East and North Hertfordshire NHS Trust
Trust Board (Public)

Meeting Room 1 / StarLeaf

4 November 2020 10:30 - 4 November 2020 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:30
2	Apologies for absence: MC		
3	Declaration of Interests	All	
4	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, joseph.maggs@nhs.net, by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
5	Minutes of Previous Meeting For approval 5. 02.09.20 Public Trust Board - Draft Minutes.pdf 7	Chair	
6	Patient Story For discussion	Chief Nurse	10:35
7	Chief Executive's Report For discussion 7. CE Board Report - November 2020.pdf 17 7. Appendix A - A message from Nick Carver – time... 21	Chief Executive	10:45

#	Description	Owner	Time
8	Integrated Performance Report For discussion 8. IPR Month 6.pdf 23	Chief Executive	10:55
9	Phase 3 Recovery and Covid Update For discussion 9. P3 Recovery and COVID Preparedness Update.... 65	Chief Operating Officer	11:10
10	Board Assurance Framework 2020-21 For discussion 10. Board Assurance Framework - November Boar... 79	Associate Director of Governance	11:25
11	Finance, Performance and People Committee Report to Board For discussion 11. (a) FPPC Board Report Sept 2020.pdf 117 11. (b) FPPC Board Report October 2020.pdf 121 11. (b) Appendix 1 - Staff Flu Vaccination Board Re... 125	Chair of FPPC	11:40
11.1	FPPC Annual Review and Terms of Reference For approval 11.1 FPPC Annual Evaluation and ToR Review.pdf 127	Chair of FPPC	
12	Quality and Safety Committee Report to Board For discussion 12. (a) QSC Board Report Sept 2020.pdf 141 12. (b) QSC Board Report Oct 2020.pdf 145	Chair of QSC	11:50
12.1	QSC Annual Review and Terms of Reference For approval 12.1 QSC Annual Evaluation and ToR Review.pdf 149	Chair of QSC	
12.2	Learning from Deaths Report For information 12.2 LfD Report.pdf 163	Deputy Medical Director	

#	Description	Owner	Time
13	Audit Committee Report to Board For discussion 13. Audit Committee Board Report October 2020.p... 181	Chair of Audit Committee	12:05
13.1	Audit Committee Annual Review and Terms of Reference For approval 13.1 Audit Committee Annual Evaluation and Term... 185	Chair of Audit Committee	
13.2	Standing Orders and Standing Financial Instructions For approval 13.2 SFIs and SOs Oct 2020 Review.pdf 199	Director of Finance / Trust Secretary	
14	CTC Report to Board For discussion 14. CTC Board Report September 2020.pdf 325	Chair of CTC	12:15
14.1	Charity Annual Report and Accounts 2019-20 For approval 14.1 (a) Cover Report.pdf 329 14.1 b) ENHT Charity Annual Report and Accounts... 331 14.1 c) ENHT Charitable Fund - Audit Completion R... 369 14.1 d) Letter of Representation.pdf 395	Chair of CTC	
15	Actions Log For information 15. Public Trust Board Actions Log.pdf 399	Trust Secretary	12:25
16	Annual Cycle For information 16. Board Annual Cycle 2020-21.pdf 401	Trust Secretary	
17	Data Pack For information 17. Data Pack.pdf 405		

#	Description	Owner	Time
18	Date of next meeting 13 January 2020		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday, 2 September 2020 at 10.00am at the Lister Hospital, Stevenage & via StarLeaf Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Dr David Buckle	Non-Executive Director (via conference-call)
	Dr Peter Carter	Non-Executive Director (via conference-call)
	Ms Karen McConnell	Non-Executive Director
	Ms Val Moore	Non-Executive Director (via conference call)
	Mr Bob Niven	Non-Executive Director (via conference call)
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance and Deputy Chief Executive
	Dr Michael Chilvers	Medical Director (via conference call)
	Ms Rachael Corser	Chief Nurse
	Mrs Julie Smith	Chief Operating Officer (via conference call)
	Mrs Sarah Brierley	Director of Strategy (via conference call)
	Mr Kevin Howell	Director of Estates and Facilities (via conference call)
Also in attendance from the Trust:	Ms Jude Archer	Associate Director of Governance (via conference call)
	Mr Tom Pounds	Deputy Director of Workforce and OD (via Conference Call)
	Mr Joseph Maggs	Trust Secretary
	Mr David Brewer	Head of Engagement (via conference call)
	Ms Julia Smith	Corporate Governance Officer (Minutes, via conference)
	Mrs Alison Studer	Assistant Trust Secretary (via conference call)
Also in attendance	Mr Paul Morgan	Patient Story (via conference call)
	Ms Deborah Price	(via conference call)
	Ms Amica Patel	CQC (via conference call)

20/040 APOLOGIES FOR ABSENCE

20/040.1 Apologies were received from Mr Jonathan Silver, Non-Executive Director, Mr Biraj Parmar, NExT Director and Mr Duncan Forbes Chief People Officer.

20/041 DECLARATIONS OF INTEREST

20/041.1 There were no declarations of interest.

20/042 QUESTIONS FROM THE PUBLIC

20/042.1 There were no questions from the Public.

20/043 **MINUTES OF PREVIOUS MEETINGS**

20/043.1 The minutes of the last public meeting of the Trust Board had been approved previously.

20/044 **PATIENT STORY**

20/044.1 The Chief Nurse introduced Mr Morgan, the son of Sylvia, a patient who passed away in 2019. She said she had spoken to Mr Morgan in January regarding Sylvia's experience with the Trust and discussed the learnings that could be made.

20/044.2 Mr Morgan explained that since his mothers' death he had seen a multitude of paperwork and understood that the detail had been used by the Trust to improve processes as well as staff training.

20/044.3 Mr Morgan described his mothers' lifestyle to the Board explaining she had been independent in her own home with the support of her family and where her pain was managed.

20/044.4 Mr Morgan informed the Board that on admission to hospital his mothers' pain medication and skin treatment were stopped which caused her to suffer from tolerance withdrawal. He said there were multiple effects of this including incorrect assessments due to her being uncommunicative. Mr Morgan highlighted to the Board that Sylvia contracted a chest infection in hospital and was discharged to a nursing home. The discharge letter had failed to mention some of the medication which had led to it being stopped in error. She was readmitted to hospital where her treatment restarted and she passed away five days later.

20/044.5 Mr Morgan said from his perspective the assessment of care for his mother appeared muddled in the hospital. He said an independent care assessment had been commissioned and due to an incomplete care assessment which was sent to several care homes his mother was rejected. A social worker overrode the plan to discharge her to her own home but she was eventually discharged to a nursing home. Mr Morgan said that on her medical notes her pain level had been recorded incorrectly. He said it was hard to get hospital staff to listen to him as someone who managed his mother's care.

20/044.6 Mrs Schroder thanked Mr Morgan for sharing his experience and his mothers' story and offered her apologies on behalf of the Board for the shortcomings he had articulated. She explained that a lot of work had been undertaken to ensure all the learnings were used from Sylvia's story for staff training and process improvement.

20/044.7 Mr Carver thanked Mr Morgan for talking to the Board and explained that the Trust had developed new methods to communicate with patients and their families which would help to ensure that everyone involved in the care of patients were heard.

20/044.8 Dr Buckle commented that with COVID restrictions it was possible that relatives and carers could find it even more difficult to be heard. He suggested that this was something for the Director of Nursing and Board to be aware of and monitor carefully.

20/044.9 The Director of Nursing also thanked Mr Morgan for sharing his story. It was noted that it was the intention to develop a video for staff to use to support further learning within the organisation.

20/045 **CHIEF EXECUTIVE'S REPORT**

20/045.1 The Chief Executive provided assurance that throughout the height of the COVID pandemic the Board had met on a regular basis, both formally and informally (at least every two weeks and often weekly). The Chief Executive explained that at the beginning of the COVID pandemic the Trust Board had committed to providing the best care to local people and to provide the best level of support to staff. He reported that the Trust had cared for over 6000 patients to date who potentially had COVID and the hospital had been reorganised to manage those patients. He advised that there were currently no COVID confirmed patients in the hospital.

20/045.2 The Chief Executive informed the Board that the hospital was now in a different phase of responding to the pandemic and consideration of how services could be reinstated in line with the restrictions was taking place. He said the ambition was to accelerate to near to pre-COVID normal levels of patients as well as preparing for the demands of winter and potential local and national COVID surges.

20/045.3 The Chief Executive then provided a summary of the key aspects of the Integrated Performance Report, as set out below.

Safe

20/045.4 The Chief Executive reported that in the reporting period the hospital admitted six new COVID confirmed patients, one of which was believed to be hospital associated. He said that since July 24th there had been no new cases of COVID and that the Trust had low numbers of hospital associated cases overall.

20/045.5 The Chief Executive informed the Board that 26% of patients had received Sepsis intervention within one hour. He said this was below the target and will be monitored by the Quality and Safety Committee to ensure compliance with the target by March 2021.

20/045.6 The Chief Executive explained that there had been an increase in grade 2 tissue incidents as a result of medical device pressure ulcers. The Chief Nurse commented that in Critical Care the positioning of patients through COVID has been done in a different way to support their respiratory needs which had caused the increase. She informed the Board that the Quality Improvement Team are reviewing this and will make recommendations as appropriate.

20/045.7 The Chief Executive reported to the Board that one patient at MVCC had tested positive for Legionella. He said the source had not been identified but all procedures had been reviewed and provide reasonable assurance.

Caring

20/045.8 The Chief Executive explained to the Board that visiting was restricted and the Trust had used alternative methods to engage with relatives by utilising digital platforms.

20/045.9 The Chief Executive informed the Board that in usual circumstances the Friends and Family Test results would be benchmarked but that this data was not available nationally. He commented that this data would be available in December when benchmarking would recommence.

Effective

20/045.10 The Chief Executive explained to the Board that from June to July there had been a substantial reduction in the rates of crude mortality and said mortality rates across the Trust were encouraging.

20/045.11 The Chief Executive informed the Board that mortality reviews had resumed and two new review areas have been introduced. He said these new areas were patients who died on readmission within 28 days and patients who died in the Community (COVID and non-COVID) within 28 days of discharge.

Responsive

20/045.12 The Chief Executive informed the Board that the Trust's cancer performance was encouraging. He said the Trust was one of a small number across the East of England that had achieved all eight cancer standards. He said there had been a significant increase in the RTT 52 week breaches and to manage this, the patients were being risk stratified.

Well Led

20/045.13 The Chief Executive informed the Board that there had been an in-month increase in staff turnover but over the last few months staff turnover was in fact lower than over the last few years.

20/045.14 The Chief Executive explained to the Board that staff appraisals were behind target but there was a focus on updating mandatory training and appraisals.

Sustainability

20/045.15 The Chief Executive informed the Board that through the Covid period there were different financial arrangements. He said block payments had been a significant feature and moving forward the expectation was for more sophisticated block payments which will be both incentivised and penalised.

20/045.16 Following the Chief Executive's summary, Mr Niven commented that the readmission rate hadn't reduced as much as admissions and asked what the implications of this were. The Medical Director explained that there had been an increase in the number of patients readmitted and this was the same as the national picture. The Medical Director commented that he would like to undertake a deep dive into mortality throughout the COVID period. He said CHKS had offered support to analyse the mortality data which would help to provide clarity for COVID and non-COVID patients.

20/045.17 Mrs Schroder commented that the Sepsis analysis was carried out on a reduced number of patients and asked if this had affected the figures. The Chief Nurse explained that there had been lower numbers of inpatients and the sample size was reduced as the Sepsis team had been redeployed. She said that was why the date

of March 2021 had been set to achieve targets.

20/045.18 Mrs Schroder asked whether the cancer patients being risk stratified were based on clinical need and whether health inequalities were being accounted for in the process. The Medical Director explained that the specialities were prioritising patients based on individual risk assessments, largely on the basis of clinical need.

20/045.19 The Chief Operating Officer commented that the demand and capacity modelling and risk stratification will capture patients at greatest risk. She said there were also opportunities to work with Primary Care to ensure all information was captured at the beginning of the patient journey.

20/045.20 Dr Buckle commented on the challenges of understanding the mortality data for the Covid period and that focus should be on areas that will improve patient outcomes. The Medical Director explained that based on the data available so far, the Trust had not recorded a marked increase in mortality and that non COVID patient mortality may be slightly better than the national benchmark. He said CHKS will be used to help interpret the data.

20/046 INTEGRATED PERFORMANCE REPORT M4

20/046.1 The key issues regarding the IPR were discussed under the Chief Executive's update, as above.

20/047 RECOVERY AND PHASE 3 UPDATE

20/047.1 The Chief Operating Officer explained to the Board that recovery of activity had been the main focus post the height of the COVID-19 pandemic. She said a recovery steering group had been established that was supported by task and finish groups to oversee this work.

20/047.2 The Chief Operating Officer informed the Board that planning was underway to manage winter pressures and any local or national COVID surges. She said capacity was being created across Outpatients, Day Surgery and Electives to ensure patients received the care they need.

20/047.3 The Chief Operating Officer explained to the Board that work was underway with the speciality teams to develop initiatives to ensure they can achieve the phase 3 targets for recovery as requested by NHS England. She said a lot of these initiatives the Trust had already planned for this year and had been expedited for recovery.

20/047.4 The Chief Operating Officer explained to the Board that the submission deadline was 21st September and a plan of how targets would be achieved would be developed. She said this work was underway with the specialities using deep dives, demand and capacity modelling and Executive Director support.

20/047.5 Ms Moore asked what was being done to understand the attitudes and behaviours of patients who were reticent on returning to the hospital setting whilst managing the backlog. The Chief Operating Officer explained that the Trust is using all opportunities to work with Primary Care and reinforce the messaging that the hospital is open.

She said Clinical colleagues are reviewing the backlog to understand the most urgent and vulnerable patients.

20/047.6 Mrs McConnell asked if there were interdependencies between the recovery and ward reconfiguration and if there were financial implications. The Chief Operating Officer explained that the ward reconfiguration is interlinked with recovery, she said ensuring the bed base is right will support the patient need. The Chief Executive commented on the complexity of the task the Trust was undertaking.

20/047.7 Mr Niven about what funding, if any, is available. The Director of Finance explained that there are several areas that have funding available through bids that had been submitted, including the Emergency Department.

20/048 BOARD ASSURANCE FRAMEWORK

20/048.1 The Associate Director of Governance explained to the Board that the strategic risks had been reviewed and updated to reflect the operational priorities and changing environment. She said the reviewed risks had been endorsed by the Audit Committee and Executive Committee. The Associate Director of Governance asked the Board to approve the changes to risks.

20/048.2 The Associate Director of Corporate Governance assured the Board that focus will remain on the delivery of actions to mitigate risks. She said the Audit Committee will continue to undertake deep dives regarding specific risks.

20/048.4 Mrs Schroder commented that there were a high number of risks rated red and asked if benchmarking was done against other Acute Trusts. The Associate Director of Governance explained that benchmarking had not currently taken place in 2020 due to the delay with the review. She said the Audit Committee looked at standardising the risk matrix and this will link to the risk register.

20/048.5 The Board approved the revised strategic risks for 2020/21.

20/049 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

20/049.1 The Board received the report of the Finance, Performance and People Committee which was held on 29 July 2020. Mrs McConnell noted that the Committee had considered the WDES and WRES reports at the meeting.

20/049.2 Mrs McConnell highlighted to the Board that the FPPC had received good financial assurance during the pandemic and would continue to seek assurance at future meetings. She also commented that the update on the digitalisation strategy had been very useful.

20/050 WORKFORCE DISABILITY EQUALITY STANDARD AND WORKFORCE RACE EQUALITY STANDARD REPORTS

20/050.1 The WDES and WRES reports were provided for Board approval, following initial consideration by the FPPC.

20/050.2 Mrs Moore commented that she attended the staff network meetings in August which had been well attended. The Director of Strategy suggested linking together staff networks with partner organisations' network groups so there is a broader context, particularly with the smaller groups.

20/050.3 Mr Niven highlighted that improving staff declaration rates would enable the Board to make more informed decisions on the best way to support staff groups.

20/050.4 Mrs Schroder asked about progress with the actions and the Deputy Director of Workforce and OD advised that the actions are on track for each of the deadlines within the report. It was also noted that a Board Development session regarding equality and diversity had been scheduled.

20/051 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

20/051.1 The Board received a summary report of the Quality and Safety Committee meeting which took place on 28 July 2020.

20/051.2 It was confirmed that there had been zero confirmed hospital acquired cases of COVID since the case referred to in the report.

20/052 SAFEGUARDING ANNUAL REPORT

20/052.1 The Board received the Safeguarding Annual report.

20/052.2 The Chief Nurse summarised the Safeguarding Annual Report for the Board. There has been a 40% increase in service requests over the last year which had resulted in a requirement for increased capacity.

20/052.3 Care of Adults with Learning Disabilities is an area of focus within the Trust. Changes regarding the Deprivation of Liberty Safeguards were also expected to take place soon.

20/052.4 The Board recorded their thanks to the safeguarding team for their work, particularly in the context of the increase in requests that they had managed. The Board noted and approved the annual report.

20/053 COMPLAINTS, PALS AND PATIENT EXPERIENCE QUARTERLY AND ANNUAL REPORTS

20/053.1 The Board received the Patient Experience Quarterly and Annual Reports. The Chief Nurse summarised the key points, stating that the National Cancer Survey response results had not improved from the previous year. This was an issue that the patient experience team were working to address.

20/053.2 The Chief Nurse stated that there has been an increase in patients recommending the Trust but also an increase in complaints as activity was increasing. The complaints team has subsequently been strengthened, putting patient experience at the forefront of the service.

20/053.3 Ms Moore congratulated the team regarding their responsiveness to

complaints and PALS during the COVID pandemic.

20/053.4 Dr Carter also commented that the survey results regarding staff friends and family test results were generally positive.

20/054 HEALTH AND SAFETY ANNUAL REPORT

20/054.1 The Board received the Health and Safety Annual Report (previously presented to the Quality and Safety Committee). The Director of Estates and Facilities advised that in future elements of Health and Safety and other estates compliance issues will be amalgamated and reformatted to show the information in a more efficient manner. The Board noted and approved the annual report.

20/055 AUDIT COMMITTEE REPORT TO BOARD

20/055.1 The Board received an update of the Audit Committee meeting held on 20 July 2020 from Mrs McConnell (in Mr Silver's absence). It was noted that the Sustainability Update will return to the audit committee to be discussed in October. The other significant item of business considered by the Committee was the Annual Audit Letter, as detailed below.

20/056 ANNUAL AUDIT LETTER

20/056.1 Mrs McConnell noted that the Annual Audit Letter summarised the external auditor's opinion and findings regarding the annual audit of the accounts. It was noted that the Audit Conclusions were positive and an unqualified opinion had been provided, following the Trust breaking even in the financial year 2019 – 2020.

20/056.2 Mr Niven commented that there had been a reduction in outstanding internal audit actions which was positive progress but there was further work needed to ensure the Trust remained on top of them.

20/057 CTC REPORT TO BOARD

20/057.1 The Board received an update of the extraordinary meeting of the Charity Trustee Committee that took place in August to discuss the £300,000 charitable donations received for the '#hereforeachother' fund related to COVID.

20/057.2 Mr Niven highlighted that the Committee had agreed in principle to the applications considered, which included providing funding for the staff networks and to refurbish a number of staff areas, subject to a fuller discussion on staff support at this Trust Board meeting.

20/057.3 The Board supported the approach and were pleased to see the funds being used to improve the staff facilities. Implementation of the above will be discussed at the next meeting of the CTC.

20/058 STAFF WELLBEING SUPPORT

20/058.1 The Board received an update on Staff Wellbeing Support. The Deputy Director of Workforce and OD highlighted that staff have been working in unprecedented times and circumstances, and the Trust was committed to ensuring they feel supported. The report

highlighted the approach taken.

20/058.2 The main points of the report were highlighted including the strategic approach the Trust was taking and the next steps planned. The support available for staff ranged from support with staff testing to psychological support.

20/058.3 The Chair commented that the programme appeared to provide a good wraparound support service. She suggested that measurable outcomes are important.

20/058.4 Mr Niven highlighted that the report was extensive and it needs to be communicated in a simple yet effective manner to have the broadest reach possible.

20/059 STRATEGY COMMITTEE – TERMS OF REFERENCE

20/059.1 The Director of Strategy advised that the delivery framework agreed by the Board previously would come into effect from September. One of the recommendations of the framework was for the creation of a bi-monthly Strategy Committee. The Board was presented with the draft Terms of Reference for the Strategy Committee.

20/059.2 The Board discussed that the Strategy Committee may undertake deep dives on some of the issues relevant to the Board meetings but will not detract from the Board's role and responsibility in overseeing and shaping strategy.

20/059.3 The Board approved the new Strategy Committee Terms of Reference, to be monitored and reviewed in-year, with some minor amendments to the membership (to include the Director of Finance and Chief Operating Officer).

20/060 ACTION LOGS

20/060.1 The Board noted the content of the latest Public Board Actions Log.

20/061 ANNUAL CYCLE

20/061.1 The Board noted the Annual Cycle 2020/2021.

20/062 DATA PACK

20/062.1 The Board noted the data pack.

20/063 **DATE OF NEXT MEETING**

20/063.1 The next meeting of the Board of Directors will be on Wednesday 4th November 2020.

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Ellen Schroder

Trust Chair

November 2020

Chief Executive's Report

November 2020

Proposed National Lockdown

Following the Prime Minister's announcement on Saturday regarding the introduction of a planned four week lockdown from Thursday, I have written today to Trust employees (see attached Appendix A).

I have outlined below the progress that the Trust has made in retaining elective services and have provided an update on the current position in respect of Covid 19.

Fortnightly Board briefings will be held with effect from 18 November 2020.

Recovering Elective Services

Colleagues will be aware that NHS organisations are required to return to near normal levels of non Covid health services, whilst preparing for winter and increased numbers of Covid patients.

The Chief Operating Officer will report in some detail on our response to these considerable challenges.

I will, however, share in this report two graphs that illustrate that considerable progress has been made.

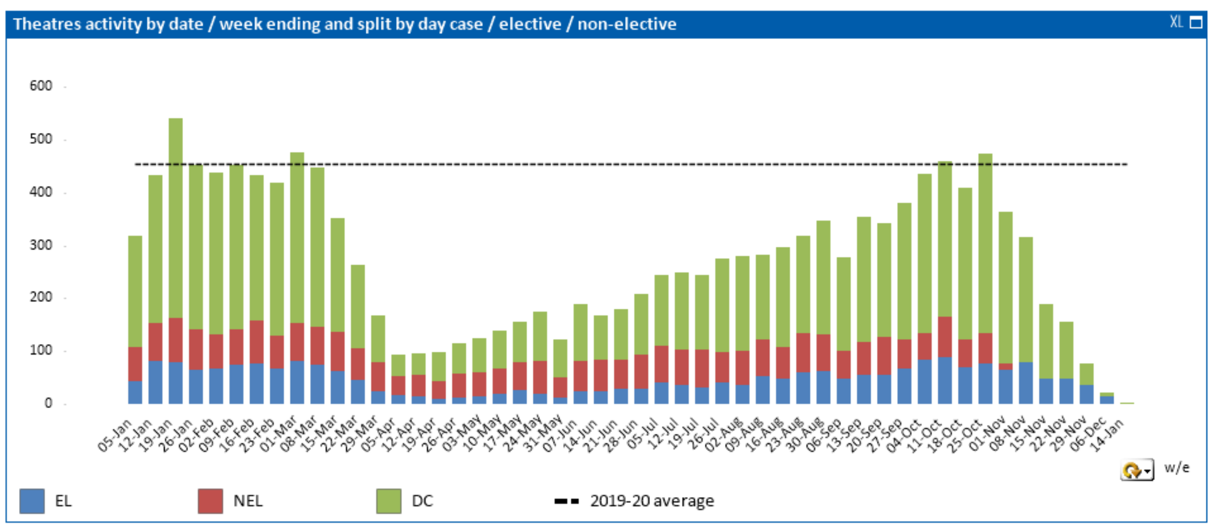


Figure 1 - Demonstrates the recovery in theatre activity after the period of peak Covid activity.

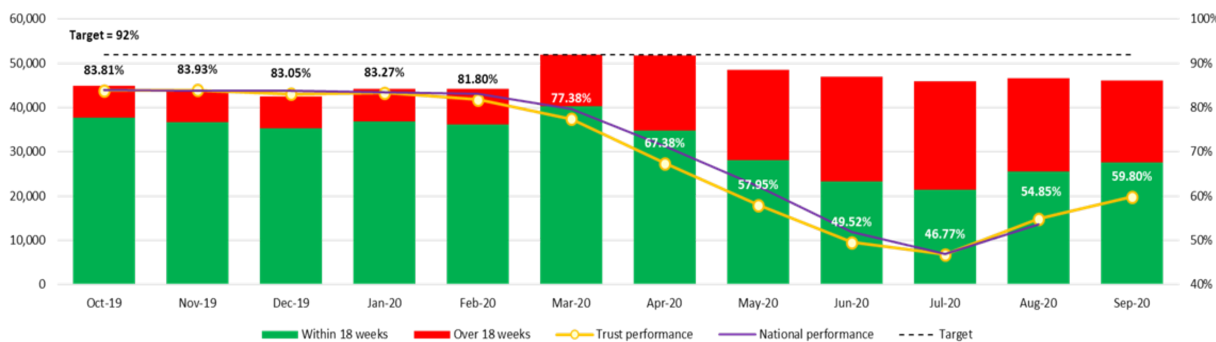


Figure 2

Which is taken from the Integrated Performance Report summarises the total number of patients waiting by month. Following restoration of elective services the total number of patients waiting fell by nearly 6,000 or 11% in September compared to March, with total patients waiting just 3% higher than in March 2019.

The number of over 18/52 waiters dropped by nearly 6,000 between July and September or 24%, although this cohort of patients is still 150% larger than March 2019.

Clearly it is vitally important that we continue to treat elective patients and address the needs of these long waiting patients. It is especially interesting that, like other Trusts, referral levels have been significantly reduced since the start of the Pandemic and it is reasonable to assume that a backlog of patients will peak in future months.

Covid-19

At the time of writing there are 19 patients with Covid-19 in the Trust, 3 of whom are being cared for in Critical Care.

A total of 33 patients with Covid have been admitted since 1 October 2020 and 6 patients have sadly died in this second period.

As a Trust we have a greater capacity to care for more patients with Covid-19 that during the first wave. It should, however, be noted that during the first wave many patients with non Covid-19 did not present. This will present additional challenge in the event of rising Covid 19 admissions.

The current increase in Covid patients is accompanied by emergency activity levels at 85% of last year's levels.

Creating an Inclusive Workforce

A Board Development Session was held on the 7th October to explore the theme of building an inclusive workforce with a focus upon race equality.

During the Board Development Session members reflected upon the existence of racism on an interpersonal, structural and institutional level across society. It was recognised that Covid-19 has disproportionately impacted the black, Asian and minority ethnic (BAME) community and that the "black lives matter" movement has highlighted a history of racial discrimination.

The Board heard the personal stories of a number of members of our BAME staff, were shocked by some of their experiences and emphasised that our ambition is to be a workplace that is equitable, free from discrimination, where everyone can bring their best, feel valued and all have opportunities to develop their talents and progress their careers. This benefits our employees, patients, the Trust and whole community.

In future Board meetings our Acting Chief People Officer will outline our strategy for delivering on this ambition.

From: ENH-TR, Communications (EAST AND NORTH HERTFORDSHIRE NHS TRUST)
Sent: 02 November 2020 12:18
Subject: A message from Nick Carver – time to pull together, stay apart

Message from
Nick Carver, Chief Executive

NHS
East and North Hertfordshire
NHS Trust

Dear colleague

I wanted to write to you following the government announcement over the weekend about the forthcoming national lockdown.

I know that many of you will be feeling anxious – about what it means for us here at work, for loved ones, and simply about the practicalities of another lockdown.

What you have achieved this year in caring for our patients has been nothing short of outstanding. And I know how tough it has been for many of you, both physically and emotionally.

The next month, and indeed into the new year, will once again be incredibly challenging as we treat an increasing number of patients with COVID-19 – alongside other winter pressures. But I know that we will continue to pull together as one team, to deliver care to our communities who need us now, more than ever.

By working together, and working differently, we have made exceptional progress in restarting much of our elective and diagnostic activity. We will continue to deliver non-urgent and elective care, working with our partners in primary care, social care, and the independent sector for support. Across the local area, we will continue to prioritise those patients with the most clinically-urgent needs.

Preparedness

As far as we can be, we are prepared for this next phase in the pandemic. Our Gold Command was stepped up a few weeks ago to daily meetings, and our "flat-packed" initiatives from the first phase of the pandemic are ready to be implemented again, as soon as needed. Our winter plan is ready to be activated early if the need arises.

Clinically, we know a lot more about the best treatment for our patients with COVID-19. And we have more than sufficient supplies of PPE in stock.

However, I do not underestimate the impact on you as we enter this next phase. It is more important than ever that we look after ourselves as best we can, and support each other.

Pull together, stay apart

There are a few things that we can all do to help ourselves and each other:

- Ensure that you take breaks and annual leave where possible – rest is crucial.

- If you haven't already – have your flu jab. Not only to protect you, your family and your patients, but also in anticipation of any forthcoming COVID-19 vaccine, for which you may need to have had a gap of a few weeks after receiving your flu jab. Most of you have had your flu jab already – thank you.

- Continue to wear face masks, observe good hand hygiene, and maintain social distancing – particularly during break times. I know this is hard, as it is now too cold to sit outside. But you must keep your distance – we cannot risk whole services or teams through one instance of staff sitting too close during a break.

- If you think you may have symptoms of COVID-19, please stay at home and contact Health@Work for advice – and get tested as soon as possible. Any days off for COVID-related or suspected sickness will not count against your record.

- If you are contacted by Test and Trace, please work through our trust risk assessment with your manager as this will supersede any contact from Test and Trace.

- Seek support early if you need to – there are lots of local and national options to support your mental health, from phone lines and talking therapy through to counselling for post-traumatic stress disorder (PTSD). You can call our dedicated Health@Work line on **0333 332 5445**, available 8am to 4pm Mon-Sun.

- Check in with your team mates as often as you can – ask how they are feeling and support them to seek advice if needed.

Keep talking

I and other senior leaders continue to be here daily to work with you – please continue to let us know what challenges you are facing and we will do everything we can to support you.

As our bronze, silver and gold command are stepped up, please escalate any issues via this system, or your manager.

And remember, you can always email me at AskNickCarver@nhs.net

Nick

Nick Carver
Chief Executive

Agenda Item: 8

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020
Integrated Performance Report – Month 6

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 6 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC – 27.10.20 and FPPC – 28.10.20		
Director: All Directors	**Presented by:** Chief Executive	**Author:** All Directors / Head of Information and Business Intelligence

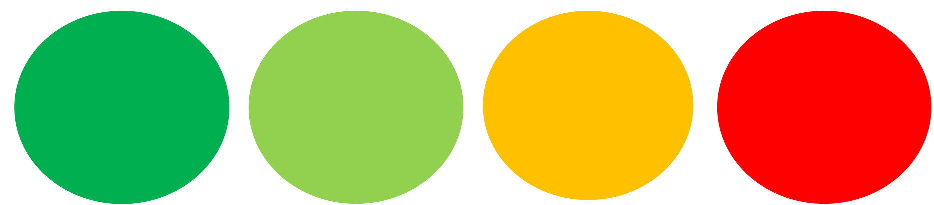
Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

Integrated Performance Report

Month 06 | 2020-21



Data correct as at 23/10/2020

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NHS Oversight Framework

Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Quarterly	Sep-20	Local	1.9	1.6	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Apr-20 - Sep-20	National	0	1	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Oct-20	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Sep-20	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Sep-20	National (excl. IS)	95.0%	97.3%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Sep-20	National (excl. IS)	90.0%	96.1%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Sep-20	National (excl. IS)	93.0%	100.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Sep-20	National (excl. IS)	93.0%	92.6%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Sep-20	National (excl. IS)	93.0%	95.7%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Sep-20	National (excl. IS)	93.0%	66.7%	
Safe	Emergency c-section rate	Monthly	Sep-20	Local	16%	15.62%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Sep-20	NHSI	0	tbc	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Oct-19- Sep-20	National	20.12	25.33	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Oct-19- Sep-20	National	0.60	1.58	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Oct-19- Sep-20	National	6.85	6.86	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Oct-19- Sep-20	National	15.85	16.36	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Aug-19 - Jul-20	National	100	83.2	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Jun-19- May-20	National	100	89.3	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Feb-20-Jul-20	National	59.0	53.2	

Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Sep-20	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	Sep-20	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Sep-20	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	Sep-20	National	1	n/a	
Financial controls	Agency spend	Monthly	Sep-20	National	1	n/a	

Operational performance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Sep-20	National	95%	84.6%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Sep-20	National	92%	59.80%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Aug-20	National	85%	85.15%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Aug-20	National	90%	0.00%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Sep-20	National	1%	29.38%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

Leadership and workforce

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Organisational health	Staff sickness	Monthly	Sep-20	Local	3.8%	4.07%	
Organisational health	Staff turnover	Monthly	Sep-20	Local	12.0%	12.9%	
Organisational health	Proportion of temporary staff	Monthly	Sep-20	Local	-	10.9%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality Improvement Dashboard

Safe, Caring and Effective Services Headline Metrics

Hospital-acquired pressure ulcers
All categories

Serious Incidents
All incidents reported in-month

Patient Falls
Rate of falls per 1,000 overnight stays

Patient Falls
Proportion resulting in moderate harm or above

Sepsis Screening and Management
Timely treatment of sepsis with IV antibiotics in ED

Complaints
Number of written complaints received

Complaints
Proportion responded to within agreed timeframe

Friends and Family Test
Total responses - inpatients

COVID-19

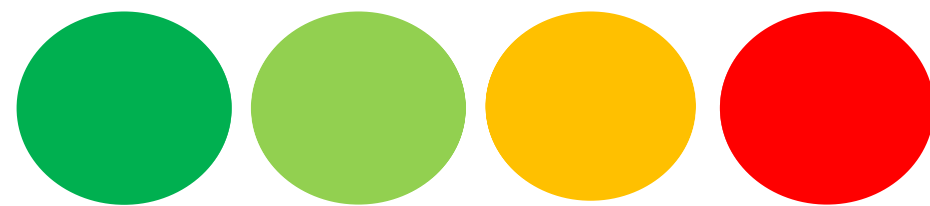
Friends and Family Test
Total responses - emergency departments

COVID-19

In-month — Mean — UCL / LCL — LCL / UCL — 7 or more points above / below the mean — High / low point — National

Safe Services

Month 06 | 2020-21



Safe Services

Key Issues

Patient Falls
- There were 67 inpatient falls recorded in September.
- Number of falls in September resulting in serious harm = 1.

Serious Incidents & Never Events
- It has been 9 days since the last reported Never Event (as at 8th October 2020).
- There wer 4 serious incidents reported in September:
  - 1 fall .
  - 1 hospital acquired thrombosis.
  - 1 connection of oxygen to air.
  - 1 post partum death.

Infection Prevention & Control
- COVID-19: 10 new inpatient cases in September. (10 Community Onset). Since 14/05/20, 9 Definite & Probable Healthcare Associated cases & 59 Indeterminate & Community Onset cases.
- MRSA bacteraemia = 0 Hospital Onset cases in September.
- C difficile infections = 2 reportable cases in September. (2 Hospital Onset).
- E.coli bacteraemia = 2 Hospital Onset case in September.
- MSSA bacteraemia = 2 Hospital Onset cases in September.
- Klebsiella bacteraemia = 0 Hospital Onset cases in September.
- Pseudomonas aeruginosa bacteraemia = 3 Hospital Onset cases in September.
- Hand hygiene compliance improved to 92.95% in September from 92.16% in August (target 80%).

Hospital-acquired Pressure Ulcers
- There were the following reported for September:
  - Category 4 incl. (d) = 0
  - Category 3 incl. (d) = 0
  - Category 2 incl. (d) = 10
  - MM incl. (d) = 4
  - Unstageable incl. (d) = 3
  - SDTI incl. SDTI (d) = 7

Sepsis
- The sample of Inpatients for Q2 is 26: July (6), Aug (4) , Sep (16)
- The sample of ED Patients for Q2 is 114: July (19), Aug (37), Sep (58) above the Trust target (50).
- The sample showed the average time in Emergency Attendances receiving antibiotics within 1 hour of Red Flag has deteriorated to 73% in September and is currently below Target (95%).
- The sample showed an average time to antibiotic administration within in patient setting remained at 50% within 1 hour of Red Flag in September.
- 25% of patients received all Sepsis 6 interventions within 1 hour of Red Flag triggers in September.

VTE/HAT

Executive Response

Patient Falls
- The Trust has successfully completed the submission into the National falls audit programme.
- Local continuous improvement priorities include working with wider MDTs within clinical areas to ensure safer medication management and review the trust falls risk assessment eligibility.
- 1 Fall resulted in serious harm in Sept
- Themes from falls incidents remains a priority within Trust Safety Programme – Harm Free Care.

Executive Response

Serious Incident Review Panel
- 28 cases were presented to the SIRP in September 2020.
- 5 cases require RCA investigation; 4 have been declared SI's, 5 triggered local learning reviews, 7 require more information for discussion. 6 no further action and 1 thematic review.

Infection Prevention & Control
- The Board Assurance Framework (BAF) was reviewed and outstanding actions have been closed with the exception of the two gaps below, which will be carried over to our winter BAF report which will be launched at October TIPCOG and November TIPCC. Although these have actions have also been advanced.
- Consistent approach needed across all sites and clinical and non-clinical areas for risk assessments, key messages and provision of necessary equipment and processes to ensure compliance with guidance.
- Decontamination Group needs to be re-established to ensure fully compliant.
- COVID Specialist Advisory Group (SAG) continued to review PHE COVID-19: Guidance for the remobilisation of services within health and care settings Infection prevention and control recommendations to identify any gaps in Trust practice. On review the Trust was largely compliant with PHE guidance and minimal changes were required. The main change noted was the identification of patients as low, medium, and high risk . However, this corresponds to the Trust rag rating as (low) green, (medium) amber, (high) red, and (high) black. A gap identified was all staff wearing face masks in all non-clinical areas , regardless of having achieved COVID-19 Secure status and the two metre social distancing requirement. A risk assessment was completed by Jude Archer the Associate Director of Governance and Lorraine Williams ,Infection Prevention & Control Lead Nurse, which was presented to the Executive Directors where it was agreed that this action would be taken as part of an escalation process triggered by national and local information.
- Proactive webinars and teaching sessions continue to be provided to help guide the Trust through guidance changes and the local position.

Hospital-acquired Pressure Ulcers
- It has been 323 days since the trust last reported grade 4 pressure ulcer.
- Every hospital acquired Pressure Ulcer is investigated by a Tissue Viability Nurse. This is to enable identification of gaps in care so that learning can be identified and delivered. Quality improvement work continues within critical care.
- In compliance with the new NHSI PU recommendations the terms Unavoidable and Avoidable will no longer be used, however, where RCA shows no omissions in care and therefore no learning this will be captured and reported, so far this accounts for 23% of YTD pressure ulcers and is our most common RCA theme.
- The most common theme from RCA second to "no learning" is reduced skin inspection at 21% followed by equipment provision at 17%.
- Learning from previous serious incidents is taught during our restarted pressure ulcer prevention study day in alliance with Nurse education.

Sepsis
- A key cross cutting theme across ED & In patient setting is team work and peer support to complete all aspects of the sepsis bundle.
- Themes in ED continue to show less compliance with fluid output and delays in blood cultures in the 1st hour. The in clinical team ED have used 'team time' to have a targeted focused on sepsis and AKI/ FBC in Sept and have purchased new scales to assist with accurate measurement and have team discussion by nursing teams and drs that BC must be taken even when a clear source of infection appears evident.
- Themes within inpatient setting also focus on blood cultures and fluid balance on the ward- CCOT supporting ward teams to recognise the importance and rationale for accurate fluid balance measurement.

VTE/HAT
- The national programme for measurement of VTE risk assessment remains suspended due to COVID-19 pandemic.
- Internal VTE risk assessment audit continues through pharmacy department audit programme.
- Due to the time lag between diagnosis of potential Hospital Acquired Thrombosis and the undertaking of phased RCA review it is important to note that the number of HAT reviews completed monthly do not correspond to the cases added for review in that month and can relate to previous months. Therefore there will naturally be a 3 month delay in data clarification.
- All HAT incidents where any concern in care identified are presented to SIRP. There were no HATS presented in August 2020.

Safe Services

Nosocomial Covid-19 infection	Total	Definite hospital onset (>=15 days post admission)	Probable hospital onset (8-14 days post admission)	Indeterminate onset (3-7 days post admission)	Community onset (<=2 days post admission	Total Definite & Probable hospital onset	Total Indeterminate & Community onset	
SEPTEMBER (Weekly reporting commenced wef 14/05/20)	10	0	0	0	10	9	59	

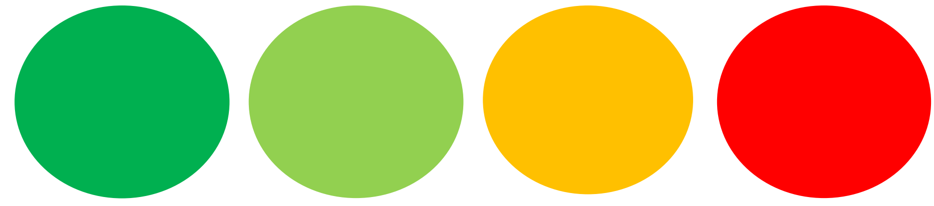
Domain	Metric	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Events and Incidents	Number of Never Events	0	1	0	0	0	0	0	0	0	0	0	0	1	
	Number of Serious Incidents	5	5	4	8	4	1	0	4	2	4	3	3	4	
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Category 3 - inc Category 3 (d)	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Category 2 - inc Category 2 (d)	2	2	2	0	3	3	3	3	3	3	12	10	10	
	Mucosal membrane (d) Device-related	-	2	0	0	0	1	0	0	1	4	1	2	4	
	Unstageable inc Category Unstageable (d)	1	1	1	1	1	1	0	1	0	0	1	1	3	
	SDTI inc STDI (d)	3	5	0	7	9	9	7	10	7	5	8	8	7	
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	19			36			14			26			
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	40%	50%	38%	28%	25%	33%	n/a	0%	60%	67%	50%	50%	
	Emergency attendances with Sepsis - sample size	50	49			169			21			114			
	Emergency attendances receiving IVABs within 1 hour of Red Flag	95%	67%	71%	79%	68%	66%	78%	n/a	50%	76%	63%	92%	73%	
	Sepsis six bundle compliance - ED	90%	12%	22%	73%	14%	14%	29%	n/a	0%	29%	26%	32%	25%	
Patient Falls	Number of patient falls	72	59	75	77	70	77	35	48	35	43	46	56	67	
	Rate of patient falls per 1,000 overnight stays	4.0	4.1	5.5	5.2	5.0	6.2	2.8	7.2	4.3	5.1	4.5	5.4	6.2	
	Number of patient falls resulting in serious harm	0	0	0	0	0	0	1	1	1	1	0	0	1	

Safe Services

Domain	Metric	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
VTE	VTE risk assessment	95%	88.8%	87.5%	87.9%	88.0%	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Cases for HAT review (12 month rolling average)	-	15	16	16	17	17	17	16	16	16	17	17	18	
	HAT reviews completed (12 month rolling average)	-	15	16	17	16	17	16	16	14	14	14	12	16	
	HATs confirmed potentially preventable	-	1	0	0	0	2	3	0	0	0	0	0	5	
Infection Control	Number of MRSA incidences	0	0	0	2	1	0	0	0	0	0	0	0	0	
	Rate of MRSA incidences per 100,000 bed days	0.6	0.0	0.0	11.4	5.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	Number of c.difficile incidences Healthcare-associated	4	7	7	5	2	4	6	3	4	2	3	3	2	
	Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	39.8	41.1	28.4	11.5	24.6	34.6	26.2	33.8	17.5	17.3	17.3	11.9	
	Number of e.coli incidences	-	8	4	2	3	2	3	3	1	1	2	1	1	
	Rate of e.coli incidences per 100,000 bed days	18.5	45.5	23.5	11.4	17.3	12.3	17.3	26.2	8.4	8.7	11.5	5.8	6.0	
	Number of MSSA incidences	-	4	1	1	1	0	0	0	0	2	0	2	2	
	Rate of MSSA incidences per 100,000 bed days	8.0	22.7	5.9	5.7	5.8	0.0	0.0	0.0	0.0	17.5	0.0	11.5	11.9	
	Number of klebsiella incidences	-	0	2	3	0	1	0	0	1	0	0	0	0	
	Rate of klebsiella incidences per 100,000 bed days	7.6	0.0	11.7	17.0	0.0	6.2	0.0	0.0	8.4	0.0	0.0	0.0	0.0	
	Number of pseudomonas aerudinosa incidences	-	0	0	1	1	1	0	0	0	0	1	0	3	
	Rate of pseudomonas aerudinosa incidences per 100,000 bed days	3.7	0.0	0.0	5.7	5.8	6.2	0.0	0.0	0.0	0.0	5.8	0.0	17.9	
	Hand hygiene audit score	80%	89%	86.9%	92.3%	92.2%	90.3%	91.3%	94.1%	92.5%	92.4%	93.6%	92.2%	93.0%	

Caring Services

Month 06 | 2020-21



Caring Services

Key Issues

Friends and Family Test (FFT)

- The proportion of positive responses for Inpatients (97.3%), Antenatal (96.1%) and Postnatal Community (66.7%) all improved in September. Postnatal Community is below the Trust target.
- The proportion of positive responses for A&E (96.1%), Births (92.6%), Postnatal Ward (95.7%) and Outpatients (95.7%) have decreased in September. Births are below Trust target.
- Total responses for Births (27) and Outpatients (419) have both increased in September.
- Total Responses for Inpatients (803) and A&E (103) have both decreased in September and both are below the Trust targets.

Complaints

- Total number of complaints received in September 2020 = 76 The breakdown by division is as follows:
  - Surgery 19
  - Medicine 21
  - W&C 26
  - CSS 8
  - Cancer 2
  - Operations 0
- 100% of complaints received were acknowledged within 3 working days in September.
- 100% were responded to within the agreed timeframe in September.
- 22 Complaints remain open prior to July 2020.
- There were 98 open complaints at end of September 2020.

Executive Response

Friends and Family Test (FFT)

- The proportion of positive responses in Sept for IP (97.3%) was up from Aug (95.5%), A&E (96.1%) was down from Aug (98.29%) and OP (95.7%) was also down from Aug (96.0%). All are above their Trust targets in Sept.
- The proportion of positive responses for Antenatal, Births, Postnatal Wards and Community increased overall to 92.8% in Sept, up from 78.5% in Aug. The number of responses across all four categories remained low in Sept (56) compared to pre-pandemic (March 2020 - 234).
- Total responses for Inpatients (803) down from Aug (1031), OP (419) increased slightly from Aug (392).
- Total responses for A&E (149) have decreased each month since June.
- In September we saw another increase in the number of completed paper surveys and online/tablet submissions but this remains below the levels pre-pandemic. The number of post discharge phone calls made to capture feedback decreased in September due to staff annual leave.
- We are now asking the new FFT question 'overall, how was your experience of our service?' and using different collection methods/time, the FFT results since April should not be compared to those prior to March 2020.
- Hospital visiting is still restricted and permitted circumstances remain: if the patient is end of life; supporting someone with a mental health issue, a learning disability, autism, or dementia, where not being present would cause the patient to be distressed; they are a birthing partner accompanying a woman in labour; or they are a parent or appropriate adult visiting their child. Restrictions on visiting continue to be kept under constant review by the patient experience group.
- Whilst hospital visiting is restricted, the 'Stay in Touch' service continues to enable friends and relatives to send messages to inpatients via the Trust website. This service is now provided by the Voluntary Response Team. There were 129 messages and 180 photos delivered to our patients.

Themes from complaints & PALS

- Themes raised by complainants and as a result divisions have action plans to improve the services.
- The Pathology Department are working closely with patients and staff to support and maintain compliance with social distancing.
- Medicine Division are implementing improvements for patient discharges, following a cluster of discharge issues leading to a serious incident being declared. A discharge steering group diving the improvements with a number of work streams.
- Womens Services are supporting women while restrictions are in place due to pandemic to enable them to attend maternity scans and appointments safel; remains under review.
- We are developing an improvement plan to minimise reopened complaints and support complex cases.

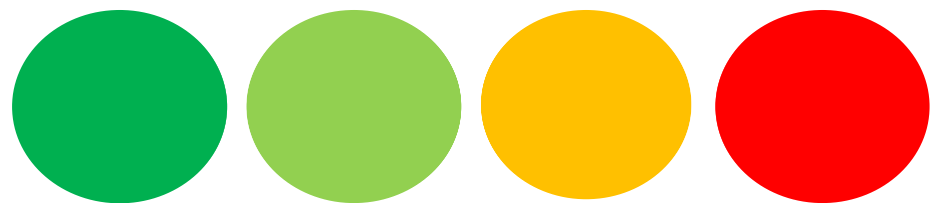
Quality Improvement: Discharges

- Triangulation of complaints, patient feedback and patient safety data has highlighted the requirement to prioritise a review and improvement of our whole systems and processes surrounding the discharge of our patients.
- This is a Trust wide, multi-professional and collaborative approach.

Domain	FFT	Metric	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.3%	97.6%	96.3%	96.7%	96.8%	97.3%	92.7%	90.7%	93.8%	96.8%	95.5%	97.3%	
		Total number of responses	1,778	2,102	2,071	1,847	1,975	1,946	1,288	233	689	705	780	1,031	803	
	A&E	Proportion of positive responses	90%	90.0%	89.3%	88.5%	91.3%	94.4%	93.1%	100.0%	92.9%	89.0%	96.6%	98.3%	96.1%	
		Total number of responses	1,241	727	439	338	424	356	188	8	56	282	149	117	103	
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	n/a	100.0%	n/a	100.0%	0.0%	100.0%	
		Birth Proportion of positive responses	93%	95.6%	90.3%	94.6%	95.4%	93.9%	98.2%	95.7%	n/a	100.0%	100.0%	100.0%	92.6%	
		Birth Total number of responses	137	135	124	93	65	114	110	23	0	2	1	8	27	
		Postnatal ward Proportion of positive responses	93%	84.4%	83.9%	85.9%	86.2%	83.3%	92.7%	95.7%	n/a	100.0%	100.0%	100.0%	95.7%	
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	n/a	100.0%	n/a	66.7%	
	Outpatients	Proportion of positive responses	95%	94.8%	95.0%	95.8%	96.8%	95.9%	96.4%	97.6%	95.8%	99.0%	98.9%	96.2%	95.7%	
		Total number of responses	-	3,127	2,133	1,777	2,429	2,273	1,276	83	271	204	369	392	419	
Complaints		Number of written complaints received	92	120	93	71	90	116	84	27	46	63	85	51	76	
		Rate of written complaints received	1.9	2.2	1.8	1.6	1.8	2.5	2.1	1.0	1.4	1.6	2.1	1.3	1.6	
		Proportion of complaints acknowledged within 3 working days	75%	100%	100%	100%	100%	100%	100%	100%	100%	82%	100%	100%	100%	
		Proportion of complaints responded to within agreed timeframe	80%	88%	92%	90%	80%	88%	88%	83%	95%	98%	99%	100%	100%	

Effective Services

Month 06 | 2020-21



Key Issues

Crude Mortality
- The in-month crude mortality rate decreased from 12.1 deaths per 1,000 admissions in August to 11.9 in September.
- The rolling 12-months crude mortality rate increased slightly again to 13.3 deaths per 1,000 admissions in the 12 months to September, but remains lower than the most recently available national rate of 14.1 deaths per 1,000 admissions (Aug-19 to Jul-20).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has reduced to 60.4 in July.
- The rolling 12-months HSMR reduced slightly to 83.2 in the 12 months to July.
- The Trust remains in the best performing quartile of Trusts for HSMR.
- HSMR is usually available 2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to May has decreased slightly to 89.26.

Re-admissions
- The re-admission rate for 12 months to July has increased d to 10.4% from the June position of 10.3%.

Learning from Deaths
- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant Specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.
- Following the core COVID-19 period the conduct of mortality reviews has now restarted. Our reviewers have worked hard to clear the backlog of reviews and the completion rate for deaths in scope currently stands at 62%.
- In addition to routine reviews 2 areas have been identified for further assurance and learning on the back of the COVID-19 pandemic: (1) Review of COVID-19 patients who died on a readmission within 28 days; (2) Deaths in the Community (COVID-19/nonCOVID-19) within 28 days of discharge. Detail of outcomes will be shared with the Board via the quarterly Learning from Deaths report.
- The monthly Mortality Surveillance Committee recommenced in June 2020 following a 3 month suspension due to COVID-19.
- Work to integrate our mortality review process into the new Datix iCloud platform when this is implemented into the Trust is underway.

Executive Response

Mortality
- Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI.

Crude Mortality
- This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. It is the factor with the most significant impact on HSMR.

Executive Response (continued)

Crude Mortality (continued)
- The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. together with our continued drive to improve the quality of our coding.
- Our crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12 month crude mortality rate was consistently better than the national average. While our rate increased significantly in April 2020 at the start of the peak COVID-19 period, this has steadily decreased and returned to levels similar to pre-COVID-19 period. While our latest rolling 12 month figure has increased slightly, it remains lower than the national rate.

Hospital Standardised Mortality ratio (HSMR)
- Our current HSMR of 83.2 (rolling 12 months to July 2020) positions us in the best performing quartile of Trusts nationally. We remain focussed on driving further improvement.
- Following a number of outlier alerts within the Cardiology basket of diagnosis groups, a collaborative review has commenced between the Specialty and Coding to gain a better understanding and assurance regarding the underlying reasons for this.

Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements to SHMI, there has now been a sustained period of stability. The latest figure of 89.3 (May 2020) sees the Trust extremely well positioned within the 'as expected' band 2. Our position relative to our national peers currently stands at 18th out of acute non-specialist trusts (125).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital for the previously stated reasons that (i) the SHMI model was not designed for pandemic activity which might reduce the robustness of the results if such activity were included (ii) that the creation of temporary specialist hospitals (such as NHS Nightingale) would result in some trusts having more activity than others, making it inappropriate to band trusts as having a higher or lower than expected number of deaths when this would likely be as a result of COVID-19 activity.

Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. The period Mar-April 2020 saw a marked fall in numbers of readmissions, with numbers steadily increasing in May and June. While in March the readmissions represented a reduction as a percentage of admissions, this rate saw significant increases in April/June. The position has stabilised in June/July. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging.

Learning from Deaths
- In addition to the outcomes of cases escalated to Specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.
- Work remains ongoing with Business Informatics and the Head of Coding to gather appropriate data and set up reports to monitor, provide assurance and in time learning regarding COVID-19/non-COVID -19 deaths.

Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

Effective Services

Crude mortality per 1,000 admissions
In-month

45 40 35 30 25 20 15 10 5 0

13 13 14 14 15 15 33 21 15
10 10 12 12 11 10 9 10 8 8 9 11 10 13 11.9

O N D J F M A M J J A S O N D J F M A M J J A S

Crude mortality in-month — Mean — LCL — UCL — National month

Crude mortality per 1,000 admissions
Rolling 12-months

15.0 14.5 14.0 13.5 13.0 12.5 12.0 11.5 11.0 10.5 10.0

13 13 13 12 12 12 11 11 11 11 11 11 11 11 11 11 11 11 12 12 13 13 13 13.3

O N D J F M A M J J A S O N D J F M A M J J A S

Crude mortality rolling 12-months — National rolling 12-months

HSMR
In-month

120 110 100 90 80 70 60 50

93 86 80 82 101 82 91 95 98 84 77 72 83 72 76 74 97 104 80 90 87 83 84 60.4

A S O N D J F M A M J J A S O N D J F M A M J J

HSMR in-month — Mean — LCL — UCL — Standard (100)

HSMR
Rolling 12-months

110 105 100 95 90 85 80

97 96 94 92 91 89 89 88 87 87 87 87 86 85 85 84 84 86 85 85 83 83 84 83.2

A S O N D J F M A M J J A S O N D J F M A M J J

HSMR rolling 12-months — Standard (100)

SHMI
Rolling 12-months - published quarterly

115 110 105 100 95 90

110.3 111.3 109.7 106.2 106.5 105.6 102.3 102.7 102.1 102.9 107.4 105.4 102.7 99.9 94.0

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3

2015-16 2016-17 2017-18 2018-19

SHMI quarterly — Standard (100)

SHMI
New methodology (from Jan-19)

93.0 92.0 91.0 90.0 89.0 88.0

91.9 91.9 91.5 91.2 91.3 90.6 90.5 90.5 90.1 89.9 89.5 89.0 90.5 89.3 90.2 89.3 89.3

Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20

SHMI — Standard (100)

Effective Services

Length of Stay
Elective Length of Stay (days)

Elective LoS — Mean — UCL — LCL

Length of Stay
Non-elective Length of Stay (days)

Non-elective LoS — LCL — UCL — Mean

Re-admissions
Absolute number - Aug-18-Jul-20

Re-admissions — Mean — UCL — LCL

Re-admissions
Re-admission rate - Aug-18-Jul-20

Re-admission rate — Mean — LCL — UCL — National

Specialist Palliative Care
Proportion of patients with whom their preferred place of death was discussed

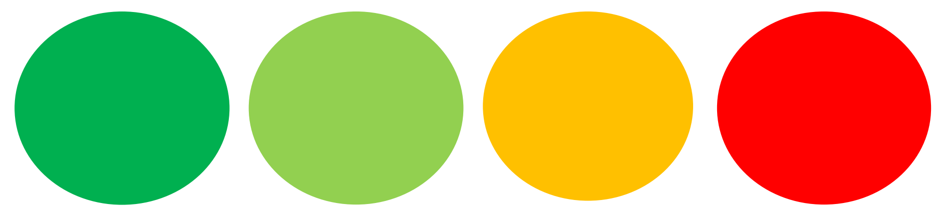
PPD recorded rate — Mean — UCL — LCL

Specialist Palliative Care
Individualised care pathways

Individualised care pathways — Mean — LCL — UCL

Responsive Services

Month 06 | 2020-21



Key Issues

A&E
- Performance for the month of September 2020 was 84.84%.
- There were no 12-hour trolley waits reported in September.

Cancer Waiting Times
- The Trust achieved 7 out of the 8 national targets for cancer performance in August.
- The Trust 62-day performance for August was 85.1%.
- Good progress continues on the speciality cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for September was 59.80%, this is an improvement from the 54.85% reported in August.
- The September backlog was 18,562, a decrease of 2,463 from 21,025 in August.
- There were 735 52-week breaches reported in the September incomplete position, an increase of 131 from the 604 reported in August.

Diagnostics
- DM01 performance for September was 29.38% against the national standard of 1% and the August position of 38.04%.

Stroke
- Stroke performance for September was 50.7%.
- Thrombolysis performance is at 5.3% in September, below the Trust target of 11%.
- Door-to-needle performance has decreased again in September to 25.0%, and remains well below the target of 70%.
- CT 1hr to scanning has decreased to 45.3% in September which is below the Trust target of 50%.
- There were 33 breaches in September. Challenging or complex diagnosis is the reason for 16 of these breaches.

Executive Response

A&E
- September has been a challenging month. The main contributory factor in September has been availability of nursing staff to o pen escalation and increased assessment/short stay capacity. In addition, turnaround times of swab results continued to cause blo cks in assessment flow.
- Non-Admitted performance was sustained. DARTing for walk-ins as well as ambulance arrivals along with regular board rounds continued.
- Ambulance handover continues to be an area of focus. Key initiatives between EofE and community are underway to avoid conveyance. Discussions continue to agree direct to frailty pathways.

Cancer Performance (August)
- In August, the Trust achieved 7 of the 8 national targets and all three 28 day FDS standards for cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31 - day First Treatment, 31-day Subsequent for Radiotherapy, Chemotherapy, Surgery, 28 day FDS 2WW, 28 day FDS Breast Symptom, 28 days for Screening Patients and 62 day Urgent Referral to Treatment of all cancers. Canc er performance is available one month in arrears.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For August 2020 the Trust performance was 95.8%.
- In August 2020, the Trust wide average days wait for first appointment is at 11 days and the majority of patients were seen b etween 8 and 12 days.
- The Trust has not consistently delivered against the Breast Symptomatic national standard which requires 93% of patients refe rred to have attended the 1st Outpatient appointment within 14 days. For August 2020, the Trust performance was 98.7%.

Executive Response (continued)

Cancer Performance (August - continued)
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent surgery. For August 2020 the Trust Chemotherapy performance was 99.4%, the Trust Radiotherapy performance was 97.7% and the Trust subsequent Surgery performance was 96.2%.
- The Trust performance for 31-day to first definitive treatment was 98.2%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In August 2020, the Trust performance for the Faster Diagnosis is 77.4% for the 2ww patients, 83.8% for Breast Symptomatic and 100% for screening patients.
- Reported 62-day performance for August 2020 was pre-sharing 83.3% and post-sharing 85.1%.

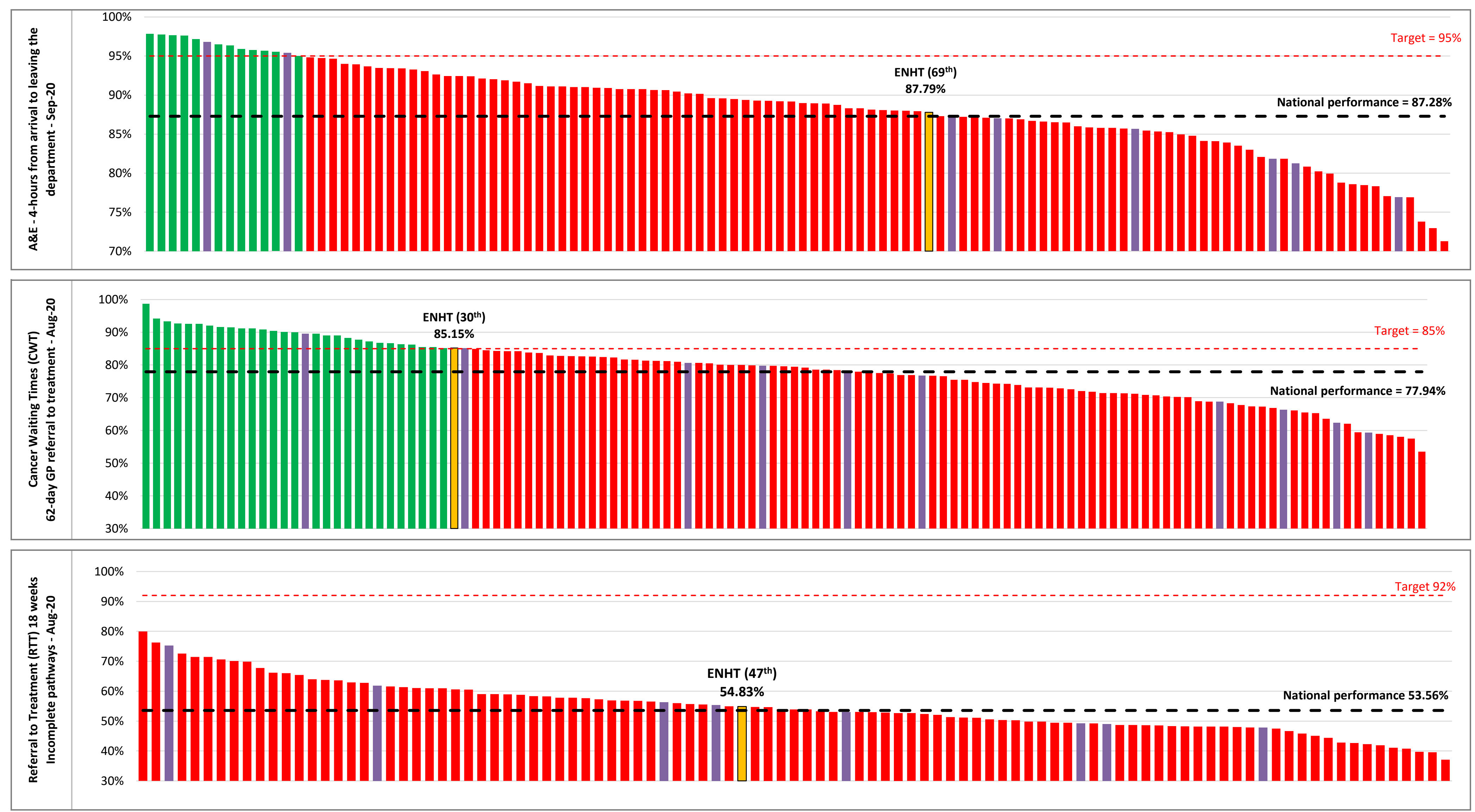
RTT
- Performance improved in August, but remains significantly below the required performance standard of 92%. Backlog pressures have increased due to delays to treatment as a result of the COVID-19 pandemic. The number of patients greater than 52 weeks has increased, but the overall PTL size has reduced in line with the reduction in referrals during the pandemic.
- Clinicians continue to review their elective PTLs, risk-stratified and clinically prioritising patients according to clinical need. All admitted patients are being risk stratified against the Royal College guidelines. Patients are recorded as P1, P2, P3, P4, P5 and P6.
- The Trust has developed a plan to deliver the required activity targets of 100% (of last year's activity) for Outpatients and 90% (of last year's activity) for elective inpatient/day case.
- The independent sector is being utilised to treat our waiting patients.
- There are now 17 theatres operational on the Lister site, plus 4 in the private sector.
- Patients who refuse to shield prior to their treatment remains an issue and is likely to slow performance improvement, and increase the overall size of the PTL and increase patient waiting times.
- Robust weekly RTT PTL management is in place.

Diagnostics
- Capacity has been restored to 100%, across all diagnostics with support from the independent sector.
- The Trust is following a post-COVID-19 diagnostic recovery plan in order to meet the national 100% recovery against last year's activity, and expect DM01 performance to be achieved in the next two months.
- Changes in IPC regulation and the access to more testing have allowed an improvement in list utilisation.
- Transformational work in Gastroenterology has restored throughput to 100% capacity for lower examinations and plans are in place for upper examinations to return to 100% in September. Endoscopy is now functioning in 5 of the 6 available rooms; the 6th room will reopen in October.

Stroke
- Direct impact mainly due to changes in standard operating procedures in ED and CT scanning relating to COVID-19 policies. These impacted on delays to patients' pathways and therefore on indicators within the Stroke performance.
- Impact on of ED activity numbers and the spilt across the Red/Yellow ED - impact on capacity of clerking patients following a DTA within the 4hrs.
- SNNAP rating performance reduction - main contributing factors are - OT/PT non-compliance of establishment in-line with National Specification - business case has been provided for approval to levels to be compliant and therefore provide the requirement of delivery of care in accordance of the SNNAP requirement.
- Direct impact on MDT working due to OT/PT staffing levels.
- 4hr performance under performance against the 63% target - due to number of factors, of the 33 breaches 51% of which relate to challenging diagnostic/Complex case
- Door to Needle performance - Task and Finish group for Thrombolysis pathway - to review and improvement plans for recovery of performance- pathway for CTA requesting to be carried out by Stroke nurses and criteria based approval.
- Thrombolysed within 60-minutes of arrival rate was 25% September. In light of the changes to all services due to COVID-19 both ambulance and ED triage and scanning protocols added some delays. Internal analysis of each case is to be carried out for future learning to be carried forward.
- CT performance - due to the increase demand to CT services - pathway being reviewed for early indication of demand for CT - to support capacity and adherence to the 1hr target.

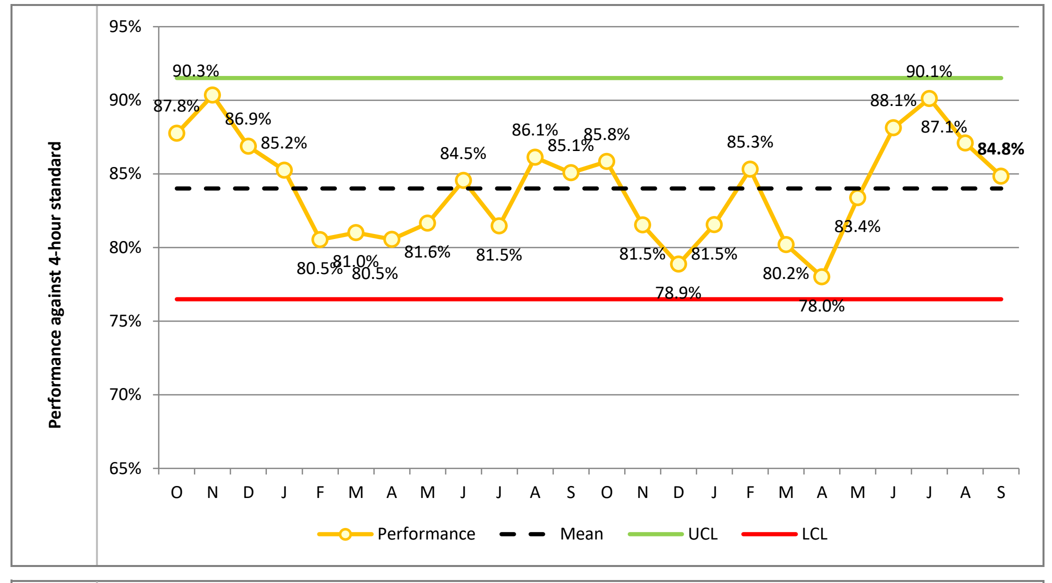
Responsive Services

Trust performance against all Trusts nationally

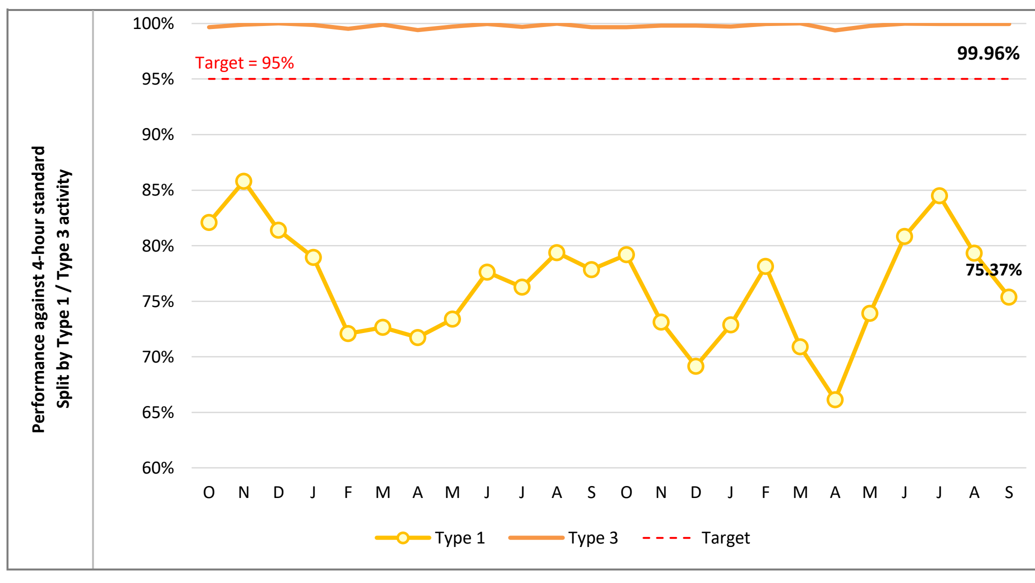


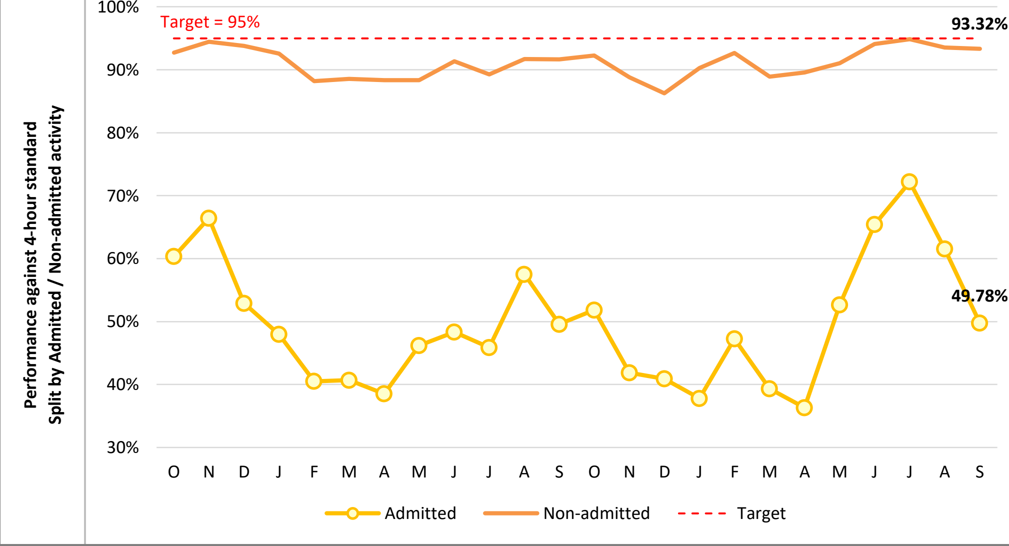
Responsive Services

Emergency Department Performance



Domain	Metric	Target	Aug-20	Sep-20	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	31%	27%	▼	
	Ambulance handover breaches 30 minutes	334	285	317	▲	
	Ambulance handover breaches 60-minutes	73	19	24	▲	
	Attendance to admission conversion rate	-	39.9%	38.9%	▼	
	Time to initial assessment 95th centile	15	38	46	▲	
	Time to treatment Median	60	68	69	▲	
	Left department before being seen for treatment	5%	0.99%	0.77%	▼	
	Unplanned re-attendance rate	5%	5.97%	5.86%	▼	





Responsive Services

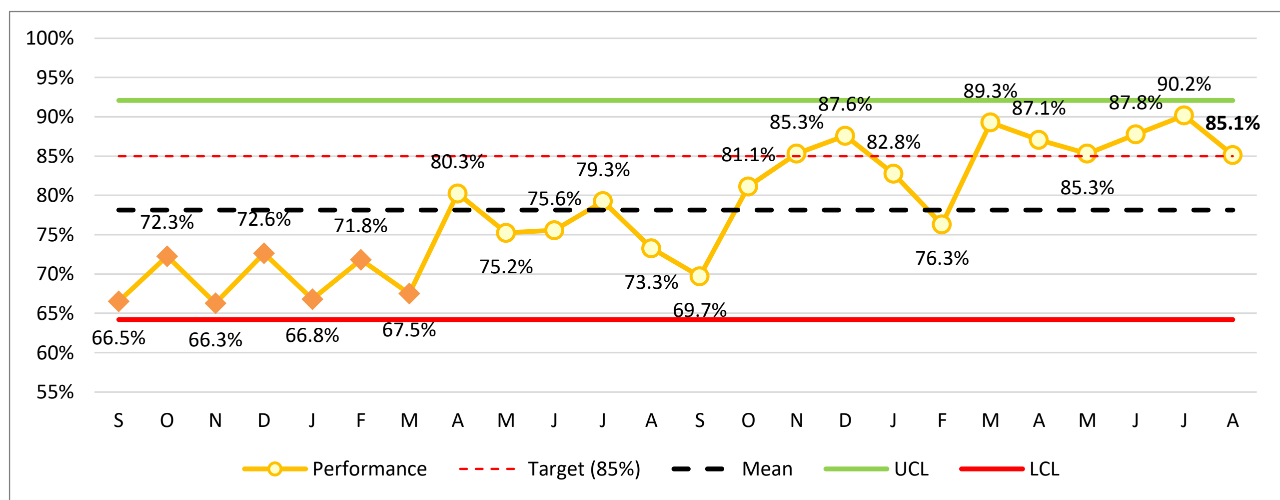
Cancer Waiting Times

12-months' performance - all standards

Standard	Target	2019-20								2020-21					
		Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD
Two week waits Suspected cancer	93%	97.22%	98.50%	97.43%	97.87%	96.47%	98.08%	98.77%	96.95%	97.72%	99.35%	99.32%	92.80%	95.84%	96.61%
Two week waits Breast symptomatic	93%	95.76%	95.37%	98.39%	95.52%	97.96%	95.70%	97.14%	94.10%	79.31%	100.00%	98.59%	97.98%	98.67%	96.89%
31-day First definitive treatment	96%	95.98%	96.88%	99.00%	98.29%	97.82%	98.98%	97.89%	96.57%	98.60%	98.50%	98.63%	94.59%	98.22%	97.64%
31-day subsequent treatment Anti-cancer drugs	98%	99.41%	99.48%	100.00%	99.45%	98.16%	99.49%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	99.78%
31-day subsequent treatment Radiotherapy	94%	97.27%	98.25%	96.54%	99.26%	98.81%	99.36%	98.06%	97.96%	98.56%	98.59%	99.04%	99.30%	97.70%	98.66%
31-day subsequent treatment Surgery	94%	85.19%	65.52%	84.21%	93.55%	79.07%	86.21%	95.83%	83.55%	94.44%	96.15%	100.00%	95.00%	96.15%	96.45%
62-day GP referral to treatment	85%	69.71%	81.14%	85.31%	87.60%	82.76%	76.32%	89.27%	79.82%	87.08%	85.31%	87.78%	90.16%	85.15%	87.07%
62-day Specialist screening service	90%	73.68%	100.00%	69.23%	100.00%	100.00%	44.44%	66.67%	76.67%	38.46%	0.00%	NIL	20.00%	0.00%	26.09%

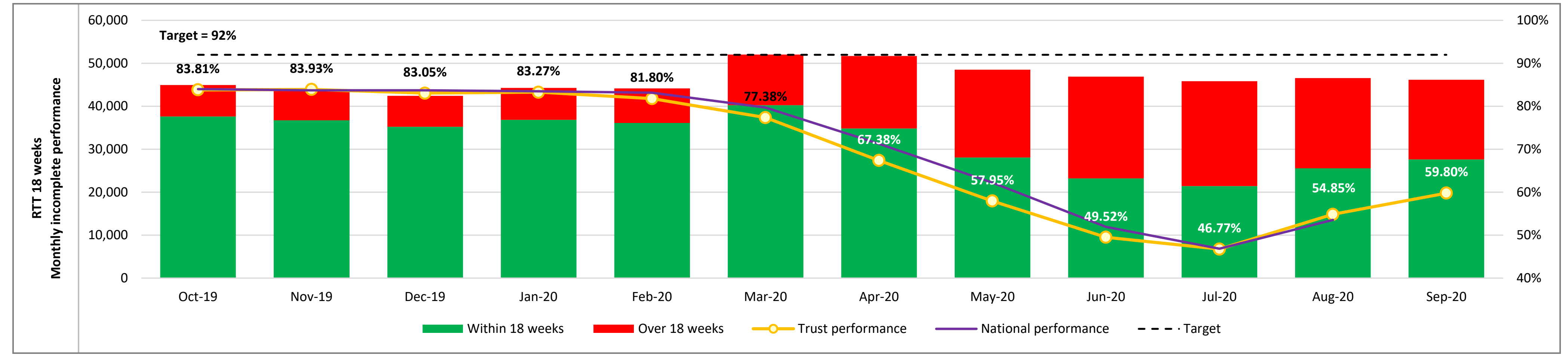
62-day GP referral to treatment Aug-20

Tumour Site	OK	Breach	Total	Perf.
Breast	24.5	1.0	25.5	96.08%
Gynaecology	5.0	0.0	5.0	100.00%
Haematology	4.0	2.0	6.0	66.67%
Head and Neck	3.0	1.0	4.0	75.00%
Lower GI	4.5	4.0	8.5	52.94%
Lung	4.0	2.0	6.0	66.67%
Other	1.0	0.0	1.0	100.00%
Skin	18.0	4.0	22.0	81.82%
Testicular	0.0	0.0	0.0	-
Upper GI	3.0	0.0	3.0	100.00%
Urology	19.0	1.0	20.0	95.00%
Total	**86.0**	**15.0**	**101.0**	**85.15%**



Responsive Services

RTT 18 weeks

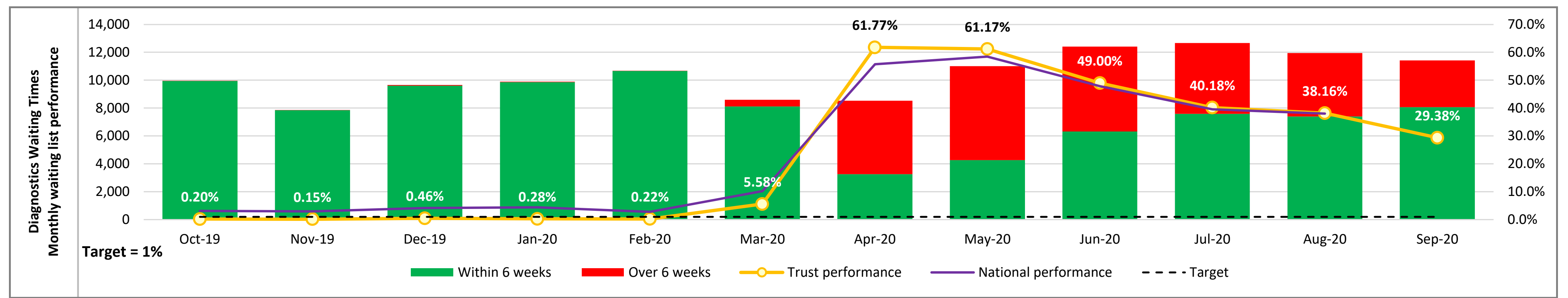


RTT 18 weeks
In-month performance by Specialty - Sep-20

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 40 weeks	Over 52 weeks	
General Surgery	230	49.57%	0	288	70.83%	1	1,880	1,258	3,138	59.91%	235	41	747
Urology	127	83.46%	0	363	88.71%	0	1,457	860	2,317	62.88%	183	13	659
Trauma & Orthopaedics	38	26.32%	1	585	64.10%	10	1,860	1,869	3,729	49.88%	771	249	899
Ear, Nose & Throat (ENT)	97	25.77%	0	570	54.21%	0	1,851	984	2,835	65.29%	121	22	811
Ophthalmology	74	13.51%	0	387	55.81%	0	2,346	2,099	4,445	52.78%	364	14	1,027
Oral Surgery	25	12.00%	0	283	32.16%	0	897	1,110	2,007	44.69%	282	78	385
Plastic Surgery	106	53.77%	0	578	96.89%	0	1,841	260	2,101	87.62%	78	15	1,049
Cardiothoracic Surgery	1	100.00%	0	9	88.89%	0	13	8	21	61.90%	1	0	5
General Medicine	0	-	0	61	98.36%	0	1,055	48	1,103	95.65%	2	0	306
Gastroenterology	122	68.85%	1	227	59.47%	0	2,591	2,502	5,093	50.87%	540	60	929
Cardiology	41	73.17%	0	447	53.47%	0	1,781	1,512	3,293	54.08%	100	4	663
Dermatology	0	-	0	233	76.82%	0	750	171	921	81.43%	12	0	364
Thoracic Medicine	33	93.94%	0	352	66.76%	0	874	853	1,727	50.61%	73	2	392
Neurology	0	-	0	193	80.83%	0	508	160	668	76.05%	19	6	281
Rheumatology	1	100.00%	0	230	26.09%	0	571	378	949	60.17%	28	1	212
Geriatric Medicine	0	-	0	33	90.91%	0	123	83	206	59.71%	2	0	61
Gynaecology	77	66.23%	0	511	75.15%	0	2,189	603	2,792	78.40%	150	34	1,061
Other	84	80.95%	0	2,682	79.34%	12	5,029	3,804	8,833	56.93%	859	196	2,971
Total	**1,056**	**55.97%**	**2**	**8,032**	**70.85%**	**23**	**27,616**	**18,562**	**46,178**	**59.80%**	**3,820**	**735**	**12,822**

Responsive Services

Diagnostics Waiting Times



Diagnostics Waiting Times
In-month performance by Modality - Sep-20

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	973	366	1,339	27.33%	14	1,633	320	11	**1,964**
	Computed Tomography	1,191	134	1,325	10.11%	17	3,464	569	1,335	**5,368**
	Non-obstetric ultrasound	4,050	1,172	5,222	22.44%	52	5,350	369	60	**5,779**
	DEXA Scan	323	395	718	55.01%	112	180	64	1	**245**
Physiological Measurement	Audiology - audiology assessments	29	2	31	6.45%	0	33	0	0	**33**
	Cardiology - echocardiography	599	849	1,448	58.63%	368	550	0	0	**550**
	Neurophysiology - peripheral neurophysiology	47	68	115	59.13%	11	85	0	0	**85**
	Respiratory physiology - sleep studies	34	1	35	2.86%	0	10	0	0	**10**
	Urodynamics - pressures & flows	35	42	77	54.55%	19	44	0	0	**44**
Endoscopy	Colonoscopy	380	121	501	24.15%	36	288	0	0	**288**
	Flexi sigmoidoscopy	128	46	174	26.44%	25	124	0	0	**124**
	Cystoscopy	50	11	61	18.03%	7	113	0	0	**113**
	Gastroscopy	226	149	375	39.73%	95	245	0	0	**245**
Total		**8,065**	**3,356**	**11,421**	**29.38%**	**756**	**12,119**	**1,322**	**1,407**	**14,848**

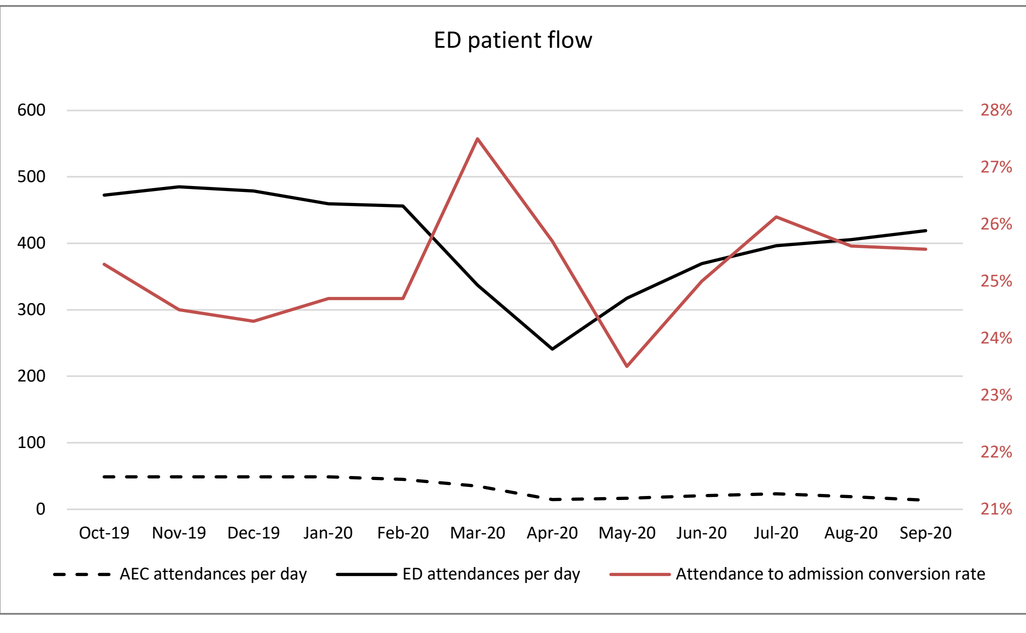
Domain	Metric	2019-20 Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Stroke	Trust SSNAP grade	A	B	B	B	C	C	C	A	B	B	B	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	100.0%	88.9%	85.7%	75.0%	83.3%	75.0%	80%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	
	4-hours direct to Stroke unit from ED Trajectory	-	n/a	n/a	n/a	n/a	n/a	n/a	-	52.1%	72.1%	80.1%	76.6%	63.7%	74.8%	
	4-hours direct to Stroke unit from ED Actual	90%	60.3%	57.1%	54.0%	40.8%	51.9%	67.7%	63%	55.0%	73.8%	66.7%	67.9%	69.9%	50.7%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	90%	59.5%	58.2%	58.7%	41.2%	53.1%	68.8%	63%	55.6%	74.6%	68.8%	69.1%	69.9%	54.5%	
	Number of confirmed Strokes in-month on SSNAP	-	81	71	53	74	54	67	-	57	65	71	58	73	75	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	87.5%	88.7%	90.2%	84.9%	86.8%	97.0%	80%	94.6%	90.8%	92.6%	91.1%	89.0%	89.0%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	65.4%	45.1%	67.9%	52.7%	55.6%	64.2%	50%	59.6%	56.9%	61.4%	46.6%	56.2%	45.3%	
	Scanned within 12-hours - all Strokes	100%	97.5%	95.8%	94.4%	94.6%	94.4%	98.5%	100%	94.7%	98.5%	95.7%	100.0%	94.5%	96.0%	
	% of all stroke patients who receive thrombolysis	11%	12.5%	11.3%	7.7%	5.4%	17.0%	14.9%	11%	14.5%	18.8%	11.4%	15.5%	9.6%	5.3%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	-	70.0%	50.0%	25.0%	25.0%	33.3%	20.0%	70%	0.0%	8.3%	37.5%	44.4%	28.6%	25.0%	
	Discharged with JCP	80%	86.0%	81.1%	85.3%	73.6%	97.0%	78.1%	80%	83.8%	82.1%	93.3%	97.2%	93.3%	92.3%	
	Discharged with ESD	40%	47.7%	61.4%	48.6%	54.2%	55.9%	56.8%	40%	69.0%	54.5%	52.1%	56.1%	56.3%	64.9%	

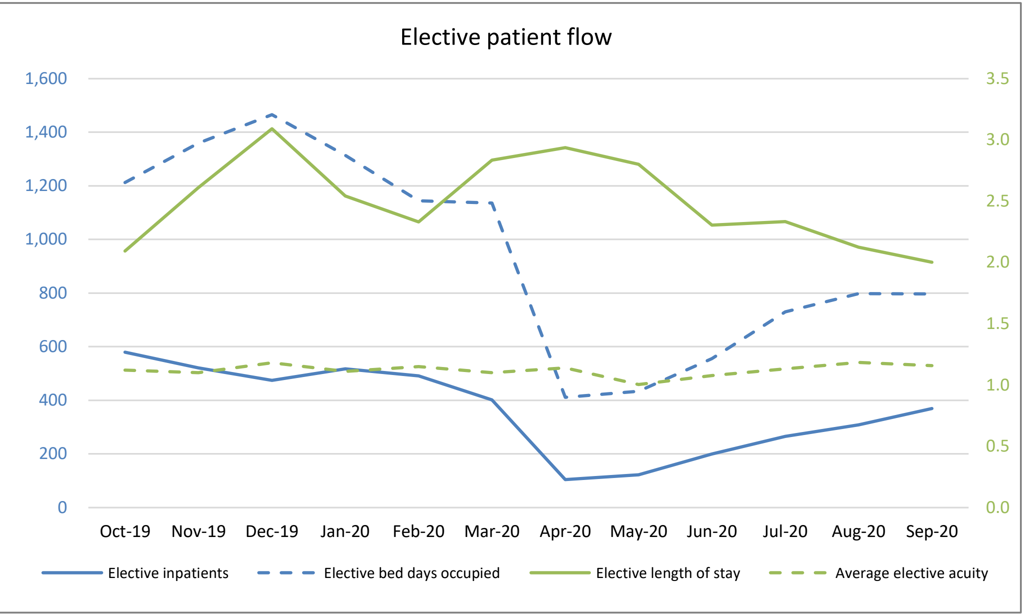
Breaches Sep-20	Breach reasons			
		• Challenging diagnosis / complex cases = **16** • Late referral to stroke services = **3** • Share care - transfers = **3** • Bed capacity = **2**	• Pathway issue = **2** • Inpatient stroke = **2** • Unknown - further validation = **4**	**Total Breaches: 33**

Responsive Services

Patient Flow

Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	14,649	14,556	14,848	14,243	13,228	10,457	7,228	9,838	11,091	12,289	12,578	12,580	
	Attendance to admission conversion rate	25.3%	24.5%	24.3%	24.7%	24.7%	27.5%	25.7%	23.5%	25.0%	26.1%	25.6%	25.6%	
	ED attendances per day	473	485	479	459	456	337	241	317	370	396	406	419	
	AEC attendances per day	49	49	49	49	45	35	15	17	20	23	19	14	
	4-hour target performance %	85.8%	81.5%	78.9%	81.5%	85.3%	80.2%	78.0%	83.4%	88.1%	90.1%	87.1%	84.6%	
	Time to initial assessment 95th centile	51	61	62	64	59	59	40	38	34	35	38	46	
	Ambulance handover breaches 30-minutes	215	360	453	458	274	394	316	235	76	242	285	317	





Responsive Services

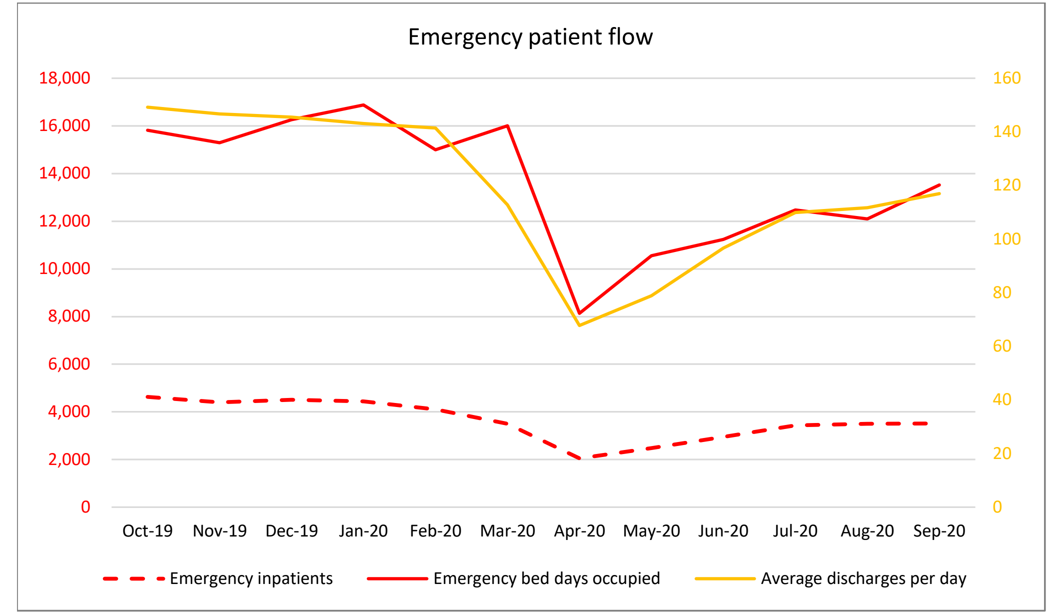
Patient Flow

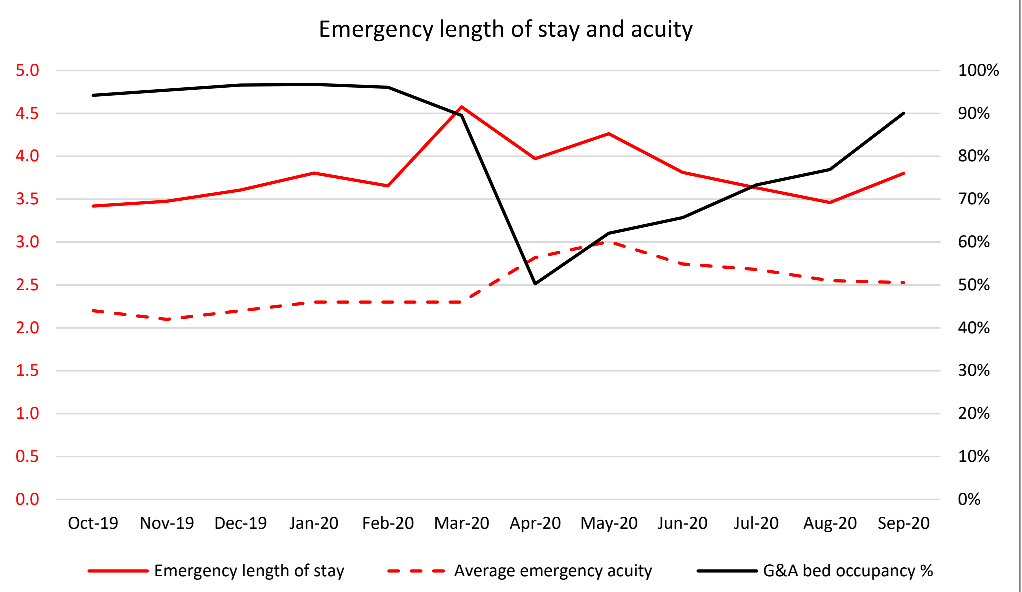
Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Elective Inpatient Flow Indicators	Elective inpatients	579	521	474	517	491	401	104	122	200	265	308	369	
	Elective bed days occupied	1,212	1,359	1,465	1,314	1,144	1,136	411	434	555	730	798	796	
	Elective length of stay	2.1	2.6	3.1	2.5	2.3	2.8	2.9	2.8	2.3	2.3	2.1	2.0	
	Daycase rate %	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	87.9%	86.6%	86.8%	85.2%	87.2%	
	Average elective acuity	1.12	1.10	1.18	1.11	1.15	1.10	1.14	1.00	1.08	1.13	1.18	1.16	
Emergency Flow Indicators	Emergency inpatients	4,624	4,401	4,510	4,438	4,103	3,497	2,047	2,477	2,947	3,433	3,503	3,521	
	Average discharges per day	149	147	145	143	141	113	68	79	97	110	112	117	
	Emergency bed days occupied	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,556	11,232	12,471	12,102	13,521	
	Emergency length of stay	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3	3.8	3.6	3.5	3.8	
	Average emergency acuity	2.2	2.1	2.2	2.3	2.3	2.3	2.8	3.0	2.7	2.7	2.6	2.5	
	G&A bed occupancy %	94%	95%	97%	97%	96%	89%	50%	62%	66%	73%	77%	90%	
	Patients discharged via Discharge Lounge	546	457	383	433	393	311	310	467	488	564	509	518	
	Discharges before midday	12.9%	13.4%	15.0%	13.6%	14.2%	15.3%	11.7%	12.2%	13.8%	11.8%	11.7%	10.7%	
	Weekend discharges	14.2%	16.3%	16.4%	15.2%	16.2%	13.3%	14.2%	15.7%	12.9%	13.9%	15.9%	14.7%	
	Proportion of beds occupied by patients with length of stay over 14 days	20.3%	23.9%	19.4%	21.8%	22.8%	23.8%	13.6%	18.4%	17.8%	15.4%	16.1%	19.2%	
	Proportion of beds occupied by patients with length of stay over 21 days	11.9%	14.6%	10.7%	11.7%	13.7%	13.9%	6.8%	9.1%	9.6%	7.2%	7.6%	10.6%	

Responsive Services

East and North Hertfordshire NHS Trust

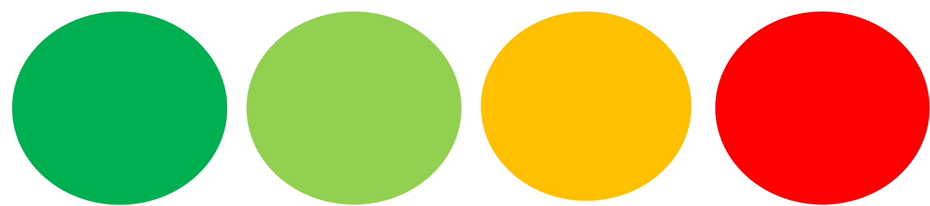
Patient Flow





Well-led Services

Month 06 | 2020-21



Key Issues

Staff Wellbeing
- Sickness absence due to mental health has increased by 156 days in September to 1,799 days absent. This is now outside of the target threshold. The number of days lost due to muscular skeletal issues decreased by 159 days in September to 1,431 days and remains outside of the target threshold.
- Overall sickness absence rates have increased to 4.07% in September, above the target threshold of 3.8%. This figure continues to be an improved position against the same point in the previous year (4.25%).

Staff Experience
- Turnover has reduced slightly to 12.9% compared to last month (12.8%).
- Staff friends and family results both show progress towards the target with 51.1% recommending the Trust as a place to work (up from 47.7%) and 76.0% who would recommend the Trust as a place for care (up from 68.6%) and is above the target threshold of 70%.

Staff Development
- Since the pause to appraisals due to the impact of COVID-19 appraisal rates have continued to fall. In September the compliance rate dropped from 62.53% to 61.0%.

Vacancy Rate
- The vacancy rate for all staff groups remains at 5.7% in September.
- The budgeted clinical unavailability for Nursing & Medical staff continues to decrease from its highest positions in April (39.9%) to 26.3% in September.

Staffing and Pay bill
- Agency spend of 3.3% and Bank Spend of 7.9% are both above their target thresholds. Agency Spend is increasing from previous month, while Bank Spend is decreasing.

Executive Response

- Following the work delivered during the peak of the pandemic to make staff health and wellbeing an organisational priority, the trust has continued to develop its offer to establish long term sustainable support services. The trust has a same day referral service in place for any physical health issue sustained at work or otherwise and will provide physio support where required. This has proved successful in helping to minimise long term absence due to muscular skeletal issues and should help to bring the absence rate to within normal levels. The continued developing relationship with the new employee assistance provider ensures physiological support is available at all times. The Trust is in the final stages of setting up a more specialist trauma therapy service with partner Trusts to support staff with more acute issues. This service will also be set up to support the capability within the organisation in providing physiological support to staff. The Trust has also agreed a roll-out program of training to support staff including mental health first aid and Schwartz round facilitation.

Executive Response (continued)

- The Health at Work team have set plans in place for the implementation of the flu vaccine. The aim is for all staff to receive the flu vaccine, however this year, due to Covid-19, it is important that staff are vaccinated as early as possible. Therefore the trust is targeting an 85% completion rate by the end of October.
- The trust continues to prioritise developing the capability of our leaders while adapting to the new environment for learning. This is being achieved through bite sized learning delivered directly in the working environment. This covers a broad range of topics focused on helping our leaders to lead with compassion. This is part of a common approach that has been launched across the ICS that has been led by ENHT. In August the Trust completed 135 bite sized sessions across the Trust.
- The staff experience group (SEG) continues to focus on the development of initiatives in response to the needs of staff. The August SEG included an hour workshop to discuss how we can develop a culture of civility and respect. Rather than concentrate on things that we already know such as the outcome of last years staff survey and the behaviours that people say they are experiencing, we explored what the cause of these behaviours may be. A detailed paper demonstrating the change programme is due to be presented at the November 2020 Finance Performance and People Committee.
- Staff forums are being set up within the Divisions as a way of people having a direct influence over how the division is responding to feedback in the staff survey and the people pulse survey. Is set up as a safe place for our people to raise concerns, influence how these can be addressed and provide examples of best practice that can be shared across the Trust. Progress reviews are monitored at the Divisional SMTs and quarterly SEG.
- August saw the launch of the new appraisal paperwork. The template moves the appraisal conversation about you, your work, your career and your future. The template is supported by a user guide and tutorials for managers to ensure that a quality conversation takes place and the output is accurately recorded. As August is the first full month adapting to a new process there was an expected dip in the completion rates. However, throughout September and October there will be a focused effort through divisional accountability forums to complete appraisals. From April 2021 the trust will move to an annual window for all staff appraisal to be complete.
- The nursing vacancy has improved and remains a significant focus. There are 88 nurses in the pipeline, which includes 12 newly registered nurses and 35 international nurses. Several pieces of work remain underway which may affect the vacancy rate, these include the bed reconfiguration and the Task and Finish Group on data aligning, which will create a single source of data truth.
- Key to addressing the staffing shortfalls in the coming months is the effective deployment of staff and helping to maximise staffing capacity. Work is underway to review the skill of the workforce to redistribute staff to accommodate organisational and service needs. An example of this is creating resource pools that can be used depending of the triggers identified. Rostering is also a key tool to assess capacity against demand and acuity therefore emphasis is on a speedy rollout plan for both Medical & Non Medical with a target that full rollout by March 21.

Well-led Services

Staff and Workforce Development

East and North Hertfordshire
NHS Trust

Domain	Metric	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Work	Vacancy Rate	6%	7.6%	6.3%	6.8%	7.3%	7.0%	6.6%	6.3%	6.9%	5.9%	5.5%	4.9%	5.7%	5.7%	
	Time to hire (weeks)	10	13.6	13.7	10.5	10.3	11.6	13.3	13.0	9.6	12.9	13.0	13.0	13.0	12.0	
	Recruitment experience	4	tbc	tbc	tbc	tbc	tbc	4.5	4.6	4.5	4.5	4.5	4.5	4.6	4.3	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	tbc		1.34			1.00			1.30			1.40		
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	tbc		1.01			1.50			1.24			0.84		
	Agency Spend (% of WTE)	4%	3.8%	3.7%	3.7%	3.7%	4.0%	4.0%	4.1%	3.6%	3.2%	2.7%	3.6%	3.0%	3.3%	
	Bank Spend (% of WTE)	10%	10.5%	8.9%	10.4%	10.1%	11.5%	10.9%	12.7%	10.9%	8.2%	8.0%	9.6%	9.2%	7.9%	
	% of staff on eRoster	> 90%	tbc	tbc	tbc	tbc	49.0%	49.0%	49.0%	62.0%	62.0%	63.0%	63.0%	63.0%	64.0%	
	% of fully approved rosters in advance of 8 weeks	60%	25.0%	30.0%	29.0%	33.0%	39.0%	32.0%	26.6%	26.7%	33.6%	31.8%	21.3%	16.7%	25.0%	
	% of actual clinical unavailibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	26.7%	24.1%	25.0%	25.5%	27.0%	25.9%	29.8%	39.9%	36.2%	31.6%	27.3%	26.6%	26.3%	
	Pulse survey Flexibility	55%	tbc		53.0%			52.0%			55.5%			59.5%		
Grow	Statutory & mandatory training compliance rate	90%	88.7%	89.9%	89.6%	90.0%	88.6%	88.9%	87.2%	84.0%	79.6%	77.5%	81.8%	81.6%	84.6%	
	Appraisal rate	90%	86.3%	84.7%	87.4%	84.0%	83.1%	82.0%	78.6%	75.0%	71.5%	70.2%	66.8%	62.5%	61.0%	
	Pulse survey Training and development opportunities	55%	tbc		73.0%			55.0%			48.1%			53.0%		
	Pulse survey Talent management	55%	tbc		60.8%			50.0%			53.1%			47.1%		
	Likelihood of training and development opportunities (BAME)	1	tbc		tbc			tbc			tbc			tbc		
	Likelihood of training and development opportunities (Disability)	1	tbc		tbc			tbc			tbc			tbc		
	LMCPD places filled	800 (cum)	12	79	149	120	93	55	57	0	0	0	0	tbc	tbc	

Well-led Services

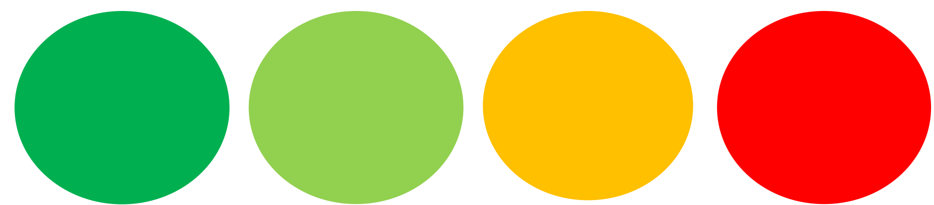
Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Thrive	Pulse survey My leader	75%	tbc	70.3%			79.9%			77.9%			81.4%			
	Pulse survey Harnessing individuality	60%	tbc	51.7%			51.7%			60.8%			59.8%			
	Pulse Survey Not experiencing discrimination	95%	tbc	91.2%			62.2%			71.0%			72.2%			
	Turnover Rate	12.2%	12.8%	12.3%	12.7%	12.8%	12.8%	12.9%	12.9%	12.9%	12.8%	12.6%	12.9%	12.8%	12.9%	
	Model employer targets (% achieved)	100%	tbc	tbc			83%			83%			66%			
	Average length of suspension (days)	20	119	98	12	0	8.5	32	63	62	70	0	0	0	0	
	Average length of Disciplinary (excluding suspensions) (days)	60	105	122	115	77	150	179	248	212	304	183	111	102.5	158.0	
	Average length of Grievance (including dignity at work) (days)	60	112	133	159	92	124	131	163	214	199	0	0	28	2	
Care	Pulse survey Well-being	70%	tbc	66.5%			43.5%			67.0%			74.8%			
	Pulse survey Reasonable adjustments	50%	tbc	tbc			39.2%			67.5%			67.4%			
	Staff FFT Recommend as a place to work	60%	52.6%	58.0%			37.3%			47.7%			51.1%			
	Staff FFT Recommend as a place of care	70%	79.0%	66.0%			64.6%			68.6%			76.0%			
	Sickness Rate	3.8%	4.25%	4.25%	4.23%	4.35%	4.38%	4.15%	6.79%	7.28%	5.51%	3.96%	3.72%	3.72%	4.07%	
	Sickness FTE Days Lost	6,777	6,871	7,199	6,903	7,304	7,380	6,569	11,528	12,002	9,504	6,649	6,543	6,490	6,861	
	Mental health related absence (days lost)	1,650	1,527	1,575	1,258	1,282	1,173	1,011	1,253	1,620	1,640	1,794	1,889	1,643	1,799	
	MSK related absence (days lost)	1,285	1,567	1,217	1,200	1,241	1,278	1,394	1,252	961	1,216	1,152	1,407	1,580	1,431	

Sustainable Services

Month 06 | 2020-21



Sustainable Services

Key Issues

- The Trust reports a Month 56 I&E position of breakeven. This is in line with the expectations of the exceptional COVID financial framework that has been implemented across the NHS in England between 1st April and 31st July 2020. The framework was subsequently extended until the 30th September 2020. Further guidance has now been received in respect of arrangements that will apply over the remainder of the 20/21 financial year, and a briefing paper outlining the impact will be presented to the October Finance Committee.
- In the context of this current financial framework the Trust has received SLA income funding from commissioners in line with the block payment values calculated by NHSE. In addition the Trust has received a fixed 'Top Up' payment of £8.4m YTD direct from the Department of Health to address the difference between its received SLA income and its underlying cost base.
- Furthermore, the Trust has claimed an additional retrospective COVID specific True Up relating to the YTD reporting period. This claim equalises the impact of COVID -19 expenditures net of the underlying financial position to ensure that the Trust is able to report a breakeven position as directed by NHSE. The value of this COVID True Up YTD is £8.0m, the COVID True Up specifically claimed for September was £3.4m.
- The scale of the September True Up has higher than the rate claimed in previous months, this reflects the impact of specific costs that have presented in September, namely back dated medical staffing pay award for 20/21 and significant stepped increases in high cost drug expenditures.
- As previously reported to the Finance Committee and Trust Board a series of data capture and reporting systems have been implemented to ensure that the Trust is accurately and transparently able to report the addition COVID costs that it has occurred in the year to date that cover the specific financial impacts associated with the current incident. These have been detailed in specific reports to the FPPC and are also presented within national monitoring returns.
- In the YTD the Trust calculates that it has incurred specific COVID costs of £12.1m. Of this quantum some £7.0m pertains to additional pay costs to both support its revised clinical model and also to address higher levels of staff sickness and unavailability. The remainder pertains to extra non pay costs incurred such as PPE. In addition the Trust also estimates that in the YTD the value of Category C 'Other Income' receipts was some £3.8m less than a normal 'business as usual ' run rate. The reductions being particularly pronounced in respect of Private Patient and R&D income receipts.
- The volume and value of SLA patient care activity that was undertaken by the Trust in September remains below normal run rate levels. Comparing Month 6 activity delivery with February (the last full pre-COVID month), total A&E attendances were 3% less, Outpatients attendances were 20% less, total bed days occupied by patients 11% less and Day cases & inpatient elective activity was 19% less. Had activity and income been priced and reported on a PbR basis rather than through a block, receipts would have been some £43.0m less than actually received.
- Whilst elective activity levels in September remained considerably below normal prior year levels across most Points of Delivery in the Trust, they did nevertheless represent a significant improvement upon August level.

Executive Response

- The Trust has adapted its financial governance regime in response to the current exceptional financial framework arrangements that have been introduced. A summary of financial control and governance changes that have been made were presented to the Finance and Performance Committee at its April meeting. These arrangements will continue to be monitored via regular reports to both this Committee and also to the Audit Committee going forward across the duration of the incident.
- The Trust has also refined and developed its financial reporting arrangements to provide additional granularity in respect of the value and type of optional costs incurred by the Trust as it supports necessary COVID capacity and its associated impacts. These are reflected in amended reports to Committees, the Trust Board and internal budget holders and management teams.
- In respect of national Phase 3 recovery guidance the Trust worked across August and September to carefully build a clear and accurate understanding of its existing levels of baseline elective and emergency capacity within the constraints of the COVID operating environment. The Trust has then agreed actions to supplement this activity and capacity to enable it to meet the targets and priorities identified with Phase 3 recovery guidelines. As such the Trust has proposed a plan that delivers an elective plan in the second half of the year that is compliant with targets, and similarly that it is able to deliver emergency and urgent services across the winter period.
- However, the Trust is also clear that the capacity that will be required to achieve these goals is significantly greater than the financial resources that are expected to be provided via base block payments and the prospective COVID top up envelope. These resources will be needed to be supplemented with access to COVID system resources. The Trust has included these additional capacity costs within its draft financial returns. Given the recent confirmation of system level resources that will be available in to support operational plans the Trust will engage with system colleagues in respect of funding arrangements. An update to confirm progress will be provided to the October FPPC meeting.
- The Trust is also mindful of the impact of the 'elective incentive scheme'. In order to ensure that the Trust and the system are able to manage the risk of activity underperformance the Trust has introduced a weekly activity delivery group. This is led by the Director of Finance, support by finance and information specialists and attended by senior operational managers. This will monitor and track activity delivery and agree and implement remedial actions where appropriate.
- Availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the current COVID-19 incident. It is important therefore that the Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. This will be an important competent in the Trust's recovery process.

Sustainable Services

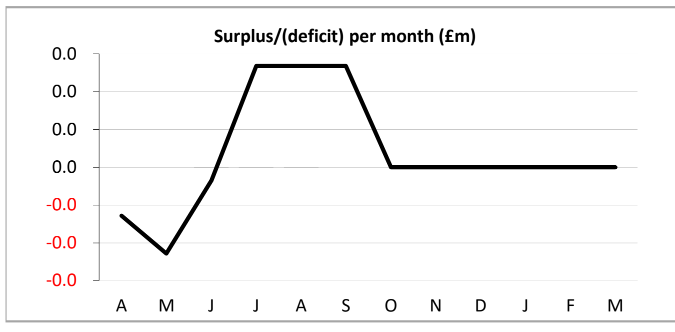
Finance Plan Performance

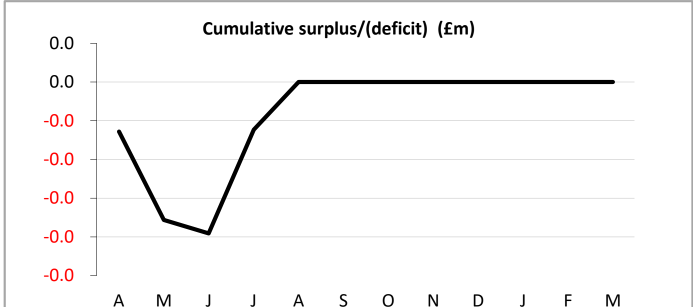
Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.4	34.6	33.8	36.6	33.4	36.6	36.2	36.2	36.2	36.2	35.9	36.2		216.0	216.8	0.8
	Other Income Earned	5.2	4.3	3.6	4.5	4.1	8.0	2.3	2.5	2.2	2.5	2.5	2.8		29.2	14.7	-14.5
	Pay Costs	24.6	24.6	24.7	24.9	24.5	27.4	26.2	25.7	24.9	25.4	25.5	26.8		152.5	154.5	2.0
	Non Pay Costs inc Financing	16.3	15.3	15.8	16.1	15.0	17.5	14.9	14.4	15.2	16.2	15.9	17.0		92.6	93.6	1.0
	Underlying Surplus / (Deficit)	0.6	-1.0	-3.1	0.0	-1.9	-0.3	-2.6	-1.4	-1.8	-3.0	-3.0	-4.8		0.0	-16.6	-16.6
	Top up payments	-	-	-	-	-	-	2.6	1.4	1.8	3.0	3.0	4.8		0.0	16.6	16.6
	Retained Surplus / Deficit	2.3	0.632	-1.4	1.9	-0.0	1.6	-0.0	0.0	-0.0	-0.0	-0.0	-0.0		0.0	-0.0	0.0
Paybill Metrics	Substantive Pay Costs	21.2	21.2	21.3	21.2	20.9	22.9	22.6	22.4	22.3	22.1	22.3	23.8		142.7	135.5	-7.2
	Premium Pay Costs Overtime & WLI	0.3	0.3	0.3	0.3	0.3	0.4	0.2	0.1	0.0	0.0	0.1	0.1		0.7	0.4	-0.2
	Premium Pay Costs Bank Costs	2.2	2.2	2.2	2.5	2.3	2.9	2.6	2.3	2.0	2.4	2.3	2.1		6.8	13.7	6.9
	Premium Pay Costs Agency Costs	0.9	0.9	0.9	1.0	1.0	1.2	0.9	0.8	0.7	0.9	0.8	0.9		2.4	4.9	2.5
	Premium Pay Costs As % of Paybill	13.9%	13.8%	13.8%	14.8%	14.5%	16.5%	14.0%	12.7%	10.7%	13.0%	12.4%	11.1%		6.4%	12.3%	5.9%

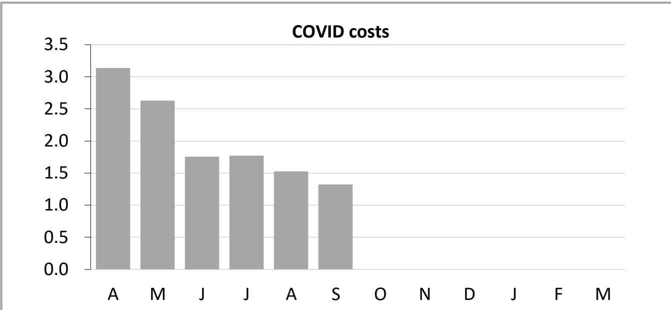
Sustainable Services

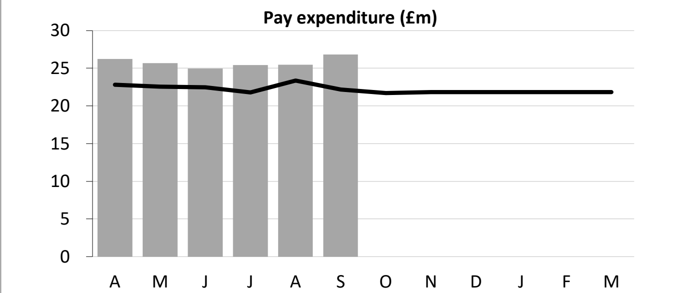
Finance Plan Performance

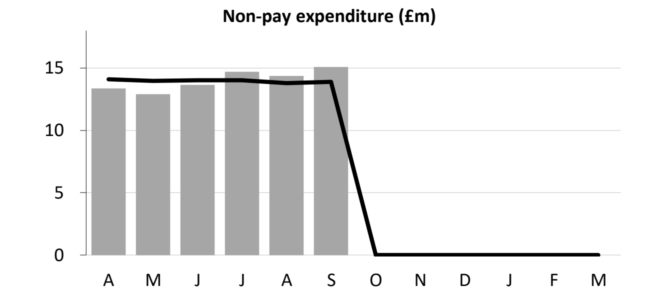
Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	4	4	4	4	4	4	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Liquid Ratio (Days)	4	4	4	4	4	4	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	I&E Margin	3	3	3	3	3	2	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Distance from Plan	1	1	1	1	1	1	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Agency Spend vs. Ceiling	1	1	1	1	1	1	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	
	Overall Finance Metric	3	3	3	3	3	3	n/a	n/a	n/a	n/a	n/a	n/a		1	n/a	











Sustainable Services

SLA Contracts - Income Performance

By Point of Delivery	In-Month Planned Income	In-Month Actual Income	In-Month Income Variance	YTD Planned Income	YTD Actual Income	YTD Income Variance
A&E Attendances	2,329	2,131	-197	13,973	11,299	-2,674
Daycases	3,091	2,344	-748	18,547	8,495	-10,052
Inpatient Elective	1,918	1,348	-570	11,507	5,275	-6,232
Inpatient Non Elective	9,712	8,519	-1,193	58,271	45,976	-12,296
Maternity	2,546	2,317	-229	15,276	14,642	-635
Other	3,684	3,360	-324	22,104	18,790	-3,314
Outpatient First	2,106	1,855	-251	12,635	9,374	-3,261
Outpatient Follow Ups	2,274	2,380	106	13,645	11,078	-2,566
Outpatient Procedures	1,156	914	-242	6,936	3,666	-3,270
NHSE Block Impact	-280	3,014	14,662	-1,677	43,628	14,662
Other SLAs	65	65	0	388	388	0
Block	843	843	0	5,056	5,056	0
Drugs & Devices	3,682	4,370	688	22,092	22,388	295
Chemotherapy Delivery	607	558	-49	3,639	3,080	-559
Radiotherapy	1,216	1,036	-180	7,294	6,464	-830
Renal Dialysis	1,182	1,084	-98	7,092	6,862	-230
Total	36,130	36,137	7	216,778	216,460	-318

By Commissioner	In-Month Planned Income	In-Month Actual Income	In-Month Income Variance	YTD Planned Income	YTD Actual Income	YTD Income Variance
East & North Herts CCG	21,634	21,634	0	129,807	129,808	1
Specialist Commissioning	8,167	8,204	37	49,003	46,394	-2,609
Bedfordshire CCG	2,486	2,486	0	14,917	14,917	1
Herts Valleys CCG	1,404	1,404	0	8,423	8,423	0
Cancer Drugs Fund	426	762	336	2,558	4,263	1,705
Luton CCG	326	326	0	1,957	1,957	0
PH - Screening	379	176	-203	2,273	847	-1,426
Other	1,307	1,145	-162	7,841	9,850	2,009

By Division	In-Month Planned Income	In-Month Actual Income	In-Month Income Variance	YTD Planned Income	YTD Actual Income	YTD Income Variance
Cancer Services	6,624	7,132	508	39,746	38,028	-1,718
Medicine	12,116	10,906	-1,209	72,694	59,942	-12,752
Women & Children	5,051	4,558	-493	30,307	26,501	-3,806
Clinical Services	2,160	2,165	5	12,962	10,299	-2,663
Surgery	10,544	8,278	-2,266	63,266	37,588	-25,678
NHSE Block Impact	-280	3,014	3,293	-1,677	41,338	43,015
Other	-86	83	170	-519	2,763	3,282

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	13,745	13,769	14,126	13,467	12,432	9,714	6,656	9,155	10,251	11,423	11,873	12,080		80,367	61,438	-18,929
	Chemotherapy Atts	2,348	2,261	2,241	2,528	2,177	2,049	1,631	1,634	2,192	2,354	2,145	2,072		13,616	12,028	-1,588
	Critical Care (Adult) - OBD's	584	668	633	707	460	619	700	728	488	512	737	466		3,701	3,631	-70
	Critical Care (Paeds) - OBD's	605	498	583	558	265	416	448	509	434	546	494	342		3,330	2,773	-557
	Daycases	4,070	3,841	3,215	3,662	3,420	2,504	852	1,127	1,551	2,051	2,147	2,773		23,745	10,501	-13,244
	Elective Inpatients	579	521	474	526	491	401	140	155	241	313	374	407		3,370	1,630	-1,740
	Emergency Inpatients	4,624	4,401	4,510	4,465	4,103	3,497	2,047	2,477	2,947	3,433	3,503	3,521		25,693	17,928	-7,765
	Home Dialysis	144	150	164	160	148	160	147	140	139	150	99	112		992	787	-205
	Hospital Dialysis	6,313	6,264	6,627	6,444	6,288	6,549	6,172	6,323	6,547	6,737	6,130	6,107		38,660	38,016	-644
	Maternity Births	467	440	436	414	414	420	393	443	445	443	433	405		2,653	2,562	-91
	Maternity Bookings	518	507	475	530	514	481	517	468	498	550	466	471		3,003	2,970	-33
	Outpatient First	9,788	9,312	8,354	9,598	8,867	7,228	3,033	5,961	5,631	5,703	5,706	6,378		53,583	32,412	-21,171
	Outpatient Follow Up	18,795	17,931	15,640	18,627	16,347	14,389	6,549	6,463	9,311	11,385	11,876	14,287		103,698	59,871	-43,827
	Outpatient procedures	8,029	6,750	6,449	7,799	7,053	4,749	1,725	2,037	3,128	4,065	4,655	5,236		44,447	20,846	-23,601
	Radiotherapy Fractions	4,764	4,800	4,828	5,232	5,061	4,772	4,663	4,379	4,190	3,927	3,394	3,892		29,687	24,445	-5,242

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	202	198	231	195	196	138	52	67	81	103	126	145		215	96	-119
	Emergency Spells per Day	145	143	142	139	143	109	65	76	94	107	109	113		140	98	-42
	ED Attendances per Day	443	459	456	434	444	313	222	295	342	368	383	403		439	336	-103
	Outpatient Atts per Working Day	1,592	1,545	1,903	1,642	1,613	1,256	595	761	821	920	1,112	1,177		1,601	898	-703
	Elective Bed Days Used	1,212	1,359	1,465	1,314	1,144	1,136	411	434	555	730	798	796		8,285	3,724	-4,561
	Emergency Bed Days Used	15,821	15,290	16,258	16,883	15,004	16,000	8,134	10,556	11,232	12,471	12,102	13,521		94,358	68,016	-26,342
Efficiency	Admission Rate from A&E	25%	24%	24%	25%	25%	27%	26%	24%	25%	26%	26%	26%		23.3%	25.3%	2.0%
	Emergency - Length of Stay	3.4	3.5	3.6	3.8	3.7	4.6	4.0	4.3	3.8	3.6	3.5	3.8		3.8	3.8	0.0
	Emergency - Casemix Value	2,222	2,116	2,213	2,331	2,264	2,382	2,819	3,005	2,744	2,683	2,553	2,527		2,297	2,722	425
	Elective - Length of Stay	2.1	2.6	3.1	2.5	2.3	2.8	2.9	2.8	2.3	2.3	2.1	2.0		2.5	2.4	-0.1
	Elective - Casemix Value	1,121	1,104	1,180	1,110	1,145	1,103	1,140	1,004	1,077	1,131	1,183	1,158		1,105	1,116	11
	Elective Surgical DC Rate %	87.5%	88.1%	87.2%	88.0%	87.4%	86.2%	85.9%	87.9%	86.6%	86.8%	85.2%	87.2%		85%	87%	1.6%
	Outpatient DNA Rate % - 1st	11.0%	11.6%	12.1%	11.7%	11.6%	13.0%	10.8%	12.5%	13.7%	13.7%	12.0%	10.9%		6.5%	12.3%	5.8%
	Outpatient DNA Rate % - FUP	7.3%	7.1%	6.8%	6.1%	6.4%	7.4%	5.7%	5.5%	13.7%	13.7%	12.0%	10.9%		7.5%	5.9%	-1.6%
	Outpatient Cancel Rate % - Patient	10.1%	9.6%	10.9%	9.8%	9.9%	12.3%	5.7%	3.0%	2.9%	3.3%	4.7%	5.5%		10.4%	4.2%	-6.2%

Sustainable Services

Activity and Productivity

Domain	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	6.3%	6.6%	6.7%	6.6%	7.0%	12.7%	28.2%	25.5%	17.7%	14.0%	10.3%	9.6%		6.9%	14.7%	7.8%
	Outpatients - 1st to FUP Ratio	1.9	1.9	1.9	1.9	1.8	2.0	2.2	1.1	1.7	2.0	2.1	2.2		1.9	1.8	-0.1
	Theatres - Ave Cases Per Hour	2.8	3.0	2.7	2.8	2.7	2.6	1.2	1.5	1.5	1.9	2.0	2.0		2.9	1.6	-1.2
	Theatres - Utilisation of Sessions	83%	88%	84%	87%	87%	81%	67%	75%	74%	75%	75%	78%		85%	74%	-11%
	Theatres - Ave Late Start (mins)	16	17	17	18	17	21	29	31	22	24	24	22		27	25	-1.3
	Theatres - Ave Early Finishes (mins)	38	25	36	31	32	41	36	66	65	71	58	56		39	59	19.3

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

Activity Measures	2019-20 YTD	2020-21 YTD	Change
Emergency Department Attendances	79,186	61,438	-17,748
Emergency Department Ave Daily Atts	433	336	-97
Admission Rate from ED %	23.2%	25.3%	2%
Non Elective Inpatient Spells	24,862	17,928	-6,934
Ave Daily Non Elective Spells	136	98	-38
Daycase Spells	21,914	10,501	-11,413
Elective Inpatient Spells	3,324	1,630	-1,694
Ave Daily Planned Spells	138	66	-72
Day Case Rate	87%	87%	0%
Adult & Paeds Critical Care Bed Days	6,635	6,404	-231
Outpatient First Attendances	53,192	32,412	-20,780
Outpatient Follow Up Attendances	103,419	59,871	-43,548
Outpatient First to Follow Up Ratio	1.9	1.8	-0.1
Outpatient Procedures	45,557	20,846	-24,711
Ave Daily Outpatient Attendances	1,105	618	-487

Workforce Measures	2019-20 YTD	2020-21 YTD	Change
Average Monthly WTE's Utilised	5,857	5,122	-735
Average YTD Pay Cost per WTE	25,187	30,172	19.8%
Staff Turnover	12.8%	12.8%	0.0%
Vacancy WTE's	863	5,714	4,851
Vacancy Rate	14.1%	25.2%	11.2%
Sickness Days Lost	38,202	48,049	9,847
Sickness Rate	4.1%	4.7%	0.6%
Agency Spend- £m's	6.3	4.9	-1.4
Temp Spend as % of Pay Costs	4.3%	3.2%	-1.1%
Ave Monthly Consultant WTE's Worked	327.1	345.6	18.5
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,460.8	2,489.3	28.5
Qual : Unqualified Staff Ratio	26 : 10	24 : 10	-0.1
Ave Monthly A&C and Senior Managers WTE's	1,299	1,332	33
A&C and Senior Managers % of Total WTE's	22.2%	11.0%	-11.1%

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

Capacity Measures	2019-20 YTD	2020-21 YTD	Change
Non Elective LoS	3.8	3.8	0.0
Elective LoS	2.5	2.4	-0.1
Occupied Bed Days	102,643	71,740	-30,903
Adult Critical Care Bed Days	3,629	3,631	2
Paediatric Critical Care Bed Days	3,006	2,773	-233
Outpatient DNA Rate	8%	6%	-2.2%
Outpatient Utilisation Rate	60%	28%	-31.8%
Total Cancellations	65,615	66,117	502
Theatres - Ave Cases per Hour	2.7	1.6	-1.0
Theatres - Ave Session Utilisation	80%	74%	-6.0%
Theatres - Ave Late Start (mins)	24	25	1
Theatres - Ave Early Finishes (mins)	35.5	58.7	23
Radiology Examinations	209,312	154,332	-54,980
Drug Expenditure (excl HCD & ENH Pharma) - £000s	4,512	4,184	-328
High Cost Drug Expenditure - £000s	20,744	22,135	1,391

Finance & Quality Measures	2019-20 YTD	2020-21 YTD	Change
Profitability - £000s	-3,381	25	2,766.3
Monthly SLA Income £000s	34,532	36,134	2,186
Monthly Clinical Income per Consultant WTE	£105,560	£104,548	£1,801
High Cost Drug Spend per Consultant WTE	£63,411	£64,042	-£3,065
Average Income per Elective Spell	£1,134	£1,116	-£68
Average Income per Non Elective Spell	£2,355	£2,722	£557
Average Income per ED attendance	£174	£185	£21
Average Income per Outpatient Attendance	£130	£130	-£18
Ave NEL Coding Depth per Spell	n/a	n/a	n/a
Procedures Not Carried Out	1,196	612	-263
Best Practice HRGs (% of all Spells)	2.2%	4.4%	3.5%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jun-20	11,243	9,961	-1,282
Non-elective re-admissions within 30 days % Rolling 12-months to Jun-20	8.73%	8.99%	0.27%
SLA Contract Fines - £000's	10	0	-10

Sustainable Services

HFMA Finance Training Compliance

Division	Not started	In progress	Passed	Total	%
CANCER	34	3	47	84	56%
CSS	12	1	41	54	76%
DATA QUALITY/CODING	0	1	4	5	80%
FACILITIES	1	1	1	3	33%
FINANCE	7	2	125	134	93%
FINANCE - INFORMATION	2	0	12	14	86%
FINANCE - IT	0	2	3	5	60%
MEDICINE	99	16	104	219	47%
NURSING PRACTICE	8	0	0	8	0%
PMO	0	0	48	48	100%
STRATEGY	3	0	0	3	0%
SURGICAL	62	5	54	121	45%
W&C	35	5	68	108	63%
WORKFORCE	7	0	4	11	36%
FINANCE - INCOME	0	0	5	5	100%
#N/A	5	0	0	5	0%
(blank)	190	23	294	507	58%
Grand Total	**465**	**59**	**810**	**1,334**	61%

Phase 3 Recovery & COVID Update

Trust Board

4th November 2020

Phase 3 Recovery

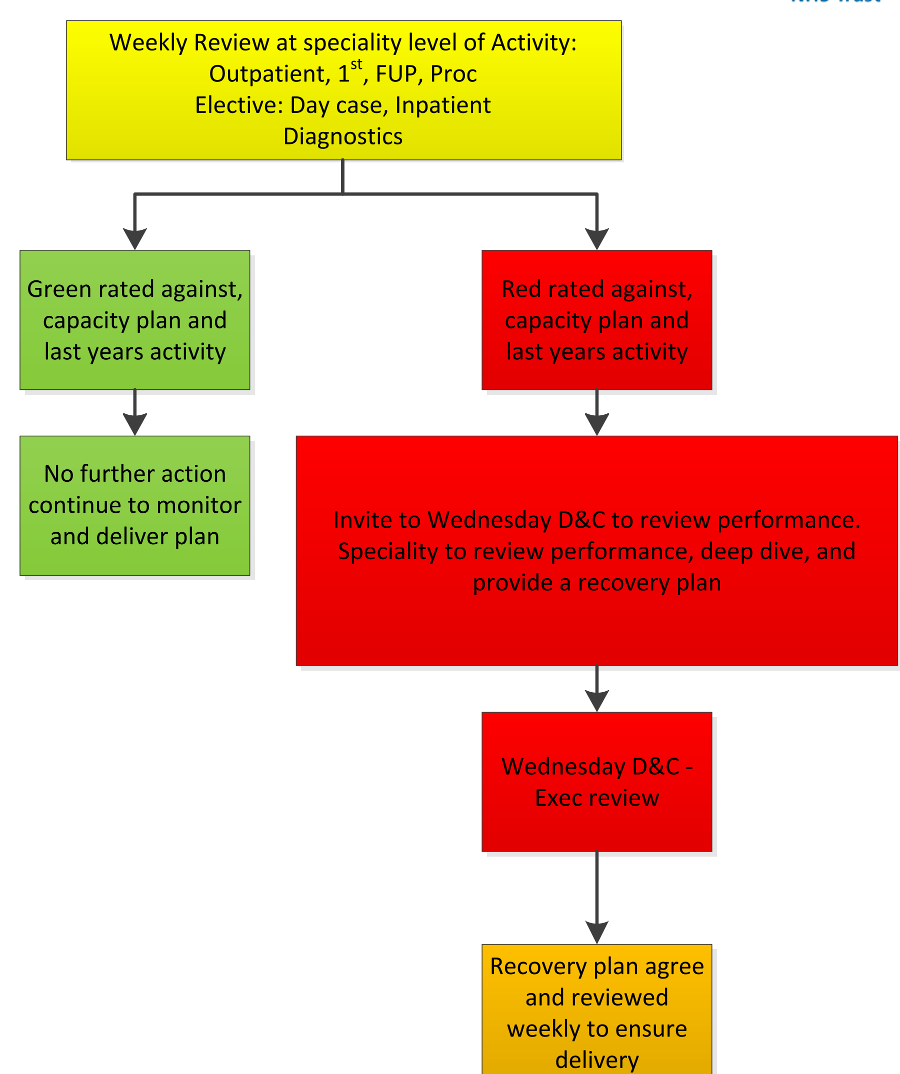
- The expectation for Phase 3 recovery from the COVID-19 pandemic is for organisations to return to near-normal levels of activity between now and winter including;
  - In October, delivering at least 90% of last year's activity for both overnight electives and for outpatient/day-case procedures;
  - Delivering 100% of last year's levels of MRI/CT and endoscopy procedures by October; and
  - Outpatient activity to be 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the remainder of the year.
- ENHT undertook detailed demand and capacity modelling in order to inform its Phase 3 submissions, and to identify additional actions that would be required in order to bridge any gap in delivery against the Phase 3 targets.

Phase 3 – Operational plan

- Patient risk stratification and prioritisation – clinical need
- Independent sector – 30 sessions per week, low risk patients
- Additional sessions – utilising evenings weekends where possible
- Theatre and Outpatient efficiency/throughput
- Use of non face to face clinics
- Patient risk stratification and prioritisation
- Demand and capacity analysis – Gastroenterology, understanding the need

Phase 3 – Monitoring and Review

- Services signed working to plan, with agreeing investment as required;
- Escalation process in place for specialties who fail to meet plan with support given to recover activity levels;
- Daily monitoring of activity delivered of all services is available via Qlikview;
- Weekly review at service line. If service is in a negative position – greater than -10 the General Manager will attend the weekly Activity Recovery Meeting to articulate:
  - the reasons for non delivery
  - the recovery plan and trajectory
- If the service line is unable to deliver or recover then another service line within the division will be required to over deliver against its original plan.



Quality | People | Pathways | Ease of use | Sustainability

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

Phase 3 - Performance Overview

Day cases

7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month

Actual | Capacity - Core | Capacity - WLI | Capacity - IS | 2019-20 | Target

Elective

700
600
500
400
300
200
100
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month

Actual | Capacity - Core | Capacity - WLI | Capacity - IS | 2019-20 | Target

Total | First | Follow-up | **Outpatient Attendances**

50,000
40,000
30,000
20,000
10,000
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month

Actual | Capacity - Core | Capacity - WLI | Capacity - IS | 2019-20 | Target

Outpatient Procedures

10,000
8,000
6,000
4,000
2,000
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month

Actual | Capacity - Core | Capacity - WLI | Capacity - IS | 2019-20 | Target

Quality | People | Pathways | Ease of use | Sustainability

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

Risks to delivery

- Winter and COVID pressures – the likelihood that there will be an increase in non elective pathways
- Critical Care Capacity – theatres staff to support additional (above baseline) ventilated capacity
- Testing – maintaining current levels
- Shielding – reluctance for patients to shield prior to treatment
- Patients not attending due to COVID fear
- Pathway changes prior to COVID and impact on outpatient procedures, which have been replaced by one stop clinics
- Staffing – sickness, shielding

Quality People Pathways Ease of use Sustainability

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

COVID Planning (1)

- A table top exercise to discuss preparations for a COVID second wave was held in September 2020 with key leads across the Trust, and identified initial constraints and triggers that would support the hospital's COVID preparedness;

- The Trust has established the following in order to prepare for, and monitor, the emerging position with regards to the COVID second wave:

  - A daily 8:45 huddle across operational, clinical and nursing teams to understand the current COVID position within the Trust, and any actions that are required;
  - A COVID second surge dashboard that has a set of agreed internal metrics and triggers (clinical, operational and staffing) to support identification of a changing COVID position and supportive actions;
  - Key forums to review IPC guidance and processes, PPE stocks and testing;
  - The ability to quickly reintroduce successful measures from the first COVID way, through the flat pack approach that was taken during the summer months;
  - Development of a cohorting plan for COVID patients as the prevalence of COVID positive patients increases within the Trust;
  - The Trust has been asked to contribute to the Regional ITU Surge Centres workforce plans.

COVID Planning (2)

- Over the last few months, the Trust has received additional ventilators, and is in a position where it could support 24 ventilated patients in Critical Care before needing to pull staffing from theatres to support ongoing delivery;
- Preparations for Covid are incorporated into the Weekend and Winter Planning meetings to ensure that there is oversight;
- The Trust submits a daily COVID status report covering new and total COVID cases in both general and critical care beds; Staff absences due to COVID related issues; COVID related deaths and mortuary capacity;
- A dashboard that identifies changes in the internal position linked to COVID has been developed to support identification of triggers and to support timely action, has been developed.

COVID Vaccination Programme

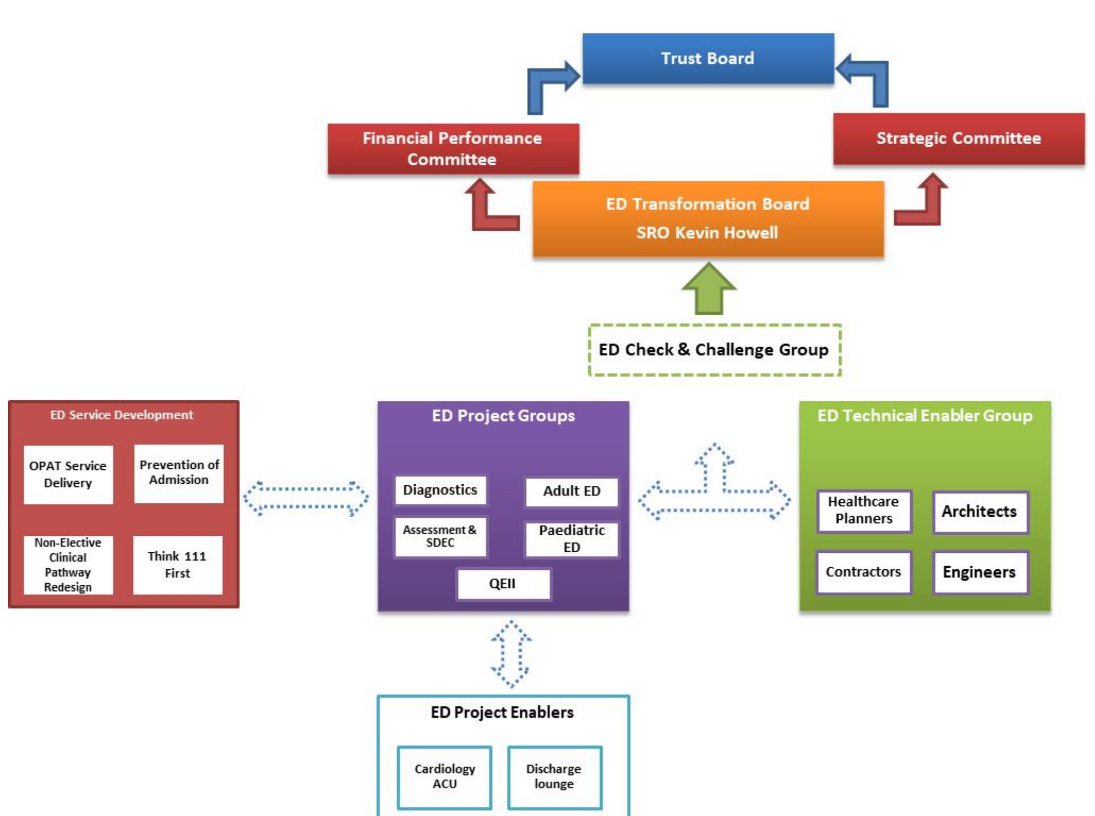
- In preparation for mobilisation of a COVID vaccine as and when one becomes available, a Steering Group to lead the COVID Vaccination Programme is in place, with Martin Armstrong (Deputy CEO and Director of Finance) acting as the SRO for the programme;

- The Steering Group is supported by the following Task and Finish Groups to ensure all aspects of the programme are considered and developed as appropriate:

  - Pharmacy (focused on the capacity to receive, store and distribute the vaccine);
  - Logistics (focused on the thoroughfare and volume of lorries and deliveries that may be coming through the site);
  - Staff vaccination.

- The above internal structures have been put in place as ENHT is working with national and regional teams to prepare for a staff vaccination programme and to discuss the potential of becoming a local distribution hub.

ED Capital Programme



- Kevin Howell, Director of Estates and Facilities is acting as the SRO for the ED Capital Programme;
- Project groups are in place to progress pathway transformation that supports the ED design, to confirm the capacity required for each service through the new configuration of the physical space, and to progress the final design and build of the programme;
- The main elements of the programme to be delivered in 2020-21 relate to enhanced Radiology provision and expanded assessment and Same Day Emergency Care areas.

Quality People Pathways Ease of use Sustainability

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

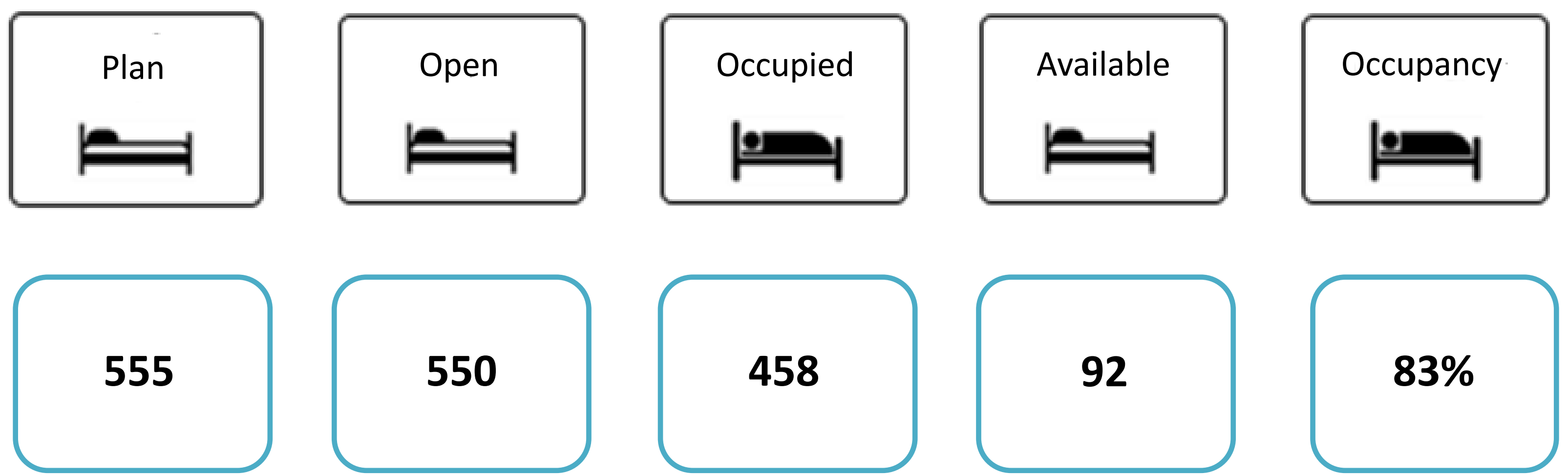
Profiled use of Beds

Agreed Bed Plan

	Oct – Dec	Jan – Mar
Unmitigated requirement (staffed capacity)	585	607
Unmitigated requirement (occupied beds @ 92%)	537	558
Impact of Planned Mitigation Initiatives	**30**	**35**
Mitigated Bed Plan (staffed capacity)	555	572
Mitigated Bed Occupancy (@92%)	**507**	**523**

- During July and August 2020, modelling was undertaken to ascertain the number of inpatient beds that would need to be available and staffed to meet patient demand for the remainder of 2020-21.
- This modelling was based on expected admission rates for both non-elective and elective care, length of stay expectations, and a series of bed initiatives that would positively impact on the inpatient requirements by avoiding overnight admissions, reducing length of stay and maximising use of the Independent Sector.
- The agreed bed plan also provides for expanded critical care capacity, additional Respiratory Support Unit beds and two Enhanced Medical Beds, in order to ensure higher acuity beds are available during the Winter period and any COVID-19 second surge.

Current General and Acute Bed Position



Notes:
1) The Plan reflected above is the plan for the period October to December 2020 for General and Acute, and Critical Care beds.
2) The Open beds refers to currently staffed and available beds.
3) The stated position is as of 8am on 27 October 2020.

Quality | People | Pathways | Ease of use | Sustainability

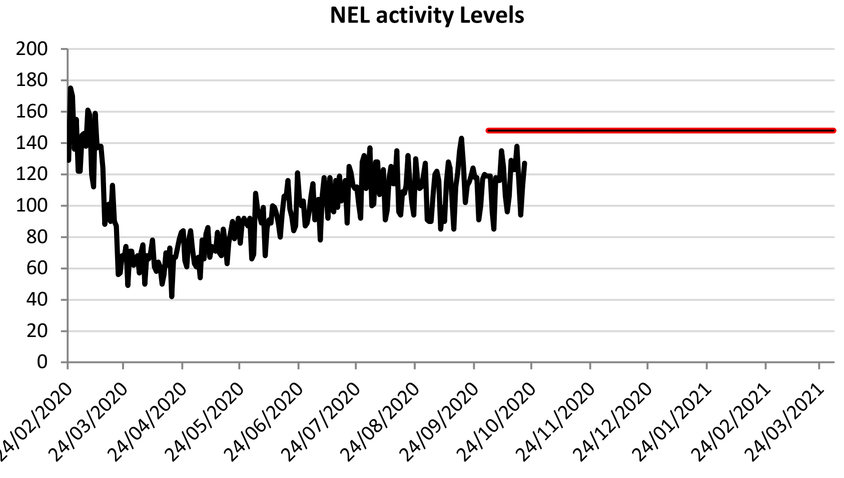
Proud to deliver high-quality, compassionate care to our community

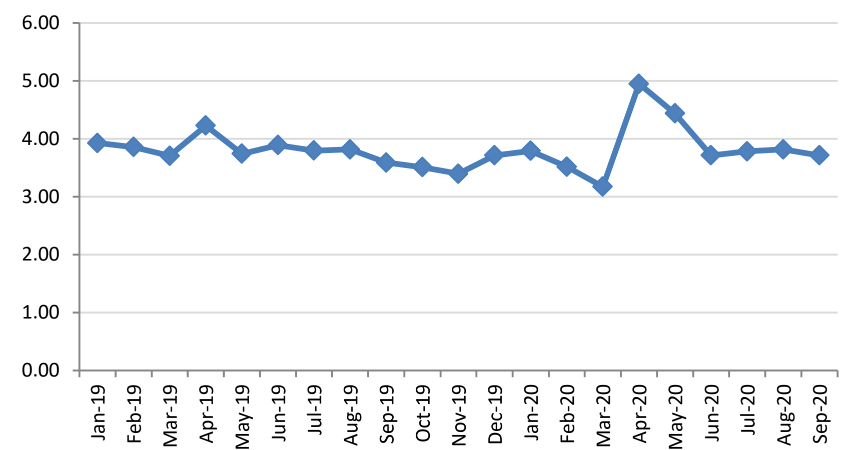
Current Activity Profile

- Following a sharp week-on-week increase in ED and non-elective activity levels from the end of May, these volumes have stabilised and flattened out since mid-August 2020;

- However, non-elective length of stay has been operating at a consistently higher rate compared to the plan since the middle of August 2020, and whilst the rate of same day discharges is in line with the proportion pre-COVID, there has not be the expected increase in same day discharges as modelled in the plan;

- In order to put the Trust in the best possible position going into the peak of Winter and a potential COVID second surge, the modelling and assumptions that underpin the bed plan are being reviewed and plans will be developed as to any actions (both internal and with system partners) to meet any changing requirements that this review identifies.





Quality | People | Pathways | Ease of use | Sustainability

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

Next Steps

- There are a number of key actions being prioritised over the coming weeks to enhance the current bed position :

  - Identifying additional physical space where expanded medical and surgical clinics can be delivered from over the coming months;

  - Internal focus on improving discharge, reducing length of stay and implementation of criteria led discharge, through a daily "star chamber" approach with clinical, nursing and operational leads to ensure medically optimised patients are identified and that planning for discharge starts upon admission;

  - External focus, with a weekly "drum beat" with system colleagues to understand what resource is required on a daily basis to discharge patients from acute beds;

  - A review of current prevention of admission and early supported discharge schemes across acute and community services to understand where current delivery of these schemes could be enhanced further, or to identify further opportunities for pathways to be delivered outside of an acute setting through partnership working.

Agenda Item:10

BOARD PUBLIC SESSION – NOVEMBER 2020
Board Assurance Framework Risks 2020-21

Purpose of report and executive summary (250 words max):
The review of the BAF risks ensuring they reflect the strategic risks for 2020/21 was delayed this year from April 2020 due to the national pandemic and the operation planning process for 2020/21 being suspended. The review recommenced in June with each of the Directors. The strategic risks have been reviewed, updated and the changes have been endorsed by the Executive Committee, Committees of the Board (QSC, FPPC and Audit Committee) and Board in July-September 20.

The risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. This now includes the new Strategy Committee. The Audit Committee will continue to have a deep dive review of a risk at each meeting. This is identified from referral by Board or by the Audit Committee Chair. The Committee reviewed Risk 12 – Pandemic at its meeting in October 2020; they were assured that is was comprehensive and provided additional challenge if the risk could be reduced to 15. Discussion held on the current rationale for the 20 rating due to the current complexities and challenges and recent SI's from delays to treatment. Agreed to keep the rating under review Feedback from the Internal and External Auditors was positive on the comprehensiveness of the BAF. Key points:

- the Trust's strategic risks for the Board Assurance Framework 2020/21 on one page. Appendix a.
- how the risks map across the Trust's strategic priorities and draft objectives for 2020/21v8 and providing assurance on the coverage. Appendix b
- the full current BAF, appendix c. The reviews in October included the implementation of the revised methodology on scoring the likelihood of the risk occurring, based on frequency that the risk / effects have occurred (see matrix below).
- Three residual scores have been reduced:
  Risk 11 MVCC has been reduced from 16 to 12. Rationale includes: Mitigations in place and staffing recruitment and retention being managed. Programme is progressing to the revised agreed timelines - transfer decision in September 2021 and completion in April 2022. The Programme Manager is now in post.
  Risk 5 Digital from 16 to 12; Review of the risk undertaken with CIO. Rationale: Current focus is delivery of tactical solutions to deliver the five priorities for year-end rather than the full approved digital road map and longer term clinical strategy; accepting initial risk to the delay to the digital road map and clinical strategy. The review of the risk has been transferred to the new Strategy Committee and operationally via Transformation and Performance Delivery Oversight Group.
  Risk 7 Governance: from 16 to 12. Rationale: Risk reviewed taking into account the assurances and frequency scoring matrix.

At the September Board there was a commitment to undertake some benchmarking of the risk profile of the Trust's BAF against other NHS Trusts. Following review of eight different Trust's Board Assurance Frameworks this has not identified any significant differences in organisational risk profiles. See appendix a.

Action required: For approval

Previously considered by: Audit Committee, QSC and FPPC in October 20. Minor amendments post committees. Following discussion at FPPC the Capital risk will be reviewed to take into account the short term risk of spending capital allocation for 2020/21 and the longer term position of availability of capital. QSC recommended target dates for risk score changes be added to the summary page.

Director: **Chief Nurse**	**Presented by: Associate Director of Governance**	**Author: Associate Director of Governance**

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	X☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes – CQC compliance will link with all the BAF Risks
Any other risk issues (quality, safety, financial, HR, legal, equality):

Board Assurance Framework: 2019/20 and transition to 2020 / 21

Risk Scoring Guide

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

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

Trust risk scoring matrix and grading – (during October we are implementing the revised methodology/scoring of likelihood/frequency of the risk)

Likelihood

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

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2020/21	Lead Executive	Committee	Current Risk October	Last Month September	3 months ago	6 months ago)	Target Score	Target dates for risk score/ changes
001/20 *	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**16**	**16**	N/A	N/A	**12**	June 21
002/20 *	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	**FPPC**	**16**	**16**	N/A	N/A	**12**	April 21
003/20 *	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**16**	**16**	N/A	N/A	**12**	TBC
004/20	There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments	Director of Finance	**FPPC**	**20**	**20**	**20**	**20**	**16**	TBC
005/20	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy *(October review completed – risk reduced)*	Chief Information Officer	**Strategy**	**12** ↓	**16**	**16**	**16**	**12**	At target
006/20	There is a risk ICP partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Strategy	**Strategy**	**12**	12	N/A	N/A	8	Dec 20
007/20 *	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives *(October review completed – risk reduced)*	Chief Executive / Chief Nurse	**Board**	**12** ↓	**16**	N/A	N/A	**12**	21/22
008/20 *	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	TBC
009/20 *	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	**FPPC & QSC**	**16**	**16**	N/A	N/A	**12**	March 21
010/20 *	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements	Director of Estates	**QSC**	**20**	**20**	**20**	**20**	**10**	TBC
011/20 was 012/20	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC *(October review completed – risk reduced)*	Director of Strategy	**Strategy**	12 ↓	16	16	N/A	12	TBC
012/20 *	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	**20**	20	20	N/A	15	April 21

scope or articulation of the risk has changed for 2020/21 and is therefore not directory comparable to 2019/20.

Board Assurance Framework Heat Map – October 2020

	Consequence / Impact				
Frequency / Likelihood	**1 None / Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5**
5 Certain	low 5	moderate 10	high 15	high 20 (004/20)	high 25
4 Likely	low 4	moderate 8	moderate 12	high 16 (004/20 target; 001/20, 009/20, 007/20, 002/20, 005/20, 012/20, 003/20, 011/20)	high 20 (010/20)
3 Possible	very low 3	low 6	moderate 9	moderate 12 (007/20, 005/20, 011/20; targets 005/20, 011/20, 012/20, 009/20, 003/20, 01/20, 002/20; 006/20)	high 15 (008/20)
2 Unlikely	very low 2	Low 4	Low 6	moderate 8 (targets 007/20, 006/20)	moderate 10 (targets 010/20, 008/20)
1 Rare	very low 1	very low 2	Very low 3	Low 4	Low 5

008/20 Existing risk score

011/20 Target risk score

Movement from previous month

Risk Profile Benchmarking, October 2020

Trust	Number of Risks on BAF	Number of risks scoring 15 and above on BAF	Comments
Our Trust	12	10	Currently reviewing risk scores with each Director alongside against our likelihood scoring.
Trust 1 (PAH)	11	9	Similar profile of risks
Trust 2 (WHHT)	23	10	Risks very specific and articulated in greater operational detail. Risks scored as Low/ Medium/ High / Extreme. The risk matrix has not been published.
Trust 3 (CUH)	12	6	Similar profile of risks. Includes predicted date for reaching target risk. BAF reviewed by the Board Committee each month and the Board four times a year.
Trust 4 (CPCCG)	16	10	One BAF risk (Pandemic) noted as 25.
Trust 5 (TRWT)	13	11	
Trust 6 (HCT)	11	7	
Trust 7			Trust 2020 Board papers reviewed – BAF not published
Trust 8			Trust 2020 Board papers reviewed – BAF not published

REVIEW OF STRATEGIC RISKS FOR 2020/21 – MAPPED TO TRUST STRATEGIC PRIORITIES AND DRAFT OBJECTIVES 20/21

Our Priorities

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

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

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

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

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

Our Objectives 2020/21 v8 final draft

a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation (R2 Workforce, R3 Finance , R5 Digital, R7 Governance, R8 Quality, R9 Culture, R11 MVCC, R12 Pandemic)

b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care (R1 Op Delivery, R3 Finance, R4 Capital, R5 Digital, R8 Quality, R9 Culture, R10 Estates)

c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care (R2 Workforce, R7 Governance, R8 Quality, R9 Culture, R12 Pandemic)

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

e) Safely recover operational performance affected by the COVID-19 pandemic (R1 Op Delivery, R3 Finance , R4 Capital ,R5 Digital, R10 Estates, R12 Pandemic)

f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic (R1 Op Delivery, R2 Workforce , R3 Finance , R5 Digital, R7 Governance, R8 Quality, R12 Pandemic)

g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand (R1 Op Delivery , R4 Capital, R8 Quality, R5 Digital , R8 Quality, R7 Governance, R9 Culture

h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS (R2 Workforce, R6 ICP, R7 Governance, R8 Quality, R9 Culture, R10 Estates, R12 Pandemic)

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Trust Strategic Aim:

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

Trust Strategic Objective:

b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care
d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider
e) Safely recover operational performance affected by the COVID-19 pandemic
f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic
g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand

Source of Risk:	Strategic Objective IPR
BAF REF No:	001/20

Principal Risk Description: What could prevent the objective from being achieved?
Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery

Risk Open Date:	01/07/2020	**Executive Lead/ Risk Owner**	**Chief Operating Officer**
Risk Review Date:	Oct-20	**Lead Committee:**	**FPPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence	**Inherent Risk** (Without controls):	4	5	20	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk Stratification of patients - Oversight by Clinical Advisory Group (Consultant Chair) Use of Private Sector (One Hatfield & Pinehill) Recovery programme - operation restart with governance structure and Recovery Steering Group with workstreams New Trust Delivery Framework (commencing September) Cancer Board Systemwide group chaired by Trust COO (SARG) COVID Specialist advisory group Task and Finish Group re Gastro surviellence and waiting list Weekly PTL Management - Cancer, RTT Recovery plans in place for diagnositics - Ultrasound and MRI	Flat packing of COVID Pandemic escalation plans / COVID Policies and procedures Sustained cancer performance - achieved the 8 cancer standards on June Recovery dashboard divisional and specialty based Monthly IPR and performance reports to FPPC and Board Deep dive reports to FPPC - ED performance and configuration; endoscopy review and Demand and capacity transformation model (Sept 20)	Sustained cancer performance		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Complexity of operation restart in the context of COVID National changes to gudiance and policy requiring local response at short notice. Phase 3 capacity modeling to deliver national targets within financial model	Define metrics to support monitoring of recovery Assurance on compliance with NICE changes and GIRFT Capacity to support increased demandpost COVID - Endoscopy and other specialities - delievery against plans Review of Harm review process / policy Effectivness of winter planning initiaitves / transformation with community	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

	Outcome of COVID tests to support optimum discharge	Red	Effective controls may not be in place and assurances are not available to the Board.	
Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
Operation Restart Programme with risk stratification recovery steering group	**COO**		In progress - weekly recovery steering group. Risk stratificaiton of patients on waiting list / surviellence and follow ups. Phase 3 activity submission	In progress
Ward reconfiguration Programme	COO/ Director of Estates/Chief Nurse		Capital funding bid - awaiting confirmation of outcome. To support elective programme and inpatinet risk reduction. Assessment area for medical and surgery combined	In progress
Implement Organisational restructure	COO		Consultation launched in August 2020. To go live in October. To go live 1 November 2020. Recuitment underway for vacant posts. DD for unplanned care due to commence in December 20.	In progress
Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	COO		In progress - weekly recovery steering group. Risk stratificaiton of patients on waiting list / surviellence and follow ups. Phase 3 activity submission	
Review 7 day working	Medical Director/COO			
Review performance metrics	COO			
Summary Narrative:				

October 20: Risk discussed and reviewed with COO including the risk likelihood score using the new standardised methodology. Risk remains at '16'. Rationale: Performance recovery plan in place in line with Simon Stevens Phase 3 national letter but this is with the competing challenge of COVID and winter pressures. Recent SI's delcared following delay in follow up and survielienceand delays to treatment following impact of COVID (nationally elective pathways were ceased although the Trust were able to use the private sector facilities for urgent procedures. Good example of the postitive work being undertaken was presented to FPPC in September and Harm review process reviewed and presented to QSC in September. Clear actions and risk stratification in place to improve/ recover the position. Deep dive of the harm reviews monitored through QSC (review October). Anticiate the risk will not reduce further prior to June 2021.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aims: Sustainability, Quality, People	**We provide a portfolio of services that is financially and clinically sustainable in the long term . We deliver high quality, compassionate srevices consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.**
Strategic Objectives: a,c,f,h	**Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation. Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care. Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic. Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Paartnerhsip and ICS.**

Source of Risk:	strategic objectives
BAF REF No:	02
Risk Open Date:	Sep-20
Executive Lead/ Risk Owner	**Chief People Officer**
Risk Review Date:	Oct-20
Lead Committee:	**FPWC and QSC**

Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public.**

Causes	Effects:
i) Failure to develop effective workforce plan/workforce model for each service that takes account of new/different ways of working. ii) Failure to maximise staffing options through the use of flexible working inititiatives. iii)Failure to work collaboratively across the Integrated Care System. iv) Failure to develop staff to be able to work more flexibly in terms of role design.	i) Current staffing models may not be cost-effective. ii) There may be an adverse impact on service quality and safety. iii) Recruitment costs may be higher than necessary. iv) Staff may not have the required skill set to support innovative role design and ways of working.

Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
Inherent Risk (Without controls):	4	4	16	
Residual/ Current Risk:	4	4	16	⟺
Target Risk: **(Spring 2021)**	4	3	12	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i) A process by which articulation of clinical strategy is linked to organisational redesign and workforce modelling. Ii)Workforce transformation approach to service development. iii)Demand and Capacity Modelling. iv) People Strategy action planning will seek to mitigate this risk.	i) Care Quality Commission service inspections ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC and Board			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) Inadequate links between service planning and workforce planning. Ii) Lack of horizon scanning to allow early recognition of potential skills gaps. iii) National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. iv) COVID challenge to existing workforce model - ability to maximise using staff flexibily taking into account capability and covid risk assessments	i) the variation between current staffing arrangements and optimum workforce model is not yet quantified. Ii) ability readily monitor capability, speicalist skills and risk assessments to maximise using staff flexibily	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	**Status:** Not yet Started/In Progress/ Complete

i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and prvision of necessary educational support.	Chief People Officer		Staff deployment is being reviewed in light of the bed reconfiguration project, and this will also impact on recruitment activity. Working with Transformation Team on review and development of workforce models	In progress
ii) Roll out of EDI agenda in relation to recruitment and selection, in particular the use of inclusion ambassadors and staff development programmes.	Chief People Officer		The Trust is using inclusion amabassadors in the recruitment process for posts at senior levels.	In progress
iii) Pilot strengths based recruitment	Chief People Officer		This pilot is currently taking place.	In progress
iv) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability.	Chief People Officer		Deputy Director of People Capability commenced in October 2020.	In progress
iv) Improve the offer to staff around flexible working.	Chief People Officer		Further to the Q1 Pulse Survey, work is underway to improve staff experience in areas whether survey responses identified particular issues, such as lack of support for flexible working.	In progress
Summary Narrative:				

October 2020: Review of the risk undertaken with CPO. Risk remains a 16. Taking into account the current complexities of COVID, winter and maintaining activity. It is anticipated that this will not reduce until Spring 2021.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

<table>
<tr><td>Strategic Aim:</td><td colspan="6">Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term</td></tr>
<tr><td>Strategic Objective:</td><td colspan="2">a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation
b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care
d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider
e) Safely recover operational performance affected by the COVID-19 pandemic
f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic</td><td>Source of Risk:</td><td>- Operating Plan
- Use of Resources
- Financial Framework 2020/21</td><td>BAF REF No:</td><td>003/19</td></tr>
<tr><td colspan="3" rowspan="2">Principal Risk Description: What could prevent the objective from being achieved?
Risk of financial delivery due to the radical change of the NHS Financial Framework</td><td>Risk Open Date:</td><td>01/04/2018</td><td>Executive Lead/ Risk Owner</td><td>Director of Finance</td></tr>
<tr><td>Risk Review Date:</td><td>Oct-20</td><td>Lead Committee:</td><td>FPPC</td></tr>
<tr><td>Causes</td><td>Effects:</td><td>Risk Rating</td><td>Impact</td><td>Likelihood</td><td>Total Score:</td><td>Risk Movement</td></tr>
<tr><td rowspan="3">i) Change in the national funding framework during COVID
ii) Mid Year Change in Funding Framework
iii) Good financial management and governance not maintained
iv) Allocation of Resources via System Mechanisms
v) Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience)
vi) Dilution of financial understanding and knowledge within divisional teams</td><td rowspan="3">i) Significant increase in costs above funding levels
ii) Financial balance not maintained
iii) Failure to track expenditure causation
iv) Unable to invest in service development
v) Challenge in tracking spend for regulatory and audit purposes
vi) System funds allocated on differential basis
vii) Spend committed recurrently in response to non recurrent circumstances
viii) Breakdown of regular financial / business performance meetings</td><td>Inherent Risk (Without controls):</td><td>4</td><td>5</td><td>20</td><td rowspan="3"></td></tr>
<tr><td>Residual/ Current Risk:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target Risk: (Time frame TBC)</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td>Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)</td><td>Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?</td><td colspan="2">Positive Assurance (Internal or External) Evidence that controls are effective.</td><td colspan="2">Positive Assurance Review Date</td><td>Key Performance Metrix aligned to IPR</td></tr>
<tr><td>i. Regular Monthly financial reporting arrangements in place
ii. COVID expenditure tracking and approval processes in place
iii. Recruitment approval mechanisms in place
iv. Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes
v. Attendence at regular national, regional and ICS DOF briefing and engagement sessions
vi. Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues
vii. Mth 1-6 and M7-12, internal budget frameworks in place
viii. Strong framework of BI financial reporting tools deployed to track and monitor delivery
viiii. Weekly Demand & Capacity meetings to track P3 delivery achievement and asscoiated PAM meetings to support accurate and comprehensive activity capture
x. Bi Weekly - MVCC Due Diligence meeting, plus Critical Infrastructure meeting</td><td>- Monthly Finance Reports to FPC, Board and Divisions (L1)
- Monthly cash reporting to FPC / Trust Board and NHSI(L2)
- COVID governance and reporting briefing to FPPC
- COVID financial planning updates to monthly FPPC and Exec Committee
- Monthly Accountability Framework ARMs including Finance (L1)
- Bi- Monthly Financial Assurance Meetings & PRM with NHSE (L1)
- Regular Data quality and Clinical Coding updates to PAM and AC (L2)
- Weekly D&C activity tracking meetings
- Forecast activity and winter planningbed model in place linked to M7-12 financial plan - Internal Audit - Payroll and Pay Policies 'limited assurance' - action plan in place</td><td colspan="2">- Internal Audit Programme in place for 20/21 - re: key financial controls
- Delivery of 2019/20 financial plan and unqualified opinion on the Annual Report and Accounts.</td><td colspan="2"></td><td></td></tr>
</table>

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
- Inconsistent delivery of routine budget management meetings across divisions - New divisional financial management arrangements still be to deployement - Variable capture and escalation of winter and in year cost pressures - Temporary staffing control environment in respect of medical and nursing staffing - Consistent communication and briefing of the COVID financial framework to divisional teams at a detailed velev.	• Impact of COVID and revised future funding frameworks on Trust financial sustaiability strategy • Embedding of core financial and bsuiness comptencies within divisional teams • Clarity in respect of NHS contract and business arrangements for 21/22 • Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings - Assurance in respect of the delivery of the 20/21 winter bed plan within agreed parameters, with the asscoiated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
Presentation of M7-12 financial framework to FPPC and Trust Board	Director of Finance	Oct	Scheduled	In Progress
Divisional Financial Management arrangements to be reviewed and implemented	Director of Finance / MD's (Planned & Unplanned)	Nov	DDOF and Finance SMT reviewing with new divisional teams	In Progress
Development of Service Line Management arrangements	Director of Finance / MD's (Planned & Unplanned)	Q4	Action Plan update to Nov DOG meeting	In Progress
Review and Refresh of the Trust Financial Sustainability Strategy	Director of Finance	Q4	Progress Report to FPPC	In Progress
Continue to develop BI and support divisions / directorates using effectively	Director of Finance	on going	Ongoing embedding and further development of dashboards and data sets development	In progress
Business Planning Guidance for 20/21 to be agreed and implemented	Director of Finance	Q3	Paper outlining arrangements to Nov Exec Committee and FPPC	In Progress
Summary Narrative:				

October 2020: Review of the risk undertaken by Director of Finance. Risk remains a 16 timeframe for reaching target risk remains under review.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality, compassionate services, consistently across all our sites** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**					
Strategic Objective:	**e) Safely recover operational performance affected by the COVID-19 pandemic** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand**		**Source of Risk:**	Business Plan, Clinical Strategy	**BAF REF No:**	004/20
Principal Risk Description: What could prevent the objective from being achieved? **There is a risk that there is insufficient capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments**			**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner**	**Director of Finance**
			Risk Review Date:	Oct-20	**Lead Committee:**	**FPPC**
Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of available capital resources to enable investment ii) Weakness in internal prioritisation processes iii) Weak in year delivery mechanisms to ensure commitment of resources iv) Poor link of capital resources to strategic objectives v) Requirement to repay capital loan debts vi) Volume of leased equipment not generating capital funding resources vii) COVID capital funding arrangements impact BAU capital requirements	i) Poor patient experience ii) Patient Safety iii) limited ability to invest in IMT, equipment and services developments iv) limited innovation v) impact on delivery of clinical strategy	**Inherent Risk** (Without controls):	4	5	25	
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	4	16	
Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.		**Positive Assurance Review Date**		**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts • Monitoring of risks and incidents • STP/ ICS reallocation/ monthly meeting - Equipment review process to support covid 19 pandemic requirements - Implementation of the new Capital and Cash Framework - Detailed Qlikview Capital Monitoring Application in place - Bi weekly MVCC Critical Infrastructure group with stakeholders	• Report on Fire Safety to Executive Committee (L2) • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Deep dive review of the risks and mitigations (December 2018) • New Monthly Fire Safety Committee established March (includes other sites)	- External Audit process reviews the appropriate accounting and treatment of capital assets.				
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**				

• Not fully compliant with all Fire regulations and design • No effective arrangements presently in place to monitor and control space utilisation across the Trust • No formalised equipment replacement plan or long term capital requirement linked through to LTFM • Weaknesses in Estates and facilities monitoring structures and reporting - Site Development Control Plan	- Availability of capital through either internal or national funding sources - Awaiting outcome of capital bids submitted through COVID / national Funding streams - Implementation of the new capital and Cash Framework - Transparent mechanisms to access Section 106 funding - Long Term Capital Investment Plan to regulate investment	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Estates strategy to support the trust clinical strategy	Director of Estates and Facilities	Q4	Development to be reported via FPPC and Strategy Committee	Not yet started
ii) Develop capital equipment replacement plan	Deputy Director of Finance	Ongoing	Ongoing	In progress
iii) Develop programme for Charity to support with fundraising	Deputy Director of Finance / Head of Charities	Ongoing	Ongoing	In progress
iv) Agree capital investment for 2020/21 and monitor delivery	Executive	May 2020 and ongoing	Capital programme approved through FPPC in May 2020. CRG will monitor delivery. Regular	In progress
v) Review other sources of funding / opportunities for investment	Director of Finance / Project leads	Ongoing	Review processes in place to track NHSE response to COVID bids	in progress
vI) Undertake detailed space utilisation survey, implement revised strategy and then monitor	Director of Estates and Facilities	Q4		
Summary Narrative:				

October 2020: Review of the risk undertaken by Director of Finance. Risk remains a 20 timeframe for reaching target risk remains under review.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-2021

Strategic Aim:	**Trust Strategic Aims:** **Quality: To deliver high-quality,compassionate services,consistently across all our sites** **Pathways: To develop pathways across care boundaries, where this delivers best patient care** **Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term** **Aims from the Digital strategy:** **1. RECORD Invest in our systems to record clinical information electronically that is stored in single, digitally- secure, integrated record which is paper-free at the point of care reducing repetition and improving safety, using fit for purpose equipment, networks, patient-facing technology and 'Internet of Things'** **2. SUPPORT Provide staff with easy to use, complete and up-to-date, high quality clinical information, and access to clinical decision- making tools and guidelines, enabling clinicians to consistently deliver best practice care** **3. SHARE Enable better co-ordination of pathways of care across a portfolio of services by sharing (with informed consent) clinical information with the patient and other care professionals involved in the patient's care, both within the Trust and the wider health and social economy**

Strategic Objective:	**Trust Objective: a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider** **e) Safely recover operational performance affected by the COVID-19 pandemic** **g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand** **Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strategy	**BAF REF No:**	005/20
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy		**Risk Open Date:**	Jun-20	**Executive Lead/ Risk Owner**	**Chief Information Officer (CIO)**
		Risk Review Date:	Oct-20	**Lead Committee:**	**FPPC**

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

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**		**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**

Staff Engagement Risk: Digital steering group(Consultant led design focus) and IT steering Group (Project Led delivery led) are in place for project Governance, prioritisation and to support clinical engagement **Business Risk:** CIO is member of the executive team and CIO/CCIO have an agenda item on at the Private board to ensure board members are apprised of progress and risks. **Financial / Resource Availability Risk:** Finance and PMO to be involved throughout the Business case process **Financial / Resource Availability Risk:** Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriate **Knowledge & Experience Risk:** Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained. New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee, FPC and Board (L2) • Weekly Executive monitoring(Where appropraite) aligned with clinical strategy - staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
ii) Poor attendance from stakeholders at the Digital steering group ii) Availability of capital to deliver priorities iii) No long term digital plan beyond 2022 (Contractual end date for Lorenzo) iv) Key Digital roles not recruited to. v) Integration into Divisional planning for resource management **delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X re inicianteve expection that we to implement with listtle time and enable of - systems / timeface to enable local scruitinty**	Publication of the roadmap and measures of progress Availabilty of funding to support delivery Recuitment strategy DSO and IGM capacity to support the DPIA processes	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	
Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Publish Digital roadmap and engage with CAG to ensure each Project board has a clinical chair. Programmes only commence with appropaite stakeholder engaement	CIO	Jul-20	Approved by FPPC in July 2020	In progress
ii) Seek investment through ICS where available	CIO	Dec-20	on going	In progress, Complete
iii) Long term Lorenzo strategy/commercials to be finalised	CIO	Jan-21	Position paper to FPPC in July 2020	

iv)Complete IT workforce review and actively engage in the martket with HR support for recruting good candidates at pace.		Aug-20	Recruitment in progress - on track with recuirtment schedule - made offers by end of month	in progress
v Implementation of a Business partner process (Post Silver)	CIO	Jul-20	recruitment process on track - end of year	In progress
vi) Relaunch of EMPA roll out		Aug 20	Training and rollout plan recommenced and on track	In progress
Summary Narrative:				

October 2020: Review of the risk undertaken with CIO. Risk reduce to 12. Current focus is delivery of tatical solutions to delivery the five priorities for year end rather than the approved digital road map and longer term clinical strategy; accepting initial risk to the delay to the digital road map and clinical strategy. Continues under review at FPPC and operationally via transformation and performance delivery oversight group.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

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

Trust Strategic Objective:	**h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	National directives	**BAF REF No:**	Risk 006/20
Principal Risk Decription: What could prevent the objective from being achieved? ICP partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability		**Risk Open Date:**	01-Apr-20	**Executive Lead/ Risk Owner**	**Director of Strategy**
		Risk Review Date:	Oct-20	**Lead Committee:**	**Strategy**

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

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Vascular Hub project with West Herts and PAH • ENH improvement methodology • Integrated discharge team • OD support for ICP development • Joint QIPP/CIP approach for 20/21 Enabling workstreams with nominated lead Executive Director representative Development Director in post	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
• Partnership Board Scope for accelerated development of ICP and governance arrangements that support transformation at pace • Need to agree 20/21 priorities for transformation Need to commence pan-organisational improvement work Need to identify clinical leadership capacity to drive greater pan	Availability of population health data to inform priorities for transformation and improvement Partnership Board to commence Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign.	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	

system understanding of servces and pathways and associated improvement work Need to influence and understand future ICP relationship with ICS Identification of dedicated capacity support ICP collaboration		Red	Effective controls may not be in place and assurances are not available to the Board.	
Action Plan to Address Gaps				
Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Establish an effective ICP Partnership Board, governance and shared strategic direction	Director of Strategy	Jun-20	First meeting scheduled for 23 June 2020. Initial ICP governance being reviewed to support reset and build on pandemic response . Aug-20 : Partnership Board has reviewed and confirmed streamlined governance to support clinical leadership and delivery. Development of ICP strategic framework to be informed by population health data work underway.	In progress
ii) Agreeand deliver system approach to building on collaboration and service transformation during pandemic response	Director of Strategy/ COO	Ongoing	Adaptation of pre pandemic ICP governance to support agile approach to collaboarative transformation to be considered by fr st Partnership Board together with recomendations for reconfirming/ refining clear ICP strategic direction and priorities informed by population health data. Aug-20: ICP involvement in Phase 3 recovery planning - the trust is looking to ICP partnership to support delivery of recovery activity to help meet the needs of the community we serve.	In progress
iii) Confirm and implement ENH improvement methodology across ICP	Director of Improvement	Ongoing	Aug-20: The Director of Improvement s leading the ongoing development of the ENH way internally - this is being adopted for capacity and demand work informing specilty recovery plans. He also expects to work with the newly appointed ICP Development Director to support the adoption of a consistent improvement approach across the ICP, supported by ICP collaboration.	
iv) Identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	Medical Director/Director of Nursing	Ongoing	Under consideration in order to align with planned operational restructure. Aug - 20: The Executive Committee agreed that the restructure of the Medical Director's office would not include a deputy medical director for integration role currently due to affordability. Alternative ways of identifying and releasing clinical capacity to foster pan organisation clinical integration and pathway development are being explored.	In progress
v) Develop and agree contractual mechanisms/behaviours which support collaboration and system-wide integration whilst minimising adverse impacts on individual organisations	Director of Finance	Ongoing		
Summary Narrative:				

Aug -20: The Trust is increasingly seeking to engage ICP partners to develop a collaborative approach to meeting patients' needs. Whilst the ICP Partnership Board and supporting gvernance is at an early stage, the Trust is committed to supporting its clinical and operational staff to engage with this, enabled by a restructure of the Operations Directorate, led by the Chief Operating Officer, Medical Director and Director of Nursing .

October 20: Risk discussed and reviewed with Director of Strategy, including the risk likelihood score using the new standardised methodology. Risk remains at '12'. Rationale: The pace of ICP development and transformation of pathways is currently slow and impeded by the COO unable to attend the ICP Transformation and Development Group - changing of the time to enable this is currently being consulted on; once resolved (approx December), it is anticpated that the risk can be reduced to the target risk of '8'. This also takes into account that the Development Director is now in post and Executive Directors have been nominated to support the enabling workstreams.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**

Source of Risk:	Strategic Objectives External reviews	**BAF REF No:**	**007/20**
Risk Open Date:	01.04.2020	**Executive Lead/ Risk Owner**	**Chief Executive**
Risk Review Date:	Oct-20	**Lead Committee:**	**Board**

Principal Risk Decription: What could prevent the objective from being achieved?
There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives

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

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division (from January 2018) • Commissioned external reviews	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2) • Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3)	Internal Audit report - risk management , performance framework, IG 2019 NHSI Infection control review - green - June 2019 Review of progress with QTP workstreams with NHSI/CCG - June 2019. Internal Audit - Surgical division governance - reasonable		

• Commissioned external reviews • Review of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Quailty dashboard / compliance dashboard CQC steering group and action plan 2019/20 action plan to deliver the Trust strategy -Strategic programme board and trsut board monitoring - Safer sharps group - Daily Covid group, policies, pods in situ on Lister and QEII sites. Incident gold/silver command structure in place from mid March 2020 and reviewed weekly to ensure meets organisaitonal needs - Reviewed Board and Committee Governance structures approved in March 20 New weekly Quality Assurance meeting established in April - chaired by DoN/MD - supported by Compliance team and dashboard. (to support interim governance arrangement and quailty oversight durign pandemic) - transitioning back to BAU committees Sept - Nov Central record of contract / pathway reviews and agreed changes Record of national / regulatory changes and trusts response Delivery framework implemented in September 2020. Partnership Board and ICP Board and groups established and link to divisional strucutres	• Annual review of SFI/SFOs (L3) • Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • 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 +) • Internal Audit Report – Assurance and Risk Management (- reasonable assurance (L3) • Board development session on Risk and Risk Appetite, Feb 2019 • Internal Audit – Performance Framework report - reasonable assurance March 19) - Internal Audits 2019/20 scheduled for Data Quailty; Divisional Governance; HSE improvement notices on Sharps, Violence and aggression and moving and handling (-ve) Action plan in progress of delivery - Desktop reivew of Pandemic Flu plan scheduled for February 20 - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting	Internal Audit - Surgical division governance - reasonable assurance - July 2019. CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires mprovement. CYP achieved good. MVCC retained requires improvement. 6 monthly Quailty Account progress reported to QSC November and Board in January. Deep dive reviews on QI areas to QSC in December. Business continuity - compliant assessment validated 2019 Risk and Assurance Internal Audit - reasonable assurance May 20: Review of Major incident structures June 2020- Unqualified opinion on the Annual Report and Accounts June 2020- ICP BAF reviewed at QSC IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID Postive feedback from ICO regarding an enquiry August 2020 Internal Audit - substancial assurance - HSE action plan HSE closure of COVID riddor.	CQC IPC review July 2020	

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
Effectiveness of goverancne structures at ward to Divisional level • Fully embedding Performance Management Framework/Accountability Framework • Implementation of Internal Audit Recommendations • NHSI Undertaking January 2019 / CQC section 29a warning - surgery and QEII UCC - HSE Improvement notices received on V&A, MSD and sharps in October 2019 - Number of previous meetings - stepped down to support major incident (covid pandemic)	• Embedded risk management - CRR and BAF • Embedding effective use of the 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 • Oversight of GIRFT programme and other exteranl reviews and follow up - follow up investigations on V&A and Sharps incidents - MH equipment - review and replacement programme - specialist training	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Monitor delivery of Risk Management implementaion plan 2020/21	Associate Director of Governance / Risk Manager	ongoing	Monthly reports to Board committees . Current capacity issues. Good divisional and directorate active engagement with the Risk Register. Risk clinics being established Sept/Oct to review 20+ risks and implement the scoring methodology for the likihood of the risk materialising	In progress
ii) Consider independant well led review in line with the national guiidance	Associate Director of Governance / Trust Secretary	Nov-20	Previous external review 2017 (best practice - 3 yearly). Examples of other trust reviews collated.	In progress
iii) Review of governance structures in line with the Divisional Restructure	Associate Director of Governance / DCOOs	Nov-20	In progress. - Phased approach.	In progress
iv) Review and implement the compliance framework	Associate Director of Governance	Oct-20	Rephasing the implemenation of the compliance framework - commence testing the audit tools for the fundimental standards in June. 50% review of table top fundimental standards completed to date. Review of compliance framework in line with CQCs new Transitional Regulatory Approach.	In progress

v) Review of governance with ICS/ ICP	Trust Secretary and Associate Director of governance		Partnership Board established. ICP structures in place, linking to Divisional structures	In progress
v) develop and implement action plan to address HSE findings and improvement notices	Associate Director of Governance	January 2020 - action plan to HSE July 2020	Action plan under development. Scheduled to present draft action plan to Executive Committee through to QSC in November/December. Trust partnership engaged. Action taken 23.10.19 to have a security officer in the ED 24/7 with immediate effect. Reviewing H&S structure to support a more proactive service across the Trust. Meeting with HSE January 2020 and updated action plan submitted, revised compliance timelines agreed. Monitoring delivery . End April - Evidence submission to HSE to consider compliance with the V&A and Sharps improvement notices - awaiting outcome. On track for compliance with M&H at end July. Testing of actions to ensure implemention is in progress and onoing. Awaiting outcome from HSE following submission of evidence. 100% compliant with sharps and V&A actions. 4 open actions for M&H to ensure actions embedded re training but not part of the core improvement notice. - Internal Audit review = substancial assurance	In progress
v) Review of strategic decision making during pandemic outbreak against the legal framework / advice - and ensure clear audit trail	Associate Director of Governance	end of May 2020 - revised to June	In progress. For discsussion at Audit Committee	Completed
vi)Review of Performance framework and meeting structures to support delivery of the Trust Objectives	Executives	Jul-20	Financial Governance Proposal presented to FPPC in May 2020. Review of Performance framework and supporting meeting proposal to Executive Committee 4 June 2020. Revised delivery framework approved by executive - for Board approval in July. Followed by review of supportive meeting strucutres	In progress
vi) Review Board members visibility and mechanisms of assurance outside of the meeting structure during the pandemic / restart	Trust Secretary and Associate Director of governance	Aug-20	Plans agreed with Chair and NEDs, including attendance at interviews, flex /rotation of attendance in person /virtual for Board and Committees - supporting social distancing and visits. Remains under review	in progress
Summary Narrative:				

October 2020: Risk reviewed and discussed with the Director of Nursing and reduced to 12- taking into account the assurances and frequency scoring matrix.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

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

Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **c) Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care** **f) Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic** **g) Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand** **h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**	**Source of Risk:**	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:**	**008/20**

Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience**	**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Nurse/ Medical Director**
	Risk Review Date:	Oct-20	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of consistant approach to quality improvement. 1. Preliminary plans to develop a culture of continuous quality imporvement skiills imbedded wihtin a stregethiend capablity & capacity infrastructue ii)Limited staff engagement 2. Capturing and pro-actively providing ontinous leanring opportunies require more structred strategy and deployment iii) Inconsistent ward to board governance structures and systems 3. Current governace structrues requires strengthening to reliably seel assurance of leanring	1) Limited learning oppurtunites from current and future continuous quality activities 2) Poorer patient and staff expereince 3)Limited leadership development of all staff 4) impact on reputation iv) increased regulatory scruitny	**Inherent Risk** (Without controls):	5	4	20	⟺
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Reports to QSC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical effectiveness/ Patient Safety/Patient Experience Committee/ Health and Safety Committee reports (L2) • Nursing and Midwifery Executive Committee	• Clinical effectiveness committee / Patient Safety Committee/ Patient Experience Committee • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SIs and Learning from death investigations	• NHSI Infection control review June 2019 - Green • CQC Inspection report 2019 - Requires Improvement overall - UCC and surgery improved to requires improvement. • CYP achieved good. • MVCC retained requires improvement. • 6 monthly Quality Account progress reported to QSC November		

• Nursing and Midwifery Executive Committee • Invasive procedure Clinical Group • 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 Strategy reports and Quality Improvement deep dives to QSC • CQC Inspection report July 2019 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3) • NHSI Infection control review June 2019 - green (L3) • Quality Dashboard / Compliance dashboard • Internal Audit scheduled , Clinical audit and effectiveness procsses, Patietn safety incndent management. • RCN Clinical Leadership Programme • Pathways to Excellence Programme • Harm Free Care Collaborative • Deteriorating Patient Collaborative (Quality Improvement Break through Series Learning Collaborative) New Quality Assurance Meeting - weekly - chaired by DoN/MD supported by complaince team and dashboard. PPE clinical advisory group Covid risk assessments Covid Track & Testing Clnical Advisory Group Covid skills & training faculty Continuous Quality Patient Co-design forum Weekly Quality Huddle Recruitment of Quality Excelllence Matrons & Pathway to Excellence Programme Manager Quality Assurance Board and dashboard	• SIs and Learning from death investigations • Serious Incident Review Panel • Strengthened TIPCC membership and ToRs • Quality and safety visits • Medication safety quality peer reviews • Safety huddles • Quality Huddles (bi-weekly) • Policies and procedures • Quality Strategy updates • Divisional Quality Manager posts in each division • Weekly review meetings of CQC improvement plans • Clinical Harm Review Panel (Weekly) • Invasive Procedure Clinical group (safer Surgery Collaborative) • Recruitment and deployment of Quality Improvement team • Deteriorating Patient Quality Improvement Collaborative • Harm Free Care Collaborative • Thrombosis committee • Safer Sharps Committee • Appointment of Associate Medical Director for Quality Improvement & Safety • Recruitment of Improvement Director Patient experience feedback - new mechanisms and quartely review. Reduction in outstanding complaints and SI's Internal Audit Programme Joint meeting Quailty Oversight Meeting with NHSI, CCG and CQC bi monthly	• 6 monthly Quality Account progress reported to QSC November and Board in January. • Deep dive reviews on QI areas to QSC in December. • Quality Improving team KPis • Successful compleition of intial 2 waves of Pathway to Excellence achievements, and planning of wave 3 underway. • Sustain reduction cardiac arrest rates 7 day services - internal audit - reasonable assurance - Internal Audit - Clinical Audit (Substancial assurance) July 2020 - Internal Audit - SI's (reasonable assurance) July 2020 - CQC review of IPC BAF - compliant with all 10 KLOE - July 20 - CQC - positive medicines managemetn review - covid 19 focused, Aug 20.

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
• 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 Complex discharge pathway	• Consistency in following care bundles • Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance • Embedding of learniing from SIs/Learning from Deaths • Data quality • Delivery against CQC improvement plan - Delivery of harm review process following COVID impact on 52wk waits , follow up and survielience Effectivness of Pathway for safe discharging of complex patients - complaints and referals	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Delivery of the Quality Strategy Priotrities	Chief Nurse / Medical Director	ongoing	Improving Patient Discharges Group with 4 delivery workstreams established.	In progress
ii) Delivery and monitoring of CQC improvement plans for Surgery Lister and UCC QEII and other core pathways and emergency support programme requirements	Associate Director of Governance / Chief Nurse	ongoing	Full review of action plan with each pathway in July and August 20 ; outcome will be presented to QSC. Postive meetings with CQC re IPC and Medicines Optimisation under the CQC's ESP.	In progress
iii) review of structures and mechanisums to support embedding learning across the organisation	Associate Director of Governance / Chief Nurse		In progress -	In progress
iv)• Complete Gap analysis on GIRFT reports and develop and monitor action plans	Medical Director	ongoing	GIRFT visits continue and accumulation of actions currently being undertaken. Non-Exectutive has been identified to chair GIRFT oversight committee.	Started
iv) Implement 7 day services plan	Medical Director	ongoing	Report to QSC June 2019. Steering group established. Information gathering started against each 7 day standard and current baseline of PA allocation. Action	In progress
Implement the pathways to excellence programme	Chief Nurse		Programme recommenced in July 2020	In progress
Review of Quailty safety and governance structures (including meeting structures) to support delivery of Quailty Governancne across the organisation	Associate Director of Governance / Chief Nurse		In progress -	In progress

Review harm review and mortality review processes due to increased demand following COVID	Medical Director / Associate Director of Governance	Aug-20	Mortality reviews recommenced and priorisied. Harm review process is under review to ensure clear oversight and governance and inline with the Royal College of Surgeons prioritisation guidance.- work is in parallel to workstream on capacity / demand and review and risk stratification of patients - 52wks, survielience and follow ups.	Inprogress
Summary Narrative:				

October 2020: Risk review independantly with the Chief Nurse and Medical Director and taking into account the recent never event (last one approx 18 months ago), review of the harm process in view of the impact of COVID on RTT, follow up and survielience, the discharge themes from complaints. Actions and improvement plans are in place to support improvement and transformaiton - supported by the ENH Way and Transformation Teams and Quailty Improvement Teams working together. Re alignment of the Divisional and operational structures will support quality governance. Medical directors office now being established under a revised structure. CD JD reviewed along with Clinical Governance and Audit Lead JD. leadership development for the new consultants and improved communications through a quarterly medical director news letter. Linking with workforce team re a hospital at night team review and support developments. Medical workforce oversight group and job planning /temp recruitmnt /group being reinstated.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aims: Sustainability, Quality, People	**We provide a portfolio of services that is financially and clinically sustainable in the long term. We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.**				
Strategic Objectives: a,b,c,f,g,h	**Enhance clincial leadership and service line delivery to further improve service quality, safety and transformation. Improve patient outcomes, experience and efficiency by enhancing speciality-level inpatient care. Support our people to feel valued and fully engaged to maximise their efforts to deliver quality and compassionate care. Work with partners to meet the health and care needs of our community through and beyond the COVID-19 pandemic. Harness innovation, technology and opportunities for new models of care to right size and optimise our capacity to meet demand.**	**Source of Risk:**	strategic objectives	**BAF REF No:**	009/20
Principal Risk Decription: What could prevent the objective from being achieved? **There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community.**		**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
		Risk Review Date:	Oct-20	**Lead Committee:**	**QSC, FPWC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	4	**16**	⟺
		Residual/ Current Risk:	4	4	**16**	
		Target Risk: (March 2021 and then review longerterm targwt risk)	4	3	**12**	

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

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i)Failure to review and update some staffing policies ii)Need to develop education approach to supporting staff in under-represented groups iii) Need senior leadership development programmes to support the service improvement and transformation agenda.	Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk.	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action:	Lead:	Due date	Progress Update	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	Chief People Officer	ongoing	Developing a paper on the work relating to Culture, Civility and Respect due to be presented to FPPC in November 2020.	
ii) Develop improved education and training offer for all staff groups.	Chief People Officer		Now managed through the Education Board, with a combi ned staff capability team supporting this agenda as part of the People Team.	
iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	Chief People Officer		The Trust is engaging with the EDI agenda through development and promotion of staff networks, which will feed into the Staff Experience Group. Speaking Up and Black History Month	
iv) Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	Chief People Officer			
v) Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	Chief People Officer		The Staff Engagement Group meets regularly and will roll out a schedule of activities over the course of 2020.	
vi) Roll out talent management approach and support career conversations across whole Trust.	Chief People Officer		The new approach to staff appraisals was launched in July 2020 and has been well received.	
Summary Narrative:				

October 2020: Risk reviewed with CPO. Risk remains at 16, it is anticiped this will remain at this level until March 2020. The last staff survry did not see a shift in reduction of B&H. It is hoped the publication of the staff survery results and consideration to local intelligence will then enable the risk to be reduced. Focus in October 2020 of Speaking Up month and Black History Month. Developing a paper on the work relating to Culture, Civility and Respect due to be presented to FPPC in November 2020.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Strategic Aim:	**Quality: To deliver high-quality,compassionate services,consistently across all our sites** **Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**
Strategic Objective:	**b) Improve patient outcomes, experience and efficiency by enhancing specialty-level inpatient care** **e) Safely recover operational performance affected by the COVID-19 pandemic h) Play a leading role in developing sustainable and integrated services through the ENH Integrated Care Partnership and ICS**

Source of Risk:	Risk register /AE reports
BAF REF No:	010/20
Risk Open Date:	22/01/2019
Executive Lead/ Risk Owner	**Direcotr of Estates and Facilities**
Risk Review Date:	Oct-20
Lead Committee:	**FPPC**

Principal Risk Decription: What could prevent the objective from being achieved?
There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	25	
		Residual/ Current Risk:	5	4	20	⟷
		Target Risk: (Timeframe TBC)	5	2	10	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Fire Policy and Procedures Training – mandatory awareness training and fire wardens Ward based evaluation training for Sisters completed December 2018. Communication Plan Fire Compliance meeting (monthly). Detailed Action Plan in place to address the recommendations of the 2 Fire AE reports, broken down into weekly tasks. Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. . Capital funding to make the necessary changes to the Estate to ensure compliance with guidance and fire compliance. Revenue funding to fund improvements. Detailed Action Plan in place to address the gaps in Estates & Facilities Compliance. Interim Fire Safety Officer in post from 11 Feb 2019 Reports to Health and Safety Committee Weekly environmental audits Water safety group and action plan Revised governance structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements. Revised governanec structure adopted within Estates & Facilities, along with a new Estates & Facilities Management Assurance Group (EFMAG), to receive reports and monitor progress. EFMAG report sto H&S Committee, within its revised governance arrangements.	Authorised Engineers report 2018. (L3 –ve) Annual fire report to Quality & Safety Committee. Papers to Executive Committee / Quality & Safety Committee. Audits of high risk areas on Lister site Works completed on wards 10/11 MVCC 2018 Desktop Fire evacuation exercise carried out December 2018.(lister) Ward evacuation plans displayed in each ward and checked. January 2019 New Monthly Fire Safety Committee established March 2019 – includes representation from other sites – reports to H&SC and QSC PLACE reviews Internal audit of estates and facilities compliance scheduled for Q3/4 E&F escalation reporting to both TIPCC and H&S Committees from EFMAG, adopting araes to celebrate and areas of concern. Trusts Water Safety Group is receiving trend analysis data on laboratory testt results, and the situation is stable, although continues to be significant. Final independent compliance audit report received October 19. Compartmentation works/firedamp works/alarm works are now underway from discretionary capital and additional backlog maintenance capital. There has been delays to the completion of numerous areas of work due to the Covid 19 pandemic and the need for the transformation of various areas to deal with the influx of patients. This is also affected the ability to train people due to social distancing. Capital works are now planned over the next two years with the highest risk items being dealt with at the earliest opportunity and training being brought back in line within the next six months.	AE Water Safety Report to Water Safety Group (Nov 19) confirmed positive progress in relation to water safety Compliance status report following review to date to FPPC in June 20 In a bid to formalise and standardise the reporting structure for the estates and facilities division new assurance documentation will be issued which reflects the same scoring mechanism and visual indicators across all of the statutory compliance issues. Within these assurance documents will be how we have supported through detailed and available evidence the validation of any assurance that goes towards board. All information packs and evidences are being drawn together in a bid to populate PAM and also for into our building management system, planet, to allow us to involve our operational maintenance teams and keep them informed of requirements.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received.	Reasonable Assurance Rating: G, A, R	
Ineffective estates and facilities governacne structures Estate strategy due for renewal Lack of capital funding to bring the Lister and other sites to compliance Lack of revenue funding for training Fire risk assessments and actions due for Fire Safety Officer review Actions identified from Fire desktop review Confirmation all AO's now in post and visibilty of work programme Gaps in ongoing assurance on water safety identified Limited visibility on the compliance status for the Trusts satellites locations. Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme.	Full implementation of the Fire Strategy Effective Estates and facilities governance structures Limited assurance from other sites trust operates from Visiibility of AE reports and actions Limited assurance for Ventilation and decontamination - action plan in place £4.2 million has been made available to attempt to counteract high level backlog maintenance risk. This £4.2 million has approximately £800,000 set aside for fire mainly in the investment into the alarm systems and the potential issues with spandex panels on the main tower. These works are in addition to the funding that was approved in 2019 which allows for an additional £750,000 this year and 750,000 thousand next year into our infrastructure. Collection of the Premisis assurance model (PAM) documentation is underway – we will create an evidence library which should be complete in quarter four – we have appointed an external company to undertake the review of all areas and workshops will be held within the next three months. PAM will as a consequence of the review will produce a GAP analysis which will drive our response by identifying areas of priority investment for capital and revenue funds.	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Review and implement revised estates and facilities governance and reporting structure	Director of Estatesand Facilities	01/09/2019 revised date with Director April 2020	Paper presented to QSC in June 2019 outlining key workstreams. Implemention of the supporting committees commences with water safety, ventilation and electrical safety. E&F Governance structure and reporting arrangements were revised in August 2019, and to be reviewed 4th Qtr 2019/20. February - E&F structure and governance structure under review with new Director of Estates and Facilities. The outcome of a structural change to the division will be the presentation of a "state of the nation" report. As part of the state of the nation report there will be a declaration and methodology on how we deal with governance and who will have the responsibility and the obligation to provide evidence.	
iii) Review of Estates Strategy	Director of Estates and Facilities	Mar-20	on hold until new estates and facilities director in post from January 2020. New Estates and Facilities Director commenced January 2020. Review of Estates Strategy Commenced The estate strategy requires a clinical strategy to be completed and ratified. All estate strategies should be led by the clinical strategy. In addition to this we are currently undertaking a transformation of our environments to reflect the changes which has happened during the pandemic. We need to await the completion of these transformations and agreements with our partners in the rest of the health economy that previous assumptions with regards to activity and services we provide still hold true. In the meantime and includes state strategy or statement of intent will be created for presentation to the board in the fourth quarter	

iv) review and implement mechanisms to ensure Estates, Facilities and Fire compliance assurance is received from partner organisations where trust operates from	Director of Estates and Facilities	Dec-19	Paper presented to QSC in June 2019 outlining key workstreams. Trust risk assessments have been shared with the relevant partners. Correspondence issued to all satellites CEO's requesting assurance on their water compliance and all areas of the HTM's and health & safety, for completeness. External review of compliance completed.	
iv) Substantive recuitment into leadership structure and other vacancies	Director of Estates and Facilities	Dec-20	Structure reviewed in July 2020 The proposed structure for the estates and facilities division has now been shared with the other executives following a review to attempt to maintain any structural changes within the current financial budgetary constraints. This in the main has been achieved the Deputy director of Estates and facilities (business and compliance manager) is undergoing final review of its grading. The revised structure will be included within the first state of the nation report which is due in quarter four is expected that all posts will be filled before the end of that quarter.	
v) Work with STP partners to ensure STP Estate Strategy reflects Trust priorities	Director of Estates and Facilities	Dec-20	ENH was represented at a meeting in September 2019, with the regional Estates & Facilities Directors. STP Estates Strategy completed and rated as Good by NHSI/E, Estates and Facilities continue to be representative and attend to all STP estate strategy meetings. Whilst the current Director of Estates knows the majority of the other officers in the region from prior works within Watford and Hillingdon he is attempting to make personal and professional partnerships with all concerned.	
iv)				
Summary Narrative:				

October 2020: risk reviewed by Direcotr of Estates and team - no changes. Associate Director of Governance to have follow up discussion regarding the scoring and aims / timeframes for reduction.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020-21

Trust Strategic Aim:

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

Trust Strategic Objective:	**a) Enhance clinical leadership and service line delivery to further improve service quality, safety and transformation** **d) Develop a future vision for the Trust's cancer services and support work with partners to transfer MVCC to a tertiary provider**
Source of Risk:	Specialist Commissioning review
BAF REF No:	011/20 (was 12)
Risk Description:	**There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC.**
Risk Open Date:	Apr-20
Executive Lead/ Risk Owner	**Director of Strategy**
Risk Review Date:	Oct-20
Lead Committee:	**Strategy**

Causes	Effects:
i) Continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii)inability of NHSE to reach agreement with providers , including investment required, and execute the transaction	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retenetion, morale and research. ii) Potential impaxt of pathways of care at Trust sites.Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and greater financial impact on the Trust iv) Potential impact on quality and safety

Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
Inherent Risk (Without controls):	4	5	**20**	⇩
Residual/ Current Risk:	4	3	12	
Target Risk:	4	3	12	

Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Trust (and divisional) Clinical Strategy Mount Vernon Cancer Centre Review Programme Board Transition Team Weekly director level call with UCLH and NHSE. Escalation reporitng to Executive Committee and Board . Internal MVCC Task & Finish Group established, linking into NHSI/E fortnightly confernance calls on topic. Clinical policies	• Regular reports to FPC and the Board (L2) • Regular reporting into the Strategy Committee (from October) Clinical Advisory Group Capacity and demand modelling Monitoring of Quailty Indicators and audit of admissions policy Director of Finance leading internal due diligence .	Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 Positive Risk Review with Specialist Commissioners, December 2019 , Jan 20 NHSE approved the reccomendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to the outcome of due diligence. NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**	
i) Agreement of funding of costs of due diligence and transition between organisations ii) Internal capacity to progress due diligence and engagement on long term service modelling iii) Preferred provider capacity to progress due diligence and service model development iii) Availability of capital funding for investment	Impact of COVID 19 on the timeline of transfer	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Lead:	Due date	Progress Update	**Status:** Not yet Started/In Progress/ Complete
i) Support NHSE to recommence and deliver MVCC Strategic Review Phase 2	Director of Strategy	June 2020 onwards	April 20 - because of delays caused by pandemic response , agreed provisional restart date of June 2020 and transfer target of April 21. Subject to confirmation with UCLH. May 20 - Programme Board met 15/5/20 and approved outline timetable for next phase of review. Work with UCH and MVCC clinicians to develop a new clinical model for MVCC to commence before the end of Q1, including input from patient experieince. Aug 20 - Programme Board met 18 Aug. Agreed revised timeline proposed by NHSE and UCLH whivch would deliver Business Transfer Agreement in Sept 21 and transfer in Apr 22. UCLH Programme Director has commenced in post.	
ii) Conclude negotiations regarding due diligence and transfer costs and deliver due diligence	Director of Finance	Jun-20	The MVCC transfer Task & Finish group has resumed meeting and planning activity during May. The group has identified specific workstreams that can recommence activity to generate information and data to support the Due Diligence process with UCH and NHSE, that will cumulmunate in the developement of a joint Business Case that would underpin the transaction. The Trust has communicated the resumption of this actvity to UCH to ensure that joint up work between the the two organisations can recommence where practicable. Bi weekly Task and Finish groups chaired by the Director of Finance remain diarised going forward to co-ordinate this activity. Aug 20 - Trust due diligence continues. UCLH due diligence has commences but due to organisational priorities, is running behind the ENHT data gathering. A critical infrastructure group has been set up led by NHSE with key stakeholders in order to support shared understanding and agreement on responses to critical infrastructure issues prior to transfer.	In progress
iv) Confirm planned equipment replacement programme including addressing need to replace LA1	COO/ Director of Strategy	Jun-20	LA1- 12 month extension for LA1 agreed with suppliers and commissioner wef September 2019. Business case to replace LA1 drafted and capacity and demand modelling shared with NHSE. 20/21 equipment requirements to be considered in Trust 20/21 capital planning process . May 20 - acitivty and capacity modelling refreshed to include potential COVID impact on demand and effects of hypofractination for beast cancer. Shared with NHSE. Trust in dsicussions with UCH regarding financial mechasnism to support funding linac purchase. Busines continuity plans being refreshed to support interim service. Aug 20 - mitigation plan for loss of LA1 in 20/21 agreed internally and with NHSE. External modelling indicates that this capacity is not required but that the next linac due for replacement (LA9) will need replacing to sustain capacity to meet demand. NHSE have commissioned external work to support resilience of LA9 this year and the Trust will undertake bunker enabling works in year in readiness for a new linac installation in 21/22. Funding for the new linac is to be identified in dsicussion with NHSE and UCLH.	
iv) Continue to support and monitor continuous quality and safety improvement and assurance at MVCC	Chief Nurse/Medical Director	Ongoing	Compliance and risk lead attend the MVCC risk clinic and clinical governance meetings.Audit results shared with the Trust and Specialist Commissioners. 47% of CQC 'must do' & 'should do' actions completed. actions Planned review of internal governance to ensure meet needs of Division, Trust and Commissioners. Scheduling CQC mock review for Q3.	
Summary Narrative:				

Aug 20 - The transfer programme has recommenced . Phase 2 (future service model and location) is being led by UCLH with NHSE. The Trust is fully engaged and supporting this work. In anticipation of a reduction in the director of strategy's capacity following her appointment as joint director of strategy with Hertfordshire Community trust, the Trust is recruiting a fixed term senior programme director to support the director of strategy and internal leaders drive the Trust's transfer and future service redesign programme to provide additional capability.
October 20: Risk discussed and reviewed with Director of Strategy, including the risk likelihood score using the new standardised methodology. Risk reduced to '12', the target risk. Rationale includes: Mitgations in place and staffing recruitment and retention being managed. Programme is progressing to the revised agreed timelines - transfer decision in September 2021 and completion in April 2022. This also takes into account that the Programme Manager is now in post.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2020/21

Strategic Aim:	**Quality: To deliver high quality, compassionate services, consistently across all our sites Pathways: To develop pathways across care boundaries, where this delivers best patient care People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**					
Strategic Objective:	**People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term**		**Source of Risk:**	External	**BAF REF No:**	012/20 (was 13 and orginally COVID focused_
Principal Risk Decription: What could prevent the objective from being achieved? **Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**			**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner**	**Chief Operating Officer/ Chief Nurse**
			Risk Review Date:	Oct-20	**Lead Committee:**	**Board**
Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Covid 19 outbreak/pandemic increases nationally and world wide - increasing testing, self isolation, school closures, sickness ii) Potential increased need of respiratory and critical care beds iii) Potential increase from containment to 'social distancing' iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment and side room capacity	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive. Potential up to 20% of staff off sick in peak of outbreak ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk: Anticipate reduction to 15 in Spring 2021	5	4	20	⟺
		Target Risk:	5	2	10	
Controls/ Risk Treatment: **(Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.		**Positive Assurance Review Date**		**Key Performance Metrix aligned to IPR**
Major incident policy and Business continuity plans in place. Major Incident Command structure - Gold , silver, bronze - GOLD and SILVER command structures reviewed/adapted to ensure continued support to organisation / major incident Communcation plan - internal and external Emergency Planning Group - Chaired by COO COVID Specialist advisory group with task and finish group strucutre reporting to it	Business continuity - compliant assessment validated 2019 MVCC Business continuity tested 29 February - 01 March Montoring of Fit testing training / compliance Action plan - reviewed daily to respond to changing position Desk top review of pandemic flu plan completed Participating in regional STP covid table top exercise scheduled for 10.03.20	Business continuity - compliant assessment validated 2019 MVCC Business continuity tested 29 February - 01 March Legal guidance of trust responsibilites under civil contingency act - reported to Board April 2020. Critical care capacity maintained approx 50% 3 wks without any Hospital Acquired COVID				

COVID Specialist advisory group with task and finish group strucutre reporting to it. (Revised October 2020) including Testing Clinical Advisory Group Supporting staff testing through available routes- Action plans/workstreams Review of Pathways and local BCP's Linked intoand represented at Local and National resilience fourms/ communications/ conference calls Oncall rotas at various levels Fit testers and training / PPE logistics and Clinincal Advisory group Reviewed Board and Committee Governance structures approved and inplace in March 20 New weekly Quality Assurance meeting established in April - chaired by DoN/MD - supported by Compliance team and dashboard. (to support interim governance arrangement and quailty oversight during pandemic) Central record of contract / pathway reviews and agreed changes Record of national / regulaory changes and trusts response Patient experience inititives - tell us more, post discharge calls, patient laison role (on 9's), keep in touch - video calls and weblink to send photos/messages Staff skills and simulation training Critical care surge plan in place internal and regional Review and monitoring of O2 supply Increased mortuary capacity Monitoring, review and recording of all national guidance and directives recieved re pandemic Staff well being hub and deployment / reassignment processes Extensive works to supporting cohorting of covid patients ICP BAF June 2020 People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making	Participating in regional STP covid table top exercise scheduled for 10.03.20 Doning and doff training Task and Finish Groups - minutes and plans Incident management log Daily Gold command covid 19 briefings Record of national / regulaory changes and trusts response Record of contract/ pathway changes Record of all national guidance and trust response Covid 19 dash board - capacity of CCU, covid and non covid beds and occupancy Review and monitoring of O2 supply - Pipework upgraded in critical areas ICP BAF June 2020 People and placed based risk assessments - awards of COVID Secure (Non clinical) and COVID Commended (Clinical) Social distancing	5 wks without any Hospital Acquired COVID IPC BAF presented to QSC CQC review of IPC BAF July 2020 - assuranced on all ten KLOE CQC assurance on Medicines Management during COVID COVID SAG - review of structure. mins and action log. October 2020 EPRR report to QSC, September 2020. Review of ED pathway to Exective Committee and FPPC		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective	**Gaps in Assurance:** Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing 2.Possibility of staff coming back or being exposed to people who have come back from the affected regions and presenting for work without checking with Health at Work first. 3.Possibility of Trust visitors coming back or being exposed to people who have come back from the affected regions and presenting at the Trust. 4.There is a risk that patients are not screened on admission as per questions based on PHE guidance about recent travel. 5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take 6. There is a risk people in the community with symptoms are directed to ED, when they should stay at home - due to unclear community guidance 7. Business continuity plans may need to include WN-CoV. 8. Updates to national advice daily as the position changes 9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing	BCP's for high risk areas / small specialitist services Continuity of supplies as position changes - awaiting further national guidance on PPE Ability to step up capacity esp in respiratory and critcal care pathways Senario planning of all pathways / cohorting On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) October 2020: CQC Published FIRST re ED Prepareness - benchmarking commenced - engaement meeting with CQC being scheduled. Recruiting into PPE lead	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	Chief Nurse/ Medical Director	on going	meets weekly to problem solve, provide guidance and direction; gain assurance . Staff testing strategy under development. COVID Specialist advisory group , Chaired by Chief Nurse/ Medical Director with task and finish group structure reporting to it. (Revised October 2020)	In progress
ii) Testing Clinical Advisory Group leading policy, guidance and expertise regarding patients and staff testing	Medical Director	on going	Meets weekly to respond to changes to guidance and recommend changes to Covid SAG. Currently considering programme for testing staff - asymptomatic; response to LU4 local outbreak; trust patient testing. As above	In progress
iii) Develop trust approach and implementation plan for the Flu Campaign 2020/21	CPO	Q3	Campaign commenced. 31% as at 2nd wk October 2020. Comms in place and local peer vaccinators. Assurance Report due for FPPC in October and November Board.	In progress

iv) Continue Developing partnership working with Community and Care/Nursing homes to provide expertise to support care and treatment to prevent admission to hospital and improve outcomes	Chief Nurse	May / June 20	In place. Action closed. Trust remains represented on national learning group.	complete
v) Review lessions learnt to date from the COVID pandemic to inform trust wide major incident planning/ business continuity and pandemic prepardness	COO/ Chief Nurse	Oct-20	Initial Lessons learnt presented to Execs and Committees. Reflection and planning session held 23 September 2020 to inform planning, and triggers for MI response. Table top review held in September - Daily 'gold' meeting reinstated; supported by local dashboard (triggers inline with Opel status and leading indicators developed). Triggers re instating for flatpacked services under review. Annual review of all business continuity plans commenced in October 20 (this also supports EU Exit readiness).	In progress
vi) Prepare for National COVID Vaccination Programme in line with National Guidance	CPO / Emergency Planning	TBC once National Timeline confirmed	Task and finish group established including Chief Nurse, Operations, Estates, Medicines Management, HR.	In progress
Summary Narrative:				

October 2020: Risk reviewed with Emergency Planning Lead and COO. Reviewed assurances, controls, actions and level of risk. Review of risk - agreed likelihood of '4' likely x consequence '5'. Staffing is a critical factor currently - staff unable to work due to self isolation and unable to redeploy staff as during 'phase 3' operation recovery of services remains a competing priority whilst also managing winter pressures. Anticipate reduction to 15 in Spring 2021 . Proactive controls and mitigations remain in place to support readiness for a COVID second surge - our local Trust response and potential for mutual aid to our local Trusts.

Agenda Item: 11 (a)

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 30 SEPTERMBER 2020 EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 30 September 2020. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites.	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care.	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term.	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the FPC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 30 SEPTEMBER 2020

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

The following Non-executive Directors were present:
Karen McConnell (FPPC Chair), Ellen Schroder (Trust Chair), Jonathan Silver (Non-Executive Director), Bob Niven (Non-executive Director) and David Buckle (Associate Non-Executive Director).

The following core attendees were present:
Martin Armstrong (Director of Finance), Julie Smith (Chief Operating Officer), Thomas Pounds (Deputy Chief People Officer), Sarah Brierley (Director of Strategy), Michael Chilvers (Medical Director) and Rachael Corser (Chief Nurse).

MATTERS CONSIDERED BY THE COMMITTEE:

FPPC EVALUATION AND TERMS OF REFERENCE REVIEW
The FPPC received a short presentation on the effectiveness of the Committee and a review of the Terms of Reference. The FPPC endorsed the report, accepted the recommendations and approved the changes to the Terms of Reference.

The report and Terms of Reference are attached as item 11.1.

MONTH 5 FINANCE REPORT
It was reported that the Trust remained at a breakeven position at Month 5 in line with the national framework. The Trust received top-up Covid funding to maintain the breakeven position.

OVERVIEW OF FINANCIAL SUSTAINABILITY
The FPPC received a presentation on the financial sustainability of the Trust outlining key considerations in relation to the future financial strategy. Further detail would be considered at future meetings once the strategy had been discussed at the Strategy Committee.

COVID PHASE 3 DELIVERY AND FINANCIAL FRAMEWORK
The FPPC received a presentation detailing phase 3 recovery activity and the challenging financial implications. It was noted that part of the challenge in the second half of the year will be the change in the funding framework towards a system wide financial framework. The Committee considered next steps and will receive a financial plan for approval at the next meeting in October.

CAPITAL PROGRAMME REVIEW
The FPPC received an update regarding the Trust's Capital Projects, it was noted that some projects have been affected by Covid where access to areas has been restricted. Mitigation to prevent slippage of the Capital Programme was also noted. The Committee requested further details regarding the total capital budgets for the year, actual spend to date and proposed activity for the second half of the year at the next meeting. In particular this was to provide oversight and assurance that the capital funding available will be deployed within the current financial year.

BUSINESS CASE PROCESS
The FPPC received a short report regarding proposed changes to the Business Case Process. The Committee noted the current and proposed processes and supported the changes.

MVCC DUE DILIGENCE PROCESS
The Committee received a presentation on the MVCC due diligence highlighting the risks and mitigation in place. It was noted that the timeline had been delayed due to Covid-19 with a provisional transfer date of April 2022 discussed.

IMPROVING SERVICES THROUGH DEMAND AND CAPACITY PLANNING
The FPPC received both an endoscopy and a demand and capacity transformation presentation. The endoscopy recovery was a challenge which was ultimately successful due to a multidisciplinary approach. One key result is the Trust is the first Acute Trust in the region to implement FIT testing within secondary care. Key issues were highlighted within the covering reports and it was noted that the transformation model would be used as a blueprint for future transformations within the specialties. The endoscopy recovery and the approach adopted were welcomed by the Committee. The Committee requested that improvements arising from the demand and capacity transformational model for other priority specialities would come to future meetings

ED PERFORMANCE AND RECONFIGURATION UPDATE
The Committee received an update regarding the Trust's current Emergency Department's performance (87% compliance against the 4 hour standard for August) and actions taken to improve performance. In addition, they received an update regarding the reconfiguration of the red and yellow ED which was put in place during Covid-19. An overview of the ED capital programme was also given.

PERFORMANCE REPORT
The FPPC considered the key points in relation to operational performance for Month 5. The Committee noted that the cancer waiting times at the Trust YTD were all within target with the exception of the 62-day specialist screening service which was at 28% whereas the target is 90%. This is currently being reviewed and an update will be provided at the next meeting. Additionally, the Committee agreed to have a deep dive into stroke performance in December's meeting.

FLU VACCINATION PROGRAMME
The Committee received a presentation on the staff flu vaccination campaign plan. The campaign began this week and further updates will be given in future meetings.

PULSE SURVEY AND NHS STAFF SURVEY UPDATES
The FPPC was provided with the latest feedback and responses from the people pulse survey and given assurance of how the Trust will act upon feedback. Additionally, the Committee were given a presentation on the Trust's approach to carrying out the staff survey for 2020 and ensuring maximum uptake.

DIRECT ENGAGEMENT OF MEDICS
The FPPC received a presentation regarding Direct Engagement of Medics, which is an employment model for agency doctors. The Committee were provided with a review of direct engagement activity and performance.

NON-MEDICAL EROSTERING PROGRESS REPORT
The FPPC received an update regarding the progress of the erostering roll out and the performance to date, including the continued opportunities that exist around moving all staff onto a system based roster platform.

LEARNING FROM THE IMPERIAL COLLEGE HEALTHCARE TRUST DISCIPLINARY CASE

The FPPC received an update on how the Trust will utilise the learnings from this case. A paper will be brought to the Committee in November.

PEOPLE RISK REPORT

The Committee noted the latest report which provided an update on the risks currently identified on the Trust's risk register by the people team.

BOARD ASSURANCE FRAMEWORK

The FPPC considered the latest BAF. The BAF will be considered again at the Committee in October.

Karen McConnell
Finance, Performance and People Committee Chair

October 2020

Agenda Item: 11 (b)

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE – 28 OCTOBER 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Finance, Performance and People Committee (FPPC) meeting held on 28 October 2020. The report includes details of any decisions made by the FPPC under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites.	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care.	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term.	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the FPC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 28 OCTOBER 2020

SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 NOVEMBER 2020

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder, Jonathan Silver, Bob Niven, Biraj Palmer

Finance Update Month 6
It was reported that month 6 was the final month of the Covid financial framework. September was also the first month of the phase 3 activity recovery and there were increased costs. Although activity continued to increase in September there was a shortfall against the P3 target. This shortfall against target (£0.3m) has not been included in the figures in line with guidance issued by NHSE/I. The Trust will receive top-up Covid funding to maintain the breakeven position for month 6.

Covid Assurance Report
The FPPC received an update on the implementation of the Covid financial framework. It was noted that costs within the Trust had moved in line with NHSE/I expectations. In addition, the Trust made 45 applications for Covid capital funding of which 23 have been approved and 21 are awaiting decision with 1 having been denied.

Debt Recovery Progress Report
The FPPC received an update regarding the Trust's debt recovery progress. Significant progress has been made on the overall debt position with a 55% improvement within the first half of the financial year. New processes have been established which will continue to improve the debt recovery systems going forward.

Capital Programme Review
The FPPC received an update regarding the Trust's Capital Projects, including a rag rating for each capital programme scheme. Details regarding the total capital budget, spend to date and proposed activity was provided. It was noted that a consolidated list to support oversight of the spending of the capital allowance will be provided at the next meeting of the FPPC. The vascular capital programme scheme has been referred for a deep dive to the Strategy Committee in December.

Financial Plan Months 7 - 12
The FPPC received a presentation regarding the financial plan for months 7–12. The Covid emergency funding came to an end in September and it was noted that the funding framework has now changed to a system wide financial framework which does not have a retrospective element. It was also noted that the Trust has a statutory duty to remain at breakeven.

Elective incentive Scheme and Phase 3 Recovery
The FPPC received a presentation informing them of the NHSE/I elective incentive scheme which sets targets each month with the aim of re-establishing pre-Covid levels of elective activity and the Trust's current plans to achieve that aim. It was noted that the calculation of payments will be on actual activity priced at tariff and then compared with the baseline. The relevant marginal rate will then be applied to the difference. It was noted that targets are set at system wide, not provider level. Key risks to operational delivery included winter and Covid pressures, staffing and testing.

ENHT Way Development
The FPPC received a presentation outlining the Trust's new continuous improvement model. The soft launch of this new way of working is scheduled for 13th November 2020. The ENH way will support transformation of how pathways, patient outcomes and quality of care is

delivered whilst ensuring performance targets are met and clinical and financial sustainability are maintained. The approach was welcomed by the Committee.

Improvement Team Development

The Committee received a presentation detailing the PMO rebranding. The Transformation Office will adopt the organisations design principles agreed as part of the Trust's Covid pandemic learning to ensure there is a standardised and value-based approach to how the Trust embarks on new programmes. It is a matrixed way of working which will be embedded into the whole organisation with the inclusion of clinical advocates.

Corporate Matrix Working

The Committee was updated regarding corporate matrix working. The intention of matrix working is to provide better corporate support at all levels of the organisation, and to support empowerment of the new divisional structures.

Performance Report

The FPPC considered the key points in relation to operational performance for month 6. September had been a challenging month for ED with a performance of 84.84% against the 4 hour target. The Committee noted the steps being taken to secure improvements in performance and the expectation that the 'yellow ED' and 'red ED' reconfiguration will improve operations once it has been implemented. Performance against the Cancer targets remains strong. A deep dive into Stroke Performance will be presented to FPPC in December.

Winter Plan Mobilisation

The Committee received a presentation detailing the mobilisation plan for the winter period. The update included the current bed status and bed planning for the remainder of the year, winter planning progress, current emergency planning resilience and response position, and planning and preparation for the second Covid surge.

Health and Wellbeing

The Committee were updated regarding the staff flu vaccination progress and discussed the target which stood at 85% (current performance was approximately 50%). The NHSE assurance checklist was noted and would be presented at the next Trust Board meeting (see appendix 1).

Resourcing

The FPPC received a review about resourcing activities and performance between July and September 2020, including developments, branding and a forecast into the staffing position until March 2021. The current vacancy rate at the Trust is 5.7% with clinical support staff having the highest vacancy rate overall. Staffing levels in relation to activity was noted as a key area for review. It was agreed that a deep dive into temporary staffing will take place at the January meeting.

Board Assurance Framework

The FPPC considered the latest BAF. It was agreed to review risk 4, insufficient capital resources at the November FPPC. The Committee agreed that oversight of risk 5, the digital programme, will move to the Strategy Committee.

EU Exit Risk
The Committee received a paper noting the EU transition position and the approach the Trust has adopted to support risk mitigation and assurance. The Committee agreed that an update will be received at the FPPC each month.

Karen McConnell
Finance, Performance and People Committee Chair

October 2020

Agenda Item: 11 (b) Appendix 1

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

Staff Flu Vaccination Board Report

Purpose of report and executive summary (250 words max): It is a requirement that all Trusts are to provide assurance to their Board that all appropriate steps have been taken to ensure maximum uptake of staff flu vaccinations. This checklist is the standard proforma to confirm that all appropriate actions are in place.		
Action required: For assurance		
Previously considered by: FPPC – 27.10.20		
Director: **Acting Chief People Officer**	**Presented by:** **Acting Chief People Officer**	**Author:** **Head of Health at Work**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): None

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Healthcare Worker flu vaccination best practice management checklist

For public assurance via trust boards

A	Committed leadership	Trusts self-assessment – 19/10/2020
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers.	Staff flu vaccination plan presented by Chief People Officer, Board committed to achieving the ambition of vaccinating all frontline healthcare workers- 2nd Sep
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	Quadrivalent (QIV) flu vaccine ordered and provided.
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt.	Evaluation paper presented.
A4	Agree on a board champion for flu vaccine.	Board champion- Chief People Officer.
A5	All board members receive flu vaccination and publicise this.	Drop in vaccine clinic in Trust management corridor during first week.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	Team formed monthly meeting since May 2020.
A7	Flu team to meet regularly from September 2020	Meetings planned until end on October 2020.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published- sponsored by senior clinical leaders & trade unions.	Rationale for healthcare worker flu vaccination and facts published on KC, discussed in Friday Glisser. Promotional videos presented from Medical Director, Chief Nurse and CPO
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Clinic schedules promoted
B3	Board and senior managers having their vaccinations to be publicised.	Board & senior manager vaccination photos publicised on social media
B4	Flu vacation programme and access to vaccination on induction programmes.	Flu vaccines available at each induction
B5	Programme to be publicised on screensavers, posters and social media	Publicised on screensavers, posters and social media
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Daily vaccine uptake data available on QlikView and discussed at daily meetings
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	2 peer vaccinators for each clinical area requested. Vaccinators encouraged to be released to vaccinate in usual working hours, where this is not possible bank payments are supporting protected vaccination time. There are currently 51 active peer vaccinators across most clinical areas.
C2	Schedule for easy access drop in clinics agreed	Central areas for drop in clinics at each site including porta cabin at Lister main entrance.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Schedule for mobile clinics 7 days a week including early morning and later evening. Peer vaccinator availability over all shift patterns
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Business case submitted by CPO. Bank payments for peer vaccinators to support protected vaccination time. Incentives for top 3 peer vaccinators. Coffee vouchers –end of October
D2	Success to be celebrated weekly.	In weekly bulletin.

Agenda Item: 11.1

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020
FPPC Annual Evaluation and Review of Terms of Reference

Purpose of report and executive summary (250 words max):

This annual review considers how the FPPC has met its duties under its Terms of Reference during 2019/20, based upon analysis of the work of the Committee over the period (as evidenced through the minutes and summary reports) and also taking into account the feedback received via a survey of Committee members.

The findings of the review indicate that the FPPC has met its duties in the period, however the following recommendations are made to further strengthen the effectiveness of the Committee:

- To review and update the schedule for workforce reports to support stronger outcomes and ensure they are strategically focussed,
- To continue to monitor the forward plan regularly throughout the year to ensure that duplication with other Committees is avoided,
- To continue to strengthen the FPPC's approach to risk by ensuring the work of the Committee is focussed by the key risk areas,
- Following the pause due to COVID, to re-establish a programme of deep dives as a means for the FPPC to engage with and gain assurance from service lines and operational teams.

The Terms of Reference have been reviewed and updated and are attached for consideration.
Reflections and recommendations relating to changes following the COVID pandemic are set out in Appendix 1.

The report and updated Terms of Reference were considered by the FPPC at the meeting on 30 September.

The Trust Board is asked to approve the annual review and updated Terms of Reference.

Action required: For approval

Previously considered by:
FPPC – 30.09.20

Director:	**Presented by:**	**Author:**
Director of Finance	**FPPC Chair**	**Trust Secretary**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Governance

Any other risk issues (quality, safety, financial, HR, legal, equality):

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Introduction

The FPPC is a key assurance committee of the Trust Board. As defined by its Terms of Reference (last reviewed and approved by the Trust Board in November 2019), the purpose of the Committee is: '… to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.'

This annual review considers how the Committee has met its duties under its Terms of Reference during 2019/20, based upon analysis of the work of the Committee over the period (as evidenced through the minutes and summary reports) and also taking into account the feedback received via a survey of Committee members.

Additionally, this report considers the changes that were made to the governance structures during the COVID pandemic from March 2020.

Meetings and membership

There were no significant changes to the meeting format and membership over 2019-20. (The temporary changes in response to the COVID pandemic are detailed separately later in the report). Any changes to Board personnel are outlined in the Trust's Annual Report 2019-20.

Reporting arrangements

The Chair, supported by the Trust Secretariat, provides a summary report for consideration by the Trust Board after each meeting. These reports were ceased for a brief period during the COVID pandemic period as the whole Board was in attendance at the meetings.

Key duties and responsibilities of the FPPC:

The following section of the report explores how the FPPC has met its key duties and responsibilities under its Terms of Reference.

Finance

- The Committee considered a review of successes and issues arising from the 2018/19 CIP scheme as part of the planning process for the 2019/20 programme, as well as monitoring delivery of the 19/20 programme.
- The Committee periodically received an update on key financial risks and opportunities as the Trust worked towards its financial plan for 2019/20.
- A key consideration for the Committee through the year was the Trust's pay bill. The Committee worked with the Audit Committee to seek assurance on this issue and any control weaknesses.

- On behalf of the Board, the FPPC reviewed the costing submission, ensuring it met the expected requirements.
- The FPPC were kept appraised of the year end forecast on a regular basis, supporting and scrutinising the updates as the Trust moved towards achieving the control total target for the first time in five years.

Performance

- The FPPC continued to monitor performance on a monthly basis through the 'Responsive services' section of the IPR. This provided the Committee with data on performance against each of the national performance standards. Improvements in the cancer standards were one of the most significant developments in terms of operational performance over the course of 2019/20.
- The FPPC spent some time early in the year agreeing a format and process for a series of deep dives from the operational teams. These deep dives covered key operational performance issues, as well as other updates on issues such as CIP plans and compliance. The deep dives concerned a range of services and issues, including theatres and outpatients. The Committee also developed a mini dashboard to monitor progress following some of the deep dives.
- The FPPC reviewed winter initiatives in summer 2019, with a view to identifying which initiatives could be replicated the following winter to aid operational performance.

Workforce

- The Committee reviewed and endorsed key workforce strategies and policies, including the Employee Relations Strategy 2019-24 and the People Strategy.
- The FPPC received regular assurance reports on issues such as the staff flu vaccination programme and high value contactors and agency staff.
- The FPPC reviewed and recommended the Workforce Disability Equality Standards and Workforce Race Equality Standards submissions for final approval by the Trust Board.
- The Committee also received regular updates regarding workforce risks and mitigating actions being taken.

Strategy and IM&T

- The FPPC has been kept appraised of the process for the transfer of the Mount Vernon Cancer Centre and received assurance regarding the due diligence process.
- The FPPC received regular updates regarding the Trust's Digital strategy as the Trust moved out of the stabilisation period and approved the draft Digital Strategy 2019-2024.
- The Committee received updates on key strategic projects throughout the year.

Response to the COVID pandemic

Changes to the governance process were made following the pandemic in March. These are detailed and explored further in Appendix 1.

Changes to the remit of the FPPC

It was agreed in 2019 that the FPPC would include a greater focus on workforce issues at their meetings. The Terms of Reference were expanded accordingly in November 2019 and the report cycle was updated to include workforce reports regarding areas such as training compliance, workforce planning and equality and diversity.

The view from the survey results is that the increased focus on workforce has been welcomed, but greater foreplanning and focus (with clear outcomes etc.) would be beneficial going forward.

During the course of 2019/20, it was discussed and agreed that a separate sub-committee of the Board would be established to focus on strategy as part of the implementation of a revised delivery framework for the Trust. The Terms of Reference for the new Strategy Committee were approved by the Board when they met on 2 September. The FPPC's Terms of Reference have been updated to reflect a shift in focus on strategy issues. It is hoped that this will also help to improve capacity at the FPPC meetings.

Conclusion

The findings of the review indicate that the FPPC has met its duties in the period. The financial and operational performance improvements (which have now been sustained over several years) are evidence of this.

Recommendations for 2020/21:

- To review and update the schedule for workforce reports to support stronger outcomes and ensure they are strategically focussed,
- To continue to monitor the forward plan regularly throughout the year to ensure that duplication with other Committees is avoided,
- To continue to strengthen the FPPC's approach to risk by ensuring the work of the Committee is focussed by the key risk areas,
- Following the pause due to COVID, to re-establish a programme of deep dives as a means for the FPPC to engage with and gain assurance from service lines and operational teams.

Reflections and recommendations relating to changes in relation to the COVID pandemic are set out in Appendix 1.

The Committee’s Terms of Reference have been reviewed as part of this process and some updates are proposed. These are primarily to reflect the impact of the new Strategy Committee. The updated Terms of Reference are attached as Appendix 3.

The Committee are asked to:

- Consider the findings of the review and consider any further actions.

- Recommend the amended Terms of Reference and approve this annual review for submission to the Trust Board.

Appendix 1 – Changes to meetings as a result of the COVID pandemic

Summary of changes:

FPPC and QSC: Initially the FPPC and QSC meetings were combined in order to streamline business. Additionally, there was a focus on core business only. These meetings were then separated into two distinct meetings but held on the same morning, before being moved back to their original meeting dates. Agendas have gradually returned to BAU though some changes to the report cycles remain in place.

Audit Committee: The Audit Committee continued to meet as planned, albeit on different dates on account of the changes to the deadline for the submission of the annual report and accounts for 2019/20.

Charity Trustee Committee: The CTC meeting scheduled for June was initially postponed but later reinstated and held as originally planned.

Trust Board: The Trust Board continued to meet on a regular basis, though it has not been possible for meetings to be held in public. The Trust continued to publish a range of reports and data that would ordinarily have been published as part of the public Trust Board meeting pack. The Trust Board did not hold a Board Development session in the period, but instead held additional meetings of the Trust Board on the dates that those sessions had been planned.

Other arrangements: Regular meetings were scheduled for the Non-Executive Directors to keep in contact with the Chief Executive and other Executives on a rolling basis.

The Trust was guided by the national guidance in putting these arrangements in place and anecdotally appears to have maintained Board and Committee meetings to a fuller extent than many other trusts.

The feedback received to date is that the changes were generally effective and welcome.

Current position:

As at the start of September 2020, the intention is to return to the original meeting schedule for the remainder of the year.

Recommendations:

As the Trust prepares for and begins to enter the winter period, it is proposed that the situation is monitored on a regular basis and discussions are held with the Committee Chairs and lead Executives to agree changes to meetings on a case by case basis. It is recommended that meetings should be kept separate as far as possible.

It is also proposed that, should meetings and agendas need to be reduced and streamlined, a focus on risks is maintained and used to inform agenda planning.

It is suggested that the revised approach in terms of the IPR is maintained for now and reviewed as appropriate in-year.

Appendix 2 – Survey findings

In terms of the FPPC agendas and papers, do you feel these are structured effectively and cover the right issues?

The respondents agreed that agendas and papers were mostly structured effectively and covered the right issues. It was suggested that some further work could be undertaken to ensure workforce papers are planned and reflected in the forward look, based on risk areas and strategically focussed.

Do you feel able to challenge the Trust at the meetings?

The respondents all confirmed that they felt able to challenge the Trust at the meetings.

Do you think enough time and attention is given to the key areas of Committee's remit?

The respondents agreed that this is mostly the case, though on occasions timings can be challenging. The introduction of the Strategy Committee was noted as a possible enabler of greater capacity at the FPPC meetings.

What do you think has worked well over the last year and what do you see as the main achievements of the Committee?

The respondents highlighted the inclusion of workforce issues within the agenda and the strong financial governance to support the financial improvement journey as issues that had worked well. Other achievements that were highlighted included assurance on the digital strategy and the effective deep dives in areas including theatres and PTL management. The open and honest discussions and chairing were also highlighted.

What do you see as being the main areas for improvement for the FPPC over 2020/21?

Suggestions included:

- Ensuring there is no duplication between QSC and FPPC agendas
- Stronger focus on key risk areas in relation to people
- Work on ensuring papers / presentations are succinct
- Increased involvement with the new operational structure

Do you feel the FPPC has effective links with the Board and other sub-committees? How could this be improved?

The respondents agreed there were good links with the other Committees but it was acknowledged that avoiding duplication regarding some issues was a potential challenge, particularly as the Strategy Committee is established.

In terms of the changes made to the meetings in response to the COVID pandemic:

- What do you think worked well and could be retained?

- What do you think we could do differently if further changes are required over the remainder of the year?

- How do you think we can ensure an agile approach going forward?

- Any thoughts on the changed approach in terms of the IPR?

Respondents were positive about the changes made in response to the COVID pandemic. It was noted that the change to electronic meetings posed some challenges but had mostly been successful.

It was recognised that some changes in approach may need to be re-enacted over winter, depending on the pressures faced. This may involve a truncated agenda and agile approach supported by maintaining a strong focus on risk. It was suggested that separate meetings had been more effective than joint meetings.

The point was also made that the Committee should be careful to ensure that COVID issues do not dominate the agendas.

It was suggested that the approach in terms of the IPR could continue to be monitored and considered over the remainder of the year.

How effective do you think the Committee's approach to risk has been and how could this be strengthened?

It was felt that the approach to risk had improved over the year but could be strengthened further, including by ensuring the work of the Committee is focussed by the key risk areas. It was noted that a new risk scoring mechanism should enable greater oversight of the key issues and support better analysis.

Any other comments?

Respondents believed that on the whole the FPPC has been effective in exercising its duties.

FINANCE, PERFORMANCE AND ~~WORKFORCE~~ PEOPLE COMMITTEE

TERMS OF REFERENCE

1. Purpose

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

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls;
- ~~maintaining oversight of the development and implementation of the Trust's digital strategy;~~
- ~~to monitor the creation and operation of the Trust's estates strategy;~~
- overseeing risk management for the duties of the Committee.

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

2. Status & Authority

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

3. Membership

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

Core Attendees:

Chief Executive
Director of Finance
Chief Operating Officer
Director of Strategy
Chief People Officer
Director of Nursing
Medical Director
~~Associate Director of Corporate Governance~~

Attendees:

Trust Secretary
Deputy Director of Workforce and OD
Associate Director of Governance
Chief Information Officer
~~PMO Director~~Director of Transformation
Deputy Director of Finance Financial Management

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Deputy Director of Finance Financial Planning

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 and prior to Trust Board meeting. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

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

To approve:

- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To approve and recommend to the Board:

- The Trust's Marketing strategy and review and monitor progress against this;
- The Trust's Business Plan, including the approved financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy including the Long Term Financial Model;
- Proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities;
- Adoption of the annual plan and budgets for revenue and capital;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- The Cost Improvement Programme. Any potential concerns on quality are to be referred to the Quality and Safety Committee (QSC).

To monitor and review:

- Enabling strategies (specifically the digital, estates, capital and people strategies) and their impact on the Medium Term Financial Strategy including the Long Term Financial Model as appropriate. However, it is expected that much of this work will take place at the Strategy Committee from October 2020;
- The capital programme and work of the Capital Review Group;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor ~~in~~ in-year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- Progress against the Sustainability Transformation Plan;

- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:

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

To monitor and review:

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

6.3 Financial Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHS Performance Management Framework (NHS Trust). This review should include:

To determine or approve:

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

To recommend to the Board:

- The application of contingency funding where appropriate;

To monitor and review:

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

6.4 Operational Performance

To monitor and review the Trust's operational performance, including consideration of issues such as winter preparedness, significant operational service developments and compliance with national performance standards.

The Committee will receive regular updates regarding the national performance standards, currently:

- A&E,
- Cancer waiting times,
- Referral to treatment,
- Diagnostics,
- Stroke.

6.45 Workforce

To monitor and review:

- The people strategy and key indicators in relation to finance and performance;
- Reports relating to: workforce planning, inclusion, resourcing, employee relations, appraisals and statutory and mandatory training, and staff survey actions.
- Any other workforce matters deemed relevant to the role of the Finance, Performance and ~~Workforce~~ People Committee (as opposed to the QSC).

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6.~~6~~7~~5~~ Other duties

To monitor and review:

- Procurement activities, progress against savings targets, tender waivers and key strategic tenders.
- Major change projects which may impact on the core areas of the Committee's work.

6.76 Risk Reporting

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

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Executive 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;
- ~~FPWC~~ FPPC annual evaluation and review of its terms of reference.

9. Support

The ~~Associate Director of Corporate Governance or~~ Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

Agenda Item: 12

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 30 SEPTEMBER 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary:

To present the report from the QSC meeting of the 30 September 2020 to the Board.

Action required: For discussion

Previously considered by:
N/A

Director:	**Presented by:**	**Author:**
Chair of QSC	Chair of QSC	Trust Secretary / Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

The discussions at the meetings reflect the BAF risks assigned to the QSC.

Any other risk issues (quality, safety, financial, HR, legal, equality):

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QUALITY AND SAFETY COMMITTEE MEETING – 29 SEPTEMBER 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON WEDNESDAY 4 NOVEMBER 2020

The following Non-Executive Directors were present:
Ellen Schroder, David Buckle, Peter Carter, Val Moore

The following core attendees were present:
Rachael Corser, Michael Chilvers, Nick Carver (between 09:30 – 10:30), Julie Smith

Matters considered by the Committee:

Sepsis Deep Dive
The Quality and Safety Committee heard a Sepsis related patient story that demonstrated the potential severity of Sepsis even when the teams are taking the appropriate actions. It was reported that the Trust was performing well out of hours and under pressure. The Committee discussed areas for improvement including fluid balance charts and more education around the identification of deteriorating patients. There was also recognition that over the past two years significant improvements had already been made.

Quality Assurance Dashboard
The Quality Assurance Meeting dashboard provided a range of key performance metrics including Serious Incidents, risks, patient experience, safeguarding and CQC compliance. The Committee were informed that there was a plan to review and scope one single risk from the four risks scoring over 20 submitted by the Plastics team.

The Committee discussed the HSE Improvement notices.

The Committee were informed of a recent Never Event that had occurred. They were assured there was no patient harm and the learning was being shared.

IPC Report
The Committee noted the content of the IPC report. The Chief Nurse explained that over the last two reporting periods there had been only one probable hospital acquired case of COVID-19. She said there was continued messaging about social distancing and the use of PPE to staff.

The Chief Nurse informed the Committee that work was ongoing to address the water safety issues at MVCC. She said PHE and NHSE/I had both been supportive of the work being undertaken.

Safer Staffing Report
The Chief Nurse highlighted that the overall Fill rate had reduced through August and was expecting a further reduction throughout September. She commented that there had been a reduction in staff sickness in the same time period though the effects of the pressures of the last six months was now potentially having a greater impact on staff sickness.

Clinical Harms Review
The Medical Director explained that the process had a new SOP. He said the most significant change was to the risk stratification of patients which had been recommended by the Royal College of Surgeons.

The Medical Director explained that the Deputy Chief Operating Officer was managing the RTT breach recovery. He said it had been estimated that up to 40% of breaches were likely to be as a result of data anomalies. He said an additional 14 data validators were being used to authenticate the data.

The Medical Director informed the Committee that patients were being prioritised based on their clinical need. He said it would mean some patients may wait for longer than others but the most vulnerable would be seen by a Clinician sooner.

Learning from Deaths
The Medical Director presented the report to the Committee and highlighted that the broad mortality numbers had plateaued. He said the Medical Examiners would commence in post on October 1st and their initial focus would be on Critical Care and Cardiology.

The Medical Director reported that the early COVID mortality data had been analysed and it indicated the majority of COVID deaths in the Trust were elderly male patients.

NHS Patient Safety Strategy
The Chief Nurse commented that the strategy had been published earlier in the year. She explained that the proposal was for the Deputy Chief Nurse to manage the strategy and enter the role of Patient Safety Specialist, along with Dr Brammal (Associate Medical Director, Patient Safety).

BAF
The Associate Director of Governance confirmed that the risks overseen by the Committee had been covered through the agenda.

The Associate Director of Governance reported that the next significant risk review would introduce the new risk matrix and would be undertaken over the next two to three weeks. She confirmed that the risk reviews would be undertaken with the Divisions and would commence with the risks scored at 20 and above.

Emergency Preparedness
The Chief Operating Officer presented the report to the Committee and informed the members that the Trust remained compliant against the EPRR core standards. She reported that the Trust's COVID incident management would accelerate as required however activity would not be stepped down without due consideration.

REPORTS FOR NOTING

Maternity Dashboard
The Committee noted the content of the Maternity Dashboard.

IPR
The Committee noted the month 5 report.

Peter Carter, Chair
September 2020

East and North Hertfordshire
NHS Trust

Agenda Item: 12

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

QUALITY AND SAFETY COMMITTEE – MEETING HELD ON 27 OCTOBER 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 27 October 2020 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary / Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the QSC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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QUALITY AND SAFETY COMMITTEE MEETING – 27 OCTOBER 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON WEDNESDAY 4 NOVEMBER 2020

The following Non-Executive Directors were present:
Ellen Schroder, David Buckle, Peter Carter, Val Moore, Biraj Parmar

The following core attendees were present:
Michael Chilvers, Nick Carver, Julie Smith, Jude Archer

Matters considered by the Committee:

Harm Review (Clinical Prioritisation)

The QSC received a deep dive regarding the national mandate to undertake a clinical prioritisation process for admitted patients. Some patients required a conversation with a clinician for the priority level to be determined whilst others could be prioritised through an administrative process. The Committee discussed the possibility of healthcare inequalities and fully informed consent if some patients decide they cannot shield for two weeks prior to having surgery. It was agreed that further detail in relation to possible health inequalities and an additional deep dive in relation to the harm review process in general would be provided for a future meeting. The Committee also discussed the help that system partners might provide in this work.

Discharge SI

The Committee considered a deep dive regarding the findings arising from a review of incidents associated with patient discharges. 310 incident forms from across a two year period were reviewed and the key themes identified included medication incidents, communication errors and incidents involving cannulas left in place. The report also included the key messages from the recent 'Hospital discharge service: policy and operating model' guidance. The Committee was informed of the actions the Trust would be taking in response to the findings of the review, including redesigning documentation to create 'discharge passports' for patients. The Committee recognised that there were multifactorial issues that would need to be addressed but welcomed the insight this review provided and supported the actions being taken.

Quality Assurance Dashboard and Compliance Update

The Committee noted the latest edition of the Quality Assurance Dashboard and compliance report. It was reported that the number of complaints received had increased in line with increased activity within the Trust.

Regarding latest developments in relation to the CQC, it was noted that the CQC had recently published its draft strategy for 2021and that the Trust was due to undergo a virtual CQC assessment in relation to Patient FIRST - a support tool designed by clinicians, including practical solutions that all emergency departments should consider as a means of supporting good, efficient and safe patient care.

The Committee also discussed the latest position in terms of the HSE improvement notice.

Infection Prevention and Control Report

The IPC lead nurse attended the meeting to present the latest IPC report. The report showed good progress in relation to a number of the KPIs. One area where challenges remained was in relation to SSIs and a different approach with greater ownership of the performance at a local level was being deployed to address this. The Committee also discussed the latest position in terms of managing patients with Covid, including regarding nosocomial infections. The Committee would discuss the details of recent outbreaks and possible nosocomial infections in further detail and review how the Trust benchmarked against other trusts at the next meeting.

Safer Staffing Report

The September Safe Staffing Report was considered by the Committee. It was reported that there had been a slight decrease in Care Hours Per Patient Day, mainly due to challenges with fill rates and in relation to opening the winter ward. Sickness had also increased across the qualified and non-qualified nursing staffing groups. The Committee concluded that most of the indicators presented in the report indicated increasing pressure on staffing. The Committee also discussed some of the additional staffing challenges in terms of providing care for mental health patients.

VTE Service Update

The Committee considered a report which summarised the half year performance in terms of hospital acquired thrombosis (April – Sept 2020). Trends and themes had been reviewed and learning identified, with processes and structures being reviewed and established to improve performance. One of the most significant challenges would be improving VTE risk re-assessment rates and ensuring ownership of the issues at a local level. The Committee noted the update.

SI Report

The Committee considered the latest SI report which provided an update on serious incidents for 2020, including an overview of the numbers and types of incidents declared and key trends. It was reported that the rate of incident reporting had increased in line with the increased activity undertaken at the Trust over recent months. It was reported that the total number of SIs was reduced in the year to date (also thought to be related to reduced activity) and that there had been one Never Event reported in September (the first in almost one year). The Committee discussed the details of the Never Event and noted the report.

BAF 2020/21

The latest BAF was presented to the QSC. The risks had been reviewed and updated using the new risk scoring methodology, which had led to a reduction in three of the risk scores. It was noted that the Audit Committee had recently undertaken a deep dive regarding the pandemic risk. The report also included some benchmarking following analysis of other NHS trusts' BAFs. The Committee noted the report.

Appraisal and Statutory and Mandatory Training

The QSC received an update regarding the Trust's appraisal and statutory and mandatory training processes. Compliance had reduced significantly over the Covid period but there had been an increase in compliance more recently. It was reported that an elearning system was now in place and some of the challenges associated with the implementation of an electronic system were being addressed. It was also noted that the appraisals system had recently been revised and the new system was based on an annual cycle of appraisal conversations. The Committee noted the update.

Junior Doctors Contract Quarterly Update

The guardian of safe working hours joined the meeting to present the latest quarterly report. For the period there were 22 exception reports submitted regarding overtime hours. From the beginning of August 2020, all junior doctors were back on their training rotas, having previously been on Covid-19 emergency rotas. There were no patient safety concerns to report and all the outstanding reports carried over from the last report had been completed and closed. The Committee were advised that there was limited benchmarking available but from informal feedback it appeared that the Trust's reporting levels were not dissimilar to other organisations. The Committee noted the update.

QSC Annual Review 2019-20 and Review of Terms of Reference

The Committee considered the QSC annual review 2019-20 and review of Terms of Reference. The review concluded that the Committee had fulfilled its duties but made a couple of recommendations to further strengthen the effectiveness of the Committee. The Committee endorsed the review and draft Terms of Reference for approval by the Trust Board.

The report is attached as a separate agenda item.

The following reports were noted by the Committee:

- Maternity Dashboard
- Integrated Performance Report M6
- Perinatal Mortality Review Group Report

Ellen Schroder, Deputising as Committee Chair

October 2020

Agenda Item: 12.1

TRUST BOARD – PUBLIC SESSION – 4 NOVEMBER 2020
QUALITY AND SAFETY COMMITTEE ANNUAL REVIEW 2019-20

Purpose of report and executive summary (250 words max):
The purpose of the report is to provide the findings of the Quality and Safety Committee annual review for 2019-20.

The review has not highlighted any material issues and concludes that the QSC has met its duties under its terms of reference, but recognises the challenges posed by the Covid pandemic.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to reflect the creation of the new Strategy Committee and to clarify the Committee's remit in relation to workforce matters.

To support strengthening the effectiveness of the Committee, the following actions are recommended for consideration:
- To review the annual cycle for the remainder of the year to ensure reports / deep dives are prioritised by risk and to explore the possibility of returning to a BAU / deep dive structure as part of the production of the 21/22 annual cycle.
- To develop guidance for report presenters to ensure salient points are highlighted succinctly and to help structure deep dive presentations.

The Trust Board is asked to approve the annual review and updated Terms of Reference.

Action required: For approval

Previously considered by:
QSC – 27.10.20

Director: Director of Finance	**Presented by:** QSC Chair	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

Any other risk issues (quality, safety, financial, HR, legal, equality):
Quality, safety, reputational, governance

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

QUALITY AND SAFETY COMMITTEE
ANNUAL REVIEW 2019/20

Executive Summary

The Quality and Safety Committee (QSC) is a key assurance committee of the Trust Board. The following extract from the Committee's current Terms of Reference sets out the current purpose of the Committee:

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

This annual review considers how the QSC has met its duties under its terms of reference over the course of 2019/20 and also considers the impact and influence of the Covid pandemic in 2020/21 to date. Consideration of the QSC meeting minutes, reports to the Board and the findings of a survey of QSC members have been used to inform the findings of this report.

The review has not highlighted any material issues and concludes that the QSC has met its duties under its terms of reference, but recognises the challenges posed by the Covid pandemic.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to reflect the creation of the new Strategy Committee and to clarify the Committee's remit in relation to workforce matters.

To support strengthening the effectiveness of the Committee, the following actions are recommended for consideration:

- To review the annual cycle for the remainder of the year to ensure reports / deep dives are prioritised by risk and to explore the possibility of returning to a BAU / deep dive meeting structure as part of the production of the 21/22 annual cycle.
- To develop guidance for report presenters to ensure salient points are highlighted succinctly and to help structure deep dive presentations.

The Committee is asked to:

- Discuss the findings of the effectiveness review and consider any further actions.
- Recommend the amended terms of reference and approve this annual review for submission to the Board.

Summary of Key Findings

Meetings and Membership

The QSC met eleven times during 2019/20. The meetings took place on a monthly basis, with the exception of August, when no Board committees are routinely scheduled.

There were no personnel changes affecting the QSC over 2019/20. Dr Peter Carter remained as Chair of the Committee and Ms Moore and Dr Buckle remained as the other Non-Executive Director members of the Committee. Changes to the executive director roles during 2019/20 are reflected in the Trust's annual report.

Review of workforce reporting

The split of workforce issues between FPPC and QSC was agreed as part of last year's annual review process. At that point, it was agreed the majority of workforce issues would be assigned to the FPPC's remit; however there were some specific issues that it was felt would be more appropriate for the QSC to maintain oversight of. The FPPC review concluded that the allocation was broadly correct but highlighted the need to ensure a strategic focus from the reports and to ensure that duplication between the committees is avoided. Some minor changes are proposed in relation to the QSC Terms of Reference to clarify which issues fall within its remit.

QSC meeting format

There was a change to the meeting format from September 2019, when the Committee decided to implement alternating 'Deep Dive' meetings (to consider certain topics in greater detail) and 'BAU' meetings (where most routine reports were considered). This system was in place up until the point at which changes were made due to the Covid pandemic. It is suggested that a hybrid approach remains in place for the remainder of the year and that the Committee considers reverting to the alternating meeting format from April 2021, if capacity allows at the time.

QSC Member Survey

The efficacy of the Committee has also been assessed by sending a questionnaire to Committee members and others who regularly attend the meetings. A total of 7 responses were received. The key findings under each question are detailed below.

Does the agenda cover the correct topics?

The respondents agreed that the agendas broadly cover the correct topics.

Are there topics on the agenda that are too operationally focused?

The respondents mostly agreed that the agenda items are not too operationally focussed.

Do you think there are topics not included on the agenda that should be?

Suggestions for additional focus were:

- Staff and patients' quality and safety experiences
- Relevant ICS / ICP developments
- EOLC

It was also suggested that consideration should be given to how the Committee engages with the new divisional structures, in particular regarding deep dives, which could be an opportunity for cross pollination of ideas. The issue of the split between the FPPC and QSC of workforce matters was also raised.

Do you feel that there is adequate time to discuss each topic in detail?
The respondents agreed this was generally the case, supported by the chairing of the meetings.

Are discussions summarised and is the conclusion clear?
The respondents felt this was mostly achieved but some greater clarity on conclusions may be helpful.

Do you feel that enough time and attention is given to the key areas of the Committee's remit?

- *Strategically managing risk*
  Mostly agreed (this was the category that most respondents felt was covered to a lesser extent than the others)
- *Ensuring compliance*
  Mostly agreed
- *Improving quality*
  Mostly agreed

Do you feel able to challenge the Trust at the meetings?
Yes, all respondents agreed. There was feedback that the level of challenge from the NEDs was effective and constructive.

In terms of the changes made to the meeting in response to the COVID pandemic:
- What do you think worked well and could be retained?
- What do you think could be done differently if further changes are required over the next 6 months?
- How do you think the Committee can maintain an agile approach going forward?

Respondents mostly felt that the Committee has responded well to the challenges posed by Covid whilst maintaining an effective focus on quality and safety. The changes in relation to the IPR and the introduction of the Quality Assurance Dashboard were welcomed.

It was felt that the steps taken during the pandemic were the correct ones and a similar agile and pragmatic approach would be needed going forward. There was a suggestion that there could be greater focus on specific topic areas outside of the meeting if required.

There was some appetite to return to the BAU / deep dive meeting format when the right time comes.

Some of the technical challenges of holding meetings virtually were also highlighted.

How has the Committee added value to the Trust's operations over the last year?
The respondents highlighted the greater focus on quality and safety, a good oversight of key issues and engagement with divisional and operational colleagues to provide assurance.

Any other comments on how the Committee's effectiveness could be improved.
Suggestions / comments included:

- Reducing the amount of information provided at each meeting and greater assurance of the role of the QSC subcommittees
- Providing clear guidance to presenters that reports should be taken as read and only salient points need to be presented
- To consider how best to provide assurance of progress against Quality Account priorities throughout the year

- The skill mix and background of the NEDs supports effective input and discussion at Committee meetings.

Key duties and responsibilities of the QSC:

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

Managing Risk

The Committee has continued to consider the BAF and risk register report on a monthly basis, and agendas have been formulated so as to ensure that the core elements of the agenda are in relation to the key strategic risks.

The QSC has been kept informed of the developments regarding CQC inspections and also regarding the Trust's HSE inspection in September 2019. The Committee was also kept informed of progress against key actions arising from reviews.

The Committee has also been kept informed of estates and facilities compliance and risks, and was alerted to the key challenges the Trust faced whilst was recruiting a permanent Director of Estates and Facilities. The permanent Director of Estates and Facilities commenced in post in January 2020 and has recently agreed with the Chair a new process and format for reporting of compliance going forwards.

Emergency Preparedness and Resilience reports have also been considered by the Committee on a regular basis providing assurance regarding the Trust's ability to respond to a business continuity incident. The QSC has monitored the Trust's EPRR core standards assurance rating submission – currently 'fully compliant'. The Trust's Covid pandemic response was also coordinated through the EPRR team and has been included as a feature of recent EPRR update reports considered by the Committee.

Up to the start of the Covid pandemic, the QSC continued to receive a rolling programme of presentations from each division which included details of divisional objectives, governance structures, quality, safety and risks. Any significant issues were highlighted to the Trust Board through the QSC summary reports. Consideration will now be given to how and when to reinstate these presentations.

The Committee sought assurance that Cost Improvement Plans had been judged to be clinically appropriate and that capital bid programmes had undergone a rigorous process of prioritisation and risk assessment. The QSC were assured that all CIP schemes were subject to formal review by the Medical Director and Director of Nursing.

The QSC has continued to maintain a focus on key risk areas from a patient safety perspective, considering deep dives into areas including the clinical excellence accreditation framework, safer surgery and NATSSIP and pressure ulcers.

The Committee has worked closely with the Audit Committee, reviewing and commenting on the draft internal audit plan and reviewing the clinical audit annual report.

The Committee received monthly updates on nurse staffing levels – even into the Covid period when the national reporting requirements were reduced. The Committee also considered the two biannual nursing establishment reviews before they were considered by Trust Board for final approval.

The QSC has continued to receive a monthly update regarding the Trust's clinical harm review process.

Ensuring Compliance

The Medical Director and Chief Nurse have continued to ensure that the QSC has been informed of and equipped to monitor the Trust's compliance with the national and local quality safety governance standards and frameworks, both through routine reports and on an ad hoc basis depending on national publications etc.

The QSC has received a regular compliance report throughout the period. This has covered issues including compliance with CQC standards, document management and information governance (including the Trust's Data Security Protection Toolkit submission).

The QSC received a monthly IPC report and assurance from the Chief Nurse regarding actions to address any issues identified. A new IPC lead nurse commenced in post during the period and the Committee has monitored the Trust's IPC performance over the transition period. The Committee has maintained a focus on the key challenges in terms of IPC. IPC has also been a particular focus in relation to Covid.

The QSC has continued its role of reviewing and endorsing the annual responsible officer's report regarding medical staff revalidation, prior to submission (however the national process has been altered in 2020 due to the Covid pandemic).

Through the reports scheduled on the annual cycle the QSC has ensured that it monitors compliance with a range of regulations and standards on a periodic basis, including infection prevention and control, fire safety, controlled drugs and medical devices.

The QSC has also reviewed and approved a number of annual reports including the Patient Experience Annual Report, Health and Safety Annual Report and Safeguarding Annual Report (the latter two reports were referred to the Trust Board for final approval).

The QSC received the draft Quality Account for comments and approval at the meeting on 24 June 2020 (later than usual due to changes to the national deadline as a result of Covid).

Improving Quality

The QSC received the annual report of the formal arrangement with the University of Hertfordshire. The Committee noted progress on the priority work streams which report into the Joint Management Committee. The Committee also considered reports regarding the internal education arrangements and plans to centralise the Trust's approach in this regard.

The QSC has continued to closely monitor the Trust's mortality rates, which performed well during the period, receiving a quarterly Learning from Deaths report, as well as regular updates through the Integrated Performance Report. The Committee has also scrutinised mortality outliers and the ongoing work to improve mortality and will consider information regarding mortality of Covid patients as it becomes available.

The Committee was kept informed of the work the Trust undertook in relation to the Learning from Deaths national requirements and also in relation to the implementation of 7 day working. The implementation of the Medical Examiners role was delayed due to Covid but is due to commence from October.

The QSC has continued to monitor new, ongoing and closed incidents and Serious Incidents, including trends and key themes.

The QSC has also continued to closely monitor complaints data, including response times and the common categories for complaints. The Committee have also reviewed the feedback from external surveys regarding patient experience. It was the intention to hold a deep dive in relation to complaints before the Covid pandemic and this is now planned for later in 2020.

A key component of the dep dive programme prior to its pausing was the quality improvement work streams. This enabled the Committee to monitor progress and provide support in terms of the development of the programmes.

As agreed when the committees were reviewed last year, the QSC included workforce deep dives within its schedule for the year, and held a session regarding the staff survey results.

The Committee has maintained its oversight of key escalations from ward and service level by receiving escalation reports from its subcommittees at each meeting.

Reporting Arrangements

The QSC has continued to report key issues to the Board after each meeting and to obtain assurance on those issues referred to it by the Board or other Board committees. The reports to the Board clearly highlight the key areas that the QSC wishes to bring to the attention of the Trust Board. The reports are presented to the Board by the QSC Chair.

The QSC's actions log provides a clear audit trail of the actions it has agreed as well as the closure of those actions. It is monitored by the Committee at each meeting.

Impact of Covid

The QSC was arguably affected by Covid to a greater extent than some of the other sub-Committees, primarily due to the greater level of input required from clinical staff. The QSC continued to meet on a monthly basis, although considered a reduced and more focussed agenda (and at one point held a joint meeting with the FPPC). The agendas and meetings have mostly returned to the regular format of the previous 'BAU' meetings and it is the intention to maintain a similar approach for the remainder of the year, although with some changes to the annual schedule to focus efforts and resources where they will have most impact.

During the pandemic the key points and performance metrics of a number of the regular reports were presented through a single, combined quality assurance dashboard. The quality assurance dashboard has so far remained in place as other aspects of the Committee meetings return to BAU and has proven an effective means of highlighting key issues to the Committee.

In terms of the deep dive plan, it is suggested that resuming the alternating 'deep dive' and 'BAU' meeting system would not be the most effective use of the Committee's time for the remainder of 20/21. Instead it is proposed that meetings that combine the key elements of both meeting formats are held for the remainder of the year. The annual cycle will be reviewed with the Medical Director and Chief Nurse to ensure the deep dives are prioritised based on risk area and value added. It is proposed that the possibility of returning to a BAU / deep dive structure is reviewed as part of the production of the 21/22 annual cycle.

A separate document outlining the changes that were made to the Committee meetings is attached as Appendix 2.

Conclusion

The review has not highlighted any material issues and concludes that the QSC has met its duties under its terms of reference, but recognises the challenges posed by the Covid pandemic.

The Committee's terms of reference have been reviewed and the proposed amendments are highlighted in Appendix 1. These are primarily to reflect the creation of the new Strategy Committee and to clarify the Committee's remit in relation to workforce matters.

To support strengthening the effectiveness of the Committee, the following actions are recommended for consideration:

- To review the annual cycle for the remainder of the year to ensure reports / deep dives are prioritised by risk and to explore the possibility of returning to a BAU / deep dive meeting structure as part of the production of the 21/22 annual cycle.
- To develop guidance for report presenters to ensure salient points are highlighted succinctly and to help structure deep dive presentations.

The Committee is asked to:

- discuss the findings of the effectiveness review and consider any further actions
- recommend the amended terms of reference and approve this annual review for submission to the Board

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

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

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

2. Status and Authority

The Committee is constituted as a formal committee of the Trust Board.

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

The Committee challenges and provides assurance on all areas of risk to the Audit Committee and the Trust Board. Please note: the Audit Committee provides an independent and objective review of the appropriateness and fitness for purpose of the Trust's systems of internal control to the Trust Board.

3. Membership

Three Non-Executive Directors, one of whom will chair the committee.

Core Attendees

Chief Executive
~~Director of Nursing & Patient Experience~~Chief Nurse
Medical Director
Chief Operating Officer
~~Either the Deputy Director of Workforce or~~ Chief People Officer
Director of Strategy
Associate Director of ~~Corporate~~ Governance

Other attendees:
Chief Pharmacist
~~Associate Director of Quality and Safety~~Patient Safety Leads
Trust Secretary

In addition to the above list of attendees the committee will co-opt attendance as required from the Chief Information Officer~~ / Head of Information~~, Divisions, Infection Control, Health and Safety, Patient Safety, Clinical Governance, Information Team etc.

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

4. Quorum

The Committee will be quorate if two non-executive members are present, and two core attendees; one of which must be the Medical Director or Director of Nursing or their nominated representative.

5. Frequency of Meetings

The Committee will normally meet monthly. The format of the meetings will be agreed with the Committee Chair and some meetings may include a focus on deep dive presentations if deemed appropriate and effective. ~~Committee intends to alternate between holding a meeting that is focussed on a series of deep dives and one that considers regular reports and updates. These meetings will be flexed during the year if required.~~ The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

All attendees are expected to attend each meeting or to send a nominated deputy when they are unable to do so.

6. Duties

Managing Quality and Safety Risks

- To provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- To endorse and monitor the Trust's key governance strategies relating to quality and safety, such as the Quality Strategy.
- To review and monitor the Board Assurance Framework and the Corporate Risk Register risks assigned to the Committee, ensuring appropriate action is taken to mitigate risks where possible and advise the Board where acceptance of risk may need to be considered
- To monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS resolution~~-~~, Health & Safety Executive (HSE), NHS Improvement (NHSI) and ensure action is taken for compliance.
- To improve and develop the effectiveness of the assurance systems across the Trust by monitoring activity across the Trust through regular reports specified by the Committee in the Committee's Annual Cycle, and by exception
- To receive reports and monitor the progress in mitigating quality and safety risks arising from the Trust's major service developments

- To ~~annually,~~ receive ~~Divisional~~ presentations from the Divisional teams on progress with divisional objectives, governance structures, quality, safety and risk, including compliance with CQC pathways
- To review the quality risk assessment of the CIP programme
- To work with the Audit Committee when appropriate, and specifically in agreeing the Annual Internal Audit plan and providing a review of effectiveness on the clinical audit.

Ensuring Compliance

- To monitor and advise the Board on progress against national and local quality and safety governance standards and compliance framework.
- To receive and review regular progress reports for achieving compliance against all aspects of the Quality of Services through the monitoring of the Fundamental Standards and CQC regulations.
- To monitor and advise the Board on compliance with the Hygiene Code and CQC Registration and Regulation
- To receive reports on the changes to Healthcare Regulation and assurance as to how the Trust will manage this process
- To review and approve the annual reports as stated in the annual cycle, with the exception of Health and Safety and Safeguarding which will be scrutinised prior to final approval by Trust Board
- To approve the annual declaration of the Data Security and Protection toolkit
- Working with the Audit Committee to approve the Quality Account

Improving Quality

- To endorse and monitor the implementation of the Trust's key quality strategies~~, including the Risk Management Strategy and Quality Strategy~~.
- To receive regular reports from the Trust and Divisions on Patient Safety and Clinical Quality and Outcomes ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Patient Experience Indicators ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Nurse/Patient Indicators and safer staffing ensuring appropriate action is taken.
- To review the biannual nursing establishment review prior to consideration and decision by the Trust Board.
- To support the implementation of quality improvement programmes
- To be advised of the progress of any major quality initiatives in the Trust
- To receive regular reports on workforce capability, including learning~~,~~ and education, statutory and mandatory training, talent management, ~~Health and Wellbeing, Organisation Culture~~employee relations, clinical staffing establishment requirements and the report of the Guardian of Safe Working Hours.
- To consider reports regarding any other workforce issues where there is a clear and direct link to quality and safety issues, such as regarding the work of the Freedom to Speak Up Guardian.
- To consider a series of deep dives on ~~key~~ the above listed workforce areas, liaising with the Finance, Performance and ~~Workforce~~ People Committee where appropriate.
- To monitor the quality and safety performance metrics.
- To monitor the delivery of the annual plan and receive the annual report from the Joint Management Group in relation to the Trust's partnership with the University of Hertfordshire.

7. Reporting arrangements

The Committee will provide a report of each meeting to the Trust Board. It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

The Committee will provide reports to the Audit Committee as requested.

The core attendees and attendees will provide reports to the committee in relation to all areas of their portfolio and in line with the Annual Cycle and Action Log.

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

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

- The Committee report to Trust Board
- QSC annual evaluation and review of its terms of reference

9. Support

The ~~Associate Director of Corporate Governance and~~ Trust Secretary will ensure the committee is supported administratively and advising the Committee on pertinent areas.

Appendix 2 – Changes to meetings as a result of the COVID pandemic

Summary of changes:

FPPC and QSC: Initially the FPPC and QSC meetings were combined in order to streamline business. Additionally, there was a focus on core business only. These meetings were then separated into two distinct meetings but held on the same morning, before being moved back to their original meeting dates. Agendas have gradually returned to BAU though some changes to the report cycles remain in place.

Audit Committee: The Audit Committee continued to meet as planned, albeit on different dates on account of the changes to the deadline for the submission of the annual report and accounts for 2019/20.

Charity Trustee Committee: The CTC meeting scheduled for June was initially postponed but later reinstated and held as originally planned.

Trust Board: The Trust Board continued to meet on a regular basis, though it has not been possible for meetings to be held in public. The Trust continued to publish a range of reports and data that would ordinarily have been published as part of the public Trust Board meeting pack. The Trust Board did not hold a Board Development session in the period, but instead held additional meetings of the Trust Board on the dates that those sessions had been planned.

Other arrangements: Regular meetings were scheduled for the Non-Executive Directors to keep in contact with the Chief Executive and other Executives on a rolling basis.

The Trust was guided by the national guidance in putting these arrangements in place and anecdotally appears to have maintained Board and Committee meetings to a fuller extent than many other trusts.

The feedback received to date is that the changes were generally effective and welcome.

Current position:

As at the start of September 2020, the intention is to return to the original meeting schedule for the remainder of the year.

Recommendations:

As the Trust prepares for and begins to enter the winter period, it is proposed that the situation is monitored on a regular basis and discussions are held with the Committee Chairs and lead Executives to agree changes to meetings on a case by case basis. It is recommended that meetings should be kept separate as far as possible.

It is also proposed that, should meetings and agendas need to be reduced and streamlined, a focus on risks is maintained and used to inform agenda planning.

It is suggested that the revised approach in terms of the IPR is maintained for now and reviewed as appropriate in-year.

Agenda Item: 12.2

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

Learning from Deaths Report

Purpose of report and executive summary (250 words max):

Reducing mortality is one of the Trust's key objectives.

This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

Action required: For discussion

Previously considered by:
Mortality Surveillance Committee 9 September 2020
Quality and Safety Committee 27 October 2020

Director:	Presented by:	Author:
Medical Director	Deputy Medical Director	Mortality Improvement Lead

Trust priorities to which the issue relates:		Tick applicable boxes
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☐
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

No

Any other risk issues (quality, safety, financial, HR, legal, equality):

Detailed on page 1 of report

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

SECTION 1: LEARNING FROM DEATHS REPORT SUMMARY

1.1 Introduction

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The time intervals between quarterly reports have been flexed to allow prior approval by the Mortality Surveillance Committee.

The transition from Dr Foster to CHKS as a reporting source has now been completed. This is the first report utilising only CHKS data to show our latest position. It should be noted that the CHKS figures cannot be compared with past data from Dr Foster, however the trends should be similar in both sets of data.

Further information on the key metrics, developments and current risks summarised on this page can be found in Sections 2 and 3, together with Appendix 1.

1.2 Key metrics

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

Metric	Result
Crude mortality	Crude mortality is 1.26% for the 12 month period to July 2020 compared to 1.27% for the latest 3 years.
HSMR: (data period Jun19 – May20)	HSMR for the 12 month period is **83.53, 'First quartile'.**
SHMI: (data period Apr19 – Mar20)	Headline SHMI for the 12 month period is **90.17 'as expected band 2'.**
HSMR – Peer comparison	ENHT is ranked 2nd (out of 9) within the Model Hospital list* of peers.

* We are now comparing our performance against the peer group indicated for ENHT in the Model Hospital, rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

1.3 Headlines

- COVID-19
- HSMR has remained stable and is in the first quartile
- SHMI is stable in the 'as expected band' following a period of sustained reduction
- Medical Examiners: office space identified; planned commencement 1 October
- Mortality Review Tool development/Datix IQ: implementation commencing
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee, Board and joint meetings with ENHCCG – restarting following initial COVID period.

1.4 Current tasks

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
COVID-19	2.1
7 day service	2.5.1
Care bundles	2.5.2
Medical Examiner Introduction	2.5.3
Mortality Review – need for significant development of content/IT tool/process	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

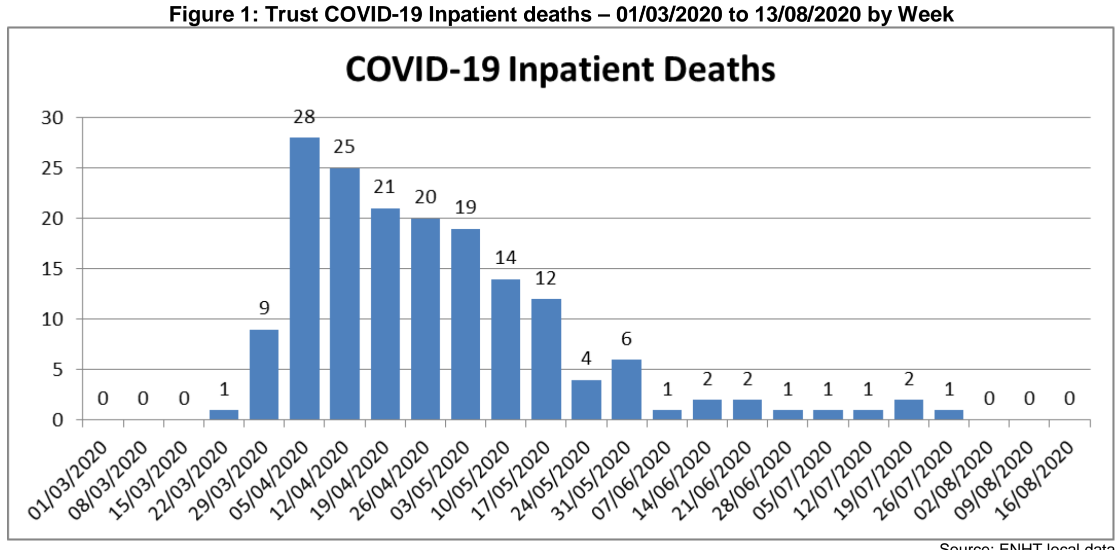
SECTION 2: MORTALITY PERFORMANCE

2.1 COVID-19

2.1.1 COVID-19 mortality data

The first COVID-19 death reported in the Trust occurred on 19 March 2020. Figure 1 shows subsequent deaths by week up to 13 August 2020. The dates shown are 'week-ending' dates. This chart shows our local peak occurred week ending 5 April 2020.

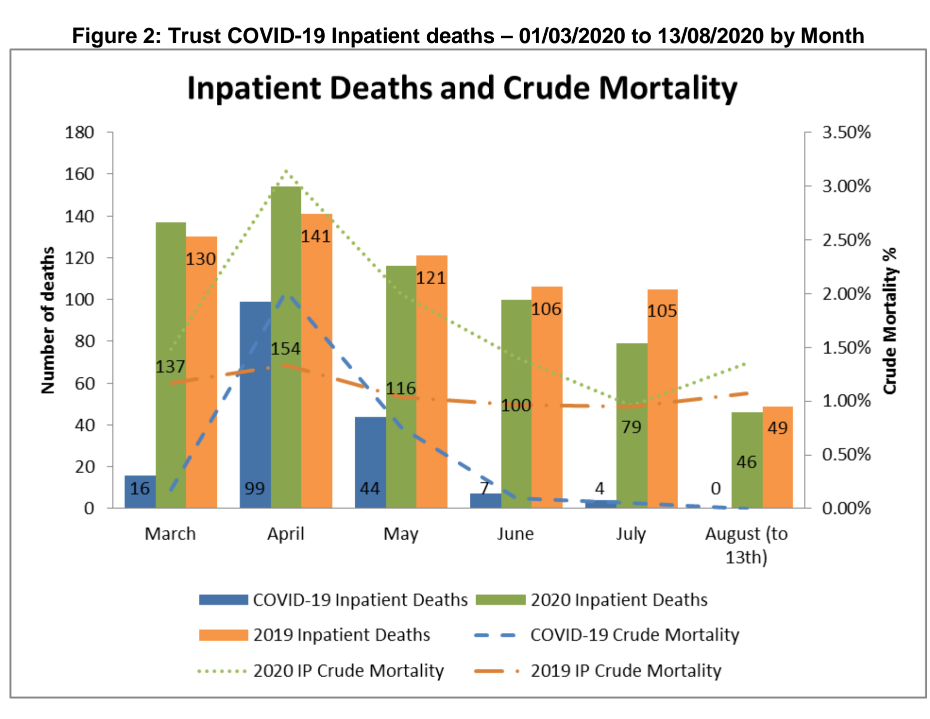
Figure 1: Trust COVID-19 Inpatient deaths – 01/03/2020 to 13/08/2020 by Week



Source: ENHT local data

Figure 2 below shows COVID-19 deaths relative to total Trust in-patient deaths, with a comparison to last year's data. It also indicates the associated crude mortality rates. Looking at the latest three months, the number of COVID-19 Inpatient deaths has reduced dramatically. So while the number of Inpatient deaths for 2020 were lower than 2019, the higher 2020 In-Patient Crude Mortality rate in June is indicative of the reduction in the corresponding number of inpatient spells.

Figure 2: Trust COVID-19 Inpatient deaths – 01/03/2020 to 13/08/2020 by Month



Please note that the COVID-19 Crude Mortality has been calculated from the 2020 monthly discharges (and is not a proportion of the COVID-19 related discharges). This data has been taken from our ENHT data warehouse.

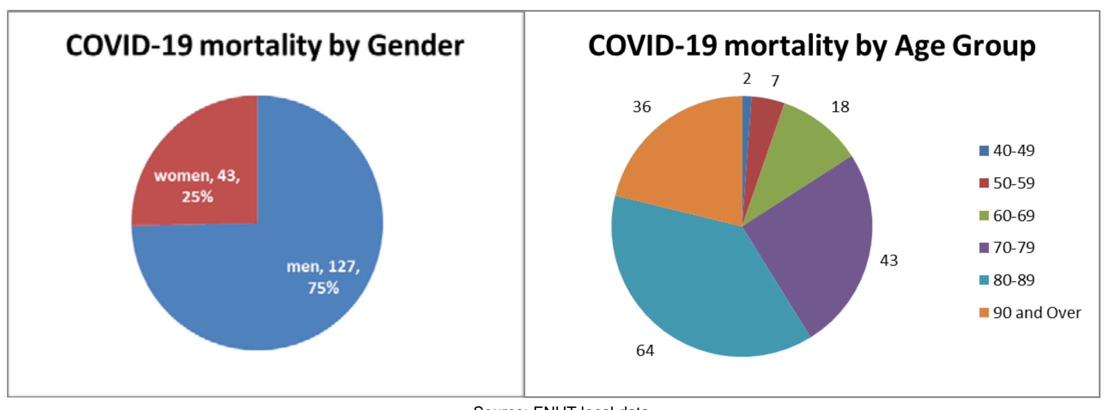
The multi-layered effects of the COVID-19 pandemic will make meaningful analysis and comparisons regarding mortality data challenging. To date our local data has shown the following trends.

There were 170 COVID-19 Inpatient deaths at the trust from 01 March 2020 to 13 August 2020 (latest data available at time of writing – 14 August 2020), this figure includes both patients who tested positive for COVID-19 and patients who had a clinical assessment of COVID-19.

Figures 3 and 4 show that our local findings regarding those patients worst impacted by the virus are broadly in line with nationally reported outcomes, namely; that significantly more men than women die from the disease and that the elderly are worst hit.

Fig 3: COVID-19 Inpatient deaths (01/03/20-13/08/20) by Gender

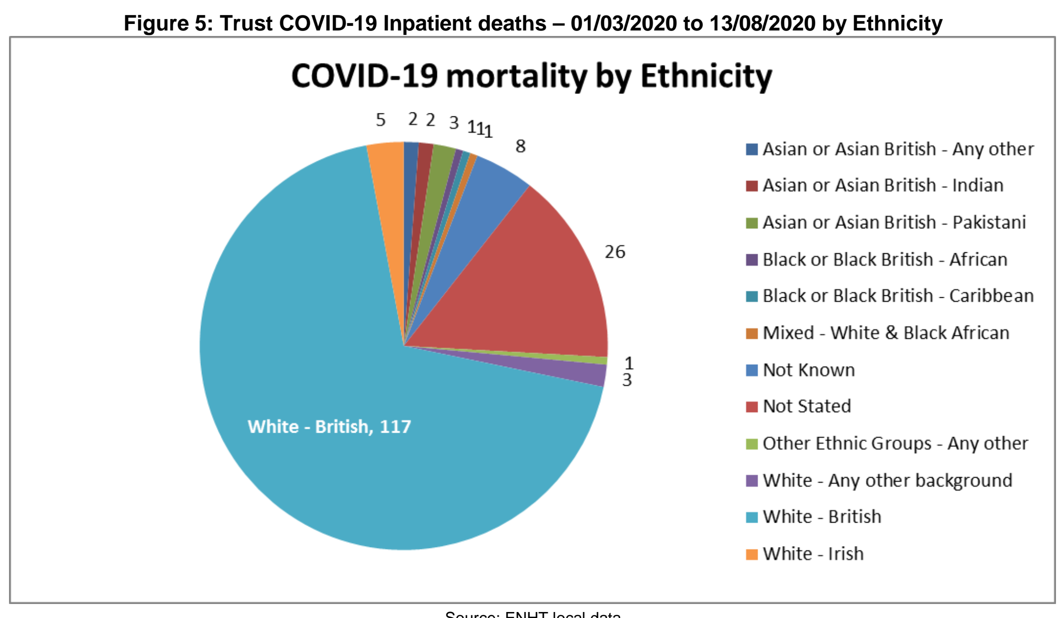
Fig 4: COVID-19 Inpatient deaths (01/03/20-13/08/20) by Age



Source: ENHT local data

Figure 5 does not demonstrate a bias towards the BAME population, but this may be a reflection of the demographics of the Hertfordshire region.

Figure 5: Trust COVID-19 Inpatient deaths – 01/03/2020 to 13/08/2020 by Ethnicity



Source: ENHT local data

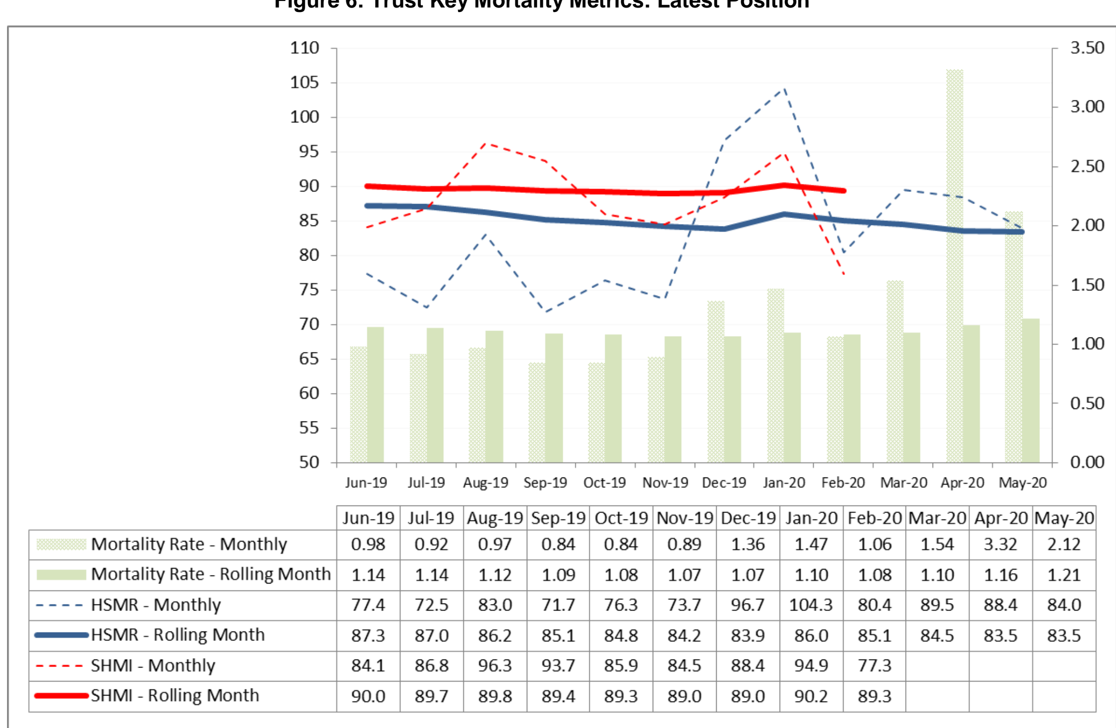
2.1.2 COVID-19 Effect on mortality review process

During the initial response to COVID-19 all but priority mortality reviews were suspended to allow clinicians to focus on the requirements of the pandemic. As we entered our Restart Programme, our standard review process was resumed. In additional to our BAU service, in order to better understand the impact of COVID-19, two specific cohorts of patients have been identified for further scrutiny: i) COVID-19 patients who died on a readmission to hospital within 30 days of discharge, ii) non-COVID patients who died in the community within 30 days of discharge. These reviews are in progress and learning from them will be reported in due course.

2.2 Key metrics

2.2.1 Trust key metrics overview

Figure 6: Trust Key Mortality Metrics: Latest Position



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Mortality Rate - Monthly	0.98	0.92	0.97	0.84	0.84	0.89	1.36	1.47	1.06	1.54	3.32	2.12
Mortality Rate - Rolling Month	1.14	1.14	1.12	1.09	1.08	1.07	1.07	1.10	1.08	1.10	1.16	1.21
HSMR - Monthly	77.4	72.5	83.0	71.7	76.3	73.7	96.7	104.3	80.4	89.5	88.4	84.0
HSMR - Rolling Month	87.3	87.0	86.2	85.1	84.8	84.2	83.9	86.0	85.1	84.5	83.5	83.5
SHMI - Monthly	84.1	86.8	96.3	93.7	85.9	84.5	88.4	94.9	77.3			
SHMI - Rolling Month	90.0	89.7	89.8	89.4	89.3	89.0	89.0	90.2	89.3			

The chart above shows the Trust's latest in-month and rolling 12 month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI. This shows that the rolling 12 month position has remained relatively stable for HSMR and SHMI, however in-month Crude Mortality for April and May 2020 significantly has increased.

Crude mortality: CHKS compares performance of crude mortality and reports that the average national crude in-patient mortality (for HES Acute trusts, all admissions excluding well babies) is 1.36%, and is 1.45% for the Model Hospital peer group for the twelve months to May 2020. This compares to 1.21% within ENHT for the same period. The Trust's locally recorded crude mortality rate, stands at 1.26% for the latest twelve months to July 2020.

HSMR: Our rolling 12 month HSMR for the last 6 months has remained broadly stable, with only small fluctuations seen. 83.53 was reported for the latest period (June 2019 to May 2020), compared to 83.58 for the previous release May 2019 to April 2020.

SHMI: While figure 6 above from CHKS data shows SHMI to February 2020 (89.3) NHS Digital has now refreshed to show the rolling 12 months to March 2020. It reports the Trust's SHMI currently standing at 90.17 for this period. This remains in the 'as expected' range, and shows a small increase from the previous month's release.

From the NHS Digital July 2020 publication (March 2019-February 2020) onwards, COVID-19 activity has been excluded from the SHMI. It was noted that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19, and therefore excluded, is monitored in a new contextual indicator 'Percentage of provider spells with COVID-19 coding'. For the April 2019-March 2020 SHMI calculation, 0.1% of the Trust's spells were excluded.

2.2.2 Trust In-month trend (crude/HSMR)

Figure 6 below provides the latest available in-month position, not only for crude and HSMR mortality rates, but also volume of deaths. The drop in number of deaths after the winter season spike observed in Dec19-Jan20 was followed by the COVID-19 outbreak. This resulted in a second spike in April 2020. The number of deaths in the last three months has fallen, however the Crude Mortality rate line is less steep for these three months which shows there were proportionately fewer discharges.

The HSMR indicator partially excludes COVID-19 patients from the methodology as patients with a primary diagnosis of COVID-19 (in the first episode or second episode if the first contains a primary diagnosis of a sign or symptom) are placed in CCS group '259 - Residual codes; unclassified' and this is not one of the 56 CCS groups included in the HSMR model. This explains why HSMR did not follow the second spike in the number of deaths seen in April 2020.

Figure 6: Trust Crude Mortality/HSMR latest in-month trend

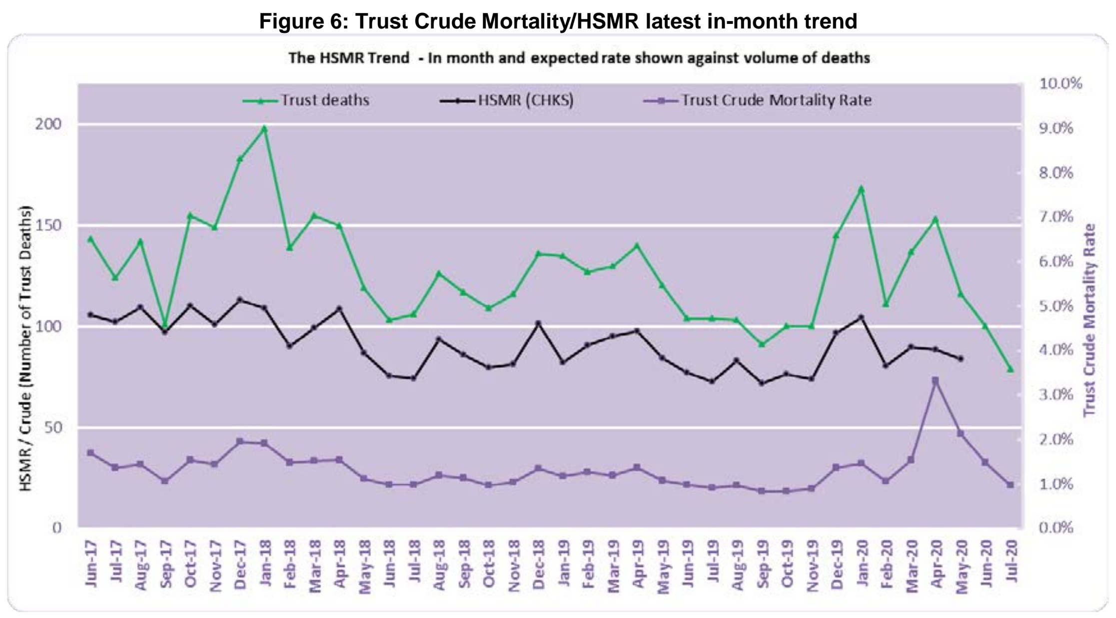
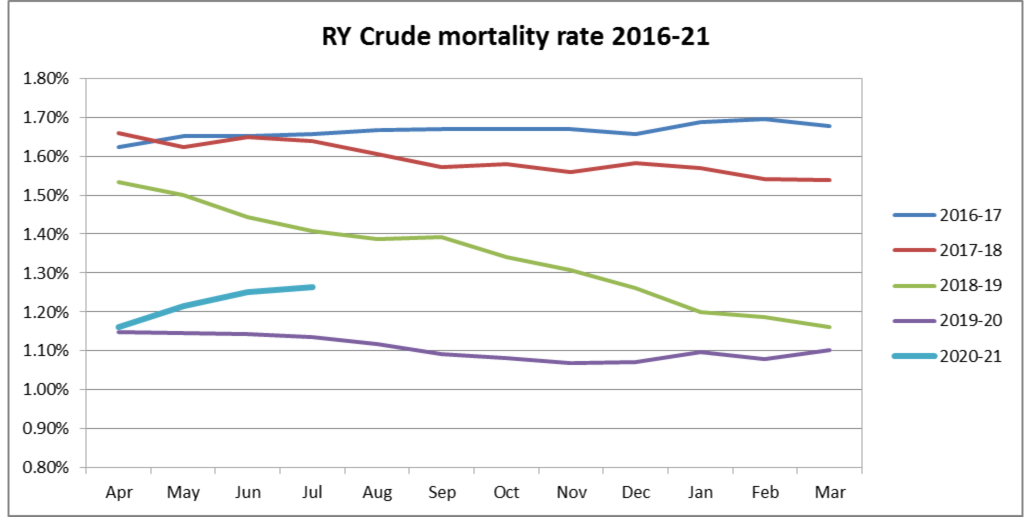


Figure 7 shows the trend in crude mortality rates over recent years. While this provides a good indication of the improving picture up to February 2020, it should be borne in mind that it has not been possible to use data solely from one source. This is due to the need for rolling year calculations to be based on

changing data sources (pre-Lorenzo, our data warehouse [EDW] and most latterly CHK).

The recent increases in crude mortality rate reflects the number of deaths from the COVID-19 outbreak coupled with the reduced inpatient activity at the Trust during March-July 2020.

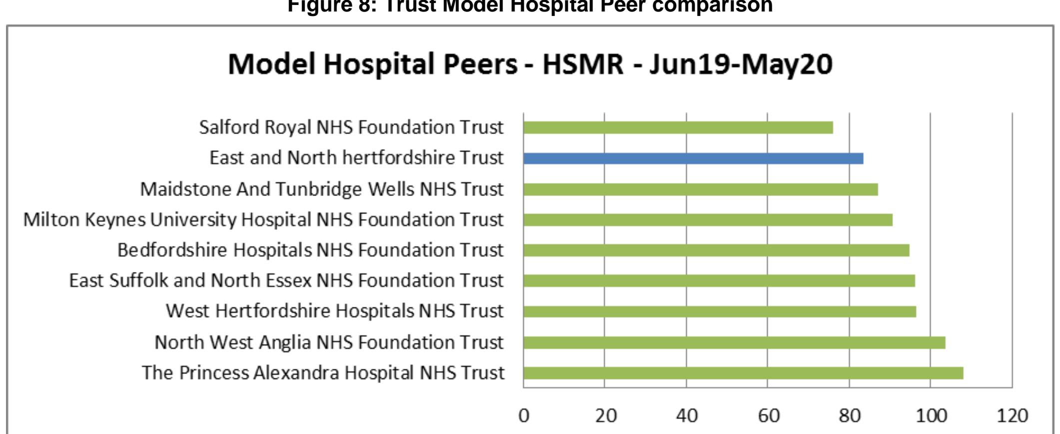
Figure 7: 5 year crude mortality trend



The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation which means that crude mortality can be used as a useful predictor of coming HSMR performance. However, given the treatment of COVID-19 patients in the HSMR methodology (detailed above), there may be less of a correlation seen during the COVID period.

2.2.3 Trust HSMR peer comparison

Figure 8: Trust Model Hospital Peer comparison



We have adopted the peer group indicated for ENHT in the Model Hospital framework, in place of the geographical East of England group of hospitals for the purposes of performance assessment. It was felt that this should provide a better indication of performance. Figure 8 above shows how well placed we

continue to be within this group. Note, the number of trusts in our peer group has decreased since the last report due to recent mergers.

2.2.4 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR Jun 2019 to May 2020

	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Rolling 12M
Cancer (Spec)	80.6	0.0	94.9	0.0	65.4	0.0	78.7	45.6	74.4	62.0	0.0	62.4	0.0	45.2
Clinical Support Services (Spec)	47.8	24.5	55.1	124.3	24.2	18.0	0.0	56.1	0.0	61.4	0.0	0.0	36.5	36.6
Medicine (Spec)	90.5	82.1	73.2	84.3	76.7	79.3	76.6	97.9	108.3	82.9	89.6	93.6	85.7	86.3
Surgery (Spec)	61.1	70.7	76.4	68.7	51.2	98.4	78.4	105.3	107.6	69.6	117.3	92.8	108.7	87.7
Women's & Children's (Spec)	0.0	123.8	0.0	0.0	0.0	0.0	0.0	93.1	89.0	0.0	0.0	0.0	0.0	28.4
Trust	**84.4**	**77.4**	**72.5**	**83.0**	**71.7**	**76.3**	**73.8**	**96.7**	**104.3**	**80.4**	**89.5**	**88.4**	**84.0**	**83.5**

Source: CHKS (scorecard alerts coloured)

Table 3 shows Trust and Divisional monthly HSMR performance for the latest rolling 12 month period to May 2020. The CHKS red and amber alerts coding has been used, to show HSMR above the 75th percentile Model Hospital peer group value, with red being statistically significant and amber not statistically significant. The Rolling 12 months Divisional figures are showing amber alerts for Cancer and Surgery.

2.2 Key quality measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on the quality of care provided by the Trust.

Table 4 below shows HSMR/SMR, together with average Length of Stay and Readmissions within 28 days. Length of Stay is an average of Bed days (excluding well babies, regular attenders or renal dialysis patients) by Spells. From CHKS, Readmissions are spells where the patient was readmitted as an emergency within 28 days of the discharge of previous admission, and this is shown as a percentage of total spells (excluding well babies, regular attenders or renal dialysis patients). The arrows show direction of change compared to the previous report (March 2019 to February 2020).

The amber and red alerts are relative to peers in our Model Hospital peer group.

Table 4: Key Quality Measures June 2019 – May 2020

	Trust Total		Elective		Non-Elective	
HSMR	83.5	↓	109.0	↑	83.2	↓
SMR	86.3	↑	85.0	↑	86.3	↑
Average Length of Stay	1.8	↑	0.2	↔	3.6	↔
Readmissions within 28 days (%)	8.6%	↓	3.9%	↓	14.1%	↓

Source: CHKS (scorecard alerts coloured)

2.3 Mortality alerts

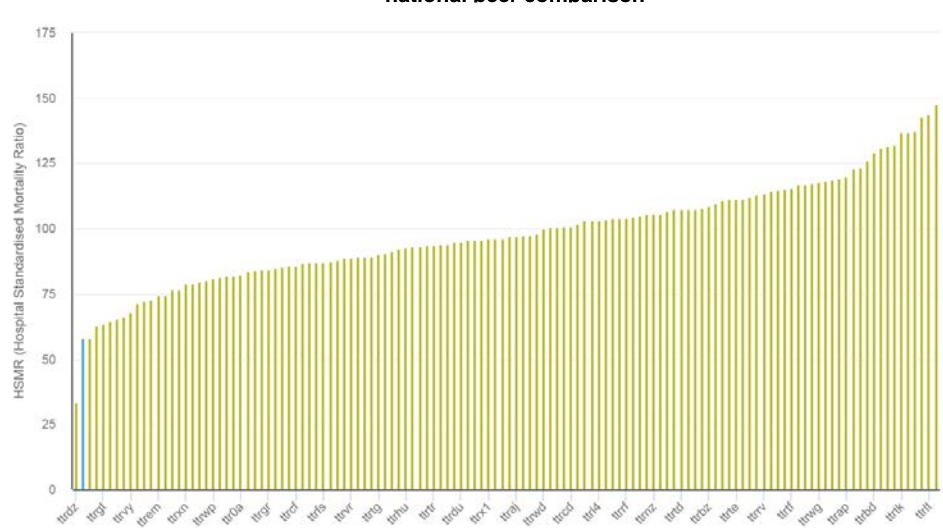
2.3.1 CQC CUSUM alerts

As previously reported, in March 2018 the Dr Foster Unit at Imperial College alerted the CQC to the Trust's CUSUM alerts for Septicaemia. In November 2018, following a request for further information, we provided a report to the CQC detailing the findings of our internal investigation. One focus of the investigation was an in-depth review of sepsis coding following the changes to national protocols. This resulted in

significant changes being made to realign our coding with our new understanding of the requirements, with supporting training given to ensure a standardised approach moving forward. Since this time the CQC has continued to monitor the situation via its regular Engagement meetings with the Trust.

While the latest refresh of CHKS shown in figure 9 below, shows the Trust extremely well placed compared to our national peers, significant fluctuations have been seen in our recent in-month data, with HSMR 115.50 reported for May 2020. This will be looked at in further detail to better understand whether coding or clinical reasons underpin the situation and clarify whether there is any cause for concern.

Figure 9: Septicemia (except in labour) HSMR R12m to May-20: national peer comparison



2.3.2 Other external alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

Specialty update provided in January:

- KPIs published on the NHFD website are better than NHFD mean in all categories
- Mortality has come down (as anticipated)
- Last recorded: the Trust achieved 6.0% compared to national of 6.3%.

National Stroke Audit: Mortality Alert (January 2020)

- We were contacted by the Sentinel Stroke National Audit Programme (SSNAP) in January 2020 to advise that while our position did not fall above the limit of 3 standard deviations from predicted mortality, and that we were therefore not classified as a mortality outlier, we were ‘quite close’ to the threshold
- Although there was no formal requirement to act, a Chief Executive response was provided outlining the assurance work already undertaken and indicating that further work would follow to ensure no further opportunities for learning and improvement had been missed.

National Emergency Laparotomy Audit (NELA)

- Internally work had been ongoing with development of a GAP analysis following the 2019 National Laparotomy Audit Report
- CCG request for update by NELA Lead at March 2020 Mortality Review Group meeting (cancelled due to COVID)
- Eastern AHSN Peer Review completed 28 February 2020, which cited the high adjusted mortality rate of 13% (Year 5 data), which ranked the Trust in the bottom 20% of reporting hospitals in the UK and Wales, among the key areas for improvement focus.

As we emerge from the initial COVID phase, further development and monitoring of improvement work in these areas is recommencing.

2.3.3 HSMR CUSUM alerts

From CHKS, HSMR CUSUM alerts have been shown for the following five CCS groups for the latest rolling year to May 2020 (Amber alert: 95% detection threshold; Red alert: 99.7% detection threshold), with Table 5 showing the CUSUM alerts sorted in descending order of “Excess Deaths”.

Table 5: HSMR CUSUM Alerts June 2019 to May 2020

	Relative Risk	Observed Deaths	Expected Deaths	“Excess” Deaths
100 - Acute myocardial infarction	142.24	62	43.6	18.41
101 - Coronary atherosclerosis and other heart disease	310.68	14	4.5	9.49
38 - Non-Hodgkin`s lymphoma	174.24	15	8.6	6.39
145 - Intestinal obstruction without hernia	160.23	15	9.4	5.64

Source: CHKS (CUSUM alerts coloured)

Figure 10 shows the Trust HSMR for Coronary atherosclerosis and other heart disease has for the past 10 months breached the second upper control limit (three standard deviations).

Figure 10: Coronary atherosclerosis CUSUM chart June 2019 to May 2020

Previous work to understand the underlying causes of the coronary atherosclerosis alert showed a number of deaths which had been incorrectly coded, with appropriate amendments made. While the number of deaths involved is relatively small, the relative percentage of excess deaths remains high.

2.3.4 SHMI outlier alerts

Table 6 shows the SHMI outlier alert by SHMI group according to CHKS (Amber alert: lower confidence limit above national average; Red alert: lower confidence limit in upper quartile).

Table 6: SHMI outlier alerts from March 2019 to February 2020

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
57 - 100: Acute myocardial infarction	133.39	68	50.98	17.02

Source: CHKS (alerts coloured)

While there are currently no red alerts, as congestive heart failure has previously alerted, and remains an amber outlier for HSMR, it remains on our radar.

As various elements of the Cardiology diagnoses basket have continued to alert over the last year, further investigation of the underlying causes has been agreed with the Cardiology Clinical Director. Learning will be reported in due course.

2.4 Specific actions to address high mortality conditions

Mortality Alerts meetings, chaired by the Medical Director, are usually held monthly to review HSMR/SHMI CUSUM/outlier alerts, with agreed actions feeding into the Mortality Surveillance Committee.

The HSMR/SHMI trends of alerting groups are tracked. Investigation usually starts with coding reviews. Where concerns or uncertainty persist Specialty clinical reviews are requested. A watching brief is maintained until there is assurance regarding performance. When the number of deaths is very small, or the diagnosis group consists of a number of sub categories, the situation may be monitored before action is taken. During the initial COVID 19 preparation and peak period this work was suspended. This assurance work is now recommencing.

2.5 Associated trust initiatives

2.5.1 Seven day services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. Originally ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. Nationally it has now been indicated that all Trusts must be compliant with these standards by 2020. The four prioritised standards are:

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

To date the Trust has not achieved compliance with the four prioritised standards.

Following the development and submission of speciality level business cases, a clinical Seven Day Service Investment Review Panel was held on 3rd March to prioritise investment recommendations for the delivery of seven day services in 2020/21. The membership of the panel consisted of Divisional Chairs, Divisional Directors and colleagues from corporate departments such as finance and HR. The recommendations were due to be presented to the Executive Board for approval, however due to ongoing contract negotiations with Commissioners and the timing of the COVID-19 pandemic, this has not happened. Seven Day Service steering group meetings have been stepped down to operationalise the pandemic response. The plans developed by the divisions will contribute to the wider Trust-wide portfolio to deliver effective and sustainable services during the Trust recovery phase and beyond.

2.5.2 Care bundles

Our work to improve the use of available care bundles is strongly supported by the CCG via the Mortality Review Group. Consideration of how best to provide Director level clinical support to drive this work forward has been subsumed into a wider review of the structure of the current Associate Medical Director support function, which is now moving forward with the creation of the Office of the Medical Director. Further detail should be available in time for my next report.

In the meantime there are already quality improvements underway regarding key care bundles such as Sepsis, AKI and Pneumonia. It is intended that work in the year ahead will focus on GAP analyses to provide a platform for future initiatives. Sepsis and AKI work has continued during the initial COVID period, albeit in a different shape. Now that we enter the next pandemic phase it will be important to review how best to proceed.

2.5.3 Medical Examiner

As previously reported a team of Medical Examiners has now been recruited from within the Trust's existing consultant body and includes a Lead and Deputy, and multi-disciplinary representation. The Medical Examiner function will sit within Clinical Support Services.

The Lead Medical Examiner has continued to work towards the introduction of the service. However, the planned pilot start date of 1 March 2020, was postponed due to the COVID-19 pandemic. Despite this fact the Medical Examiners have liaised with the Bereavement team throughout the crisis to give advice regarding death certification.

In July 2020 suitable office space to house the team was finally identified. A new target date for commencement of the Medical Examiner service of 1 October 2020 has been set, allowing for appropriate preparation/settling in time.

As previously reported, the update from NHS Improvement in June 2019 highlighted the need for close collaboration between the Medical Examiner function and Learning from Deaths programme, with Medical Examiners being responsible for flagging cases warranting further review. This required interaction will be taken into account both at the outset of the Medical Examiner introduction and as plans progress for the migration of the Trust's mortality review process to the Datix iCloud platform.

2.5.4 Coding/data quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. These are not only of direct significance regarding the provision of better quality information, but are also resulting in greater engagement by Clinicians as confidence in data provided to them increases. The seeds of this cultural shift should support future improvements.

During the COVID-19 pandemic Clinical coding has also been working with the NHS Classifications department regarding latest WHO guidance regarding COVID to ensure consistency and accuracy in our coded data. Clinical Coding has been actively supporting Intensive Care Data collection such as ICNARC data. Clinical Coding continues to support the Independent sector activity provided for the Trust, its data collection and monitoring processes, escalating concerns when needed.

COVID-19 finds clinical engagement more proactive in the drive to improve efficiencies and move services forward to a "new normal" with collaboration of all teams across the Trust.

SECTION 3: LEARNING FROM DEATHS

3.1 Mortality case record review process and methodology

Following the decision to adopt the Datix iCloud platform to support our Clinical Governance framework, initial background technical implementation work has been completed. Following delays caused by COVID-19, the next phase of development discussions between Datix and the governance and quality leads have now commenced.

3.2 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below. In this report data has been provided for both quarter 3 and quarter 4.

3.2.1 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1.

It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2020-21 deaths which can appear to skew the data. Therefore for the sake of transparency and robust governance during Q1 it should be noted that 6 ACONs were concluded where the Mortality Surveillance Committee agreed an avoidability of death score of less than 3.

Table 7: Q1 2020-21 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
ACON 461	2019-20	Yes	1	Definitely avoidable
ACON 416 ACON 450 ACON 453 ACON 471	2018-19 2019-20 2019-20 2019-20	Yes Yes Yes Yes	2	Strong evidence of avoidability
ACON 465	2018-19	Yes	3	Probably avoidable: more than 50-50

All these cases had been investigated by the Patient Safety team as Serious Incidents. Remedial action plans have been put in place commensurate with the severity of the incidents and detailed information provided in the Serious Incident report submitted to the Quality and Safety Committee.

It should be noted at during this period the Patient Safety team were able to complete a significant number of Serious Incidents that had been in progress for some time, a fact that is reflected in the increased number of ACONs concluded with a score of ≤3.

In addition to agreeing on the avoidability of death, the Mortality Surveillance Committee now also makes an independent assessment of the quality of care received by the patient. This assessment is based on the following scale, taken from the PRISM mortality review model:

Table 8: Q1 2020-21 Concluded ACONs: Avoidability Score ≤3

Quality of Care Rating (PRISM model)	Definition
A	Excellent
B	Good
C	Adequate
D	Poor
E	Very poor

This report will detail concluded ACONs where the quality of care was assessed as D/E.

Table 9: Q1 2020-21 Concluded ACONs: Quality of Care Rating D/E

Quality of Care Rating	ID	Serious Incident
D	ACON 385 ACON 416 ACON 451 ACON 452 ACON 454 ACON 465 ACON 471 ACON 478	Yes Yes No Yes Yes Yes Yes Yes
E	ACON 450 ACON 453 ACON 461	Yes Yes Yes

From the above table it can be seen that of the 11 cases where care was considered to have been poor or very poor, 10 had been raised and investigated as Serious Incidents.

In the one case that had not been considered as a Serious Incident, the concern related to a delayed diagnosis, and the fact that neurological advice had only been

given verbally. While the Committee considered that overall the care given by the Stroke team was appropriate and that an earlier diagnosis would have been unlikely to have changed the outcome, the quality of care rating reflected the importance of the learning and potential impact to a different patient.

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to in 3.1 above.

As the current dashboard does not cover all the data that the national guidance requires, the additionally mandated detail is provided below.

3.2.2 Learning disability deaths

Table 10: Q1 Learning Disability Deaths

	Apr-20	May-20	Jun-20
Learning disability deaths	5 (+1 Community)	3	0

In Q1 8 deaths occurred of patients with a learning disability. All have been reported to the national LeDeR programme. To date all of these have undergone regular mortality review. 5 were considered to be unavoidable with no concerns raised. Three cases have been escalated as ACONs, with outcomes pending. Additionally there was one death of a child, a known epileptic, who was sadly brought to the Trust RIP. In line with policy an RIR was conducted into this death although the death occurred in the Community, which did not highlight any areas of concern/learning.

3.2.3 Severe mental illness deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. No clear indication was given in the national guidance regarding what definition should be attached to the term ‘severe mental illness’.

As previously reported, following discussions with our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust (HPFT), we decided to base our criteria for mortality review on the ‘red flags’ detailed in the national guidance for NHS mental health trusts, which was drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018.

Internal approval has been given to include a supporting alert on Lorenzo. Further work will be required prior to the alert being activated, including creation of a supporting SOP to ensure there is clarity regarding identification of relevant patients and use of the alert. This will be taken forward via the ‘Treat as One’ Task and Finish Group.

Additionally, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients has been devised by the Business Information team. This will not only include patients with Lorenzo flags, but will also use the relevant ICD10 codes recommended by HPFT.

Unfortunately, progress via the 'Treat as One' Task and Finish Group and Information report has stalled due to COVID-19 and will need to be resumed. No known deaths of patients with severe mental illness have occurred in Q1.

Table 11: Q1 Severe Mental Illness Deaths

	Apr-20	May-20	Jun-20
Severe mental illness deaths	0	0	0

3.2.4 Stillbirth, children and maternity deaths

Q1 statistics are provided below:

Table 12: Q1 Stillbirth, Children and Maternity Deaths

	Apr-20	May-20	Jun-20
Stillbirth	0	1	3
Children	0* (+1 Community)	0	0
Maternity	0	0	0

* 1 death occurred in the Community, the child sadly being admitted RIP. As reported under 3.2.2. above an RIR was conducted in line with policy. No learning was identified.

3.2.5 Serious Incidents involving deaths

Table 13: Q1Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Apr-20	May-20	Jun-20
Serious Incidents reported	0	0	0
Serious Incidents: final report approved*	3	0	0

Key learning:

- Potential missed opportunity to better inform a decision due to limited communication as patient's first language was not English
- Requirement for a pathway for the management of e-cigarettes
- Requirement to ensure patients are on a follow-up programme before discharge
- Delay in treatment due to failure to identify a deteriorating patient
- Limited knowledge when caring for patient with liver issues in an outlying ward
- Gap in knowledge about commencing a blood transfusion at night
- Urgency of a request was not appreciated and therefore not made clear.

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

3.2.6 Learning from complaints

Table 14 below provides detail of the number of complaints received in Q1 that relate to a patient who has died while an inpatient.

Table 14: Q1 Complaints Involving a Patient Death

	Apr-20	May-20	Jun-20
Complaints received relating to an in-hospital death	0	1	0

Key themes:
Concerns related to whether the patient was fit for discharge as they were subsequently readmitted and sadly died.

3.2.7 Learning from inquests

Table 15: Q1 Inquests into a Patient Death

	Apr-20	May-20	Jun-20
Requests for a Report to the Coroner	2	3	2
Regulation 28: Report to Prevent Future Deaths	0	0	0

3.2.8 Learning from mortality reviews

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

Due to COVID-19 relatively few ACONs were concluded in Q1 2020-21 partly due to competing commitments and partly due to a significant reduction in the conduct of Specialty meetings to discuss cases and Committee meetings to consider Specialty outputs. For this reason a themes diagram for Q1 and Q2 will be included in my next report. This will cover all ACONs concluded in Q1/2, whether the patient's death occurred in the current or previous year.

Throughout the year emerging themes are shared across the Trust via RHDs and other interested specialist groups including the Deteriorating Patient Committee, End of Life Committee and Seven Day Services Steering Group. The information will also be used to inform broad quality improvement initiatives. Information sharing continues in the COVID era, even if the avenues for communication may at times need to be altered.

4.0 Options/recommendations

The Committee is invited to note the contents of this Report.

Appendix 1: ENHT Learning from deaths dashboard June 2020

NHS **East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: June 2020** Department of Health

Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
390	1484	119	841	0	1

Time Series: Start date 2017-18 Q1 End date 2020-21 Q1

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)		
This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%

Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	121	100.0%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	12	10	9	0	0

Time Series: Start date 2017-18 Q1 End date 2020-21 Q1

Agenda Item: 12

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

AUDIT COMMITTEE – MEETING HELD ON 19 OCTOBER 2020

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of the 19 October 2020 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of AC	**Presented by:** Chair of AC	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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AUDIT COMMITTEE MEETING – 19 OCTOBER 2020
SUMMARY TO THE TRUST BOARD MEETING HELD ON 4 NOVEMBER 2020

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, Bob Niven

Sustainability Update
The Director of Estates and Facilities reported to the Committee regarding the Trust's sustainability performance. Little progress had been made since the last meeting so a recovery plan and timetable could not be presented at this meeting. An external company has now been sourced to create the sustainability development management plan. Subject to approval, a sustainability manager will also be appointed. A further update will be provided in January.

Cyber Security Update
The Digital Operations Director and Deputy CIO presented a verbal cyber security report as the Data Security Officer role is open and recruitment is taking place. An external security service has been sourced in the meantime to keep risk at a minimum. The Trust also works closely with NHS Digital regarding any cyber security threats, which is working well.

Board Assurance Framework and Deep Dive
The Associate Director of Governance presented the Board Assurance Framework which had been approved by the Board. The framework continues to be reviewed through the board sub-committees to ensure the agendas are focused on the risk discussions and priorities. There has been a focus on standardising the methodology for the scoring.

The Committee received a deep dive into risk 12, risk of pandemic. It had been updated but the risk score remains at 20 due to the multi-layers of risk with winter pressures, phase 3 recovery plus Covid-19. It was advised that a special advisory board led by medical and nursing meets weekly to review all guidance and the preparation is in place.

Data Quality & Clinical Coding Report
The Head of Data Quality updated the Committee on the work of the data quality team, which has been focused on P3 recovery, working closely with all services across different work streams all of which are having to adapt to new ways of working. There is a plan in place to complete work on cleansing access plans and the consultant master file projects that were delayed due to the change in priorities during the first surge of Covid-19.

The Head of Clinical Coding informed the Committee that staffing levels would improve as replacements were being recruited into positions vacant since the previous year. The team have been vigilant in data recording in areas such as SDEC to ensure they are recorded on Lorenzo timely and accurately. The team are also actively supporting the Independent Sector data capture.

INTERNAL AUDIT REPORTS

Internal Audit Report and Internal Audit Action Tracker
The Internal Auditors informed the Committee that due to the Covid pandemic, the reports had been running slightly behind plan, although 5 reports have now been issued with 2 further reports to be completed shortly.

Of the 5 completed reports, 1 was issued with Substantial Assurance, 2 with reasonable Assurance and 2 with Limited Assurance:

Clinical Audit	Substantial Assurance
Serious Incidents and Duty of Candour	Reasonable Assurance
Pay policy	Limited Assurance
Payroll	Limited Assurance
Management of medical Devices	Reasonable Assurance

Additionally, two further people have been recruited into the team, the online portal is being used and an STP benchmarking report has been completed and will be circulated.

The Committee also received the latest internal audit action tracker. The number of open actions had reduced from 33 to 18 so good progress has been made.

Counter Fraud Progress Report
The Local Counter Fraud Specialist presented the report to the Committee. She highlighted that the Covid risk review, the fraud newsletter and the finance and HR presentations had all been issued.

EXTERNAL AUDIT REPORTS:

Charity Account Audit and Charity Annual report and Accounts 2019-2020
The Committee received a verbal update on the Charity Account report from the external auditors. They were informed that the audit is almost complete with no misstatements or issues identified to date, and their report will be finalised and circulated by email to the Audit Committee members the following week.

The Committee reviewed the Charity Accounts which were approved subject to minor amendments and finalisation of the report from the External Auditors.

OTHER REPORTS

Audit Committee Annual Evaluation and Terms of Reference
The Trust Secretary presented the annual evaluation of the Audit Committee and proposed updated Terms of Reference. The findings of the review indicate that the Committee has met its duties and there were two recommendations. The Committee approved the amendments.

The report is attached as a separate agenda item.

Standing Order and Standing Financial Instruction Annual Evaluation
The Committee discussed the proposed amendments to the SO and SF instructions. No significant changes were proposed and it was endorsed and recommended for approval at the Board meeting in November.

The report is attached as a separate agenda item.

Conflict of Interest Annual Update and Register of Gifts and Hospitality Register
The Trust Secretary presented the COI Annual review and the Gifts and Hospitality Register. The Committee were informed that the task of administering the COI process has grown considerably and a proposal has been written recommending an automated digital system which is compatible with the systems the Trust currently uses. The Committee approved the Gifts and Hospitality and Conflicts of Interest registers for publication on the basis that to was updated to reflect the recent changes to the Executive team.

Jonathan Silver
Audit Committee Chair

October 2020

Agenda Item: 13.1

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

Audit Committee Annual Evaluation and Review of Terms of Reference

Purpose of report and executive summary (250 words max):

This annual review considers how the Audit Committee has met its duties under its Terms of Reference during 2019/20, based upon analysis of the work of the Committee over the period (as evidenced through the minutes and summary reports) and also taking into account the feedback received via a survey of Committee members.

The findings of the review indicate that the Audit Committee has met its duties in the period, however the following recommendations are made to further strengthen the effectiveness of the Committee:

- Some tightening and strengthening of administrative processes – including regarding report length and clarity of purpose,
- To maintain the focus on implementation of the findings of internal audits.

The Terms of Reference have been reviewed and updated and are attached for consideration as Appendix 1. Reflections and recommendations relating to changes following the COVID pandemic are set out in Appendix 2.

The report and updated Terms of Reference were considered by the AC at the meeting on 19 October.

The Trust Board is asked to approve the annual review and updated Terms of Reference.

Action required: For approval

Previously considered by:
Audit Committee – 19.10.20

Director: Director of Finance	**Presented by:** AC Chair	**Author:** Assistant Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Governance

Any other risk issues (quality, safety, financial, HR, legal, equality):

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AUDIT COMMITTEE
ANNUAL REVIEW 2019/20

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 2019/20, a review of the Trust's Standing Orders and Scheme of Delegation and the findings of a survey of Audit Committee members and regular attendees.

This review concludes that the Committee met its duties under its terms of reference. The feedback from Committee members and attendees was positive and the review has not identified any significant changes that are required at this time, however the following recommendations are made to further strengthen the effectiveness of the Committee:

- Some tightening and strengthening of administrative processes – including regarding report length and clarity of purpose,
- To maintain the focus on implementation of the findings of internal audits.

The terms of reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1.

The Committee is asked to:

- Discuss the findings of the effectiveness review and consider any further actions.
- Recommend the amended terms of reference and approve this annual review for submission to the Board.

Summary of Key Findings

➢ **Meetings and Membership**

The Audit Committee met formally on five occasions during 2019/20 and also held an auditor panel meeting after the Audit Committee meeting on 20 January regarding the External Audit contract and on 6 February 2020 regarding the Internal Audit and LCFS contract.

There were no significant changes to the meeting format and membership over 2019/20. The membership of the Committee remained the same during the course of the year, Mr Jonathan Silver remained as Chair of the Audit Committee. Mr Niven and Mrs McConnell remained as members of the Committee throughout the period. The Director of Finance (regular attendee at the meetings of the Audit Committee) remained in post throughout 2019/20. Throughout 2019/20, the Internal Audit and LCFS function was provided by RSM UK and External Audit services provided by BDO.

The temporary changes in response to the COVID pandemic are attached separately as Appendix 2.

The Committee met in February 2020 to consider applications from three companies for the internal auditor and LCFS contract. Their recommendation was then put to the Trust Board for formal approval. A new provider has been in place since April 2020.

Whilst the Committee did not formally meet in private with the auditors on a regular basis during 2019/20, the Audit Committee Chair and the Director of Finance was in contact with the auditors throughout the period and in advance of the meetings.

A review of the Committee's minutes demonstrated an appropriate level of scrutiny and challenge could be evidenced throughout its meetings.

➢ **Reporting Arrangements**

The Chair, supported by the Trust Secretariat, provides a summary report for consideration by the Trust Board after each meeting. 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.

➢ **Committee Survey**

The efficacy of the Audit Committee has been assessed by issuing a questionnaire to Committee members plus executives who regularly attend and the internal and external auditors. There were a total of eight responses. A summary of the findings are provided below:

- The Committee agendas and papers were structured effectively and covered the rights issues, although it was mentioned that if not mandatory content then the frequency of some items could be altered. It was suggested throughout the survey that a reduction in the length of the papers would be more productive and there could be greater clarity in terms of the purpose of the paper.
- It was agreed that the appropriate people were at the meeting although mentioned that heads of Divisions could be invited more frequently whenever there is an issue of relevance.

- It was agreed that there is sufficient time to discuss key agenda items.
- All respondents felt able to question and challenge the Trust at the meetings.
- It was felt that the Committee had added value to the Trust's operations over the last year through:
    - In-depth review of performance and advice
    - Effective contribution to good governance
    - Providing a good coverage of accounts
    - Helping to ensure a reasonable level of scrutiny and observance of requirements
    - Appropriate planning of internal audit activities and maintaining a strong focus on counter fraud activities and culture
- It was generally felt that the Committee's approach to risk has been effective, although it was mentioned that the risk reports have at times been overly detailed. Plus it was suggested gaining additional insight on risk from both the internal and external auditors would be beneficial. It could also be strengthened through continuing the practice of undertaking periodic deep dives into BAF risk items.
- It was generally felt that there is not duplication of agenda points with other Committees, although the risk of duplication is highest with FPPC.
- It was felt that the Audit Committee has been served well by both the Internal Auditors and the External Auditors over the year April 2019 – March 2020.
- It was felt that the Committee's effectiveness could be improved through:
    - Some tightening of administrative processes
    - Better implementation of the findings of internal audits.

On the whole, the responses received were positive regarding the efficacy of the Committee.

How the Committee has met its responsibilities, as set out in the terms of reference:

- **Governance, Risk Management and Internal Control**

The Audit Committee received the latest version of the Board Assurance Framework at every meeting from May 2019. In March 2020, the review of the Framework was delayed as the national operating plan deadline had been delayed. Responsibility for scrutiny of the individual risks recorded on the BAF was assigned to the Quality and Safety Committee or the Finance, People and Performance Committee, depending on the nature of the risk, whilst the Audit Committee was concerned with monitoring the process and systems of risk management as a whole. In 2019/20 the Audit Committee also began to consider a deep dive into one of the BAF risks at each meeting. In July 2019 the AC discussed the strategic risks presented by the fact that the position of Director of Estates and facilities position had been vacant for an extended period of time. In January 2020 the new Director of Estates and Facilities had started in the role ensuring a strategy for Estates and Facilities would be prioritised.

In May 2019 the AC reviewed and endorsed the final draft of the Annual Governance Statement 2018/19. The AC recommended the Annual Report and the AGS for approval by the Trust Board subject to minor changes. The Audit Committee has also undertaken this process for the 2019/20 AGS.

As part of its governance responsibilities, the Audit Committee reviewed the declarations of the interests and gifts and hospitality register for the period to October 2019.

In March 2020 the COVID-19 risk was reviewed and would be continually reviewed through Gold Command and reported in all future Board and Committee meetings through the BAF.

➢ Internal Audit

At the March 2020 meeting, the Committee received the Head of Internal Audit's draft opinion, which would be included within the AGS for 2019/20 'The organisation has an adequate and effective framework for risk management, governance and internal control.' The final opinion issued was unchanged from the draft received in March.

The Committee received regular progress reports from its internal auditors (RSM UK) on internal audit work undertaken during 2019/20. The audits received by the Committee over the year covered areas including performance framework, deterioration of patients, theatre productivity governance arrangements, pseudonymisation, data quality – integrated performance, management of sickness absence, permanent and temporary vacancy authorisation and consultant planning.

The Committee discussed in more detail the audits that received only a 'partial assurance' opinion, often inviting the lead director to the meeting to discuss the findings. There were no 'no assurance' opinions issued during the year.

The committee continued to closely monitor completion of actions arising from audits, recognising that this was a key mechanism for internal audits to add value to the Trust's operations. Whilst the Audit Committee has been pleased by the improvement over the year, it considers that there is further room for improvement and continues to monitor performance into 2020/21 with an aspiration to aim for substantial compliance.

The proposed Internal Audit plan for 2020/21 was presented to the Audit Committee in January 2020, which was noted, and then finalised when the new internal auditors commenced in the role in April 2020.

The Internal Auditors presented an update of their work in March 2020 which was the final handover at committee level from RSM. The new Internal Auditors, TIAA commenced in April 2020.

➢ External Audit

The Committee worked closely with the Trust's external auditors (BDO) on the external audit of the Trust's annual report and accounts 2019/20.

The committee received the letter of representation in May 2019, recognising it was subject to change, dependent on the outcome of the final audit work. It was then considered by the Trust Board at the meeting on 23 May 2019.

In January 2020 the External Auditors provided a summary of the key audit matters they believed were important to the Audit Committee in reviewing the planned audit strategy for the Trust and Group for the year ending March 2020.

In March 2020, the Committee were informed that in response to COVID-19, a revised timetable for production of NHS organisations annual accounts 2019/20 had been issued. However, the Trust would largely follow the original timetable for the completion of the work.

The Trust's annual accounts 2019/2020 and External Audit report on the year-end accounts were considered at the Audit Committee meeting held on 16 June 2020. The Audit committee endorsed both the 2019/2020 Final Accounts and the Annual report for submission to the Board for approval.

The Committee also received updates regarding the Trust Charity and the ENH Pharma Ltd accounts. The audits for the Charity accounts 2019/20 are due to be completed in October 2020. The ENH Pharma accounts are consolidated into the Trusts accounts. The external audit of the ENH Pharma accounts will be completed in October / November 2020.

➢ Other Assurance Functions

Other assurance functions undertaken by the Audit Committee in 2019/20:

- The Committee received updates regarding the Trust's sustainability development management strategy. This remains a focus of the Committee.
- The Committee has received regular updates from the Data Quality and Clinical Coding teams. The policy has been uploaded to the knowledge centre (the Trust's intranet) and so is readily available for all staff.
- The Committee received updates regarding Clinical Audit.
- The completion of actions was an area discussed which needed improvement and the Committee continues to keep an interest in this area.
- The Committee has also continued to seek assurance regarding cyber security, receiving regular updates detailing actions in relation to cyber security and providing robust challenge where actions have not been achieved.
- The Committee received twice-yearly reports regarding the Trust's significant losses/special payments.
- The Committee approved the new policy for handling patient claims, the reporting of other special payments and the loss of any Trust assets.
- The Committee reviewed and recommended to the Trust Board the annual review of the Trust's Standing Orders and Standing Financial Instructions.

➢ Counter Fraud

The Audit Committee continued to monitor the work of the Local Counter Fraud Specialist (LCFS) throughout the year, a service provided by the Trust's internal auditors.

The AC received a regular LCFS progress report at its meetings throughout the year, detailing the work of the LCFS. The issues discussed over the course of the year included conflicts of interest, counter fraud and bribery awareness training and payroll.

The AC approved the LCFS work plan for 2020/21 at the meeting on 16 June 2020.

The Annual report for 2019/20 was considered at the June 2020 Audit Committee meeting.

➢ **Management Involvement**

The Committee continued to request attendance by the relevant director or senior manager whenever it considered a report provided less than adequate assurance and received specific reports from individual functions within the organisation (such as clinical audit) relating to overall arrangements for governance, risk management and internal control.

➢ **Financial Reporting**

One of the key duties of the Audit Committee is to review the annual report and accounts before submission to the Board. The Committee undertook this role at its meeting on 20 June 2020, recommending the reports for approval by the Trust Board at the Trust Board meeting which followed on 22 June 2020.

Conclusion

This review concludes that the Committee met its duties under its terms of reference. The feedback from Committee members and attendees was positive and the review has not identified any significant changes that are required at this time, however the following recommendations are made to further strengthen the effectiveness of the Committee:

- Some tightening and strengthening of administrative processes – including regarding report length and clarity of purpose,
- To maintain the focus on implementation of the findings of internal audits.

The terms of reference have been reviewed and some minor changes are suggested. The proposed amendments are highlighted in Appendix 1.

The Committee is asked to:
- Discuss the findings of the effectiveness review and consider any further actions.
- Recommend the amended terms of reference and approve this annual review for submission to the Board.

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 Associate Director of Governance, 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,

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality and Safety (QSC), the Finance, Performance and People Committee (FPPC), Strategy Committee and the Charity Trustee Committee (CTC).

In reviewing the work of the 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. 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.

Support

The Trust Secretary and Assistant Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent issues/areas.

Appendix 2 – Changes to meetings as a result of the COVID pandemic

Summary of changes:

FPPC and QSC: Initially the FPPC and QSC meetings were combined in order to streamline business. Additionally, there was a focus on core business only. These meetings were then separated into two distinct meetings but held on the same morning, before being moved back to their original meeting dates. Agendas have gradually returned to BAU though some changes to the report cycles remain in place.

Audit Committee: The Audit Committee continued to meet as planned, albeit on different dates on account of the changes to the deadline for the submission of the annual report and accounts for 2019/20.

Charity Trustee Committee: The CTC meeting scheduled for June was initially postponed but later reinstated and held as originally planned.

Trust Board: The Trust Board continued to meet on a regular basis, though it has not been possible for meetings to be held in public. The Trust continued to publish a range of reports and data that would ordinarily have been published as part of the public Trust Board meeting pack. The Trust Board did not hold a Board Development session in the period, but instead held additional meetings of the Trust Board on the dates that those sessions had been planned.

Other arrangements: Regular meetings were scheduled for the Non-Executive Directors to keep in contact with the Chief Executive and other Executives on a rolling basis.

The Trust was guided by the national guidance in putting these arrangements in place and anecdotally appears to have maintained Board and Committee meetings to a fuller extent than many other trusts.

The feedback received to date is that the changes were generally effective and welcome.

Current position:

As at the start of September 2020, the intention is to return to the original meeting schedule for the remainder of the year.

Recommendations:

As the Trust prepares for and begins to enter the winter period, it is proposed that the situation is monitored on a regular basis and discussions are held with the Committee Chairs and lead Executives to agree changes to meetings on a case by case basis. It is recommended that meetings should be kept separate as far as possible.

It is also proposed that, should meetings and agendas need to be reduced and streamlined, a focus on risks is maintained and used to inform agenda planning.

It is suggested that the revised approach in terms of the IPR is maintained for now and reviewed as appropriate in-year.

Agenda Item: 13.2

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

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

Purpose of report and executive summary (250 words max):

To present the annual review of Trust's SOs and SFIs to the Trust Board for approval.
This review has identified some minor amendments required, in particular regarding:

- information on the Board Committees,
- to clarify that video / telephone attendance at meetings will be deemed to constitute a presence in person at the meeting,
- to update the sections regarding counter fraud and bribery,
- to clarify the spending and approvals limits in relation to charitable funds.

The changes are noted on tracked changes for ease of reference.
(Note: contents page/page numbers will be updated in the final version)

Action required: For approval

Previously considered by:
Audit Committee – 19.10.20

Director:	**Presented by:**	**Author:**
Director of Finance	**AC Chair / Director of Finance**	**Deputy Director of Finance/ Financial Controller/ Trust Secretary**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☐
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☐
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Aligns to Governance and Financial BAF risks.

Any other risk issues (quality, safety, financial, HR, legal, equality):

There is a risk to the financial performance of the Trust if there is not a robust governance process in place. The Trust is required to have Standing Orders, Standing Financial Instructions and a Scheme of Delegation as part of its constitution.

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

REPORT TO TRUST BOARD NOVEMBER 2020

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, in particular regarding:

- information on the Board Committees,
- to clarify that video / telephone attendance at meetings will be deemed to constitute a presence in person at the meeting,
- to update the sections regarding counter fraud and bribery,
- to clarify the spending and approvals limits in relation to charitable funds.

1.5 The Trust Board is asked to approve these revisions.

2. Key changes

Below are the key amendments to this document and a reference to sections updated

Section	**Key changes**
Various	Finance, Performance and Workforce Committee name changed to Finance, Performance and People Committee (FPPC).
3.11 (iv) Quorum	Added a paragraph to clarify that video / telephone attendance at meetings will be deemed to constitute a presence in person at the meeting.
4.8.4 Committees	Updated purpose of the Board Committees in line with the 2020 reviews of the Terms of Reference and with the inclusion of the Strategy Committee.
Various but in particular 11.5 Fraud, Bribery and Corruption	Various updates to reflect latest guidance and best practice regarding responsibilities and requirements in relation to fraud, bribery and corruption.
Appendix 2 Detailed Limits of Delegation Policy – Charitable Funds	The approval limits have been updated in line with the Charity's scheme of delegation and Terms of Reference.

3. Recommendations

The Trust Board is requested to approve the revision to the Standing Orders, Standing Financial Instructions and Scheme of Delegation as illustrated in the appendix.

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: ~~Associate Director of Corporate Governance~~ Trust Secretary
Financial Controller
Director of Procurement
Local Counter Fraud Specialist

Approved by: Audit committee

Trust Ratification: Trust Board

Mrs Ellen Schroder (Trust Chair), ~~6 November 2019~~

Policy issued:

To be reviewed before:

To be reviewed by: ~~Associate Director of Corporate Governance~~Trust Secretary / Financial Controller

Doc Registration No. CG05 **Version No.**

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

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

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

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

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

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

Key messages

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

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EAST AND NORTH HERTFORDSHIRE NHS TRUST

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

October 202019

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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 ~~Associate Director of Corporate Governance /~~Trust Secretary).

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

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

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

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

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

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust (Appointed by NHS Improvement);

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

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

- the Chief Executive;
- the Director of Finance

The Trust shall have not more than 11 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of the Trust's Chair and Members of the Trust

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

2.3 Terms of Office of the Chair and Members

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

2.4 Appointment and Powers of Vice-Chair

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

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

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

2.5 Joint Members

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

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

- (a) either or both of those persons may attend or take part in meetings of the Board;
- (b) if both are present at a meeting they should cast one vote if they agree;
- (c) in the case of disagreements no vote should be cast;
- (d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Patient and Public Involvement

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

2.7 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

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

(3) **Director of Finance**

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

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

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

The Chair shall liaise with the NHS Improvement - Appointments over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

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

2.8 Corporate role of the Board

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

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

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(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 Trust Secretary -at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chair and Trust Secretary-.

(5) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, 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 Chair~~-~~ of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

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

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

iii) **Amendments to motions**

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

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

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

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

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

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act I960 resolving to exclude the public, including the press (see Standing Order 3.17).

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

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

3.8 Motion to Rescind a Resolution

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

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

3.9 Chair of meeting

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

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

3.10 Chair's ruling

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

3.11 Quorum

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

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

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

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

3.12 Voting

(i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote.

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

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

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

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

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

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

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

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

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

3.14 Variation and amendment of Standing Orders

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

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

3.15 Record of Attendance

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

3.16 Minutes

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

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

3.17 Admission of public and the press

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

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

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

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

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

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

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

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

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

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

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

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 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 ~~Quality and Safety Committee~~relevant sub-committee.~~.~~

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

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

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls;
- ~~maintaining oversight of the development and implementation of the Trust's digital strategy;~~
- ~~to monitor the creation and operation of the Trust's estates strategy;~~
- overseeing risk management for the duties of the Committee.

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

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

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

iii) Auditor Panel - In line with the requirements of the Local Audit and Accountability Act 2014 the Trust has established an Auditor Panel to enable the Trust to meet its statutory duties by advising on the selection, appointment and removal of the External Auditors and on maintaining an independent relationship with them. The Terms of Reference are approved by the Trust Board and reviewed on a periodic basis. The committee is comprised of the Audit Committee Non-Executive Directors.

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

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 England and Improvement (NHSE/I) 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 Managing Conflicts of Interest Policy for East and North Hertfordshire NHS Trust staff;

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

6.3 Standing Financial Instructions

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

6.4 Specific guidance

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

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

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

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

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

ii) In addition to Board Members Declarations of Interest also applies to all Directors, both Executive and Non-Executive, Senior Managers (Divisional Directors, Divisional Chairs, agenda for change band 8d and above and the Trust Secretary-), Consultants and other Decision Making Staff – (all budget holders, administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions, who have the power to enter into contracts on behalf of Trust.). As set out in the Managing 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 Trust 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.

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

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 Managing Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.2 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

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

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Approve the establishment of a subsidiary company and the associated articles of association and operating framework
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and held by the Trust Secretary
	THE BOARD	**Audit** 1 Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from DoF on financial performance. 4. Receive reports from the Chie Executive on performance matters by exception.

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
	QUALITY AND SAFETY COMMITTEE	The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such education and talent management, or where there is a clear and direct link to quality and safety issues.~~such as organisational culture and education and talent management~~. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy. Please note the Trust's Audit Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and ~~Workforce~~ People Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny. A full list of responsibilities can be viewed in the Terms of reference for the committee which are appended to this document

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	FINANCE, PERFORMANCE AND PEOPLE AND PERFORMANCE COMMITTEE	The purpose of the Finance, Performance and Workforce People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust. The Committee's work will include: • maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy; • providing scrutiny of operational performance; • monitoring elements of the Trust's people strategy, particularly in relation to resourcing and key controls; • maintaining oversight of the development and implementation of the Trust's digital strategy; • to monitor the creation and operation of the Trust's estates strategy; • overseeing risk management for the duties of the Committee. The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System Sustainability and Transformation Partnership that may impact on the work of the Committee. A full list of responsibilities can be viewed in the Terms of reference for the committee
	EXECUTIVE COMMITTEE	The Executive Committee is the executive decision making body of the Trust and is a forum for handling complex, major organisational issues. Its purpose is: • to oversee the effective operational management of the Trust, including achievement of the Trust strategy, statutory duties, NHS priorities, local targets and requirements. • to support the delivery of safe and high quality patient centred care • to direct and influence the Trust service strategies and other key service improvement strategies which impact on these, in accordance with the Trust overall vision, values and business strategy. • to manage and monitor clinical quality, finance performance and activity. It will ensure executive decision-making and sign-up to delivery through group and personal accountability.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		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 COMMITTEE	The purpose of the Charity Trustee Committee is: • To ensure a robust strategy for delivery of the Charity aims and objectives • To champion the charity and its development, providing leadership both within the Trust and externally • To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, East & North Herts Hospitals (registered charity no 1053338). A full list of responsibilities can be viewed in the Terms of reference for the committee
	STRATEGY COMMITTEE	The Strategy Committee is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. To provide Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee. A full list of responsibilities can viewed in the Terms of Reference for the Committee.
	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.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		A full list of responsibilities can be viewed in the Terms of reference for the committee.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
1 & 5	**CHIEF EXECUTIVE & TRUST SECRETARY**	**Review scheme of delegation**
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	*Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • 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.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.24	BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHSI – Appointments to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and Trust Values.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	DIRECTOR OF FINANCE	All members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board a delivery plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.4	BUDGET HOLDERS	All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.1.5	BUDGET HOLDERS	All budget holders will sign up to their allocated budgets at the commencement of each financial year.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Authorised signatory list is maintained by the finance Department and available on request
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	Appropriate Executive Director	Make a written case to support the need for a prepayment.
21.2.4	Director of Finance	Approve proposed prepayment arrangements.
21.2.4	Budget Holder	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	Chief Executive	Authorise who may use and be issued with official orders.
21.2.6	Managers and Officers	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	Chief Executive Director of Finance	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	Director of Finance	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	Director of Finance	The DoF will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.1	BOARD	Will approve the Trust's plans for applications for short-term or longer-term borrowings and loans
22.1.2	Board	Approve a list of employees authorised to make applications and sign loan documentation on behalf of the Trust. (This must include the CE and DoF.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising at least one other member for loan and borrowing application and documentation submission..
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS,and NHS Counter Fraud Authority as required by NHS Counter Fraud Standards for Providers.
26.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	Approve write off of losses (within limits delegated by DH).
26.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
26.2.7	DIRECTOR OF FINANCE	Maintain losses and special payments register.
27.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.1	DIRECTOR OF FINANCE	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	TRUST SECRETARY	Shall ensure that a Freedom of Information Scheme is published and maintained.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
30	TRUST SECRETARY	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

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 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 Trust 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 (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.

(g) overseeing the LCFS function and compliance with the NHS Counter Fraud Authority Standards for Providers.

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, bribery or corruption, and in conjunction with the Local Counter Fraud Specialist (LCFS) and NHS Counter Fraud Authority in cases of fraud, bribery or corruption;
~~deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;~~

(d) 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 and LCFS 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.

11.3.5 The LCFS will be notified where the internal audit function identifies inadequacy of poor application of financial and other management controls which may present a risk of fraud, bribery or corruption occurring.

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, Bribery 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 NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.

11.5.2 The Director of Finance is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

11.5.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist (LCFS) to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority Standards for Providers.

11.5.4 The LCFS shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority Standards for Providers, the NHS Counter Fraud Manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

11.5.5 If it is considered that evidence of offences exist and that a prosecution is appropriate, the LCFS will consult with the Director of Finance to obtain the necessary authority and agree the appropriate route for pursuing any action i.e. referral to the police or to the NHS Counter Fraud Authority.

11.5.6 The LCFS will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

11.5.7 The LCFS will ensure that measures to mitigate against identified risks are included within an organisational work plan which ensures that an appropriate of resource is available to the level of any risks identified. Work will be monitored by the Director of Finance and outcomes reported to the Audit Committee.

11.5.8 In accordance with the Raising Concerns at Work (Freedom to Speak Up) Policy, the Trust shall have a whistleblowing mechanism in place to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national NHS fraud and corruption reporting line, as provided by the NHS Counter Fraud Authority.

11.5.9 The Trust will report annually on how it has met the standards as set out by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Director of Finance and Audit Committee Chair shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority.

~~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 Director of Finance and shall work with staff in NHS Counter Fraud Authority and equivalents and in accordance with the Standards for NHS Counter Fraud Standards for Providers and any other relevant guidance.~~

~~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 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;

(d) 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;

(e) 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 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 unless permitted under Department of Health Estates and Facilities guidance which may require specific Department 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 –**

(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 electronically on the e- Procurement portal Bravo Solutions
(b) .

(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 electronically.

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 Electronically via the e-Tendering portal Bravo

(ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iii) 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.

(iv) Every tender received shall be marked electronically with the date of opening.

(v) 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;
- each entry to this register shall be signed by those present.

(vi) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing 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 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,.

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 Bravo/JA 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 Director of ProcurementDirector of Procurement

(iii) The Director of Procurement (Hertfordshire NHS Procurement) as guardian for the Bravo 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 Director 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 Director 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 2018/19. 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 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 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 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.

24.1.3 Capital Review ~~Control~~ Group, (reports to the FPPC 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~~FPPC;

(c) Sets the capital budgets following approval by ~~DEC~~FPPC;

(d) monitors progress of capital projects against budget;

(e) reports to the FPPC 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~~Deputies Group and Capital Review Group should consider sources of funding including purchase, private or other finance and lease funding. The Trust uses ~~-~~Lifecycle Group Limited to support the management of its lease portfolio. All lease proposals must be organised by ~~Leaseguard~~ Lifecycle unless the Finance ~~and~~, Performance and People Committee specifically agree alternative arrangements. Lifecycle 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 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 and People 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 CommitteeDeputy Directors' Group 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 CommitteeDeputy Directors' Group 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 and People 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 and People 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, bribery and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS who will decide, in consultation with the Director of Finance~~, whether notification to NHS Counter Fraud Authority is appropriate~~. The External Auditor will be notified of all frauds. All fraud investigations will be reported to the NHS Counter Fraud Authority and Audit Committee.

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 Trust 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 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 Trust 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 2017and 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 NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution 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. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the 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 NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS 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 Director 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 Director 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 £ £118,113) 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 Director 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 ' Bravo system and a register of tenders maintained by the Board Secretary.

Contract or purchase over OJEU limit (currently£118,113)

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 give approval.

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, limits Unchanged
	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 or Associate 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 or Associate 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 or Associate 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), 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 for the provision of goods and services	Over £1,000,001	Subject to Board approval	Director of Procurement No change to approver limits
	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	Unchanged
	Over £10,001and up to £50,000	Divisional Director/Divisional Chair/Assistant Director of Corporate area	Unchanged
	Up to £10,000	General Manager, Divisional Nursing Services Manager, Head of Service	Unchanged
Pharmaceuticals	Any value	Director of Finance, Chief Operating Officer	Unchanged
	Up to £50,000	Head Pharmacist	

Catalogue or Non-Catalogue Orders, including Estates and Catering, once contracts have been agreed and non purchase order invoices	Over £750,001	Chief Executive or as delegated to Director of Finance	UnchangedDirector of Finance – over £1,000,001 Other Executive Directors £500,001 and up to £1,000,000
	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	UnchangedOver £50,001 and up to £500,000
	Over £10,001 and up to £50,000	Divisional Director/Assistant Director of Corporate area	Unchangedover £5,001 and up to £50,000
	Over £5,000 and up to £10,000	General Manager, Divisional Nursing Service Manager, Head of Service	Unchanged Up to £5,000
	Over £1,001 and up to £5,000	Departmental head / Budget Manager (Band 8 and above)	UnchangedNew limit
	Up to £1,000	Budget Manager (Band 7)	UnchangedNew limit
Pharmaceuticals	Any value	Director of Finance, Director of Operations	Unchanged
	Up to £50,000	Head Pharmacist	Unchanged

2. **Invoices excepted from the Purchase Order Process**

Type	Amount	Authorised Officer	Current Approver
All payment types below	Over £250,000	Director of Finance	Unchanged
Utilities (Phones, Electric, Gas, Water, Waste Collections)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £50,000	Head of relevant area (IT, Estates)	Unchanged
Rates	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £50,000	Director of Estates	Unchanged
Lease car invoices	Over £5,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Up to £5,000	Financial Controller	Unchanged
Computershare invoices (nursery vouchers)	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
	Over £5,001 and Up to £50,000	Financial Controller	~~Up to £50,000~~Unchanged
	Up to £5,000	Deputy Financial Controller	No limit

3. **Other Payments**

Payment Type	Amount	Responsible Officer	Current approver
All payment types below	Over £250,000	Director of Finance	Unchanged
	Over £50,001 and up to £250,000	Deputy Director of Finance	Unchanged
NHS Supply Chain invoices for 'top up' of materials management	Up to £50,000	Approved by Financial Controller/Deputy Financial Controller	Unchanged
Payroll Payments	Main Trust Payroll	Director of Finance or Deputy in his/her absence	Unchanged
	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	Unchanged
Contractual payments on termination e.g. lieu of notice or redundancy	Over £10,001	Director of Finance	Unchanged
	Up to £10,000	Chief People Officer	Unchanged
Removal Expenses	Over £8,001	Director of Finance	Unchanged
	Up to £8,000	Chief People Officer or Director of Workforce	Unchanged

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	Unchanged
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)	Unchanged
	Between £10,001 and £50,000	Chief People Officer and Chief Executive	Unchanged
	Up to £10,000	Chief People Officer or Director of Workforce	Unchanged

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)	Unchanged
	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	Unchanged
	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	Unchanged
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.		Unchanged

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
Expenditure on fund raising	Up to £2,500	Head of Charity (if within approved annual budget)	New limit
Other expenditure	Up to £500	Head of Charity + Divisional Director / Nominated substitute + Financial Controller / Executive Director	New limit
All income and other	Up to £5,000	~~Approved fund~~	~~Unchanged~~Approved

expenditure agreements		~~holder~~Charity Management Team (CMT)	fund holder
	Over £5,001 and up to £500,000	Charitable Trustees Committee (CTC)	Unchanged
	Over £500,001	Trust Board	Unchanged

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: 14

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020
CHARITY TRUSTEE COMMITTEE – MEETING HELD 14 SEPTEMBER 2020
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Charity Trustee Committee (CTC) meeting held on 14 September 2020.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Corporate Governance Officer / Trust Secretary

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 14 SEPTEMBER 2020

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director), David Buckle (Non-Executive Director), Sarah Brierley (Director of Strategy) and Rachael Corser (Chief Nurse)

Key decisions made under delegated authority:
The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
Refurb the previous open bore MRI room to have two clinical bays.	£11,080	Approved. MVCC have been asked to match fund approximately £5,500 to reduce the CTC request to £5,580.
Landscaping of Circular wooded walkway at Mount Vernon to create a walking route around site to support patient and staff wellbeing.	£30,000	Not approved at this meeting. The Committee recommended that the proposal be discussed by the Staff Wellbeing Committee to understand the perceived value by staff.
10 Rad 8 Masimo saturation monitors, 2 Rad 95 saturation monitors, 2 Rad 97 saturation monitors £11,500 4 alaris syringe drivers £5000 5 portable nebulisers for the community nursing team £250	£16,750	Not approved. The Committee had some concerns about the extent to which this application was over and above the NHS requirement.
Making our maternity wards a nicer and more comforting experience and environment for new mothers and babies during COVID -2 birthing pools £19,525 -6 Telemetry monitoring sets Max £5,400 -Blackout blinds for MLU and CLU TBC -Birthing stools, 4-6 floor mats, radios and murals £5952 -50 Staff equipment bags for community midwives £2,500 -5 Gynae multifunction couches £10,000	£44,000	Birthing Pools £19,525 approved subject to confirmation of feasibility with Estates and Facilities. Head of Charity support the team with identifying the most appropriate funding opportunities for the other aspects of the proposal.
Restructure and recruitment plan for charity team outlined in charity activity update paper which includes re-banding data administrator and promoting to data and donor	£15,792	Approved

engagement lead and increase resource to an extra day. Increasing communication and engagement officer hours to 4 days from 2.5 days.		

Other outcomes:

Staff Support and Well-Being Proposals Update
It was reported to the CTC that the governance process for each of the five projects was being developed and Accountable Officers identified. They heard that five Task and Finish Groups were being established. The Committee urged speed in delivery and discussed the possibility of a Project Co-ordinator being appointed on a six month fixed term. The Committee agreed that an update report would be presented to the Executive Committee in advance of the December CTC meeting.

NHS Charities Together Funding update
The Committee were presented with an update on the Stage 2 and Stage 3 of the funding awards. They were informed that the funding had been allocated to ICS areas and will be held by Hertfordshire Community Trust as the lead Charity. It was explained to the Committee that applications for funding would need to be made but a list of possible funding projects was being developed.

Public Lottery Proposal
The Committee were presented with a proposal to join a public lottery organised by a third party. The Committee were informed that signing up would be low cost and low risk and the Charity would receive 60p for every £1 made through the lottery with the 40p paying for the prize fund and administration. The Committee approved the proposal to join the Hospice Association Lottery.

Charity Activity Update
It was reported to the Committee that following a reduction in activity due to the COVID-19 pandemic there was an opportunity to reshape the team for a renewed focus on income generation and to enhance the Charity brand. The Committee were informed that the Charity had many new donors with potential for future engagement that would need to be developed.

Charity Finance Report
The Committee were informed that the Charity expenditure was in line with expectation. It was reported to the Committee that this year Gifts in Kind would be disclosed. The Committee heard that the Charity Investment position had improved compared to March.

Investment Portfolio Update and Investment Strategy
The Committee discussed the development of an investment strategy. They were informed that the contract with the current Fund Managers (Rathbones) was due to expire at the end of March 2021. The Committee discussed the options for provision of the service beyond March 2021. The Committee agreed to develop the aims and objectives of an investment strategy by December 2020 and explore the possibility of extending the current contract for a short period to enable the process to be concluded in time before tendering began.

Charity Annual Report 2019/20
The Committee were presented with the draft Charity Annual Report and Accounts. Following approval from the Auditors the Annual Report and Accounts would be presented to the Board for approval.

Process for Funding for Training
The Committee discussed a new proposal for the allocation of Charitable funds for training to ensure a consistent approach for staff to have the opportunity for development opportunities. The Committee approved the process.

Acceptance and Refusal of Donations Guidelines
The Committee were informed that the policy had been updated to provide clarity on the process for considering donations offered under exceptional circumstances (such as the COVID pandemic) that may ordinarily be declined. The Committee approved the updated guidelines.

Divisional Fund Management Reports: CSS and Medicine
The Committee noted the content of the fund management reports for the CSS and Medicine divisions.

Next Major Charity Appeal Process Update
The Committee agreed to support the generation of proposals for a major fundraising appeal and asked that the preferred options be presented to the next CTC for a recommendation to Board.

Bob Niven
Chairman of the Charity Trustee Committee

October2020

Agenda Item: 14

TRUST BOARD - PUBLIC SESSION – 4 NOVEMBER 2020

CHARITY ANNUAL REPORT AND ACCOUNTS 2019/20

Purpose of report and executive summary:

To present to the Board in its role as Corporate Trustee the Charity Annual Report and Accounts 2019-20 and Letter of Representation for approval, and to consider and note the findings of the Audit Completion Report for the East and North Hertfordshire NHS Trust Charitable Fund for the year ended 31 March 2019.

Action required: For approval

Previously considered by:

Draft versions of the Charity Annual Report and Accounts 2019/20 were considered by the CTC on 14 September 2020 and Audit Committee on 19 October 2020.

The draft Audit Completion Report was circulated by email to members of the Audit Committee and CTC on 27 October.

Director:	Presented by:	Author:
Chair of AC	Chair of AC	Assistant Trust Secretary

Trust priorities to which the issue relates:		Tick applicable boxes
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)

N/A

Any other risk issues (quality, safety, financial, HR, legal, equality):

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

East & North

Hertfordshire Hospitals' Charity

Annual Report and Accounts 2019/20

FUNDRAISING REGULATOR

Registered charity no. 1053338

Foreword by the Chair of the Charity Trust Committee

I am very pleased to be presenting the 2019/20 Annual Report for the East and North Hertfordshire Hospitals' Charity on behalf of the Trustees.

This year we have raised more than £1.09m in fundraised income thanks to the marvellous generosity, dedication and hard work of fundraisers, donors, supporters, volunteers, staff and the charity team itself.
This has enabled us to fund £1.089m of projects ranging from an interactive flooring projector in the children's emergency department through to a high tech Sonosonite ultrasound scanner for use in our specialist preterm labour antenatal clinic. The charity supported projects to enhance patient care at our cancer centres which includes funding the complementary therapy team at Lynda Jackson, new seating in the outpatients waiting area and a pager system so patients can have lunch or sit in the garden while they wait for their appointment.

In the course of the year the Lister Butterfly end-of-life service received the Pride of Stevenage Awards and our Lister Neonatal Unit Families Group was recognised by Hertfordshire Chamber of Commerce for its voluntary fundraising efforts and contribution to the local community. Highlights also included setting up our first men's health committee to support patients with prostate cancer and launching our SafeSpace appeal to help children with mental health issues and complex needs.

The final month of the year brought a bigger challenge to our NHS trust than we ever could have imagined. The global COVID-19 pandemic hit and our staff faced it head on as the rest of the world locked down.

The trust continued working hard to deliver exceptional care for patients. The charity team also responded immediately and launched the #HereForEachOther appeal to fund projects to enhance the physical and emotional wellbeing for staff.

We were overwhelmed by the huge kindness and generosity shown by the community through financial giving and also donations of groceries, protective clothing and of tablet computers to enable our isolated patients keep in touch with loved ones.

We are very proud of all we have achieved this year and we go into 2020-21 as determined as ever to help the East and North Hertfordshire NHS Trust to continue to provide high quality patient care in challenging times.

Thank you

Bob Niven
Chair of the Charity Trustee Committee
On behalf of the Corporate Trustee

About the Charity

The Trustee presents its annual report and financial statement audited by the independent auditor for the year ended 31 March 2020, which has been prepared in accordance with the Charities Act 2011 and the Charities Statement of Recommended Practices (FRS 102)

East and North Hertfordshire Hospitals' Charity exists to create the best possible experience for all patients within the East and North Hertfordshire NHS Trust. The four hospitals we support are the Lister in Stevenage, the New QEII in Welwyn Garden City, Hertford County and Mount Vernon Cancer Centre in Northwood, with more than 550,000 people cared for at our sites every year.

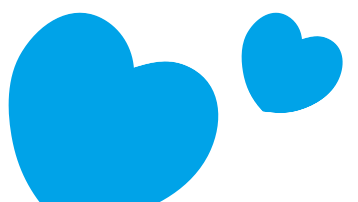
We raise funds to purchase the very best kit and equipment, to enable our staff to undertake leading-edge research and to purchase special extras. All of these ensure our patients receive gold-standard treatment and care whilst at one of our hospitals. Importantly, we only fundraise for projects that are outside of statutory funding responsibilities – everything we do goes above and beyond.

As a charity we are fortunate to receive support from patients saying thank you for the care they received, friends and family that wish to remember a loved one, dedicated fundraisers taking part in a whole host of events, trusts, foundations and corporates that believe in our vision, and legacies from those that are passionate about ensuring our work continues in the future.

We are immensely proud of all we have achieved this year and we will go into 2020/21 ready to support our NHS trust into recovery and beyond.

Thank you

Our Year at a Glance



April

- We got muddy at the Warrior Adrenaline Race.
- We delivered hundreds of Easter Smiles to patients and staff.

May

- Over 60 supporters braved our first ever abseil down the Lister Hospital tower block, raising more than £19,000.
- Sainsbury's Coreys Mill partnered with us as part of their 150 year celebration – giving us more than 150 hours of voluntary support.

June

- Stephen Cornell's golf day raised over £9,000 for Mount Vernon Cancer Centre and Men's Health Appeal.
- Maternity staff got colourful at the Colour Run to raise funds for recliner chairs.
- The Lister Neonatal Unit Families Group was shortlisted for the Hertfordshire Chamber of Commerce Awards.

July

- Thames Materials raised over £32,500 at its annual golf day for the Lynda Jackson Macmillan Centre, bringing its total raised over the years to more than £100,000.
- We celebrated the 71st anniversary of the NHS with cake!
- Neonatal Dads rowed, cycled and ran as part of their 12-hour triathlon challenge at the Lister.

August

- Alfie Pitt, our young ambassador, officially opened the interactive sensory floors in the children's emergency department.
- Christine Hunter skydived for the Lynda Jackson Macmillan Centre.
- 11 cyclists took part in the Prudential Ride London, raising more than £7,300.

September

- Over 1000 runners took part in Moor Park 10k and the junior fun runs.
- Simon Speller Mayor of Stevenage took part in a Men's Health 12 hour Spinathon challenge.
- Baroness Cox hosted an event at the House of Lords which was attended by our medical staff, ambassadors and donors.

October

- Official opening of the Morcellator and HoLEP) service for prostate cancer patients.
- Solicitors and Will Writers across Hertfordshire supported our first Make a Will Week.
- We wore green on World Mental Health Day.

November

- We celebrated our Trust staff at the Annual Celebration of Excellence Awards.
- Our Neonatal Unit marked World Prematurity Day.
- Supporters courageously walked on fire and lego bricks at the Lister to raise funds for our charity.

December

- Our community helped us spread smiles by donating thousands of gifts for patients.
- Runners got festive at our Santa runs in Stevenage and Northwood.
- Our Hospital staff wore their favourite Christmas Jumpers to raise funds.

January

- Austins Family Funeral Directors presented us with a cheque for over £5,000 as part of their Butterfly Service charity of the year partnership.
- Denise and Ian Clinch won £1,000 as part of our 'Win a grand for Christmas' draw kindly sponsored by Putterills.

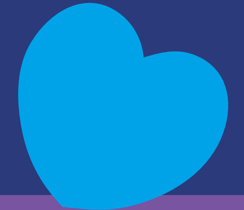
February

- Keeley Russell and the Simon Cooper Foundation raised £10,000 for scalp coolers for the Lister Macmillan Cancer Centre.
- Letchworth Rugby Club joined our Men's Health appeal raising more than £2,000 for prostate cancer.
- We organised our first Love Your Hospital Week and a Valentine's Market at the Lister.

March

- Renal team celebrated World Kidney Day with a cake sale.
- Ocado donated £5000 towards our SafeSpace appeal, helping children and young people in crisis.
- We set up an urgent response to support staff and patients through COVID-19.

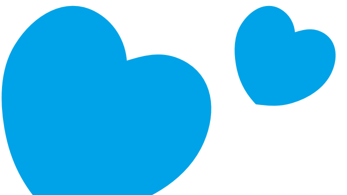
Our Performance



WE SAID WE WOULD...	WE DID IT!
Implement our new website and grow our social media following	The new charity website launched in January 2019 and we had 702 donations totalling £34,767 in the financial year. Charity followers on Facebook have increased by 275% and 21% on Twitter.
Increase income in all areas of fundraising	A fundraising team has been recruited, which covers all areas of fundraising. Growth targets have been set and at year date and we have seen an increase in all income areas across the board bar Community and Trusts and Foundations: • Individual Giving has increased by £15,413. • In memory income has increased by £23,562. • Corporate income has increased by £7,551. • Tin collections has increased by £6,305. • Lottery has increased by £6,637. • Major Donor income has increased by £31,621. Chart Lodge – we secured a significant donation of £182,374 which was awarded to our charity to maintain Chart Lodge and support patients staying at Mount Vernon Cancer Centre Trusts and Foundation income has decreased by £222,179 from the previous year. We received a six figure grant for our Big Build appeal in the previous year which explains why 18/19 income was significantly higher for this stream Community income has decreased by £64,337 from the previous year. This is because two high value charity events in aid of Mount Vernon Cancer Centre in 2018/19 weren't repeated this year.
Improve user satisfaction for accessibility and attractiveness from donors	Donors can now donate online, and all have a lead fundraiser who they can liaise with. Feedback is constantly positive and is seen in practice through a nomination in the staff awards for the charity team: 'The support I have received from the Charities Team since has been nothing but incredible and feel as much as they support everyone else, they deserve to be recognised for the incredible work they carry out. The support they provided to me has been second to none. The constant contact throughout numerous events I have taken part in and concerts I have arranged ensured that I wasn't on my own. Collectively they have always asked how they can help, inside and outside of their usual hours and sometimes bringing equipment to me and going out of their way which has made a difference to what I have been doing'

Grow our number of staff ambassadors and champions year on year	14 Charity Staff Ambassadors can be viewed on our website. In addition 168 new staff engaged with the charity this year. Our charity events are viewed as team building opportunities and there are regular divisional staff-led fundraising activities. Most notably, two fundraisers in Clinician Support Services raised over £3,000 from a quiz night and raffle in August. From January 2019 to present, staff members have raised funds to the value of £22,460 (not including staff lottery) and 85 individual staff members have organised their own fundraising event or activity or taken part in one of our charity-organised events to support our charity.
Continue to deliver our wonderful Butterfly Service and volunteering service at Mount Vernon	Our Butterfly Service made 2,055 visits over the year, supporting 535 dying patients and their families. The service won the Pride of Stevenage Awards and Angela Fenn, Butterfly Service Coordinator, featured on our new charity film which was launched at our House of Lords evening. Our volunteering service at MVCC recruited 41 new volunteers, bringing their total to 200+ volunteers supporting patients and staff.
Grow our supporter base and widen reach	Donor data is gained and stored in line with GDPR and since April 2019 1,409 new donors have been added to the database. Since 2017 the number of donors on record has increased by 493%. The Christmas mailing was able to be sent to 772 donors this year as compared to 400 donors last year.
Increase our fundraising activity to generate unrestricted income	Unrestricted income is generated through; Staff Lottery; Collection Cans; Sponsorship, Direct mails and fundraising activities planned by the charity team. At month 7 £340k had been raised as unrestricted income, this is 55% of all income raised and an exceptional amount.
Steward and retain our incredible supporters	A number of successful cultivation events have taken place which has enabled us to successfully thank and retain/ reignite donors. Measures are being put in place to track repeat gifts.

The Year Ahead

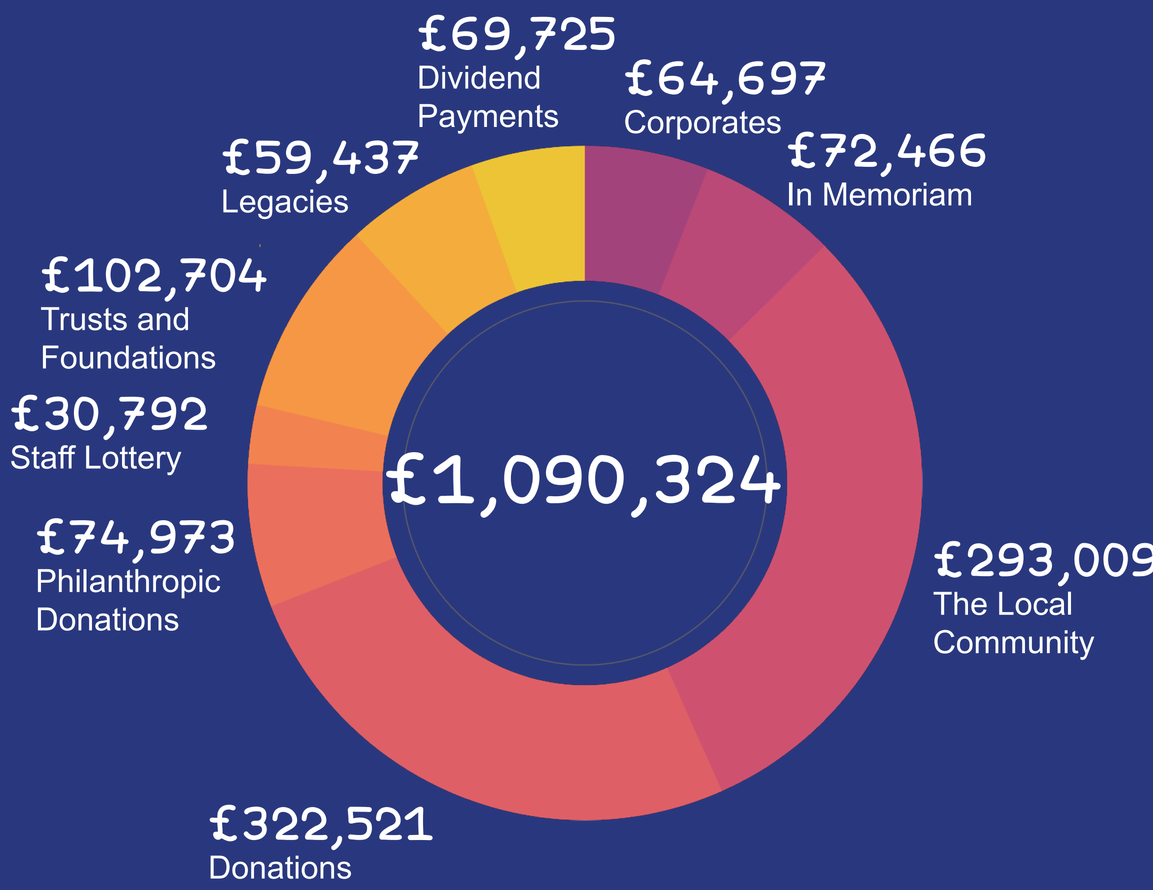


Our Charity's strategic aims for **2020/21** are to:

- Continue to raise funds through safe and cost effective methods that do not expose our staff, donors and supporters to COVID-19 risks.
- Proactively increase the value and number of applications made to Trusts and Foundations.
- Cultivate new donors and supporters identified during the #HereForEachOther appeal.
- Further engage with senior clinicians and medical staff to build on our grateful patient programme
- Continue to deliver excellent donor care and stewardship to ensure our donors have increased lifetime value
- Increase brand awareness at our hospitals and in the community.
- Continue to generate good quality donor data.
- Strengthen our Trust partnership.
- Rebrand our appeals programme and to have identified a new compelling major project to launch at the start of January 2021.
- To develop a new charity fundraising strategy focused on building the strength of Lister, New QEII and Hertford County Hospitals, as our NHS Trust manages the transfer of Mount Vernon Cancer Centre to an alternative healthcare provider

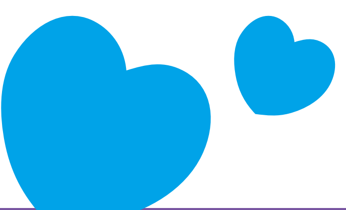
Our Fundraising in Numbers in 2019/20

In 2019/20 we raised



Our Charity Appeals

How we spent our money in 2019/20



We spent... £387,282 on fundraising activity

We spent... £1,089,291 on charitable activity

Money we spend going above and beyond for our patients includes:

Voluntary services: £116,806
Allowing our award-winning Butterfly Volunteer Service and the Mount Vernon Community Engagement team continue their excellent support work.

Research: £92,398
Funding research posts at Mount Vernon Cancer Centre enabling us to conduct innovative and world leading research projects to enhance treatment for patients.

Lynda Jackson Macmillan Centre: £212,074
Providing invaluable information and advice, support and complementary services to our cancer patients and their families.

Training and wellbeing: £48,588
Funding a wide variety of non-statutory training courses, conferences education programmes and study leave enabling staff to grow and develop their skills

Governance costs: £144,682

Enhancing patient experience: £474,742
Providing the best environment for our patients by funding innovative medical equipment to improve comfort, support services, iPads and entertainment systems including free WiFi, toys and play equipment and welcoming artwork.

Our 6 Pillars of Impact

We support the East and North Hertfordshire NHS Trust to deliver compassionate care to patients, visitors and families, ranking all of our activity under 6 Pillars of Impact. Over the forthcoming pages we take a look at just one of the many projects we've funded over the past year under each pillar.

1

Research Projects
Pillar One
To drive innovation for treatment and care

2

Art and refurbishment
Pillar Two
At our hospitals to improve visitor experience

3

Training and wellbeing
Pillar Three
Initiatives to support staff

4

Cutting-edge medical equipment and technology
Pillar Four
To enhance our treatment

5

Support services, equipment and items
Pillar Five
To improve patient experience

6

Volunteering projects
Pillar Six
To support staff and patients

Focus on... Research Projects

Case Study: ScarWork

One breast cancer survivor wrote:

"This non-invasive treatment has mentally, emotionally and physically helped more than drugs could ever. Thank you for helping me."

One of the leading edge projects we fund is ScarWork, led by Dr Beverley de Valois, a researcher of Integrative Medicine in the Supportive Oncology Research Team at Mount Vernon Cancer Centre.

ScarWork was recently introduced into the UK from the USA, this manual therapy addresses the consequences of surgical scarring.

After treatment, clients often say their scars feel softer, mobility has improved and they feel less pain. As well as improving the appearance of scars, the therapy addresses the emotional aspects of scarring.

Focus on...
Art and Refurbishment

Case Study: Fern Garden at Mount Vernon

We use art projects and garden spaces to inspire better health and wellbeing for our patients.

In collaboration with Ginnie Abubakar *(pictured above)* and the community engagement team at Mount Vernon, we worked closely with our partners, the Centre of Sustainable Health Care, to develop our outdoor spaces at the centre. Funding from the Heathrow Community Fund enabled the exciting redesign of the garden outside our chemotherapy unit and the hard landscaping was completed in March to create an open large, accessible space.

With additional charity funding in place to complete the project, we will establish a calm and therapeutic space where patients can receive their treatment or meet their accompanying family member or friend.

Case Study: Staff Initiatves

Focus on...
Training and Wellbeing

We enabled our staff to go above and beyond for our patients and their families with more than £24,000 of training, including maternity yoga, a child trauma specialist, anxiety management in palliative care and a Sage and Thyme course for bereavement training.

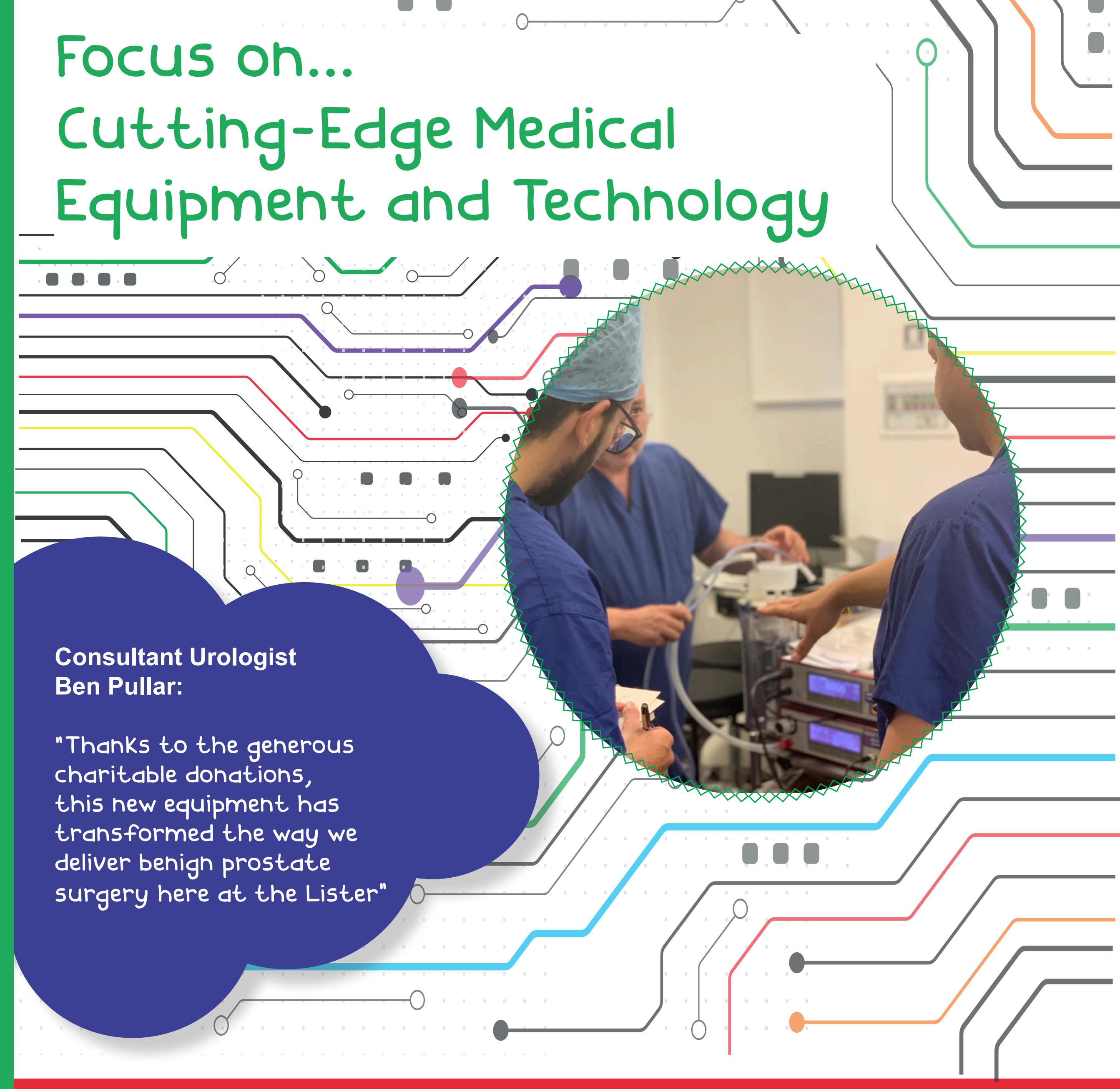
We also funded conference and networking days to give our staff the opportunity to develop their skills and learn new theory and practice.

We are proud to fund our Trust annual Celebration of Excellence Awards Evening, a night dedicated to thanking and recognising our staff and their achievements.

On the 5th July we funded and hosted a Big Tea party to celebrate the 71st Anniversary of the NHS

Case Study: Morcellator

Focus on... Cutting-Edge Medical Equipment and Technology



Consultant Urologist Ben Pullar:

"Thanks to the generous charitable donations, this new equipment has transformed the way we deliver benign prostate surgery here at the Lister"

Every year we fund innovative high tech pieces of equipment that allow for better diagnostics leading to quicker requests, enhanced patient experience and clinical outcomes.

One of our major appeals in the past year was for a morcellator, a thin telescope-like instrument that will enable us to introduce Holmium Laser Enucleation of the prostate (HoLEP) as part of the male bladder outlet obstruction service at the Lister. It is not standard issue in an NHS hospital and will allow our patients to be seen more effectively and more comfortably.

It means 80 per cent of patients will be discharged on the same day, compared to a 2/3 day stay in hospital.

Focus on... Support Services, Equipment and Items

Case Study: Interactive Sensory Flooring

Another fantastic appeal raised £22,300 for two interactive flooring systems for the Children's Emergency Department and Bramble waiting area at the Lister.

The flooring projects games, puzzles and fun images on the ground so children can play and distract themselves from pain, injury while they wait for treatment. The interactive projectors will provide hours of fun, distraction and stimulation for 30,000 children a year.

The guest of honour at last August's opening was Alfie Pitt, pictured above. He joined the appeal as one of our star fundraisers to say thank you for the amazing care he received at Lister when he was treated for cancer.

Focus on...

Volunteering Projects

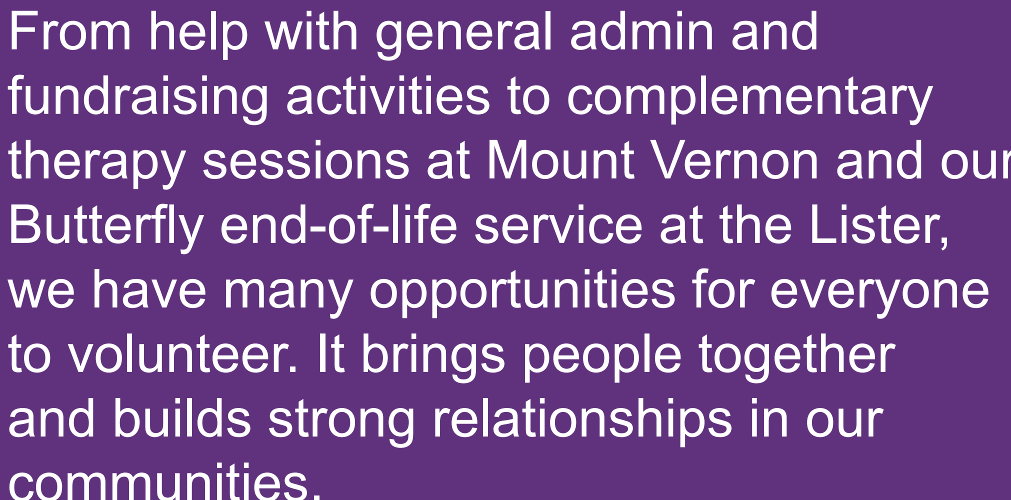
With **more than 550 volunteers** across our four sites, volunteering is a key part of the above and beyond care we offer our patients.

Our charity support the Trust to deliver volunteering projects by funding the Mount Vernon Community Engagement team, Lister patient experience lead and the Award winning Butterfly Volunteer service.

Case Study: All of our wonderful volunteers!

As Chrissy, one of our team, states:

"I truly feel I get more out of volunteering at Mount Vernon Cancer Centre than the help I give."



From help with general admin and fundraising activities to complementary therapy sessions at Mount Vernon and our Butterfly end-of-life service at the Lister, we have many opportunities for everyone to volunteer. It brings people together and builds strong relationships in our communities.

Volunteers form a crucial part of our team, learning new skills and building confidence while enabling staff to focus on our patients' needs.

The Charity has a Corporate Trustee, the East and North Hertfordshire NHS Trust. The NHS Trust Board of Directors, which comprises six Non-Executive Directors (including Trust Chair) and five Directors, represent the NHS Trust in this matter. The NHS Trust Board, as Corporate Trustee, delegates responsibility to a Board Committee, the Charity Trustee Committee (CTC). This committee meets at least four times a year and the Chair of the Committee reports to the Trust Board, as Corporate Trustee, following each meeting.

The strategy of the East and North Hertfordshire NHS Trust Charitable Fund is to support East and North Hertfordshire NHS Trust by providing funds to benefit patients including providing staff training to further develop our services and support staff to feel valued. It does this by purchasing supplementary and complementary equipment or services that the Trust is unable to provide funding for through exchequer sources. The Charity carries out fundraising activities and relies upon the generosity of patients and their relatives and other donors who are familiar with, or who are sympathetic and generous in their support to their local NHS service.

The Head of Charity is responsible for the day-to-day management of charitable funds, working with individual fund advisors to ensure the funds are spent in line with service priorities and donor wishes. The Trustee relies on these staff to ensure the effective use of charitable funds earmarked for their clinical areas by applying their local or specialist knowledge.

Trustee responsibility in relation to the financial statements

The Charity Trustee is responsible for preparing a Trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Charity Trustee to prepare financial statements for each year which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period. In preparing the financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently.
- observe the methods and principals in the applicable Charities SORP.
- make judgements and estimates that are reasonable and prudent.
- state whether applicable accounting standards have been followed, subject to any material departures that must be disclosed and explained in the financial statements.
- the financial statements are prepared on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the financial statements comply with the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations, and of the provisions of the Trust Deed. They are also responsible for the safeguarding of the assets of the Charity and taking reasonable steps for the prevention and detection of fraud and other irregularities. The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website in accordance with legislation in the United Kingdom governing the preparation and dissemination of financial statements.

Constitution, objects and power

The Trustee has been appointed under section 11 of the NHS and Community Care Act 1990. The East and North Hertfordshire NHS Trust Charitable Funds held on trust are registered with the Charity Commission, number 1053338. The objectives of the Charity are prescribed by section 93 of the National Health Service Act 1977 – in particular for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the East and North Hertfordshire NHS Trust. All new Trustees are given appropriate induction on their responsibilities as a Trustee, as laid down in guidance by the Charity Commission.

Risk management

The Charity Trustee Committee, on behalf of the Trustee, ensures that the Charity has met its obligations for risk management as set out in the Trust's Risk Management Strategy. It has a framework for risk identification and has reviewed the strategic business and operational risks that the Charity faces. The Trustee regularly reviews the risks and the Charity Management Team ensures actions are taken to mitigate the risks and monitor these. The Charity continued to review and strengthen its governance arrangements during 2019/20.

Public Benefit Statement

The Trustees confirm that they have complied with the duty in section 4 of the Charities Act 2011 and have due regard for the Charity Commission's general guidance on public benefit. Our Charity's objective is to support any charitable purpose relating to East and North Hertfordshire NHS Trust, including research. The Trustees ensure that this purpose is carried out for public benefit by working to the following aim: Our Charity's core function is to make a real positive impact on patient care within our Trust. We continue to help our hospitals innovate, improve and, most importantly, provide excellent care to our community above and beyond NHS funding. By supporting great science, excellent patient care and staff wellbeing within the East and North Hertfordshire NHS Trust, we are helping our local community to be healthier by providing the best care we can. The Charity does not provide facilities directly to the public but provides facilities for the hospital and, in so doing, for the patients and staff of the hospitals.

Reserves and reserve policy

The Trustee recognises its obligation to ensure that funds received by the Charity should be spent effectively in accordance with the funds' objectives. The Charity's reserves comprise of those funds that are freely available for its general purposes. The reserves are held at a level that will ensure the charity can pay their committed expenditure. The Trustee considers it prudent that reserves should be sufficient to avoid the necessity of realising fixed assets held for the Charity's use.

Investment Policy

The Investment Policy is to ensure the creation of sufficient income and capital growth to enable the Charity to carry out its purposes consistently year by year with due and proper consideration of future needs and maintenance of, if possible, an enhancement of the value of the invested funds while they are retained. With regard to investments, the Trustee excludes the tobacco sector, as defined by those companies that derive their income from such trading. The Trustee also excludes companies that derive more than 10% of their revenues from the manufacture of alcoholic beverages, armaments, gambling, high interest rate lending or pornography.

Expenditure on Charitable Activities

During the year the Charity paid £1,089,291 for the benefits of the patients of East and North Hertfordshire NHS Trust. This spending comprised of the following under our 6 Pillars of Impact:

Research Projects

The Charity funded research expenditure of £92,398 and helped with specific research activities at Mount Vernon Cancer Centre.

Art and refurbishment

This is a new pillar of funding of £22,528 for the Charity as we recognise the importance of art and health wellbeing for our patients, our visitors and our staff. We are looking to improve many areas throughout the Trust with garden projects and interactive arts projects. We have begun work on the Fern Garden at Mount Vernon with funding from The Centre of Sustainable Healthcare and the Heathrow Community Fund.
At the Lister with funding from John Lewis we are installing dementia bus stops, a familiar place for our dementia patients to sit and wait for their appointments.

Training and wellbeing

Staff education and wellbeing totalled £48,588 and helped to finance staff education, training and development which are over and above what is required by the NHS. This training helped to equip staff with additional relevant skills to improve patient care and treatment, such as:

- A sage and thyme course to be able to provide bereavement training for a radiographer at Mount Vernon Cancer Centre.
- A study for one of our paediatric nurses to become a specialist in dealing with child trauma.
- A course for one of our midwifes to be able to teach maternity yoga for expectant mothers.
- Attendance at the UK Kidney Conference for one of our renal dieticians to learn about best practices.
- Study for one of our cancer centre physiotherapists to learn more about anxiety management in palliative care and progressive conditions.

Cutting Edge Medical Equipment and Technology

The charity funded £384,104 to purchase a huge variety of equipment from small to large, including:

- A 3kg portable Edge Sonosite ultrasound machine for use in the preterm labour/ delivery and antenatal clinic.
- The Morcellator which will enable us to provide more efficient and less intrusive treatment for patients with symptoms relating to the prostate.
- Oxygen saturation monitors for parents to be able to monitor their new baby's oxygen levels whilst at home.
- The purchase of a SPEC-CT has enabled us to get compressive diagnostic information from one scan.
- A new x-ray machine at Hertford County Hospital will improve patient experience, by offering a full range of diagnostic services in a state-of-the-art air-conditioned room.

Support Services, Equipment and Items

The Charity spent £280,185 on improving and enhancing patient experience including smaller equipment, services and items, including:

- All our complementary services at Lynda Jackson Macmillan Centre (£212,074).
- An interactive floor in the children's department to keep children distracted.
- Tea sets for refreshments for bereaved families.
- Specialist medical chairs to improve patient comfort.
- Awards for All funding for Hospital Youth Worker activities.

Volunteering Projects

The expenditure on voluntary activities and services totalled £116,806, such as:

- Community Engagement Service consisting mainly of staff cost expenditure supporting the volunteers at Mount Vernon Cancer Centre.
- The Butterfly Volunteers Service providing an end-of-life companion service at Lister Hospital. The vision for the project is to provide one-to-one compassionate listening, comfort and companionship for patients who have been identified by the multi-disciplinary team as being in the last few days and hours of life, particularly for those with few or no visitors who would otherwise be alone.

Governance costs and overhead costs for raising funds
The Charity expended £144,682 on governance and overheads which consist of finance support staff costs, stationary, audit fee and salary costs for the Charity.

Reference and administrative information

Corporate Trustee

East and North Hertfordshire NHS Trust

Principal Office

Management Suite
Lister Hospital
Coreys Mill Lane
Stevenage
SG1 4AB

Auditors

BDO LLP
16 The Havens Ransomes Europark Ipswich
Suffolk IP3 9SJ

Bankers

Lloyds Bank Plc Stevenage Branch 3 Town Square
Stevenage
SG1 1BG

Investment advisors

Rathbone Brothers PLC
8 Finsbury Circus
London
EC2M 7AZ

Charity Number

1053338

Corporate Trustee

The Charity is the legal responsibility of a Sole Corporate Trustee – East and North Hertfordshire NHS Trust. The Non-Executive and Executive Directors for the Trust for the year ending 31st March 2020 were as follows:

Name	Role
Ellen Schroder*	**Chair**
Nick Carver	**Chief executive**
Bob Niven*	**Non-executive director**
Val Moore*	**Non-executive director**
Jonathan Silver	**Non-executive director**
Peter Carter	**Non-executive director**
David Buckle*	**Non-executive director**
Karen McConnell	**Non-executive director**
Michael Chilvers	**Medical Director**
Martin Armstrong*	**Director of Finance**
Rachael Corser*	**Director of Nursing**
Sarah Brierley* **(to May 2019)**	**Acting Director of Strategy**
(from May 2019)	**Director of Strategy**
Julie Smith	**Chief Operating Officer**
Susan Young **(to June 2019)**	**Interim Chief People Officer**
Duncan Forbes **(from June 2019)**	**Chief People Officer**

The Board delegates responsibility for oversight of the Charitable Funds to the Charity Trustee Committee, the membership of which comprised of those members annotated with an*

Finance Report

Finances

In the 2019/20 financial year the Charity received a total income of £1,090k - £634k of donations, grants and legacy income, £386k from other trading activities and investment income of £70k. The Charity is indebted to the generosity of patients, their families and carers, well-wishers and friends who have donated so generously to the work of the Charity.

The overall financial performance of the Charity recorded a net decrease in funds of £680k compared to the previous years increase due to the purchase of large pieces of equipment and decrease in legacies income. The valuation of the investment fund has been valued at £293k lower than at the start of the year. This decrease is due to the impact of COVID-19 on market performance.

Events since the year end and future plans

The Trustee does not expect any significant changes in the objectives of the Charity in the forthcoming year and intends to continue to manage all charitable income and expenditure within best practice guidelines of the Charities Commission. The Trustee continues to be mindful of the impact that NHS priorities may have on current charitable fund priorities.

In line with the 2017 – 2020 Charity Strategy the new staffing structure is now in place and the Trustee expects to see significant progress towards our strategic aims in 2019/20.

Statement of Trustee's Responsibilities

The Trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice). Charity law requires the Trustee to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources, including the net income or expenditure, of the Charity for the year. In preparing those financial statements the Trustee is required to:

• select suitable accounting policies and then apply them consistently;
• observe the methods and principles in the Charities SORP;
• make judgments and accounting estimates that are reasonable and prudent;
• state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
• prepare the financial statements on a going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is also responsible for keeping accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, and regulations made thereunder. The Trustee is also responsible for safeguarding the assets of the Charity and therefore takes reasonable steps for the prevention and detection of fraud and other irregularities.

Auditors

The Trustees declare that:

a) so far as each of the Trustees at the time of the report are aware, there is no relevant information of which the Auditors are unaware, and

b) they have taken all steps they ought to have taken to make themselves aware of any information and to establish that the Auditors are aware of this information

By Order of the Trustee:

(Signed) ……………….………………. Date:
Chief Executive – East and North Hertfordshire NHS Trust

(Signed) ………………………………… Date:
Trust Chairman – East and North Hertfordshire NHS Trust

Statement of Financial Activities for the year ended 31 March 2020

	Note	2019/20 Unrestricted Funds £'000	2019/20 Restricted Funds £'000	2019/20 Total Funds £'000	2018/19 Unrestricted Funds £'000	2018/19 Restricted Funds £'000	2018/19 Total Funds £'000
Income and endowments	**2.0**						
Donations, legacies and Grants	2.1	550	84	634	495	281	776
Income from other trading activities	2.2	337	49	386	357	0	357
Income from investments	2.3	70	0	70	70	0	70
Income from charitable activities		957	133	1,090	922	281	1,203
Expenditure on charitable activities	**3.0**						
Expenditure on raising funds	3.1	(384)	(3)	(387)	(285)	(0)	(285)
Expenditure on charitable activities	3.2	(828)	(252)	(1,080)	(1,228)	(287)	(1,515)
Other expenditure	3.3	(10)	0	(10)	(11)	0	(11)
Total Expenditure on charitable activities		(1,222)	(255)	(1,477)	(1,524)	(287)	(1,811)
Net (losses)/gains on investments		(206)	(87)	(293)	97	0	97
Net income/(expenditure)		**(471)**	**(209)**	**(680)**	**(505)**	**(6)**	**(511)**
Net movement in funds		(471)	(209)	(680)	(505)	(6)	(511)
Reconciliation of Funds							
Total funds brought forward		2,528	1,173	3,701	3,033	1,179	4,212
Movement of funds in year		(471)	(209)	(680)	(505)	(6)	(511)
Total funds carried forward		**2,057**	**964**	**3,021**	**2,528**	**1,173**	**3,701**

The notes on pages 29 to 32 form part of these accounts.

Balance Sheet as at 31 March 2020

	Notes	2019/20 Unrestricted Funds £'000	2019/20 Restricted Funds £'000	2019/20 Total Funds £'000	2018/19 Unrestricted Funds £'000	2018/19 Restricted Funds £'000	2018/19 Total Funds £'000
Fixed Assets							
Investments	8.1	1,456	936	2,392	1,511	1,174	2,685
Total Fixed Assets		1,456	936	2,392	1,511	1,174	2,685
Current Assets							
Receivables	9.1	84	0	84	435	0	435
Cash at bank and in hand	9.2	529	51	580	601	0	601
Total Current Assets		613	51	664	1,036	0	1,036
Current Liabilities							
Payables: Amounts falling due within one year	10	(12)	(23)	(35)	(19)	(1)	(20)
Net Current Assets/(Liabilities)		601	28	629	1,017	(1)	1,016
Net Assets		2,057	964	3,021	2,528	1,173	3,701
Funds of the Charity							
Unrestricted funds	12	2,057	0	2,057	2,528	0	2,528
Restricted funds	13	0	964	964	0	1,173	1,173
Total Funds		**2,057**	**964**	**3,021**	**2,528**	**1,173**	**3,701**

The notes on pages 29 to 32 form part of these accounts.

Signed on behalf of the corporate trustee:

Signature: Chief Executive

Print Name

Date:

Signature: Chairman

Print Name

Date:

Statement of cash flows for the year ended 31 March 2020

	Notes	Total Funds 2019/20	Total Funds 2018/19
		£'000	£'000
Net cash used in operating activities	11	(91)	(317)
Cash flow from investing activities			
Interest and dividends received		70	70
Proceeds from sale of investments		0	0
Purchase of investments		0	0
Net cash inflow/(outflow)from investing activities		70	70
CHANGE IN CASH AND CASH EQUIVALENTS IN THE YEAR		(21)	(247)
Cash and cash equivalents beginning of period		601	848
CASH AND CASH EQUIVALENTS AT END OF PERIOD		580	601

Notes to the Accounts

Note 1 Accounting policies

(a) Basis of preparation and assessment of going concern

The accounts (financial statements) have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to the accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice "Accounting and Reporting by Charities" preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) issued on 16 July 2014 and the Charities Act 2011.

The Charity constitutes a public benefit entity as defined by FRS102.

The Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern.

(b) Funds structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor or trust deed. There are eleven restricted funds held by the Charity, and the names of the funds and purpose is stated in note 13.1 to the accounts.

Unrestricted income funds comprise those funds which the Trustees are free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds where the Trustees, at their discretion, have created a fund for a specific purpose.

(c) Income recognition

All income is recognised once the Charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

Donations are recognised when the Charitable Trust has been notified in writing of both the amount and settlement date. In the event that a donation is subject to conditions that require a level of performance before the Charity is entitled to the funds, the income is deferred and not recognised until either those conditions are fully met, or the fulfilment of those conditions is wholly within the control of the Charity and it is probable that those conditions will be fulfilled in the reporting period.

Legacy gifts are recognised on a case by case basis following the granting of probate when the administrator/executor for the estate has communicated in writing both the amount and settlement date. In the event that the gift is in the form of an asset other than cash or a financial asset traded on a recognised stock exchange, recognition is subject to the value of the gift being reliably measurable with a degree of reasonable accuracy and the title to the asset having been transferred to the charity.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the Charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

(d) Expenditure recognition

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the Charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

All expenditure is accounted for on an accruals basis. All expenses including support costs and governance costs are allocated or apportioned to the applicable expenditure headings. For more information on this attribution refer to note (f) below.

Grants payable are payments made to third parties in the furtherance of the charitable objects of the Charitable Trust. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grant awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Trust.

(e) Irrecoverable VAT

Irrecoverable VAT is charged against the expenditure heading for which it was incurred.

Notes to the Accounts (cont.)

(f) Allocation of support and governance costs

Support and governance costs have been allocated between expenditure on raising fund and charitable activities. Governance costs comprise all costs involving the public accountability of the Charity and its compliance with regulation and good practice. These costs include costs related to statutory audit and legal fees together with an apportionment of overhead and support costs.

Governance costs and support costs relating to charitable activities have been apportioned based on the number of individual grant awards made in recognition that the administrative costs of awarding, monitoring and assessing research grants, salary support grants and postgraduate scholarships are broadly equivalent. The allocation of support and governance costs are analysed in note 3.4.

(g) Costs of raising funds

The costs of generating funds consist of Fundraiser salaries, merchandise purchases, raffle prizes and lotto winnings as well as direct costs to events as shown in note 3.1. Also included is the allocated support and governance costs.

(h) Charitable activities

Costs of charitable activities include allocated governance costs, capital expenditure and an apportionment of support costs as shown in note 3.2.

(i) Intangible fixed assets and amortisation

All assets costing more than £1,000 are capitalised and valued at historical cost. Amortisation is charged on a straight-line basis over the assets estimated useful lives. The Charity have not recorded any assets for 2019/20

(j) Fixed asset investments

Investments are a form of basic financial instrument and are initially recognised at their transaction value and subsequently measured at their fair value as at the balance sheet date using the closing quoted market price. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors.

(k) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and their opening carrying value or their purchase value if acquired subsequent to the first day of the financial year. Unrealised gains and losses are calculated as the difference between the fair value at the year end and their carrying value. Realised and unrealised investment gains and losses are combined in the Statement of Financial Activities.

		Unrestricted Funds	Restricted Funds	Total 2019/20	Unrestricted Funds	Restricted Funds	Total 2018/19
2	**Income and endowments**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
2.1	**Donations and legacies**						
	Donations	388	84	472	243	34	277
	Legacies	59	0	59	173	0	173
	Grants Received from Trusts and Foundations	103	0	103	79	247	326
		550	84	634	495	281	776
2.2	**Income from other trading activities**						
	Events	262	49	311	284	0	284
	Lottery and Raffles	32	0	32	24	0	24
	Merchandise Sales	0	0	0	17	0	17
	Gift Aid	43	0	43	32	0	32
		337	49	386	357	0	357
2.3	**Income from investments**						
	Income from Equity Investments	69	0	69	69	0	69
	Interest on cash deposits	1	0	1	1	0	1
		70	0	70	70	0	70

		Unrestricted Funds £'000	Restricted Funds £'000	Total 2019/20 £'000	Unrestricted Funds £'000	Restricted Funds £'000	Total 2018/19 £'000
3	**Expenditure on charitable activities**						
3.1	**Expenditure on raising funds**						
	Fundraising Salaries	246	0	246	163	0	163
	Fundraising expenditure	51	2	53	45	0	45
	Just Giving charges	5	1	6	5	0	5
	Lottery	14	0	14	14	0	14
	Prizes & raffles	1	0	1	0	0	0
	Merchandise Purchases	0	0	0	9	0	9
	Support and Governance cost	67	0	67	49	0	49
		384	3	387	285	0	285
3.2	**Expenditure on charitable activities**						
	Patient Welfare, Equip, Ward Extras and Services	202	183	385	364	75	439
	Research Salary, Travel, Equipment & Training	84	13	97	102	10	112
	Staff Education, Training & Equipment	39	3	42	46	2	48
	Capital Equipment/Building Works/Refurbishments	333	53	386	565	200	765
	Wifi Project Expenditure	34	0	34	13	0	13
	Support and Governance cost	136	0	136	138	0	138
		828	252	1,080	1,228	287	1,515
3.3	**Other expenditure**						
	Fundraising Software	10	0	10	11	0	11
		10	0	10	11	0	11

All staff costs were paid by East and North Herts NHS Trust and recharged to the Charity

3.4 **Allocation of support and governance cost**

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity. The bases of allocation used is direct allocation - where a cost is wholly attributable to a particular activity

	Fundraising Activity £'000	Charitable Activity £'000	Total cost 2019/20 £'000	Fundraising Activity £'000	Charitable Activity £'000	Total cost 2018/19 £'000
Finance Management/Admin Costs	48	0	48	0	50	50
Management & Administration	39	0	39	0	77	77
Audit Fees	6	0	6	0	8	8
Membership	10	0	10	0	0	0
Travel Expenditure	0	0	0	0	0	0
Stationery & Printing	1	0	1	0	3	3
Overhead Costs	32	67	99	49	0	49
	136	67	203	49	138	187

4 **Details of certain items of expenditure**

4.1 **Trustee expenses**

There were no trustee expenses during the current or prior year.

4.2 Fees for audit of the accounts

	Total 2019/20 £'000	Total 2018/19 £'000
Auditor's fee for reporting on accounts.	8	8
	8	8

This fee is inclusive of VAT.

5 Paid Employees

The Charity did not employ staff during the current or prior year.

6 Grant making Costs

The Charity made no grants during the current or prior year.

7 Tangible Fixed Assets

The Charity has no tangible fixed assets.

8 Fixed Assets

8.1 Investment Assets

	Total 2019/20 £'000	Total 2018/19 £'000
Carrying (market) value 1 April 2019	2,685	2,588
Cash at 1 April 2019	0	0
Add : Additions to investments at cost	0	0
Less : Disposals at opening value	0	0
Funds drawdown	0	0
(Loss) /gain on investments	(293)	97
Cash	0	0
Carrying (market) value at 31 March 2020	2,392	2,685

8.2 Analysis of investments

	Total 2019/20 Market value at year end £'000	Proportion %	Total 2018/19 Market value at year end £'000	Proportion %
UK Fixed Interest	215	9.00%	239	8.90%
Overseas Fixed Interest	0	0.00%	0	0.00%
UK Equities	868	36.30%	994	37.00%
Alternatives	383	16.00%	371	13.80%
Overseas Equities	844	35.30%	1,015	37.80%
Property	0	0.00%	0	0.00%
Cash	81	3.40%	66	2.50%
	2,392	100%	2,685	100%

Investment fixed assets are included at their mid-market price ex div at 31 March 2020.
Investments in equities and fixed asset securities are all traded on recognised stock exchanges.

All investments are managed in accordance with the Charity's investment policy.

9 Debtors, prepayments and cash

	Total 2019/20 £'000	Total 2018/19 £'000
9.1 Debtors		
Prepayments	6	6
Accrued income	78	429
Total debtors falling due within one year	84	435
9.2 Cash in bank and Deposit Account		
Deposit Account	579	600
Current Account	0	0
Petty cash	1	1
Total cash at bank and in hand	580	601

10 Creditors falling due within one year

	Total 2019/20 £'000	Total 2018/19 £'000
Accruals and other deferred income	35	20
Total creditors falling due within one year	35	20

11 Reconciliation of net movement in funds to net cash flow from operating activities

	Total 2019/20 £'000	Total 2018/19 £'000
Net movement in funds	(680)	(511)
Add back depreciation charge	0	0
Deduct interest income shown in investing activities	(70)	(70)
Deduct gains/add back losses on investments	293	(97)
Funds drawdown		
Decrease/(increase) in debtors	351	363
Increase /(decrease) in creditors	15	(1)
Net cash used in operating activities	(91)	(317)

12 **Unrestricted Funds**

12.1 **The following funds are unrestricted and have balances over £50,000**

Mount Vernon Cancer Centre - Patient & Staff Welfare, Medical Equipment, Research
Lister Hospital - Patient & Staff Welfare, Medical Equipment, Research
Chart Lodge - Patient Welfare
Cancer Research - Patient Welfare - Research for Cancer Patients
Lynda Jackson Macmillan Centre - Patient & Staff Welfare and Medical Equipment
Supportive Oncology Research at Mount Vernon - Patients Welfare - Research into Oncology

12.2 **Transfers between funds**

Big Build income was transferred to it's own fund.
Legacy income was transferred to Chart Lodge fund.

13 **Restricted Funds**

13.1 **The following funds are restricted at 31 March 2020, and the objectives of these funds are stated below**

Analysis of Restricted Charitable Funds

	FUND NAME	OBJECTIVES OF FUND
A	Brown Cancer Research Legacy	Legacy
B	Lister MacMillan Cancer Centre	Funds and Grants used for end of life care at Lister Hospital
C	John Bush Legacy	John Bush legacy
D	Big Build	To build a new Neonatal Unit
E	Butterfly Appeal	End of Life service
F	Forget-Me-Not Appeal	Funds used for Elderly Care Services at Lister Hospital
G	Forster Suite - Restricted	Funds used for Cancer Services at Lister Hospital
H	Millie Apthorpe Restricted Fund	Grant received for a services for one day at week at Barnet Hospital
I	Magic of Play	Funds used for the childrens wards
J	LAKPA	Grant received for advisor role within Renal
K	Patient Transport Lounge	Funds used for Patient Transport Lounge

		Fund balances at 31.3.19 £'000	Incoming resources £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.20 £'000
A	Brown Cancer Research Legacy	1	0	(1)	0	0
B	Lister MacMillan Cancer Centre	31	20	(5)	(4)	42
C	John Bush Legacy	726	0	(178)	(47)	501
D	Big Build	236	42	(13)	(20)	245
E	Butterfly Appeal	43	31	(21)	(4)	49
F	Forget-Me-Not Appeal	98	34	(0)	(12)	120
G	Forster Suite - Restricted	4	0	(4)	0	0
H	Millie Apthorpe Restricted Fund	11	0	(11)	0	0
I	Magic of Play	20	3	(22)	0	1
J	LAKPA	3	2	0	0	5
K	Patient Transport Lounge	0	1	0	0	1
		1,173	133	(255)	(87)	964

13.2 **Total fund movement**

	Fund balances at 31.3.19 £'000	Incoming resources £'000	Outgoing resources £'000	Gains / (losses) £'000	Fund balances at 31.3.20 £'000
Fund totals	3,701	1,090	(1,477)	(293)	3,021

13.3 **Commitments and Contingencies**

The Charity has committed staff costs for the following areas:
Linda Jackson Macmillan Centre of £21k per month based at Mount Vernon Hospital.
Voluntery Services of £11k per month across both Lister and Mount Vernon Hospital sites.

There are active fundraising appeals to raise funds to continue these services.

14 **Contingent Asset**

The Charity has been named as one of the beneficiaries of a legacy which is subject to contingent liability of £5k due to potential claim against the deceased.

15 **Transactions with related parties**

15.1 No remuneration or other benefits were paid to a trustee.

15.2 No loans were made payable or due to the Charity.

15.3 Other transaction with trustees or related parties:

Name of the trustee;	East & North Hertfordshire NHS Trust
Relationship to charity;	Corporate Trustee
Nature of transaction;	Contributions to NHS
Value:	2019/20 £1,287k (2018/19 £1,559k)
Included in the £1,287k is £76k included in accruals	
Name of the trustee;	Ellen Schroder
Relationship to charity;	Trust Chair
Nature of transaction;	Charity event
Value:	£1,750
Name of the trustee;	Schroder Charity Trust
Relationship to charity;	Trust Chair is a member
Nature of transaction;	To purchase to equipment
Value:	£5,000
Name of the trustee;	Bob Niven
Relationship to charity;	Charity Chair
Nature of transaction;	Charity event
Value:	£2,980
Name of the trustee;	Nick Carver
Relationship to charity;	Chief executive
Nature of transaction;	Charity event
Value:	£390
Name of the trustee;	Sarah Brierley
Relationship to charity;	Interim Director of Strategy
Nature of transaction;	Charity event
Value:	£30
Name of the trustee;	Rachael Corser
Relationship to charity;	Director of Nursing
Nature of transaction;	Charity event
Value:	£20
Name of the trustee;	Mike Chilvers
Relationship to charity;	Medical Director
Nature of transaction;	Charity event
Value:	£628
Name of the trustee;	Karen McConnell
Relationship to charity;	Non-executive director
Nature of transaction;	Charity event
Value:	£390
Name of the trustee;	Val Moore
Relationship to charity;	Non-executive director
Nature of transaction;	Charity event
Value:	£40
Name of the trustee;	David Buckle
Relationship to charity;	Non-executive director
Nature of transaction;	Charity event
Value:	£1,850
Name of the trustee;	
Relationship to charity;	Jonathan Silver
Nature of transaction;	Non-executive director
Value:	Charity event
	£1,750

Report to the Audit Committee

EAST AND NORTH HERTFORDSHIRE NHS TRUST CHARITABLE FUND

Audit Completion Report: Year ended 31 March 2020

IDEAS | PEOPLE | TRUST

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WELCOME
Introduction

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We have pleasure in presenting our Audit Completion Report to the Audit Committee. This report is an integral part of our communication strategy with you, a strategy which is designed to ensure effective two way communication throughout the audit process with those charged with governance.

It summarises the results of completing the planned audit approach for the year ended 31 March 2020, specific audit findings and areas requiring further discussion and/or the attention of the Audit Committee. At the completion stage of the audit it is essential that we engage with the Audit Committee on the results of our audit of the financial statements comprising: audit work on key risk areas, including significant estimates and judgements made by management, critical accounting policies, any significant deficiencies in internal controls, and the presentation and disclosure in the financial statements.

We look forward to sharing these matters with the Audit Committee and receiving the your input through discussion with the Audit Committee Chairman.

We would also like to take this opportunity to thank management and staff for the co-operation and assistance provided during the audit.

Rachel Brittain, Director
for and on behalf of BDO LLP
[TBC] October 2020

Rachel Brittain
Engagement lead

t: 020 7893 2362
m: 07971 716487
e: Rachel.Brittain@bdo.co.uk

Ross Beard
Project Manager

t: 01473 320785
m: 07966 282745
e: Ross.Beard@bdo.co.uk

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed primarily for the purpose of expressing our opinion on the financial statements. This report has been prepared solely for the use of the Audit Committee and Those Charged with Governance and should not be shown to any other person without our express permission in writing. In preparing this report we do not accept or assume responsibility for any other purpose or to any other person. For more information on our respective responsibilities please see the appendices.

OVERVIEW
Executive summary

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This summary provides an overview of the audit matters that we believe are important to the Audit Committee in reviewing the results of the audit of the financial statements of the East and North Hertfordshire NHS Trust Charitable Fund ('the Charity') for the year ended 31 March 2020.

It is also intended to promote effective communication and discussion and to ensure that the results of the audit appropriately incorporate input from those charged with governance.

Overview

Our audit work is substantially complete and, subject to the successful resolution of outstanding matters, we anticipate issuing our opinion on the financial statements for the year ended 31 March 2020 ahead of the reporting deadline.

Outstanding matters are listed on page 22 in the Appendices.

There were no significant changes to the planned audit approach and no additional significant audit risks have been identified.

No restrictions were placed on our work.

Audit report

We anticipate issuing an unmodified audit opinion on the financial statements.

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Final materiality

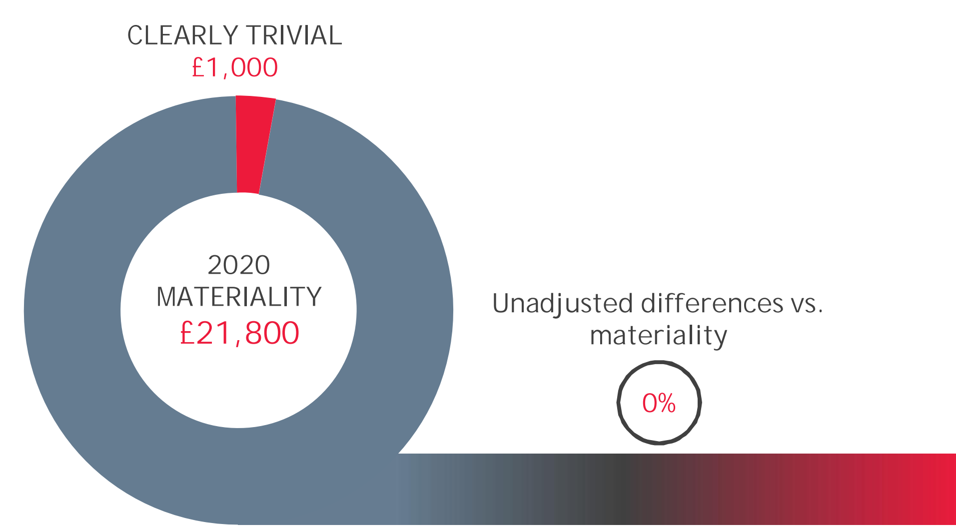
Final materiality was determined based on 2% of outturn gross income for the reporting period 2019/20.

Material misstatements

We did not identify any material misstatements.

Unadjusted audit differences

We did not identify any audit differences that have not been adjusted for.



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Financial reporting

- We have not identified any non-compliance with accounting policies or the applicable accounting framework.
- No significant accounting policy changes have been identified impacting the current year.
- The Trustee's Annual Report is consistent with the financial statements and knowledge acquired in the course of the audit.

Other matters that require discussion or confirmation

- Confirmation on fraud, contingent liabilities and subsequent events.
- Control deficiencies in relation to legacy income recognition and financial statement preparation.
- Letter of Representation.

Independence

We confirm that the firm and its partners and staff involved in the audit remain independent of the Charity in accordance with the FRC's Ethical Standard.

AUDIT RISKS OVERVIEW

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As identified in our Audit Plan, we assessed the following matters as being the most significant risks of material misstatement in the financial statements. The below risks include those risks which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit and the direction of the efforts of the engagement team.

Audit Risk	Risk Rating	Significant Management Estimates or Judgement	Use of Experts Required	Error Identified	Significant Control Findings	Discussion points / Letter of Representation
Management override of controls	Significant	Yes	No	No	No	Yes
Revenue recognition	Significant	Yes	No	No	No	No

Areas requiring your attention

MANAGEMENT OVERRIDE OF CONTROLS

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ISA (UK) 240 presumes that management is in a unique position to perpetrate fraud.

Significant risk	■
Normal risk	
Significant management judgement	
Use of experts	
Unadjusted error	
Adjusted error	
Additional disclosure required	
Significant control findings to be reported	
Letter of representation point	■

Risk description

ISA (UK) 240 - The auditor's responsibilities relating to fraud in an audit of financial statements requires us to presume that the risk of management override of controls is present and significant in all entities.

Work performed

We carried out the following planned audit procedures:

- Tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements.
- Reviewed accounting estimates and judgements applied by management in the financial statements to assess their appropriateness and the existence of any systematic bias.
- Reviewed for any significant transactions that are outside the normal course of business for the entity or that otherwise appear to be unusual to obtain an understanding of the business rationale of any such transactions.

Results and conclusion

Our audit did not identify any evidence of systematic bias or management override in the processing of journals entries and other adjustments, and making of significant accounting estimates.

We have not identified any unusual transactions or transactions that are outside the normal course of business for the Charity.

REVENUE RECOGNITION

Under auditing standards there is a presumption that income recognition presents a fraud risk.

- Significant risk
- Normal risk
- Significant management judgement
- Use of experts
- Unadjusted error
- Adjusted error
- Additional disclosure required
- Significant control findings to be reported
- Letter of representation point

Risk description

Under International Standard on Auditing 240 "The Auditor's responsibility to consider fraud in an audit of financial statements" there is a presumption that income recognition presents a fraud risk.

This risk may arise from the use of inappropriate accounting policies, failure to apply the Charity's stated accounting policies or from an inappropriate use of estimates in calculating revenue. Recognition of grants and legacies requires a degree of interpretation and transactions are typically high in value, so the presumed significant risk will apply to these streams. Recognition of other income streams is more straight forward and they are typically high volume low value transactions, as such we rebut the presumed significant risk in respect of these.

Work performed

We carried out the following planned audit procedures:

- Carried out audit procedures to update our understanding of the Charity's internal control environment for the significant income streams.
- Substantively tested increased samples of grants and legacy income to supporting documentation, to conclude on whether income has been recognised appropriately in the correct accounting period.
- Agreed investment income recognised to third party confirmation.
- Assessed the completeness of income recognised through review of legacy correspondence and Charity Trustee Committee minutes, and sample testing from income sheets to the ledger.
- Tested a sample of income received around the year end to ensure it was recognised in the correct period.

Results and conclusions

Audit procedures did not identify income omitted from reporting, recognised at an incorrect value or in an incorrect period.

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GOING CONCERN

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We are required to highlight any judgements about events or conditions that may cast significant doubt over the entity's ability to continue as a going concern

Management's assessment of going concern

We have considered management's assessment of the charity's ability to operate as a going concern and appropriateness of preparing the financial statements on a going concern basis.

Specific events/conditions considered for indication of doubt over the charity's ability to continue as a going concern were coronavirus and the future transfer of services.

Whilst parts of the charity sector are experiencing reductions in donations due to coronavirus, for instance due to cancellation of events, the impact on charitable funds linked to NHS hospitals has been softened by donations received to help with the pandemic.

Whilst the charity's most recent forecasts show an adverse variance against plan, its fixed costs are low and it is able to adjust its charitable expenditure in line with fluctuations in its income.

The expected transfer of funds linked to Mount Vernon cancer services has been postponed until 2022 and so does not impact on the charity's going concern status for the year following approval of the 2019/20 financial statements.

MATTERS REQUIRING ADDITIONAL CONSIDERATION

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Fraud

Whilst the Corporate Trustee has ultimate responsibility for prevention and detection of fraud, we are required to obtain reasonable assurance that the financial statements are free from material misstatement, including those arising as a result of fraud. Our audit procedures did not identify any fraud. We will seek confirmation from you whether you are aware of any known, suspected or alleged frauds during 2019-20.

Related parties

Whilst you are responsible for the completeness of the disclosure of related party transactions in the financial statements, we are also required to consider related party transactions in the context of fraud as they may present greater risk for management override or concealment or fraud.

We did not identify and significant matters in connection with related parties.

Laws and regulations

We have made enquiries of management regarding compliance with laws and regulations and reviewed correspondence with the relevant authorities.

We did not identify any non-compliance with laws and regulations that could have a material impact on the financial statements.

AUDIT DIFFERENCES: SUMMARY

Summary for the current year

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Unadjusted audit differences: detail 1
Unadjusted disclosure omissions and improvements
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No adjusted or unadjusted audit differences were identified during the audit.

REPORTING ON OTHER INFORMATION

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We comment below on other reporting required to be considered in arriving at the final content of our audit report:

Matter	Comment
We are required to report on whether the financial and non-financial information in the Corporate Trustee's Annual Report is consistent with the financial statements and the knowledge acquired by us in the course of our audit.	We are satisfied that the other information in the Corporate Trustee's Annual Report is consistent with the financial statements and our knowledge.

OVERVIEW

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Opinion on financial statements

We anticipate issuing an unmodified opinion on the financial statements.

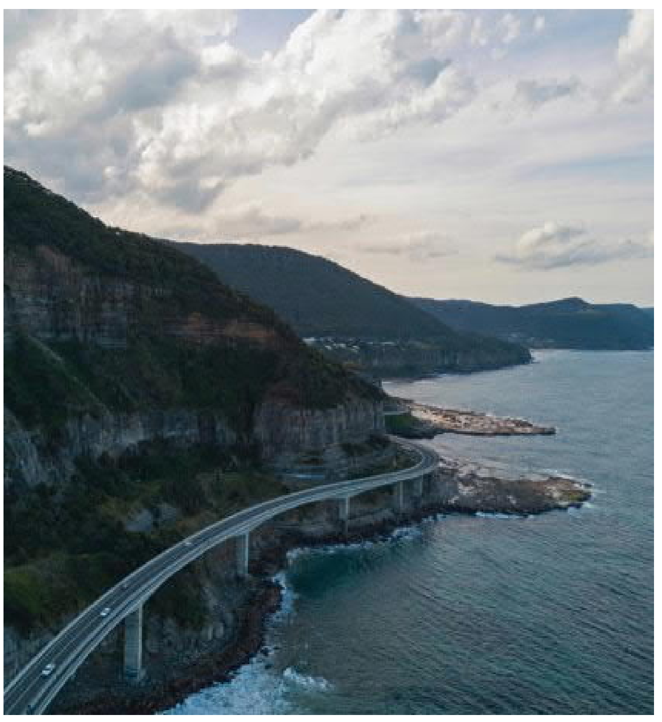
There are no matters that we wish to draw attention to by way of 'emphasis of matter'.

Conclusion relating to going concern

We have nothing to report in respect of the applicability of the going concern basis of accounting or the Charity's ability to continue as a going concern for a period of at least twelve months from the date of approval of the financial statements.

Other information

We have not identified any material misstatements within the 'other information' that would need to be referred to in our report.



SIGNIFICANT DEFICIENCIES

We are required to report to you, in writing, significant deficiencies in internal control that we have identified during the audit. These matters are limited to those which we have concluded are of sufficient importance to merit being reported to the Audit Committee.

As the purpose of the audit is for us to express an opinion on the Charity's financial statements, you will appreciate that our audit cannot necessarily be expected to disclose all matters that may be of interest to you and, as a result, the matters reported may not be the only ones which exist.

As part of our work, we considered internal control relevant to the preparation of the financial statements such that we were able to design appropriate audit procedures. This work was not for the purpose of expressing an opinion on the effectiveness of internal control.

No control deficiencies were identified during the audit.

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INDEPENDENCE

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Under ISAs (UK) and the FRC's Ethical Standard we are required, as auditors, to confirm our independence.

Under ISAs (UK) and the FRC's Ethical Standard, we are required as auditors to confirm our independence.

We have embedded the requirements of the Standards in our methodologies, tools and internal training programmes. Our internal procedures require that audit engagement partners are made aware of any matters which may reasonably be thought to bear on the integrity, objectivity or independence of the firm, the members of the engagement team or others who are in a position to influence the outcome of the engagement. This document considers such matters in the context of our audit for the year ended 31 March 2020.

We have not identified any relationships or threats that may reasonably be thought to bear on our objectivity and independence.

We confirm that the firm, the engagement team and other partners, directors, senior managers and managers conducting the audit comply with relevant ethical requirements including the FRC's Ethical Standard or the IESBA Code of Ethics as appropriate and are independent of the Charity.

Should you have any comments or queries regarding any independence matters we would welcome their discussion in more detail.

FEES

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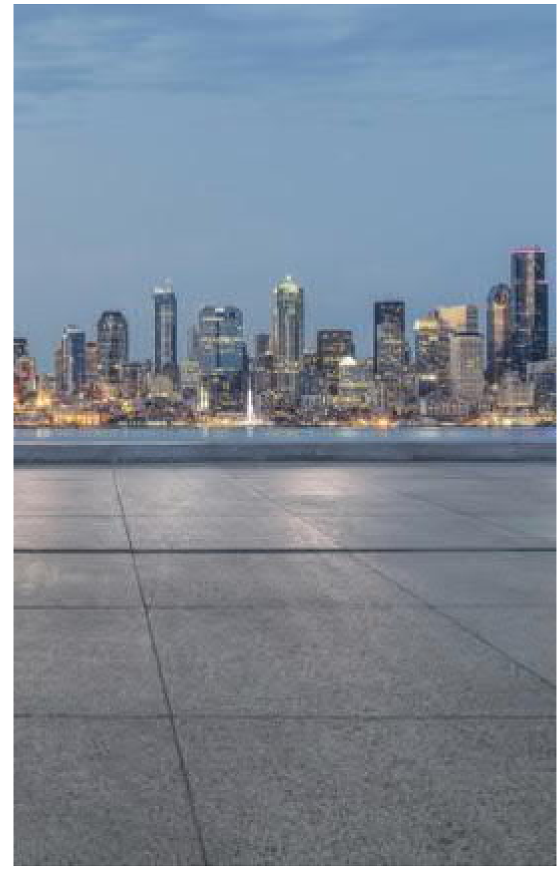
Fees summary

	2019/20	2018/19
	£	£
Audit fee		
• Financial statements of the Charity	5,400	5,805
Total fees	5,400	5,805



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RESPONSIBILITIES AND REPORTING

Responsibilities and reporting

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Our responsibilities and reporting

We are responsible for performing our audit under International Standards on Auditing (UK) to form and express an opinion on your financial statements. We report our opinion on the financial statements to the Corporate Trustee of the Charity.

We read and consider the 'other information' contained in the Corporate Trustee's Annual Report. We will consider whether there is a material inconsistency between the other information and the financial statements or other information and our knowledge obtained during the audit.

What we don't report

Our audit is not designed to identify all matters that may be relevant to the Audit Committee and cannot be expected to identify all matters that may be of interest to you and, as a result, the matters reported may not be the only ones which exist.

ADDITIONAL MATTERS WE ARE REQUIRED TO REPORT

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	Issue	Comments
1	Significant difficulties encountered during the audit.	No exceptions to note.
2	Written representations which we seek.	We enclose a copy of our draft representation letter.
3	Any fraud or suspected fraud issues.	No exceptions to note.
4	Any suspected non-compliance with laws or regulations.	No exceptions to note.
5	Significant matters in connection with related parties.	No exceptions to note.

COMMUNICATION AND REPORTS ISSUED

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Those Charged with Governance (TCWG)

References in this report to Those Charged With Governance are to the Board of the Corporate Trustee of the Charity as a whole. For the purposes of our communication with those charged with governance you have agreed we will communicate primarily with the Audit Committee of the Charity's Corporate Trustee.

Communication, meetings and feedback

We request feedback from you on our planning and completion report to promote two way communication throughout the audit process and to ensure that all risks are identified and considered; and at completion that the results of the audit are appropriately considered.

We have met with management throughout the audit process. We have issued regular updates during the audit process with clear and timely communication, bringing in the right resource and experience to ensure efficient and timely resolution of issues.

Communication	Date	To whom
Audit Planning Report	26 October 2020	Audit Committee
Audit Completion Report	26 October 2020	Audit Committee

OUTSTANDING MATTERS

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We have substantially completed our audit work in respect of the financial statements for the year ended 31 March 2020.

The following matters are outstanding at the date of this report. We will update you on the outcome of these procedures in a revised completion report on conclusion of the audit:

- Clearing points arising from Manager/Director review. These require further documentation from the charity relating to the value of commitments in note 13.3 and to payments made post year end.
- Final review and approval by you of the financial statements.
- Letter of representation, as attached on page 24 to be approved and signed.

AUDIT QUALITY

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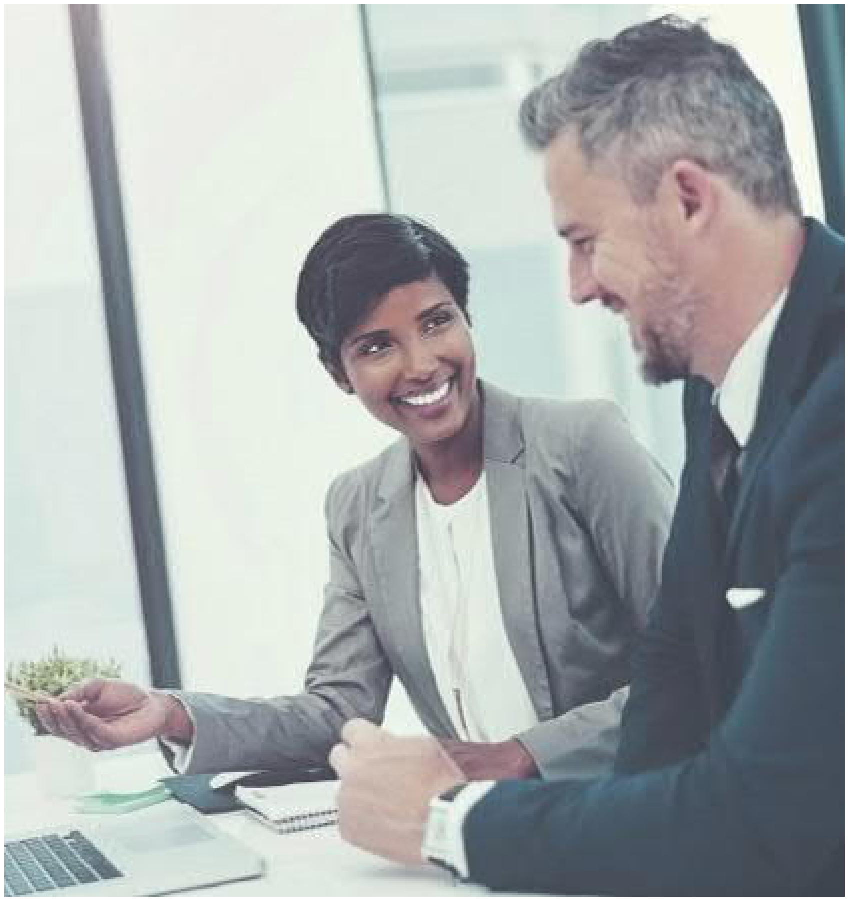

BDO is totally committed to audit quality

It is a standing item on the agenda of BDO's Leadership Team who, in conjunction with the Audit Stream Executive (which works to implement strategy and deliver on the audit stream's objectives), monitor the actions required to maintain a high level of audit quality within the audit stream and address findings from external and internal inspections.

BDO welcomes feedback from external bodies and is committed to implementing a necessary actions to address their findings.

We recognise the importance of continually seeking to improve audit quality and enhancing certain areas. Alongside reviews from a number of external reviewers, the AQR (the FRC's Audit Quality Review team), QAD (the ICAEW Quality Assurance Department) and the PCAOB (Public Company Accounting Oversight Board who oversee the audits of US companies), the firm undertakes a thorough annual internal Audit Quality Assurance Review and as member firm of the BDO International network we are also subject to a quality review visit every three years.

We have also implemented additional quality control review processes for all listed and public interest audits.

More details can be found in our Transparency Report at www.bdo.co.uk

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[ENHT Charitable Fund Letter headed paper]

BDO LLP
55 Baker Street
London
WIU 7EU

Dear Sirs

Financial statements of East and North Hertfordshire NHS Trust Charitable Fund for the year ended 31 March 2020

We confirm that the following representations given to you in connection with your audit of the Charity's financial statements (the 'financial statements') for the year ended 31 March 2020 are made to the best of our knowledge and belief, and after having made appropriate enquiries of other Members of the Board of the Corporate Trustee and officials of the Charity.

We have fulfilled our responsibilities as the Corporate Trustee for the preparation and presentation of the financial statements, and in particular that the financial statements give a true and fair view of the financial position of the Charity as of 31 March 2020 and of its income and expenditure and cash flows for the year then ended in accordance with the applicable financial reporting framework and for making accurate representations to you.

We have provided you with unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence. In addition, all the accounting records of the Charity have been made available to you for the purpose of your audit and all the transactions undertaken by the Charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and relevant meetings of the Corporate Trustee, have been made available to you.

Going concern

We have made an assessment of the Charity's ability to continue as a going concern for a period of at least twelve months from the date on which the financial statements were approved for release. As a result of our assessment we consider that the Charity is able to continue to operate as a going concern and that it is appropriate to prepare the financial statements on a going concern basis.

In making our assessment we did not consider there to be any material uncertainty relating to events or conditions that individually or collectively may cast significant doubt on the charity's ability to continue as a going concern.

Laws and regulations

In relation to those laws and regulations which provide the legal framework within which the Charity's business is conducted and which are central to our ability to conduct our business, we have disclosed to you all instances of possible non-compliance of which we are aware and all actual or contingent consequences arising from such instances of non-compliance.

Post balance sheet events

Other than those disclosed in the financial statements there have been no events since the balance sheet date which either require changes to be made to the figures included in the financial statements or to be disclosed by way of a note. Should any material events of this type occur, we will advise you accordingly.

Fraud and error

We are responsible for adopting sound accounting policies, designing, implementing and maintaining internal control, to, among other things, help assure the preparation of the financial statements in conformity with generally accepted accounting principles and preventing and detecting fraud and error.

We have considered the risk that the financial statements may be materially misstated due to fraud and have identified no significant risks.

To the best of our knowledge we are not aware of any fraud or suspected fraud involving management or employees. Additionally, we are not aware of any fraud or suspected fraud involving any other party that could materially affect the financial statements.

To the best of our knowledge we are not aware of any allegations of fraud or suspected fraud affecting the financial statements that have been communicated by employees, former employees, analysts, regulators or any other party.

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Misstatements

You have not advised us of any unadjusted misstatements in the financial statements or other information in the Annual Report.

Related party transactions

We have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware. We have appropriately accounted for and disclosed such relationships and transactions in accordance with the applicable financial reporting framework.

Other than as disclosed in note 15 to the financial statements, there were no loans, transactions or arrangements between the charity and the charity's trustees or their connected persons at any time in the year which were required to be disclosed.

Carrying value and classification of assets and liabilities

We have no plans or intentions that may materially affect the carrying value or classification of assets or liabilities reflected in the financial statements.

Litigation and claims

We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements and these have been accounted for and disclosed in accordance with the requirements of accounting standards.

Confirmation

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each member of the Corporate Trustee's Audit Committee has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

Signed on behalf of the Corporate Trustee

[TBC] 2020

FOR MORE INFORMATION:

Rachel Brittain
Engagement Lead

t: 020 7893 2362
m: 07971 716487
e: rachel.brittain@bdo.co.uk

Ross Beard
Assistant Manager

t: +44(0)1473 320785
m: +44(0)7966 282745
e: Ross.Beard@bdo.co.uk

The matters raised in our report prepared in connection with the audit are those we believe should be brought to your attention. They do not purport to be a complete record of all matters arising. This report is prepared solely for the use of the organisation and may not be quoted nor copied without our prior written consent. No responsibility to any third party is accepted.

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BDO LLP
55 Baker Street
London
WIU 7EU

Lister Hospital
Coreys Mill Lane
Stevenage
Herts SG1 4AB

Tel: 01438 314333

4th November 2020

Dear Sirs

Financial statements of East and North Hertfordshire NHS Trust Charitable Fund for the year ended 31 March 2020

We confirm that the following representations given to you in connection with your audit of the Charity's financial statements (the 'financial statements') for the year ended 31 March 2020 are made to the best of our knowledge and belief, and after having made appropriate enquiries of other Members of the Board of the Corporate Trustee and officials of the Charity.

We have fulfilled our responsibilities as the Corporate Trustee for the preparation and presentation of the financial statements, and in particular that the financial statements give a true and fair view of the financial position of the Charity as of 31 March 2020 and of its income and expenditure and cash flows for the year then ended in accordance with the applicable financial reporting framework and for making accurate representations to you.

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We confirm that the financial statements are free of material misstatements, including omissions.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware. Each member of the Corporate Trustee's Audit Committee has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

Signed on behalf of the Corporate Trustee

Date:

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

Agenda item: 15

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PUBLIC TRUST BOARD ACTIONS LOG TO 4 NOVEMBER 2020

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Board Annual Cycle 2020-21

Notes regarding the annual cycle:

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

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	*Dec 2020	Jan 2021	*Feb 2021	Mar 2021
Standing Items										
Chief Executive's Report				X		X		X		X
Integrated Performance Report	X	X		X		X		X		X
Board Assurance Framework	X	X		X		X		X		X
Data Pack				X		X		X		X
Patient Testimony (Part 1 where possible)	X	X		X		X		X		X
Employee relations (Part 2)	X	X		X		X		X		X
COVID-19 Recovery	X	X		X		X				
Board Committee Summary Reports										
Audit Committee Report		X		X		X				X
Charity Trustee Committee Report		X				X		X		
Finance, Performance and People Committee Report		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X
Strategy										
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)*										X (TBC)
Strategy Quarterly Update		X				X				X

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	*Dec 2020	Jan 2021	*Feb 2021	Mar 2021
System Working (ICS and ICP) Updates (Part 2)	X	X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update		X				X		X		X
Other Items										
Audit Committee										
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report	X ***(Extraordinary Board session TBC)***									
Annual Audit Letter				X						
Audit Committee TOR and Annual Report						X				
Raising Concerns at Work Report		X								
Review of Trust Standing Orders and Standing Financial Instructions						X				
Charity Trustee Committee										
Charity Annual Accounts and Report						X				
Charity Trust TOR and Annual Committee Review						X ***Deferred to January***		X		
Finance, Performance and People Committee										
Finance Update (Part 2)				X		X		X		X
FPPC TOR and Annual Report						X				
Digital Strategy Update (Part 2)		X				X ***Due to be considered by the Strategy Committee in December***				X

Board Annual Cycle 2020-21

Items	3 Jun 2020	1 Jul 2020	Aug 2020	2 Sept 2020	*Oct 2020	4 Nov 2020	*Dec 2020	Jan 2021	*Feb 2021	Mar 2021
Equality and Diversity Annual Report and WRES				X						
Gender Pay Gap Report										X
Market Strategy Review (TBC)										X
Quality and Safety Committee										
Complaints, PALS and Patient Experience Report				X						X
Safeguarding and L.D. Annual Report (Adult and Children)		X								
Detailed Analysis of Staff Survey Results										X
Learning from Deaths		X				X		X		
Nursing Establishment Review		X ***Deferred***						X		
Responsible Officer Annual Review				X ***Deferred due to national changes regarding revalidation***						
Patient Safety and Incident Report (Part 2)						X		X		
University Status Annual Report										X
QSC TOR and Annual Review						X				
Shareholder / Formal Contracts										
ENH Pharma (Part 2)		X								

DATA PACK

Contents

1. Data and Exception Reports:

FFT

2. Performance Data:

CQC Outcomes Summary

1. Data and Exception Reports:

FFT

Friends and Family Test - September 2020

APPENDIX 2

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	100.00	0.00	10	2	0	0	0	0	12	80
5B	100.00	0.00	5	1	0	0	0	0	6	45
6A	94.12	0.00	14	2	1	0	0	0	17	79
6B	100.00	0.00	6	8	0	0	0	0	14	67
7A	80.00	20.00	3	1	0	0	1	0	5	5
7B	84.42	5.19	38	27	5	3	1	3	77	174
8A	92.86	2.38	33	6	1	1	0	1	42	63
8B	93.44	3.28	38	19	1	0	2	1	61	143
9A	100.00	0.00	15	2	0	0	0	0	17	55
9B	100.00	0.00	19	22	0	0	0	0	41	54
10A	100.00	0.00	6	6	0	0	0	0	12	32
10B	100.00	0.00	6	7	0	0	0	0	13	68
11A	100.00	0.00	3	0	0	0	0	0	3	70
11B	NA	NA	0	0	0	0	0	0	0	0
ICU1	100.00	0.00	6	0	0	0	0	0	6	9
ICU2	100.00	0.00	1	0	0	0	0	0	1	3
AMU1	NP	NP	0	0	0	0	0	0	0	845
AMU2	NP	NP	0	0	0	0	0	0	0	77
Ashwell	100.00	0.00	19	7	0	0	0	0	26	39
Barley	100.00	0.00	10	6	0	0	0	0	16	9
Pirton	100.00	0.00	21	7	0	0	0	0	28	47
Swift	100.00	0.00	1	1	0	0	0	0	2	197
Day Surgery Centre, Lister	100.00	0.00	66	8	0	0	0	0	74	252
Day Surgery Treatment Centre	98.63	0.00	65	7	1	0	0	0	73	236
Endoscopy, Lister	100.00	0.00	159	8	0	0	0	0	167	686
Endoscopy, QEII	100.00	0.00	5	1	0	0	0	0	6	76
Cardiac Suite	100.00	0.00	30	2	0	0	0	0	32	81
MEDICINE/SURGERY TOTAL	97.07	1.07	**579**	**150**	**9**	**4**	**4**	**5**	**751**	**3492**
Bluebell ward	100.00	0.00	15	3	0	0	0	0	18	159
Bluebell day case	NP	NP	0	0	0	0	0	0	0	1
Neonatal Unit	100.00	0.00	25	6	0	0	0	0	31	86
WOMEN'S/CHILDREN TOTAL	100.00	0.00	**40**	**9**	**0**	**0**	**0**	**0**	**49**	**246**
MVCC 10 & 11	100.00	0.00	2	1	0	0	0	0	3	35
CANCER TOTAL	100.00	0.00	**2**	**1**	**0**	**0**	**0**	**0**	**3**	**35**
TOTAL TRUST	97.26	1.00	**621**	**160**	**9**	**4**	**4**	**5**	**803**	**3773**

Continued over .....

Inpatients/Day by site	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister	97.23	1.01	614	158	9	4	4	5	794	3662
QEII	100.00	0.00	5	1	0	0	0	0	6	76
Mount Vernon	100.00	0.00	2	1	0	0	0	0	3	35
TOTAL TRUST	**97.26**	**1.00**	**621**	**160**	**9**	**4**	**4**	**5**	**803**	**3773**

Accident & Emergency	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister A&E/Assessment	96.12	2.91	87	12	1	3	0	0	103	8372
QEII UCC	NP	NP	0	0	0	0	0	0	0	4194
A&E TOTAL	**96.12**	**2.91**	**87**	**12**	**1**	**3**	**0**	**0**	**103**	**12566**

Maternity	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. eligible to respond
Antenatal	100.00	0.00	1	2	0	0	0	0	3	459
Birth	92.59	3.70	19	6	1	0	1	0	27	405
Postnatal	95.65	0.00	15	7	1	0	0	0	23	405
Community Midwifery	66.67	33.33	2	0	0	0	1	0	3	512
MATERNITY TOTAL	**92.86**	**3.57**	**37**	**15**	**2**	**0**	**2**	**0**	**56**	**1781**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	95.17	4.14	99	39	0	4	2	1	145
QEII	98.57	0.00	64	5	1	0	0	0	70
Hertford County	100.00	0.00	21	4	0	0	0	0	25
Mount Vernon CC	92.16	4.90	69	25	3	4	1	0	102
Satellite Dialysis	97.40	0.00	63	12	2	0	0	0	77
OUTPATIENTS TOTAL	**95.70**	**2.63**	**316**	**85**	**6**	**8**	**3**	**1**	**419**

Trust Targets	% Would recommend
Inpatients/Day Case	96%>
A&E	90%>
Maternity (combined)	93%>
Outpatients	95%>
NP = Not provided	

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected eight of the core services provided by East and North Hertfordshire NHS Trust across Lister Hospital, the New Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led services are** in eight core service lines:

At **Lister Hospital** CQC inspected:

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatient

At the **New QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

At the **Mount Vernon Cancer Centre** CQC inspected:

- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

At the July 2019 inspection, these core services were rated either as requires improvement or good.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and effective and **requires improvement** for and safe, responsive and well led.

We were rated as **requires improvement** for use of resources

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔🡐 Dec 2019	Good 🡑 Dec 2019	Good ➔🡐 Dec 2019	Requires improvement ➔🡐 Dec 2019	Requires improvement ➔🡐 Dec 2019	Requires improvement ➔🡐 Dec 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement →← Dec 2019	Good →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

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 (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan has been developed against all of these and was submitted to CQC on 22 January 2020. 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	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Surgery	Inadequate December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Critical care	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
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 December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
End of life care	Good December 2019	Requires Improvement December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019

New QEII

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients and diagnostic imaging	Requires Improvement December 2019	N/A	Good December 2019	Requires Improvement December 2019	Good December 2019		Requires Improvement July 2018
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Outpatients	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016

Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Medical care (including older people's care)	Requires Improvement December 2019 →←	Good December 2019 →←	Good December 2019 →←	Requires Improvement December 2019 →←	Requires Improvement December 2019 →←		Requires Improvement December 2019 →←
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 December 2019 →←	N/A	Good December 2019 →←	Requires Improvement December 2019 →←	Requires Improvement December 2019 ↓		Requires Improvement December 2019 ↓
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 December 2019 →←	Good December 2019 →←	Good December 2019 →←	Good December 2019 →←	Good December 2019 →←		Good December 2019 →←
Overall	Requires Improvement December 2019 →←	Good December 2019 →←	Good December 2019 →←	Requires Improvement December 2019 →←	Requires Improvement December 2019 →←		Requires Improvement December 2019 →←

Community Health Services for Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-Led		Overall
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