and effective use of funds;
- There has been a greater focus on funding of capital items.

Areas to consider:

- Although respondents generally felt that the Committee provides stewardship of the charitable resources compliance with Charity governance and Trust policies, it was felt that there is room for further development;
- The majority of respondents felt that significant improvements have been evident following the appointment of the new Head of Charity and look forward to further developments. There are a significant number of plans in the pipeline;
- The majority of respondents felt that there is room for improving a clear framework for prioritising charitable expenditure and spending existing charitable monies.

Strategic

<u>Charity Governance</u>
The CTC ensured policies and procedures were in place to allow the effective day-to-day management of The Charity and its funds.

The new Head of Charity has been undertaking a review of all staff policies and guidelines including: reviewing how contact with donors is conducted in accordance with the new GDPR, governance procedures for the application of funding. All other policies and guidelines will continue to undergo a review.

In September 2017 the draft Strategy for the Charity for 2017-2020 was presented to the Committee with the aim to further develop the Charity into a high performing operation providing

a high level of support to the Trust's patients and hospitals. The strategy will be supported by a detailed three year action plan. The final proposed strategy was approved by the Trust Board in January 2018.

The CTC were assured that the Charity was GDPR compliant in readiness for the new policy that came into force on 25 May 2018.

Charitable Management Team (CMT) Meetings

The CTC received regular updates on activities of the Charity Management Team (CMT) meetings, which take place once a month to ensure the Charity's strategic key performance indicators (KPIs) are being met. The new Head of Charity has developed the CMT so that attendees now include representatives from Divisions to support the expansion of the Charity and to ensure that funding is allocated in the best interest of patients.

Increase fundraising, increasing spend income effectively and evidence of the impact of this spend is required to become a 'best in class' Hospital Charity. In order to achieve this, the following governance improvements were implemented:

- a redesign of the charitable fund application form and an increased level of support for applicants is being provided;
- processes have been put in place for improved capture of evidence in relation to the impact of Charity projects to demonstrate how they have improved patient experience;
- Head of Charity now liaises directly with the Discretionary Spend Panel to reduce staff administration time on applications.

Divisional Fund Management Reports

Throughout 2017/18 the CTC received Divisional fund management updates on charitable activities from Cancer, Surgery, Education and Training, Medicine and Women & Children. The reports provided the Committee with information on what Divisions have been delivering well in terms of use of charitable funding and what has proved more challenging, reports included reasons and next steps. One focus of all Divisions has been to consolidate funds as agreed by the CTC. The CTC requested that divisions follow the correct governance procedures when requesting funds and provide clear evidence that funding would improve patient experience. Planning ahead was also recommended to support the Charity with forward planning financially.

Annual Report and Accounts 2017/18

In September 2017 the CTC approved the Annual Report and Accounts for 2017/18, subject to Audit.

The targets for 2017/18 continued to be ambitious and challenging:

- to raise at least £2m
- 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 elderly care wards at Lister are able to take advantage of an enhanced, appropriate care environment
- to fund requests for equipment
- to make best use of the John Bush legacy by helping patients at the MVCC
- to deliver a robust strategy which will enable the Charity to develop a sustainable income base for the future

Investment Policy and Portfolio

The CTC received quarterly updates from the Trust's investment adviser on the Charity's portfolio. In March 2018 the Committee were advised by the Charity Investors that markets had been unstable since the beginning of the year; however, the strengthening economic growth and low inflation have kept interest rates positive. The report highlighted that a lower than expected dividend had been received for the second successive month. The Charity will challenge Rathbones with regard to future investment options. Following discussions on the

Charity's current financial position it was agreed that no draw-down would be necessary at this time.

CTC approved the investment policy update for final approval at Board

Operational

Charity development
The minutes and papers demonstrate that potential fundraising appeals in line with the needs of the Trust have been identified to maximise income and not restrict Charity spend to donations already received.

Income activity
The CTC received regular updates on top line income activity and progress of the Charity to meet the income plan 2017/18.

Although a challenging year for operational management the final income target was surpassed by £652k.

Activities during 2017/18 included:

- community-led fundraising
- skydive
- marathon

Corporate successes included the Transform Foundation donating a significant sum of money to establish a bespoke Charity website that will go live in autumn 2018.

Approvals of Expenditure Over £5k
During 2017/18 the CTC reviewed and endorsed funding requests for the following from charitable funds:

- Funding from the MVCC general fund for a continuation of funding beyond March 2018;
- *£36,450* - Funding approved for laser system for the new Siemens MRI scanner that was donated by the Paul Strickland Scanner Centre;
- *£500,000* - John Bush Legacy funding for clinical research post approved and referred to Board for final sign off on account of the sum involved;
- *£50,000* - John Bush Research Suite MVCC;
- *£675,000* - SPE-CT scanner approved and referred to Board for final sign off on account of the sum involved;
- *£260,000* - Refurbishment of Hertford County Hospital X-Ray room;
- *£17,250* - Extended Pharmacy Education and Training to support the Hospital Pharmacy Transformation plan.

Further requests were deferred to ensure that all requests go through the correct internal governance procedure prior to final consideration by CTC.

Reporting to Board

The Committee has reported to the Trust Board as Corporate Trustee following each meeting and the CTC actions log provides a clear audit trail of actions agreed through to closure.

CONCLUSION

The overall conclusion of this annual review is that the Committee has discharged its duties under its Terms of Reference during 2017/18. The CTC continues to champion and raise awareness of the Charity and its development, both externally and within the Trust, provides

stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies.

The Committee and team are committed to continue to strengthen the Charity through implementation of the strategy, and further development of reporting and governance arrangements during 2018/19. To support the strengthening and effectiveness of the Committee in 2018/19 the following recommendations are highlighted from the review:

- Develop a clear statement of charity criteria and priorities, which is currently under consideration
- To have draft minutes and action log available to CMT and CTC within two weeks of the meeting to support the work programme progressing
- Explore with the Investors more concise reports

The CTC is asked to approve the report and the revised Terms of Reference which have been reviewed and minor changes made. It is proposed that consideration to the finance representative on the membership of the committee to be either the Director of Finance or representative. Appendix 1 CTC Terms of reference attached. The outcome will then be presented to Board as Corporate Trustee for final approval.

Appendix 1

CHARITY TRUSTEE COMMITTEE
TERMS OF REFERENCE

1. Purpose & Authority

The purpose of the Charity Trustee Committee is to:

- ensure a robust strategy for the delivery of the Charity aims and objectives;
- champion the Charity and its development, providing leadership both within the Trust and externally;
- 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 and North Herts Hospitals Charity (registered Charity no 1053338).

2. Authority

The Charitable Trustee Committee is authorised to:

- ~~to~~ investigate any activity within its Terms of Reference;
- ~~to~~ obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

3. Membership of the Committee

Membership (with voting rights):

- two Non-Executive Directors
- Director of Finance / Finance Representative
- Director of Strategy
- Director of Nursing/representative

In attendance:

- Head of Charity
- Charity Financial Accountant
- Financial Controller
- Company Secretary
- Head of Engagement
- additional attendees selected by the Committee as deemed necessary to fulfil its function, including the Charity Independent Investment Advisor at least annually, Trust Financial Controller and Director of Business Development and Partnerships.

The Chair of the Committee shall be one of the Non-Executive Directors selected by the Board. In their absence, meetings shall be chaired by the other Non-Executive Director.

If a conflict of interests is established, the member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

A minimum of two members must be present, of which one must be a Non-Executive Director and one must be an Executive Director.

5. Meetings

The Charitable Trustee Committee will meet at least four times a year (as near as practical to quarter ends). The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Key duties and responsibilities

a. To ensure a robust strategy for the delivery of the Charity aims and objectives including:

- to approve and monitor the Charity and Strategy and Charity Management Team Annual Plan and Priorities.

b. To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies:

- ensuring policies and procedures are in place that allow the effective day to day management of the Charity and its funds;
- ensuring the Charity satisfies all regulatory, legal and NHS compliance requirements;
- ensuring funding provides added value to patients and staff, above those afforded by Exchequer Funds;
- ensuring expenditure is in line with donors' expectations of an NHS Charity;
- ensuring effective systems are in place to manage budget holders and ensuring they demonstrate adherence to charitable objectives in spending charitable monies;
- to recommend the appointment of Investment Managers to provide investment advice and manage the Trust's investment portfolio through an agreed Investment Policy, so as to safeguard the Charity's future while maximising income;
- ensuring the Charity's financial dealings are systematically accounted for;
- to ensure appropriate mechanisms are in place to manage restricted and designated monies, and to use monies as agreed with the donor or negotiate alternative arrangements;
- receive and provide scrutiny to the Charity's Annual Report and Accounts, prior to final approval by the Corporate Trustee;
- encouraging a culture of expending expendable income unless there is a clear reason to accumulate;
- establishing a Reserves Policy and monitoring its implementation;
- providing assurance updates to the Audit Committee regarding the governance and risk management of the charitable funds;
- reviewing and approving the Fundraising and Communications Strategies and the resources required to implement them;
- monitoring performance against financial and other key performance targets
- setting a clear framework for prioritising charitable expenditure, and establishing appropriate approval processes for agreeing new campaigns and spending existing charitable monies;
- to ensure appropriate delegation of charitable expenditure;
- to authorise the establishment of any new funds;
- for charitable funds' schemes with a value of between £5,000 and £500,00:
    - Reviewing and, if appropriate, authorising
    - Ensuring that the Investment Committee, and where appropriate the Executive Committee, reviews and monitors the application and implementation of charitable funds schemes.

c. To champion the Charity and its development, both externally and within the Trust to include:

- providing inspiring, reflective and visible leadership of the Charity, clearly communicated to all stakeholders;
- growing the reputation and profile of the Charity (and by association, the Trust);
- advocating and being ambassadors for charitable giving to the Charity within the community;
- developing through high donor activities a network of seriously influential stakeholders who see themselves as business partners in the Trust's future, and personally cultivating and stewarding these relationships;
- leading and encouraging the Board in achieving similar and appropriate support for the Charity.

7. Reporting arrangements

The Committee will report to the Trust Board, as Corporate Trustee, following each meeting.

8. Support

The Company Secretary will advise the Committee on pertinent governance issues and ensure it is supported administratively, including:

- agreement of agenda with Chairman and attendees and collation of papers;
- taking the minutes;
- keeping a record of matters arising and issues to be carried forward.

9. Review

The Terms of Reference of the Committee shall be reviewed by the Trust Board (Corporate Trustee) annually.

Reviewed August 2018

DATA PACK

Contents

1. Data & Exception Reports:

FFT

Health & Safety Indicators

2. Performance Data:

CQC Outcomes Summary

3. Risk and Quality Committee Reports:

Safer Staffing

1. Data & Exception Reports:

FFT

Health & Safety Indicators

Friends and Family Test - September 2018

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	82.46	8.77	33	14	2	3	2	3	57	111	51.35
5B	95.24	0.00	16	4	1	0	0	0	21	57	36.84
7B	97.62	2.38	53	29	0	1	1	0	84	172	48.84
8A	100.00	0.00	21	14	0	0	0	0	35	69	50.72
8B	85.71	6.12	28	14	3	3	0	1	49	143	34.27
11B	88.75	2.50	52	19	4	1	1	3	80	149	53.69
Swift	96.25	1.25	56	21	2	1	0	0	80	178	44.94
ITU/HDU	100.00	0.00	9	1	0	0	0	0	10	14	71.43
Day Surgery Centre, Lister	97.28	0.39	203	47	3	1	0	3	257	393	65.39
Day Surgery Treatment Centre	97.63	0.59	148	17	3	0	1	0	169	514	32.88
Endoscopy, Lister	99.30	0.00	257	25	2	0	0	0	284	892	31.84
Endoscopy, QEII	100.00	0.00	95	10	0	0	0	0	105	259	40.54
SURGERY TOTAL	96.34	1.22	**971**	**215**	**20**	**10**	**5**	**10**	**1231**	**2951**	41.71
SSU	90.48	0.00	14	5	1	0	0	1	21	119	17.65
AMU	100.00	0.00	31	6	0	0	0	0	37	120	30.83
Pirton	90.16	0.00	46	9	6	0	0	0	61	61	100.00
Barley	100.00	0.00	18	2	0	0	0	0	20	25	80.00
6A	80.00	0.00	2	2	1	0	0	0	5	111	4.50
6B	89.74	2.56	26	9	1	1	0	2	39	63	61.90
11A	100.00	0.00	43	20	0	0	0	0	63	72	87.50
ACU	95.45	0.00	15	6	0	0	0	1	22	98	22.45
10B	96.00	0.00	18	6	1	0	0	0	25	85	29.41
Ashwell	89.47	0.00	13	4	2	0	0	0	19	45	42.22
9B	96.88	0.00	44	18	1	0	0	1	64	69	92.75
9A	100.00	0.00	38	0	0	0	0	0	38	38	100.00
Cardiac Suite	100.00	0.00	39	3	0	0	0	0	42	91	46.15
MEDICINE TOTAL	95.83	0.22	**347**	**90**	**13**	**1**	**0**	**5**	**456**	**997**	45.74
10AN Gynae	95.95	0.00	48	23	2	0	0	1	74	95	77.89
Bluebell ward	95.71	0.00	45	22	2	0	0	1	70	199	35.18
Bluebell day case	50.00	0.00	0	1	1	0	0	0	2	2	100.00
Neonatal Unit	100.00	0.00	23	0	0	0	0	0	23	64	35.94
WOMEN'S/CHILDREN TOTAL	95.86	0.00	**116**	**46**	**5**	**0**	**0**	**2**	**169**	**360**	46.94
10	91.30	0.00	18	3	2	0	0	0	23	62	37.10
11	100.00	0.00	14	12	0	0	0	0	26	45	57.78
CANCER TOTAL	95.92	0.00	**32**	**15**	**2**	**0**	**0**	**0**	**49**	**107**	45.79
TOTAL TRUST	96.17	0.84	**1466**	**366**	**40**	**11**	**5**	**17**	**1905**	**4415**	43.15

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	95.95	0.91	1339	341	38	11	5	17	1751	4049	43.25
QEII	100.00	0.00	95	10	0	0	0	0	105	259	40.54
Mount Vernon	95.92	0.00	32	15	2	0	0	0	49	107	45.79
TOTAL TRUST	**96.17**	**0.84**	**1466**	**366**	**40**	**11**	**5**	**17**	**1905**	**4415**	**43.15**

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/Assessment	88.42	2.41	355	195	46	6	9	11	622	9827	6.33
QEII UCC	100.00	0.00	25	2	0	0	0	0	27	3414	0.79
A&E TOTAL	**88.91**	**2.31**	**380**	**197**	**46**	**6**	**9**	**11**	**649**	**13241**	**4.90**

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	90.91	0.00	7	3	1	0	0	0	11	452	**2.43**
Birth	96.67	2.00	106	39	2	1	2	0	150	440	**34.09**
Postnatal	88.59	3.36	91	41	9	5	0	3	149	440	**33.86**
Community Midwifery	100.00	0.00	34	6	0	0	0	0	40	546	**7.33**
MATERNITY TOTAL	**93.43**	**2.29**	**238**	**89**	**12**	**6**	**2**	**3**	**350**	**1878**	**18.64**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	94.34	1.42	450	150	18	3	6	9	636
QEII	94.57	1.55	510	221	26	5	7	4	773
Hertford County	95.57	0.49	146	48	4	1	0	4	203
Mount Vernon CC	97.27	0.00	146	32	3	0	0	2	183
Satellite Dialysis	95.05	1.98	80	16	2	2	0	1	101
OUTPATIENTS TOTAL	**94.88**	**1.27**	**1332**	**467**	**53**	**11**	**13**	**20**	**1896**

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														
			Financial Year 2018-19											
	2018/19		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	1	0	0	2							3
Visitor Incidents	RIDDOR incidents		0	0	0	0	0	1							1
	H&S public liability claims		0	3	0	1	0	0							4
	Slips, Trips & Falls		0	0	1	0	1	3							5
The Workforce (Including Contractors) Incidents	RIDDOR incidents		0	2	0	1	3	3							9
	Slips, Trips & Falls		3	7	2	2	6	6							26
	Employer liability claims		0	1	1	2	1	1							6
	Sharps incidents		13	14	12	19	20	10							88
	Workplace stress		3	4	9	5	4	8							33
	Contact dermatitis/latex		0	0	0	0	0	0							0
	Musculoskeletal injuries		7	4	6	7	2	4							30
	Physical assault		7	15	14	10	9	6							61
	H & S training (Compliance) (YTD = Latest Available Position)		90%	89%	89%	90%	90%	92%							90%
	Significant workplace fires		0	0	0	0	0	0							0
	Total Staff		5894	5891	5868	5909	5855	5870							35287

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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Average monthly total
RIDDOR Incidents		0	2	0	1	3	3	0	0	0	0	0	0	9
RATE %	Red < 0.62 Amber 0.62-0.57 Green > 0.57	0.000	0.340	0.000	0.169	0.512	0.511	0.000	0.000	0.000	0.000	0.000	0.000	0.255
Slips, Trips and Falls		3	7	2	2	6	6	0	0	0	0	0	0	26
RATE %	Red <1.05 Amber 1.05 - 0.96 Green >0.96	0.509	1.188	0.341	0.338	1.025	1.022	0.000	0.000	0.000	0.000	0.000	0.000	0.737
Sharps Injuries		13	14	12	19	20	10	0	0	0	0	0	0	88
RATE %	Red < 2.37 Amber 2.37-2.16 Green > 2.16	2.206	2.377	2.045	3.215	3.416	1.704	0.000	0.000	0.000	0.000	0.000	0.000	2.494
Mgr Referrals to OH for Stress		3	4	9	5	4	8	0	0	0	0	0	0	33
RATE %	Red < 0.72 Amber 0.72-0.65 Green > 0.65	0.509	0.679	1.534	0.846	0.683	1.363	0.000	0.000	0.000	0.000	0.000	0.000	0.935
Work related Musculosketal Injuries		7	4	6	7	2	4	0	0	0	0	0	0	30
RATE %	Red < 0.94 Amber 0.94 - 0.86 Green > 0.86	1.188	0.679	1.022	1.185	0.342	0.681	0.000	0.000	0.000	0.000	0.000	0.000	0.850
Physical Assault		7	15	14	10	9	6	0	0	0	0	0	0	61
RATE %	Red < 1.50 Amber 1.50-1.36 Green > 1.36	1.188	2.546	2.386	1.692	1.537	1.022	0.000	0.000	0.000	0.000	0.000	0.000	1.729
Total Staff		5894	5891	5868	5909	5855	5870	0	0	0	0	0	0	35287

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. The returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement took place on 11 April 2018.

At **Lister Hospital** CQC inspected:

- Urgent and emergency care
- Surgery
- Medicine
- Maternity
- Services for children and young people at Lister Hospital.

At the **QEII Hospital** CQC inspected:
- Urgent Care Centre

At the **Mount Vernon Cancer Centre** CQC inspected:
- Medicine
- Chemotherapy
- End of Life Care

At the October 2015 inspection, these core services were rated either as inadequate or requires improvement, apart from surgery, which was rated as good overall.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and **requires improvement** for and safe, effective, responsive and well led.
We were rated as **requires improvement** for use of resources

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Good → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018	Requires improvement → ← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Queen Elizabeth II Hospital	Inadequate ➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Inadequate ➔ Jul 2018	Inadequate ➔ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ➔ Jul 2018	Good ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Good ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018	Requires improvement ➔➔ Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA 2008 (Regulated Activities), Regulations 2010 Cleanliness and infection control
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

An action plan has been developed against all of these and was submitted to CQC on 24 August 2018. This will be monitored by the Quality Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

Site Ratings

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good July 2018 ↑↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑	Good July 2018 ↑↑	Good July 2018 ↑↑
Medical care (including older people's care)	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Surgery	Inadequate July 2018 ↓↓	Requires Improvement July 2018 ↓	Good July 2018 →←	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓	Inadequate July 2018 ↓↓
Critical care	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016
Maternity	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Good July 2018 ↑
Services for children and young people	Requires Improvement July 2018 →←	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
End of life care	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Requires Improvement March 2016
Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

New QEII Hospital

Urgent and emergency services	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓
Outpatients and diagnostic imaging	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Inadequate July 2018 ↓

Hertford County Hospital

Outpatients	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	N/A	Good March 2016	Good March 2016	Good March 2016	Good March 2016

Mount Vernon Cancer Centre

Medical care (including older people's care)	Requires Improvement July 2018 ↑	Good July 2018 ↑	Good July 2018 →←	Requires Improvement July 2018 ↑	Requires Improvement July 2018 →←	Requires Improvement July 2018 ↑
End of life care	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Inadequate July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Outpatients	Good March 2016	Good March 2016	Good March 2016	Requires Improvement March 2016	Good March 2016	Good March 2016
Chemotherapy	Requires Improvement July 2018 ↓	Good July 2018 →←	Good July 2018 ↓	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←
Radiotherapy	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Requires Improvement July 2018 ↑	Good July 2018 →←	Good July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←	Requires Improvement July 2018 →←

Community Health Services for Children, Young People and Families

Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016	Good March 2016

3. Risk and Quality Committee Reports:

Safer Staffing

East and North Hertfordshire NHS
NHS Trust

Safe Nurse Staffing Levels

September 2018

Executive Summary

The overall RN day fill rate decreased by 0.3% and CSW day fill rate decreased by 2.2%. Our temporary staffing demand decreased from August to September. The demand decreased most significantly for unregistered staff as we recovered from the spike in demand in August. Bank filled hours increased and Agency filled hours decreased. The CHPPD delivered in September has remained static. We have opened escalation beds in the discharge lounge on 5 occasions in September.

The number of shifts initially triggering red decreased from 256 in August to 228 in September which equates to 7.86% in August and 7.44% in September.

There has been an increase of risk assessed patients requiring 1-1 care that displayed particularly challenging behaviour and a high number of wards requiring enhanced care. This is further explored in section 2.4 of the paper.

Purpose of Report:
1. To provide an assurance with regard to the management of safe nurse and midwifery staffing for the month of September 2018. **2.** To provide a summary report of quality metrics for the month of September 2018 as indicators of patient safety. **3.** To provide context for the Trust Board on the UNIFY safer staffing submission for the month of September 2018.

Assessment parameters and criteria
To assess that ward staffing levels are safe the following parameters will be assessed: The Thresholds will be agreed at the Nursing Workforce committee. 1. Patient safety was delivered through consistent, appropriate, staffing levels for the service. **Criteria:** Unify RN fill rate, Unify CHPPD and staff to patient ratio's **Thresholds**: • Unify = Red if falls below 90% Day or Night • CHPPD = Red if falls below 7 (model hospital median is 7.5 as of March 2018) • Staff to patient ratio =Red if falls below 1:8 RN on Day 1:10 on Night 2. Staff were supported in their decision making by effective reporting **Criteria**: Percentage of red triggering shifts and percentage of shifts that remained partially mitigated.

Threshold:
Staffing = Red if:
- There are any outstanding red unmitigated shifts

Staffing = Amber if:
- Over 33% of shifts Amber, with no unmitigated reds

Staffing = Green if:
- Under 33% of shifts are Amber, with no unmitigated reds

3. Staffing risks were effectively escalated to an appropriate person.

   Criteria: Red Flag reportable events and DATIX report

   Threshold:
   - All red flags are resolved by the end of each shift.
   - All Datix reports are reviewed and actioned and closed by the relevant manager within 2 weeks.

4. The Board are assured of safe staffing for nursing and midwifery

   Criteria: Board reports and discussion covering overview of safe staffing levels

Threshold:
- Bi annual establishment review, Monthly Safer Staffing review, daily staffing meetings.

Performance Assessment for month of September 2018

1. **Patient safety was delivered through consistent, appropriate, staffing levels for the service.**

   Performance: RN day fill rate 95.0% RAG rating of Amber.
   CHPPD 7.6 RAG rating of Green.

2. **Staff were supported in their decision making by effective reporting**.

   Performance: No shifts remained red in month following mitigation. RAG rating of Green.

3. **Staffing risks were effectively escalated to an appropriate person**.

   Performance: 321 red flags were raised in month, 56 remain open. 23 Datix reports were escalated in month which have all been reviewed. RAG rating of Amber.

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.

1. **Patient safety was 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

The Trust's safer staffing submission has been submitted to Unify for September within the Unify data submission deadline. SafeCare has been used as the data source for patients as at 23:59 in the absence of patient data reports from Lorenzo. 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 (%)
95.0%	**93.7%**	**96.9%**	**114.7%**

The Unify submission for registered fill % decreased slightly in September with the average day fill % for registered nurses decreasing from 95.3% in August to 95.0% in September.

Factors affecting Planned vs. Actual staffing

Ward Moves

Michael Sobell House relocated 10 beds on to Ward 11 as of the 18th June. The patients and staff providing care for these patients have been included on Ward 11 for the purposes of the Nurse Staffing Return from the date of relocation as per advice from NHS Digital.

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:

- **10B, 11A, 5A, 5B, 6A, 6B, 7B, 8A, 8B, 9A, 9B, ACU, AMU-A, AMU-W, Ashwell, Barley, Pirton, and SSU** – Had an increased demand for patients requiring enhanced care which resulted in an increased CSW fill in these areas.
- **Swift** – RN day fill fell below 90% in September; this is due to the reduced occupancy on the wards. Patient needs were met as actual CHPPD delivered was greater than the required hours of care (see Appendix 3).
- **SAU** – RN Day fill rate fell below 90%, EMTs and pre PIN Nurses were utilised to mitigate the RN shortfall whilst vacant posts are being recruited into.
- **Ward 11** – Registered and Unregistered Day and Night Fill fell below 90% in month; this is due to reduced occupancy on the ward. Patient needs were met as actual CHPPD delivered was greater than the required hours of care (see Appendix 3).

- **7B** – Had an uplift to their CSW establishment in July. These posts are still to be recruited to which has increased the temporary staffing demand and has impacted on CSW day and night fill which fell below 90%.
- **8A** – CSW Day Fill rate fell below 90% in September, due to high sickness and parenting leave in this staff group alongside vacancies. Temporary staffing fill could not match the demand.
- **SSU** – CSW Day Fill rate fell below 90% in September as the ward has a 46% vacancy rate for this staff group.
- **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.

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 has remained at 7.6 in June, July, August and September.

To calculate the CHPPD for September the patient days over the month have been taken from SafeCare. A full table of CHPPD by ward can be seen in Appendix 2.

Table 2 – Average Care Hours per Patient Day

Trust-wide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	**4.8**	**2.8**	**7.6**

The actual gaps in care hours v's the required gaps in care hours by clinical areas, are shown in Appendix 3. The data is Appendix 3 is output from SafeCare and differs from the UNIFY submission as the UNIFY submission uses one patient census at 23:59 and SafeCare uses three census periods during the day.

1.2 Patient to staff ratios:

Staff to patient ratio (registered) data is shown on the roster dashboard as per Appendix 4. The Trust adheres to national recommendations and has an average staff to patient ratio in surgery of 1:7.06 and medicine of 1:6.33 once speciality areas have been removed, for the month of September**.**

2. Staff were 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. These meetings feed into the operations centre to ensure that risk is being balanced throughout the day and night. Each ward is rag 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 and monitoring of nurse staffing levels across the organisation. The senior nursing team launched a new site safety meeting week commencing 24.9.18. This meeting gives a site overview of current issues and concerns relating to capacity, quality, patient care and safety concerns and supports informed decision making across the day. Initial feedback from the staff has been really positive, further work is ongoing to enhance and develop the meeting further to ensure site safety and quality oversight.

2.2 Staffing levels and shifts that trigger red

The number of shifts initially triggering red decreased from 256 in August to 228 in September which equates to 7.86% in August and 7.44% in September. Appendix 5 shows the % of shifts that triggered red in month and remained red and Appendix 6 and Appendix 7 gives a breakdown by ward.

Comparison of red triggered shifts between September 2017 and September 2018 shows a decrease of 3.18% in the number of shifts triggering red in month.

Out of the shifts triggering red, all of the 228 shifts that initially triggered red were mitigated. Shifts triggering red are explored below.

Chart 1 below shows the % of shifts triggering red in month and the % of shifts that remained triggered red; the % shifts triggering red has shown a linear decrease. This is multifactorial, the reasons for the decrease in red triggering shifts was due to annual leave at lower limits and lower levels of sickness compared to August.

Chart 1

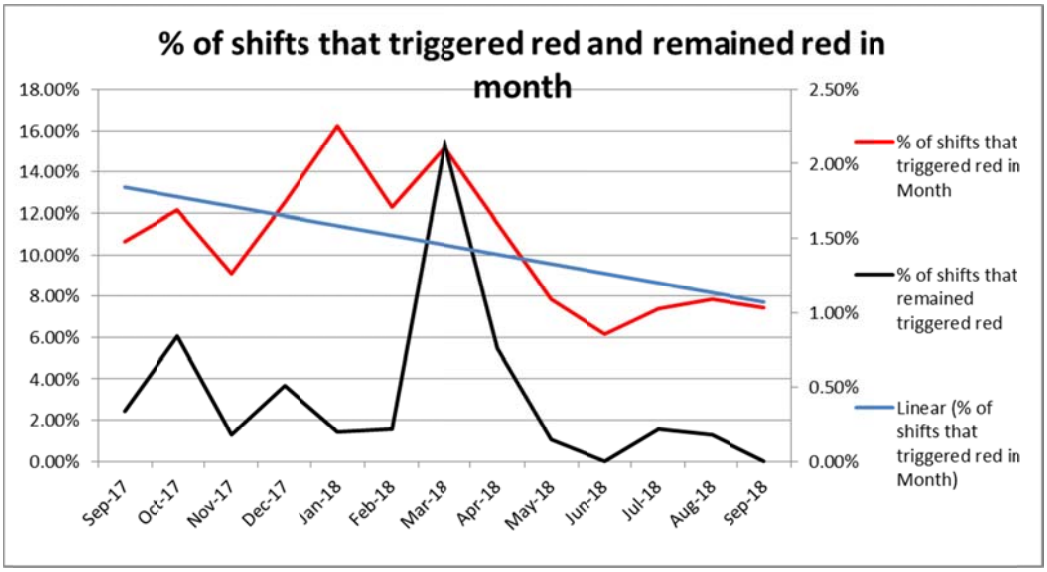
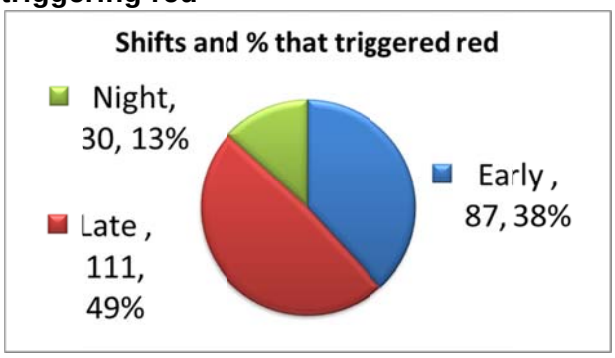


Chart 2 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

Chart 2 – Shifts initially triggering red



A list of all the shifts triggering red and those with high numbers of red shifts can be found in Appendix 6. Twelve wards triggered red on 10% or more of the shifts in September which is a decrease from fourteen wards in August.

Red shifts are mitigated by moving staff between wards to balance staff numbers and skill mix. Table 3 below shows the shift breakdown for each of these wards.

Table 3 – 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**
ACU	13	15	2	30	33.33
Ashwell	6	2	2	10	25.00
11A	8	6	3	17	18.89
SAU	2	13	0	15	16.67
7B	2	11	2	15	16.67
Barley	8	4	2	14	15.56
AMU-A	5	8	1	14	15.56
6B	5	6	1	12	13.33
8A	4	5	3	12	13.33
Swift	2	6	3	11	12.22
9A	7	3	0	10	11.11
10B	4	3	2	9	10.00

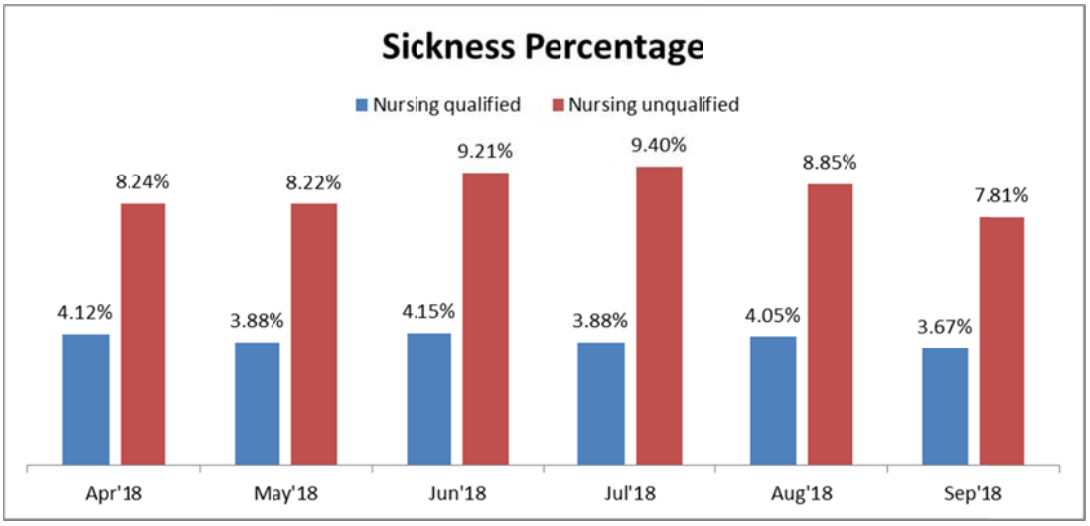
The Top 10 list of wards with the greatest % of shifts remained Amber can be seen in Appendix 8. The Unify fill rates for those wards are above 90% and actual CHPPD delivered exceeded the planned CHPPD service model with the exception of 11A. This was due to high acuity and dependency of the patients (including specialing requirements) in these areas which meant that although CHPPD were in line with the planned model of care, wards were RAG rated as amber.

2.3 Summary of factors affecting red triggering shifts

Several key factors have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – Overall fill rate for temporary staffing increased by 0.1% from 76.9% in August to 77.0% in September, this is as a result of a decrease in demand particularly for unqualified staff. Bank fill rates increased, but agency fill rates decreased, therefore the net impact was 0.1% increase in fill. The slight increase in fill resulted in 17,076 unfilled hours (23.0% of demand unfilled). This is a decrease from 18,471 unfilled hours in August (23.1% unfilled). See Appendix 9.
- Sickness – Chart 3 shows that sickness levels decreased for both qualified and unqualified staff in September.
- Specialing requirements impact on the care hours required on a ward on a shift by shift basis. If the specialing needs are not covered this may cause the ward to trigger red.

Chart 3 – Sickness Percentage by Staff Group



2.4 The Enhanced Nursing care team (ENCT)

The Enhanced Nursing care team continue to streamline the service for patients requiring enhanced care (specialing) and have been recognised by NHSI as a best practice team to support our most vulnerable high-risk patients. For the month of September 100 risk assessments were received by the team which is an increase of 5 patients referred compared to August. Chart 4 shows that the patient referred to the team is continuing to increase since 2016. The trust is seeing a higher acuity of patients and a higher number of patients requiring enhanced care support compared to 2016. There has also been an increase in patients nursed in a side room, for infection control reasons, an increase in mental health referred patients who require 1-1 that could not be cohorted and a higher number of wards requiring enhanced care.
The team review all risk assessed patients on a daily basis and step the level of enhanced care up or down as required to provide a streamlined flexible service. The team continue to develop the service to ensure improved patient care and outcomes. Where demand exceeds capacity the shifts will be put out to temporary staffing to cover the requirement. Chart 5 shows the breakdown of care hours provided by the ENCT, NHS Professionals and Agency. Agency care hours have decreased from 548.73 in August to 150 in September. This is mainly due to Agency padlock controls and the redeployment of the team rotating 3 hourly to support the enhanced care need part covering and working with carers on a live basis over numerous wards to support our patients. There continues to

be robust check and challenge in place for all enhanced care requirements. The director of PMO is working with the team to look at and review the process and workload.
The team has been chosen as finalists for the Skills for Health, Health Heroes Workforce Planning Team Award category which will be judged on 25th November.

Chart 4

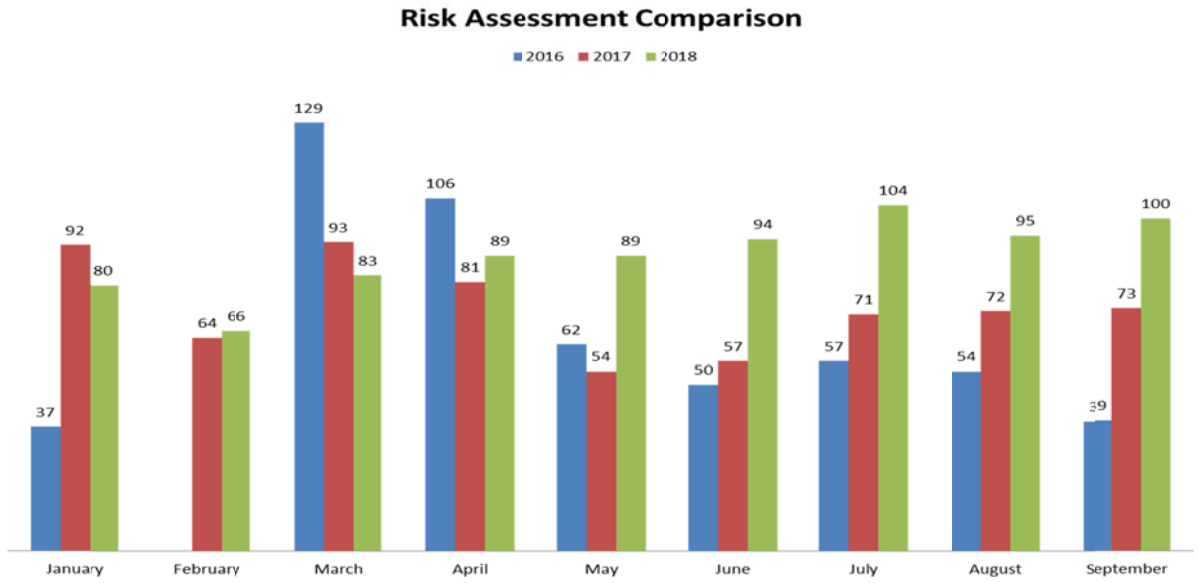
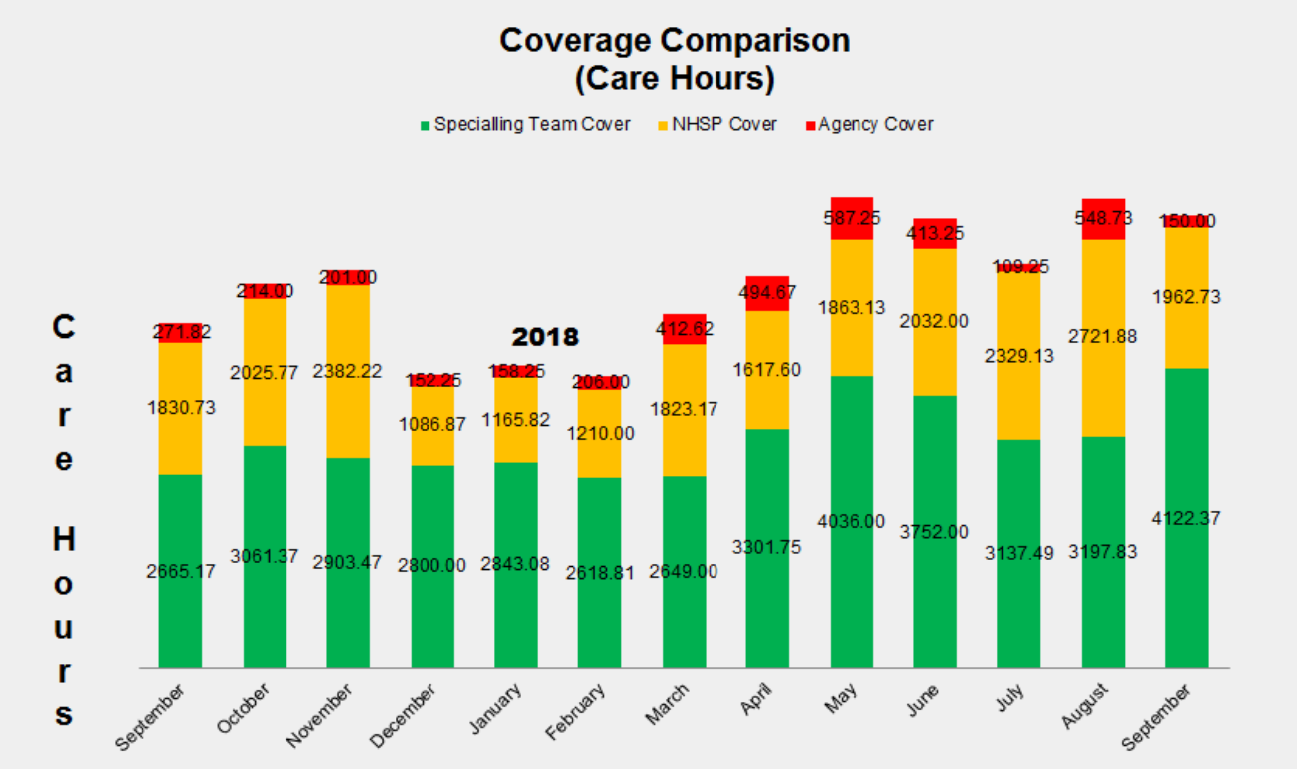


Chart 5



3. Staffing risks were 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.

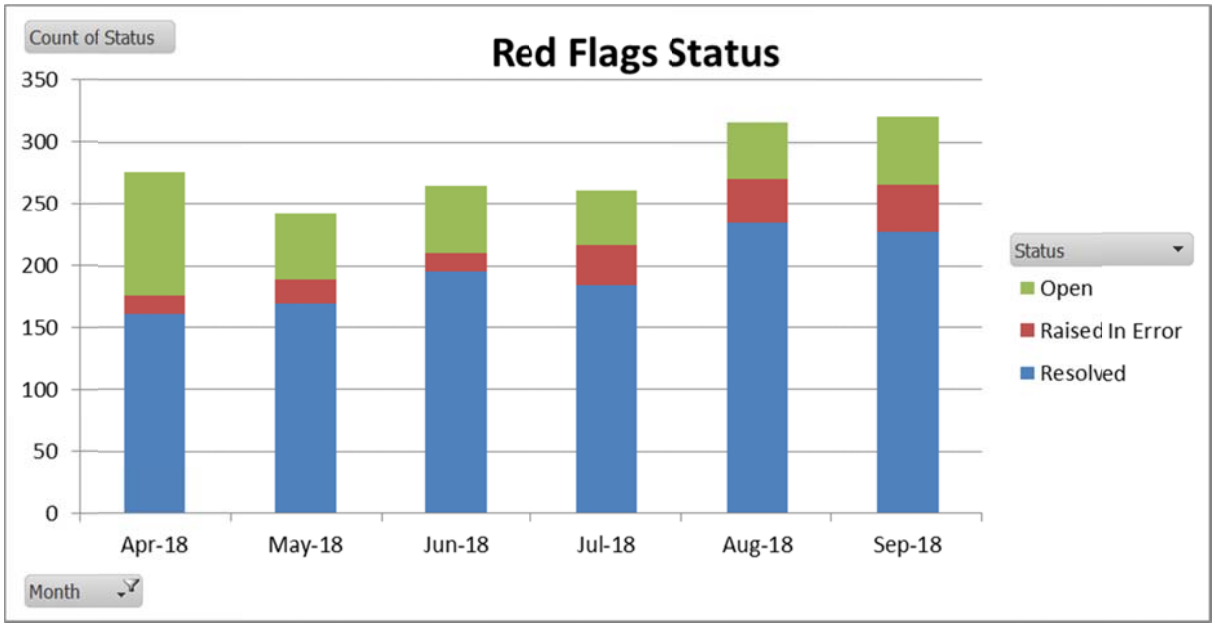
3.1 Red Flags

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 are appropriate to the staffing challenges they need to escalate on a shift.

There is ongoing development to resolve red flags at the staffing meetings to identify where staffing levels have impacted the quality of care on the wards. When a ward raises a red flag the matron must visit the ward to assess the challenges and risk the ward is facing and put measures in place to support this area appropriately. Chart 6 below shows the number of red flags raised each month over the last 6 months and their status.

Chart 6

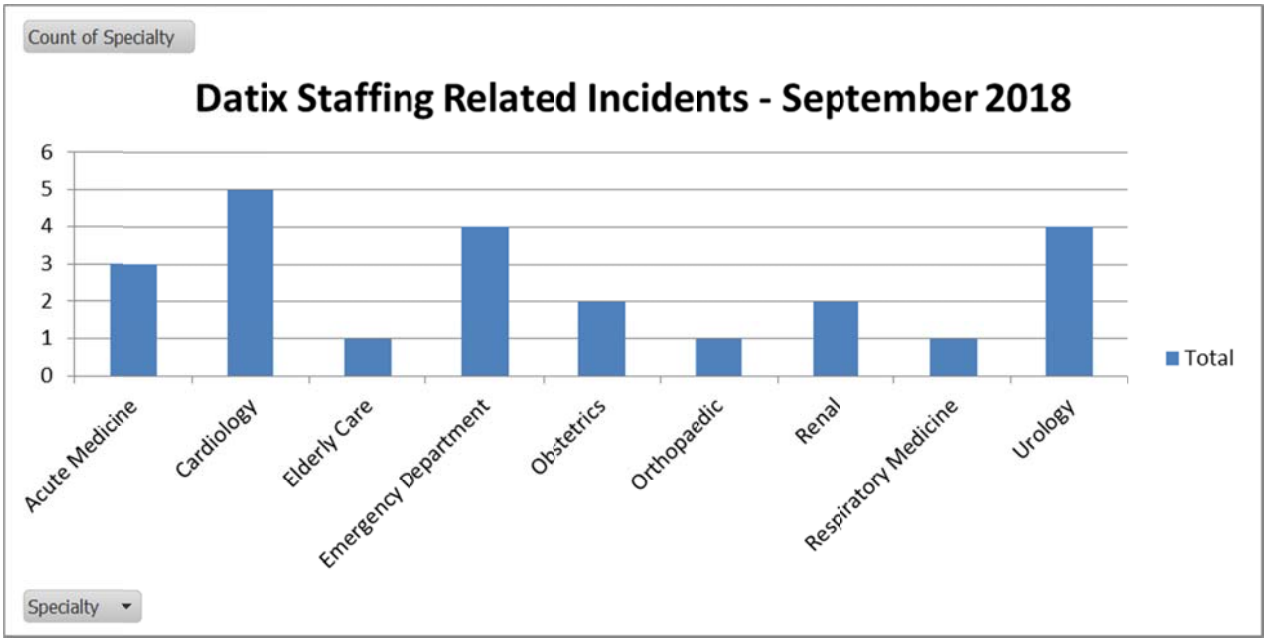


4. Datix

Chart 7 below shows the number of staffing related Datix incidents logged in September by speciality.

There were 23 staffing related Datix raised in September. All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate. All Datix for September have been reviewed and actioned by the department managers.

Chart 7



5. The Board are assured of safe staffing for nursing across the organisation

The overall RN day fill rate decreased by 0.3% and CSW day fill rate decreased by 2.2%. Our temporary staffing demand decreased from August to September. The demand decreased most significantly for unregistered staff as we recovered from the spike in demand in August. Bank filled hours increased and Agency filled hours decreased. The CHPPD delivered in September has remained static.

The Safer Staffing Team continues to monitor staffing at the three Daily Staffing meetings and twice weekly staffing look ahead meetings. A new site safety meeting commenced on Monday the 24th September to review staffing, quality and safety across the Divisions in conjunction with the Operational Team.

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	93.9%	97.1%	96.1%	117.0%
11A	92.4%	97.6%	98.2%	110.0%
11B	97.3%	101.6%	100.3%	100.6%
5A	93.4%	89.6%	93.0%	110.5%
5B	94.8%	93.0%	95.9%	120.3%
6A	97.1%	99.0%	99.8%	120.8%
6B	90.9%	95.3%	102.3%	115.4%
10A Gynae	103.4%	95.6%	100.9%	97.3%
7B	95.7%	101.1%	93.6%	140.5%
8A	96.3%	87.0%	94.8%	106.3%
8B	94.7%	108.5%	92.0%	125.0%
9A	99.6%	105.3%	95.2%	145.4%
9B	94.5%	115.7%	98.3%	144.1%
ACU	91.7%	123.1%	97.7%	128.3%
AMU-A	90.5%	84.4%	90.1%	106.9%
AMU-W	109.0%	81.9%	98.6%	115.4%
Ashwell	94.7%	112.3%	101.5%	129.6%
Barley	101.6%	112.0%	101.2%	141.4%
Bluebell	100.9%	94.5%	99.6%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	102.2%	91.5%	101.1%	#DIV/0!
Gloucester	103.9%	90.0%	102.0%	92.4%
CLU	96.7%	64.4%	99.2%	99.8%
Mat MLU	99.2%	88.3%	100.3%	99.9%
Pirton	90.8%	90.8%	98.0%	124.2%
SAU	89.7%	105.1%	95.5%	93.4%
SSU	105.5%	84.1%	98.9%	113.3%
Swift	88.1%	76.8%	92.3%	85.3%
Ward 11	72.9%	61.3%	83.3%	85.8%
Total	**95.0%**	**93.7%**	**96.9%**	**114.7%**

Appendix 2

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.01	2.63	5.65
11A	4.12	1.87	5.98
11B	4.49	3.43	7.92
5A	3.15	2.49	5.64
5B	3.36	2.79	6.14
6A	3.26	2.75	6.02
6B	3.66	2.65	6.31
10A Gynae	5.49	2.59	8.09
7B	3.03	2.65	5.68
8A	3.01	2.06	5.07
8B	3.16	2.28	5.44
9A	3.02	2.77	5.80
9B	3.05	2.60	5.65
ACU	4.44	2.95	7.38
AMU-A	5.87	3.76	9.62
AMU-W	4.31	3.18	7.50
Ashwell	3.41	3.30	6.71
Barley	3.75	3.04	6.80
Bluebell	9.28	2.49	11.76
Critical Care 1	14.80	2.22	17.01
Dacre	7.46	1.14	8.60
Gloucester	5.26	4.24	9.50
CLU	38.02	6.94	44.96
Mat MLU	28.86	9.07	37.94
Pirton	4.76	2.74	7.50
SAU	7.33	3.72	11.05
SSU	4.15	2.55	6.71
Swift	4.23	2.47	6.70
Ward 11	6.39	3.25	9.64
Total	**4.8**	**2.8**	**7.6**

Appendix 3

Unit	Average of Daily Required CHPPD	Average of Daily Actual CHPPD	Variance Required vs Actual
10B	6.36	5.61	-0.75
11A	6.61	5.87	-0.74
11B	5.72	6.89	1.17
5A	5.84	5.48	-0.36
5B	6.82	6.06	-0.76
6A	6.42	6.03	-0.39
6B	6.75	6.47	-0.28
7B	5.70	5.64	-0.06
8A	5.65	5.16	-0.49
8B	5.82	5.73	-0.09
9A	6.35	6.84	0.49
9B	6.63	5.73	-0.90
ACU	8.10	7.23	-0.87
AMU-W	8.19	7.42	-0.77
Ashwell	7.51	6.57	-0.94
Barley	8.40	7.18	-1.22
Critical Care 1	16.04	14.98	-1.06
Pirton	7.92	7.41	-0.51
SSU	6.84	6.76	-0.08
Swift	4.90	6.32	1.42
Ward 10	5.09	9.22	4.13
Grand Total	**7.03**	**6.89**	**-0.15**

Appendix 4

Units	Nurses to Patient Ratio (Registered)	Units	Nurses to Patient Ratio (Registered)
Critical Care 1	1:1.63	6B	1:6.41
Bluebell	1:2.86	SAU	1:6.55
Ward 11	1:3.88	8B	1:6.78
AMU-A	1:4.19	Ashwell	1:7.16
10A Gynae	1:4.43	6A	1:7.24
Pirton	1:5.13	5B	1:7.33
ACU	1:5.54	9B	1:7.65
AMU-W	1:5.71	9A	1:7.79
Barley	1:5.71	5A	1:7.79
SSU	1:5.84	7B	1:7.98
11A	1:5.87	8A	1:8.02
Swift	1:5.95	10B	1:8.09
11B	1:6.06		

Appendix 5

Month	% of shifts that triggered red in Month	% of shifts that remained triggered red
Sep-17	10.62%	0.34%
Oct-17	12.16%	0.84%
Nov-17	9.07%	0.18%
Dec-17	12.51%	0.51%
Jan-18	16.21%	0.20%
Feb-18	12.28%	0.22%
Mar-18	15.22%	2.15%
Apr-18	11.49%	0.76%
May-18	7.83%	0.15%
Jun-18	6.17%	0.00%
Jul-18	7.37%	0.22%
Aug-18	7.86%	0.18%
Sep-18	7.44%	0.00%

Appendix 6

	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
9A	7	3	0	10	11.11
9B	2	3	2	7	7.78
Barley	8	4	2	14	15.56
Pirton	2	2	1	5	5.56
6A	5	1	0	6	6.67
10B	4	3	2	9	10.00
11A	8	6	3	17	18.89
ACU	13	15	2	30	33.33
AMU-A	5	8	1	14	15.56
SSU	1	2	0	3	3.33
AMU-W	2	3	0	5	5.56
6B	5	6	1	12	13.33
7A	0	0	0	0	0.00
Ashwell	6	2	2	10	25.00
A&E	0	3	1	4	4.44
CDU	2	0	0	2	2.22
UCC	0	0	0	0	0.00
	70	**61**	**17**	**148**	**10.26**
8A	4	5	3	12	13.33
8B	1	1	0	2	2.22
SAU	2	13	0	15	16.67
11B	2	3	0	5	5.56
7B	2	11	2	15	16.67
5A	0	2	0	2	2.22
5B	3	3	2	8	8.89
Swift	2	6	3	11	12.22
Critical Care 1	0	0	1	1	1.11
	16	**44**	**11**	**71**	**8.77**
10A Gynae	0	4	0	4	4.44
Bluebell	1	1	0	2	2.22
Child A&E	0	1	2	3	3.33
NICU	0	0	0	0	0.00
Dacre	0	0	0	0	0.00
Gloucester	0	0	0	0	0.00
Mat MLU	0	0	0	0	0.00
Mat CLU 1	0	0	0	0	0.00
	1	**6**	**2**	**9**	**1.25**
Ward 10	0	0	0	0	0.00
	0	**0**	**0**	**0**	**0.00**
TRUST TOTAL	**87**	**111**	**30**	**228**	**7.44**

Appendix 7

	FINAL 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
9A	0	0	0	0	0.00
9B	0	0	0	0	0.00
Barley	0	0	0	0	0.00
Pirton	0	0	0	0	0.00
6A	0	0	0	0	0.00
10B	0	0	0	0	0.00
11A	0	0	0	0	0.00
ACU	0	0	0	0	0.00
AMU-A	0	0	0	0	0.00
SSU	0	0	0	0	0.00
AMU-W	0	0	0	0	0.00
6B	0	0	0	0	0.00
7A	0	0	0	0	0.00
Ashwell	0	0	0	0	0.00
A&E	0	0	0	0	0.00
CDU	0	0	0	0	0.00
UCC	0	0	0	0	0.00
	0	0	0	0	0.00
8A	0	0	0	0	0.00
8B	0	0	0	0	0.00
SAU	0	0	0	0	0.00
11B	0	0	0	0	0.00
7B	0	0	0	0	0.00
5A	0	0	0	0	0.00
5B	0	0	0	0	0.00
Swift	0	0	0	0	0.00
Critical Care 1	0	0	0	0	0.00
	0	0	0	0	0.00
10A Gynae	0	0	0	0	0.00
Bluebell	0	0	0	0	0.00
Child A&E	0	0	0	0	0.00
NICU	0	0	0	0	0.00
Dacre	0	0	0	0	0.00
Gloucester	0	0	0	0	0.00
Mat MLU	0	0	0	0	0.00
Mat CLU 1	0	0	0	0	0.00
	0	0	0	0	0.00
Ward 10	0	0	0	0	0.00
	0	0	0	0	0.00
TRUST TOTAL	0	0	0	0	0.00

Appendix 8

	FINAL AMBERS					Day		Night				
Ward	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and were judged to be Amber	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Service Model CHPPD	Required CHPPD SafeCare	Actual worked CHPPD
Barley	26	24	17	67	74.44	101.61%	112.04%	101.21%	141.44%	5.94	8.4	7.18
9B	23	19	20	62	68.89	94.50%	115.70%	98.33%	144.15%	5.28	6.63	5.73
ACU	24	22	12	58	64.44	91.67%	123.07%	97.67%	128.30%	6.19	8.1	7.23
10B	24	19	13	56	62.22	93.94%	97.05%	96.09%	117.04%	5.44	6.36	5.61
11A	22	21	12	55	61.11	92.40%	97.61%	98.19%	110.00%	6.07	6.61	5.87
6B	22	20	7	49	54.44	90.88%	95.34%	102.28%	115.40%	6.43	6.75	6.47
8A	17	20	11	48	53.33	96.34%	86.99%	94.83%	106.26%	5.12	5.65	5.16
9A	19	19	9	47	52.22	99.59%	105.26%	95.20%	145.37%	5.29	6.35	6.84
Pirton	15	23	9	47	52.22	90.76%	90.80%	97.98%	124.22%	6.18	7.92	7.41
6A	19	19	9	47	52.22	97.12%	99.02%	99.76%	120.78%	5.51	6.42	6.03
Ashwell	18	20	9	47	52.22	94.73%	112.27%	101.51%	129.56%	5.93	7.51	6.57

Appendix 9

NHSP hours YTD report